Texas Medicaid

Provider Procedures Manual

November 2026

Volume 2

Provider Handbooks

Home Health Nursing and Private Duty Nursing Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

HOME HEALTH NURSING AND PRIVATE DUTY NURSING SERVICES HANDBOOK

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1 General Information

This handbook contains information about Texas Medicaid fee-for-service benefits. The information in this handbook is intended for home health nursing services. Nursing services include home health skilled nursing visits, home health aide services, and private duty nursing services. The Handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these therapies.

For information about managed care services, refer to the Medicaid Managed Care Handbook. Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in Section 8, "Carve-Out Services" in the Medicaid Managed Care Handbook (*Vol. 2, Provider Handbooks*).

Important: *All providers are required to read and comply with Section 1: Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information about enrollment procedures.

1.1 Client Eligibility for Home Health Nursing and Aide Services

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the client is eligible to receive. To verify client Medicaid eligibility and retroactive eligibility, the home health agency, durable medical equipment (DME), or medical supplier must verify eligibility by accessing the Medicaid Client Portal for Providers. Additionally, eligibility can be verified by calling the Automated Inquiry System (AIS) at 1-800-925-9126 or the Texas Medicaid & Healthcare Partnership (TMHP) Electronic Data Interchange (EDI) Help Desk at 1-888-863-3638.

Home health clients do not need to be homebound to qualify for services.

The Medicaid client must be eligible on the date of service (DOS) and must meet all of the following requirements to qualify for home health services:

- Have a medical need for home health professional services, DME, or medical supplies that is documented in the client's plan of care (POC) and considered a benefit under home health services
- Receive services that meet the client's existing medical needs and can be safely provided in the client's home
- Receive prior authorization from TMHP for most home health professional services, DME, or medical supplies

Refer to: Subsection A.12.3, "Automated Inquiry System (AIS)" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*).

Note: *Texas Health Steps (THSteps)-eligible clients who qualify for medically necessary services beyond the limits of this home health services benefit may receive those services through the Comprehensive Care Program (CCP).*

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1.1.1 Prior Authorization Requests for Clients with Retroactive Eligibility

Retroactive eligibility occurs when the effective date of a client's Medicaid coverage is before the date the client's Medicaid eligibility is added to TMHP's eligibility file, which is called the "add date."

For clients with retroactive eligibility, prior authorization requests must be submitted after the client's add date and before a claim is submitted to TMHP.

For services provided to fee-for-service Medicaid clients during the client's retroactive eligibility period, i.e., the period from the effective date to the add date, prior authorization must be obtained within 95 days from the client's add date and before a claim for those services is submitted to TMHP. For services provided on or after the client's add date, the provider must obtain prior authorization within three business days of the date of service.

The provider is responsible for verifying eligibility. The provider is strongly encouraged to access the Medicaid Client Portal for Providers, TexMedConnect, or AIS to verify eligibility frequently while providing services to the client. If services are discontinued before the client's add date, the provider must still obtain prior authorization within 95 days of the add date to be able to submit claims.

Refer to: "Section 4: Client Eligibility" (*Vol. 1, General Information*).

1.1.2 Client Evaluation

When a home health agency receives a referral to provide home health nursing and therapy services for a client who is eligible for Texas Medicaid, the agency-employed registered nurse (RN) must evaluate the client in the home before calling TMHP for prior authorization. A home evaluation by the agency-employed RN is required for SN, home health aide (HHA), occupational therapist (OT), physical therapist (PT), DME, or medical supplies requested on a home health services POC. It is expected that appropriate referrals will be made between home health agencies and DME suppliers for care. It is recommended that DME suppliers keep open communication with the client's physician to ensure the client's medical record is current.

This evaluation must include assessment of the following:

- Medical necessity for home health services, DME, or medical supplies requested.
- Client safety.
- Appropriateness of care in the home setting.
- Capable caregiver available if clients are unable to perform their own care or monitor their own medical condition.

Following the RN's assessment or evaluation of the client in the home setting for home health services needs, the agency-employed RN who completed the home evaluation must contact TMHP for prior authorization within three business days of the start of care (SOC).

1.2 Client Eligibility for PDN Services

PDN is considered medically necessary when a client has a disability, physical, or mental illness, or chronic condition and requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status.

To be eligible for PDN services, a client must meet all the following criteria:

- Be birth through 20 years of age and eligible for Medicaid and THSteps
- Meet medical necessity criteria for PDN
- Have a primary physician who must:
  - Provide a prescription for PDN.

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- Establish a POC.
- Provide documentation to support the medical necessity of PDN services.
- Provide continuing medical care and supervision of the client, including, but not limited to, examination or treatment within 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 months of the PDN extension SOC date, whichever is more frequent (for extensions of PDN services). This requirement may be waived based on review of the client's specific circumstances.

  Note: *The physician visit may be waived when a diagnosis has already been established by the physician, and the client is under the continuing care and medical supervision of the physician. A waiver is valid for no more than 365 days, and the client must be seen by his or her physician at least once every 365 days. The 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 client's medical record.*

- Provide specific written, dated orders for the client who is receiving continuing or ongoing PDN services.
- Require care beyond the level of services provided under Texas Medicaid (Title XIX) home health services.

Clients who are birth through 17 years of age must reside with a responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

PDN is based on the need for skilled care in the client's home; however, these services may follow the client and may be provided in accordance with 42 CFR §440.80. The POS must be able to support the client's health and safety needs. It must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and backup utilities, communication, fire, and safety systems must be available at all times.

The amount and duration of PDN must always be commensurate with the client's medical needs. Requests for services must reflect changes in the client's condition that affect the amount and duration of PDN.

2 Enrollment

Refer to: Subsection 1.7.16, "Private Duty Nursing (PDN) Providers" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for enrollment information.

3 Home Health Skilled Nursing and Home Health Aide Services

3.1 Services, Benefits, Limitations, and Prior Authorization

Home health skilled nursing (SN) and HHA visits are a benefit of Texas Medicaid Title XIX home health services when a client requires home 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. For clients who are 20 years of age or younger, SN and HHA visits are a benefit of Texas Medicaid Title XIX home health services when a client requires nursing services for an acute condition, a chronic condition, or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis. SN visits are

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intended to provide SN care to promote independence and support the client living at home. HHA visits are intended to provide personal care services under the supervision of an RN, PT, or OT employed by the home health agency to promote independence and support the client living at home.

The following codes are a benefit of Texas Medicaid:

Procedure Codes		
G0156	G0299	G0300

Title XIX home health services must be provided by a licensed and certified home health agency enrolled in Texas Medicaid.

When the client's needs are beyond the benefit of Title XIX home health services, additional benefits may be accessed through the following:

- Services for clients who are 20 years of age or younger may include, but are not limited to, private duty nursing (PDN) or personal care services (PCS).
- Services for clients who are 21 years of age or older may include, but are not limited to, long-term care assistance.

Refer to: Section 4, "Private Duty Nursing (PDN) Services - CCP" in this handbook for information about PDN services.

Subsection 2.12, "Personal Care Services (PCS) (CCP)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about PCS services.

3.1.1 Medical Necessity

SN and HHA visits are considered medically necessary for a client who:

- Requires skillful observations and judgement 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
- Requires general supervision of nursing care provided by an HHA over whom the RN is administratively or professionally responsible.

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

3.2 Skilled Nursing and Home Health Aide Services

All SN and HHA services must be prior authorized.

The following definitions apply to Title XIX Home Health SN and HHA visits:

- Acute is defined as a condition or exacerbation that is anticipated to improve and reach resolution within 60 days.
- Part-time is defined as SN or HHA visits provided less than eight hours per day for any number of days per week. Part-time visits may be continuous up to 7.5 hours per day (not to exceed a combined total of three 2.5 hour visits).

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- Intermittent is defined as SN or HHA visits provided for less than eight hours per visit and less frequently than daily. Intermittent visits may be delivered in interval visits up to 2.5 hours per visit, not to exceed a combined total of three visits per day.

SN visits are nursing services ordered by a physician or an allowed practitioner, 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). 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 and typically has an end-point. SN visits may be provided on consecutive days.

Note: *An allowed practitioner is an individual licensed in Texas as a physician assistant (PA), a certified nurse practitioner (CNP), or a clinical nurse specialist (CNS).*

HHA visits are services ordered by the physician or allowed practitioner, included in the nursing Texas Medicaid home health services POC, and are services the HHA is permitted to perform under State law. HHA visits may be considered when a client requires services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis and typically has an end-point. HHA visits will not be considered unless the client also requires SN or therapy services. HHA visits may be provided on consecutive days.

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about home health PT, OT, and ST services.

3.2.1 Skilled Nursing Visits

SN visits are limited to SN procedures performed by an RN or LVN licensed to perform these services under the Texas Nursing Practice Act and include the following:

- Direct SN care, and parent, guardian, or caregiver training and education
- SN observation, assessment, and evaluation by an RN, provided a physician or an allowed practitioner specifically requests that a nurse visit the client for this purpose, and the physician or allowed practitioner's order reflects the medical necessity for the visit
- Supervision of delegated services provided by an HHA or others over whom the RN is administratively or professionally responsible

SN care consists of those services that must, under State law, be performed by an RN or LVN, and meet the criteria for SN services specified in the Code of Federal Regulations (42 CFR §§ 409.32, 409.33, and 409.44):

- 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 client, and the accepted standards of medical and nursing practice.
- The fact that the SN service 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.
- 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 SN service.
- 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 service cannot be regarded as a SN service.
- Some services are classified as SN services on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if reasonable and necessary to the treatment of the client's illness or injury, would be a benefit on that basis. However, in some cases, the client's

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condition may cause a service that would ordinarily be considered unskilled to be considered an SN service. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.

- A service, which, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other caregivers. Where the client needs the SN care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary to the treatment of the illness or injury.
- The SN services must be reasonable and necessary to the diagnosis and treatment of the client's illness or injury within the context of the client's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the client's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the client's particular medical needs, and within accepted standards of medical and nursing practice. A client's overall medical condition is a valid factor in deciding whether skilled services are needed. A client's diagnosis should never be the sole factor in deciding whether the service the client needs is either skilled or not skilled.
- The determination of whether the services are reasonable and necessary should be made in consideration of the physician or allowed practitioner's determination that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the client when the services were ordered, and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.
- The SN care must be provided on a part-time or intermittent basis.

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician or an allowed practitioner, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teachings of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician or an allowed practitioner.
- Development of the nursing care plan.

Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.

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- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

3.2.2 Home Health Aide Visits

HHA visits are intended to provide hands-on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self-administered.

Any HHA services offered by a home health agency must be provided by a qualified HHA under the supervision of a qualified licensed individual (e.g., RN, PT, or OT) employed by the home health agency.

The duties of an HHA during a visit include, but are not limited to:

- Obtaining and recording the client's vital signs (temperature, pulse, respirations, blood pressure)
- Observation, reporting and documentation of the client's status, and the care or service furnished
- Personal care (hygiene and grooming) including, but not limited to:
  - Sponge, tub, or shower bath
  - Shampoo, sink, tub or bed bath
  - Nail and skin care
  - Oral hygiene
- Toileting and elimination care
- Ambulation
- Exercise
- Range of motion
- Safe transfer
- Positioning
- Assisting with nutrition and fluid intake
- Household services essential to the client's health care at home
- Assistance with medications that are ordinarily self-administered
- Reporting changes in the client's condition and needs
- Completing appropriate documentation

3.2.2.1 Supervision of Home Health Aides

Supervision, as defined by the Texas Nursing Practice Act, is the process of directing, guiding, and influencing the outcome of an individual's performance of an activity.

An RN or therapist (PT or OT) must provide the HHA written instructions for all the tasks delegated to the HHA. A therapist may prepare the written instructions if the client is receiving only HHA visits, which do not include delegated SN tasks, in addition to the therapy services.

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The requirements for HHA supervision are as follows:

- When only HHA visits are provided, an RN must make a supervisory visit to the client's residence at least once every 60 days. The supervisory visit must occur when the HHA is providing care to the client.
- When SN, PT, or OT visits are provided in addition to an HHA visit, an RN must make a supervisory visit to the client's residence at least every two weeks. The supervisory visit must occur when the HHA is providing care to the client.
- When only PT or OT visits are provided in addition to HHA visits, the appropriate therapist may make the supervisory visit in place of an RN. The supervisory visit must occur when the HHA is providing care to the client.
- Documentation of HHA supervision must be maintained in the client's medical record.

3.3 Home Health Skilled Nursing and Home Health Aide Services Providers

Providers must be a licensed and certified home health agency enrolled in Texas Medicaid and must comply with all applicable federal, state, and local laws and regulations, and Texas Medicaid's policies and procedures.

All providers must maintain written policies and procedures for:

- Obtaining consent for medical treatment for clients in the absence of the primary caregiver that meets the standards of the Texas Family Code, Chapter 32.
- Obtaining physician or allowed practitioner's signatures for all telephone orders within 14 calendar days of receipt of the order.

Providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service. The essential elements of safe and effective home health SN and HHA services include a trained parent, guardian, or caregiver, a primary physician or an allowed practitioner, competent providers, and an environment that supports the client's health and safety needs.

- The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client.
- Necessary primary and back-up utility, communication, and fire safety systems must be available.

A parent or guardian, primary caregiver, or alternate care giver may not provide SN or HHA services even if he or she is an enrolled provider or employed by an enrolled provider.

3.4 Authorization Requirements

Home Health SN and HHA visits require prior authorization.

Prior authorization of SN or HHA visits requires that a client's primary physician or an allowed practitioner:

- Provides an order for SN or HHA visits or recertification, identifying that the prescribed SN or HHA visits are medically necessary as defined in the Statement of Benefits
- The physician or allowed practitioner's documentation in the client's medical record must support the prescribed SN or HHA visits are medically necessary as defined in the Statement of Benefits
- The physician or allowed practitioner's documentation in the client's medical record must support that the client's medical condition is sufficiently stable to permit safe delivery of SN or HHA visits as described in the home health services POC

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- Establishes a medical POC, which is maintained in the client's medical record
- Provides continuing care and medical supervision
- Provides specific written, dated orders for clients receiving SN or HHA visits
- Reviews and approves the home health services POC at least every 60 days, or more frequently as the physician or allowed practitioner determines necessary, including but not limited to when the client's condition changes

SN visits requested primarily to provide the following will not be prior authorized:

- Respite care
- Child care
- Activities of daily living for the client
- Housekeeping services
- Routine post-operative disease, treatment, or medication teaching after a physician or an allowed practitioner visit
- Routine disease, treatment, or medication teaching after a physician or an allowed practitioner visit
- Individualized, comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act

Note: *Clients who are 20 years of age or younger may be eligible for private duty nursing services and personal care services through Texas Medicaid Private Duty Nursing Services and Personal Care Services Policies.*

HHA visits requested for the following will not be prior authorized when:

- Primarily requested to perform housekeeping services
- Provided to a client residing in a hospital, SN facility, or intermediate care facility

Note: *Clients who are 20 years of age or younger may be eligible for private duty nursing services and personal care services through Private Duty Nursing (PDN) Services - THSteps-CCP or Personal Care Services (PCS) - THSteps-CCP).*

Certain facilities are required by licensure to meet all the medical needs of the client. SN or HHA visits will not be authorized for clients receiving care in any of the following facilities:

- Hospitals
- SN facilities
- Intermediate care facilities for the individuals with intellectual disability (ICF-IID)
- Special care facilities, including but not limited to, sub-acute units or facilities for the treatment of acquired immune deficiency syndrome (AIDS)
- Prescribed pediatric extended care centers, unless the SN and/or HHA services are provided before or after PPECC services, when rendered on the same day.

When a client, client's responsible adult, client's physician or an allowed practitioner notifies the SN and/or HHA service provider that the client also receives services from a PPECC, the SN and/or HHA service provider must coordinate services with the PPECC provider to prevent duplication of services.

Note: *It is anticipated that the provision of SN and/or HHA services, in addition to PPECC would be uncommon.*

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3.4.1 Initial Assessment and Reassessments

When a provider has received a referral and has physician or allowed practitioner's orders for SN or HHA services, the provider must have an RN perform an initial client assessment in the client's home.

A client can be referred to a home health agency for SN or HHA services by:

- The client
- The client's physician or allowed practitioner
- The client's family

The client assessment or reassessment should include, but is not limited to, the following:

- A nursing assessment of medical necessity for the requested visits, which includes:
  - Complexity and intensity of the client's care
  - Stability and predictability of the client's condition
  - Frequency of the client's need for SN care
  - Identified medical needs and goals
  - Description of wounds, if present
  - Cardiac status
- Whether the setting can support the health and safety needs of the client and is adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client.
- Comprehension level of parent, guardian, caregiver, or client.
- Receptivity to training and ability level of the parent, guardian, caregiver, or client.

The initial assessment and any reassessments performed by an RN are required when changes in the client's condition occur during the course of the authorization period. If there is no change in the client's condition, the reassessment must document medical necessity, as defined in the Statement of Benefits, to support continued and ongoing SN or HHA visits beyond the initial 60 day authorization period.

A reassessment is required when the SN and/or HHA provider is notified by the client, client's responsible adult, the client's physician or allowed practitioner that PPECC services have been initiated.

3.4.2 Home Health Services Plan of Care Requirements

The initial assessment or reassessments are used to establish and revise the home health services POC and must support the client's medical necessity for SN services, HHA services, PT services, and OT services.

> ***Note:*** *Providers must use the Texas Medicaid home health services POC located on the TMHP Prior Authorization Texas Medicaid Forms web page; the Centers of Medicare and Medicaid (CMS) Form 485 will not be accepted.*

The POC must be initiated and written in a clear and legible format by the RN and include the following:

- The client's Medicaid number, the physician or allowed practitioner's license number, and the provider's Medicaid number
- Date the client was last seen by the physician or allowed practitioner
- The start of care (SOC) date for home health services
- All pertinent diagnoses
- The client's mental status

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- The prognosis
- The types of service requested, including the number of visits and 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
- Available caregiver
- List all community or state agency services the client receives in the home including, but not limited to, primary home care (PHC), community based alternative (CBA), medically dependent children's program (MDCP)
- Instructions for timely discharge or referral
- Documentation of coordination with PPECC, when a client receives ongoing skilled nursing in a PPECC setting. When a client receives PPECC, the SN and/or HHA provider must provide a medical rationale to support the need for SN and/or HHA services, when PPECC services are provided on the same day.

The POC must be accompanied by the physician or allowed practitioner's signed and dated orders, or must be signed and dated by the physician or allowed practitioner. The POC must include the SOC date (when the services will begin) and must be signed and dated by the assessing RN.

When a provider has received signed physician or allowed practitioner's orders for SN or HHA visits, the POC does not require a physician or an allowed practitioner's signature before the provider contacts the claims administrator for prior authorization of services. The POC must be signed and dated by a physician or an allowed practitioner familiar with the client prior to submitting a claim for services, and no later than 30 days from the SOC date.

The type and frequency of visits, supplies, or DME must appear in the POC before the physician or allowed practitioner signs the POC and may not be added after the physician or allowed practitioner has signed the POC. If any change in the POC occurs during a prior authorization period (additional visits, supplies, or DME), the provider must update the POC, have the physician or allowed practitioner sign the updated POC, and contact the claims administrator for prior authorization.

Note: *Verbal physician or allowed practitioner orders may only be given to people authorized to receive them under state and federal law. They must be reduced to writing, signed and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service. The physician or allowed practitioner must sign the written copy of the verbal order within two weeks, or per agency policy if less than two weeks. A copy of the written verbal order must be maintained in the client's medical record prior to and after being signed by the physician or allowed practitioner.*

Note: *All documentation, including all written and verbal orders, and all physician- or allowed practitioner-signed POCs, must be maintained by the physician or allowed practitioner, and the home health agency must keep the original, signed copy of the POC in the client's medical record.*

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The client must be seen by a physician or allowed practitioner within 30 days of the initial SOC, and at least once every six months thereafter unless the client's condition changes.

A revised POC is required for every request for any change in SN or HHA visits. The revised POC must include all continuing and new orders. The revised POC must be updated to document any changes in the client's condition or diagnosis.

A new POC is required with every request for recertification. The new POC must include all continuing and new orders. The new POC must document all changes in the client's condition or diagnosis and reflect the need for continued SN or HHA services in relation to the original need for care. The physician or allowed practitioner must certify he or she has provided continuing care and medical supervision including, but not limited to, examination or treatment of the client within six months or when the client's condition has changed.

3.4.2.1 Written Plan of Care (POC)

A home health services POC is required for SN, HHA, OT, or PT services. The POC is not required as an attachment with the claim, but a signed and dated POC must be maintained by the provider and primary physician in the client's medical record. The client's primary physician must recommend, sign, and date a POC. The POC must be initiated by the RN in a clear and legible format.

Refer to: Subsection 4.6, "Frequency and Duration Criteria for PT, OT, and ST Services" in the *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about PT, OT, and ST services.

Services billed in excess of those authorized for the prior authorization week or month are subject to recoupment.

For the home health services POC to be valid, the primary physician must sign and date it, and indicate when the services will begin. The home health agency must update and maintain the POC at least every 60 days or as necessitated by a change in the client's condition.

3.4.2.2 DME and Medical Supplies Submitted with a Plan of Care (POC)

The cost of incidental medical supplies used during an SN or HHA visit are included in the rate for G0299 and G0300. Medical supplies left at the home for the client to use must be billed with the National Provider Identifier (NPI) enrolled as a DME supplier after prior authorization has been granted by the TMHP Home Health Services Prior Authorization Department.

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for information about DME and medical supplies prior authorization.

When the home health services POC is used to submit a prior authorization for DME or medical supplies that will be used in conjunction with the professional services provided by the agency, such as SN, HHA, OT, or PT, the home health agency's DME NPI must be submitted on the POC, and all of the requested DME and medical supplies must be listed in the "Supplies" section of the POC.

The POC does not require a physician's signature before prior authorization of professional services, DME, or medical supplies is requested but does require the assessing RNs dated signature. The POC must be signed and dated by a primary physician familiar with the client prior to submitting a claim for services and no later than 30 days from the SOC date.

If the home health agency uses the Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form, the agency must complete Section A. A primary physician familiar with the client must complete, sign, and date Section B prior to submission to TMHP for prior authorization of the requested DME or medical supplies.

The following information is required to consider these medical supplies for prior authorization:

- Item description

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- Procedure code
- Quantity of each medical supply requested
- Manufacturer's suggested retail price (MSRP) for items that do not have a maximum fee assigned

Refer to: Subsection 2.2, "Services, Benefits, Limitations and Prior Authorization" in the *Durable Medical Equipment, Medical Supplies, and Nutritional Products Handbook* (*Vol. 2, Provider Handbooks*) for information about DME and medical supplies prior authorization.

3.4.3 Prior Authorization of SN and HHA Services

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

Home Health SN and HHA services require prior authorization. Providers must obtain authorization within three business days of the SOC date for an initial authorization. For recertifications, providers must obtain authorization within seven business days of the new SOC date. During the authorization process, providers are required to deliver the requested services from the SOC date, which is the date agreed to by the physician or allowed practitioner, the RN, the Home Health Agency, and the client, parent, guardian, or caregiver. The SOC must be documented on the POC.

A provider requesting prior authorization for SN or HHA Services must submit the following documentation:

- A completed client assessment
- A completed Texas Medicaid home health services POC that must:
  - Be signed and dated by the assessing RN
  - Signed and dated by the physician or allowed practitioner or submitted with the signed and dated physician or allowed practitioner's orders.

Note: *To complete the prior authorization process by paper, the SN or HHA provider must fax or mail the completed documentation to the Home Health prior authorization unit and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.*

Note: *To complete the prior authorization process electronically, the SN or HHA provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.*

Note: *All documentation, including all written and verbal orders, and all physician- or allowed practitioner-signed POCs, must be maintained by the ordering physician or allowed practitioner, and the home health agency must keep the original, signed copy of the POC in the client's medical record.*

Requests must be based on the medical needs of the client. Documentation must support the quantity and frequency of intermittent or part-time SN or HHA visits that will safely meet the client's needs. The amount and duration of SN or HHA visits requested will be evaluated by the claims administrator.

The home health agency must ensure the requested services are supported by the client assessment, POC, and the physician or allowed practitioner's orders.

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The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician or allowed practitioner, home health agency, RN, and client, parent, guardian, or caregiver. SN and HHA visits will be prior authorized for no more than 60 days at a time. As a client's problems are resolved and goals are met, a client's condition is expected to become more stable, and the client's needs for SN and HHA services may decrease.

3.4.3.1 Routine Laboratory Specimens

SN visits to obtain routine laboratory specimens may be considered when the only alternative to obtain the specimen is to transport the client by ambulance.

3.4.3.2 Home Phototherapy

SN visits to address hyperbilirubinemia will not be considered for prior authorization if the client has an open authorization for home phototherapy. Home phototherapy is reimbursed as a daily global fee and includes coverage of SN visits for client, parent, or caregiver teaching and monitoring, and customary and routine laboratory work.

3.4.3.3 Prothrombin Time/Internationalized Normalized Ration (TP/INR) Home Testing Device

SN visits will not be authorized for the set-up or teaching of the Prothrombin Time/Internationalized Normalized Ration (TP/INR) home testing device.

3.4.3.4 Total Parenteral Nutrition (TPN)

SN visits to address total parenteral nutrition (TPN) must:

- Be provided by an RN appropriately trained in the administration of TPN.
- Include education of the client or caregiver regarding the in-home administration of TPN before administration initially begins.
- Include the use and maintenance of required supplies and equipment.
- Occur at least once every month to monitor the client's status and to provide ongoing education to the client or caregivers regarding the administration of TPN.

For clients receiving PDN who also require TPN administration education, intermittent SN visits may be considered for separate prior authorization when:

- The PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation to support the medical need for an additional skilled nurse to perform TPN.

The SN services may be prior authorized only for the client or caregiver training in TPN administration.

3.4.3.5 Instruction in the Self-administration of Prescribed Injections

For clients receiving SN visits, instruction to the client or caregiver in the self- administration of prescribed injections (IM, SQ, or IV), including but not limited to Factor 8 and IVIg are considered part of the existing authorized skilled nursing home visits. Additional nursing visits for teaching and (initial) supervision to the client or caregiver will not be allowed.

Instruction and initial supervision must be provided by an RN appropriately trained in the administration of the drug or product being administered, and the client and caregiver must be involved in the decision to self-administer the medication.

The client or caregiver administering the injectable medication (IM, SQ, or IV), including but not limited to Factor 8 product or IVIg, must:

- Be medically stable.

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- Have a history of compliance with other medications.
- Have a simple drug regimen.
- Have the ability to read and understand directions on the medication label.
- Demonstrate knowledge of the administration technique, maintenance of the required supplies and equipment, and storage requirements.

SN visits will not be approved for the sole purpose of instructing the client on the use of the subcutaneous injection port device. Any necessary instruction must be performed as part of the office visit with the prescribing physician or allowed practitioner.

3.4.3.6 Prior Authorization Status and Limitations

The claims administrator will notify the provider of the authorization or other action taken on the request for services.

Up to a maximum combined total of three SN and HHA visits may be prior authorized per day. One visit may last up to a maximum of 2.5 hours. SN or HHA visits may be provided on consecutive days.

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

A nurse or HHA may be authorized to provide services to more than one client over the span of the day as long as:

- Each client's care is based on an individualized POC; and
- Each client's needs and POC do not overlap with another client's needs and POC.

Settings in which a nurse or HHA provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving home health services, foster homes, and independent living arrangements.

A prior authorization for SN or HHA visits is no longer valid when:

- The client is no longer eligible for Medicaid;
- The client no longer meets the medical necessity criteria for SN or HHA services;
- The place of service cannot provide for the health and safety of the client;
- The client, parent, guardian, or caregiver refuses to comply with the attending physician or allowed practitioner's plan of treatment and compliance is necessary to assure the health and safety of the client; or
- The client changes providers and the change of notification is submitted to the claims administrator in writing with a prior authorization request from the new provider.

3.4.3.7 Canceling a Prior Authorization

The client has the right to choose their home health agency provider and to change providers. If the client changes providers, TMHP must receive a change of provider letter with a new POC or Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form. The client 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 client is responsible for notifying the original provider of the change and the effective date. Prior authorization for the new provider can only be issued up to three business days before the date TMHP receives the change of provider letter and the new Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.

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3.4.4 Medicare and Medicaid Prior Authorization

Qualified Medicare Beneficiaries (QMB) are not eligible for Medicaid benefits. Providers should not submit prior authorization requests to the TMHP Home Health Services Prior Authorization Department for these clients.

For eligible Medicare and Medicaid clients, Medicare is the primary insurance and providers must contact Medicare first for prior authorization and reimbursement. Home health service prior authorizations may be given for HHA services, certain medical supplies, or DME suitable for use in the home in one of the following instances:

- When an eligible Medicaid client (enrolled in Medicare) does not qualify for home health services under Medicare because SN care, OT, or PT are not a part of the client's care.
- When the medical supplies and DME are not a benefit of Medicare Part B and are a home health services benefit.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's third party resources or other insurance.

Note: *If the client has Medicare Part B coverage, contact Medicare for prior authorization requirements and reimbursement. If the service is a Part B benefit, do not contact TMHP for prior authorization.*

To ensure that Medicare benefits are used first in accordance with Texas Medicaid regulations, the following procedures apply when requesting Medicaid prior authorization and payment of home health services for clients:

- Contact TMHP for prior authorization of Medicaid services (based on medical necessity and home health services benefits) within 30 days of the date on the MRAN. Fax a copy of the original MRAN and the Medicare appeal review letter to the TMHP Home Health Services Prior Authorization Department for prior authorization.
- An MRAN is not required when a client is eligible for Medicare or Medicaid and needs HHA visits only. However, a skilled supervisory nursing visit must be made on the same day as the initial HHA visit and at least every 60 days (on the same day an HHA visit is made) thereafter as long as no skilled need exists. An SN supervisory visit is reimbursable, but an SN visit made for the primary purpose of assessing a client's nursing care is not. The SOC date will be the date of the first requested Medicare home health services visit as listed on the original MRAN.

  Note: *Claims for State of Texas Access Reform (STAR)+PLUS MQMB clients (those with Medicare and Medicaid) should always be submitted to TMHP as noted on these pages. The STAR+PLUS health plan is not responsible for these services if Medicare denies the service as not a benefit.*

For Medicaid qualified Medicare beneficiary (MQMB) clients, do not submit prior authorization requests to TMHP if the Medicare denial reason states "not medically necessary."

Medicaid will only consider prior authorization requests if the Medicare denial states "not a benefit" of Medicare.

When the client is 65 years of age or older or appears otherwise eligible for Medicare (e.g., a person who is blind or disabled), but has no Part A or Part B Medicare, the TMHP Home Health Services Prior Authorization Department uses regular prior authorization procedures. In this situation, the claim is held for a midyear status determined by HHSC. The maximum length of time a claim may be held in a "pending status" for Medicare determination is 90 days. After the waiting period, the claim is paid or denied. If denied, the EOB code on the R&S report indicates that Medicare is to be billed.

Refer to: Subsection 3.2.1, "Skilled Nursing Visits" in this handbook.

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Home health providers should follow these guidelines:

- Clients who are 64 years of age and younger without Medicare Part A or B:
- If the agency erroneously submits an SOC notice to Medicare and does not contact TMHP for prior authorization, TMHP does not assume responsibility for any services provided before contacting TMHP. The SOC date is no more than three business days before the date the agency contacts TMHP. Visits made before this date are not considered a benefit of Texas Medicaid.
- Clients who are 65 years of age and older without Medicare Part A or Part B and clients with Medicare Part A or B regardless of age:
- In filing home health claims, home health providers may be required to obtain Medicare denials before TMHP can approve coverage. When TMHP receives a Medicare denial, the SOC is determined by the date the agency requested coverage from Medicare. If necessary, the 95-day claims filing deadline is waived for these claims, provided TMHP receives notice of the Medicare denial within 30 days of the date on the MRAN containing Medicare's final disposition.
- If the agency receives the MRAN and continues to visit the client without contacting TMHP by telephone, mail, or fax within 30 days of the date on the MRAN, TMHP will provide coverage only for services provided from the initial date of contact with TMHP. The SOC date is determined accordingly. TMHP must have the MRAN before considering the request for prior authorization.

TMHP will not prior authorize or reimburse the difference between the Medicare payment and the retail price for Medicare Part B eligible clients.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

3.5 Home Health SN and HHA Procedure Billing and Limitations

Home Health SN or HHA visits provided by home health agencies enrolled in Texas Medicaid must be billed using procedure codes G0299 (SN), G0300 (SN), and G0156 (HHA) and will be reimbursed per visit of up to 2.5 hours; not to exceed a combined total of three visits per day (7.5 hours total).

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021.

When services are provided to more than one client in the same setting, only the units directly provided to each client at distinct, separate time periods will be reimbursed. Provider documentation must support the services were delivered at distinct, separate time periods. Total home health services billed for all clients cannot exceed the individual provider's total number of hours spent at the place of service.

One as needed (PRN) SN visit may be reimbursed every 30 days outside of the prior authorized visits when SN visits have been authorized for the particular client.

For reimbursement purposes, Home Health SN or HHA services are always billed as place of service 2 (home) regardless of the setting in which the services are actually provided. SN or HHA services provided in the day care or school setting will not be reimbursed.

For all clients, SN visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes
- Independent living arrangements

For all clients, HHA visits may be provided in the following locations:

- Home of the client, parent, guardian, or caregiver
- Foster homes

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- Independent living arrangements

An immediate relative, parent or guardian, primary caregiver, or alternate care giver may not be reimbursed for HHA services even if he or she is an enrolled provider or employed by an enrolled provider.

SN and/or HHA services may be billed on the same day as PPECC services, but they may not be billed simultaneously with PPECC services. SN and/or HHA services may be billed before or after PPECC services.

Note: *SN and/or HHA services are subject to retrospective review and possible recoupment when the medical record does not document the provision of SN and/or HHA services are medically necessary based on the client's situation and needs. The service provider's record must explain all discrepancies between the service hours approved and the service hours provided. For example: the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.*

3.5.1 Skilled Nursing Visit for TPN Education

The nurse providing the intermittent SN visit for TPN services will only be reimbursed for time spent delivering client or family instruction and for direct client TPN services. The services delivered must be documented in the client's record.

PDN and SN should not be routinely performed on the same date during the same time period.

PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided, including but not limited to:

- The start and stop time of each nursing provider's specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

A skilled nursing visit for TPN education is not allowable in a PPECC setting.

3.5.2 Medication Administration Limitations

Nursing visits for the purpose of administering medications are not a benefit if one of the following conditions exists:

- The medication is not considered medically necessary to the treatment of the individual's illness or is not approved by the Food and Drug Administration (FDA) or is being used for indications not approved by the FDA.
- The administration of medication exceeds the therapeutic frequency or duration by accepted standards of medical practice.
- A medical reason does not prohibit the administration of the medication by mouth.
- The client, a primary caregiver, a family member, or neighbor have been taught or can be taught to administer subcutaneous (SQ/SC), intramuscular (IM), and intravenous (IV) injections and has demonstrated competency.
- The medication is a chemotherapeutic agent or blood product SQ/SC, IM, and IV injections.

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4 Private Duty Nursing (PDN) Services - CCP

4.1 Services, Benefits, Limitations, and Prior Authorization

PDN services are a benefit of the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) for Medicaid clients who are 20 years of age or younger. PDN services are 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 the level of SN visits normally authorized under Texas Medicaid Home Health SN and Home Health Aide (HHA) Services. PDN services may be provided by a registered nurse (RN) or a licensed vocational nurse (LVN).

Note: *Texas defines a licensed practical nurse (LPN) as a licensed vocational nurse (LVN).*

Procedure code T1000 is a benefit of Texas Medicaid when PDN services are provided by a home health agency or an independently enrolled RN/LVN.

Providers must submit the appropriate modifier(s) from the table below for reimbursement purposes. Independently enrolled RNs or LVNs must include modifier U3 along with TD or TE for reimbursement purposes. Specialized care (procedure code T1000 with UA modifier) requires prior authorization.

Texas Medicaid allows additional reimbursement for specialized care associated with clients who are dependent on invasive ventilator life support or clients with a functioning tracheostomy. A client who is ventilator dependent means that the client requires an invasive ventilator to help them breathe and they cannot breathe on their own without assistance. Invasive mechanical ventilation is defined as the delivery of positive pressure to the lungs via an endotracheal or tracheostomy tube.

To receive additional reimbursement for specialized care, the PDN provider must include procedure code T1000 with modifier UA on the prior authorization request for PDN services.

Specialized care must meet all prior authorization requirements listed in the UA Modifier Requirements section to be approved.

Modifiers	
TD	Registered nurse (RN)
TE	Licensed vocational nurse (LVN)
U3	Independently enrolled provider
UA	Specialized services for clients with an invasive ventilator or functional tracheostomy

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 requires specialized services for invasive ventilator management.*

Because of the nature of the service being provided, some billing situations are unique to PDN. These billing requirements are as follows:

- All hours worked on one day must be billed together, on one detail.
- Nurse A works 7 a.m. to 11 a.m. and then returns and works 7 p.m. to 11 p.m. Services must be billed for eight hours (32 units of 15 minutes each) on one detail for that date of service.
- Nurse B works 7 p.m. to 7 a.m. Services must be billed on two separate details since the shift begins and ends on two different calendar days. The first detail should include 7 p.m. to 11:59 p.m. (20 units of 15 minutes each) and the second detail should include 12 a.m. to 7 a.m. (28 units of 15 minutes each).

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- An individually-enrolled nurse will not be reimbursed for more than 16 hours of PDN services in one day.

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

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

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

Example: *If the prior authorized PDN hours for Client A is four hours, Client B is six hours, and the actual time spent with both clients is eight hours, the provider must bill for the actual one-on-one time spent with each client, not to exceed the client's prior authorized hours or total hours worked. It would be acceptable to bill four hours for Client A and four hours for Client B, or three hours for Client A and five hours for Client B. It would not be acceptable to bill five hours for Client A and three hours for Client B. It would be acceptable to bill ten hours if the nurse actually spent ten hours onsite providing prior authorized PDN services split as four hours for Client A and six hours for Client B. A total of ten hours cannot be billed if the nurse worked only eight hours.*

For reimbursement purposes, PDN services must always be submitted with place of service "home" regardless of the setting in which services are actually provided. PDN services may be provided in the following settings, but are not limited to the:

- Client's home.
- Nurse provider's home.
- Client's school.
- Client's daycare facility.

A parent or guardian of a minor client, or the client's spouse may not be reimbursed for PDN services even if he or she is an enrolled provider or an owner of a home health agency.

PDN services are subject to retrospective review and possible recoupment when the medical record does not document the provision of PDN services are medically necessary based on the client's situation and needs. The PDN services provider's record must explain all discrepancies between the service hours approved and the service hours provided. For example: the parents released the provider from all responsibility for the service hours or the agency was not able to staff the service hours. The release of provider responsibility does not indicate the client does not have a medical need for the services during those time periods.

4.1.1 Medical Necessity

Texas Medicaid defines medically necessary EPSDT services as health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability, physical or mental illness, or chronic conditions.

Medicaid clients who are 20 years of age or younger, and who are eligible for THSteps, are entitled to all medically necessary PDN services to promote independence and support the client living at home.

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PDN services are considered medically necessary when a client 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.

The following elements should always be addressed in documentation submitted with a request for PDN services:

- 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.

4.1.2 PDN Services

All PDN services must be prior authorized.

PDN 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.

PDN services are nursing services ordered by a physician, included in the nursing plan of care (POC), and provided by an RN or LVN.

> ***Note:*** *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA. The APRN or PA provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.*

Professional nursing provided by an RN, as defined in the Texas Nursing Practice Act, means that the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves:

- The observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes.
- The maintenance of health or prevention of illness.
- The administration of a medication or treatment as ordered by a physician, podiatrist, or dentist.
- The supervision of delegated nursing tasks or teaching of nursing.
- The administration, supervision, and evaluation of nursing practices, policies, and procedures.
- The performance of an act delegated by a physician.
- Development of the nursing care plan.

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Vocational nursing, as defined in the Texas Nursing Practice Act, means a directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures. Vocational nursing involves:

- Collecting data and performing focused nursing assessments of the health status of an individual.
- Participating in the planning of the nursing care needs of an individual.
- Participating in the development and modification of the nursing care plan.
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual.
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs.
- Engaging in other acts that require education and training, as prescribed by board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency.

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).

- 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.
- 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.
- 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.
- 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.
- Some services are classified as a nursing care on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters), and if medically necessary for the treatment of the client's illness or injury, would be covered on that basis. However, in some cases, the client's condition may cause a service that would ordinarily be considered unskilled to be considered nursing care. This would occur when the client's condition is such that the service can be safely and effectively provided only by a nurse.
- A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the client, the client's family, or other responsible adults.

Because Texas Medicaid is obligated to provide all medically necessary PDN services, a parent or guardian is not obligated to provide PDN services even if the parent or guardian has received the appropriate training. Medically necessary PDN services will not be denied to clients based on the parent or guardian's ability to provide the necessary PDN services.

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.

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.

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4.1.3 PDN Providers

PDN services must be provided by a licensed home health services agency or a licensed and certified home health services agency enrolled in Texas Medicaid or by an RN or LVN enrolled independently with Texas Medicaid. PDN providers must comply with all applicable federal, state, and local laws and regulations and Texas Medicaid policies and procedures.

All providers must maintain written policies and procedures for:

- Obtaining consent for medical treatment for clients in the absence of the parent or guardian that meet the standards of the Texas Family Code, Chapter 32.
- Obtaining physician signatures for all telephone orders within 14 calendar days of receipt of the order.

PDN providers must only accept clients on the basis of a reasonable expectation that the client's needs can be adequately met in the place of service. The essential elements of safe and effective PDN services include a responsible adult when the client is a minor child, a contingency plan, a primary physician, competent providers, and an environment that supports the client's health and safety needs.

The place of service must be able to support the health and safety needs of the client and must be adequate to accommodate the use, maintenance, and cleaning of all medical devices, equipment, and supplies required by the client. Necessary primary and back-up utilities, communications and fire safety systems must be available.

Clients who are 17 years of age or younger must reside with an identified responsible adult who is either trained to provide nursing care or is capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

An identified responsible adult is an individual 18 years of age or older who has agreed to accept the responsibility for a client's provision of food, shelter, clothing, education, nurturing, and supervision. Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, individuals court-appointed as managing conservators, and other family members by birth or marriage.

An identified contingency plan is a structured process, designed by the responsible adult and the PDN provider, by which a client will receive care when a scheduled private duty nurse is unexpectedly unavailable, and the responsible adult is unavailable, or is not trained, to provide the nursing care. The identified responsible adult must be able to initiate the contingency plan.

The responsible adult's signature must be on the form acknowledging:

- Information about PDN has been discussed and received.
- PDN may change or end based on a client's need for nursing care.
- PDN is not authorized for the primary purpose of providing respite, childcare, ADLs, or housekeeping.
- All requirements have been met before seeking prior authorization for PDN.
- The responsible adult has participated in the development of the POC and the nursing care plan for the client.
- Emergency plans have been made and are part of the client's care plan.
- The client or responsible adult agrees to follow the physician's POC.

Note: *A responsible adult of a minor client or a client's spouse may not be reimbursed for PDN even if the responsible adult is an enrolled provider or employed by an enrolled provider.*

PDN services may be delivered in a provider or client ratio other than 1:1.

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4.1.4 Authorization Requirements

PDN services require prior authorization.

Specialized care under the UA modifier requires prior authorization.

All requests for PDN services must be based on the current medical needs of the client.

PDN services will not be prior authorized when:

- The client does not meet medical necessity criteria as defined in the Statement of Benefits.
- The client does not have a primary physician;
- The client is not 20 years of age or younger;
- When the client's needs are not beyond the scope of services available through Medicaid Title XIX Home Health SN or HHA Services because the needs can be met on a part-time or intermittent basis.

Requests for PDN must be based on the current medical needs of the client.

The following criteria are considered for PDN prior authorization:

- The documentation submitted with the request is complete.
- The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
- The explanation of the client's medical needs is sufficient to support a determination that the requested services correct or ameliorate the client's disability, physical or mental illness, or chronic condition.
- 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.
- There is no TPR financially responsible for the services.

Only those services that meet the medical necessity criteria for PDN are reimbursed. Before the TMHP Prior Authorization Department or MCO determines the requested nursing services do not meet the criteria, the Medical Director contacts the treating physician to determine whether additional information or clarification can be provided that would allow for the prior authorization of the requested PDN. If the Medical Director is not successful in contacting the treating physician or cannot obtain additional information or clarification, the Medical Director makes a decision based on the available information.

Providers must obtain prior authorization within three business days of the SOC for services that have not been prior authorized. During the prior authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed to by the physician, the PDN provider, and the client or responsible adult and is indicated on the submitted POC as the SOC date.

> ***Note:*** *The TMHP Prior Authorization Department does not prior authorize an SOC date earlier than seven calendar days before contact with TMHP.*

Requests for nursing services must be submitted on the required Medicaid authorization forms and include supporting documentation. The supporting documentation must:

- Clearly and consistently describe the client's current diagnosis, functional status, and condition.
- Consistently describe the treatment throughout the documentation.
- Provide a sufficient explanation as to how the requested nursing services correct or ameliorate the client's disability, physical or mental illness, or condition.

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4.1.4.1 Authorization Forms

The CCP Prior Authorization Request Form must be completed, signed, and dated by the physician. When PDN services are ordered, by signing the form the physician attests and certifies the client's medical condition is sufficiently stable to permit safe delivery of PDN as described in the plan of care. All requested dates of service must be included.

The POC must be recommended, signed, and dated by the client's primary physician. A POC must meet the standards outlined in the 42 CFR §484.18 related to the written POC. The primary physician must review and revise the POC, in consultation with the provider and the responsible adult, for each prior authorization, or more frequently as the physician deems necessary or the client's situation changes.

The Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form addresses PDN eligibility criteria, nursing care plan summary, health history summary, 24-hour schedule, and the rationale for the hours of PDN requested.

The following is a description of the nursing care plan summary:

- The nursing care summary is not a complete nursing care plan.
- Information must be client-focused and detailed.
- The problem list must reflect the reasons that nursing services are needed. The problem list is not the nursing care plan. Providers must identify two-to-four current priority problems from their nursing care plan. The problem does not need to be stated as a nursing diagnosis. The problems listed must focus on the primary reasons that a licensed nurse is required to care for the client. Other attached documents are not accepted in lieu of this section.
- The Goals must relate directly to the problems listed and be client-specific and measurable. Goals may be short- or long-term; however, for many clients who receive PDN, the goals generally are long-term.
- The Outcomes are the effects of the provider's nursing interventions and must be measurable. Generally, these are more short-term than goals. For initial requests, list expected outcomes. Extension requests should note the results of nursing interventions.
- The Progress must be viewed as a "yardstick" or continuum on which progress toward goals is marked. Initial requests must state expected progress for the authorization period. Extension requests must list the progress noted during the previous authorization period. It is recognized that all progress may not be positive.
- The addendum must summarize the client's health problems relating to the medical necessity for PDN.
- The addendum must clearly communicate a picture of the client's overall condition and nursing care needs.
- The summary of recent health history is imperative in determining whether the client's condition is stable or if new nursing care needs have been identified. This section gives the PDN provider an opportunity to describe the client's recent health problems, including acute episodes of illness, hospitalizations, injuries, and so on. The summary should create a complete picture of the client's condition and nursing care needs. The summary may cover the previous 90 days, even though the authorization period is 60 days; however, the objective of the summary is to capture the client's recent health problems and current health priorities. This section should not be merely a list of events. This section is the place to indicate the frequency of nursing interventions if they are different from the physician's order on the POC, such as, the order may be for a procedure to be PRN (Pro Re Nata "As Needed"), but it is actually being performed every two hours.
- The addendum must include the rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client's health problems and goals.

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- The addendum must include the provider's plan to decrease hours or discharge from service (if appropriate).

All direct-care services must be identified in the client's 24-hour daily schedule. It is understood that the schedule may change, as the client's needs change. The TMHP Prior Authorization Department does not have to be notified of changes in the schedule except as they occur when a PDN recertification is requested.

4.1.4.2 Primary Physician Requirements

The client must have a primary physician 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 physician visit may be waived when a diagnosis has already been established by the physician, and the client is under the continuing care and medical supervision of the physician. A waiver is valid for no more than 365 days, and the client must be seen by his or her physician at least once every 365 days. The 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 client's medical record.

> ***Note:*** *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

The primary physician must:

- Provide a prescription for PDN services
- Recommend, sign, and date a plan of care (POC)
- Sign a statement of need that PDN services are medically necessary
- Maintain documentation that the client's medical condition will allow safe delivery of PDN services as described in the POC

The physician recommended POC must include the following:

- The client's Medicaid number, the physician's license number, and the provider's National Provider Identifier
- Date the client was last seen by the physician
- The start of care (SOC) date for PDN services
- All pertinent diagnoses
- The client's mental status
- The prognosis
- The types of service requested, including the amount, duration, and frequency
- The equipment or supplies required
- Settings or mode(s) for required equipment (e.g., ventilator, oxygen)
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including the dose, route, and frequency

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- 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
- List all community or state agency services the client receives in the home (including, but not limited to, PCS, Community First Choice (CFC), MDCP
- Instructions for timely discharge or referral
- Client specific goals, including if receiving PPECC, the goal of ensuring coordination of ongoing skilled nursing services with the PPECC provider.
- If the client 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.

Refer to: 42 CFR §484.18 for additional information about POC requirements.

Physician Recertification of PDN services:

- The primary physician's medical care must comply with the THSteps periodicity schedule.
- The primary physician must provide specific, written, dated orders for clients who are receiving continuing or ongoing PDN services.

4.1.4.3 UA Modifier Requirements

The UA modifier allows additional reimbursement for specialized care associated with clients who are dependent on invasive ventilator life support or clients with a functioning tracheostomy and who meet the clinical indications listed below.

For the use of the UA modifier, a client who is ventilator dependent means that the client requires an invasive ventilator to help them breathe and they cannot breathe on their own without assistance.

Prior authorization requests for specialized care under the UA modifier must be submitted with requests for PDN services. Requests for specialized care under the UA modifier must include the modifier with the HCPCS code, a brief description of the requested services, and documentation of medical necessity on the CCP Prior Authorization Request Form.

Note: *PDN services must be considered for prior authorization even if the services for specialized care (UA modifier) are denied.*

Note: *Documentation of medical necessity is also required on the Home Health Plan of Care and the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers forms.*

PDN providers requesting prior authorization for specialized care under the UA modifier must submit all the documentation requirements for PDN services. In addition, providers must submit the clinical indications, as supported by a physician's order and documented in the POC justifying the use of the UA modifier.

Clinical indications for specialized care include the following:

- Clients who require a home ventilator with invasive interface (e.g., tracheostomy) associated with one of the following:
  - Neuromuscular disease
  - Thoracic restrictive disease

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- Chronic respiratory failure consequent to chronic obstructive pulmonary disease
- Congenital central hypoventilation syndrome
- Chronic lung disease of infancy (e.g., bronchopulmonary dysplasia)
- Obesity hypoventilation syndrome
- Restrictive disorder of chest wall
- Other conditions requiring invasive ventilation supported with documentation of medical necessity by a physician

- Clients with a functioning tracheostomy requiring both suctioning and other specified types of nursing care (e.g., dressing changes, skin care, humidification, or changing tracheostomy tubes and ties). Documentation in the treatment plan must include specific interventions and care.

Note: *Texas Medicaid will not approve a request for specialized care (UA modifier) if the client has a tracheostomy but does not meet the above requirements.*

Texas Medicaid will not approve clients with the following clinical indications for specialized care:

- Clients who use a non-invasive ventilator
- Clients who use a ventilator for the sole purpose of functioning as a respiratory assistance device (RAD), including continuous positive airway pressure (CPAP), auto-titrating positive airway pressure (APAP), bilevel positive airway pressure (BPAP, BiPAP), or adaptive servo-ventilation (ASV)

4.1.4.4 PDN Provider Requirements

When a provider receives a referral for PDN services, the provider must have an RN perform a nursing assessment of the client within the client's home environment. This assessment must be performed before seeking prior authorization for PDN services, with any request for PDN services recertification, or any request to modify PDN service hours. The assessment includes, but is not limited to, the determination of:

- Medical necessity for PDN services
- Safety of providing care in the proposed setting;
- Appropriateness of care in the place of service
- Receptivity to training and ability level of the parent, guardian, or responsible adult
- 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 client from obtaining medically necessary services. Certain school services are provided to meet education needs, not medical needs.

When an RN completes a client 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.

Note: *The TMHP Prior Authorization Department does not review or authorize PDN based on partial or incomplete documentation.*

4.1.4.5 Prior Authorization of PDN Services

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

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Refer to: Subsection 5.5.1.2, "Document Requirements and Retention" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for additional information about electronic signatures.

PDN services require prior authorization. Providers must obtain authorization within three business days of the SOC for services that have not been prior authorized. During the authorization process, providers are required to deliver the requested services from the SOC date. The SOC date is the date agreed upon by the physician, the PDN provider, and the client, parent, or guardian and is indicated on the submitted POC as the SOC date.

Note: *Not including PDN services provided during the authorization process, coverage periods may not coincide with calendar weeks or months. A prior authorized week coverage period begins from the day of the week the prior authorization period begins on and continues for seven days. For example, if the prior authorization starts on a Thursday, the prior authorization week runs Thursday through Wednesday. The number of nursing hours authorized for a week must be contained in that prior authorization week. Hours billed in excess of those authorized for the PAN week are subject to recoupment.*

A PDN provider requesting prior authorization for PDN services must submit all of the following documentation:

- A completed CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date.
- A completed POC form, signed and dated by the primary physician 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 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. The Nursing Addendum form must include:
  - An updated problem list
  - An updated rationale or summary page
  - A contingency plan
  - A 24-hour daily care flowsheet
  - A signed Acknowledgement

All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to, nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity as defined in this handbook.

The request can be submitted as follows:

- To complete the prior authorization process by paper, the PDN provider must fax or mail the completed PDN Request Documentation to the TMHP Prior Authorization Department and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.
- To complete the prior authorization process electronically, the PDN provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated documentation in the client's medical record at the provider's place of business.

Requests for authorizations of PDN services should always be commensurate with the client's medical needs. Requests for services should reflect changes in the client's condition that affect the amount and duration of PDN.

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For clients who are receiving PDN services who also require phototherapy, parent or guardian education, instructional use of the phototherapy equipment, and obtaining laboratory specimens collection are included in the PDN care provided.

Authorizations for more than 16 hours per day will not be issued to a single, independently enrolled nurse.

The length of the authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and client, parent, or guardian. PDN services will not be authorized for more than 180 calendar days at a time.

The TMHP Prior Authorization Department or MCO is required to notify the client, parent, or guardian, physician, and provider of the approval, denial, or other action taken in response to the authorization request by fax or mail.

Home Health Agencies must provide written notice to clients of their intent to voluntarily terminate PDN services at least five calendar days prior to terminating services, except in situations of a potential threat to the provider's personal safety.

Independently enrolled RNs or LVNs must provide written notice to clients of his or her intent to voluntarily terminate services at least 30 calendar days prior to terminating services, except in situations where there is a potential threat to the nurse's personal safety.

For clients who are receiving PDN services who also require TPN administration education, intermittent SN visits may be separately authorized when the SN services are for client or client caregiver training in TPN administration, and the PDN provider is not an RN appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.

Refer to: Subsection 3.3, "Home Health Skilled Nursing and Home Health Aide Services Providers" in this handbook for detailed information about SN benefits.

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.

4.1.4.6 Initial Authorization

An initial PDN prior authorization request requires all of the following documentation:

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

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- A signed Acknowledgement

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to, nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity as defined in this handbook.

Initial requests must be submitted within three business days of the SOC date.

Initial requests may be prior authorized for a maximum of 90 days.

Completed initial requests must be received and dated by the TMHP Prior Authorization Department within three business days of the SOC. The request must be received by the TMHP Prior Authorization Department no later than 5 p.m., Central Time, on the third day to be considered received within three business days. If a request is received more than three business days after the SOC, or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

4.1.4.7 Revisions

The provider may request a revision at any time during the authorization period if medically necessary. The provider must notify the TMHP Prior Authorization Department at any time during an authorization period if the client's condition changes and the authorized services are not commensurate with the client's medical needs.

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

Revisions during a current authorization period must fall within that authorization period. If the revision is requested outside of an authorization period, the provider must request a new authorization and submit the following documentation:

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

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

Note: *All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity.*

Revised services may be prior authorized for up to a maximum of 180 calendar days.

A request for a client that does not satisfy the criteria listed above for a 180 calendar day authorization may be authorized for a period up to 90 calendar days.

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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. The provider must maintain the physician-signed POC in the client's record. PDN providers should not submit a revised POC unless they are requesting a revision.

Completed requests for revision of PDN hours during the current authorization period must be received by TMHP Prior Authorization Department within three business days of the revised SOC. The request must be received by TMHP Prior Authorization Department no later than 5 p.m., Central Time, on the seventh day to be considered received within three business days. If a request is received more than three business days after the revised SOC or after 5 p.m., Central Time, on the third day, authorization is given for dates of service beginning three business days before receipt of the completed request.

Revisions to a current certification must fall within the certification period. If the revision extends beyond the current certification period, new authorization documentation must be submitted to TMHP Prior Authorization Department.

4.1.4.8 Required Coordination between PDN and Prescribed Pediatric Extended Care Centers (PPECCs)

When a client or client's physician notifies the PDN provider that the client also receives services from a Medicaid enrolled PPECC provider, the PDN provider must coordinate services with the PPECC provider. Both PDN and PPECC services are considered ongoing skilled nursing. A client has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing where PPECC services are available. 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. Skilled nursing hours are not expected to increase when the client utilizes a combination of both PDN and PPECC services, unless there is a documented change in medical condition, or the authorized hours are not commensurate to the client's medical needs and additional hours are medically necessary.

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, recertified, and revised.

Both providers must maintain documentation that the client or the client's responsible adult has participated in the development of the POC (e.g., the completed PPECC POC and Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers, with client or client responsible adult signatures on the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers).

Both providers must discuss with the client or the client's responsible adult how care will be coordinated between the two providers.

When a new service is initiated for ongoing skilled nursing services, and the client wants to receive both PDN and PPECC services, the TMHP Prior Authorization Department will compare the Nursing Addendum's 24-hour daily care flow sheets and medical necessity documentation (e.g., authorization requests). Upon subsequent approval of PDN or PPECC services, the provider who submitted the initial prior authorization request that established the number of authorized skilled nursing hours will have their authorized hours reduced to prevent duplication (e.g., if the client currently has PDN, and then adds PPECC services, the PDN hours will be reduced).

When hours are reduced, the PDN or PPECC provider affected by the reduction will be notified by the TMHP Prior Authorization Department when the reduction is effective, and the revised amount of authorized hours. Providers that are affected by the reduction are only required to submit a revision request and documentation of medical necessity if there is a change in the client's medical condition or the client's medical needs are not commensurate with authorized hours and additional ongoing skilled nursing hours are medically necessary. No action is required from the provider affected by the reduction if additional hours are not medically necessary.

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4.1.4.9 Client Receives both PDN and PPECC and Shifts Services from One to the Other

A client receiving both PDN and PPECC services may choose to shift approved hours from one ongoing skilled nursing provider to another.

The receiving provider (PDN or PPECC provider who will gain hours in the shift) must submit all required documentation for a revision.

The sending provider (PDN or PPECC provider who will lose hours in the shift) will receive a notice from the TMHP Prior Authorization Department with revised (decreased) hours and the effective date of the reduction. The sending provider does not need to take any action unless there is a change in the client's medical needs, and additional ongoing skilled nursing hours are medically necessary. If there is a medical need for additional ongoing skilled nursing hours, the sending provider may submit a revision request.

The total combined hours between PDN and PPECC services are not expected to increase without client medical necessity for additional hours (e.g., change in client condition or authorized hours are not commensurate with the client's medical needs).

4.1.4.10 Recertifications

Recertifications may be prior authorized for up to a maximum of 180 calendar days.

The following criteria must be met before a client receives a recertification:

- The client must have received PDN services for at least 90 calendar days
- No significant changes in the client's condition for at least 90 calendar days
- No significant changes in the client's condition are anticipated
- The client's parent or guardian, physician, and provider agree the recertification is appropriate

A recertification request must be submitted at least 7 calendar days before, but no more than 30 days before, a current authorization period will expire. The PDN provider must submit the following documentation with the recertification request:

- A completed CCP Private Duty Nursing six-month authorization signed and dated by the primary physician, nurse provider, and client, parent, or guardian
- A completed CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date
- A completed POC form, signed and dated by the primary physician 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 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

  Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

  Note: *All documentation must be maintained by the requesting PDN provider. The PDN provider may be asked to submit additional documentation including, but not limited to nurse's notes, medication administration records, seizure logs, and ventilator logs to support medical necessity.*

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The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the expiration of the authorization period, and this documentation must be maintained in the client's record. PDN providers should not submit a revised POC unless requesting a revision.

Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) may sign all documentation related to the provision of private duty nursing services on behalf of the client's physician when the physician delegates this authority to the APRN or PA.*

The provider may request a revision of a recertification at any time during the recertification period if medically necessary. The provider must notify the claims administrator at any time during a recertification period if the client's condition changes and the authorized services are not commensurate with the client's medical needs.

All authorization timelines apply to recertifications.

Completed extension requests must be received and dated by TMHP Prior Authorization Department at least seven calendar days before, but no more than 30 days before, the current authorization expiration date. The request must be received by TMHP Prior Authorization Department no later than 5 p.m., Central Time, on the seventh day, to be considered received within seven calendar days. If a request is received less than seven calendar days before the current authorization expiration date, or after 5 p.m., Central Time, on the seventh day, authorization is given for dates of service beginning no sooner than seven calendar days after the receipt of the completed request by TMHP Prior Authorization Department.

The nursing care provider must notify TMHP Prior Authorization Department at any time during the authorization period if the client's condition and need for SN care significantly changes.

4.1.4.11 Special Circumstances

PDN services provided in a school or day care facility, at the request of the family, may be authorized provided the client requires the requested amount of PDN services if in the home.

PDN services may be provided in a hospital, SN facility or intermediate care facility for the individuals with intellectual disabilities, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the client, and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the client.

4.1.4.12 PDN Services Provided in Group Settings

PDN services may be authorized in a provider or client ratio other than 1:1.

An RN or LVN may be authorized to provide PDN services to more than one client over the span of the day as long as:

- Each client's care is based on an individualized POC
- Each client's needs and POC do not overlap with another client's needs and POC

Settings in which a PDN provider may provide services in a provider-client ratio greater than 1:1 include, but are not limited to, homes with more than one client receiving PDN, foster homes, or independent living arrangements.

4.1.4.13 Termination of Authorization

Authorization for PDN services will be terminated when:

- The client is no longer eligible for Medicaid
- The client no longer meets the medical necessity criteria for PDN services
- The place of service does not support the health and safety of the client

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- The client, parent, or guardian refuses to comply with the service plan and compliance is necessary to assure the health and safety of the client

4.1.4.14 Appeal of Authorization Decisions

Providers may appeal denials or modifications of requested PDN services with documentation to support the medical necessity of the requested PDN services. Appeals must be submitted to the TMHP Prior Authorization Department with complete documentation and any additional information within two weeks of the date on the decision letter. If changes are made to the authorization based on this documentation, TMHP Prior Authorization Department will go back no more than three business days for initial, or revision requests and no more than seven calendar days for recertification requests when additional documentation is submitted.

The client, parent, or guardian will be notified of any denial or modification of requested services and will be given information about how to appeal the TMHP Prior Authorization Department decision.

All documentation must be submitted together, and requests are not reviewed until all documentation is received. If complete documentation is received at TMHP Prior Authorization Department by 3 p.m., Central Time, a response is returned to the provider within one business day. Complete documentation for initial, revision, recertification, and extension requests for PDN authorizations include all of the following:

- CCP Prior Authorization Request Form on the TMHP website at www.tmhp.com.
- Home Health Plan of Care (POC) on the TMHP website at www.tmhp.com.
- Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers on the TMHP website at www.tmhp.com.

4.1.4.15 Start of Care (SOC)

The SOC is the date that care is to begin, as agreed on by the family, the client's physician, and the provider, and as listed on the POC and the CCP Prior Authorization Request Form. Providers are responsible for determining whether they can accept the client for services.

Once the provider accepts a client for service and accepts responsibility for providing PDN, the provider is required to deliver those services beginning with the SOC date. Providers are responsible for a safe transition of services when the authorization decision is a denial or a reduction of services. Providers are required to notify the physician and the client's family on receipt of an authorization, a denial, or a change in PDN.

Providers must submit complete documentation no later than three business days from an SOC date to obtain initial coverage for the SOC date.

Note: *Texas Medicaid (Title XIX) home health services does not authorize an SOC date earlier than three business days before contact with TMHP.*

For PDN recertification, TMHP Prior Authorization Department must receive complete documentation no later than three business days before the SOC date. It is recommended that recertification requests be submitted up to 30 days before the current authorization ends.

During the prior authorization process for initial and recertification requests, providers are required to deliver the requested services from the SOC date.

4.1.4.16 Client and Provider Notification

When PDN is approved as requested, the provider receives written notification. The provider is responsible for notifying the client or family and the physician of the authorized services.

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The TMHP Prior Authorization Department or MCO notifies the client and provider in writing when the following instances occur:

- PDN is denied.
- PDN hours authorized are less than the hours requested on the POC.
- PDN hours are modified (e.g., hours are requested by the week but are authorized by the day).
- The TMHP Prior Authorization Department or MCO receives incomplete information from the provider.
- Dates of service authorized are different from those requested.
- The provider is responsible for notification and coordination with the physician and family.

4.1.5 Limitations with Other Services

4.1.5.1 PDN Services with PCS, SHARS, or PPECC

When clients are receiving both PDN services and PCS from an individual person over the same span of time, all services will be reimbursed according to the maximum allowable fee schedule.

Texas Medicaid will not reimburse providers for PDN services that duplicate services provided by school districts under the SHARS program. If a provider bills Texas Medicaid for PDN services provided to a client at school, then the school district may be asked to provide documentation that it is not also providing PDN services to the same client at the same time and seeking reimbursement for the service under the SHARS program.

PDN services may be billed on the same day as PPECC services, but may not be billed simultaneously with PPECC services. PDN may be billed when it occurs before or after PPECC services.

4.1.5.2 PDN Provided During a Skilled Nursing Visit for TPN Administration Education

For clients who are receiving PDN services who also require TPN administration education, intermittent SN visits may be separately reimbursed when the SN services are for the client or caregiver training in TPN administration.

Refer to: Subsection 3.3, "Home Health Skilled Nursing and Home Health Aide Services Providers" in this handbook for detailed information about SN benefits.

PDN and SN should not be routinely performed on the same date during the same time period.

PDN and SN will not be considered for reimbursement when the services are performed on the same date during the same time period without prior authorization approval.

If the SN visit for TPN education occurs during a time period when the PDN provider is caring for the client, both the PDN provider and the nurse educator must document in the client's medical record the skilled services individually provided, including but not limited to:

- The start and stop time of each nursing provider's specialized task(s)
- The client condition that requires the performance of skilled PDN tasks during the SN visit for TPN education
- The skilled services that each provided during that time period

Both the intermittent SN visit and the PDN services provided during the same time period may be recouped if the documentation does not support the medical necessity of each service provided.

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Intermittent SN visits for clients who receive PDN and who require TPN administration education may be considered for separate prior authorization if:

- The PDN provider is not an RN who has been appropriately trained in the administration of TPN, and the PDN provider is not able to perform the function.
- There is documentation that supports the medical need for an additional skilled nurse to perform TPN.

The SN services may be prior authorized only for the client and caregiver who will be trained in TPN administration.

Clients whose only SN need is the provision of education for self-administration of prescribed subcutaneous (SQ), intramuscular (IM), or intravenous (IV) injections will not qualify for PDN services.

Nursing hours for the sole purpose of providing education to the client and caregiver may be considered through intermittent home health SN visits.

5 Documentation Requirements

All documentation, including that which supports medical necessity, and the comprehensive treatment plan related to the therapy services that were prior authorized and provided, must be maintained in the client's medical record and made available upon request.

Documentation elements that are routinely assessed for compliance in retrospective review of client records include, but are not limited to, the required documentation noted previously, as well as the following:

- All entries are legible to people other than the author, dated (month, day, year, time), and signed by the author.
- Each page of the record documents the client's name and Medicaid identification number.
- Client assessment time is documented at the beginning of each shift.
- All nurses' arrival and departure times are documented with signature and time in the narrative section of the nurses' notes.
- Entries in the nursing flowsheet or narrative notes must be dated and timed every 1 to 2 hours and must include the following:
- The client's condition.
- The name of the medication, dose, route, time given, client response, and other pertinent information is recorded when medication is administered.
- The name of treatment, time given, route or method used, client response, and other pertinent information is provided when treatments are administered.
- The amount, type, times given, route or method used, client response, and other pertinent information is provided when feedings are administered.
- The POC and documentation of services correlate with and reflect medical necessity for the services provided on any given day.
- A request for prior authorization must include documentation from the provider to support the medical necessity of the service, equipment, or supply.
- Client's arrival or departure from the home setting is documented with the time of arrival, departure, mode of transportation, and who accompanied the client.

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- Documentation of teaching the client or the client's responsible adult includes the length of time, the subject of the teaching, the understanding of the subject matter by the person receiving the teaching, and other pertinent information.
- Supervisory visits include specifics of the visit.
- If a client is receiving SN services through another program or service in addition to PDN, such as MDCP, each provider's shift notes designate specifically which type of service they are providing during that shift.

6 Claims Filing and Reimbursement

6.1 Claims Filing

Providers may purchase CMS-1500 or UB-04 CMS-1450 paper claim forms from the vendor of their choice. TMHP does not supply them.

When completing a CMS-1500 or a UB-04 CMS-1450 paper claim form, all required information must be included on the claim, as TMHP does not key information from attachments.

Refer to: "Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*) for information on electronic claims submissions.

"Section 6: Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for instructions on completing paper claims.

Subsection 6.6, "UB-04 CMS-1450 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for paper claims completion instructions.

6.1.1 Home Health Skilled Nursing and Home Health Aide Providers

Providers must use only type of bill (TOB) 321 in Form Locator (FL) 4 of the UB-04 CMS-1450. Other TOBs are invalid and will result in a claim denial. Home health services must be submitted to TMHP in an approved electronic format or on a CMS-1500 or a UB-04 CMS-1450 paper claim form. Submit home health DME and medical supplies to TMHP in an approved electronic format, or on a CMS-1500 or on a UB-04 CMS-1450 paper claim form.

Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding Healthcare Common Procedure Coding System (HCPCS) code or narrative description. The prior authorization number must appear on the CMS-1500 paper claim form in Block 23 and in Block 63 of the UB-04 CMS-1450 paper claim form. The certification dates or the revised request date on the POC must coincide with the DOS on the claim. Prior authorization does not waive the 95-day filing deadline requirement.

Home health service claims should not be submitted for payment until Medicaid certification is received and a prior authorization number is assigned.

6.1.2 PDN Providers

Independently enrolled RNs or LVNs providing PDN services must submit claims on the CMS-1500 claim form. PDN Providers who are home health agencies must submit claims on the UB-04 CMS-1450 claim form.

PDN providers must submit claims for services in an approved electronic claims format or on the appropriate claim form based on their provider type. Home health agencies must submit claims on the UB-04 CMS-1450 paper claim form. Independently enrolled nurses must submit claims on the CMS-1500 paper claim form.

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6.1.3 Method for Counting Minutes for Timed Procedure Codes

All claims for reimbursement of procedure codes paid in 15-minute increments are based on the actual amount of billable time associated with the service. For those services for which the unit of service is 15 minutes (1 unit = 15 minutes), partial units should be rounded up or down to the nearest quarter hour.

Time intervals for 1 through 12 units are as follows:

Units	Number of Minutes
0 units	0 minutes through 7 minutes
1 unit	8 minutes through 22 minutes
2 units	23 minutes through 37 minutes
3 units	38 minutes through 52 minutes
4 units	53 minutes through 67 minutes
5 units	68 minutes through 82 minutes
6 units	83 minutes through 97 minutes
7 units	98 minutes through 112 minutes
8 units	113 minutes through 127 minutes
9 units	128 minutes through 142 minutes
10 units	143 minutes through 157 minutes
11 units	158 minutes through 172 minutes
12 units	173 minutes through 187 minutes

6.2 Reimbursement

The reimbursement methodology for professional services delivered by home health agencies is a statewide visit rate calculated in accordance with 1 TAC §355.8021.

Home health agencies are reimbursed for DME and medical supplies in accordance with 1 TAC §355.8023.

PDN services are reimbursed in accordance with 1 TAC §355.8441.

Providers can refer to the OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*).

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