Medicaid Services Manual
Transmittal Letter

December 26, 2023

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

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

Background And Explanation

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

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

Entities Financially Affected: Home Health Agency provider type (PT 29).

Financial Impact on Local Government: Unknown at this time.

These changes are effective:

Material Transmitted	Material Superseded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

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

q. Respite care;

r. Duplication of services;

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

t. Travel time to and from the recipients residence;

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

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

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

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

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

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

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

1403.1B PROVIDER RESPONSIBILITY

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

1. PROVIDER QUALIFICATIONS

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

2. MEDICAID ELIGIBILITY

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

3. THIRD PARTY LIABILITY (TPL)

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

4. PHYSICIANS ORDER AND PLAN OF CARE

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

5. PRIOR AUTHORIZATION

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

6. ELECTRONIC VISIT VERIFICATION (EVV)

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

~~6.~~7. PLACE OF SERVICE

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

~~7.~~8. HOME HEALTH AGENCY VISITS

a. Evaluation visit

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

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

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

b. Supervisory visit

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

c. Visit types

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

~~8.~~9. RECIPIENT RIGHTS

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

~~9.~~10. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

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

a. CHILD ABUSE

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

child has been abused or neglected. For minors under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected abuse.

Refer to NRS 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adult aged 60 and over, the Division for Aging Services (DAS) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

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

~~10.~~11. COMPLAINT RESOLUTION

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

a. The provider must maintain records that identify the complaint, the date received and the outcome; and
b. The provider must submit documentation regarding the complaint to Nevada Medicaid Central office (NMCO) immediately upon request.

~~11.~~12. TERMINATION OF SERVICES

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

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

2. The recipient is ineligible for Medicaid;

3. The recipient requests termination of services;

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

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

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

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

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

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

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

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

b. IMMEDIATE TERMINATION

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

c. ADVANCE NOTICE TERMINATION

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

d. NOTIFICATION REQUIREMENTS

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

~~12.~~13. RECORDS

The provider must maintain medical records which fully disclose the extent and nature of the service provided to the recipient and which supports fees or payments made. Medical and financial records and all other records provided must be maintained for an interval of

not less than six years. Following HIPAA Privacy Regulations contained in 45 CFR 160 and 164, the provider must make records available upon request to the Division.

1403.1C RECIPIENT RESPONSIBILITY

1. The recipient or personal representative shall:

a. Provide the HHA with a valid Medicaid card;

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

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

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

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

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

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

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

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

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

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

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