MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 10-35

Distribution: Private Duty Nursing (PDN)

Issued: September 1, 2010

Subject: Change in Healthcare Common Procedure Coding System (HCPCS) Codes; Reporting Change in Beneficiary's Condition/PDN as a Transitional Benefit

Effective: October 1, 2010

Programs Affected: Medicaid

CHANGE IN HCPCS CODES FOR PDN

The following change to PDN coding does not apply to PDN for beneficiaries 21 years of age or older provided as a waiver service under the MI Choice Waiver or Habilitation Supports Waiver.

Effective October 1, 2010, the Michigan Department of Community Health (MDCH) will require providers to bill the following HCPCS codes in one-hour increments as required in the 2010 HCPCS coding book.

- **S9123 – Nursing care, in the home; by registered nurse, per hour**
- **S9124 – Nursing care, in the home; by licensed practical nurse, per hour**

Since October 1, 2004, PDN has been billed and paid in 15-minute increments. This change to one-hour increments brings MDCH into compliance with the appropriate codes that must be used for private duty nursing billing under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The requirements for Revenue Code 0582, and the TT modifier used for ratios of more than one patient per nurse in the same setting, will remain the same.

Billing Instructions

PDN services are prior authorized in hours. Therefore, when billing for services, the total number of hours billed - whether with S9123 and/or S9124 - must not exceed the total number 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.**

Service Log

The following is an example of the required service log illustrating the revised "Units" column which must reflect "Hours" effective for dates of service on and after October 1, 2010.

(Beneficiary Name and Birth Date)						
Name	**Date of Service**	**Start Time**	**Stop Time**	**Units (Hours)**	**Nurse Signature & Date**	**Parent/Caregiver Signature & Date**
(name RN/LPN)	10/06/10	8:00 a.m.	12:00 p.m.	4		
(name RN/LPN)	10/07/10	8:00 a.m.	4:20 p.m.	8		
(name RN/LPN)	10/08/10	7:45 a.m.	1:00 p.m.	5		
(name RN/LPN)	10/9/10	12:00 p.m.	5:45 p.m.	5		

PDN agencies should refer to the Billing & Reimbursement for Institutional Providers Chapter of the Medicaid Provider Manual for instructions on claim completion and requirements for the processing of claims. Medicaid-enrolled Registered Nurses (RN) or Licensed Practical Nurses (LPN) should refer to the Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.

CHANGE IN BENEFICIARY'S CONDITION/PDN AS A TRANSITIONAL BENEFIT

Medicaid policy requires that the integrated plan of care (POC) be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes warranting a decrease in the number of approved hours, or a discontinuation of services, the provider must report the change to the appropriate authorizing agent (i.e., the Program Review Division, Children's Waiver, or Habilitation Supports Waiver). Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDCH will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided, and MDCH was not notified of the change in condition.

In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.

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. When you submit an e-mail, include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

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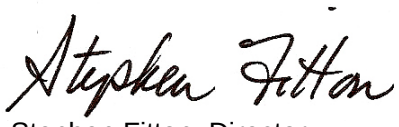

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