CHAPTER 9-000 HOME HEALTH AGENCIES

9-001 Standards for Participation: The home health agency shall complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90), and submit the form to the Nebraska Department of Health and Human Services Finance and Support for approval to participate in the Nebraska Medical Assistance Program (NMAP).

9-001.01 Definition of Home Health Agency: Home health agency means a proprietary or nonproprietary agency or organization, or a part of an agency or organization, who is licensed and meets the requirements for participation in Medicare or the Joint Commission on Accreditation of Healthcare Organization.

9-001.02 Purpose: NMAP covers home health agency services to assist clients attain or retain their capacity for independence or self-care in the least restrictive environment by providing payment -

1. For the most appropriate and cost effective medical care necessary to maintain, rehabilitate, or improve the clients' quality of life;
2. To agencies who meet Medicare certification by the Nebraska Department of Health_and Human Services Regulation and Licensure, accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) for home health agencies, or to agencies licensed/certified/accredited in other states; and
3. For medical services provided to medically and categorically needy clients who are eligible for NMAP.

9-002 Covered Services: NMAP covers the following home health agency services:

1. Skilled nursing services by -
   a. A registered professional nurse; or
   b. A licensed practical nurse;
2. Home health aide services;
3. Physical therapy provided by a licensed physical therapist (see 471 NAC 17-000);
4. Speech therapy provided by a licensed speech pathologist (see 471 NAC 23-000);
5. Occupational therapy provided by a licensed/certified occupational therapist (see 471 NAC 14-000); and
6. Durable medical equipment and medical supplies (see 471 NAC 7-000).

See 471 NAC 9-002.08 for specific guidelines for NMAP's coverage of home health agency services and 471 NAC 9-002.08A for limitations.

9-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

9-002.01A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

9-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. In addition, services provided by a home health agency require referral from the client's primary care physician (PCP) and prior authorization by the PCCM Network Administrator. Providers shall contact the PCP before providing services. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

9-002.02 Medical Necessity: All home health services must be -

1. Necessary to a continuing medical treatment plan;
2. Prescribed by a licensed physician; and
3. Recertified by the licensed physician at least every 60 days.

Therapies must be recertified every 30 days by the licensed physician.

Durable medical equipment and medical supplies must meet the guidelines outlined in 471 NAC 7-000.

9-002.03 Definition of Home Health Service: Home health services are services provided to a client in the client's place of residence. The residence does not include a hospital, skilled nursing facility, or nursing facility.

A client who requires and is authorized to receive extended-hour home health nursing services in the home setting may use his/her approved hours outside of the home during those hours when his/her normal life activities take him/her out of the home, i.e., attend school, therapeutic activities, etc. The Department will not authorize any additional hours of nursing service beyond what would normally be authorized. If a client wishes to receive nursing services to attend school or other activities outside the home, but does not need nursing services in the home, nursing services cannot be authorized.

To be eligible for home health services, the attending physician shall certify that -

1. ~~The client is considered to be homebound and cannot receive the services in an outpatient/physician office setting;~~Based on the client's medical condition, Home Health services are medically necessary and appropriate services to be provided in the home;
2. Extended home nursing/aide services are medically necessary; or
3. That observation/teaching in the home environment is an integral and necessary part of the plan.

9-002.04 Plan of Care and Treatment Record: The home health agency shall maintain a clinical record that includes the plan of care signed by the physician responsible for the client's care. The attending physician and home health agency personnel shall review the total plan of treatment at least every 60 days.

The home health agency shall maintain these records on all NMAP clients and make them readily available upon the Department's request.

9-002.05 Home Health Aides: A home health aide may provide services to a client in the client's home to meet personal care needs resulting from the client's illness or disability if the care is not available to the client without payment by NMAP. The services must be -

1. Necessary to continuing a medical treatment plan;
2. Prescribed by a licensed physician;
3. Recertified by the licensed physician at least every 60 days; and
4. Supervised by a registered nurse.

9-002.05A Services: Home health aide services may include -

1. Helping the client to assume recommended responsibility and to follow other medical recommendations;
2. Preparing and serving special food;
3. Helping the patient with the care of the mouth, skin, and hair; and
4. Assisting the patient with eating, dressing, getting in and out of bed, bathing, etc.

Skilled nursing visits are not a prerequisite for the provision of home health aide services.

9-006 Limitation: For extended-hour aide services, the Department generally limits aide services to 56 hours/week (8 hrs/day x 7 days/wk). Central Office approval must be obtained for services in excess of 56 hours per week.

The client's needs must be assessed to determine whether the needs can best be met by an aide visit or a minimum block of 4 hours of extended-hour aide services.

9-002.07 Prefilling Insulin Syringes: The Department reimburses home health agencies for prefilling insulin syringes for blind or disabled diabetic clients who are unable to perform this task themselves and there is no one else available. The Department considers this a professional nursing service which may be provided only through a professional nurse visit.

9-002.08 Guidelines for Coverage:

	SERVICE	NMAP COVERS:	NMAP DOES NOT COVER:
1.	Medications	Intravenous or intramuscular injections and intravenous feeding. Oral medications covered only where the complexity of the medical condition (physical/psychological) and the number of drugs require a licensed nurse to monitor, detect, and evaluate side effects (this must be well-documented). rather than by mouth.	Injections that can be self-administered (insulin); drugs not considered an effective treatment for condition given; a medical reason does not exist for providing drug by injection
2.	Vitamin B-12 Injections	Initially once a week for a maximum of 4-6 weeks and then once a month when maintenance is established for the treatment of pernicious anemia and other macrocytic anemias, and neuropathies associated with pernicious anemia.	For other conditions which are not specifically covered.
3.	Decubitus and Skin Disorders	When specific physician orders indicate skilled care -- requiring prescribed medications and treatment. Usually Stage III (deep without necrotic tissue) and Stage IV (deep with necrotic tissue). Infected decubiti included when treatment is specifically ordered by the physician.	Preventative and palliative measures, decubiti are minor usually Stage I (reddened area or inflammation) or Stage II (superficial skin break and redness surrounding).
4.	Colostomy, Ileostomy, Gastrostom	During immediate postoperative time when maintenance care and control by the patient or family is being established; includes initial teaching.	General maintenance care.
5.	Bowel and Bladder Training	Teaching of skills and facts necessary to adhere to a specific formal regime.	General routine maintenance program or treating

	SERVICE	NMAP COVERS:	NMAP DOES NOT COVER:
6.	Urethral Catheters and Sterile Irrigations	Insertions and changes when active urological problems are present and/or client is unable to do physician-ordered irrigations.	Routine catheter maintenance care.
7.	Observation and Evaluation	Observation and evaluation requiring the furnishing of a skilled service for an unstable condition The client has had a recent acute episode (past 30-60 days) or there is a well-documented history of noncompliance without nursing intervention. Significant high <u>probability</u> that complications would arise (within 30 to 60 days) without the skilled supervision of the treatment program on an intermittent basis.	General needs. Absence of any clear indication that the condition is unstable.
8.	Teaching and Training Activities	Teaching or training requiring the the skills or knowledge of a nurse. Injections, irrigating of a catheter, care of ostomy, administration of medical gases, respiratory treatment, preparation and following a therapeutic diet, application of dressing to wounds involving prescription medications and aseptic techniques, bladder training, bowel training (only when bowel incontinency exists), use of adaptive devices & special techniques when loss of function has occurred, care of bed-bound patient, performance of body transfer activities; requires specific documentation.	Visits made <u>solely</u> to remind or emphasize the need to follow instructions; when services are duplicated.
9.	Enemas/Removal of Impactions	When skills of a nurse are required; if complexity is established because of the condition of the patient.	

	SERVICE	NMAP COVERS:	NMAP DOES NOT COVER:
10.	Dressings	Aseptic technique and prescription medications used.	Non-infected closed postoperative wound or chronic controlled conditions (stasis ulcers).
11.	Casts	If orders reflect other than routine care.	General supportive care.
12.	Home Health Aides	Primary function of aide is for personal care which is made specific by the licensed nurse; must be under the supervision of a licensed nurse; and treatment plan established by physician indicates need.	
13.	Diabetic (Blind or Disabled)	Visits to prefill insulin syringes.	
14.	Teaching & Training (Postpartum)	Teaching and training require the skills or knowledge of a nurse. Limited to two visits, unless unusual situation is well documented.	Visits made solely to remind or emphasize the need to follow instructions.
15.	Draw or Collect Laboratory Specimens	Covered only if ~~the client is strictly homebound, and cannot get to the physician's office for ordered laboratory tests.~~ based on the client's medical condition, Home Health services are medically necessary and appropriate to be provided in the home.	These services for nursing home clients.

9-002.08A Occupational Therapy, Physical Therapy, and Speech, Hearing, and Language Therapy:

9-002.08A1 Services for Individuals Age 21 and Older: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals age 21 and older as a Home Health Agency service only when the following criteria is met. The services must -

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
   a. The services must be restorative when there is a medically appropriate expectation that the patient's condition will improve significantly in a reasonable period of time;
   b. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
   c. The services must have been recommended in a Department-approved individual program plan (IPP); or
   d. The services must have been recommended in an individual education plan (IEP) or an individual family service plan (IFSP) (see 471 NAC 17-002.04).

These therapies for adults (age 21 and older) are a Home Health Agency Service only when there is no other method for the client to receive the service. Services must be prior authorized by Central Office staff. Substantiating documentation must be submitted with the claim.

9-002.08A2 Services for Individuals Age 20 and Younger: The Nebraska Medical Assistance Program (NMAP) covers occupational therapy, physical therapy, and speech, hearing, and language therapy services for individuals birth to age 20 as a Home Health Agency service when the following criteria is met. The services must -

1. Be prescribed by a physician;
2. Be performed by, or under the direct supervision of, a licensed physical therapist; and
3. Meet one of the following criteria:
   a. The services must be reasonable and medically necessary for the treatment of the client's illness or injury;
   b. The services must have been recommended in a Department-approved IPP; or
   c. The services must have been recommended in an individual education plan (IEP) or an individual family service plan (IFSP) (see 471 NAC 17-002.04).

9-002.09 Durable Medical Equipment: Durable medical equipment and medical supplies provided by a home health agency must meet all requirements outlined in 471 NAC 7-000.

9-002.10 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division of the Department of Health and Human Services Finance and Support.

9-002.11 Extended-Home Nursing Services: Provision of extended-home nursing services (RN or LPN) must be authorized by Central Office staff. These services are authorized for eligible adults or children when -

1. Night hours are necessary so the caregiver/parents may sleep;
2. Day hours to cover work/school for the caregiver/parents; and/or
3. Respite hours to cover relief time for caregiver/parents.

Extended-home nursing services are authorized only when the client's care needs must be provided by skilled nursing personnel in the absence of the caregiver/parents. Children must have documented medical needs that cannot be met by the regular child care provider system.

Any change in the client's condition or schedule of the caregiver/parents require a reevaluation of the approved nursing hours.

Written verification of the caregiver/parents' work/school schedule must be submitted initially, annually and anytime there is a change in those hours.

Nursing care hours approved specifically for sleep and/or work/school must be used as authorized, i.e., night hours, are to be used at night, work hours are to be used only when the caregiver/parents are both actually working.

Nursing hours are approved for the client when the caregiver/parent attends education classes working toward a degree. Hours are not covered for any additional degrees beyond an initial college degree.

9-002.11A Nursing Coverage at Night: Caregivers/families may be eligible for night hours if the client requires procedures on an ongoing basis throughout the night hours. Night hours will be authorized only if the monitoring and treatments cannot be accomplished during day and evening hours. The rationale for night hours is to provide caregivers/families with sleep so they can care for the client during the day. The goal must be to develop treatment and sleep patterns so the client can sleep during the night and nursing coverage will not be necessary. The medical necessity for monitoring/treatments during the night hours must be reflected in the physician's orders and nursing notes.

If a scheduled night shift is cancelled by the agency, the caregiver/family may reschedule those hours with the home health agency within the next 24 hours. When that is not possible, they may reschedule the hours within the 48 hours following the missed shift.

9-002.11B Respite: Caregivers/families who are allotted respite hours on a weekly or monthly basis can use those hours in any time configuration they determine best to meet their needs within a calendar month. If they would like to "pool" respite hours across two months, prior approval is required.

The number of respite hours approved is based on each individual situation, taking into consideration the client's and caregiver/family's needs.

9-003 Limitations and Requirements for Home Health Agency Services

9-003.01 Authorization: Payment for all home health agency services must be authorized. The eligibility of the client must be verified by the home health agency. The Division of Medicaid and Long-Term Care or its designee may grant authorization of payment for home health agency services.

Providers must send requests for authorization to the Division at the Central Office. To request authorization, the home health agency must submit Form CMS-1450 or the standard electronic Health Care Service Review – Request by Review and Response transaction (ASC 12N 278) (see 471-000-50 Electronic Transactions Instructions) and submit a copy of the physician's order and the home health agency's treatment plan. The home health agency must submit this documentation with the claim submitted for payment. The treatment plan must include:

1. The client's name, address, case number, and date of birth;
2. The dates of the period covered (not exceeding 60 days);
3. The diagnosis;
4. The type and frequency of services;

5. The equipment and supplies needed;
6. A brief, specific description of the client's needs and services provided; and
7. Any other pertinent documentation which justifies the medical necessity of the services.

If denied, the Department notifies the provider.

Note: For durable medical equipment and medical supplies, see requirements and procedures for prior authorization outlined in 471 NAC 7-000.

9-003.02 (Reserved)

9-003.03 Student Nurses: Medicaid does not cover skilled nursing visits by student nurses who are enrolled in a school of nursing and not employed by the home health agency, unless accompanied by a registered nurse who is an employee of the home health agency.

9-003.04 Teaching and Training: The Department limits skilled nursing visits for teaching and training on an individual basis. The Department requires specific documentation for teaching and training. The client must have a medical condition which has been diagnosed and treated by a physician. There must be a physician's order for the specific teaching and training.

The Department limits postpartum visits for teaching and training to two visits. The necessity of further visits must be justified and well documented. Court-ordered services and requests from local office staff when Adult/Child Protective Services is involved are covered services when medical necessity is documented.

9-003.05 Medical Supplies: Payment for supplies normally carried in the nursing bag and incidental to the nursing visit is included in the per visit rate. This includes but is not limited to disposable needles and syringes, disposable gloves, applicators, tongue blades, cotton swabs, 4 x 4's, gauze, bandages, etc.

Medical supplies not normally carried in the nursing bag may be provided by pharmacies, medical suppliers, or the home health agency under requirements outlined in 471 NAC 7-000.

9-003.06 Second Visit on Same Day: The medical necessity of a second visit on the same date of service must be well documented. Substantiating documentation must be submitted with Form CMS-1450, or the request for prior authorization with the standard Health Care Claim: Institutional transaction (ASC X12N 837).

9-003.07 Enterostomal Therapy: NMAP recognizes enterostomal therapy visits as a skilled nursing service.

9-003.08 Nursing Services (RN and LPN) for Adults Age 21 and Older: NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older (this includes Nursing Services, 471 NAC 13-000):

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.
2. Per diem reimbursement for all other in-home nursing service shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

   Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

9-003.09 Supervisory Visits: Skilled nursing visits required for the supervision of LPN or aide services may not be billed as a skilled nursing visit. The cost of supervision is included in the payment for the LPN or aide service.

9-003.10 Extended-Home Health-Tech Rates: High-tech hourly rates are approved when clients require:

1. Ventilator care;
2. Tracheostomy care which involves frequent suctioning and monitoring; and/or
3. Care/observation of unstable, complex medical conditions requiring advanced nursing knowledge/skills.

9-003.11 Advance Directives: Medicaid-participating home health agencies shall comply with these regulations (see 471 NAC 2-005).

9-004 Payment for Home Health Agency Services: The Department makes payment for medically prescribed and Department-approved home health agency services provided by home health agencies that meet Medicare certification or JCAHO accreditation. The Department may request a cost report from any participating agency.

NMAP pays for covered home health agency services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for each respective procedure in the Nebraska Medicaid Home Health Agency Fee Schedule in effect for that date of service. See 471-000-57.

Note: Durable medical equipment and medical supplies are reimbursed according to the payment methodology outlined in 471 NAC 7-000.

9-004.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

9-004.02 Medicare Coverage: Medicare coverage is considered to be the primary source of payment for home health agency services for eligible individuals age 65 and older and for certain disabled beneficiaries. NMAP does not make payment for services denied by Medicare for lack of medical necessity. NMAP may cover services denied by Medicare for other reasons if the services are within the scope of NMAP. Claims submitted to the Department for services provided to Medicare-eligible clients must be accompanied by documentation which verifies that the services are not covered by Medicare.

9-004.03 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008. Home health agency services do not require a copayment from the client.

9-005 Billing Requirements: Home health agencies shall use Form CMS-1450 or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837) to request payment from NMAP. For claim submission instructions, refer to the Claim Submission Table in the appendix 471-000-49.

HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-509).

Note: Durable medical equipment and medical supplies are billed under the home health agency provider number.

CHAPTER 13-000 NURSING SERVICES

13-001 Standards for Participation: Providers of private-duty nursing services must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure as a home health agency or individual RN/LPN or the appropriate licensing agency of the state in which s/he practices. To participate in the Nebraska Medical Assistance Program (NMAP), the provider shall complete and sign Form MC-19, "Medical Assistance Provider Agreement" (see 471-000-90), and submit the completed form to HHS for approval and enrollment as a provider.

13-001.01 Standard of Practice: RNs and LPNs must practice within their scope of practice as defined in Nebraska Administrative Code Title 172, Chapters 97, 99, 101, and 102.

13-002 Covered Services: NMAP covers RN/LPN services when ordered by the client's physician based on medical necessity. Skilled nursing services are those services provided by a registered nurse or a licensed practical nurse which s/he is licensed to perform. Private-duty nursing may be provided in the client's home or current living arrangement.

13-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

13-002.01A Health Maintenance Organizations (HMO) Plans: NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

13-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. In addition, services provided by a RN/LPN require referral from the client's primary care physician (PCP) and authorization by the NHC PCCM plan. Providers shall contact the PCP before providing services. All services provided to clients enrolled in NHC PCCM plans are billed to the Department.

13-002.02 Medical Necessity: All skilled nursing services must be -

1. Necessary to a continuing medical treatment plan;
2. Prescribed by a licensed physician; and
3. Recertified by the licensed physician at least every 60 days.

13-002.03 Definition of Nursing Service: Nursing services are services provided to a client in the client's place of residence. The residence does not include a hospital, skilled nursing facility, or nursing facility.

To be eligible for skilled nursing services, the attending physician shall certify that -

1. ~~The client is considered to be homebound and cannot receive the services in an outpatient/physician office setting;~~Based on the client's medical condition, Home Health services are medically necessary and appropriate services to be provided in the home;
2. Extended home nursing services are medically necessary;
3. That observation/teaching in the home environment is an integral and necessary part of the plan; or
4. Client's care needs require skilled nursing services to maintain/improve their health status.

A client who requires and is authorized to receive extended-hour home health nursing services in the home setting may use his/her approved hours outside of the home during those hours when his/her normal life activities take him/her out of the home, i.e., attend school, therapeutic activities, etc. The Department will not authorize any additional hours of nursing service beyond what would normally be authorized. If a client requests/requires nursing services to attend school or other activities outside the home, but does not need nursing services in the home during those hours, nursing services cannot be authorized.

13-002.04 Guidelines for Coverage:

	SERVICE	NMAP COVERS:	NMAP DOES NOT COVER:
1.	Medications	Intravenous or intramuscular injections and intravenous feeding. Oral medications covered only where the complexity of the medical condition (physical/psychological) and the number of drugs require a licensed nurse to monitor, detect, and evaluate side effects and/or compliance (this must be well-documented).	Injections that can be self-administered (insulin); drugs not considered an effective treatment for condition given; a medical reason does not exist for providing drug by injection rather than by mouth.

	SERVICE	NMAP COVERS:	NMAP DOES NOT COVER:
2.	Vitamin B-12 Injections	For physician ordered treatment of pernicious anemia and other macrocytic anemias, and neuropathies associated with pernicious anemia.	For other conditions which are not specifically covered.
3.	Decubitus and Skin Disorders	When specific physician orders indicate skilled care -- requiring prescribed medications and treatment. Usually Stage III (deep without necrotic tissue) and Stage IV (deep with necrotic tissue). Infected decubiti included when treatment is specifically ordered by the physician.	Preventative and palliative measures, decubiti are minor usually Stage I (reddened area or inflammation) or Stage II (superficial skin break and redness surrounding).
4.	Colostomy, Ileostomy, Gastrostomy	During immediate postoperative time when maintenance care and control by the patient or family is being established; includes initial teaching.	General maintenance care.
5.	Bowel and Bladder Training	Teaching of skills and facts necessary to adhere to a specific formal regime.	
6.	Urethral Catheters and Sterile Irrigations	Insertions and changes when active urological problems are present and/or client is unable to do physician-ordered irrigations.	Routine catheter maintenance care.
7.	Observation and Evaluation	Observation and evaluation requiring the furnishing of a skilled service for an unstable condition. The client has had a recent acute episode (past 30-60 days) or there is a well-documented history of noncompliance without nursing intervention. Significant high <u>probability</u> that complications would arise (within 30 to 60 days) without the skilled supervision of the treatment program on an intermittent basis.	General needs. Absence of any clear indication that the condition is unstable.

	SERVICE	NMAP COVERS:	NMAP DOES NOT COVER:
8.	Teaching and Training Activities	Teaching or training requiring the the skills or knowledge of a nurse. Injections, irrigating of a catheter, care of ostomy, administration of medical gases, respiratory treatment, preparation and following a therapeutic diet, application of dressing to wounds involving prescription medications and aseptic techniques, bladder training, bowel training (only when bowel incontinency exists), use of adaptive devices & special techniques when loss of function has occurred, care of bed-bound patient, performance of body transfer activities; requires specific documentation.	Visits made solely to remind or emphasize the need to follow instructions; when services are duplicated.
9.	Enemas/Removal of Impactions	When skills of a nurse are required; if complexity is established because of the condition of the patient.	
10.	Dressings	Aseptic technique and prescription medications used.	Non-infected closed postoperative wound or chronic controlled conditions (stasis ulcers).
11.	Casts	If orders reflect other than routine care.	General supportive care.
12.	Diabetic (Blind or Disabled)	Visits to prefill insulin syringes. Blood sugar testing, foot care.	
13.	Teaching & Training (Postpartum)	Teaching and training require the skills or knowledge of a nurse. Limited to two visits, unless unusual situation is well documented.	Visits made solely to remind or emphasize the need to follow instructions.
14.	Draw or Collect Laboratory Specimens	Covered only if ~~the client is strictly homebound, and cannot get to the physician's office for ordered laboratory tests.~~based on the client's medical condition, Home Health services are medically necessary and appropriate services to be provided in the home.	These services for nursing home clients.

13-002.05 Extended-Home Nursing Services: Provision of extended-home nursing services (RN or LPN) must be authorized by Central Office staff. These services are authorized for eligible adults or children when -

1. Night hours are necessary so the caregiver/parents may sleep;
2. Day hours to cover work/school for the caregiver/parents; and/or
3. Respite hours to provide relief for caregiver/parents.

Extended-home nursing services are authorized only when the client's care needs must be provided by skilled nursing personnel in the absence of the caregiver/parents. Children must have documented medical needs that cannot be met by the regular child care provider system.

Any change in the client's condition or schedule of the caregiver/parents require a reevaluation of the approved nursing hours.

Written verification of the caregiver/parents' work/school schedule must be submitted initially, annually and anytime there is a change in those hours.

Nursing care hours approved specifically for sleep and/or work/school must be used as authorized, i.e., night hours, are to be used at night, work hours are to be used only when the caregiver/parents are both actually working.

Nursing hours are approved for the client when the caregiver/parent attends education classes working toward a degree. Hours are not covered for any additional degrees beyond an initial college degree.

13-002.05A Nursing Coverage at Night: Caregivers/families may be eligible for night hours if the client requires procedures on an ongoing basis throughout the night hours. Night hours will be authorized only if the monitoring and treatments cannot be accomplished during day and evening hours. The rationale for night hours is to provide caregivers/families with sleep so they can care for the client during the day. The goal must be to develop treatment and sleep patterns so the client can sleep during the night and nursing coverage will not be necessary. The medical necessity for monitoring/treatments during the night hours must be reflected in the physician's orders and nursing notes.

If a scheduled night shift is cancelled by the provider, the caregiver/family may reschedule those hours with the provider within the next 24 hours. When that is not possible, they may reschedule the hours within the 48 hours following the missed shift.

13-002.05B Respite: Caregivers/families who are allotted respite hours on a weekly or monthly basis can use those hours in any time configuration they determine best to meet their needs within a calendar month. If they would like to "pool" respite hours across two months, prior approval is required.

The number of respite hours approved is based on each individual situation, taking into consideration the client's and caregiver/family's needs.

13-003 Limitations and Requirements for Skilled Nursing Services

13-003.01 Authorization: Payment for all skilled nursing services must be authorized. The eligibility of the client must be verified by the provider. The Division of Medicaid and Long-Term Care or its designee may grant authorization of payment for skilled nursing services.

Providers must send requests for authorization electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) or by submitting Form MS-81 to the Medicaid designee. Requests must include the physician's order and the treatment plan. The treatment plan must include:

1. The client's name, address, case number, and date of birth;
2. The dates of the period covered (not exceeding 60 days);
3. The diagnosis;
4. The type and frequency of services;
5. The equipment and supplies needed;
6. A brief, specific description of the client's needs and services provided; and
7. Any other pertinent documentation which justifies the medical necessity of the services.

If denied, the Department notifies the provider.

13-003.02 Teaching and Training: The Department limits skilled nursing visits for teaching and training on an individual basis. The Department requires specific documentation for teaching and training. The client must have a medical condition which has been diagnosed and treated by a physician. There must be a physician's order for the specific teaching and training.

The Department limits postpartum visits for teaching and training to two visits. The necessity of further visits must be justified and well documented. Court-ordered services and requests from local office staff when Adult/Child Protective Services is involved are covered services when medical necessity is documented.

13-003.03 Second Visit on Same Day: The medical necessity of a second visit on the same date of service must be well documented. Substantiating documentation must be submitted.

13-003.04 Enterostomal Therapy: NMAP recognizes enterostomal therapy visits as a skilled nursing service.

13-003.05 Nursing Services (RN and LPN) for Adults Age 21 and Older: NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older (this includes Nursing Services, 471 NAC 13-000):

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.
2. Per diem reimbursement for all other in-home nursing service shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level (see 471 NAC 12-013). This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

   Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

13-003.06 Extended-Hour Nursing: When providing extended-hour nursing care, the Department will authorize payment to a provider for a maximum of 48-56 hours/week, depending upon the complexity of a client's care. A maximum of 12 hours may be approved in a 24-hour period.

13-004 Non-Covered Services: NMAP does not cover nursing services when the private-duty nurse is an employee of another provider and the services performed are the responsibility of that provider.

13-005 Payment for Nursing Services: The Department pays for approved nursing services at the lower of -

1. The submitted charge; or
2. The maximum allowable fee as established by the Department. See 471-000-513.

13-006 Billing Requirements: RN/LPN providers shall submit electronically using the standard Health Care Claim: Professional transaction (ASC X12N 837) or use Form MC-82N, "Private Duty Nurse Claim Form" (see 471-000-59).

13-007 Documentation

13-007.01 Provider Documentation: The private-duty nurse shall maintain records to document services provided and the time worked for which payment is claimed. These records must be readily available upon the Department's request. Records must be retained for six years for audit purposes.

Records must include:

1. Current, signed physician's orders for the care provided;
2. Assessment of the client's health status;
3. Plan of Care;
4. Nurses' notes documenting the care provided; and
5. Time sheets documenting the date and times that care was provided.

The Department does not require that this documentation be done on any particular form. This is the responsibility of the provider.

13-007.02 Client Records: The private-duty nurse shall maintain a medical record in the client's home which includes the Form MS-81, "Certification and Plan of Care For Private-Duty Nursing."

13-007.03 Multiple RN/LPN Providers: When more than one RN/LPN is providing care for a client, the providers and client must determine which RN/LPN will be the coordinator of services. The coordinator will be responsible for completing the Form MS-81, "Certification and Plan of Care For Private-Duty Nursing," obtaining physician orders, obtaining authorization for providing services, and making copies available to the other providers.