

## Michigan Department of Community Health

**Bulletin Number:** MSA 11-31

**Distribution:** Private Duty Nursing (PDN)

**Issued:** August 1, 2011

**Subject:** Definition of PDN; Change in PDN Prior Authorization (PA) Procedure; Revised Private Duty Nursing Prior Authorization – Request for Services Form (MSA-0732); New Documentation Requirements; Reminders Regarding Prior Authorization

**Effective:** As Indicated

**Programs Affected:** Medicaid

### Definition of PDN

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Michigan Medicaid Provider Manual, Private Duty Nursing Chapter, Medical Criteria Subsection, for beneficiaries under age 21.

If beneficiaries receiving PDN demonstrate a need for personal care or Home Help services in addition to PDN, there must be coordination between the delivery of the personal care or Home Help and the PDN services, as well as documentation in the plan of care (POC) to verify there is no duplication of services.

***The following does not apply to beneficiaries whose PDN services are prior authorized by staff from the Community Mental Health Services Program or a MI Choice Waiver agent because the beneficiary is enrolled in the Children's Waiver Program, the Habilitation Supports Waiver, or the MI Choice Waiver.***

### Change in Prior Authorization (PA) Procedure

PDN services for Medicaid beneficiaries must be authorized by the Michigan Department of Community Health (MDCH) Program Review Division before services can begin and at regular intervals thereafter if continued services are determined to be necessary. Currently, a Notice of Authorization is sent to the provider upon initial approval of the PDN services, and then subsequently at one to 12 month intervals for the duration of the services.

Effective September 1, 2011, for services beginning October 1, 2011, and thereafter, the revised MSA-0732 form (attached) must be submitted every time services are requested for the following situations:

- for initial services when the beneficiary has never received PDN services under Medicaid, such as following a hospitalization or when there is an increase in severity of an acute or chronic condition;
- for continuation of services beyond the end date of the current authorization period (renewal);
- for an increase in services; or
- for a decrease in services.

Following receipt and review of the MSA-0732 and the required documentation by the Program Review Division, a Notice of Authorization is sent to the PDN provider and beneficiary or primary caregiver, either approving or denying services, or requesting additional information. Each Notice of Authorization will contain the prior authorization number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the Program Review Division.

If a beneficiary receiving PDN continues to require the services after the initial authorization period, a new MSA-0732 must be submitted along with the required documentation supporting the continued need for PDN. This request must be received by the Program Review Division no less than 15 business days prior to the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services, which in turn may result in delayed or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical needs and family situation.

If during an authorization period a beneficiary's condition changes warranting an increase or decrease in the number of approved hours, or a discontinuation of services, the provider must report the change to the Program Review Division. (Refer to the Directory Appendix for contact information.) It is important that the provider report all changes as soon as they occur, as well as properly updating the plan of care. The request to increase or decrease hours must be accompanied by an updated and signed POC; and documentation from the attending physician addressing the medical need, if the request is for an increase in PDN hours.

Often the request to begin services will be submitted by a PDN agency or individual PDN; however, a person other than the PDN provider such as the hospital discharge planner, Children's Special Health Care Services (CSHCS) case manager, physician, or physician's staff person, may submit the MSA-0732 form. When this is the case, the person submitting the request must do so in consultation with the PDN agency or individual PDN who will be assuming responsibility for the care of the beneficiary.

If services are requested for more than one beneficiary in the home, a separate MSA-0732 form must be completed for each beneficiary.

### **Revised Private Duty Nursing Prior Authorization – Request for Services Form (MSA-0732)**

The MSA-0732 form has been revised to accommodate the changes described in this bulletin. MDCH will require the use of the revised form beginning September 1, 2011, for services beginning October 1, 2011, and thereafter. Requests for PDN services received by the Program Review Division on or after September 1, 2011, and not submitted on this revised form, will be returned with the request to resubmit on the new MSA-0732.

### **New Documentation Requirements**

The following documentation is required for **all** PA requests for PDN services and must accompany the MSA-0732:

- Most recent signed and dated nursing assessment completed by a registered nurse;
- Nursing notes for two four-day periods, including one four-day period that reflects the most current medically stable period and another four-day period that reflects the most recent acute episode of illness related to the PDN qualifying diagnosis/condition;
- Most recent updated POC signed and dated by the ordering/managing physician that supports the skilled nursing services requested;

The POC must include:

- Name of beneficiary and Medicaid ID number;
- Diagnosis(es)/presenting symptom(s)/condition(s);
- Name and address of the ordering/managing physician;

- Frequency, and duration if applicable, of skilled nursing visits, and the frequency and types of skilled interventions, assessments, and judgments that pertain to and support the PDN services to be provided and billed;
  - Identification of technology-based medical equipment, assistive devices, (and/or appliances), durable medical equipment, and supplies;
  - Other services being provided in the home by community-based entities that may affect the total care needs ;
  - List of medications and pharmaceuticals (prescribed and over-the-counter);
  - All hospital discharge summaries for admissions related to the PDN qualifying diagnosis/condition within the last authorization period;
  - Statement of family strengths, capabilities, and support systems available for assisting in the provision of the PDN benefit (for renewals, submit changes only).
- Other documentation as requested by MDCH.

### **Reminders Regarding Prior Authorization**

#### **Retroactive Prior Authorization**

Services provided before PA is requested will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If the MDCH eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

#### **Beneficiary Eligibility**

Approval of a PA request on the MSA-0732 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDCH will not reimburse the provider for services provided and billed. To assure payment, the provider must verify beneficiary eligibility monthly at a minimum.

### **Manual Maintenance**

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

### **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 at [ProviderSupport@michigan.gov](mailto: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.

### **Approved**



Stephen Fitton, Director  
Medical Services Administration

**Michigan Department of Community Health  
Completion Instructions for MSA-0732  
Private Duty Nursing Prior Authorization – Request for Services**

The MSA-0732 form must be submitted every time services are requested, i.e., before services can begin and for each specified authorization period thereafter, no less than 15 days prior to the end of the current authorization period.

MDCH requests that the MSA-0732 be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDCH website [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders) >> Policy and Forms >> Forms.

This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage **with the exception of those enrolled in the Children’s Waiver, the Habilitation Supports Waiver, or the MI Choice Waiver**. Private Duty Nursing is not a benefit under Children’s Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid. A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician’s staff person. When this is the case, the person submitting the request must do so in consultation with the PDN who will be assuming responsibility for the care of the beneficiary. If services are being requested for more than one beneficiary in the home, a separate form must be completed for each beneficiary.

Refer to the Medicaid Provider Manual, Private Duty Nursing Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDCH use only.
2	Check specific box as to whether this is an initial or renewal request. If a renewal, check the INCREASE HOURS or DECREASE HOURS box only if this request demonstrates an increase or decrease in hours from the previous authorization period.
3 - 7	PDN provider information. Provide complete agency name, or name of individual (last, first, and middle initial). Designate whether RN or LPN. Include NPI number, phone number, address, and fax number.
8 - 13	Beneficiary information. Provide complete name and birth date (month, day, and year); sex, mihealth card number, complete address, and primary diagnosis using the appropriate ICD-9-CM code.
14 - 17	Other insurance information if applicable, including name of company and beneficiary’s group/policy and certificate/contract numbers.
18 - 24	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
25 - 29	Ordering physician information. Provide complete name (including MD or DO); NPI number, phone number, address, and fax number.
30 - 34	Description of the service(s) to be provided (i.e., RN, LPN), procedure code(s) ( <i>S9123 and/or S9124, depending on whether an RN, LPN or both will be providing the services -- include modifier (TT) if appropriate</i> ), and the number of total hours per month required to provide the service(s) with a start date and end date, if known.
35 - 39 42 - 48	Home environment information, including number of siblings residing in the home (include step and foster child(ren) if applicable) and if they receive PDN. Provide child’s name and mihealth card number if receiving PDN. Also provide the number of other individuals in the home requiring care (e.g., elderly parent, grandparent, disabled spouse, sibling), name(s) and number of caregivers for the beneficiary for whom services are being requested, and whether the caregiver(s) either work and/or attend school outside of the home. If so, how many hours are spent working and/or attending school. (Additional pages may be required.)
40 - 41	Current school information if child is or will be attending school during the authorization period when PDN services are being provided. Include number of hours per day and per week, including travel time.
49 - 55	If more than one PDN or PDN agency is involved, their name(s), phone number(s), fax number(s), and which PDN will be managing the care plan (i.e., the provider named in items 2 – 6, or the provider named in this space).
56	The signature certifies that: <input type="checkbox"/> the individual requesting the services understands the necessity for prior authorization for the services; and <input type="checkbox"/> the information provided on this form is accurate and complete.
57 - 59	MDCH Use Only

**Form Submission**

The completed MSA-0732 and required documentation must be mailed or faxed to:

Michigan Department of Community Health      **Fax:** (517) 241-7813  
 Program Review Division  
 P.O. Box 30170  
 Lansing, MI 48909

Questions should be directed to MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act  
 COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Michigan Department of Community Health  
**PRIVATE DUTY NURSING**  
**PRIOR AUTHORIZATION – REQUEST FOR SERVICES**

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)

**The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.**

2. INDICATE IF THIS REQUEST IS: <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL <input type="checkbox"/> INCREASE HOURS <input type="checkbox"/> DECREASE HOURS					
3. PROVIDER'S NAME (AGENCY NAME, OR INDIVIDUAL'S NAME (IF INDEPENDENT RN/LPN))		4. NPI NUMBER		5. PHONE NUMBER	
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			7. FAX NUMBER		
8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		9. SEX <input type="checkbox"/> M <input type="checkbox"/> F	10. BIRTH DATE	11. MIHEALTH CARD NUMBER	
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)			13. PRIMARY DIAGNOSIS (ICD-9-CM)		
14. OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	15. HEALTH INSURANCE COMPANY NAME		16. GROUP / POLICY NUMBER		
18. IS BENEFICIARY CURRENTLY HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO    IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER, DISCHARGE PLANNER BELOW.			ANTICIPATED DISCHARGE DATE:		
19. HOSPITAL NAME		20. HOSPITAL ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)		21. PHONE NUMBER	
22. NAME OF DISCHARGE PLANNER		23. DISCHARGE PLANNER'S PHONE NUMBER		24. DISCHARGE PLANNER'S FAX NUMBER	
25. ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL, MD OR DO)		26. NPI NUMBER		27. PHONE NUMBER	
28. PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			29. FAX NUMBER		
30. DESCRIPTION OF SERVICE		31. PROCEDURE CODE(S)	32. HOURS PER MONTH	33. START DATE	
				34. END DATE	
35. NUMBER OF SIBLINGS		36. DOES ANYONE ELSE RECEIVE PDN SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO	37. IF YES, PROVIDE CHILD'S NAME RECEIVING PDN SERVICES		
38. CHILD'S MIHEALTH CARD NUMBER					
39. NUMBER OF OTHER INDIVIDUALS IN HOME REQUIRING CARE		40. IS THE BENEFICIARY CURRENTLY IN SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	41. IF YES, HOW MANY HOURS? _____ PER DAY    _____ PER WEEK (INCLUDE TRAVEL TIME)		
42. NUMBER OF CAREGIVERS	43. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY		44. WORK OR ATTEND SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	45. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL	
	46. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY		47. WORK OR ATTEND SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	48. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL	
49. IS MORE THAN ONE PERSON/AGENCY INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO		50. NAME OF OTHER PERSON/AGENCY		51. NPI NUMBER	52. PHONE NUMBER
					53. FAX NUMBER
54. WHO WILL BE MANAGING THE PDN CARE PLAN?			55. PHONE NUMBER (IF DIFFERENT THAN #5 ABOVE)		
<p><b>56. CERTIFICATION:</b> THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR AUTHORIZATION FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR AUTHORIZATION AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF AUTHORIZED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.</p> <p>PROVIDER CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.</p>					
PROVIDER'S SIGNATURE			DATE		
<b>MDCH USE ONLY</b>					
57. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>		58. CONSULTANT REMARKS			
59.					
CONSULTANT SIGNATURE			DATE		