

# Private Duty Nursing (PDN) and Extended Home Health (EHH) Services (for Louisiana Only)

## Retired April 1, 2026

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[Instructions for Use](#)

Content mandated by Louisiana Department of Health

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## Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with state requirements.

## Coverage Rationale

### Requirements for Coverage

Medical necessity for PDN (EHH) services exists when the beneficiary:

- Is categorically eligible Medicaid beneficiary birth through 20 years of age (EPSDT eligible); **and**
- Has been prescribed PDN (EHH) by a physician; **and**
- Has a medically complex condition characterized by multiple, significant medical problems that require a minimum of three (3) or more hours of skilled nursing care, in accordance with the Louisiana Nurse Practice Act (La. R.S. 37:911, et seq), per day.

If services are determined to be medically necessary, the number of hours approved will be assessed using the Private Duty [Nursing Acuity Scale](#) as guidance.

**Note:** PDN (EHH) services may be provided in the beneficiary’s place of residence, which is defined as the place where normal life activities take place, but cannot include a hospital, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made by Medicaid for inpatient services that include room and board. (CFR § 440.70).

### Coverage Limitations and Exclusions

PDN (EHH) is not considered medically necessary for respite or custodial care, which can be performed by trained non-medical personnel.

### Documentation Requirements

The following documentation is required to be submitted with the prior authorization request for review:

- Prior authorization form
- Prescription for PDN (EHH):

- Written by a physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with State law
- That includes the number of hours of PDN
- Documentation to substantiate medical necessity of requested services including but not limited to:
  - Copy of physician progress notes documenting medical needs
  - Copy of hospital progress notes (if applicable)
  - Copy of discharge orders
  - Copy of discharge summary (if applicable/available)
- Plan of care – signed (not required if member discharging from inpatient setting)

## Nursing Acuity Scale

Skilled Nursing Needs	Points	Score
<b>Respiratory: Tracheostomy</b>		
No tracheostomy, patent airway	0	
No tracheostomy, unstable airway with desaturations and airway clearance issues	1	
Tracheostomy, routine care	2	
Tracheostomy, special care (tissue breakdown, frequent tube replacements)	3	
<b>Respiratory: Suctioning</b>		
No suctioning	0	
Nasal/oral/pharyngeal suctioning by nurse	1	
Tracheal suctioning, 2-10x/day	2	
Tracheal suctioning, > 10x/day	3	
<b>Respiratory: Oxygen</b>		
No oxygen usage	0	
Oxygen, daily use	1	
Oxygen administration based upon pulse oximetry readings	1.5	
Humidification and oxygen, direct (via tracheostomy but not with ventilator)	1.5	
<b>Respiratory: Ventilator</b>		
No ventilator, BiPap, CPAP	0	
Ventilator < 12 hours/day	2.5	
BiPap, CPAP by nurse during shift, 8 hours or <b>less</b>	3	
BiPap, CPAP by nurse during shift, <b>more</b> than 8 hours/day	4	
Ventilator, 12-24 hours/day	5	
Ventilator, continuous 24 hours/day	10	
<b>Respiratory: Nebulizer Treatments</b>		
No nebulizer treatments	0	
Nebulizer treatments (by nurse) less than daily but at least 1x/week	1	
Nebulizer treatments (by nurse) every 4 hours or <b>less</b> often but at least daily	1.5	
Nebulizer treatments (by nurse) every 4 hours or <b>more</b> often	2	
<b>Respiratory – Chest PT</b>		
No chest PT, HFCWO vest or cough assist device	0	
Chest PT, HFCWO vest, cough assist 1-4x/day	2	
Chest PT, HFCWO vest, cough assist <b>more</b> than 4x/day	4	
<b>Medication Needs (# of admin/shift, not # of medications); does not include O2/nebulizer administration</b>		
Medication delivery 1 dose admin or <b>none</b> per shift	0	
Medication delivery 2-6 dose admin/shift	1	
Medication delivery <b>more</b> than 7 admin/shift	2	

Skilled Nursing Needs	Points	Score
<b>IV Access</b>		
No IV access	0	
Peripheral IV access	1	
Central line of port, PICC line, Hickman	2	
<b>IV Medication Administration</b>		
No IV medication delivery	0	
IV med/transfusion <b>less</b> than daily but <b>more</b> than weekly	1	
IV medication admin <b>less</b> than Q4 hours	2	
IV medication admin Q4 hours or <b>more</b> often	3	
Total parenteral nutrition (TPN)	4	
<b>Bloods Draws</b>		
No regular blood draws or <b>less</b> than 2x/week	0	
Regular blood draws/IV peripheral site 2x/week	1	
Regular blood draws/Central line 2x/week	2	
<b>Nutrition</b>		
Routine oral feeding or no tube-feeding required	0	
Documented difficult/prolonged oral feeding by <b>nurse</b>	2	
Tube feeding (routine bolus <b>or</b> continuous)	2	
Tube feeding (combination bolus <b>and</b> continuous)	3	
Complicated tube feeding, required residual checks and aspiration precautions	3.5	
<b>Seizures</b>		
No seizure activity	0	
Mild seizures, at least daily, but no intervention	0	
Mild seizures, at least 4/week with each requiring minimal intervention	1	
Moderate seizures, at least once daily requiring minimal intervention	2	
Moderate seizures, 2-5/day with each requiring minimal intervention	2.5	
Severe seizures, 10/month all requiring intervention	3	
Severe seizures, at least 1x/day requiring IV/IM/rectal medication intervention	3.5	
Severe seizures, 1/day requiring IV/IM/rectal medication intervention	4	
<b>Assessment Needs</b>		
Initial assessment/shift	0	
Second documented complete assessment/shift	1	
Three or <b>more</b> complete assessments/shift	2	
Choose 1 score if at least 2 of the 4 (VS/glucose/neuro/respiratory) are ordered and documented:		
• VS/glucose/neuro/respiratory, assess 1x/day	0	
• VS/glucose/neuro/respiratory, assess 1x/shift or <b>less</b> often than every 4 hours	1	
• VS/glucose/neuro/respiratory, assess at least every 4 hours	2	
• VS/glucose/neuro/respiratory, assess at least every 2 hours	3	
<b>Elimination Needs</b>		
Continent of bowel and bladder function	0	
Uncontrolled incontinence but < <b>3 yrs.</b> of age	0	
Uncontrolled incontinence, <b>either</b> bowel or bladder > <b>3 yrs.</b> of age	1	
Uncontrolled incontinence, <b>both</b> bowel and bladder <b>3 yrs.</b> of age	2	
Incontinence and intermittent straight catheterization, indwelling, suprapubic, or condom catheter	3	

Skilled Nursing Needs		Points	Score
<b>Elimination Needs</b>			
Ostomy care, bowel, or bladder		3	
Peritoneal dialysis, performed by nurse		3	
<b>Wound Care</b>			
None of the options below apply		0	
Wound vac		2	
Stage 1-2, wound care at least daily (including tracheostomy, G/J tube site)		2	
Stage 3-4, multiple wound sites		3	
<b>Therapies</b>			
Passive range of motion at least <b>every</b> shift		1	
Splinting schedule requires nurse to remove/replace <b>every</b> shift		1	
Splinting schedule requires nurse to remove/replace at least 2x/shift		2	
<b>Issues Interfering with Care</b>			
Unwilling or unable to cooperate		1	
Weight > 100 lbs or immobility increases care difficulty		1	
Unable to express needs and wants		1	
<b>Member's Total Score</b>			

Scoring Instructions	
Scale	Acuity Level (based on score)
15-25 points = 4-8 hours/day, up to 56 hours/week	
26-35 points = 8-12 hours/day, up to 84 hours/week	
36-45 points = 12-16 hours/day, up to 112 hours/week	
46-55 points = 16-20 hours/day, up to 140 hours/week	
<b>Provider Requested Hours</b>	

## Definitions

**Private Duty Nursing (PDN)/Extended Home Health (EHH):** Home health nursing services provided for a minimum of three or more hours per day that are provided to beneficiaries under the age of 21 if determined to be medically necessary, ordered by a physician, and prior authorized.

## Applicable Codes

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

HCPCS Code	Description
<b>PDN (EHH) services require prior authorization using HCPCS code S9123, S9124, or T1000 and will be reviewed for service period of up to 60 calendar days.</b>	
S9123	Nursing care, in the Home; by registered nurse, per hour
S9124	Nursing care, in the Home; by licensed practical nurse, per hour
*T1000	Private duty/independent nursing service(s) – licensed, up to 15 minutes
T1001	Nursing assessment/evaluation

Codes labeled with an asterisk (\*) are not on the State of Louisiana Medicaid Fee Schedule and therefore may not be covered by the State of Louisiana Medicaid Program.

## References

Code of Federal Regulations (CFR). Home health services. 42 CFR 440.70. Available at: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A>. Accessed June 14, 2024.

Louisiana Department of Health Home Health Provider Manual: Chapter Twenty-Three of the Medicaid Services Manual; Section 23.1 and 23.5 – Extended Home Health. Available at: <https://www.lamedicaid.com/provweb1/Providermanuals/manuals/HH/HH.pdf>. Accessed June 14, 2024.

## Policy History/Revision Information

Date	Summary of Changes
04/01/2026	<ul style="list-style-type: none"><li>Retired policy; Louisiana plan membership disenrolled on Apr. 1, 2026</li></ul>
01/01/2025	<ul style="list-style-type: none"><li>Routine review; no change to coverage guidelines</li><li>Archived previous policy version CS102LA.A</li></ul>

## Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual<sup>®</sup> criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.