MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Home Health Agencies 03-05
Practitioner 03-04

Issued: August 1, 2003

Subject: Private Duty Nursing
Change in HCPCS Codes/Modifiers For Private Duty Nursing
Other Insurance Policy Change
Other Insurance Reminder – Avoid Medicaid Non-Payment
Other Insurance Fax Number
Accreditation Reminder
Incorporation of MSA Bulletin 03-04 (Prior Authorization Number for Children's Waiver – Private Duty Nursing)

Effective: As Indicated

Programs Affected: Medicaid
Children's Special Health Care Services (CSHCS)

THIS BULLETIN SHOULD BE SHARED WITH THE PRIVATE DUTY NURSING AGENCY'S ADMINISTRATOR AND BILLING PERSONNEL AND RN/LPN BILLING PERSONNEL.

CHANGE IN HCPCS CODES/MODIFIERS FOR PRIVATE DUTY NURSING

The Michigan Department of Community Health (MDCH) will be adopting the following new HCPCS Codes/Modifiers for private duty nursing for dates of service on and after October 1, 2003.

This change brings the MDCH into compliance with the appropriate codes/modifiers that must be used for its private duty nursing billing under the HIPAA (Health Insurance Portability and Accountability Act of 1996).

The 2003 HCPCS coding book contains the descriptions of the new codes/modifiers.

Note: For ratios of more than 2 patients per nurse, there is not a current HCPCS modifier for use. In addition, Michigan Medicaid has not authorized such a case in several years.

Description	**New HCPCS Codes/Modifiers for Dates of Service On and After October 1, 2003**	Codes/Modifiers That Cannot be Used for Dates of Service On and After October 1, 2003
Nursing Care, RN, Per Hour	S9123	T1000 TD
Nursing Care, RN, Per Hour, Holiday	S9123	T1000 TD
Nursing Care, LPN, Per Hour	S9124	T1000 TE
Nursing Care, LPN, Per Hour, Holiday	S9124	T1000 TE
Nursing Care, 1 RN to 2 Patients, Per Hour	S9123 TT	T1000 TDTF
Nursing Care, 1 RN to 2 Patients, Per Hour, Holiday	S9123 TT	T1000 TDTF
Nursing Care, 1 LPN to 2 Patients, Per Hour	S9124 TT	T1000 TETF
Nursing Care, 1 LPN to 2 Patients, Per Hour, Holiday	S9124 TT	T1000 TETF
For ratios of more than 2 patients per nurse, the provider must contact the patient's case manager at the Children's Special Health Care Services (CSHCS), Home and Community-Based Services Waiver for the Elderly and Disabled, Children's Waiver (CMHSP), or Habilitation/Support Services Waiver (CMHSP). These ratios are considered exceptional cases and require prior approval.		T1000 TDTG T1000 TETG

The above new codes/modifiers are listed in Attachments III and IV.

As indicated in Attachments III and IV, the **total** number of hours reported must not exceed the total hours that were authorized for that month. Since whole hours of care are authorized, only those hours of care that entail **a full hour** of care may be billed.

OTHER INSURANCE POLICY CHANGE

Page 5 of bulletin MSA 02-03 indicates, in part, "The authorizing program will assess and document the availability of all private health care coverage…". This particular piece of policy is being deleted. It is the responsibility of the family, private duty nursing agency, RN or LPN to **assess, investigate and exhaust all commercial insurance for the beneficiary prior to billing Medicaid.** The change is reflected in Attachment I to this bulletin.

OTHER INSURANCE REMINDER - AVOID MEDICAID NON-PAYMENT

A PRIVATE DUTY NURSING AGENCY, RN, OR LPN ARE REMINDED THAT THEY SHOULD NOT ACCEPT ANY MEDICAID PRIVATE DUTY NURSING CASE UNTIL IT HAS ASSESSED AND INVESTIGATED ALL COMMERCIAL INSURANCE THAT A BENEFICIARY MAY HAVE.

FOR ANY MEDICAID CASE ACCEPTED IN WHICH THE BENEFICIARY HAS OTHER INSURANCE, THE PROVIDER MUST FIRST FOLLOW THE RULES OF THE OTHER INSURANCE. Such rules may include obtaining a physician's order, obtaining prior authorization, and being a participating provider with the other insurance carrier. Failure to follow the rules of the other insurance may result in non-payment from Medicaid.

Many commercial insurances pay only for private duty nursing if performed by a private duty nursing agency and not an independent RN/LPN. In these cases, Medicaid will only pay as a secondary payer when services are provided by an agency - Medicaid will not cover the services if billed by an RN/LPN enrolled in the Program. The only exception would be if there is no agency within the geographic area of the patient.

OTHER INSURANCE FAX NUMBER

If a beneficiary's commercial insurance does not cover private duty nursing, the private duty nursing agency, RN, and LPN must inform Medicaid of this, prior to billing Medicaid to expedite processing of the claim. A copy of the letter of explanation or EOB MUST BE FAXED to Medicaid Third-Party Liability at **(517) 346-9874**.

If the other insurance information is not faxed, there will be a delay in the processing of the claim(s) submitted to Medicaid.

If the other insurance information is faxed, but the provider failed to enter the appropriate insurance information (e.g., Condition Code, Coordination of Benefits) on the claim, the claim will be rejected.

Once it has been established that the commercial insurance does not cover private duty nursing, a letter of explanation or EOB is valid as long as the insurance coverage remains unchanged. On an annual basis, the policyholder and provider should confirm with commercial insurance that private duty nursing coverage has not changed. An explanation of benefits letter or EOB from the carrier indicating that private duty nursing is not a covered service is required to bill Medicaid.

Attachment I of this bulletin contains the above information and additional information regarding other insurance. Providers are encouraged to review this information.

Special Note: Effective for dates of service on and after October 1, 2003, private duty nursing agencies are reminded that Michigan Medicaid specific Condition Codes (e.g., X1, X2) cannot be used. Rather, providers must use the national Condition Codes contained in the State Uniform Billing Manual.

ACCREDITATION REMINDER

As published in Program policy, private duty nursing agencies that were enrolled without accreditation must be accredited five (5) years after the date of its Medicaid enrollment. For most private duty nursing agencies that enrolled without accreditation, the five (5) years will end in the year 2007. In the event the accreditation requirements are not met, the provider will be disenrolled from Medicaid. Accreditation must be by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) **or** the Community Health Accreditation Program (CHAP) as a private duty nursing agency, **or** be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a Home and Community-Based Rehabilitation Program.

Proof of accreditation must be mailed to: Michigan Department of Community Health, Provider Enrollment Unit, P.O. Box 30238, Lansing, Michigan 48909. Along with the proof of accreditation, the provider must include a cover letter. The cover letter must include the statement that the accreditation is for a private duty nursing agency and the provider's Medicaid Provider ID Number for the location (office) that has been accredited.

INCORPORATION OF BULLETIN MSA 03-04 (PRIOR AUTHORIZATION NUMBER FOR CHILDREN'S WAIVER – PRIVATE DUTY NURSING)

Bulletin MSA 03-04 has been incorporated into this new bulletin.

MANUAL MAINTENANCE

Retain this bulletin for future reference for private duty nursing policy and procedures.

Home Health Agencies (Private Duty Nursing Agencies): Discard bulletins MSA 03-04 and MSA 02-03.

Practitioner (Medicaid Enrolled RNs and LPNs for Private Duty Nursing): Discard bulletins MSA 03-04 and MSA 02-03.

QUESTIONS

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov . When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVAL

Paul Reinhart
Deputy Director for
Medical Services Administration

PRIVATE DUTY NURSING

Private duty nursing is a Medicaid State Plan benefit when provided in accordance with the policies and procedures outlined in this bulletin and Medicaid manual. Providers must adhere to all applicable policies and procedures set forth in this bulletin and Medicaid Manual.

Private duty nursing is a Medicaid State Plan benefit for beneficiaries under age 21 who meet the medical criteria for coverage. If the beneficiary is enrolled in or receiving case management services from one of the following programs, the applicable program will authorize the private duty nursing.

- Children's Special Health Care Services (CSHCS),
- Home and Community-Based Services Waiver for the Elderly and Disabled (known as the MI Choice Waiver),
- Children's Waiver (CMHSP), or
- Habilitation/Support Services Waiver (CMHSP).

For a Medicaid beneficiary who is not receiving services from one of the above programs, the CSHCS Program will review the request for authorization and authorize the services if the medical criteria and general eligibility requirements are met.

Note: The above programs cannot seek supplemental private duty nursing hours from another Medicaid Program (i.e., CSHCS, MI Choice Waiver, Children's Waiver, Habilitation Waiver).

For beneficiaries age 21 and older, private duty nursing is a waiver service that may be covered for qualifying individuals enrolled in the following programs: MI Choice Waiver or Habilitation/Support Services Waiver. When private duty nursing is provided as a waiver service, the waiver agent must be billed for the services.

PROVISION OF PRIVATE DUTY NURSING

Private duty nursing must be ordered by a physician and may be provided by a private duty nursing agency, a Medicaid-enrolled RN or a Medicaid-enrolled LPN working under the supervision of an RN (per Michigan Public Health Code). It is up to the LPN to secure this supervision by an RN.

Supervision of a Medicaid-enrolled LPN must be by an RN who has at least one year of experience in any of the following areas: community health nursing, pediatric nursing, maternal and child health nursing, or a similar nursing practice. The Medicaid Program requires an on-site (beneficiary's home) supervisory visit by the RN of the LPN at least once every 2 months. The Medicaid-enrolled LPN must maintain documentation that verifies who the supervising RN is.

If a beneficiary's services are performed exclusively by LPNs, one of the supervisory RNs will be responsible for completing the beneficiary's physical assessment and be required to participate in the development of the beneficiary's plan of care. **Note**: Assessments and supervisory visits are not separately reimbursable.

Supervisory Nurse Visit: A Medicaid-enrolled home health agency **cannot** bill Medicaid for supervisory nurse visits of private duty nursing staff.

To enroll as a Medicaid provider, the criteria detailed in Attachment II of this bulletin must be met.

Private duty nursing is not a Medicaid benefit when rendered in a hospital, nursing facility (including nursing facility for mentally ill [NF/MI]), intermediate care facility for mentally retarded (ICF/MR), or licensed adult foster care facility.

Private duty nursing is not a Medicaid benefit when provided by an RN or LPN who is the beneficiary's spouse, legally responsible relative, step-parent, adoptive parent, legal guardian, or foster parent.

PRIOR AUTHORIZATION

Private duty nursing services must be authorized by one of the above-mentioned programs before services are provided.

Prior authorization of a particular private duty nursing provider to render services will consider the following factors: 1) available third-party resources; 2) beneficiary/family choice; 3) beneficiary's medical needs and age; 4) the knowledge and appropriate nursing skills needed for the specific case; and 5) the understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

If services are approved, the provider will receive an approval letter. The provider must maintain the letter in the beneficiary's medical record. The prior approval letter will contain a prior approval number. When billing, the prior approval number must be entered on the claim. The letter is not to be sent with the claim.

The prior authorization number is for private duty nursing only. Any CMHSP prior authorized respite services must be billed to the authorizing CMHSP.

ASSESSMENT OF THIRD-PARTY RESOURCE

The provider should not accept any Medicaid private duty nursing case until it has assessed and investigated all commercial insurance that a Medicaid beneficiary may have.

For any Medicaid case accepted in which the beneficiary has other insurance, the provider must first follow the rules of the other insurance. Such rules may include obtaining a physician's order, obtaining prior authorization, and being a participating provider with the other insurance carrier. Failure to follow the rules of the other insurance may result in non-payment from Medicaid.

Many commercial insurances pay only for private duty nursing if performed by a private duty nursing agency and not an independent RN/LPN. In these cases, Medicaid will only pay as a secondary payer when services are provided by an agency - Medicaid will not cover the services if billed by an RN/LPN enrolled in the Program. The only exception would be if there were no agency within the geographic area of the patient.

OTHER INSURANCE FAX NUMBER

If a beneficiary's commercial insurance does not cover private duty nursing, the private duty nursing agency, RN, and LPN must inform Medicaid of this prior to billing Medicaid to expedite processing of the claim. A copy of the letter of explanation or EOB MUST BE FAXED to Medicaid Third-Party Liability at (517) 346-9874.

If the other insurance information is not faxed, there will be a delay in the processing of the claim(s) submitted to Medicaid.

Once it has been established that the commercial insurance does not cover private duty nursing, a letter of explanation or EOB is valid as long as the insurance coverage remains unchanged. On an annual basis, the policyholder and provider should confirm with commercial insurance that private duty nursing coverage has not changed. An explanation of benefits letter or EOB from the carrier indicating that private duty nursing is not a covered service is required to bill Medicaid.

Medicaid will pay fixed co-pays, co-insurance and deductibles up to the allowable screen as long as the rules of the commercial coverage plan (point of service, PPO, etc.) are followed. The beneficiary must use the highest level of benefits available to them under the policy. For example, Medicaid will not pay the point of service sanction amount for the beneficiary electing to go out-of-network.

Providers may enter into agreements with third-party payers to accept payment for less than their usual and customary charges. These arrangements are often called "Preferred Provider" or "Participating Provider Agreements," and are considered payment-in-full for services rendered. Since the insured has no further liability to pay, the MDCH has no liability. The MDCH may only be billed if the third-party payer has determined the insured/beneficiary has a legal obligation to pay.

If payments are made by a commercial insurance, the amount paid, whether it is paid to the provider or the policyholder of the insurance, must be reflected on the claim to Medicaid. If the provider does not accept direct payment from the other insurance, or the other insurance company does not allow direct payment to the provider, it is the provider's responsibility to obtain the money from the policyholder. It is acceptable to bill the policyholder in this situation.

If there is court-ordered support and the provider is having trouble collecting other insurance payments sent directly to the absent parent, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or e-mail TPL@michigan.gov.

The Medicaid manual contains additional information on Other Insurance/Coordination of Benefits.

GENERAL ELIGIBILITY REQUIREMENTS

Private duty nursing is a benefit when all of the following requirements are met:

A. The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the non-institutional setting);

B. The beneficiary meets the medical criteria for private duty nursing and is under the age of 21;

C. Private duty nursing is appropriate, considering the beneficiary's health and medical care needs;

D. Private duty nursing can be safely provided in the home setting; and

E. The beneficiary, his/her family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the private duty nursing agency or the Medicaid-enrolled RN, or the supervising RN for the Medicaid-enrolled LPN) have collaborated and developed an integrated plan of care that identifies and addresses the beneficiary's need for private duty nursing. The private duty nursing must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The plan of care must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The plan of care must be updated at least annually and must also be updated as needed based on the beneficiary's medical needs.

   A written plan of care guides all services provided to the beneficiary by the private duty nursing provider. The care plan and the process for developing it reflect the beneficiary's and family's basic rights of self-determination and autonomy.

   The written plan of care must be retained in the beneficiary's medical record.

   1. Family members and the beneficiary (as appropriate to his/her maturity) participate in developing the plan of care. They are provided with accurate information and support appropriate to informed decision-making; and they must give informed consent for planned services.

   2. Beneficiary/family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of care; services delivered in the home accommodate beneficiary/family life activities.

   3. The plan includes goals directed toward increasing beneficiary/family capability, effectiveness, and control.

   4. The plan includes compensatory services to support the growth and developmental potential of each beneficiary, given his/her disability or illness.

   5. Appointments are coordinated and services are scheduled with the goals of minimizing inconvenience to the beneficiary/family, and of facilitating the family's participation in the beneficiary's care.

   6. If the services are provided by LPNs, the plan of care must identify the frequency of the supervisory RN visits.

MEDICAL CRITERIA

Meeting the medical criteria for private duty nursing requires a finding that the beneficiary meets the criteria of ***either*** **I. and III.** below ***or*** **II. and III.** below.

I. The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
   - mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or CPAP); or
   - oral or tracheostomy suctioning 8 or more times in a 24-hour period; or
   - nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
   - total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
   - continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.

II. Frequent episodes of medical instability within the past 3 to 6 months, requiring skilled nursing assessments, judgments or interventions, as described in III. below, due to a substantiated progressively debilitating physical disorder.

   - "frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past 6 months, or at least 6 episodes of medical instability related to the progressively debilitating physical disorder within the past 3 months;
   - "medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder;
   - "emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention in: placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
   - "progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III. below) is required; and
   - "substantiated" means documented in the clinical/medical record, including the nursing notes.

   Note: For beneficiaries described in II. above, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for private duty nursing. Determination of continuing eligibility for private duty nursing for beneficiaries, defined in II. above, is based on the original need for skilled nursing assessments, judgments, or interventions, as described in III. below.

III. The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

BENEFIT LIMITATIONS

The purpose of the private duty nursing benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. The benefit is not intended to supplant the care-giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary care giver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18 and the care giver must provide a minimum of 8 hours of care during a typical 24-hour period.

Note: The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the 8 hours of obligated care as discussed above, nor can the 8 hours of care requirement for beneficiaries under age 18 be met by other public-funded programs (e.g., Medicaid Home Help Program), or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

Medicaid uses the following decision guide to establish the amount of private duty nursing that should be approved. Except for emergency circumstances, Medicaid will not approve more than the maximum hours indicated on the guide.

Decision Guide For Establishing Maximum Amount Of Private Duty Nursing To Be Authorized On a Daily Basis

The Decision Guide that follows is a tool used to determine the appropriate range of nursing hours that can be authorized under the Medicaid private duty nursing benefit; it defines the 'benefit limitation' for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of private duty nursing (i.e., the number of hours) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for private duty nursing, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance will be subtracted from the hours approved under Medicaid private duty nursing. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized.

Only those factors which influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the care giver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service

planning, and should be considered when determining the actual number of hours (within the range) to authorize.

The determination of the Intensity of Care category is a clinical judgment, and is based on the following factors: the beneficiary's medical condition, the type and frequency of needed nursing assessments, judgments and interventions, and the impact of delayed nursing interventions. Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible. The '**High**' category includes beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least 1 time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. The '**Medium**' category includes beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least 1 time every 3 hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care. The '**Low**' category includes beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least 1 time every 3 hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

FAMILY SITUATION/ RESOURCE CONSIDERATIONS	INTENSITY OF CARE Average Number of Hours Per Day		
	LOW	MEDIUM	HIGH
Factor I - Availability of Care Givers Living in the Home: a. 2 or more care givers; both work or are in school F/T or P/T	4-8	6-12	10-16
b. 2 or more care givers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
c. 2 or more care givers; neither works or is in school at least P/T	1-4	4-8	6-12
d. 1 care giver; works or is in school F/T or P/T	4-8	6-12	10-16
e. 1 care giver; does not work and is not a student	1-4	6-10	8-14
Factor II - Health Status of Care Giver(s): a. Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <=14
b. Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <=13
Factor III - School: This factor limits the maximum number of hours which can be authorized for a beneficiary: a) of any age in a center-based school program for more than 25 hours per week; or b) age six and older for whom there is no medical justification for a home-bound school program. In both cases, the lesser of the maximum 'allowable' for Factors I and II, or the maximum specified for Factor III applies.			
Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day.	Maximum of 8 hours per day.	Maximum of 12 hours per day.

DEFINITIONS:

'Care giver': legally responsible person (e.g., birth parents, adoptive parents, spouses); paid foster parents; guardian or other adults who are not legally responsible or paid to provide care, but who choose to participate in providing care.

'Full-time (F/T)': working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.

'Part-time (P/T)': working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.

'Significant' health issues: one or more primary care giver(s) has a health or emotional condition that **prevents** the care giver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary care giver just had back surgery and is in a full-body cast).

'Some' health issues: one or more primary care giver(s) has a health or emotional condition, as documented by the care giver's treating physician, that **interferes** with, but does not prevent, provision of care (e.g., care giver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).

The average hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in a school, plus transportation time. **Note:** During "planned breaks" of at least 5 consecutive school days (e.g., spring break, summer vacation), additional hours can be authorized within the parameters of Factors I and II.

As a matter of Special Education law, the Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such 'health and related services' as necessary for the student to participate in his/her education program. Unless medically contraindicated, individuals of school age should attend school. **Factor III applies when determining the maximum number of hours to be authorized for an individual of school age**. The Medicaid Private Duty Nursing benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program).

EXCEPTION PROCESS

Because every beneficiary and his/her family is unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. Private duty nursing services which exceed the beneficiary's 'Benefit Limitation', as established by the *Decision Guide For Establishing Maximum Amount of Private Duty Nursing To Be Authorized on a Daily Basis,* must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published private duty nursing benefit limitations may be granted subject to the provisions of this *Exception Process*. Exceptions are time-limited, as detailed below.

Initiating and Documenting a Request for Exception: The request for an exception must be initiated by the beneficiary or his/her primary care giver. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional private duty nursing must be identified in the beneficiary's plan of care. As applicable, the plan of care must include strategies directed toward resolving the factors necessitating the exception.

Documentation must substantiate all of the following:

1. Current medical necessity for the exception;

2. Current lack of natural supports required for the provision of the needed level of support;

3. Additional private duty nursing services are essential to the successful implementation of the beneficiary's written plan of care; and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his/her condition.

Exception Criteria: Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception shall be limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

1. A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:
   a. A temporary increase in the intensity of required assessments, judgments, and interventions.
   b. A temporary need for additional training to enable the primary care giver(s) to identify and meet the beneficiary's care needs.

   The total number of additional private duty nursing hours cannot exceed 2 hours per day, for a maximum of 6 months.

2. The temporary inability of the primary care giver(s) to provide the required care, as the result of one of the following:
   a. An acute illness or injury of the primary care giver(s). The total number of additional private duty nursing hours cannot exceed 2 hours per day for the duration of the care giver's inability, not to exceed 6 months. In the event there is only 1 care giver living in the home and that care giver is hospitalized, a maximum of 24 hours per day can be authorized for each day the care giver is hospitalized.
   b. The death of the primary care giver(s) or an immediate family member. 'Immediate family member' is defined as the care giver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of 7 days.
   c. The home environment has been determined to be unstable, as evidenced by the Family Independence Agency protective or preventive services involvement. The written plan of care and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary's *Intensity of Care* category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is 3 months or the time needed to stabilize service supports and/or family situation, whichever is less. A one-time extension of up to 3 months may be made if there is documented progress toward achieving the stabilized home environment.

   'Inability' is defined as the care giver is either unable to provide care, or is prevented from providing care.

SERVICE LOG

If private duty nursing is prior approved and care is initiated, a detailed log indicating the shift hours for each date of service for each procedure must be maintained. The provider must maintain this log in the beneficiary's medical record. The following is a facsimile of a log as it might be completed for a private duty agency. A Medicaid-enrolled nurse would also maintain this type of log.

Facsimile of Log for Private Duty Nursing Agency

October 2003

Revenue Code/HCPCS Code			DATE	SHIFT	Quantity HOURS
RN	0582	S9123	10/06/03	8:00 AM - 12:00 PM	4
	0582	S9123	10/09/03	8:00 AM - 12:00 PM	4
	0582	S9123	10/15/03	8:00 AM - 12:00 PM	4
	0582	S9123	10/22/03	8:00 AM - 12:00 PM	4

CLINICAL RECORD

In addition to the Service Log, the provider must maintain clinical records as detailed in Chapter I. The clinical record must be sufficiently documented to allow another professional to reconstruct what transpired during each hour of nursing service billed to Medicaid.

MILEAGE

Reimbursement for staff mileage to the beneficiary's home is included in the hourly rate paid to the provider.

MEDICAID POLICY MANUAL AND BILLING INSTRUCTIONS

Private Duty Nursing Agency

The provider must adhere to all applicable policies and procedures set forth in the Medicaid Manual and this bulletin.

The private duty nursing procedure codes and billing instructions are contained in **Attachment III** of this bulletin**.**

Medicaid-Enrolled RN or LPN

The provider must adhere to all applicable policies and procedures set forth in the Medicaid Manual and this bulletin.

The private duty nursing procedure codes and billing instructions are contained in **Attachment IV** of this bulletin**.**

PAYMENT IN FULL

The private duty nursing provider MUST accept Medicaid's payment as payment-in-full after any and all resources have been billed. The provider must not seek, nor accept, additional or supplemental payment from any of the above-mentioned programs, or from the beneficiary or the beneficiary's legal representative. Chapter I of the Home Health and Practitioner Manuals contains additional information on payment-in-full.

PRIVATE DUTY NURSING
ENROLLMENT REQUIREMENTS

Medicaid-Enrolled Nurse

To enroll as a Medicaid provider, the Medicaid-enrolled nurse must meet the following criteria:

1. Be a Registered Nurse (RN) licensed to practice in Michigan; or be a Licensed Practical Nurse (LPN) licensed to practice in Michigan, working under the supervision of an RN.

   Supervision of a Medicaid-enrolled LPN must be by an RN licensed to practice in Michigan who has at least one year of experience in any of the following areas: community health nursing, pediatric nursing, maternal and child health nursing, or a similar nursing practice. The Medicaid Program requires an on-site (beneficiary's home) supervisory visit by the RN of the LPN at least once every 2 months. The Medicaid-enrolled LPN must maintain documentation that verifies who the supervising RN is, a copy of the RN's license, and documentation that supports that the RN supervisory visits were rendered. Documentation of the supervisory visit as signed by the RN, must be included in the clinical record. The clinical record must be complete enough to allow another professional to reconstruct what transpired during the supervisory visit.

2. Cooperate with Medicaid in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. **Note:** The Medicaid-enrolled nurse must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.

Private Duty Nursing Agency

To enroll as a Medicaid provider, the private duty nursing agency must meet the following criteria:

1. Must be accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) **or** the Community Health Accreditation Program (CHAP) as a private duty nursing agency, **or** be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a Home and Community-Based Rehabilitation Program.

   In the event a private duty nursing agency does not meet the above criteria, it may enroll if it has been authorized by Medicaid between August 1, 2001 and February 1, 2002 to provide hourly home care to a Medicaid beneficiary (e.g., letter from CSHCS Program or Children's Waiver Program). Medicaid enrollment based on these approval letters for the hourly home care will end after five years. Five years after the date of Medicaid enrollment, agencies will be required to meet the requirement in 1. above. In the event these requirements for accreditation are not met, the provider will be disenrolled from the Medicaid Program.

   Private duty nursing agencies are not permitted to avoid the above accreditation requirements by individually enrolling RNs or LPNs in the Medicaid Program.

2. Must cooperate with Medicaid in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. **Note:** The provider must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.

BILLING INSTRUCTIONS
Private Duty Nursing Agency
(Provider Type 15)

Instructions for claim completion and requirements for the processing of claims are contained in Chapter IV (Billing & Reimbursement) issued in Home Health Agencies 01-06 bulletin. The bulletin announced the implementation of Medicaid's Uniform Billing Project effective February 1, 2002.

The following should be noted:

- Each month must be billed on a separate claim.
- Each date of service must be reported on a separate claim line.
- Each claim line must report the number of hours of care in the Days or Units item for that date of service.
- The prior authorization number listed on the Medicaid authorization letter must be recorded on the claim.
- The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
- A plan of care IS NOT TO BE ATTACHED TO THE CLAIM OR OTHERWISE SUBMITTED TO THE MEDICAID PROGRAM UNLESS SPECIFICALLY REQUESTED TO DO SO BY THE PROGRAM.
- The **total** number of hours reported must not exceed the total hours that were authorized for that month.
- Since whole hours of care are authorized, only those hours of care that entail **a full hour** of care may be billed.
- Adjustments to claims are made through a total claim replacement process.

MULTIPLE BENEFICIARIES SEEN AT SAME LOCATION

The specific procedure codes listed below must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for EACH beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, as approved, the multiple beneficiary code must be used for both children. The total Medicaid reimbursement for multiple beneficiaries will be time-and-one-half for two beneficiaries.

HOLIDAYS

Medicaid allows additional reimbursement for holidays. Medicaid currently recognizes the following holidays: New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas Day.

A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.

REVENUE CODES/HCPCS CODES/MODIFIERS

When billing, the provider must use the following codes. The HCPCS Codes/Modifiers are located in the Health Care Financing Administration Common Procedure Coding System manual.

Description	Revenue Code	HCPCS Code/Modifier
Nursing Care, RN, Per Hour	0582	S9123
Nursing Care, RN, Per Hour, Holiday	0582	S9123
Nursing Care, LPN, Per Hour	0582	S9124
Nursing Care, LPN, Per Hour, Holiday	0582	S9124
Nursing Care, 1 RN to 2 Patients, Per Hour	0582	S9123 TT
Nursing Care, 1 RN to 2 Patients, Per Hour, Holiday	0582	S9123 TT
Nursing Care, 1 LPN to 2 Patients, Per Hour	0582	S9124 TT
Nursing Care, 1 LPN to 2 Patients, Per Hour, Holiday	0582	S9124 TT
For ratios of more than 2 patients per nurse, the provider must contact the patient's case manager at the Children's Special Health Care Services (CSHCS), Home and Community-Based Services Waiver for the Elderly and Disabled, Children's Waiver (CMHSP), or Habilitation/Support Services Waiver (CMHSP). These ratios are considered exceptional cases and require prior approval.		

BILLING INSTRUCTIONS
Medicaid-Enrolled RN/LPN - Private Duty Nursing
(Provider Type 10)

Detailed instructions for claim completion and requirements for the processing of claims are contained in Chapter IV (Billing & Reimbursement).

The following should be noted:

- The HCFA 1500 claim form is used for paper claim billing.
- The National Electronic Data Interchange Transactions Set Health Care Claim Professional 837 ASC X 12N version 3051 or Michigan Medicaid interim version 4010 are used for electronic billing.
- The Place of Service Code on the claim must be **12** indicating **Home**.
- Each date of service must be reported on a separate claim line.
- Each separate line must report the number of hours of care in the Days or Units item for that date of service.
- The prior authorization number listed on the Medicaid authorization letter must be recorded on the claim.
- The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
- A plan of care IS NOT TO BE ATTACHED TO THE HCFA 1500 OR OTHERWISE SUBMITTED TO THE MEDICAID PROGRAM UNLESS SPECIFICALLY REQUESTED TO DO SO BY THE PROGRAM.
- The **total** number of hours reported must not exceed the total hours that were authorized for that month.
- **Since whole hours of care are authorized, only those hours of care that entail a full hour of care may be billed.**
- Adjustments to claims are made through a total claim replacement process.

MULTIPLE BENEFICIARIES SEEN AT SAME LOCATION

The specific procedure codes listed below must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These procedure codes must be used for EACH beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary code must be used for both children. The total Medicaid reimbursement for multiple beneficiaries will be time-and-one-half for two beneficiaries.

HOLIDAYS

Medicaid allows additional reimbursement for holidays. Medicaid currently recognizes the following holidays: New Year's Day, Easter, Memorial Day, July 4, Labor Day, Thanksgiving, and Christmas Day.

A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.

HCPCS CODES/MODIFIERS

When billing on the HCFA 1500 claim form, the provider must use the following codes. The HCPCS Codes/Modifiers are located in the Health Care Financing Administration Common Procedure Coding System manual.

Description	HCPCS Code/Modifier
Nursing Care, RN, Per Hour	S9123
Nursing Care, RN, Per Hour, Holiday	S9123
Nursing Care, LPN, Per Hour	S9124
Nursing Care, LPN, Per Hour, Holiday	S9124
Nursing Care, 1 RN to 2 Patients, Per Hour	S9123 TT
Nursing Care, 1 RN to 2 Patients, Per Hour, Holiday	S9123 TT
Nursing Care, 1 LPN to 2 Patients, Per Hour	S9124 TT
Nursing Care, 1 LPN to 2 Patients, Per Hour, Holiday	S9124 TT
For ratios of more than 2 patients per nurse, the provider must contact the patient's case manager at the Children's Special Health Care Services (CSHCS), Home and Community-Based Services Waiver for the Elderly and Disabled, Children's Waiver (CMHSP), or Habilitation/Support Services Waiver (CMHSP). These ratios are considered exceptional cases and require prior approval.	