MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 27, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE /Lynne Foster/

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

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 900 – Private Duty Nursing (PDN) are being proposed to ensure compliance with federal requirements. Language restricting the provision of services solely to the recipient's place of residence has been removed. Language now allows PDN to be provided in the recipient's home or any setting where normal life activities occur. Medical necessity for the PDN program was clarified and language was updated accordingly for clarity and readability. Service limitations and prior authorization (PA) requirements for all PDN services have also been added. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. The timeframe for ongoing authorizations was changed. The chapter now requires ongoing authorizations be submitted at least 10 days prior to the end of the authorization period, versus 15 days, to align with Chapter 1400 – Home Health Agencies ongoing authorization timeframe.

PDN definitions have been moved to the MSM Addendum. MSM Addendum Sections C and I are being proposed to revise language regarding the definition of Concurrent Care and add language regarding the definition of Immediate Relative.

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

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

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

These changes are effective December 28, 2018.

MATERIAL TRANSMITTED	**MATERIAL SUPERSEDED**
MTL 21/18 MSM Chapter 900 – Private Duty Nursing	MTL 10/03, 22/07, 22/08 MSM Chapter 900 – Private Duty Nursing

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
900	**INTRODUCTION**	Language was updated and/or reworded for improved readability and clarity.
901	**AUTHORITY**	Added new language “any setting where normal life activities occur.” to align with federal requirements.
902	**DEFINITIONS**	Deleted this section. Added reference to MSM Addendum.
903.1	**POLICY STATEMENT**	Clarified language for PDN program. Added language to define “continuous,” “complex” and “substantial.” Added new language, PDN is not intended for 24-hour care.
903.1A(1)	**PROGRAM ELIGIBILTY CRITERIA**	Deleted Subsection (b) regarding “legally responsible adult providing care” and clarified language in Subsection (c) to align with federal requirements.
903.1A(2)	**COVERED SERVICES**	“Tracheotomy” was replaced with “tracheostomy” for accurate medical terminology. Replaced “to remain at home” with “prevent institutionalization.” Language was updated and/or reworded for improved readability and clarity.
903.1A(3)	**MEDICAL CRITERIA**	Section renamed “MEDICAL NECESSITY.” Deleted Skilled Nursing Need Categories within section. Examples of “skilled nursing interventions” updated for accurate medical terminology. Defined “BID” as twice per day for clarity. Added language for “Non-invasive” ventilation. “Decision Guide” section deleted. Language was updated and/or reworded for improved readability and clarity.
903.1A(4)	**NON-COVERED SERVICES**	Added new language regarding “non-skilled interventions which are custodial in nature” and included examples. New “Legally Responsible Individual (LRI)” was added to align with other MSM policy definitions. Language was updated and/or reworded for improved readability and clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
903.1B	**PROVIDER RESPONSIBILITIES**	Language added to state provider compliance with all Chapter 900 language, MSM Chapter 100 and any and all state and federal regulations. Added Social Security Act reference. Added new language "any setting where normal life activities occur." to align with federal requirements. "Termination of Services" section updated for clarity and readability regarding "Immediate Termination" and "Advanced Termination" of services. Throughout the section "patient" is replaced with "recipient" where appropriate and language was updated or reworded for clarity.
903.1C	**RECIPIENT RESONPNSIBILITIES**	Language was updated and/or reworded for improved readability and clarity.
903.1D	**AUTHORIZATION PROCESS AND REIMBURSEMENTS**	Section renamed "AUTHORIZATION PROCESS." Clarifying language added for authorized hours for recipients with new tracheostomy. Service hours may be increased to 84 hours per week. Clarifying language added for authorized hours for recipients with a new ventilator. Service hours may be increased to 112 hours per week for an eight week interval. Language added to section for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, reference to MSM Chapter 1500 for authorization process. Third Party Liability language deleted as it is duplicative to previous section earlier in Chapter. Section 903.1D(d) deleted, as holiday hour reimbursement is no longer applicable. Durable Medical Equipment changed to Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS), reference to MSM Chapter 1300 for DMEPOS policy and provider billing guide for clarity added. Section 903.1D(e) "REIMBURSEMENT" moved to end section of the chapter and renumbered. Ongoing authorization timeline changed from 15 days to 10 days for consistency with processing timeframes. Clarifying language added to "RETRO AUTHORIZATIONS" regarding services provided while Prior Authorization (PA) requests are "pending."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Ongoing authorization language clarified. Language added to authorization process and ongoing authorizations PDN acuity grid must be completed. PDN acuity grid is used to determine if PDN services are medically necessary and to authorize the number of hours required. For ongoing authorization of hours for recipients with a new tracheostomy or ventilator, clinical documentation must be submitted.
903.2A	**COVERAGE AND LIMIATIONS**	Section renamed to "24 HOUR CARE COVERAGE AND LIMITATIONS" for clarity.
903.2B	**PROVIDER RESPONSILBITIES**	Section renamed to "24 HOUR CARE PROVIDER RESPONSIBLITIES" for clarity.
903.2C	**RECIPIENT RESPONSIBILITES**	Section renamed to "24 HOUR CARE RECIPIENT RESPONSIBLITIES" for clarity.
903.2D	**AUTHORIZATION PROCESS**	Section renamed to "24 HOUR CARE AUTHORIZATION PROCESS" for clarity.
903.3	**CONCURRENT CARE**	"Multiple" replaced with "up to three" for more concise definition.
903.3A	**PROVIDER RESPONSIBILITIES**	Section renamed to "CONCURRENT CARE PROVIDER RESPONSIBILITIES" for clarity.
903.4	**OUT-OF-STATE SERVICES**	Language added to section Out-of-State Services in which a PA is required by the QIO-like vendor.
903.4A	**COVERAGE AND LIMITATIONS**	Section renamed to "OUT-OF-STATE COVERAGE AND LIMITATIONS." Language added regarding service limitation of 30 days and ongoing authorizations after the initial out-of-state authorization period must be prior authorized by the QIO-like vendor. Language from MSM 100 added to section to define locality for clarity.
903.4B	**PROVIDER RESPONSIBILITIES**	Section renamed to "OUT-OF STATE PROVIDER RESPONSIBLITIES" for clarity.
903.4C	**RECIPIENT RESPONSBILITIES**	Section renamed to "RECIPIENT RESPONSIBLITIES FOR OUT-OF-STATE SERVICES" for clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
903.5A	**COVERAGE AND LIMITATIONS**	Section renamed to “CRISIS OVERRIDE COVERAGE AND LIMITATIONS” for clarity.
903.5B	**PROVIDER RESPONSIBLITIES**	Section renamed to “CRISIS OVERRIDE PROVIDER RESPONSIBLITIES” for clarity. Reference to previous chapter section corrected.
904	**RATES AND REIMBURSEMENT**	Previously in Section 903.1(e), now a new stand-alone section which refers to billing guide and reimbursement code table for specific billing codes and reimbursements.
905	**HEARINGS**	Manual section renumbered.
906	**REFERENCES AND CROSS REFERENCES**	Section deleted.

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900 INTRODUCTION PRIVATE DUTY NURSING

Private duty nursing (PDN) is an optional benefit offered under the Nevada Medicaid State Plan. PDN provides more individual and continuous care than is available from a visiting nurse for recipients who meet specified criteria and require more than four continuous hours of skilled nursing (SN) care per day. The intent of private duty nursing is to assist recipients with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize recipient health status and outcomes. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial, complex and continuous SN care to prevent institutionalization.

PDN services may be provided, within program limitations, to a recipient in his/her home or in settings outside the home wherever normal life activities take place. Services are authorized based on medical necessity, program criteria, utilization control measures and the availability of the state resources to meet recipient needs.

All Medicaid policies and requirements are the same for Nevada Check Up, except for areas where Medicaid and Nevada Check Up policies differ as documented in Medicaid Services Manual (MSM) Chapter 3700.

901 AUTHORITY

Social Security Act (SSA) Sections 1814(a)(2)(c), 1835(a)(2)(a) and 1905(a)(8).

42 CFR 440.80 PDN services.

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

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

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

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

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

2. A hospital; or

3. A nursing facility

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

902 DEFINITIONS

Program definitions can be found in the MSM Addendum.

903 POLICY

903.1 POLICY STATEMENT

The PDN benefit reimburses medically necessary and appropriate hourly nursing services by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN. PDN services are not intended to provide 24-hour care. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial, complex and continuous skilled nursing care to prevent institutionalization.

For purposes of the chapter, "Continuous" means nursing assessments requiring skilled interventions to be performed at least every two to three hours during the Medicaid-covered PDN shift. The recipient's medical condition(s) and necessary skilled interventions must justify a shift of at least four continuous hours. "Complex" means multifaceted needs requiring SN interventions. Observation in the event an intervention is required is not considered complex skilled nursing and shall not be covered as medically necessary PDN services. "Substantial" means there is a need for interrelated nursing assessments and interventions. Interventions that do not require assessment or judgment by a licensed nurse are not considered substantial.

Service hours are determined based on medical necessity and are not related to diagnoses of mental illness (MI) or intellectual disability (ID).

903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

   a. The recipient has ongoing Medicaid eligibility for services;

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

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

2. COVERED SERVICES

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

   b. PDN services may be approved for up to 84 hours per week for new tracheostomy recipients for the initial eight-week authorization the period immediately following

discharge from the hospital.

c. PDN services may be approved for up to 112 hours per week for new ventilator dependent recipients for the initial eight-week authorization period immediately following discharge from the hospital.

d. PDN services may be approved for recipients who are chronically ill who require extensive SN care to prevent institutionalization.

3. MEDICAL NECESSITY

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

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

a. Some examples of typical "SN interventions" include, but are not limited to, the following:

1. Ventilator care.

2. Tracheostomy with related suctioning and dressing changes.

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

4. TPN.

5. Peritoneal dialysis.

6. Enteral feedings, and administration of medication, are considered a SN task when associated with complex medical problems or with medical fragility of the recipient.

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

8. Continuous oxygen administration, with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.

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

Additional skilled interventions not listed here may be considered in determining the intensity of SN needed.

4. NON-COVERED SERVICES

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

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

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

1. Administration of nebulized medications

2. Application and removal of orthotic braces

3. Application of chest vest and use of cough assist device(s)

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

c. Services provided by a legally responsible individual (LRI) or immediate family member. No reimbursement is made for services provided by an immediate relative or LRI.

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

e. Services rendered at school sites responsible for providing "school-based health service" pursuant to IDEA 34 Code of Federal Regulations (CFR)§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 (POC).

j. Service requests that exceed program limits.

k. Respite care.

l. Companion Care, baby-sitting, supervision or social visitation.

m. Homemaker services.

n. Medical Social Services (MSS).

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

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

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

903.1B PROVIDER RESPONSIBILITIES

The provider shall furnish qualified RNs and/or LPNs, under the supervision of a registered nurse to assist eligible Medicaid recipients with complex skilled nursing tasks as identified in the physician's written POC. Services are to be provided as specified in this Chapter and must meet

the conditions of participation as stated in MSM Chapter 100. The provider must comply with all local, state and federal regulations, and applicable statutes, including but not limited to Federal Law Section 1905(a)(8) of the SSA.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare certified Home Health Agency (HHA), 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 system (EVS). Verification of Medicaid eligibility is the sole responsibility of the provider agency.

3. PHYSICIAN ORDER AND PLAN OF CARE

The provider must provide PDN services initiated by a physician's order and designated in the POC which is documented on a CMS 485. The POC is a written set of medical orders signed by the physician which certify the specific HHA services that will be provided, the frequency of the services and the projected time frame necessary to provide such services. The POC is reviewed by the physician every 60 days. A new POC is required when there is a change in the recipient's condition, change in orders following hospitalization and/or change in the ordering physician.

4. PRIOR AUTHORIZATION

The provider must obtain prior authorization for all PDN services prior to the start of care. Refer to the authorization process 903.1D.

5. THIRD PARTY LIABILITY (TPL)

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

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

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

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

6. PLACE OF SERVICE

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

7. CASE INITIATION

A referral from physicians, discharge planners or recipient triggers the process for PDN hours.

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

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

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

c. Establish the safety of the recipient during the provision of services.

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

If the provider is able to initiate service, all required documents should be submitted to the Quality Improvement Organization (QIO)-like vendor.

8. CONFIDENTIALITY

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

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

Providers meeting the definition of a "covered entity" as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 CFR 160) must

comply with the applicable Privacy Regulations contained in 45 CFR 160, 162 and 164 for recipient health information.

9. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

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

a. CHILD ABUSE

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

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

Refer to Nevada Revised Statutes (NRS) 432B regarding child abuse or neglect.

b. ELDER ABUSE

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

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

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

10. RECIPIENT RIGHTS

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

11. ADVANCE DIRECTIVES

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

HHA's must also:

a. Provide written information to the recipient(s) at the onset of service concerning an individual's right under Nevada state law, NRS 449, 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 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 based on race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions).

13. COMPLAINT RESOLUTION

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

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

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

14. TERMINATION OF SERVICES

a. IMMEDIATE TERMINATION

The provider may terminate PDN services immediately for the following reasons:

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

2. The recipient is ineligible for Medicaid.

3. The recipient requests termination of services.

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

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

b. ADVANCE NOTICE TERMINATION

The provider must provide at least five calendar days advance written notice to recipients when PDN services are terminated for the following reasons:

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

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

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

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

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

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

Note: The nurse provider must comply with Nevada Administrative Code (NAC) 632 (the Nurse Practice Act) regarding patient abandonment.

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

903.1C RECIPIENT'S RESPONSIBILITIES

The recipient or personal representative shall:

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

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

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

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

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

6. Have an identified alternate LRI or a backup plan to be utilized if the primary LRI and/or the provider are unable to provide services. The PDN nurse provider is not an alternate caregiver with legal authority.

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

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

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

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

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

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

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

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

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

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

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

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

RECIPIENT RIGHTS

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

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

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

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

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

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

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

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

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

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

10. The recipient has the right to be advised, in advance, of the services that will be provided and frequency of such services.

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

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

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

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

903.1D AUTHORIZATION PROCESS

1. PRIOR AUTHORIZATION

PDN services must be prior authorized by the Nevada Medicaid QIO-like vendor, except for mileage and initial assessments. The provider must submit all required PDN PA forms to the QIO-like vendor.

The QIO-like vendor will review the request and supporting documentation for medical necessity. The PDN PA form and supporting documentation will be used to determine medical necessity and to qualify and quantify the appropriate number of PDN hours. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. 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. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. The PDN acuity grid is used to determine if PDN services are medically necessary and to authorize the number of hours required. The PDN acuity grid must be completed in its entirety, including all signatures. Incomplete or unsigned forms will result in PA denial. All forms and documentation must be submitted together. Failure to complete all sections of PDN acuity grid or failure to provide all medical documentation to support the prior authorization request may result in the number of PDN hours not being appropriately authorized.

New tracheostomy recipients may receive up to 84 hours per week, for the initial eight-week authorization period immediately following discharge from the hospital.

New ventilator dependent recipients up to 112 hours per week, for the initial eight-week authorization period immediately following discharge from the hospital.

A Medicaid recipient under 21 years of age may be eligible for additional authorized PDN hours under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Refer to MSM Chapter 1500 Healthy Kids Program for EPSDT authorization process.

If a recipient does not meet medical necessity criteria for PDN, the PA will be denied. If the request is for more hours than can be authorized according to program criteria, a Notice of Decision (NOD) will be issued by the QIO-like vendor.

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

a. INITIAL EVALUATION VISIT

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

b. DISPOSABLE MEDICAL SUPPLIES

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

c. MILEAGE

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

2. ONGOING AUTHORIZATIONS

Requests for continuing PDN services must be submitted to the QIO-like vendor at a minimum of 10 working days but no more than 30 days prior to the expiration date of the existing authorization. The completed request must be submitted to the QIO-like vendor along with a current nurse assessment and PDN assessment form. The QIO-like vendor will review for appropriate number of hours based on program criteria and program limitations. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. Hours may be reduced after the initial authorization period based on a comprehensive review of the clinical documentation. The PDN acuity grid is used to determine if PDN services are medically necessary and to authorize the number of hours required. The PDN acuity grid must be completed in its entirety, including all signatures. Incomplete or unsigned forms will result in prior authorization denial. All forms and documentation must be submitted together. Failure to complete all sections of PDN acuity grid or failure to provide all medical documentation to support the PA request may result in the number of PDN hours not being appropriately authorized.

An ongoing authorization request for 84 hours per week, after the initial eight-week authorization period immediately following discharge from the hospital for a new

tracheostomy, must include clinical documentation to support the continued need for 84 hours. If such clinical documentation is not included in the request, hours may be reduced.

An ongoing authorization request for 112 hours per week, after the initial eight-week authorization period immediately following discharge from the hospital for a new ventilator, must include clinical documentation to support the continued need for 112 hours. If such clinical documentation is not included in the request, hours may be reduced.

If a recipient does not meet medical necessity criteria for PDN, the PA will be denied. If the request is for more hours than can be authorized according to program criteria, a Notice of Decision (NOD) will be issued by the QIO-like vendor.

PDN services may be authorized for a maximum of six months.

3. ADDITIONAL AUTHORIZATIONS

a. School Break

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

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 prior authorization request (PAR) must be submitted to the QIO-like vendor along with documentation supporting medical necessity and program criteria.

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 of eligibility. Please note, if the PA request is pending and services are provided, the provider is assuming responsibility for PDN costs if the PA request is denied. A PA only approves existence of medical necessity, not recipient eligibility.

903.2 24-HOUR CARE

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

903.2A 24-HOUR COVERAGE AND LIMITATIONS

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

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

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

903.2B 24-HOUR PROVIDER RESPONSIBILITIES

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

2. The provider must submit an EPSDT screening by a physician provider 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 LRI, parent/guardian or authorized representative to provide documentation of absence due to a medical need. Such information will be released to Nevada Medicaid or their designee for determination of eligibility for this benefit.

All other policies found in Section 903.1B, Provider Responsibilities, of this chapter shall apply.

903.2C 24-HOUR CARE RECIPIENT RESPONSIBILITIES

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

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

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

903.2D 24-HOUR CARE AUTHORIZATION PROCESS

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

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

903.3 CONCURRENT CARE

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

903.3A CONCURRENT CARE PROVIDER RESPONSIBILITIES

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

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

All policies found in Section 903.1 of this chapter shall apply.

903.4 OUT-OF-STATE SERVICES

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

903.4A OUT-OF-STATE COVERAGE AND LIMITATIONS

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

Out-of-state services may be authorized when:

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

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

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

   a. Nevada residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the Division of Health Care Financing and Policy (DHCFP) refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation. Refer to the MSM 100 billing manual for catchment areas.

   b. The same services that are covered within the state of Nevada are available for payment for any qualified provider, in the catchment area, who is or will be enrolled with the plan.

   c. Nevada Medicaid does not pay for medical services rendered by health care providers outside the United States.

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

903.4B OUT-OF-STATE PROVIDER RESPONSIBILITIES

1. The out-of-state provider must contact provider enrollment at the Nevada Medicaid Central Office (NMCO) to become enrolled as a Nevada Medicaid HHA provider.

2. The out-of-state provider must comply with all provisions identified in Section 903.1B.

903.4C RECIPIENT RESPONSIBILITIES FOR OUT-OF-STATE SERVICES

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

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

The recipient must comply with all the provisions identified in Section 903.1C of this chapter.

903.5 CRISIS OVERRIDE

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

903.5A CRISIS OVERRIDE COVERAGE AND LIMITATIONS

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

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

903.5B CRISIS OVERRIDE PROVIDER RESPONSIBILITIES

The provider must contact the QIO-like vendor with information regarding the crisis situation and need for additional hours.

All other policies as discussed in Section 903.1B.

904 RATES AND REIMBURSEMENT

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

905 HEARINGS

Please reference Nevada MSM Chapter 3100 for the Medicaid Hearing process.