



# Oregon

Theodore R. Kulongoski, Governor

**Department of Human Services**

Health Services

*Office of Medical Assistance Programs*

500 Summer Street NE, E35

Salem, OR 97301-1077

**Voice (503) 945-5772**

**FAX (503) 373-7689**

**TTY (503) 378-6791**

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To: OMAP Home Health Services Providers

From: Joan M. Kapowich, Manager  
OMAP Program and Policy *Joan M. Kapowich*

Re: Private Duty Nursing Services Program; RB Revision 1

Effective: August 1, 2004

OMAP updated the Private Duty Nursing (PDN) Services Program Rulebook as follows:

OMAP revised 410-132-0055 to implement modifications to the Oregon Health Plan (OHP) Standard Benefit Package as directed by the 2003 Legislative Assembly in HB 2511. Some benefits are restored while other benefits are removed. Implementation of these amendments is approved by the Centers for Medicare and Medicaid Services (CMS).

- If you are reading this letter on OMAP's website:  
<http://www.dhs.state.or.us/policy/healthplan/rules/>,
- this administrative rulebook contains a complete set of rules for this program, including the above revisions.
- If you do not have web access and receive hardcopy of revisions, this letter is attached to the revised rule to use for replacement in your PDN Rulebook. Each rule is individually numbered for easy replacement.

If you have billing questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697. TR 554 8/1/04

*"Assisting People to Become Independent, Healthy and Safe"*  
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**DEPARTMENT OF HUMAN SERVICES**

**MEDICAL ASSISTANCE PROGRAMS**

**DIVISION 132**

**PRIVATE DUTY NURSING SERVICES**

410-132-0000 Purpose

410-132-0020 Private Duty Nursing Services

410-132-0030 Definitions

410-132-0050 Client Copayments

410-132-0055 Copayment for Standard Benefit Package

410-132-0060 Private Duty Nursing Transition into Maintenance --  
Effective for Services Provided On or after November 1, 1996

410-132-0070 Documentation Requirements

410-132-0080 Limitations

410-132-0100 Prior Authorization

410-132-0120 Billing Information -- Effective for Services Provided  
On or after November 1, 1996

410-132-0140 Instructions on How to Complete the HCFA-1500 --  
Effective for Services Provided on or after November 1, 1996

410-132-0180 Procedure Codes

410-132-0200 Provider Enrollment

## **410-132-0000 Purpose**

(1) The private duty nursing services administrative rules are included in the Office of Medical Assistance Programs' Private Duty Nursing Services Guide. The guide is also a user's manual designed to assist providers in preparing claims for services provided to Medical Assistance Program clients. It is published by the Office of Medical Assistance Programs (OMAP) to furnish medical providers with current information on program changes and governmental requirements.

(2) The Private Duty Nursing Services Guide is used along with the General Rules for the Office of Medical Assistance Programs, Oregon Health Plan Administrative Rules and the Oregon State Board of Nursing Oregon Revised Statutes and Administrative Rules. The Private Duty Nursing Services Guide includes private duty nursing administrative rules, procedure codes, instructions for completing claim forms, and examples of those forms.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-00

## **410-132-0020 Private Duty Nursing Services**

(1) The practice of nursing is governed by the following: Oregon State Board of Nursing, ORS 678.010 to 678.410, and Oregon State Board of Nursing, chapter 851, divisions 31, 45, and 47.

(2) Private duty nursing is considered supportive to the care provided to a client by the client's family, foster parents, and/or delegated caregivers, as applicable. Nursing services must be medically appropriate. Medically appropriate for private duty nursing shift care is determined by qualifying for services based on the Private Duty Nursing Acuity Grid (OMAP 591). Increases or decreases in the level of care and number of hours or visits authorized shall be based on a change in the condition of the client, limitations of the program, and the ability of the family, foster parents, or delegated caregivers to provide care.

(3) The need for private duty nursing shall be established based on a physician's order and the following information:

- (a) Nursing Assessment;
- (b) Nursing Care Plan;
- (c) Documentation of condition and medical appropriateness;
- (d) Identified skilled nursing needs;
- (e) Goals and objectives of care provided.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

## **410-132-0030 Definitions**

(1) Activities of Daily Living -- Activities usually performed in the course of a normal day in an individual's life such as: Eating, dressing, bathing and personal hygiene, mobility, bowel and bladder control, behavior modification, meal preparation, housecleaning, and food acquisition.

(2) Admission -- Acceptance of the client into the private duty nursing program contingent upon meeting the criteria as stated in rule.

(3) Basic Tasks of Client/Nursing Care -- Procedures that do not require the education or training of a registered nurse or licensed practical nurse, which cannot be performed by the client independently. Basic tasks of client/nursing care also means procedures that may be directed by the client. These basic tasks include, but are not limited to, activities of daily living. Basic tasks will vary from setting to setting depending on the client population served in that setting and the acuity/complexity of the client's care needs. Basic tasks may require the assignment and supervision of a licensed nurse. The need for supervision is at the discretion of the registered nurse. See State Board of Nursing rules that govern the practice of nursing.

(4) Critical/Fluctuating Condition -- A situation where the client's clinical and behavioral state is of a serious nature expected to rapidly change and in need of continuous reassessment and evaluation.

(5) Delegation -- A registered nurse authorizes an unlicensed person to perform special tasks of client/nursing care in selected situations and indicates that authorization in writing. Delegation occurs only after assessment of a specific situation (including the ability of the delegate), teaching the task and ensuring supervision. See State Board of Nursing rules that govern the practice of nursing.

(6) Discharge -- Client no longer meets the Office of Medical Assistance Programs' rules and criteria of the private duty nursing program.

(7) Home -- A place of temporary or permanent residence, not including a hospital, ICF/MR, nursing facility, or licensed residential care facility.

(8) Maintenance Care -- The level of care needed when the goals and objectives of the care plan are reached, the condition of the client is stable/predictable, the plan of care does not require the skills of a Licensed Nurse in continuous attendance, or the client, family, foster parents, or caregivers have been taught and have demonstrated the skills and abilities to carry out the plan of care.

(9) Medically Fragile Children's Unit (MFCU) -- A Department of Human Resources organizational unit that coordinates and may fund appropriate services for children ages 0 to 18 years with intensive medical needs that require in home and technological supports and meet MFCU criteria.

(10) Member of the Household -- Any person sharing a common abode as part of a single family unit, including domestic employees, and others who live together as part of a family unit, but not including a roomer or boarder.

(11) Plan of Care -- Written instructions detailing how the client is to be cared for. The plan is initiated by the private duty nurse or nursing agency with input from the prescribing physician. See the "Documentation Requirements" section of the Private Duty Nursing Services Guide.

(12) Private Duty Nursing Shift Care -- An RN or LPN nursing service for the client's critical/fluctuating conditions requiring the need for reassessment and evaluation with a high probability that complications would arise without skilled nursing management of the treatment program supplied in a specified block of time.

(13) Practice of Nursing -- Using the nursing process under doctor's orders to diagnose and treat human response to actual or potential health care problems, health teaching and health counseling, the provision of direct client care and the teaching, delegation and supervision of others who provide tasks of nursing care to clients. See State Board of Nursing rules that govern the practice of nursing.

(14) Private Duty Nursing Visit -- RN or LPN skilled nursing services for non-critical/stable conditions requiring reassessment and evaluation with a moderate probability that complications would arise without skilled nursing management of the treatment program supplied on an intermittent per visit basis.

(15) Respite -- Short-term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

(16) Responsible Unit -- The agency responsible for approving or denying prior authorization.

(17) Shift -- Four to twelve hours of private duty nursing.

(18) Skilled Nursing Services -- Client care services pertaining to the curative, restorative or preventive aspects of nursing performed by or under the supervision of a registered nurse pursuant to the plan of care established by the physician in consultation with the Registered Nurse. Skilled nursing emphasizes a high level of nursing direction, observation and skill. The focus of these services must be the use of the nursing process to diagnose and treat human responses to actual or potential health care problems, health teaching, and health counseling. Skilled nursing services include the provision of direct care and the teaching, delegation and supervision of others who provide tasks of nursing care to clients. Such services will comply with the Nurse Practice Act and Administrative Rules of the Oregon State Board of Nursing, which rules are by this reference made a part of.

(19) Special Tasks of Client/Nursing Care -- Tasks that require the education and training of a registered nurse or licensed practical nurse to perform. Special tasks will vary from setting to setting depending on the client population served in that setting and the acuity/complexity of the client's care needs. Examples of special tasks include, but are not limited to, administration of injectable medications, suctioning and complex wound care.

(20) Stable/Predictable Condition -- A situation in which the client's clinical and behavioral status is known and does not require the

regularly scheduled presence and evaluation of a licensed nurse. See State Board of Nursing rules that govern the practice of nursing.

(21) Teaching -- The registered nurse instructs an unlicensed person in the correct method of performing a selected task of client/nursing care. See State Board of Nursing rules that govern the practice of nursing.

(22) Visit -- Nursing service supplied on an intermittent basis in the home.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-99

## **410-132-0050 Client Copayments**

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-03

## **410-132-0055 Copayment for Standard Benefit Package**

(1) Private duty nursing services are not covered for clients receiving the Standard Benefit Package. See General Rules, 410-120-1210 for additional information.

(2) The OHP Standard Benefit Package includes limited home enteral/parenteral services and intravenous services (see 410-148-0090).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

8-1-04

**410-132-0060 Private Duty Nursing Transition into Maintenance -  
- Effective for Services Provided On or after November 1, 1996**

Private duty nursing services become maintenance care when any one of the following situations occur:

- (1) Medical and nursing documentation supports that the condition of the client is stable/predictable.
- (2) The plan of care does not require a Licensed Nurse to be in continuous attendance.
- (3) The client, family, foster parents, or caregivers have been taught the nursing services and have demonstrated the skills and ability to carry out the plan of care; or
- (4) The combined score on the Acuity Grid and Psychosocial Grid is less than 54.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 14.065

2-19-97

## **410-132-0070 Documentation Requirements**

(1) Documentation of services provided is to be maintained in the client's place of residence by the private duty nurse until discharged from service. Payment will not be made for services where the documentation does not support the definition of skilled nursing. Documentation must meet the standards of the Oregon State Board of Nursing.

(2) The private duty nurse must ensure completion and documentation of a comprehensive assessment of the client's capabilities and needs for nursing services within 7 days of admission. Comprehensive assessments must be updated and submitted to the responsible unit by the next work day after any significant change of condition and reviewed at least every 62 days. Some examples of significant change in condition are hospital admission, emergency room visit, change in status, death, or discharge from care.

(3) The nursing care plan must document that the private duty nurse, through case management and coordination with all interdisciplinary staff and agencies, provides services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each client in accordance with a written, dated, nursing care plan:

(a) The nursing care plan must be completed within 7 days after admission. The nursing care plan must be reviewed, updated, and submitted whenever the client's needs change, but at least every 62 days;

(b) The nursing care plan must describe the medical, nursing, and psychosocial needs of the client and how the private duty nurse will actively coordinate and facilitate meeting those needs. This description of needs must include interventions, measurable objectives, goals and time frames in which the goals and objectives will be met and by whom;

(c) The nursing care plan must include the rehabilitation potential including functional limitations related to Activities of Daily Living

(ADL), types and frequency of therapies, and activity limitations per physician order;

(d) The nursing care plan must include services related to school-based care according to the Individual Education Plan, if applicable;

(e) The nursing care plan must show coordination of all services being provided, for instance the client or representative, Registered Nurse (RN) case manager, Department of Human Services (DHS) case worker, physician, other disciplines involved and all other care providers involved in the client's treatment plan;

(f) The nursing care plan must include a statement of the client's potential toward discharge. Timelines must be included in the Plan outline;

(g) The nursing care plan must be available to and followed by all caregivers involved with care of the client.

(4) Documentation of private duty shift care must be written at least every hour on the narrative or flow sheet and must include:

(a) The name of the client on each page of documentation;

(b) The date of service;

(c) Time of start and end of service delivery by each caregiver;

(d) Anything unusual from the standard plan of care must be expanded on the narrative;

(e) Interventions;

(f) Outcomes including clients response to services delivered;

(g) Nursing assessment of client's status and any changes in that status per each working shift; and

(h) Full signature of provider.

(5) Documentation of delegation, teaching and assignment must be in accordance with the Oregon State Board of Nursing Rules.

(6) For documentation to be submitted with prior authorization, see Rule 410-132-0100.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-00

## **410-132-0080 Limitations**

(1) General; pertains to both shift care and visits:

(a) Private duty nursing is not covered if the client is:

(A) A resident of a nursing facility;

(B) A resident of a licensed intermediate care facility for people with developmental disabilities;

(C) In a hospital;

(D) In a licensed residential care facility.

(b) Private duty nursing is not covered solely to allow the client's family or caregiver to work or go to school;

(c) Private duty nursing is not covered solely to allow respite for caregivers or client's family;

(d) Payment for private duty nursing will not be authorized for parents, siblings, grandparents, foster care parents, significant others, members of the client's household, or individuals paid by other agencies to provide caregiving services;

(e) Costs of private duty nursing services are not reimbursable if they are provided concurrently with care being provided under home health or hospice program rules;

(f) Home nursing visits as defined in the Home Enteral/Parenteral Nutrition and IV Services Rules, are not covered in conjunction with private duty nursing services;

(g) Private duty nursing is not automatically covered in the school setting even if the Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) indicates the need. The level of need still must be determined by the score on the Private Duty Acuity Grid. All other criteria and limitations must be addressed;

(h) Holidays are paid at the same rate as non-holidays;

(i) Hours nurses spend in training are not reimbursable;

(j) Travel time to reach the job site is not reimbursable;

(k) Maintenance care is not reimbursable.

(2) Private Duty Nursing Visit:

(a) The nursing care plan and documentation supporting the medical appropriateness for private duty nursing must be reviewed every 60 days to continue the service. Reviews must be conducted by the responsible unit;

(b) Private duty nursing visits are limited to two per day.

(3) Private Duty Nursing Shift Care:

(a) Medically appropriate private duty nursing shift care for clients up to 18 years old, may be covered for acute episodes of illness, injury, or medical condition up to 62 continuous days in cases where it has been determined that skilled management by a licensed nurse is required;

(b) A client may be referred to the Medically Fragile Children's Unit (MFCU), to determine if they meet the criteria for MFCU admission at the time of the initial request for services, on or about day 50 of continuous service, or anytime thereafter (even if it is before the 62nd day) if any of the following are determined to exist:

(A) The client's medical needs are maintenance; or

(B) The client's medical needs are long term.

(c) Private Duty Nursing shift care for clients age 18 and over will be referred to Senior and Disabled Services Division (SDSD) for determination of their long-term care needs;

(d) The number of hours of private duty nursing services that a client may receive is determined by the score on the Private Duty Nursing Acuity Grid (OMAP 591):

(A) Must score greater than 60 points on the Acuity Grid to receive up to 24 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition; or

(B) Must score 50 to 60 points on the Acuity Grid to receive up to 16 hours per day immediately after discharge from a hospital or if there is a significant worsening or decline of condition; or

(C) Must score 40 to 49 points on the Acuity Grid to receive up to 84 hours per week immediately after discharge from a hospital or if there is a significant worsening or decline of condition; or

(D) If the score is 30 to 39 on the Acuity Grid then the Private Duty Nursing Psychosocial Grid (OMAP 590) will be used to determine eligibility. If the score is 24 or above, the client may receive up to 84 hours per week of shift care.

(c) The banking, saving, or accumulating unused prior authorized hours used for the convenience of the family or caregiver is not covered. Table 0080-1 (OMAP 590). Table 0080-2 (OMAP 591).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

## **410-132-0100 Prior Authorization**

(1) Payment may be made only for private duty nursing services only when authorized prior to initiation of services. It is the provider's responsibility to obtain prior authorization.

(2) The requesting provider must provide the following information in order to obtain prior authorization:

(a) Client's name and recipient ID number;

(b) Performing provider name and Office of Medical Assistance Programs (OMAP) provider number;

(c) Physician's orders for service must be dated within seven days prior to the date of request;

(d) Physician's name and provider number;

(e) Diagnosis with the ICD-9-CM codes to their highest specificity as supplied by the physician;

(f) Procedure codes;

(g) Date range of services;

(h) Frequency of service;

(i) Medical justification for services requested;

(j) The plan of care with short-term goals, long-term goals and objectives including time-lines for meeting the goals and objectives, the plan of care dated within one week of date of request;

(k) Usual and customary charge;

(l) A comprehensive assessment must be submitted with each request for private duty nursing shift care;

(m) A completed Private Duty Nursing Acuity Grid;

(n) A completed Psychosocial Grid, if needed.

(3) Prior authorization does not guarantee eligibility or payment. It is the provider's responsibility to check for the client's eligibility on the date of service and to follow all applicable rules regarding provision of service.

(4) Providers must request payment authorization for services provided for an emergency medical service on the first business day following the emergency service. This request must include all information needed to request prior authorization, and clear medical justification for the retroactive authorization.

(5) To extend an ongoing authorization, the following must be submitted at least 7 days prior to the expiration of the current prior authorization. Extension of authorization requires:

(a) Daily nursing notes from the past month;

(b) Flowsheets from the past month;

(c) Updated plan of care;

(d) Progress reports;

(e) Physician's orders for services must be dated within seven days of date of request;

(f) Recent significant clinical findings from physician;

(g) Recent clinic summaries;

(h) A current (within one week of request) completed Private Duty Nursing Acuity Grid (OMAP 591).

(6) To obtain eligibility status information:

(a) Check the client's current Medical Care Identification. An explanation of eligibility and coverage messages shown on the Medical Care Identification is included in the General Rules; or

(b) Call Automated Information System (AIS).

(7) Where to request prior authorization:

(a) Managed Health Care (MHC) Clients: Services for clients identified on their OMAP Medical Care Identification as having an "OMAP Contracted Plan" will be authorized by the plan. Contact the plan to determine their procedures;

(b) Adult and Family Services (AFS) and State Office for Services to Children and Families (SCF) Clients: Services for clients identified on the Medical Care Identification as AFS and SCF (shown on the Medical ID as CSD) will be authorized by OMAP;

(c) SDSD Clients: Those services for clients identified on the Medical Care Identification as Senior and Disabled Services Division (SDSD) clients will be authorized by OMAP;

(d) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, authorization must be obtained from the MCM Contractor prior to the initiation of services. For FFS MCM clients, OMAP will not reimburse for a service that requires payment authorization if the service is provided prior to receiving authorization from the MCM Contractor.

(e) Medically Fragile Children's Unit Clients. Services for clients identified by the Department as Medically Fragile Children will be authorized by MFCU.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

1-1-04

**410-132-0120 Billing Information -- Effective for Services Provided On or after November 1, 1996**

(1) If the client has the Basic Health Care benefit package, but is not enrolled in a prepaid health plan, bill with the appropriate OMAP unique procedure codes and follow the instructions on how to complete the HCFA-1500.

(2) Submit your claim on a HCFA-1500, electronically or on paper. Send your paper HCFA-1500 to OMAP.

(3) For information about electronic billing, contact the OMAP Electronic Billing Representative.

(4) When billing for clients with Medicare, bill on a HCFA-1500 and enter the appropriate TPR Explanation Code in Field 9.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-02

**410-132-0140 Instructions on How to Complete the HCFA-1500 -- Effective for Services Provided on or after November 1, 1996**

(1) The HCFA-1500 is a complete billing document. If there is not enough space on the HCFA-1500 to bill all procedures provided, complete a new billing form for the rest of the procedures. Do not "carry over" totals from one HCFA-1500 to another:

(a) Insured's I.D. Number. The eight digit number found on the OMAP Medical Care Identification;

(b) Patient's name. The name as it appears on the OMAP Medical Care Identification;

(c) Name of Referring Physician or Other Source. Enter the name of the referring provider;

(d) ID Number of Referring Physician: Enter the OMAP provider number or UPIN of the referring provider;

(e) Date of Service. Must be numeric. If "From-To" dates are used, a service must have been provided on each consecutive day but not more than once per day;

(f) Place of Service. Where service is provided:

(A) 4 -- patient's home;

(B) B -- school district facility.

(g) Type of Service (TOS). Enter type of service "S" in this field;

(h) Procedures, Services or Supplies. Enter the appropriate code listed in the OMAP Private Duty Nursing Services guide;

(i) Charges. Enter the provider's usual and customary charge for each line item;

(j) Days or Units. This number must match the number of days in the Date of Services field or the number of units of services provided;

(k) Total Charge. Enter the total amount for all charges listed on this HCFA-1500;

(l) Balance Due. Enter the amount due after subtracting the Amount Paid from the Total Charge. Do not include insurance write-off amounts;

(m) Provider Number. Enter the OMAP provider number of the provider to whom the check should be sent (actual service provider or the provider's billing service);

(n) Diagnosis or Nature of Illness or Injury. Enter the primary diagnosis/condition of the patient indicated by current ICD-9-CM code number. Enter up to four diagnosis codes in priority order. Carry the codes out to their highest degree of specificity. Do not enter the decimal point or unnecessary characters;

(o) Diagnosis Code. Enter a single diagnosis reference number as shown in Field 21.

(2) The following fields are required, when applicable:

(a) Other Insured's Name. If the client has other health insurance coverage as listed on the Medical Care Identification, and no payment was received from that resource, this space must be used to explain why no payment was made. Select a 2 digit "reason" code for the Third Party Resource (TPR) codes shown in the Private Duty Nursing Services guide. Be sure that this "reason" code is the first entry in Field 9, followed by the name of the Third Party Resource;

(b) Is Patient's Condition Related to. Complete only when an injury is involved;

(c) Reserved for Local Use (Emergency Services). Put a "Y" in this field if service was an emergency;

(d) Reserved for Local Use (Performing Provider). Enter the OMAP performing provider number here if a billing provider number is used in Field 33;

(e) Amount Paid. Enter the total amount paid by any other insurance or resource. Do not include OMAP copayments in this field. Do not show any payment from OMAP on this line. (If the patient has other insurance and this amount is zero, there must be a 2-digit "reason" code in Field 9.);

(f) Prior Authorization Number. If billing for a prior authorized service, enter the 9-digit Prior Authorization number here.

(3) Third Party Resource (TPR) Codes:

(a) Select one code from either the single or the multiple insurance coverage lists. Enter this code in Field 9 on the HCFA-1500 or OMAP 505;

(b) Single Insurance Coverage. Select the most appropriate code when the patient has only one insurance policy in addition to Medicaid:

(A) UD -- Service Under Deductible;

(B) NC -- Service Not Covered by Insurance Policy;

(C) PN -- Patient Not Covered by Insurance Policy;

(D) IC -- Insurance Coverage Canceled/Terminated;

(E) IL -- Insurance Lapsed or Not in Effect on Date of Service;

(F) IP -- Insurance Payment Went to Policyholder;

(G) PP -- Insurance Payment Went to Patient;

(H) NA -- Service Not Authorized or Prior Authorized by Insurance;

- (I) NE -- Service Not Considered Emergency by Insurance;
  - (J) NP -- Service Not Provided by Primary Care Provider/Facility;
  - (K) MB -- Maximum Benefits Used for Diagnosis/Condition;
  - (L) RI -- Requested Information Not Received by Insurance from Patient;
  - (M) RP -- Requested Information Not Received by Insurance from Policyholder;
  - (N) MV -- Motor Vehicle Accident Fund Maximum Benefits Exhausted;
  - (O) AP -- Insurance mandated under administrative/court order through an absent parent -- not paid within 30 days;
  - (P) OT -- Other (if above codes do not apply, include detailed information of why no TPR payment was made).
- (c) Multiple Insurance Coverage. Select most appropriate code when the patient has more than one insurance policy in addition to Medicaid:
- (A) MP -- Primary Insurance Paid -- Secondary paid;
  - (B) SU -- Primary Insurance Paid -- Secondary under Deductible;
  - (C) MU -- Primary and Secondary Under Deductible;
  - (D) PU -- Primary Insurance Under Deductible -- Secondary Paid;
  - (E) SS -- Primary Insurance Paid -- Secondary Service Not Covered;
  - (F) SC -- Primary Insurance Paid -- Secondary Patient Not Covered;
  - (G) ST -- Primary Insurance Paid -- Secondary Insurance Canceled/Terminated;

- (H) SL -- Primary Paid -- Secondary Lapsed or Not in Effect;
- (I) SP -- Primary Paid -- Secondary Payment Went to Patient;
- (J) SH -- Primary Paid -- Secondary Payment Went to Policyholder;
- (K) SA -- Primary Paid -- Secondary Denied -- Service Not Authorized or Prior Authorized;
- (L) SE -- Primary Paid -- Secondary Denied -- Service Not Considered Emergency;
- (M) SF -- Primary Paid -- Secondary Denied -- Service Not Provided by Primary Care Provider/Facility;
- (N) SM -- Primary Paid -- Secondary Denied -- Maximum Benefits Used for Diagnosis/Condition;
- (O) SI -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Policyholder;
- (P) SR -- Primary Paid -- Secondary Denied -- Requested Information Not Received from Patient;
- (Q) MC -- Service Not Covered by Primary or Secondary Insurance;
- (R) MO -- Other (if above codes do not apply, include detailed information of why not TPR payment was made);
- (S) AP -- Insurance mandated under administrative/court order through an absent parent -- not paid within 30 days.

Stat. Auth.: ORS 409  
Stats. Implemented: ORS 414.065  
1-1-03

## **410-132-0180 Procedure Codes**

(1) All private duty nursing services require prior authorization. (See definitions section of the guide).

(2) Private Duty Nursing Visit:

(a) T1030 - Nursing care, in the home, by registered nurse, per diem;

(b) T1031 - Nursing care, in the home, by licensed practical nurse, per diem

(3) Private Duty Nursing Shift Care:

(a) S9123 - Nursing care, in the home, by registered nurse, per hour - 1 unit equals one hour;

(b) S9124 - Nursing care, in the home, by licensed practical nurse, per hour - 1 unit equals one hour.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

4-1-03

## **410-132-0200 Provider Enrollment**

In order for registered nurses or licensed practical nurses to be enrolled or continue enrollment as an Office of Medical Assistance Programs provider, a copy of licensure must be submitted every two years upon renewal by the Oregon State Board of Nursing.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-00