NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

September 27, 2019
10:00 A.M. Central Time
Nebraska State Office Building, Lower Level A
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 13 of the Nebraska Administrative Code (NAC) – *Nursing Services.* These regulations govern services provided under Nebraska's Medicaid program and affects nursing services providers. The proposed changes are not substantive and do not change the scope of work. The proposed changes will provide additional clarity by removing internal direction to staff and redundant or unnecessary language from the regulations. The proposed changes also update the formatting.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8417. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8417. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Please check one.
☐ **Draft** ☒ **Final**

Has this statement been reviewed & approved by FAPA Unit (MLTC & CFS) or Budget Unit (PH)? ☒ **Yes** ☐ **No**

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Malisa McCown
Chapter:13	Date prepared: 4/8/19
Subject: Nursing Services	Telephone: 402-471-1641

Type of Fiscal Impact:

Please check all that apply

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency: N/A

Political Subdivision: N/A

Regulated Public: N/A

If indeterminable, explain why: N/A

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 13 NURSING SERVICES

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 SKILLED NURSING SERVICE. Skilled nursing services are those services provided by a private duty nurse (PDN) in a client's home or current living arrangement. Skilled nursing services do not include services provided in a hospital, skilled nursing facility, or nursing facility.

003. PROVIDER REQUIREMENTS.

003.01 GENERAL PROVIDER REQUIREMENTS. To participate in Medicaid, providers of nursing services must comply with all applicable provider participation requirements codified in Nebraska Administrative Code (NAC) Titles 471, 473, 480, and 482. In the event that provider requirements in 471 NAC 2 conflict with requirements outlined in this 471 NAC 13, the individual provider participation requirements in 471 NAC 13 will govern.

003.02 SPECIFIC PROVIDER REQUIREMENTS.

003.02(A) LICENSING. Providers of private-duty nursing services must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure, or by the appropriate licensing agency of the state in which they practice, as an individual registered nurse (RN) or licensed practical nurse (LPN).

003.02(B) PROVIDER DOCUMENTATION. The private-duty nurse must maintain records to document services provided and the time worked for which payment is claimed. These records must be available to the Department upon the Department's request. Records must be retained for no fewer than six years for audit purposes. Records must include:

(i) Current, signed physician's orders for the care provided;
(ii) Assessment of the client's health status;
(iii) Plan of Care;
(iv) Nurse's notes documenting the care provided; and
(v) Time sheets documenting the date and times that care was provided.

003.02(C) CLIENT RECORDS. The private-duty nurse must maintain a medical record in the client's home or current living arrangement which includes the Form MS-81: Certification and Plan of Care For Private-Duty Nursing.

003.02(D) MULTIPLE REGISTERED NURSE (RN) AND LICENSED PRACTICAL NURSE (LPN) PROVIDERS. When more than one registered nurse (RN) or licensed practical nurse (LPN) is providing skilled nursing services for a client, the providers and client must determine which registered nurse (RN) or licensed practical nurse (LPN) will be the coordinator of services. The coordinator must complete 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.

004. SERVICE REQUIREMENTS.

004.01 GENERAL SERVICE REQUIREMENTS.

004.01(A) MEDICAL NECESSITY. The Department incorporates the medical necessity requirements outlined in 471 NAC 1 as if fully rewritten herein. Services and supplies that do not meet the requirements in 471 NAC 1 are not covered.

004.01(A)(i) ADDITIONAL REQUIREMENTS. 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

004.01(B) AUTHORIZATION. All skilled nursing services must be authorized and the eligibility of the client must be verified by the provider. The Department or its designee may grant authorization of skilled nursing services. Providers must send requests for authorization electronically using the standard Health Care Services Review – Request for Review and Response transaction (ASC X 12N 278) or by submitting Form MS-81: Certification and Plan of Care For Private-Duty Nursing to the Medicaid designee. Requests must include the physician's order and the plan of care. The plan must include:

(i) The client's name, address, Medicaid identification number and date of birth;
(ii) The dates of the period covered (not exceeding 60 days);
(iii) The diagnosis;
(iv) The type and frequency of services;
(v) The equipment and supplies needed;
(vi) A brief, specific description of the client's needs and services provided; and
(vii) Any other pertinent documentation which justifies the medical necessity of the services.
(viii) The plan of care must be signed by or have verbal authorization from the physician at the time of prior authorization submittal. Verbal authorizations must be signed by the physician within 30 days.

004.01(C) ELIGIBILITY AND PHYSICIAN CERTIFICATION. To be eligible for skilled nursing services, the attending physician must certify that based on the client's medical

condition, skilled nursing services are medically necessary and appropriate services to be provided in the home.

004.01(D) SECOND VISIT SAME DAY. The medical necessity of a second visit on the same date of service must be documented. Substantiating documentation must be submitted with MC-82N, or the request for prior authorization with the standard Health Care Claim: Professional Transaction (ASC X12N 837).

004.02 COVERED SERVICES. The Department covers medically necessary skilled nursing services when ordered by the client's physician.

004.02(A) USE OF AUTHORIZED HOURS. A client who requires and is authorized to receive home health nursing services in the home setting may use their approved hours outside of the home during those hours when their normal life take them out of the home. The Department will not authorize any additional hours of nursing service beyond what would normally be authorized to cover the client's need for medically necessary and appropriate services provided in the home. If a client requests or 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 will not be authorized.

004.02(B) MEDICATIONS. The Department covers intravenous or intramuscular injections and intravenous feeding. Oral medications are covered only where the complexity of the medical condition (physical or psychological) and the number of drugs require a licensed nurse to monitor, detect and evaluate side effects and compliance. The complexity of the medical condition must be documented and submitted with the plan of care.

004.02(B)(i) PREFILLING INSULIN SYRINGES. The Department reimburses private duty nurses for prefilling insulin syringes for blind or disabled diabetic clients who are unable to perform this task themselves and where there is no one else available to fill the insulin syringe on the client's behalf. The Department considers this a skilled nursing service which may be provided only through a skilled nurse visit.

004.02(B)(ii) VITAMIN B-12 INJECTIONS. The Department covers injections initially once a week for a maximum of six weeks, and then once a month when maintenance is established for the treatment of pernicious anemia and other macrocytic anemias, and neuro pathies associated with pernicious anemia.

004.02(C) ADDITIONAL SERVICES FOR DIABETIC CLIENTS. Medicaid covers blood sugar testing and foot care for blind or disabled clients who are unable to perform this task themselves and where there is no one else available to perform the task on the client's behalf.

004.02(D) DECUBITUS AND SKIN DISORDERS. The Department covers this service when specific physician orders indicate that skilled nursing care is necessary, requiring prescribed medications and treatment.

004.02(E) DRESSINGS. The Department covers application of dressings when aseptic technique and prescription medications are used.

004.02(F) COLOSTOMY, ILEOSTOMY, GASTROSTOMY. The Department covers colostomy, ileostomy, and gastrostomy during immediate postoperative time, including initial teaching, when maintenance care and control by the patient or family is being established.

004.02(G) ENTEROSTOMAL THERAPY. The Department recognizes enterostomal therapy visits as a skilled nursing service.

004.02(H) ENEMAS AND REMOVAL OF IMPACTIONS. The Department covers enemas and removal of impactions when the complexity of the condition of the patient establishes that the skills of a nurse are required.

004.02(I) BOWEL AND BLADDER TRAINING. The Department covers teaching skills and facts necessary to adhere to a specific formal regimen. General routine maintenance program or treating is not covered.

004.02(J) URETHRAL CATHETERS AND STERILE IRRIGATIONS. The Department covers insertions and changes when active urological problems are present or client is unable to do a physician-ordered irrigations. Routine catheter maintenance care is not covered.

004.02(K) OBSERVATION AND EVALUATION. The Department covers observation and evaluation requiring the furnishing of a skilled service for an unstable condition. An unstable condition is evidenced by the presence of one of the following conditions:

(i) An episode in the previous 60 days;
(ii) A documented history of noncompliance without nursing intervention; or
(iii) A significant probability that complications would arise within 60 days without the skilled supervision of the treatment program or an intermittent basis.

004.02(L) CASTS. The Department covers casts if the physician's order evidences more complexity than routine or general supportive care.

004.02(M) DRAW OR COLLECTION OF LABORATORY SPECIMENS. The Department covers the collection of laboratory specimens only if based on the client's medical condition.

004.02(N) TEACHING AND TRAINING ACTIVITIES. The Department covers skilled nursing visits for teaching or training that require the skills or knowledge of a nurse. The Department limits postpartum visits for teaching and training to two visits. The necessity of further visits must be justified by additional documentation evidencing extenuating circumstances which create the need beyond two visits. The client must have a medical condition that has been diagnosed and treated by a physician and there must be a physician's order for the specific teaching and training. Visits are covered on an individual basis. The provider must maintain specific documentation of both the need for the teaching

or training, and the training provided. Documentation must be submitted along with the plan of care. Teaching or training can occur in the following areas:

(i) Injections;
(ii) Irrigating of a catheter;
(iii) Care of ostomy;
(iv) Administration of medical gases;
(v) Respiratory treatment;
(vi) Preparation and following a therapeutic diet;
(vii) Application of dressing to wounds involving prescription medications and aseptic techniques;
(viii) Bladder training;
(ix) Bowel training when bowel incontinency exists;
(x) Use of adaptive devices and special techniques when loss of function has occurred;
(xi) Postpartum visits;
(xii) Care of a bed-bound patient; and
(xiii) Performance of body transfer activities.

004.02(O) EXTENDED-HOUR NURSING SERVICES. Provision of extended-hour nursing services must be authorized by the Department or its designee. Extended-hour nursing services are authorized only when the client's care needs must be provided by skilled nursing personnel in the absence of the caregiver or parents. Children must have documented medical needs that cannot be met by a traditional child care provider system. When providing extended-hour nursing care, the Department will authorize coverage for a maximum of 56 hours a week, depending upon the complexity of a client's care. A maximum of 12 hours may be approved in a 24-hour period. Changes in the client's condition or schedule of the caregiver or parents may require a reevaluation of the approved nursing hours with written verification.

004.02(O)(i) NURSING COVERAGE AT NIGHT. Caregivers or families may be eligible for night hours if the client requires skilled procedures on an ongoing basis throughout the night hours. As used in this chapter, "night hours" refers to the period after the client has gone to bed for the day. "Day and evening hours" refers to the period of time before the client goes to bed for the day. Night hours will be authorized only if the monitoring and treatments cannot be accomplished during day and evening hours. The medical necessity for monitoring or 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 or 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.

004.03 NON-COVERED SERVICES. The Department does not cover skilled nursing services when the private duty nurse (PDN) is an employee of another provider and the services performed are the responsibility of that provider.

004.03(A) MEDICATIONS. Medicaid does not cover injections that can be self-administered; drugs not considered an effective treatment for a condition given; and

drugs for which a medical reason does not exist for providing the drug by injection rather than by mouth.

004.03(B) DECUBITUS AND SKIN DISORDERS. The Department does not cover preventative and palliative measures, and decubiti which are minor, usually Stage I, or Stage II.

004.03(C) TEACHING AND TRAINING ACTIVITIES. The Department does not cover visits made solely to remind or emphasize the need to follow instructions or when services are duplicated.

004.03(D) DRESSINGS. Visits made to dress non-infected closed postoperative wounds or chronic controlled conditions are not covered.

005. BILLING AND PAYMENT FOR NURSING SERVICES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 2. In the event that the individual billing requirements in 471 NAC 2 conflict with billing requirement outlines in the 471 NAC 13, the individual billing requirements in 471 NAC 13 will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS.

005.01(B)(i) BILLING REQUIREMENTS. Registered nurse (RN) and licensed practical nurse (LPN) providers must submit electronically using the standard Health Care Claim Professional transaction (ASC X12N 837) or use Form MC-82N: Private Duty Nurse Claim Form. The signed plan of care must be submitted with the claim.

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 2. In the event that individual billing requirements in 471 NAC 2 conflict with billing requirement outlines in this 471 NAC 13, the individual billing requirements in 471 NAC 13 will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS.

005.02(B)(i) REIMBURSEMENT. 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 in the Nebraska Medicaid Nursing Services Fee Schedule in effect for that date of service.

005.02(B)(ii) SKILLED NURSING SERVICES FOR ADULTS AGE 21 AND OLDER. The Department applies the following limitations to skilled nursing services for adults age 21 and older:

(1) Per diem reimbursement for skilled nursing services for the care of ventilator dependent clients will not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average will be computed using facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period; and

(2) Per diem reimbursement for all other in-home skilled nursing services will not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level as found in 471 NAC 12. This average will 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. If determined by the Department to be medically necessary, the per diem reimbursement may exceed this maximum for a short period of time. However, in these cases, the 30-day average of the in-home nursing per diems will 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.

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. 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 probability 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 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.