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. ELECTRONIC VISIT VERIFICATION (EVV)

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

~~5.~~6. 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.~~7. 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.~~8. 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.~~9. 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.~~10. 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.~~11. 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.~~12. 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.~~13. 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.~~14. 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.~~15. 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.~~16. 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.

5.

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. 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.

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.