MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Home Health Agencies 02-01
Community Mental Health Services Programs (CMHSPs) 02-01
Practitioner 02-01 (Medicaid Enrolled RNs and LPNs for Private Duty Nursing)

Issued: January 1, 2002

Subject: Elimination of Hourly Nursing Home Care as a Home Health Agency Benefit
Elimination of Hourly Nursing as a CMHSP Benefit
Medicaid Coverage of Private Duty Nursing

Effective: February 1, 2002

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

PURPOSE

This bulletin announces that Medicaid will no longer cover hourly nursing care when billed by a *home health agency* or a *Community Mental Health Services Program (CMHSP) for the Children's Waiver,* or for beneficiaries under age 21 receiving services through Home and Community-Based Services Waiver for the Elderly and Disabled (known as the MI Choice Waiver) or Habilitation/Support Services Waiver (Community Mental Health Services Program). This bulletin announces that hourly nursing care will be covered as a Medicaid State Plan private duty nursing benefit for beneficiaries under age 21. This private duty nursing benefit must be provided by a private duty nursing agency or Medicaid enrolled registered nurse (RN) or a licensed practical nurse (LPN) working under the supervision of an RN (per Michigan Public Health Code).

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.

HOME HEALTH AGENCIES

For beneficiaries requiring individual and continuous nursing care (i.e., hourly care), Medicaid has allowed these services to be provided under the *home health* benefit. Effective for dates of service on and after February 1, 2002, hourly nursing will no longer be a home health agency benefit. Rather, hourly nursing care will be covered as a private duty nursing benefit as explained in this bulletin.

Home health agencies that are currently authorized to provide hourly nursing care and want to continue the care must enroll in the Medicaid Program as a provider of private duty nursing, as explained in this bulletin.

NOTE: Medicaid is not eliminating coverage for nursing visits provided on a part-time or intermittent basis. Nursing visits remain a Medicaid home health benefit. The home health agency is to continue to use the procedure codes listed in the Procedure Codes Appendix of the Home Health Manual.

Home Health Agency 99-04 bulletin contains the billing instructions and lists the procedure codes for hourly home care, including nursing visits, therapy, and mileage associated with hourly home care. Home health agencies are not to bill using any of these procedure codes for dates of service on and after February 1, 2002. Home health agencies submitting claims on or after February 1, 2002 for hourly nursing services for dates of service prior to February 1, 2002, must use the UB-92 claim format and the revenue codes indicated below.

Description	Revenue Codes	Local Codes
Skilled Nursing Visit	581	70562
Hourly Nursing/Aide	582	70800 - 70825
Physical Therapy	429	70201
Occupational Therapy	439	70202
Speech Therapy	449	70611
Mileage	589	70620

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

CMHSP

Effective for dates of service on and after February 1, 2002, hourly nursing will no longer be a Community Mental Health Services Program (CMHSP) benefit for beneficiaries under age 21. Rather, hourly nursing care for these beneficiaries will be covered as a private duty nursing benefit as explained in this bulletin.

NOTE: The hourly nursing care procedure codes that the CMHSP can no longer bill Medicaid include: 10385, 10387, 10435-10438 and 10445-10448. For the Children's Waiver, other services listed in the CMHSP Manual remain covered and billable to Medicaid by the CMHSP, including assessments, treatment planning, health assessments and quarterly reviews performed by RNs.

The CMHSP Manual will be updated in the future to reflect the above change.

Supervisory Nurse Visit: A CMHSP **cannot** bill Medicaid for supervisory nurse visits of private duty nursing staff.

Billing Agent: The BILLING AGENT section of this bulletin discusses the use of a billing agent by a private duty nursing agency or Medicaid enrolled nurse.

CMHSP 98-01 bulletin: The criteria for determining the number of hours of **nursing** care published in CMHSP 98-01 bulletin no longer apply for dates of service on and after February 1, 2002. The nursing criteria has been replaced by the following criteria. The criteria published in CMHSP 98-01 bulletin continues to apply to mental health aides.

PRIVATE DUTY NURSING

Effective for dates of service on and after February 1, 2002, Medicaid will cover private duty nursing when provided in accordance with the following policies and procedures.

Private duty nursing will be 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).

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 (it is up to the LPN to secure this supervision).

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 onsite (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.

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

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

Private duty nursing is not a 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 UB-92 for private duty agencies or the HCFA 1500 for the RN and LPN. **Exception:** Approval letters issued by the Children's Waiver Program will not contain an approval number. For the Children's Waiver the provider is to retain the prior authorization letter in the beneficiary's medical record. The letter is not to be sent with the claim.

ASSESSMENT OF THIRD PARTY RESOURCE

The authorizing program will assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champus, Worker's Compensation, automobile insurance) for private duty nursing and home health services and will assist the beneficiary/family in selecting a private duty nursing provider in accordance with available third party coverage. This includes private health coverage held by, or on behalf of, a Michigan Department of Community Health beneficiary. This includes other insurance coverage for home care, as well as hospital and catastrophic care if relevant. Attachments II and III of this bulletin, as well as the Medicaid manual, contain additional information on third party billing.

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.

   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;
- "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.

~~A~~s 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 2002

Revenue Code/HCPCS Code			DATE	SHIFT	Quantity HOURS
RN	582	T1000 TD	10/06/02	8:00 AM - 12:00 PM	4
	582	T1000 TD	10/09/02	8:00 AM - 12:00 PM	4
	582	T1000 TD	10/15/02	8:00 AM - 12:00 PM	4
	582	T1000 TD	10/22/02	8:00 AM - 12:00 PM	4

MILEAGE

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

MEDICAID ENROLLMENT

Having met the Medicaid provider requirements in Attachment I, the private duty agency, RN, or LPN must then complete a Medical Assistance Provider Enrollment Agreement (DCH-1625) to enroll in the Medicaid Program. A DCH-1625 can be obtained by writing:

Michigan Department of Community Health
Provider Enrollment Unit
P.O. Box 30238
Lansing, Michigan 48909

OR

Telephoning: (517) 335-5492

If an RN or LPN is completing the application, he/she must indicate that they are requesting enrollment under the Medicaid Private Duty Nursing benefit.

If a private duty nursing agency is completing the application, the applicant must state on the application that enrollment is for a private duty nursing agency.

The completed and returned DCH-1625 must include a copy of the private duty agency's JCAHO, CHAP, or CARF accreditation, or a copy of a Medicaid prior approval letter issued within the last six months authorizing hourly care to a Medicaid beneficiary (e.g., letter from the CSHCS Program, letter from the Children's Waiver), **OR** for an RN and LPN, a copy of his/her current Michigan nursing license.

Upon meeting the requirements of provider enrollment, the private duty nursing agency will be enrolled in Medicaid as a **Provider Type 15.** The RN and LPN will be enrolled in Medicaid as a **Provider Type 10.**

MEDICAID POLICY MANUAL AND BILLING INSTRUCTIONS

Private Duty Nursing Agency

Upon enrollment in the Medicaid Program, the provider will receive a Medicaid Home Health Manual. The provider must adhere to all applicable policies and procedures set forth in the Manual.

Chapter III of the Medicaid Home Health Manual does not apply to private duty nursing. For private duty nursing coverage, providers must adhere to the policies contained in this bulletin. The agency must retain this bulletin until the Home Health Manual is updated.

The private duty nursing procedure codes and billing instructions are contained in **Attachment II** of this bulletin**.** The procedure codes listed in the Medicaid Home Health Manual, Procedure Codes Appendix must not be used. Using such codes will result in rejection of claims.

Medicaid Enrolled RN or LPN

Upon enrollment in the Medicaid Program, the provider will receive a Medicaid Practitioner Manual. The provider must adhere to all applicable policies and procedures set forth in the Manual.

Chapter III of the Practitioner Manual does not apply to private duty nursing. For private duty nursing coverage, the RN and LPN must adhere to the policies contained in this bulletin. The RN and LPN must retain this bulletin until the Practitioner Manual is updated.

The private duty nursing procedure codes and billing instructions are contained in **Attachment III** of this bulletin**.** The procedure codes listed in the Practitioner Manual, Procedure Codes Appendix must not be used. Using such codes will result in rejection of claims.

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.

BILLING AGENT

Either a private duty nursing agency, RN, or LPN may choose to obtain the services of a billing agent to bill for services rendered. Chapter I of the Home Health Manual and Practitioner Manual contains information on billing agents.

MANUAL MAINTENANCE

Home Health Agencies: Discard Home Health Agency 94-03, 98-01, and 99-04 bulletins and MSA 98-12 bulletin.

CMHSP: Discard MSA 98-12 bulletin.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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Director

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Deputy Director for
Medical Services Administration

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 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 onsite (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.

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 within the last six months 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 date of service must be reported on a separate line.
- Each separate line must report the number of hours of care in the Days or Units item for that date of service. The **total** number of hours reported must not exceed the total hours that were authorized for that month. The hours billed must be rounded up to the nearest whole number.
- The prior authorization number listed on the Medicaid authorization letter must be recorded in Form Locator 63 of the UB-92. **Exception:** Approval letters from the Children's Waiver Program will not contain an authorization number.
- 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 UB-92 OR OTHERWISE SUBMITTED TO THE MEDICAID PROGRAM UNLESS SPECIFICALLY REQUESTED TO DO SO BY THE PROGRAM.

THIRD PARTY LIABILITY

General Billing Information

Third Party Liability (TPL): Payment resources available from both private and public insurance and other liable third parties that can be applied toward a beneficiary's health care expenses.

Third Party Payer: Any individual, entity, or program that is or may be liable to pay all or part of health care costs incurred by a beneficiary. This includes Medicare, an insurance company, commercial health maintenance organization (HMO), preferred provider organization (PPO), Champus, Workers' Compensation and automobile insurance.

Private health care coverage and accident insurance, including coverage held by or on behalf of a MDCH beneficiary, is considered primary and must be billed according to the rules of the specific plan. The MDCH will not pay for services that would have been covered by the private payer if applicable rules of that private plan had been followed. A beneficiary with more than one level of private coverage must receive care at the highest level available. Providers are expected to take full advantage of the highest other insurance coverage from any third party resource (accept assignment, enrollment, participation).

Insurance carrier billing information is contained in the Carrier ID Listing in the Other Insurance Appendix of the Home Health manual.

If the provider does not participate with the commercial insurance carrier, the provider is expected to refer the beneficiary to a participating provider with the commercial coverage. Beneficiaries may obtain a list of participating providers from the insurance carrier. If a participating provider is not available, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or e-mail TPL@michigan.gov.

The Medicaid ID Card does contain Medicare and other insurance information, but the most current coverage information made known to MDCH is available from the Department's Eligibility Verification Contractor: 1-888-696-3510. Because coverage points change, it is still the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to provision of the service.

Providers must always identify third-party resources and total third-party payments when submitting a claim to the MDCH.

Other Insurance

If a Medicaid beneficiary has insurance coverage via a traditional insurance plan, or is enrolled in a commercial health maintenance organization (HMO) or other managed care plan, the rules for coverage by the commercial plan must be followed. The beneficiary must seek care from network providers and authorization or a referral must be obtained as necessary. If the coverage rules of the commercial plan are not followed, the MDCH is not liable for payment of services denied by the plan for these reasons. Medicaid will only pay for services excluded from plan coverage if they are covered Medicaid services.

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 entered in Form Locator 54. 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.

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 and third 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 or time-and-three-quarters for three 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.

REVENUE CODES/HCPCS CODES/MODIFIERS

When billing on the UB-92 claim form, the provider must use the following codes. The HCPCS/Modifiers are located in the Health Care Financing Administration Common Procedure Coding System manual.

Description	Revenue Codes	HCPCS Codes / Modifiers
Nursing, R.N., Per Hour	582	T1000 TD
Nursing, R.N., Per Hour Holiday	582	T1000 TD
Nursing, L.P.N, Per Hour	582	T1000 TE
Nursing, L.P.N, Per Hour Holiday	582	T1000 TE
R.N., 1 Nurse to 2 Patients, Per Hour	582	T1000 TD TF
R.N., 1 Nurse to 3 Patients, Per Hour	582	T1000 TD TG
R.N., 1 Nurse to 2 Patients, Per Hour Holiday	582	T1000 TD TF
R.N., 1 Nurse to 3 Patients, Per Hour Holiday	582	T1000 TD TG
L.P.N., 1 Nurse to 2 Patients, Per Hour	582	T1000 TE TF
L.P.N., 1 Nurse to 3 Patients, Per Hour	582	T1000 TE TG
L.P.N., 1 Nurse to 2 Patients, Per Hour, Holiday	582	T1000 TE TF
L.P.N., 1 Nurse to 3 Patients, Per Hour, Holiday	582	T1000 TE TG

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) issued in bulletins MSA 01-01 and MSA 01-20 to all health care practitioners. The bulletins announced the transition to the HCFA 1500 claim form.

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.
- Each date of service must be reported on a separate line item.
- Each separate line must report the number of hours of care in the Days or Units item for that date of service. The **total** number of hours reported must not exceed the total hours that were authorized for that month. The hours billed must be rounded up to the nearest whole number.
- The prior authorization number listed on the Medicaid authorization letter must be recorded in Item 23 on the HCFA 1500. **Exception:** Approval letters from the Children's Waiver Program will not contain an authorization number.
- 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 Place of Service Code (Item 24B) on the HCFA 1500 must be **12** indicating **Home**.
- Adjustments to claims are made through a total claim replacement process.

THIRD PARTY LIABILITY

General Billing Information

Third Party Liability (TPL): Payment resources available from both private and public insurance and other liable third parties that can be applied toward a beneficiary's health care expenses.

Third Party Payer: Any individual, entity, or program that is or may be liable to pay all or part of health care costs incurred by a beneficiary. This includes Medicare, an insurance company, commercial health maintenance organization (HMO), preferred provider organization (PPO), Champus, Workers' Compensation and automobile insurance.

Private health care coverage and accident insurance, including coverage held by or on behalf of a MDCH beneficiary, is considered primary and must be billed according to the rules of the specific plan. The MDCH will not pay for services that would have been covered by the private payer if applicable rules of that private plan had been followed. A beneficiary with more than one level of private coverage must receive care at the highest level available. Providers are expected to take full advantage of the highest other insurance coverage from any third party resource (accept assignment, enrollment, participation).

Insurance carrier billing information is contained in the Carrier ID Listing in the Other Insurance Appendix of the Practitioner manual.

If the provider does not participate with the commercial insurance carrier, the provider is expected to refer the beneficiary to a participating provider with the commercial coverage. Beneficiaries may obtain a list of participating providers from the insurance carrier. If a participating provider is not available, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or e-mail TPL@michigan.gov.

The Medicaid ID Card does contain Medicare and other insurance information, but the most current coverage information made known to MDCH is available from the Department's Eligibility Verification Contractor: 1-888-696-3510. Because coverage points change, it is still the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to provision of the service.

Providers must always identify third party resources and total third party payments when submitting a claim to the MDCH.

Other Insurance

If a Medicaid beneficiary is enrolled in a commercial health maintenance organization (HMO) or other managed care plan, the rules for coverage by the commercial plan must be followed. The beneficiary must seek care from network providers and authorization must be obtained as necessary. If the coverage rules of the commercial plan are not followed, the MDCH is not liable for payment of services denied by the plan for these reasons. Medicaid will only pay for services excluded from plan coverage if they are covered Medicaid services.

Medicaid will pay fixed co-pays 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 entered in Form Locator 54. 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.

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 and third 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 or time-and-three-quarters for three 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.

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 Codes / Modifiers
Nursing, R.N., Per Hour	T1000 TD
Nursing, R.N., Per Hour Holiday	T1000 TD
Nursing, L.P.N, Per Hour	T1000 TE
Nursing, L.P.N, Per Hour Holiday	T1000 TE
R.N., 1 Nurse to 2 Patients, Per Hour	T1000 TD TF
R.N., 1 Nurse to 3 Patients, Per Hour	T1000 TD TG
R.N., 1 Nurse to 2 Patients, Per Hour Holiday	T1000 TD TF
R.N., 1 Nurse to 3 Patients, Per Hour Holiday	T1000 TD TG
L.P.N., 1 Nurse to 2 Patients, Per Hour	T1000 TE TF
L.P.N., 1 Nurse to 3 Patients, Per Hour	T1000 TE TG
L.P.N., 1 Nurse to 2 Patients, Per Hour, Holiday	T1000 TE TF
L.P.N., 1 Nurse to 3 Patients, Per Hour, Holiday	T1000 TE TG