MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 26, 2008

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF OF COMPLIANCE

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

BACKGROUND AND EXPLANATIONS

Current language in Chapter 900 indicates that all Medicaid recipients that need private duty nursing are to have services authorized by DHCFP or their QIO-like vendor. When, in fact, recipients enrolled in a Managed Care Organization (MCO) are to receive prior authorization from the MCO.

This change adds language that identifies the responsibility of the Managed Care Organization as it relates to the private duty nursing prior authorization process. Additional verbiage revisions provide clarification and match the language used in other MSM chapters without changing the meaning of the policy.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 22/08	**MTL 10/03**
CHAPTER 900 – PRIVATE DUTY NURSING	CHAPTER 900 – PRIVATE DUTY NURSING

Section 903.1D.1
Added "PDN" after Private Duty Nursing

Added "Quality Improvement Organization (QIO-like vendor)"

Added "vendor" five times through section

Added "Private Duty Nursing 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."

Section 903.1D.1.a
Added "vendor"

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900 PRIVATE DUTY NURSING

INTRODUCTION

Private duty nursing (PDN) is an optional benefit offered under Nevada Medicaid State Plan. Private duty nursing provides more individual and continuous care than is available from a visiting nurse. The intent of private duty nursing is to assist the non-institutionalized recipient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. 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 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. Service may be approved 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 areas where Medicaid and Nevada Check Up policies differ as documented in 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 directions of the recipient's physician: and

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

   1. His or her own home;

   2. A hospital; or

   3. A nursing facility

Nevada has opted to provide private duty nursing in the recipient's home.

902 DEFINITIONS

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 7 days per week, or less than 8 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 care giver 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 or licensed practical nurse. 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. Service hours are determined based on skilled nursing need and are not related to diagnoses of mental illness (MI) or mental retardation (MR). 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. The services have been determined to meet the medical criteria for private duty nursing; and

f. The service can be safely provided in the home setting.

2. COVERED SERVICES

a. PDN service may be approved for recipients who need more individual and continuous skilled nursing than can be provided in a skilled nurse visit through a home health agency, and whose care exceeds the scope of service that can be provided by home health aide or personal care aide (PCA).

b. PDN services may be approved for up to 16 hours per day for <u>new</u> 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 <u>new</u> tracheotomy 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.

3. MEDICAL CRITERIA

PDN is considered medically necessary when a recipient requires the services of a licensed registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN to perform skilled nursing (SN) interventions to maintain or improve the recipient's health status. Skilled 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.

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 2 or more different skilled nursing interventions.

3. SKILLED NURSING NEED CATEGORY 3

Limited to recipients that are ventilator dependent at least 6 hours per day, or to recipients that, in addition to skilled nursing observation, have 4 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 parentural nutrition (TPN) would be considered two (2) 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 (1) SNN task.

Examples of what are typically determined to be "skilled nursing interventions" are identified below:

1. Ventilator care.

2. Tracheotomy with related suctioning and dressing changes;

3. Total parenteral nutrition (TPN);

4. Peritoneal dialysis;

5. Gastroscopy tube or nasogastric tube feedings, with related suctioning and administration of medication, are considered a SNN when associated with complex medical problems or with medical fragility of the recipient.

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

7. Oxygen-unstable – continuous oxygen administration, in combination with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.

8. Multiple sterile complex dressing change required at least BID. The dressing change must be separate from other SNN interventions such as changing a tracheotomy site dressing when associated with tracheotomy care.

Additional major procedures not listed here may be considered in determining the intensity of skilled nursing 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 PDN program and are therefore not reimbursable:

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

b. Services normally provided by a 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 at institution for the treatment of mental health or chemical addiction.

d. Services rendered to recipients in pediatric and adult day centers.

e. Services rendered at school sites responsible for providing "school based health service" pursuant to IDEA §300.24.

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

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

h. Services provided without authorization;

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

j. Service requests that exceed program limits;

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;

l. Companion Care that is intended to provide friendly or social time with a recipient;

m. 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;

n. Homemaker services;

o. Medical Social Services (MSS);

p. Duplicative services, such as personal care services that are provided during private duty nursing hours;

q. Travel time to and from the recipient's residence;

r. 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.

903.1B PROVIDER RESPONSIBILITIES

The provider shall furnish qualified registered nurses and licensed practical nurses, 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.

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 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.

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 3903.1D.

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 may have to pay.

6. PLACE OF SERVICE

The provider must provide PDN service in the recipient's place of residence or in settings where normal life activities take the recipient other than the recipient's residence. School sites are excluded as a matter of special education law (IDEA §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 an OASIS or age appropriate evaluation;

b. Complete a Nevada Medicaid PDN assessment form; and

c. Establish the safety of the recipient in the home setting.

If the provider determines the recipient is not appropriate for private duty nursing 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.

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 incident of abuse, neglect, or exploitation.

a. CHILD ABUSE

State law requires that certain person 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 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 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. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient'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 recipients 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 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 NMCO immediately upon request.

14. 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 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;

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

7. The recipient or caregiver is non co-operative in the establishment or delivery of services.

8. The recipient no longer meets the criteria for PDN 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 PDN program. The recipient may choose another provider.

b. 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.

c. ADVANCE NOTICE TERMINATION

The provider must provide at least 5 calendar days advance written notice to recipients when PDN 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 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

The provider must maintain medical records which fully discloses 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 (6) 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, 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, 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, residing in the recipient's place of residence, who accepts responsibility for the individual's health, safety and welfare. The primary care giver must be responsible for the majority of daily care in a 24-hour interval;

6. Have an identified alternate caregiver, or a backup plan to be utilized if the primary care giver 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, communication systems available for technology dependent recipients;

10. Comply with the delivery of services as outlined in the Plan of Care;

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 LRA or legal guardian 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, color, national origin, sexual orientation and diagnosis.

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

4. A recipient has the right to confidentiality with regard to information about his 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 that will be furnished, care, and frequency of visits proposed to be furnished.

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

Private Duty Nursing (PDN) services must be prior authorized by Nevada Medicaid staff (or their designee). The provider must fax a completed payment authorization request to the Quality Improvement Organization (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. 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. 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) by the QIO-like vendor.

Private Duty Nursing 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 form.

Reimbursement: The initial registered nurse visit will be reimbursed as an RN extended visit. Refer to 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 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. DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies require a prior authorization request at the time of request for Home Health Authorization (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.

Routine 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.

e. 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. Use rural billing code modifier TN.

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

f. MILEAGE

Actual mileage is reimbursed one way from the HHA/Private Duty Nurse (PDN) office to the recipient's residence. Actual mileage should be listed on the prior authorization request form to establish a base line 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 at a minimum of 15 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 along with a current nurse assessment and PDN assessment form. The QIO-like will review for appropriate number of hours using the Decision Guide and based on program criteria. PDN services may be authorized for a maximum of six months.

3. ADDITIONAL AUTHORIZATIONS

a. School Break

During "planned breaks" of at least five (5) 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 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.

903.2 24 HOUR CARE

In the event a primary caregiver is absent due to a medical need of the caregiver or a family member, 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 COVERAGE AND LIMITATIONS

1. 24-hour care is limited to 5 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 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) or primary caregiver 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 RECIPIENT RESPONSIBILITIES

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

2. The primary caregiver 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 3903.1C, Recipient Responsibilities, of this Chapter shall apply.

903.2 D AUTHORIZATION PROCESS

1. The provider may request a verbal authorization of the QIO-like 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 3 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 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 recipients (up to 3) 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 recipient. Concurrent care must be prior authorized.

903.3B 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 (42CFR 431.52). 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 COVERAGE AND LIMITATIONS

In addition to the policies described in Section 3903.1A, of this Chapter, the following apply for Out-of-State.

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);

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 PROVIDER RESPONSIBILITIES

1. The out-of-state provider must contact provider enrollment at Nevada Medicaid Central Office (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

1. The recipient or their personal representative should contact Home Health Agency providers in the geographic out-of-state region on 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 Nevada Medicaid Central Office (NMCO).

The recipient must comply with all the provision identified in 3903.1C and 3903.D of this Chapter.

903.5 CRISIS OVERRIDE

The private duty nursing 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 COVERAGE AND LIMITATIONS

1. Additional services may be covered up to twenty percent (20%) above program limits

2. Additional services are limited to one (1), sixty (60) day interval in a three year period (calendar years).

903.5B PROVIDER RESPONSIBILITIES

Must contact the Division of Health Care Financing and Policy, Central office Home Care Coordinator or designee with information regarding the crisis situation and need for additional hours.

All other policies as discussed in Section 3903.1.

904 HEARINGS

Please reference Nevada Medicaid Services Manual, Chapter 3100, for Medicaid Hearing process.

905 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 1-800-992-0900 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

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**
a.) Available caregiver has health issues± which inhibits their ability to provide any of the need ed care.	May allow an additional 2 hours per day. *NTE 25 total hours per week.*	May allow an additional 3 hours per day. *NTE 48 total hours per week.*	May allow an additional 4 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 1 hour per day. *NTE 20 total hours per week.*	May allow an additional 2 hours per day. *NTE 40 total hours per week.*	May allow an additional 3 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 2 hours per day. *NTE 14 hours per week*	Reduce allowable hours by 2 hours per day. *NTE 38 hours per week*	Reduce allowable hours by 2 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.