MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 29, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 900 – PRIVATE DUTY NURSING

BACKGROUND AND EXPLANATION

The DHCFP is proposing revisions to Medicaid Services Manual (MSM) Chapter 900 – Private Duty Nursing (PDN) to ensure compliance with federal requirements. These changes will allow for PDN to be provided in the recipient's home or any setting where normal life activities occur. The requirements for medical were clarified, prior authorization (PA) requirements have been added and service hours will be limited to 70 hours per week or 10 hours per day. In addition, ongoing PAs will be required to be submitted 10 days prior to the end of the authorization period to align with Chapter 1400 – Home Health Agencies ongoing authorization time frame and revisions to the definition of concurrent care and immediate relative are being proposed to in MSM Addendum Sections C and I.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Providers of skilled nursing services in the community setting, including, but not limited to, Home Health Agencies and Private Duty Nursing (PT 29).

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective December 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL MSM Chapter 900 – Private Duty Nursing	MTL 10/03, 22/07, 22/08 MSM Chapter 900 – Private Duty Nursing

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
900	**Introduction**	Language was updated and/or reworded for improved readability and clarity.
901	**Authority**	Added new language "any setting where normal life activities occur" to align with federal requirements.
902	**Definitions**	Deleted this section. Added reference to MSM Addendum.
903.1	**Policy Statement**	Clarified language for PDN program. Added language to define "continuous," "complex" and "substantial." Added Social Security Act (SSA) definition of "intermittent."
903.1A.1(b)	**Program Eligibility Criteria**	Deleted this section to align with federal requirements.
903.1A.1(c)	**Program Eligibility Criteria**	Added language to allow service "where normal activities take place."
903.1a.2	**Covered Services**	Language was updated and/or reworded for improved readability and clarity. "Tracheotomy" was replaced with "tracheostomy" for accurate medical terminology. Replaced "to remain at home" with "prevent institutionalization."
903.1A.3	**Medical Criteria**	Renamed "Medical Necessity." Language was updated and/or reworded for improved readability and clarity. Examples of "skilled nursing interventions" updated for accurate medical terminology. Deleted Skilled Nursing Need Categories within the section. Defined "BID" as twice per day for clarity. Added language for "Non-invasive" ventilation. "Decision Guide" section was deleted.
903.1A.4	**Non-Covered Services**	Added new language regarding "non-skilled interventions which are custodial in nature" and included examples. New "legally responsible individual (LRI)" was added to align with other MSM policy definitions. Language was updated and/or reworded for improved readability and clarity.
903.1B	**Provider Responsibilities**	Language was added to state provider compliance with all MSM 900 language, MSM Chapter 100 and any and all state and federal regulations. Added SSA reference. Added new language "any setting where normal life activities occur" to align with federal requirements. "Termination of Services" section updated for clarity and

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		readability regarding "Immediate Termination" and "Advanced Termination" of services. Throughout the section "patient" is replaced with "recipient" where appropriate and language was updated or reworded for clarity. Added the use of a CMS Outcome and Assessment Information Set (OASIS) form for recipients age 21 or older.
903.1C	**Recipient's Responsibilities**	Language was updated and/or reworded for improved readability and clarity.
903.1D	**Authorization Process and Reimbursements**	Section 903.1D was renamed "AUTHORIZATION PROCESS." Language added regarding service limitations, PDN service hours not to exceed 70 hours per week or 10 hours per day. Clarifying language added for authorized hours for recipients with a new ventilator. Service hours may be increased to 16 hours per day for an eight-week interval. Language added for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Reference to MSM Chapter 1500 for authorization process. Third Party Liability (TPL) language deleted as it is duplicative to a previous section earlier in this chapter. Section 903.1D(1)(b) was deleted as holiday hour reimbursement is no longer applicable. Durable Medical Equipment changed to Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS), reference to MSM Chapter 1300 for DMEPOS policy and provider billing guide for added clarity. Section 903.1D.d "Reimbursement" moved to Section 904. Ongoing authorization timeline changed from 15 days to 10 days for consistency with processing timeframes. Clarifying language added to "RETRO AUTHORIZATIONS" regarding services provided with Prior Authorization (PA) requests are "pending."
903.2A	**Coverage and Limitations**	Renamed to "24-HOUR CARE COVERAGE AND LIMITATIONS" for clarity.
903.2B	**Provider Responsibilities**	Renamed to "24-HOUR CARE PROVIDER RESPONSIBILITIES" for clarity.
903.2C	**Recipient Responsibilities**	Renamed to "24-HOUR CARE RECIPIENT RESPONSIBILITIES" for clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
903.2D	**Authorization Process**	Renamed to "24-HOUR CARE AUTHORIZATION PROCESS" for clarity.
903.3	**Concurrent Care**	"Multiple" replaced with "up to three" for more concise definition.
903.3A	**Provider Responsibilities**	Renamed to "CONCURRENT CARE PROVIDER RESPONSIBILITIES" for clarity.
903.4	**Out-of-State Services**	Language added stating services are required to be prior authorized by the QIO-like vendor.
903.4A	**Coverage and Limitations**	Renamed to "OUT-OF-STATE COVRAGE AND LIMITATIONS." Language added regarding service limitation of 30 days and ongoing authorizations after the initial out-of-state authorization period must be prior authorized by the QIO-like vendor. Language from MSM Chapter 100 added to define locality for clarity.
903.4B	**Provider Responsibilities**	Renamed to "OUT-OF-STATE PROVIDER RESPONSIBILITIES."
903.4C	**Recipient Responsibilities**	Renamed to "RECIPIENT RESPONSIBILITIES FOR OUT-OF-STATE SERVICES."
903.5A	**Coverage and Limitations**	Renamed to "CRISIS OVERRIDE COVERAGE AND LIMITATIONS."
903.5B	**Provider Responsibilities**	Renamed to "CRISIS OVERRIDE PROVIDER RESPONSIBILITIES." Reference to previous chapter section corrected.
904	**Hearings**	Renamed to "RATES AND REIMBURSEMENT." Previously in Section 903.1.e, now a new stand-alone section which refers to billing guide and reimbursement code table for specific billing codes and reimbursements.
905	**References and Cross References**	Section deleted and renamed "Hearings."
	Private Duty Nursing Services – Decision Tool	Section deleted.

900 INTRODUCTION PRIVATE DUTY NURSING

~~INTRODUCTION~~

Private duty nursing (PDN) is an optional benefit offered under the Nevada Medicaid State Plan. ~~Private duty nursing~~PDN provides more individual and continuous care than is available from a visiting nurse for recipients who meet specified criteria and require more than four continuous hours of skilled nursing (SN) care per day. The intent of private duty nursing is to assist ~~the non-institutionalized~~ recipients with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial, complex, and continuous skilled nursing care to prevent institutionalization. ~~This benefit is not intended to replace care giving responsibilities of parents, guardians or other responsible parties, but to promote family-centered, community-based care that enables the recipient to remain safely at home rather than in an acute or long-term care facility. Private duty nursing~~PDN services may be provided, within program limitations, to a recipient in his/her home or in settings outside the home wherever normal life activities ~~may take them~~take place. Services ~~may be approved~~are authorized based on medical necessity, program criteria, utilization control measures and the availability of the state resources to meet recipient needs.

All Medicaid policies and requirements ~~(such as prior authorization, etc.)~~ are the same for Nevada Check Up, ~~with the exception of the four~~except for areas where Medicaid and Nevada Check Up policies differ as documented in Medicaid Services Manual (MSM) Chapter 3700.

901 AUTHORITY

Federal Law Section 1905 (a) (8) of the Social Security Act
Private duty nursing is an optional benefit under Section 1905 (a) (8) of the Act.

42 CFR 440.80 Private duty nursing services

Private duty nursing services mean nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

a. By a registered nurse or a licensed practical nurse;

b. Under the direction of the recipient's physician; and

c. At the State's option, to a recipient in one or more of the following locations:

1. In the recipient's ~~His or her own~~ home~~;~~ or any setting where normal life activities occur;

2. A hospital; or

3. A nursing facility

Nevada has opted to provide private duty nursing in the recipient's home or any setting where normal life activities take place.

902 DEFINITIONS

Program definitions can be found in the MSM Addendum.

~~902.1 AUTHORIZATION NUMBERS~~

~~The assigned numbers issued by Nevada Medicaid's Quality Improvement Organization (QIO-like) or Nevada Medicaid home care staff for approved home health agency services. Authorization numbers are used for submitting claims to the Nevada Medicaid fiscal agent for reimbursement.~~

~~902.2 CAREGIVER~~

~~The legally responsible person (e.g. birthparents, adoptive parents, spouses, legal guardians, paid foster parents) and/or other adults who are not (legally) responsible or paid to provide care, but who chooses to participate in providing care to a recipient.~~

~~902.3 COMPANION CARE~~

~~A service for individuals who spend time with another individual for friendly or social reasons.~~

~~902.4 CONCURRENT CARE~~

~~Concurrent care allows for the provision of PDN services by a single nurse to care for more than one recipient simultaneously in the recipient's residence.~~

~~902.5 EXPLANATION OF BENEFITS (EOB)~~

~~Statement from a third-party payor/health plan to a beneficiary that lists the services that have been provided, the amount that was billed for each service and the amount that was paid.~~

~~902.6 FULL TIME (F/T)~~

~~Working at least 30 hours per week for wages/salary or attending school at least 30 hours per week.~~

~~902.7 IMMEDIATE RELATIVE~~

~~An immediate relative means as any of the following:~~

~~1. husband or wife;~~

~~2. natural or adoptive parent, child or sibling;~~

~~3. stepparent, stepchild, stepbrother or stepsister;~~

~~4. father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;~~

~~5. grandparents or grandchild;~~

~~6. spouse of grandparent or grandchild.~~

~~No reimbursement is made for services provided by an immediate relative.~~

~~902.8 INCAPABLE CAREGIVER~~

~~A caregiver who is unable to safely manage required care due to:~~

~~1. cognitive limitations (unable to learn care tasks, memory deficits);~~

~~2. documented physical limitations (unable to render care such as inability to lift patient);~~

~~3. significant health issues with health or emotional, as documented by the caregiver's treating physician, that prevents or interferes with the provision of care.~~

~~902.9 INHERENT COMPLEXITY~~

~~A service that by nature of its difficulty requires the skills of a trained professional to perform, monitor or teach. This definition is used by HHA's to determine the need for skilled services and the type of provider.~~

~~902.10 INTERMITTENT SERVICES~~

~~Social Security Act section 1814(a)(2)(c) and 1835(a)(2)(a) defines intermittent as to skilled nursing and home health aide care that is either provided or needed on fewer than seven days per week or less than eight hours each day for a period of 21 days or less and 28 or fewer hours each week.~~

~~902.11 PLAN OF CARE (POC)~~

~~The Plan of Care (POC) refers to the medical treatment plan established by the treating physician with the assistance of the home health care nurse.~~

~~The POC must contain all pertinent diagnoses, including the patient's mental status, the type of service, supplies and equipment required, prognosis, rehabilitation potential, functional limitations, nutritional requirements, all medications and treatments, instructions for timely discharge or referral and any additional pertinent to service provision.~~

~~902.12 PRIMARY DIAGNOSIS~~

~~The primary diagnosis is the diagnosis based on the condition that is most relevant to the current plan of care. Primary diagnosis is the first listed diagnosis for claims submission.~~

~~902.13 RESPITE~~

~~Respite is the short-term, temporary care provided to people with disabilities in order to allow responsible adults/primary caregiver a break from the daily routine of providing care for the recipient. Respite is not covered under State Plan Services.~~

~~902.14 SITTERS~~

~~Sitters refer to individual services to watch/supervise a recipient in the absence of an LRA or primary caregiver.~~

~~902.15 UNAVAILABLE~~

~~Time constraints of primary caregivers, which limit their availability to provide care due to verified employment or attendance at school.~~

903 POLICY

903.1 POLICY STATEMENT

The private duty nursing benefit reimburses medically necessary and appropriate hourly nursing services by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to ~~maintain the recipient at home~~prevent institutionalization. "Continuous" means nursing assessments requiring skilled interventions to be performed at least every two to three hours during the Medicaid-covered PDN shift. The recipient's medical condition(s) and necessary skilled interventions must justify a shift of at least four continuous hours. "Complex" means multifaceted needs requiring skilled nursing interventions. Observation in the event an intervention is required is not considered complex skilled nursing and shall not be covered as medically necessary PDN services. "Substantial" means there is a need for interrelated nursing assessments and interventions. Interventions that do not require assessment or judgment by a licensed nurse are not considered substantial. Social Security Act (SSA) Section 1814(a)(2)(c) and 1835(a)(2)(a) defines "intermittent" as skilled nursing and home health aide care that is either provided or needed on fewer than seven days per week or less than eight hours each day for a period of 21 days or less and 28 or fewer hours each week. Service hours are determined based on ~~skilled nursing (SN) need~~medical necessity and are not related to diagnoses of mental illness (MI) or ~~mental retardation~~intellectual disability (~~MR~~ID). ~~Service hours take into consideration the availability and capability of legally responsible caregivers or other willing primary caregivers.~~

903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

a. The recipient has ongoing Medicaid eligibility for services;

~~b. The recipient's legally responsible adult or primary caregiver is unavailable or incapable of providing all necessary care;~~

~~c.~~b. The services have been determined to meet the medical criteria for private duty nursing; and

~~d.~~c. The service can be safely provided in the home or setting where normal life activities take place.

2. COVERED SERVICES

a. PDN service may be ~~approved~~ authorized for recipients who need more ~~individual and~~ continuous skilled nursing care than can be provided in an intermittent skilled

nurse visit through a home health agency and whose care exceeds the scope of service that can be provided by a home health aide or personal care ~~aide~~ attendant (PCA).

b. PDN services may be approved for up to 16 hours per day for new ventilator dependent recipients for an eight-week interval in the period immediately following discharge from the hospital.

c. PDN services may be approved for up to 12 hours per day for new ~~tracheotomy~~ tracheostomy recipients for an eight-week interval in the period immediately following discharge from the hospital.

d. PDN services may be approved for recipients who are chronically ill who require extensive skilled nursing care to ~~remain at home~~prevent institutionalization.

3. MEDICAL ~~CRITERIA~~ NECESSITY

PDN is considered medically necessary when a recipient requires the services of a licensed RN or an LPN under the supervision of an RN to perform SN interventions to maintain or improve the recipient's health status. SN~~killed nursing~~ refers to assessments, judgments, intervention and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the recipient's care and the frequency of SN interventions. Services must be provided under the direction of a physician and according to a signed plan of care.

Different skilled nursing intervention refers to distinct tasks that affect different body systems and require separate skilled nursing knowledge. For example, care for a tracheostomy and care for total parenteral nutrition (TPN) would be considered two different SN tasks. Related ~~skilled nursing~~SN interventions are tasks that are an intrinsic component of the SN task. For example, suctioning is an integral part of tracheo~~s~~tomy care and would be considered one SN~~N~~ task.

~~a. The following criteria are used to establish the appropriate intensity of skilled nursing need (SNN) category.~~

~~1. SKILLED NURSING NEED CATEGORY 1~~

~~Limited to recipients who, in addition to skilled nursing observation, have at least one continuous skilled nursing need (as opposed to an intermittent need, such as wound care). An example of this category type recipient is the recipient who has a gastroscopy tube (g-tube) that receives nutritional~~

~~feedings and medication administration through the tube, but who is unable to participate or direct his/her own care.~~

~~2. SKILLED NURSING NEED CATEGORY 2~~

~~Limited to the recipients that in addition to skilled nursing observation require two or more different skilled nursing interventions.~~

~~3. SKILLED NURSING NEED CATEGORY 3~~

~~Limited to recipients that are ventilator dependent at least six hours per day or to recipients that, in addition to skilled nursing observation, have four or more different skilled nursing interventions daily*.~~

~~* Different skilled nursing intervention refers to distinct tasks that affect different body systems and require separate skilled nursing knowledge. For example, care for a tracheotomy and care for total parenteral nutrition (TPN) would be considered two different SNN tasks.~~

~~Related skilled nursing interventions are tasks that are an intrinsic component of the SN task. For example, suctioning is an integral part of tracheotomy care and would be considered one SNN task.~~

a. Some ~~E~~examples of ~~what are~~ typical~~ly determined to be~~ "skilled nursing interventions" ~~are identified below~~include, but are not limited to, the following:

1. Ventilator care.

2. Tracheostomy with related suctioning and dressing changes.

3. Non-invasive ventilation (NIV), i.e. CPAP or BiPAP, may be considered skilled nursing interventions in the management of both acute and chronic respiratory failure for recipients who are clinically unstable, and when the NIV is new. Or within 60 days of the start of CPAP or BiPAP, and stability with use is not yet established. Once NIV has been established for 60 days, if recipient is clinically stable, then NIV is no longer considered a skilled nursing intervention. CPAP or BiPAP for indications other than acute and chronic respiratory failure is not considered a skilled nursing intervention.

~~3.~~4. TPN.

~~4.~~5. Peritoneal dialysis.

~~5.~~6. ~~Gastroscopy tube or nasogastric tube~~Enteral feedings, ~~with related suctioning~~ and administration of medication, are considered a SN~~N~~ task when associated with complex medical problems or with medical fragility of the recipient.

~~6.~~7. Complex medication administration – six or more prescription medications on different frequency schedules or four or more medications requiring close monitoring of dosage and side effects.

~~7.~~8. ~~Oxygen unstable c~~Continuous oxygen administration, ~~in combination~~ with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.

~~8.~~9. Multiple sterile complex dressing change required at least ~~BID~~twice per day. The dressing change must be separate from other SN~~N~~ interventions such as changing a tracheostomy site dressing when associated with tracheotomy care.

Additional ~~major procedures~~ skilled interventions not listed here may be considered in determining the intensity of ~~skilled nursing~~SN needed. ~~The Nevada Medicaid Central Office or their designee should be contacted with information on what the procedure is and the amount of nursing skill time needed to perform this task.~~

~~b. DECISION GUIDE~~

~~The decision guide identifies the benefit limitations for individual recipients based upon the skilled nursing need intensity of care (SNN 1, SNN 2 and SNN 3) and the family/caregivers situation. Family situation includes the availability of caregivers in the home, the health status of caregivers and the recipient's attendance at school. The decision guide is Nevada Medicaid's tool used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit.~~

4. NON-COVERED SERVICES

The following services are not covered benefits under the PDN program and are therefore not reimbursable:

a. Services provided to recipients that are ineligible for Medicaid.

b. Non-skilled nursing interventions which are custodial in nature. Some examples of typical "non-skilled nursing interventions" include but are not limited to the following:

1. Administration of nebulized medications
2. Application and removal of orthotic braces
3. Application of chest vest and use of cough assist device(s)

While a PDN may perform such tasks, there must be an additional need for interventions that do require the assessment and/or judgment of a licensed nurse.

c. Services ~~normally~~ provided by a legally responsible ~~adult~~ individual (LRI), or immediate family member~~or other willing and capable caregiver~~. No reimbursement is made for services provided by an immediate relative or LRI.

~~b.~~d. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a nursing facility for the mentally ill (NF/MI) or intermediate care facility for the ~~mentally retarded~~Individuals with Intellectual disabilities (ICF/~~MR~~IID) or at institution for the treatment of mental health or chemical addiction.

~~c. Services rendered to recipients in pediatric and adult day centers.~~

~~d.~~e. Services rendered at school sites responsible for providing "school-based health service" pursuant to IDEA 34 CFR§300.24.

~~e.~~f. Services provided to someone other than the intended recipient.

~~f.~~g. Services that Nevada Medicaid determines could reasonably be performed by the recipient.

~~g.~~h. Services provided without authorization.

~~h.~~i. Services that are not on the approved plan of care.

~~i.~~j. Service requests that exceed program limits.

~~j.~~k. Respite care~~ that is intended to relieve a legally responsible adult or primary caregiver from the daily routine of providing care for the recipient.~~

~~k.~~l. Companion Care, baby-sitting, supervision or social visitation.~~ that is intended to provide friendly or social time with a recipient.~~

~~l. Sitters or services that are intended for individuals to watch or supervise a recipient in the absence of a legally responsible adult or primary caregiver and that provide no skilled care.~~

m. Homemaker services.

n. Medical Social Services (MSS).

~~n.~~o. Duplicative services, such as personal care services (PCS) that are provided during private duty nursing hours.

p. Travel time to and from the recipient's residence.

~~o. Transportation of the recipient by the private duty nurse to Medicaid reimbursable settings. PDN recipients may require immediate skilled nursing intervention. Such intervention would be precluded by the SN driving the vehicle.~~

q. Transportation of the recipient by the private duty nurse.

903.1B PROVIDER RESPONSIBILITIES

The provider shall furnish qualified ~~registered nurses and licensed practical nurses~~RNs and/or LPNs, under the supervision of a registered nurse to assist eligible Medicaid recipients with complex skilled nursing tasks as identified in the physician's written plan of care (POC). Services are to be provided as specified in this Chapter. and must meet the conditions of participation as stated in MSM Chapter 100. The provider must comply with all local, state and federal regulations, and applicable statutes, including but not limited to Federal Law Section 1905 (a) (8) of the SSA.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare certified Home Health Agency, licensed and authorized by State and Federal Laws to provide health care in the home.

2. MEDICAID ELIGIBILITY

The provider must verify, each month, continued Medicaid eligibility for each recipient. This can be accomplished by viewing the recipient's Medicaid Identification card, contacting the eligibility staff at the welfare office hot line or utilizing the electronic verification of eligibility (EVE) system. Verification of Medicaid eligibility is the sole responsibility of the provider agency.

3. PHYSICIAN ORDER AND PLAN OF CARE

The provider must provide PDN services initiated by a physician's order and designated in the POC which is documented on a CMS 485. The POC is a written set of medical orders signed by the physician which certify the specific HHA services that will be provided, the frequency of the services and the projected time frame necessary to provide such services.

The POC is reviewed by the physician every 60 days. A new POC is required when there is a change in the recipient's condition, change in orders following hospitalization and/or change in the ordering physician.

4. PRIOR AUTHORIZATION

The provider must obtain prior authorization for all private duty nursing services prior to the start of care. Refer to the authorization process ~~3~~903.1D.

5. THIRD PARTY LIABILITY (TPL)

The provider must determine, on admission, the primary payor source. If Medicaid is not the primary payor, the provider must bill the third-party payor before billing Medicaid. The provider must also inform the recipient orally and in writing of the following:

a. The extent to which payment may be expected from third-party payors; and

b. The charges for services that will not be covered by third-party payors; and

c. The charges that the ~~patient~~ recipient may have to pay.

6. PLACE OF SERVICE

The provider must provide PDN service in the recipient's place of residence or in any setting~~s~~ where normal life activities take place~~the recipient other than the recipient's residence~~. School sites are excluded as a matter of special education law (IDEA 34 CFR§300.24).

7. CASE INITIATION

A referral from ~~any source,~~ physicians, discharge planners or recipient triggers the process for private duty hours (PDN).

The provider should make an initial visit to the recipient's home or to the hospital to complete an evaluation to determine if the recipient is appropriate for PDN hours and if they can accept the case. During this visit the provider must:

a. Complete a nursing assessment, using a~~n~~ CMS Outcome and Assessment Information Set (OASIS) form for recipients age 21 or older or age-appropriate evaluation;

b. Complete a Nevada Medicaid PDN ~~assessment~~ prior authorization (PA) form and physician's POC using the CMS 485 Form; and

c. Establish the safety of the recipient ~~in the home setting~~during the provision of services.

If the provider determines the recipient is not appropriate for PDN services or they cannot accept the case, the provider must contact the Nevada Medicaid District Office ~~Care Coordinator~~ and inform them of the reason the service cannot be delivered.

If the provider is able to initiate service, ~~a request for PDN service should be faxed to the QIO-like, along with the OASIS or age appropriate nurse evaluation and the PDN assessment~~all required documents should be submitted to the QIO-like vendor.

8. CONFIDENTIALITY

The provider must ensure the confidentiality of recipient records and other information, such as the health, social, domestic and financial circumstances learned in providing services to recipients.

The provider shall not release information related to recipients without written consent from the recipient or the recipient's legal representative, except as required by law.

Providers meeting the definition of a "covered entity" as defined in the HIPAA Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

9. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers will be in compliance with all laws relating to incidences of abuse, neglect or exploitation.

a. CHILD ABUSE

State law requires that certain persons employed in certain capacities must make a report to a child protective services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect a child has been abused or neglected.

For minors under the age of 18, the Division of Child and Family Services or the appropriate county agency accepts reports of suspected abuse.

Refer to NRS 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adults aged 60 and over, the ~~Division for Aging Services~~Aging and Disability Service Division accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

For all other individuals, contact social services and/or law enforcement agencies.

10. RECIPIENT RIGHTS

The governing body of the provider agency has an obligation to protect and promote the exercise of the recipient rights. A ~~patient~~ recipient has the right to exercise his/her rights as a ~~patient~~ recipient of the provider. A ~~patient's~~ recipient's family or guardian may exercise a patient's rights when a ~~patient~~ recipient has been judged incompetent. The recipient has the right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each ~~patient~~ recipient and family with a written copy of the bill of rights. A signed, dated copy of the ~~patient's~~ recipient's bill of rights will be included in the patient's medical record. Refer to recipient rights later in this chapter.

11. ADVANCE DIRECTIVES

The provider must provide the recipient or parent/legal guardian with information regarding their rights to make decisions about their health care, including the right to execute a living will or grant a power of attorney to another individual, per 42 CFR 489.102, Patient Self Determination Act (Advance Directives).

HHA's must also:

a. Provide written information to the recipient(s) at the onset of service concerning an individual's right under Nevada state law, NRS 449~~.540 to 449.690~~, to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives;

b. Inform recipients about the agency's policy on implementing Advance Directives.

c. Document in the individual's medical record whether or not the individual has executed an Advance Directive.

d. Ensure compliance with the requirements of NRS 449.540 to 449.690 regarding Advance Directives at agencies of the provider or organization.

e. Provide (individually or with others) education to staff and the community on issues concerning Advance Directives.

f. Not discriminate against a recipient based on whether he or she has executed an Advance Directive.

12. NON-DISCRIMINATION

The provider must act in accordance with federal rules and regulations and may not discriminate unlawfully against recipients ~~on the basis of~~based on race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions).

13. COMPLAINT RESOLUTION

The provider must respond to all complaints in a reasonable and prompt manner. The provider must perform recipient/provider problem solving and complaint resolution.

a. The provider must maintain records that identify the complaint, the date received and the outcome.

b. The provider must submit documentation regarding the complaint to Nevada Medicaid Central Office (NMCO) immediately upon request.

14. TERMINATION OF SERVICES

a. IMMEDIATE TERMINATION

The provider may terminate PDN services immediately for the following reasons ~~one through five listed above~~below:~~.~~

~~a. The provider may terminate services for any of the following reasons:~~

1. The recipient or other persons in the household subjects the skilled nurse to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations or threats of physical harm.

2. The recipient is ineligible for Medicaid.

3. The recipient requests termination of services.

4. The place of service is considered unsafe for the provision of PDN services;

5. The recipient is admitted to an acute hospital setting or other institutional setting.

b. ADVANCE NOTICE TERMINATION

The provider must provide at least five calendar days advance written notice to recipients when PDN services are terminated for the following reasons:~~reasons six through ten listed above.~~

~~6.~~1. The recipient or caregiver refuses to comply with the physician's POC.

~~7.~~2. The recipient or caregiver is non-cooperative in the establishment or delivery of services.

~~8.~~3. The recipient no longer meets the criteria for PDN services.

~~9.~~4. The recipient refuses service of a skilled nurse based solely or partly on the race, religion, sex, marital status, color, age, disability or national origin.

~~10.~~5. The provider is no longer able to provide services as authorized (i.e. no qualified staff).

Note: A provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's PDN program. The recipient may choose another provider.

~~b.a. IMMEDIATE TERMINATION~~

~~The provider may terminate PDN services immediately for reasons one through five listed above.~~

Note: The nurse provider must comply with 632~~.895.6~~ of the Nurse Practice Act regarding patient abandonment.

~~c.a. ADVANCE NOTICE TERMINATION~~

~~The provider must provide at least five calendar days advance written notice to recipients when PDN services are terminated for reasons six through ten listed above.~~

~~d.~~c. NOTIFICATION REQUIREMENTS

The provider must notify the recipient and all other appropriate individuals and

agencies when services are to be terminated. The Nevada Medicaid Central Office (NMCO) ~~Home Care Coordinator~~ should be notified by telephone within two working days. The provider should submit written documentation within five working days.

The provider will send a written notice which advises the NMCO of an effective date of the action of the termination of service, the basis for the action and intervention/resolution attempted prior to terminating services.

15. RECORDS

~~902.1C~~The provider must maintain medical records which fully disclose the extent and nature of the service provided to the recipient and which supports fees or payments made. Medical and financial records and all other records provided must be maintained for an interval of not less than six years. Following HIPAA Privacy Regulations contained in 45 CFR 160 and 164, the provider must make records available upon request to the Division.

903.1C RECIPIENT'S RESPONSIBILITIES

The recipient or personal representative shall:

1. Provide the HHA with a valid Medicaid card at the start of service and each month thereafter.

2. Provide the HHA with accurate and current medical information, including diagnosis, attending physician, medication regime, etc.

3. Notify the HHA of all third-party insurance information, including the name of other third-party insurance, such as Medicare, ~~Champus~~TRICARE, Workman's Compensation or any changes in insurance coverage.

4. Inform the HHA of any other home care benefit that he/she is receiving through state plan services, such as personal care ~~aide (PCA)~~ services (PCS), intermittent HHA skilled nursing or therapy services. Services provided through another agency or program such as respite, case management or participation in a Waiver program should also be identified.

5. Have a primary ~~caregiver~~LRI, ~~residing in the recipient's place of residence,~~ who accepts responsibility for the individual's health, safety and welfare. The ~~primary care giver~~LRI must be responsible for the majority of daily care in a 24-hour interval.

6. Have an identified alternate ~~caregiver~~ LRI or a backup plan to be utilized if the primary ~~care giver~~LRI and/or the provider are unable to provide services. ~~If a single parent/caregiver is the sole person with responsibility for the recipient and becomes unable~~

~~to care for the recipient there would be no one legally capable of making decisions about a minor's care.~~ The PDN nurse provider is not an alternate caregiver with legal authority.

7. Have written emergency plans in place. The caregiver/parent should inform the provider of an alternate caregiver and/or with a plan that indicates his/her wishes if the responsible caregiver became ill or disabled and is unavailable to provide care for any other.

8. Cooperate in establishing the need for and the delivery of services.

9. Have necessary backup utilities and communication systems available for technology dependent recipients.

10. Comply with the delivery of services as outlined in the POC.

11. Sign the PDN visit forms to document the hours and the services that were provided.

12. Notify the provider when scheduled visits cannot be kept or services are no longer required.

13. Notify the provider of unusual occurrences of complaints regarding the delivery of services and of dissatisfaction with specific staff.

14. Give the provider agency a copy of an Advance Directive, if applicable.

15. Not request the provider agency staff to work more hours than authorized or to change the days/hours approved.

16. Not request the provider agency staff to provide care to non-recipients or to provide service not on the POC (babysitting, housekeeping tasks, etc.).

17. Not subject the provider or Division staff to physical and/or verbal abuse, sexual harassment, exposure to the use of illegal substances, illegal situations or threats of physical harm.

18. Not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability and/or national origin.

RECIPIENT RIGHTS

Every Medicaid recipient, their LR~~IA~~ or legal guardian, or authorized representative is entitled to receive a statement of "Recipient Rights" from their provider. The recipient should review and sign this document. The recipient's rights should include the following:

1. A recipient has the right to courteous and respectful treatment, privacy and freedom from

abuse and neglect.

2. A recipient has the right to be free from discrimination because of race, ~~creed~~religion, sex, marital status, color, age, disability, national origin, sexual orientation and/or diagnosis.

3. A recipient has the right to have his property treated with respect.

4. A recipient has the right to confidentiality ~~with~~ regarding ~~to~~ information about his/her health, social and financial circumstances and about what takes place in his home.

5. A recipient has the right to access information in his own record upon written request.

6. A recipient has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.

7. The recipient has the right to be informed of the provider's right to refuse admission to, or discharge any recipient whose environment, refusal of treatment or other factors prevent the HHA from providing safe care.

8. The recipient has the right to be informed of all services offered by the agency prior to or upon admission to the agency.

9. The recipient has the right to be informed of his condition in order to make decisions regarding his home health care.

10. The recipient has the right to be advised, in advance, of the ~~disciplines~~ services that will be ~~furnished~~provided, ~~care,~~ and frequency of ~~visits proposed to be furnished~~such services.

11. The recipient has the right to be advised, in advance, of any change in the plan of care before the change is made.

12. The recipient has the right to participate in the development of the plan of care, treatment, and discharge planning.

13. The recipient has the right to refuse services or treatment.

14. The recipient has the right to request a Fair Hearing when disagreeing with Nevada Medicaid's action to deny, terminate, reduce or suspend service.

903.1D AUTHORIZATION PROCESS ~~AND REIMBURSEMENTS~~

1. PRIOR AUTHORIZATION

PDN services must be prior authorized by the Nevada Medicaid ~~staff (or their designee)~~QIO-like vendor, except for mileage, initial assessments and family planning education. The provider must ~~fax a completed payment authorization request~~submit all required PDN PA forms to the QIO-like vendor. ~~The provider agency must submit the OASIS or age appropriate form, and the PDN assessment to the QIO-like vendor.~~

The QIO-like vendor will review the request and supporting documentation ~~utilizing the decision guide before authorizing PDN hours~~for medical necessity. The PDN PA form and supporting documentation will be used to determine medical necessity and to qualify and quantify the appropriate number of PDN hours. The QIO-like vendor will issue an authorization number for the approved PDN service hours. Service hours cannot be initiated until the QIO-like vendor has issued an authorization number. The number of authorized hours is not to exceed 70 hours per week or 10 hours per day based on a comprehensive review of all documentation submitted. For new ventilator dependent recipients up to 16 hours per day may be authorized for up to an eight-week interval in the period immediately following discharge from the hospital. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are preventive and diagnostic services available to most recipients under age 21. Refer to MSM Chapter 1500 Healthy Kids Program for EPSDT authorization process. If the request is for more hours than can be authorized according to program criteria, ~~the recipient will be issued~~ a Notice of Decision (NOD) will be issued by the QIO-like vendor.

PDN services requested for a recipient enrolled in a Managed Care Organization (MCO) must be prior authorized by the MCO. The MCO has sole responsibility for all decisions related to the PDN service for MCO recipients.

a. INITIAL EVALUATION VISIT

The initial evaluation visit does not require prior authorization from Nevada Medicaid or their QIO-like vendor. During the visit the skilled nurse evaluator must complete a nursing assessment using an OASIS or age appropriate tool. The nurse must complete a Nevada Medicaid PDN PA form.

~~Reimbursement: The initial registered nurse visit will be reimbursed as an RN extended visit. Refer to the reimbursement code table for specific billing code.~~

~~b. HOLIDAY RATES~~

~~For recipients who require 7-day-per-week home care service, an increased rate~~

~~will be paid for visits made on State recognized holidays. The holiday rate must be requested on the Nevada Medicaid Home Health Authorization Payment Request form, which covers the certification period in which the State recognized holiday(s) occur.~~

~~Nevada Medicaid currently recognizes the following holidays: New Year's Day, Martin Luther King Jr. Day, President's Day, Memorial Day, Independence Day, Labor Day, Nevada Admission Day (last Friday in October), Veteran's Day, Thanksgiving Day, Family Day (the day after Thanksgiving) and Christmas Day. The recognized holiday is the same day as State offices are closed.~~

~~Reimbursement: Time and one-half will be reimbursed for State recognized holidays. Refer to reimbursement code table for specific billing code.~~

~~c. THIRD PARTY LIABILITY~~

~~The provider must bill all other payment resources available from both private and public insurance.~~

~~d.~~b. DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies require a prior authorization request at the time of request for HHA services and are to be listed on the Home Health Prior Authorization Form. Wound care supplies will be authorized for the HHA for an initial ten-day period only. Supplies will be authorized only for the specific procedure or treatment requested. ~~Each item must be listed separately.~~ Refer to MSM Chapter 1300 regarding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) policy and the provider billing guide.

Routine supplies must be obtained from a Durable Medical Equipment (DME) or Pharmacy Provider.

~~Reimbursement: Unit price per fee schedule. Refer to the reimbursement code table for specific billing code.~~

~~e. HOME HEALTH AGENCY RATE~~

~~HHA rates are based on the recipient's place of residence at the time the service is rendered.~~

~~Reimbursement: Reimbursement is made according to regions, urban, rural and out of state, defined in the following manner:~~

~~1. Urban: In Southern Nevada, urban is Boulder City and the portion of Clark County within Las Vegas Valley including the cities of Las Vegas, North Las Vegas, Henderson and the urbanized townships. In Northern Nevada, urban includes the cities of Reno, Sparks and Carson City and unincorporated areas of Washoe County that are within 30 miles of Reno, as approved by the District Office.~~

~~2. All other areas within Nevada are classified as rural. Use rural billing code modifier TN.~~

~~3. All outside Nevada services use rural billing code modifier TN.~~

~~f.~~c. MILEAGE

Actual mileage is reimbursed one way from the HHA/PDN office to the recipient's residence. Actual mileage should be listed on the prior authorization request form to establish a baseline for reimbursement.

~~Reimbursement: Mileage is paid per actual miles. Refer to reimbursement code table for specific billing code.~~

2. ONGOING AUTHORIZATIONS

Requests for continuing PDN services must be submitted to the QIO-like vendor at a minimum of ~~15~~ 10 working days but no more than 30 days prior to the expiration date of the existing authorization. The completed request must be submitted to the QIO-like vendor along with a current nurse assessment and PDN assessment form. The QIO-like vendor will review for appropriate number of hours ~~using the Decision Guide and~~ based on program criteria and program limitations. PDN services may be authorized for a maximum of six months.

3. ADDITIONAL AUTHORIZATIONS

a. School Break

During "planned breaks" of at least five consecutive school days (e.g. track break, summer vacation), additional hours may be authorized within program limitations. A separate authorization request should be submitted for the specific number of hours requested beyond those already authorized~~. Parental availability during these breaks must also be documented.~~

b. Change in Condition/Situation

A new authorization must be requested when the recipient has a change of condition or situation that requires either a reduction in PDN hours or an increase in PDN hours. A completed PAR must be faxed to the QIO-like vendor along with documentation supporting medical necessity and program ~~criteria (parental availability/capability).~~

4. RETRO AUTHORIZATIONS

a. A request for authorization of services provided to pending recipients may be made retroactively, once Medicaid eligibility has been established. Medicaid may authorize services retroactively for covered services within limitations of program criteria. The PAR must include the date of determination ~~(DOD)~~ of eligibility. ~~Any service provided during pending status is at the provider's own risk.~~ Please note if the PA request is pending and services are provided, the provider is assuming responsibility for PDN costs if the PA request is denied. A PA only approves existence of medical necessity, not recipient eligibility.

903.2 24-HOUR CARE

In the event a ~~primary caregiver~~LRI is absent due to a medical need of the ~~caregiver~~ LRI, parent/guardian or ~~a family member~~authorized representative, a Medicaid recipient under 21 years of age may be eligible to receive 24-hour care at home through an EPSDT referral. 24-hour care must be prior authorized.

903.2A 24-HOUR COVERAGE AND LIMITATIONS

1. 24-hour care is limited to five days per calendar year;

2. No other legally responsible adult or caregiver is available to provide care;

3. 24-hour day care is medically necessary and placement in a facility would be detrimental to the recipient's health;

903.2B 24-HOUR PROVIDER RESPONSIBILITIES

1. The provider is responsible for requesting documentation that the primary caregiver or family member is absent due to a medical need.

2. The provider must submit an EPSDT screening by a physician provider ~~(31)~~ that the 24-hour care is medically necessary and placement in a facility is detrimental to the recipient's health.

3. The provider needs to secure an authorization for disclosure from the ~~Legally Responsible~~

~~Adult (LRA)~~LRI, parent/guardian or ~~primary caregiver~~authorized representative to provide documentation of absence due to a medical need. Such information will be released to Nevada Medicaid or their designee for determination of eligibility for this benefit.

All other policies found in Section 3903.1B, Provider Responsibilities, of this Chapter shall apply.

903.2C 24-HOUR CARE RECIPIENT RESPONSIBILITIES

1. The ~~primary caregiver~~LRI must provide supporting documentation of the absence of the primary caregiver due to medical need.

2. The ~~primary caregiver~~LRI must pursue the availability of alternate caregivers to provide care during the interval before requesting 24-hour care.

3. All other policies found in Section ~~3~~903.1C, Recipient Responsibilities, of this Chapter shall apply.

903.2D 24-HOUR CARE AUTHORIZATION PROCESS

1. The provider may request a verbal authorization of the QIO-like vendor if the need for such service was unanticipated. A written request, along with supporting information should be submitted as soon as possible thereafter, but no later than three working days after the verbal request.

2. The provider agency must submit a PAR along with the EPSDT screening referral and supporting documentation of the absence of a primary caregiver to the QIO-like vendor prior to the provision of 24-hour coverage, if the need for such service was anticipated.

903.3 CONCURRENT CARE

Concurrent care allows for the provision of PDN service by a single nurse to more than one recipient simultaneously. A single nurse may provide care for ~~multiple~~ up to three recipients ~~(up to three)~~ if care can be provided safely. Concurrent care allows for authorized nursing hours to be collectively used for the multiple recipients. Concurrent care allows for optimum utilization of limited skilled nurse resources while providing safe skilled nursing care to Nevada Medicaid recipients. Concurrent care must be prior authorized.

903.3A CONCURRENT CARE PROVIDER RESPONSIBILITIES

1. The provider shall evaluate and determine the safety of settings for the provision of concurrent care.

2. The provider shall adjust requests for PDN hours when concurrent care is provided.

All policies found in Section 3903.1 of this Chapter shall apply.

903.4 OUT-OF-STATE SERVICES

PDN services are allowed out-of-state for Medicaid recipients absent from the state per (42 CFR 431.52). Prior authorization is required for out-of-state services by the QIO-like vendor. Payment for services furnished in another state are reimbursed to the same extent that Nevada would pay for service provided within Nevada's boundaries. Out-of-state PDN services are reimbursed at the rural rate.

903.4A OUT-OF-STATE COVERAGE AND LIMITATIONS

In addition to the policies described in Section ~~3~~903.1A of this chapter, the following apply for out-of-state. The authorization timeframe for out-of-state services is limited to no more than a 30-day interval. For ongoing authorizations after the initial 30-day period the out-of-state provider must contact the QIO-like vendor.

Out-of-state services may be authorized when:

1. There is a medical emergency and the recipient's health would be endangered if he were required to return to the State of Nevada to obtain medical services;

2. The recipient travels to another state because the Division finds the required medical services are not available in Nevada;

3. The Division determines that it is general practice for recipients in a particular locality to use medical services in another state (e.g., Nevada counties that border other State lines);

   a. Nevada residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the DHCFP refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation. Refer to the MSM 100 billing manual for catchment areas.
   b. The same services that are covered within the state of Nevada are available for payment for any qualified provider, in the catchment area, who is or will be enrolled with the plan.
   c. Nevada Medicaid does not pay for medical services rendered by health care providers outside the United States.

~~3.~~4. The recipient is on personal business. Nevada Medicaid may reimburse for these services; however, they will be limited to service hours currently authorized.

903.4B OUT-OF-STATE PROVIDER RESPONSIBILITIES

1. The out-of-state provider must contact provider enrollment at NMCO to become enrolled as a Nevada Medicaid Home Health Agency Provider.

2. The out-of-state provider must comply with all provisions identified in 3903.1B.

903.4C RECIPIENT RESPONSIBILITIES FOR OUT-OF-STATE SERVICES

1. The recipient or their personal representative should contact HHA providers in the geographic out-of-state region in which they wish service to be provided, to determine the availability of Nevada Medicaid PDN service providers.

2. The recipient should notify the out-of-state provider who is not a Nevada Medicaid provider who is interested in becoming a provider to contact provider enrollment at NMCO.

The recipient must comply with all the provision identified in ~~3~~903.1C ~~and 3903.D~~ of this chapter.

903.5 CRISIS OVERRIDE

The PDN benefit allows, in rare circumstances, a short-term increase of nursing hours beyond standard limits in ~~a~~ crisis ~~situation~~. A crisis ~~situation~~ is one that is generally unpredictable and puts the patient at risk of institutionalization without the provision of additional hours.

903.5A CRISIS OVERRIDE COVERAGE AND LIMITATIONS

1. Additional services may be covered up to 20% above program limits.

2. Additional services are limited to one, 60-day interval in a three-year period (calendar years).

903.5B CRISIS OVERRIDE PROVIDER RESPONSIBILITIES

The provider ~~M~~must contact the ~~Division of Health Care Financing and Policy, Central Office Home Care Coordinator or designee~~QIO-like vendor with information regarding the crisis situation and need for additional hours.

All other policies as discussed in Section ~~3~~903.1.

904 RATES AND REIMBURSEMENT

Refer to the provider billing guide for instructions and the reimbursement code table for specific billing codes.

~~903~~905 HEARINGS

~~Please r~~Reference Nevada Medicaid Services Manual, Chapter 3100, for Medicaid Hearing process.

904 REFERENCES AND CROSS-REFERENCES

905.1 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following chapters:

Medicaid Services Manuals:

Chapter 100 – Eligibility, Coverage and Limitations
Chapter 1300 – DME, Prostheses and Disposable Supplies
Chapter 1400 – Home Health Agencies
Chapter 1500 – Healthy Kids Program
Chapter 1900 – Medical Transportation
Chapter 2800 – School Based Child Health Services
Chapter 3100 – Hearings
Chapter 3200 – Hospice Services
Chapter 3300 – Surveillance and Utilization Review
Chapter 3500 – Personal Care Aide Services
Chapter 3600 – Managed Care Organizations

Nevada Check Up Manual:

Chapter 1000 – Nevada Check Up Program

905.2 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS
Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS
First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

~~PHARMACY POINT OF SALE DEPARTMENT~~
~~First Health Services Corporation~~
~~Nevada Medicaid Paper Claims Processing Unit~~
~~PO Box C-85042~~
~~Richmond, VA 23261-5042~~
~~(800) 884-3238~~

~~905.3 WELFARE ELIGIBILITY OFFICES~~

~~Welfare District Offices:~~

~~Carson City (775) 684-0800~~
~~Elko (775) 753-1187~~
~~Ely (775) 289-1650~~
~~Fallon and Lovelock (775) 423-3161~~
~~Hawthorne (775) 945-3602~~
~~Henderson (702) 486-1201~~
~~Las Vegas - Belrose (702) 486-1600~~
~~Las Vegas - Charleston (702) 486-4701~~
~~Las Vegas - Owens (702) 486-1800~~
~~Las Vegas - Cannon Center (702) 486-3554~~
~~Las Vegas - Southern Professional Development Center (702) 486-1401~~
~~Pahrump (775) 751-7400~~
~~Reno - Rock Blvd (Investigations & Recovery) (775) 688-2261~~
~~Reno - Kings Row (775) 448-5000~~
~~Tonopah (775) 482-6626~~
~~Winnemucca (775) 623-6557~~
~~Yerington (775) 463-3025~~

~~905.4 STATE OFFICES~~

~~State offices in Carson City may be telephoned long distance free of charge (within Nevada only) by dialing (800) 992-0900 and asking the State Operator for the specific office:~~

~~a. Division of Health Care Financing and Policy~~
~~Nevada Medicaid Office~~
~~1100 E. William Street Suite 101~~
~~Carson City, Nevada 89701~~
~~Telephone: (775) 684-3600~~

~~b. Nevada State Health Division~~
~~Bureau of Licensure and Certification~~
~~1550 E. College Parkway, Suite 158~~

~~Carson City, Nevada 89706~~
~~Telephone: (775) 687-4475~~

~~c. NEVADA MEDICAID DISTRICT OFFICES (NMDO):~~

~~Carson City (775) 684-3651~~
~~Reno (775) 687-1900~~
~~Las Vegas (702) 668-4200~~
~~Elko (775) 753-1191~~

PRIVATE DUTY NURSNG SERVICES – DECISION TOOL

FACTOR I. Availability of Caregivers Living in Home

Household Situation and Resource Consideration	**INTENSITY OF CARE**		
*Unavailable Works or attends school either full time (FT) or part-time (PT).	**Skilled Nursing Level 1**	**Skilled Nursing Level 2**	**Skilled Nursing Level 3**
a.) 2 or more caregivers; - Both unavailable* FT or PT. *No available/capable caregiver*	Not to exceed 20 hours per week.	Not to exceed 40 hours per week.	Not to exceed 56 hours per week.
b.) 2 or more caregivers; - 1 unavailable* FT or PT. *1 available/capable caregiver*	Not to exceed 10 hours per week.	Not to exceed 20 hours per week.	Not to exceed 28 hours per week. **
c.) 2 or more caregivers; - Neither unavailable* FT or PT *2 available/capable caregivers*	0 hours per week.	Not to exceed 12 hours per week.	Not to exceed 20 hours per week.
d.) 1 caregiver; - Unavailable* FT or PT. *No available/capable caregiver*	Not to exceed 24 hours per week.	Not to exceed 48 hours per week.	Not to exceed 67 hours per week.
e.) 1 caregiver; - Not unavailable* FT or PT. *1 available/capable caregiver*	Not to exceed 12 hours per week.	Not to exceed 24 ** hours per week.	Not to exceed 34 hours per week.

****Up to 40 hours per week may be allowed when overnight care is needed.**

FACTOR II: Capability of Caregiver

Household Situation and Resource Consideration	**INTENSITY OF CARE**		
Primary caregiver as identified in Factor I above. ‡Verification required.	**Skilled Nursing Level 1**	**Skilled Nursing Level 2**	**Skilled Nursing Level 3**

‡ Includes hours attending school plus transportation time.

†† During planned breaks (i.e. summer vacation) of at least five consecutive school days, hours may be authorized pursuant to Factor I and II.

a.) Available caregiver has health issues[‡] which inhibits their ability to provide any of the needed care.	May allow an additional two hours per day. *NTE 25 total hours per week.*	May allow an additional three hours per day. *NTE 48 total hours per week.*	May allow an additional four hours per day. *NTE 67 total hours per week.*
b.) Available caregiver has moderate health issues [‡] which impacts their ability to provide all of the needed care.	May allow an additional one hour per day. *NTE 20 total hours per week.*	May allow an additional two hours per day. *NTE 40 total hours per week.*	May allow an additional three hours per day. *NTE 56 total hours per week.*

FACTOR III: Recipient's Participation in School

Household Situation and Resource Consideration	**INTENSITY OF CARE**		
Limitations imposed on the hours identified in Factor I above. Limitations imposed on all school aged recipients regardless of homebound status. [‡‡]	**Skilled Nursing Level 1**	**Skilled Nursing Level 2**	**Skilled Nursing Level 3**
a.) Recipient attends school 20 or more hours per week [‡]	Reduce allowable hours by two hours per day. *NTE 14 hours per week*	Reduce allowable hours by two hours per day. *NTE 38 hours per week*	Reduce allowable hours by two hours per day. *NTE 57 hours per week*

[‡] Includes hours attending school plus transportation time.

[‡‡] During planned breaks (i.e. summer vacation) of at least five consecutive school days, hours may be authorized pursuant to Factor I and II.