Medicaid Services Manual
Transmittal Letter

December 26, 2023

To: Custodians of Medicaid Services Manual

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Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 1400 – Home Health Agency

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 1400 – Home Health Agency are being proposed to add the requirement that providers use an Electronic Visit Verification (EVV) system in order to be in compliance with the 21st Century Cures Act. Additionally, recipients of Home Health Care services will be required to use an EVV system to confirm services rendered.

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: Home Health Agency provider type (PT 29).

Financial Impact on Local Government: Unknown at this time.

These changes are effective: January 1, 2024.

Material Transmitted	Material Superseded
MTL 30/23 MSM Ch 1400 – Home Health Agency	MTL 26/11 MSM Ch 1400 – Home Health Agency

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1403.1B(6)	**Provider Responsibility**	Language added to require the use of an EVV and reference to the newly created Addendum B for EVV system requirements.
1403.1C(1)(e)	**Recipient Responsibility**	Language added to require that recipients agree to utilize an approved EVV system to electronically confirm services were rendered. Also added reference to the newly created Addendum B for EVV system requirements.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HOME HEALTH AGENCY

1400 INTRODUCTION

HOME HEALTH AGENCY (HHA) SERVICES

The Division of Health Care Financing and Policy (DHCFP) Home Health Agency (HHA) Program is a mandated home health care benefit provided to recipients in his/her residence. HHA services are a component in the continuum of care which allows recipients to remain in his/her home. HHA services may be provided to eligible recipients, based on medical necessity, program criteria, utilization control measures and the availability of the state' resources to meet recipient needs. HHA services are provided on an intermittent basis, certified by a physician and provided under a physician approved Plan of Care (POC). The Home Health Agency (HHA) service benefit provides Skilled Nursing (SN) services, and other therapeutic services such as Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Home Health Aides or Certified Nursing Aides (CNAs). Respiratory Therapists (RT) and Registered Dieticians (RD) are also a benefit with limitations. Services are generally provided on a short-term basis as opposed to long-term custodial services.

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

1401 AUTHORITY

A. The Home Health Agency (HHA) program is a mandatory benefit under 1905(1)(18) of the Social Security Act.

B. The citation, which explains and interprets the federal regulations governing Home Health services, is found in the Code of Federal Regulations (CFR) Title 42, Part 440.70 and 441.15.

1402 RESERVED

1403 POLICY

1403.1 POLICY STATEMENT

The home health care benefit reimburses for medically necessary and appropriate home visits by skilled nurses, physical therapists, occupational therapists, speech therapists, respiratory therapists, dieticians and home health aides to Medicaid recipients. A home health agency provides skilled services and non-skilled services to recipients on an intermittent and periodic basis.

Services are intended to provide skilled intervention with emphasis on recipient/caregiver teaching. Legally responsible adults, willing caregivers and recipients are expected to be taught care which can be rendered reasonably and safely by non medical persons.

1403.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

To be determined eligible for HHA services, the following are necessary:

a. The recipient must be program eligible for Title XIX (Medicaid) or Title XXI (Nevada Check Up) services;

b. A Legally Responsible Adult (LRA) or other willing caregiver is not available or capable of providing all services;

c. The recipient must have a need for a qualifying skilled service.

d. Services must be reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipients' unique medical condition and the standard of practice within the community.

e. Services must be sufficient in amount, duration and scope to reasonably achieve its purpose;

f. Services must be provided under a Plan of Care (POC) signed by the physician;

g. Services must be provided on an intermittent and periodic basis;

h. Services must have prior authorization;

i. Services must be provided in the recipient's place of residence;

j. Services cannot be provided in a physician's office, clinic or other outpatient setting.

k. Home care services may be appropriate when one or more of the following situations exist:

1. The recipient's illness, injury or disability precludes going to the physician's office, clinic or outpatient setting;

2. A hardship would occur if service were provided outside the home, i.e., a recipient just out of the hospital following major surgery;

3. The service is contraindicated outside the home based on recipient's medical condition, i.e., a recipient who must be protected from infection;

4. The service outside the home would interfere with the effectiveness of the service, i.e., traveling an extreme distance or a recipient whose frequent service need, such as IV therapy three times per day, cannot reasonably be accommodated outside the home;

5. The recipients documented medical condition is so fragile or unstable that the physician state that leaving the home is undesirable; and

6. The service, such as teaching, can be more effectively accomplished at home.

2. COVERED SERVICES

a. Skilled nursing services provided by a licensed nurse performing skilled interventions to maintain or improve the recipient's health status.

b. Physical therapy services provided by a licensed physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

c. Occupational therapy services provided by a licensed occupational therapist to improve or restore function.

d. Speech therapy provided by a licensed speech pathologist for the treatment of speech and language disorders, communicative disabilities or swallowing disorders.

e. Respiratory therapy provided by a licensed respiratory therapist.

f. Dietician services provided by a registered dietician for consultative services for nutritional deficits or recipients at risk of nutritional deficits.

g. Home Health Aide services provided by a Certified Nursing Aide (CNA) under the supervision of a registered nurse and in accordance with the Nurse Practice Act.

3. NON-COVERED HHA SERVICES

No reimbursement or coverage will be provided for:

a. Services provided to a recipient that is ineligible or becomes ineligible for Title XIX or Nevada Check Up;

b. Services normally provided by an immediate relative, legally responsible adult or other willing and capable caregiver;

c. 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 (ICF/MR) or an institution for the treatment of chemical addiction;

d. Services rendered to recipients in pediatric or adult day care centers;

e. Services rendered at school sites which provide "school based health service" pursuant to IDEA 300.24;

f. Services provided to someone other than the intended recipient;

g. Services that the DHCFP determines could reasonably be performed by the recipient;

h. Services provided without authorization;

i. Services provided by the HHA that were not noted on the initial physician or subsequent medical orders, or Plan of Care (POC);

j. Service requests that exceed program limits;

k. Services provided at a recipients home that could have been obtained in an outpatient setting (e.g. lab work for an ambulatory recipient);

l. Services determined not medically necessary by DHCFP;

m. Homemaker services;

n. Medical Social Services (MSS);

o. Companion care that is intended to provide friendly or social time with a recipient;

p. Sitter 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;

q. Respite care;

r. Duplication of services;

s. Transportation of recipients to Medicaid reimbursable settings, unless the HHA is a Medicaid transportation provider. Refer to Chapter 1900;

t. Travel time to and from the recipients residence;

u. Routine services such as physical checkups or assessments that are performed without relationships to a treatment of diagnosis for a specific illness;

v. Routine newborn teaching and post-partum follow ups and assessments;

w. Skilled nursing visits to children for the administration of Synagis outside the guidelines of Nevada Medicaid policy;

x. Routine supplies customarily used during the course of HHA visits. These supplies are included in the staff's supplies and are not designated for a specific recipient. Routine supplies may include but are not limited to non-sterile gloves and thermometer covers. These supplies are included in the cost-per-visit of HHA service;

y. Routine personal hygiene supplies may include, but are not limited to such items as shampoos, soaps, lotions or powders, toothpaste, combs, etc.;

z. Routine disposable supplies required on a monthly basis. These supplies must be obtained from a DME or pharmacy provider (refer to Chapters 1200 and 1300);

aa. Personal comfort items which do not contribute to the treatment of an illness or injury or the functioning of a malformed body part. Personal comfort items may include but are not limited to items such as air conditioner, radios, etc.

1403.1B PROVIDER RESPONSIBILITY

The provider shall furnish skilled nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, home health aides or certified nursing aides, respiratory therapists and registered dieticians to eligible recipients as identified in the physician's written Plan of Care (POC). Services are to be provided as specified in this Chapter.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare Certified Home Health Agency (HHA) licensed and authorized by state and federal laws to provide health care services in the home.

2. MEDICAID ELIGIBILITY

HHAs must verify the recipient's eligibility for Medicaid. Authorization for home health care is valid only if the recipient is eligible for Medicaid during the month the service is provided. The provider must verify each month the continued Medicaid eligibility for each recipient. Verification of Medicaid eligibility is the responsibility of the HHA.

3. THIRD PARTY LIABILITY (TPL)

HHAs must determine, on admission to HHA services, the primary payer. If Medicaid is not the primary payer, the provider must bill the third party payor before billing Medicaid.

4. PHYSICIANS ORDER AND PLAN OF CARE

HHA services are initiated per a physicians order. HHA program services are provided per the Plan of Care (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 Plan of Care 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 physician.

5. PRIOR AUTHORIZATION

HHAs must obtain proper authorization for all Home Health Agency services prior to the start of care. Refer to the authorization process 1403.1D.

6. ELECTRONIC VISIT VERIFICATION (EVV)

Utilize an EVV system that meets the requirements of the 21st Century Cures Act to electronically document the Home Health Agency services provided to Medicaid recipients. Refer to Addendum B for more information about EVV requirements.

7. PLACE OF SERVICE

HHA services must be provided in the recipient's place of residence.

8. HOME HEALTH AGENCY VISITS

a. Evaluation visit

HHA's are required to have written policies concerning the acceptance of the recipient by the agency. This includes consideration of the physical facility available in the recipient's place of residence, homebound status and the attitudes

of family members for the purpose of evaluating the feasibility of meeting the recipient's medical needs in the home health setting.

When personnel of the HHA make an initial visit to assess the recipient the cost of the visit is considered an administrative cost and is not reimbursable as a visit at this point since the recipient has not been accepted for care. If during the course of the initial visit, the recipient is determined appropriate for home health care by the agency and the recipient received the first skilled service as ordered under the POC, the visit becomes the first billable visit as an RN extended visit.

b. Supervisory visit

A supervisory visit made by a registered nurse to complete a recertification visit or to evaluate the delivery of specific needs of the recipient by a CNA or LPN can be authorized only once every 60-62 days. This is authorized as a RN extended visit.

c. Visit types

Two types of visits may be provided under skilled nursing. These are: An extended visit, which is defined as any visit exceeding 30 minutes but not more than 90 minutes; and the nurse's brief visit, which is defined as a visit of 30 minutes or less. Visits for certified nursing aides are approved for the first hour and each additional ½ hour thereafter.

9. RECIPIENT RIGHTS

The Home Health Agency (HHA) has an obligation to protect and promote the exercise of the recipient rights. A patient has the right to exercise his rights as a patient of the provider. A patient's family or guardian may exercise a patient's rights when a patient has been judged incompetent. The recipient has the right to be notified in writing of his rights and obligations before treatment is begun. HHA's must provide each patient and family with a written copy of the recipient's bill of rights. A signed and dated statement acknowledging receipt of the patient's Bill of Rights will be included in the patient's medical record. Refer to recipient rights later in this Chapter.

10. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers will be in compliance with all laws relating to incidents 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 (DCFS) or the appropriate county agency accepts reports of suspected abuse.

Refer to NRS 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adult aged 60 and over, the Division for Aging Services (DAS) 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 local social services and/or law enforcement agencies.

11. 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; and

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

12. TERMINATION OF SERVICES

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

1. The recipient or other persons in the household subjects home care staff 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 HHA services;

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

setting;

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

7. The recipient or caregiver is non cooperative in the establishment or delivery of services;

8. The recipient no longer meets the criteria for HHA services;

9. 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. 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 HHA program. The recipient may choose another provider.

b. IMMEDIATE TERMINATION

The provider may terminate HHA services immediately for reasons one through five listed above.
Note: The nurse provider must comply with 632.895.6 of the Nurse Practice Act. Other licensed professionals must comply within their standard practice act.

c. ADVANCE NOTICE TERMINATION

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

d. NOTIFICATION REQUIREMENTS

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The QIO-like vendor must be informed of the termination of services as the Nevada Medicaid District Office (NMDO) Care Coordinator within two working days. The provider must submit written documentation regarding the termination to the NMDO within five working days.

13. RECORDS

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.

1403.1C RECIPIENT RESPONSIBILITY

1. The recipient or personal representative shall:

a. Provide the HHA with a valid Medicaid card;

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

c. Notify the HHA of all insurance information, including the name of other third party insurance coverage, such as Medicare, CHAMPUS and Veterans Administration;

d. Inform the HHA of any other home care benefit that he or she is receiving through state plan services, such as Personal Care Aide (PCA) services, Private Duty Nursing (PDN) visits or therapy services. Services provided through another agency or program such as respite, case management or participation in a Waiver program must also be identified;

e. Agree to the utilization of an approved EVV system for the Medicaid services being rendered by the Home Health Agency. Confirm services were provided by electronically approving the EVV record that reflects the services rendered. Refer to Addendum B for more information about EVV system requirements;

f. Cooperate in establishing the need for and the delivery of services;

g. Comply with the delivery of service as outlined in the Plan of Care;

h. Notify the HHA when scheduled visits cannot be kept or services are no longer required;

i. Notify the HHA of unusual occurrences or complaints regarding delivery of services or dissatisfaction with specific staff;

j. Provide the HHA with a copy of Advance Directives, if applicable;

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

l. Not request the provider agency staff to provide care to non-recipients or to provide service not on the POC (babysitting, housekeeping tasks, etc.); not subject the provider to physical and/or verbal abuse, sexual harassment, exposure to the use of

illegal substances or threats of physical harm; and

m. 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.

2. Recipient Rights

Every Medicaid recipient, their LRA or legal guardian is entitled to receive a statement of "Patient Rights" from their provider. The recipient should review and sign a statement acknowledging receipt of this document. The patient rights should include, at a minimum, the following:

a. A patient has the right to courteous and respectful treatment, privacy, and freedom from abuse;

b. A patient has the right to be free from discrimination because of race, creed, color, sex, national origin, sexual orientation, and diagnosis;

c. A patient has the right to have his property treated with respect;

d. A patient has the right to confidentiality with regard to information about his health, social and financial circumstances, and about what takes place in his home;

e. A patient has the right to access information in his own record upon written request;

f. A patient has the right to voice grievances regarding treatment of 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;

g. A patient has the right to be informed of the provider's right to refuse admission to, or discharge any patient whose environment, refusal of treatment, or other factors prevent the HHA from providing care;

h. A patient has the right to be informed of all services offered by the agency prior to, or upon admission to the agency;

i. A patient has the right to be informed of his condition in order to make decisions regarding his or her home health care;

j. The HHA must advise a patient in advance of the disciplines that will be furnished, the care to be furnished, and the frequency of visits;

k. The patient must be notified in advance of any changes in the plan of care before the change is made;

l. A patient has the right to participate in the development of the plan of care, treatment, and discharge planning;

m. A patient has the right to refuse services or treatment; and

n. A patient has the right to request a Fair Hearing when disagreeing with the DHCFP's action to deny, terminate, reduce or suspend service.

1403.1D AUTHORIZATION PROCESS AND REIMBURSEMENTS

1. PRIOR AUTHORIZATION

Home Health Agency (HHA) services may be authorized after providers fax a completed Home Health Prior Authorization form to Nevada Medicaid's Quality Improvement Organization (QIO-like vendor). The request should be submitted two days prior to the start of care. The QIO-like vendor will review and complete the authorization process for Home Health Agency (HHA) services utilizing criteria identified in a clinical decision support guide. QIO-like vendor staff will use this criterion to review for medical necessity and utilization control procedures.
The authorization number will be issued by the QIO-like vendor using a numbering system. The QIO-like vendor will fax the authorization to the requesting provider with the authorization number. The QIO-like vendor will specify the exact number of services approved. The QIO-like vendor will generate the Notice of Decision (NOD) if the services approved are less than requested and/or constitute an adverse action. A copy will be sent to the recipient and the provider.

All requests, except initial assessments, require prior authorization request. The Home Health prior authorization form must be complete, including the primary diagnosis, ICD-9 codes, descriptions of wound(s), social situation, Dates of Service (DOS), Third Party Liability (TPL), Plan of Care (POC), and specific services requested. Processing may be delayed, or a technical denial issued, if information submitted is illegible or incomplete.

In an emergent situation when the QIO-like vendor is closed, such as nights or weekends, the request for authorization must be submitted to the QIO-like vendor within two working days after the start date. An emergent situation exists when skilled nursing services are required to be implemented immediately such as in the case of wound care, IV medication, etc.

2. HOLIDAY RATES

For recipients who require seven 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 Home Health Prior Authorization 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 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 days that State offices are closed.

Reimbursement: Time and one-half will be reimbursed for State recognized holidays. Use modifier TV to designate holiday rate.

a. PRIOR RESOURCES

When the HHA has a recipient that has another insurance (Medicare or Private Insurance) and the agency has identified the services requested are not a covered benefit of the third party payor, HHA must request "bypass Medicare" or "bypass other" when requesting prior authorization.

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 a ten day period only. Supplies will be authorized only for the specific procedure or treatment requested. Each item must be listed separately. Supplies must be specifically prescribed by the physician and designated in the POC. A copy of the physician's orders specifying supplies required for home care should be retained in the recipient's HHA file and submitted to Nevada Medicaid upon request. Routine supplies or disposable supplies must be obtained from a Durable Medical Equipment (DME) or pharmacy provider.

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

c. MILEAGE

Actual mileage is reimbursed one way from the HHA office to the recipient's residence. Actual mileage should be listed on the Home Health prior authorization request form to establish a base line for reimbursement. Reimbursement: Mileage is paid per actual miles. Refer to the reimbursement code table for specific billing code.

3. AUTHORIZATION INTERVALS

Services will be authorized for three distinct periods. They are:

a. The initial authorization for all requests. Services may be authorized up to a 60 day interval, beginning with the start date.

b. The reauthorization covers an additional 60 day interval following the completion of the initial visits. This applies to the recipient who requires an extension of the same services that were requested during the initial authorization period. This period, combined with the initial authorization may be up to 120 days.

c. The long-term authorization covers the recipient with continued needs following 120 day episode. This additional authorization interval may be up to one year if services are documented as medically necessary and are expected to continue unchanged for a prolonged interval. (i.e. monthly suprapubic catheter change).

4. ONGOING AUTHORIZATION

Request for continuing HHA services must be submitted to the QIO-like vendor a minimum of ten working days but no more than 30 days prior to the expiration of the current authorization.

The authorization request must include adequate information to support medical necessity, availability of willing and able caregiver or the presence of a qualified LRA. The QIO-like vendor will review for appropriate number of hours using the decision guide and based on program criteria. HHA services may be authorized for a maximum authorization period of one year.

5. ADDITIONAL AUTHORIZATION

An additional authorization request for an additional/PRN one time only visit during a current authorization period may be submitted for authorization approval. Information must be submitted that supports the need for the additional visit. (i.e. foley catheter leaking and a needed replacement). In this situation, the Prior Authorization Request (PAR) must be submitted within 30 days of the service being provided.

6. REVIEW FOR RETROACTIVE AUTHORIZATION

If Medicaid eligibility is established retroactively, Medicaid may authorize retroactive payment to the agency for covered services within limitations of program criteria. The Home Health Prior Authorization form must include the Date of Determination (DOD) of eligibility. Retroactive authorization must be requested within 30 days from the DOD.

7. WOUND MANAGEMENT

a. Authorization for wound care will be based on the clinical decision support guide (Interqual) based on the data submitted following a skilled nursing assessment. The assessment should include the primary diagnosis, pertinent medical, surgical and social history, medication, wound history (e.g. onset, longevity, current

management) and pain. Clinical data should include a complete wound assessment (e.g. location, size, depth, partial/full thickness, tissue appearance, sinus tracts, tunneling, stages for pressure ulcers, status of wound edges, condition of skin around the wound, exudates (color, odor, amount) other wound characteristics, and the treatment plan as prescribed by the physician.

b. All initial requests for wound care will be authorized for up to a 60 day interval. All Home Health Prior Authorization forms must be submitted with the required information.

c. Ongoing request for additional visits will be approved according to the criteria identified in the clinical decision support guide. Supporting information must be submitted to the QIO-like vendor. For long-term authorizations, diagnostics studies and nutritional assessments or other evaluations may be required. Authorizations for identified services, such as a registered dietician will be approved if identified as medically necessary.

d. Disposable wound supplies will be authorized for the Home Health Agency (HHA) for an initial ten-day supply only. Thereafter the supplies must be obtained from a Durable Medical Equipment or Pharmacy provider.

e. Specialty beds or other wound care items must be obtained as required per Nevada Medicaid Services Manual, Chapter 1300.

8. ORAL MEDICATIONS

The recipient is expected to self-administer his or her oral medications. The authorization of daily visits for the administration of oral medications is not a covered benefit. A weekly visit for a medication set up may be authorized. Whether it is a brief or extended visit depends on the number of medications and the number of times per day the medications are taken. One visit may be authorized per week. A request should include a substantiating diagnosis, such as mental illness that would limit the recipient's ability to set up his/her own medications. The names and frequency of the medication taken should be on the request.

9. INJECTIONS

Requests for injections are and routinely covered and must meet medical necessity for HHA service. If determined to be medically necessary Intramuscular (IM) or Subcutaneous (SC) may be approved for brief visits only. The sole exception for this is Synagis injections. Synagis may be approved for an RN/LPN extended visit. No more than two brief visits per day may be approved (usually this is for administration of insulin). The recipient, LRA and other willing caregivers should be taught this skill.

10. LABORATORY DRAWS

Requests for laboratory draws may be authorized for brief RN visits only. An extended visit may be authorized, if there is supporting documentation that it was a difficult blood draw and required multiple attempts.

11. HOME HEALTH AGENCY CLAIMS/BILLING GUIDELINES

The Division of Health Care Financing and Policy establishes reimbursement rates for covered services. Providers submit claims using an established revenue code, HCPCS code and modifier. Reimbursement codes for HHA services are listed in the QIO-like vendor billing manual or via mail with a hard copy of the form.

a. Third Party Liability

If there is another insurance that covers or partially covers HHA services, a claim must be submitted to that entity first and a copy of the EOB must be attached to the Medicaid reimbursement claim. For services that are not a benefit of Medicare or other private insurance, it is not necessary to bill the other insurance first. Instead, note on each claim the date, phone number and the name of the person from whom the information on the insurance status was obtained. Indicate "Bypass Medicare" or "Bypass Private Insurance" (specify insurance name) on the claim.

b. HOME HEALTH AGENCY RATE

Home Health Agency 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. Providers should utilize modifiers related to service area when billing to assure appropriate payment. Instructions for claims coding can be found in the Fiscal Agent's Nevada Medicaid and Nevada Check Up UB-92 Provider Billing Manual.

3. All outside Nevada services use Rural modifier TN.

1403.2 SKILLED NURSING SERVICES (SN)

Skilled nursing services are a covered service when provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse in accordance with the POC, to be safe and effective. In determining whether a service requires the skill of a nurse, consideration must be given to the inherent complexity of the service, the condition of the patient and the accepted standards of medical and nursing practice.

1403.2A COVERAGE AND LIMITATIONS

1. Observation and Assessment

Nursing visits for observation and assessment will be reimbursed by the home health agency benefit when:

a. There is a reasonable likelihood that the recipient will experience an acute episode;

b. There is reasonable likelihood that the recipient will develop a complication (either as a result of his/her disease process or as a result of prescribed medical therapy);

c. The skills of a nurse are required to assess the recipient's health status and identify significant change;

d. The change in the recipient's health status (as a result of another acute episode or complication) is likely to respond to a change in the recipient's plan of treatment or prescribed medical therapy.

2. Performance of Skilled Procedures

Nursing visits for the performance of skilled procedures of a nurse in the home setting will be reimbursed as a skilled nursing service when the procedure can only be performed safely by a nurse.

Factors that the DHCFP considers when determining if the performance of a specific procedure requires the skill of a nurse include:

a. The complexity of the procedure to be performed;
b. The recipient's physical and functional status;

c. The presence/absence of a willing, able, and competent caregiver in the home; and

d. The service is reasonable and necessary to the treatment of the patient.

3. Examples of covered skilled nursing procedures include but are not limited to:

a. Administration of intravenous, intra-muscular, or subcutaneous medications or infusions;

b. Vitamin B-12 injections, when administered for the treatment of certain conditions, such as pernicious anemia, megaloglastic anemia, fish tapeworm anemia, certain gastrointestinal disorders or certain neuropathics with the supporting lab work;

c. Insulin administration when the recipient is unable to self-administer the insulin and there is no other willing and able caregiver available. The recipient's plan of care must continue to document that there is no willing and able caregiver available and the recipient continues to be unable to self administer the insulin with each re-certification period. Nursing visits to perform glucometer testing are not covered as it does not require the skill of a nurse to perform;

d. The administration of Synagis for recipients under the age of two years who meet established Medicaid criteria;

e. Skilled nursing visits for venipuncture are covered when the collection of the specimen cannot be performed in the cause of regularly scheduled absences from the home and is necessary for the monitoring of therapeutic blood levels of medications, monitoring of blood counts and electrolyte levels when affected by the recipient's medication regimen, and related to the recipient's illness or medical condition;

f. Nasogastric tube and gastronotomy tube feeding;

g. Ostomy care during the immediate post-operative period;

h. Tracheotomy aspiration;

i. Catheter care (uretenal or suprapublic) insertion and replacement (every 30 days for jelly or 60-90 for silicone catheters) and irrigation;

j. Wound care, when the skills of the nurse are required to safely/effectively perform the wound care; and

k. Total Parenteral Nutrition (TPN).

4. Teaching Recipient/Family to Manage Care at Home

Teaching the recipient/family/caregiver how to manage the recipient's care at home will be reimbursed on a limited and short term basis as a skilled nursing service when the teaching or training is appropriate to the recipient's functional loss, illness or injury. Teaching and/or training activities must include a time frame in the POC when goals will be accomplished. Teaching visits will be authorized according to the following criteria:

a. The skills of the nurse are required to teach the recipient/family/caregiver how to manage the recipient's care at home. The care itself may be considered to be "unskilled" (not requiring the skills or expertise of the nurse to perform the care), but the amount of skill needed to teach the care must require the skills of a nurse;

b. The teaching is reasonable and necessary for the treatment/management of the recipient's health problem(s);

c. The initial authorization for teaching visits will be authorized according to the criteria identified in the clinical decision support guide. The initial authorization may be up to a 60 day interval. Additional teaching visits may be authorized if documentation is submitted that supports the ability of the recipient and/or the caregiver to learn the material. The content or skill covered by the teaching is new to the learner and does not represent reinforcement or review of previously learned, repeated, or taught content. Teaching will not be covered when the recipient or caregiver is not able to learn or be trained.

Examples of teaching and training activities which require the skill of a licensed nurse include, but are not limited to the following:

d. Self administration of injectable medications;

e. New complex medications;

f. Complex wound care;

g. Self catherization;

h. Administration of enteral feedings; and

i. Care and maintenance of intravenous or central lines and administration of medication through such lines.

5. Skilled Psychiatric Nursing Services

Evaluation of the recipient and the performance of psychotherapy require the skills of a nurse who meets criteria for credentialing as a psychiatric nurse. Services of a non-psychiatric nurse may be ordered by the psychiatrist for visits to administer injections or behavior modifying medications.

Psychiatric mental health services are covered services and are authorized according to the criteria identified in the clinical decision support guide, when the following conditions are met:

a. The psychiatric mental health services are reasonable and necessary for the treatment of the recipient's health status; and

b. The home care services are ordered by a psychiatrist and provided under a written POC. Medical orders must be established and reviewed by the primary physician.

1403.2B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.2C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.2D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.3 SKILLED PHYSICAL THERAPY SERVICES

Periodic home visits may be made by licensed physical therapists, to provide services as ordered by a physician and identified in the POC, when the services are inherently complex and can only be performed safely and effectively by a skilled therapist, and when the recipient cannot access out-patient services.

Reimbursement is based on the diagnosis of a medical condition plus the presence of functional limitations, which can respond or improve as a result of the prescribed POC. There must be an expectation the condition will improve in a reasonable, predictable period of time.

1403.3A COVERAGE AND LIMITATIONS

Skilled physical therapy services may be authorized for home care recipients; HHA visits are included in the total available outpatient limits up to 24 visits per year. These include visits for one or more of the following:

1. Assessment of the recipient's rehabilitation needs and potential;

2. Development and implementation of a physical therapy program when it is medically necessary to the recipient's treatment;

3. Objective tests and measurements such as range of motion, strength, balance coordination, endurance, and functional ability;

4. Performance of therapeutic exercises which require the skills and expertise of a physical

therapist to implement safely/effectively;

5. Gait evaluation and gait training for persons who have an impaired ability to ambulate secondary to a neurological, muscular, or skeletal abnormality;

6. Services are required to maintain a person's function that involves complex and sophisticated procedures and the judgment/skill of a physical therapist;

7. Administration of ultrasound treatments; and

8. Administration of heat treatments only when the recipient's overall condition is such that the skills and judgment of a physical therapist are required to safely administer these treatments.

1403.3B PROVIDER RESPONSIBILITY

In addition to 1403.1B, the provider must monitor that the total number of paid visits, do not exceed the total available therapy visits (24) per year.

1403.3C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C

1403.3D AUTHORIZATION PROCESS

Refer to Section 1403.1D

In addition to 1403.1D the physical therapist must submit the completed evaluation along with the Home Health Prior Authorization form to the QIO-like vendor. The provider should contact the QIO-like vendor to determine the number of authorized visits.

1403.4 SKILLED OCCUPATIONAL THERAPY SERVICES

Periodic home visits may be made by licensed occupational therapists to provide services as ordered by the physician and identified in a signed POC. Reimbursement is based on the diagnosis of a medical condition plus the presence of a limitation, which can respond or improve as a result of the prescribed POC. There must be an expectation that the condition will improve in a reasonable period of time.

1403.4A COVERAGE AND LIMITATIONS

Skilled occupational therapy services may be authorized for home care recipients. HHA visits are included in the total available outpatient limits of up to 24 visits per year. These visits include one or more of the following:

1. Assessment of the recipient's rehabilitation potential and needs.
2. Plan/implement/supervise a therapeutic program to:

    a. Restore physical function;

    b. Restore sensory-integrative function;

    c. Provide individualized therapeutic activity as part of an overall active treatment program for persons with diagnoses of psychiatric illness;

    d. Teach compensatory techniques to improve functional independence in the performance of activities of daily living; and

    e. Provide vocational and prevocational assessment and training that is directed toward the restoration of function in ADL's lost due to illness or injury.

1403.4B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B.

1403.4C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.4D AUTHORIZATION PROCESS

A Home Health Prior Authorization form must be submitted along with the completed evaluation to the QIO-like vendor prior to the initiation of service. The initial evaluation does not require prior authorization. Refer to Section 1403.1D.

1403.5 SKILLED SPEECH LANGUAGE PATHOLOGY SERVICES

Nevada Medicaid may pay for the services of a licensed speech pathologist to provide service as ordered by the physician and identified in a signed POC. Reimbursement is based upon diagnosis and treatment of speech and language disorders that result in communications disabilities and for the diagnosis and treatment of swallowing disorders, regardless of the presence of a communication disability. There must be an expectation that the condition will improve in a reasonable period of time.

1403.5A COVERAGE AND LIMITATIONS

Skilled speech language therapy service may be authorized for home care recipients. HHA visits are included in the total outpatient limits up to 24 visits per year. These include visits for the following:

1. Diagnosis and treatment of expressive and receptive communication disorders;

2. Diagnosis and treatment of swallowing disorders;

3. Assessment of a recipient's rehabilitation needs and potential;

4. Services directed toward specific speech or voice production if a deficit exists resulting from an illness or an injury; Establishment of a hierarchy of speech-voice-language communication tasks and cueing that is directed toward the achievement of specific communication goals;

5. Training the recipient/family/caregiver to augment: the speech language communication; treatment; or to establish a maintenance program;

6. Assisting persons who are aphasic in rehabilitation of speech and language skills; and

7. Assisting a person with voice disorders to learn to control vocal or respiratory systems for correct voice production.

1403.5B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.5C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.5D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.6 RESPIRATORY THERAPY SERVICES

Respiratory therapy is a covered service through a HHA provider, when it is prescribed by a physician and provided under assigned plan of care by a licensed respiratory therapist.

1403.6A COVERAGE AND LIMITATIONS

The services of a respiratory therapist that may be provided to recipients in a home setting include:

1. Ventilator management.

   a. Weaning the recipient off a ventilator; and

b. Changing settings on ventilators, C-PAP, Bi-PAP, Bi-PAP-ST.

2. Drawing arterial blood gases when a nurse is incapable of doing so. The services of a respiratory therapist will not be reimbursed for the setting up of rental equipment.

1403.6B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.6C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.6D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.7 REGISTERED DIETICIAN SERVICES

Registered dietician services are covered by the Medicaid HHA program. A registered dietician may provide consultative services when the recipient has a nutritional deficit or is at risk for a deficit.

1403.7A COVERAGE AND LIMITATIONS

Home health agency dietician services are appropriate for but not limited to recipients with diagnoses of cachexcia, failure to thrive, poor wound healing and newly diagnosed diabetics who are unable to go outside the home for dietician services.

1403.7B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B.

1403.7C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.7D AUTHORIZATION PROCESS

In addition to Section 1401.1D the provider must submit a copy of the completed evaluation must be submitted to the QIO-like vendor along with the Home Health Prior Authorization Form. The QIO-like vendor will review the evaluation to determine if medical necessity has been met. The initial evaluation does not require prior authorization.

1403.8 HOME HEALTH AIDE SERVICES

To receive home health aide services through the HHA program, the recipient must have a qualifying skilled service and must have an impairment or deficit so that he/she requires assistance with routine activities of daily living. Services must be reasonable and necessary to the treatment of the recipient's illness or injury. Home health aides can be appropriately utilized to assist in carrying out the plan of care. Home health aide services must be incorporated into an outcome specific nursing plan. Home health aides must meet the qualifications specified by 42 CFR 484.36. When it is identified that recipient has an ongoing need for assistance with ADLs, the HHA must advise the recipient and/or caregiver about other available services (e.g. personal care aide services) that may be more appropriate to their needs.

1403.8A COVERAGE AND LIMITATIONS

Home Health Aide services may provide assistance with:

1. Personal care services, such as bathing;
2. Simple dressing changes that do not require the skills of a licensed nurse;
3. Assistance with medications that are self administered;
4. Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist, such as, routine maintenance exercise;
5. Routine care of prosthetic and orthotic device;
6. Monitoring vital signs;
7. Reporting of changes in recipient condition and needs;
8. Any task allowed under Nevada Revised Statutes (NRS), Chapter 632 – Nursing, and directed in the physician's approved plan of care (POC).

1403.8B PROVIDER RESPONSIBILITY

In addition to Section 1401.1B the HHA RN must make a supervisory visit to the recipient's residence at least once every 60 days.

1403.8C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.8D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.9 END STAGE RENAL DISEASE (ESRD) SERVICES

ESRD recipients may qualify for HHA services. A recipient diagnosed with ESRD must meet all the general requirements for the HHA program plus the recipient must require skilled services that are not directly related to his/her dialysis treatments.

1403.9A COVERAGE AND LIMITATIONS

Refer to Section 1403.1A of this Chapter.

1403.9B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.9C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.9D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.10 OUT-OF-STATE SERVICES

HHA services are allowed out-of-state for Medicaid recipients absent from the state pursuant to 42 CFR 431.52. Payment for services furnished in another state are reimbursed to the same extent that Nevada would pay for services provided within Nevada boundaries. Out-of-state HHA services are reimbursed at the rural rate, using rural modifier TN.

1403.10A COVERAGE AND LIMITATIONS

Out-of-state services may be allowed when:

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

2. The recipient travels to another state because DHCFP has determined the required medical services are not available in Nevada, or it is determined that the needed medical services or necessary supplementary resources are more readily available in another state;

3. DHCFP 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);

4. The recipient is on personal business. DHCFP may reimburse for these services; however, they will be limited to those currently listed on the recipient's Plan of Care (POC).

1403.10B PROVIDER RESPONSIBILITY

1. The out-of-state provider must contact First Health Services Corporation (FHSC) provider enrollment unit to become enrolled as a DHCFP Home Health Agency provider.

2. The out-of-state provider must also comply with all provisions in Section 1403.1D.

1403.10C RECIPIENT RESPONSIBILITY

1. The recipient or their personal representative must contact Home Health Agency providers in the geographic region of which they wish service to be provided, to determine the availability of HHA service providers.

2. The recipient must notify an out-of-state provider who is not a DHCFP provider, but who is interested in becoming a provider to contact the QIO-like vendor.

3. The out-of-state provider must also comply with all provision in Section 1403.1C.

1403.10D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.11 EARLY & PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Nevada Medicaid may authorize HHA services for medically necessary therapies on children ages 0-20 with chronic special health care needs who are referred to the program through an EPSDT screening. Physical therapy, speech therapy and occupational therapy may be authorized for six months at a time when the child has an EPSDT screening examination, which identifies the medical diagnosis and the need for such therapy. EPSDT screening examinations for these services must be updated at six-month intervals. EPSDT therapies may be authorized beyond the 24 visits per year, if medically necessary as determined by DHCFP.

Reimbursement is based on the diagnosis of a medical condition plus the presence of functional limitations, which can respond or improve as a result of the prescribed POC. There must be an expectation the condition will improve significantly in a reasonably, predictable period of time.

1403.11A COVERAGE AND LIMITATIONS

Refer to Section 1403.1A.

1403.11B PROVIDER RESPONSIBILITY

The therapist must complete the initial evaluation; identify the treatment need, therapy goals, frequency and expected duration of therapy treatment whether for occupational therapy, physical therapy, and/or speech therapy. The provider must comply with all other requirements in Section 403.1B.

1403.11C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.11D AUTHORIZATION PROCESS

The following documentation needs to be provided:

1. A completed Home Health Prior Authorization Form requesting therapy(s);

2. A copy of the evaluation and/or POC which includes therapy goals, frequency and expected duration;

3. Referral from EPSDT Screening; and
4. The provider must also comply with all other requirements of Section 1403.1D.

1403.12 SERVICES TO CHILDREN

HHA services are not intended to relieve a parent of their child caring or other legal responsibilities. HHA services for children may be appropriate when the parent is unqualified or otherwise unable to provide care. Home health agency services are intended to provide intermittent skilled intervention with emphasis on caregiver education. Legally responsible adults and other willing primary caregivers are expected to be taught care which can be rendered reasonably and safely by non-medical persons.

1403.12A COVERAGE AND LIMITATIONS

Children are not considered homebound based upon their age. Home health, intermittent skilled nursing and therapy services are available only when the child is considered so medically fragile that leaving the home poses eminent danger to the health of the child. Home health agency services are not to be provided as a convenience to parents, the physician or the physician supplier. In authorizing services to children, consideration will be given to the inherent complexity of the skilled intervention, the capacity of available primary caregivers to be taught, and the availability of these caregivers. It is expected that the legally responsible adult or willing caregiver, after demonstrating competency, will provide the service.

1403.12B PROVIDER RESPONSIBILITY

Verify the availability and capability of the legally responsible adult or primary caregiver and include such information with request.

1403.12C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.12D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.13 FAMILY PLANNING

Home health agencies providing post partum home visiting service to Medicaid eligible women, may bill for family planning education.

1403.13A COVERAGE AND LIMITATIONS

This service must be provided:

1. In conjunction with the newborn assessment screening;
2. Be provided by a registered nurse; and
3. Consist of counseling and education about:
    a. Appropriate spacing of pregnancies
    b. Family planning options.

1403.13B PROVIDER RESPONSIBILITY

Refer to Section 1401.1B of this Chapter.

1403.13C RECIPIENT RESPONSIBILITY

Refer to Section 1401.1C of this Chapter.

1403.13D AUTHORIZATION PROCESS
No prior authorization is required. Submit on UB-92 0581 -- H1011 FP, TD (Old CPT Code = C98970).

1404 HEARINGS

Please reference Medicaid Services Manual, Chapter 3100 Hearings, for hearing procedures.