NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

September 26, 2022
1:00 p.m. Central Time
Nebraska State Office Building – Lower Level A
301 Centennial Mall South, Lincoln, Nebraska
Phone call information: 888-820-1398; Participant code: 3213662#

The purpose of this hearing is to receive comments on the adoption of amendments to and repeal of the following regulations:

The following regulation is proposed for AMENDMENT:

Title 471 NAC 9 – *Home Health Agencies*

The proposed changes will streamline the regulations by removing duplicative statutory and inconsistent language from the regulations; and consolidating two chapters of regulations into one. Additional proposed changes include updating the chapter name; updating definitions; updating licensing requirements; incorporating language from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which will allow for nurse practitioner, clinical nurse specialists, and certified nurse midwife to order Medicaid home health services and certify plan of care; revising provider, general, covered, and non-covered services; updating billing requirements; updating section headings, terminology, and renumbering the regulatory chapter.

The following regulation is proposed for REPEAL in its entirety. The relevant portions of this chapter are included in the proposed amendment of Title 471 NAC 9.

Title 471 NAC 13 – *Nursing Services*

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

Interested persons may provide written comments by mail, fax, or email, 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.

In order to encourage participation in this public hearing, a phone conference line will be set up for any member of the public to call in and provide oral comments. Interested persons may provide verbal comments by participating via phone conference line by calling 888-820-1398; Participant code: 3213662#.

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 who are deaf or hard of hearing may call DHHS via the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Danielle Trejo
Chapter: Home Health Agencies and Nursing Services	Date prepared: 4/19/2022
Subject: 9 (amend) and 13 (repeal)	Telephone: 531-530-7531

Type of Fiscal Impact:

	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 9 HOME HEALTH AGENCIES AND SKILLED NURSING SERVICES

001. SCOPE AND AUTHORITY. These regulations govern services provided under the Medical Assistance Act, Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 et seq.

002. DEFINITIONS. The following definitions apply:

002.01 ADVANCED DIRECTIVE. A legal document, including, but not limited to, a living will, signed by a competent person, to provide guidance for medical and health-care decisions in the event the client becomes incapable to make such decisions.

002.02 HOME HEALTH AGENCY. A person or any legal entity which provides skilled nursing or minimum of one other therapeutic service as defined by the Department on a full-time, part-time, or intermittent basis to person in a place of temporary or permanent residence used as a the person's home.

002.03 HOME HEALTH SERVICES. 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 certified nurse midwife, nurse practitioner, and nurse specialist are able to order home health services.

002.04 SKILLED NURSING SERVICE. Skilled nursing services are those services provided by a private duty nurse (PDN) or a nurse employed by a home health agency 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. Providers of home health services must comply with all applicable provider participation requirements codified in 471 Nebraska Administrative Code (NAC) 2 and 3. In the event that participation requirements in 471 NAC 2 or 3 conflict with requirements outlined in this chapter, the participation requirements in this chapter will govern.

003.02 SPECIFIC PROVIDER REQUIREMENTS.

003.02(A) PLAN OF CARE AND TREATMENT RECORD. The home health agency must maintain a clinical record that includes the plan of care signed by the attending physician responsible for the client's care. The attending physician and home health agency

personnel must review the total plan of care and treatment record at least every 60 days. The home health agency must maintain these records on all Medicaid clients and make them readily available upon the Department's request.

003.02(B) COST REPORTS. The home health agency must provide a cost report upon a request made by the Department.

003.02(C) LICENSING. Providers of nursing services must be licensed by the Department of Health and Human Services Division of Public Health 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(D) PROVIDER DOCUMENTATION. The 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 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.

003.03 SPECIFIC PROVIDER REQUIREMENTS FOR PRIVATE-DUTY NURSE.

003.03(A) 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.

003.03(B) 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.

003.02(D) PROVIDER REQUIREMENTS. To participate in the Medicaid program, the provider must:

(i) Be a participant in the hone health and nursing services program;
(ii) Be licensed to provide home health care by the Department of Health and Human Services Division of Public Health;
(iii) Assume full responsibility of the professional management of the client's home health care;
(iv) Maintain certification;
(v) Develop the plan of care as identified by client;
(vi) Follow all applicable regulations put in place by the Department;
(vii) Comply with the requirements of 471 NAC 1; and

(viii) Be a participant in the Medicare home health program.

004. SERVICES 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. Durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) must meet the guidelines outlined in 471 NAC 7. In addition to the medical necessity criteria outlined in 471 NAC 1, all home health services and skilled nursing services must be:

(i) Necessary to a continuing medical treatment plan;
(ii) Prescribed by a licensed physician, certified nurse midwife, nurse practitioner, or nurse specialist; and
(iii) Recertified by the licensed physician, certified nurse midwife, nurse practitioner, or nurse specialist at least every 60 days.

004.01(B) PRIOR AUTHORIZATION FOR HOME HEALTH SERVICES AND SKILLED NURSING SERVICES. Durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) must meet the requirements and procedures for prior authorization outlined in 471 NAC 7. All home health agency services must be authorized and the eligibility of the client must be verified by the home health agency. The Department or its designee may grant authorization of home health agency services. To request authorization, the home health agency must submit Form MS-72, Nebraska Home Health Prior Authorization, and submit a copy of the physician, certified nurse midwife, nurse practitioner, or nurse specialist order and the home health agency's plan of care. Skilled nursing services and home health agencies must be authorized under the same criteria however, 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. The plan of care 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;
(vii) Any other pertinent documentation that justifies the medical necessity of the services; and
(viii) The plan of care must be a ~~A~~ signature or verbal authorization from the physician, certified nurse midwife, nurse practitioner, and nurse specialist at prior authorization submittal. Verbal authorizations must be signed within 30 days.

004.01(C) ELIGIBILITY AND ADVANCE PRACTICE REGISTURED NURSE OR PHYSICIAN CERTIFICATION. To be eligible for home health services and skilled nursing services, the attending physician, certified nurse midwife, nurse practitioner, or nurse

specialist must certify that based on the client's medical condition, ~~H~~home health services and skilled nursing services are medically necessary and appropriate services to be provided in the home.

004.01(D) FACE-TO-FACE VISIT. The physician, certified nurse midwife, nurse practitioner, or nurse specialist must document a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services.

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

004.01(F) SERVICES PROVIDED FOR CLIENTS ENROLLED IN NEBRASKA MEDICAID MANAGED CARE. See 471 NAC 1.

004.01(G) HEALTH CHECK SERVICES. See 471 NAC 33.

004.01(H) ADVANCE DIRECTIVES. Medicaid-participating home health agencies must comply with applicable state and federal requirements.

004.02 COVERED SERVICES. Medicaid covers the following home health agency services and private duty nursing services:

(i) Skilled nursing services by:
  (1) A registered nurse (RN); ~~or~~
  (2) A licensed practical nurse (LPN);
  (3) A certified nurse midwife;
  (4) A nurse practitioner; or
  (5) A nurse specialist;
(ii) Home health aide services by:
  (1) A nurse aide; or
(iii) Physical therapy provided by a licensed physical therapist;
(iv) Speech therapy provided by a licensed speech pathologist;
(v) Occupational therapy provided by a licensed occupational therapist; and
(vi) Durable medical equipment and medical supplies.

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 activities take them out of the home. The Department will not authorize any additional hours of nursing service beyond what would normally be authorized. If a client requests 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.

004.02(B) 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. Skilled nursing visits are not a prerequisite for the provision of home health aide services. The services must be:

(1) Necessary because the care is not available to the client without payment by Medicaid;
(2) Necessary to continuing a plan of care;
(3) Prescribed by a licensed physician, certified nurse midwife, nurse practitioner, or nurse specialist;
(4) Recertified by the licensed physician, certified nurse midwife, nurse practitioner, or nurse specialist at least every 60 days; and
(5) Supervised by a registered nurse.

004.02(B)(i) LIMITATION. For extended-hour aide services in home health and nursing services, the Department limits aide services to 56 hours a week with a maximum of 12 hours in a 24 hour period. Department approval must be obtained for services in excess of 56 hours a week. ~~The client's needs must be assessed when developing the plan of care to determine whether the needs can best be met by an aide visit or a minimum block of four hours of extended hour aide services.~~

004.02(C) MEDICATIONS. Medicaid 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. The complexity of the medical condition must be documented and submitted with the plan of care.

004.02(C)(i) PREFILLING INSULIN SYRINGES. The Department reimburses home health agencies and 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 professional nursing service that must be provided only through a professional nurse visit.

004.02(C)(ii) VITAMIN B-12 INJECTIONS. Vitamin B-12 injections are covered 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 neuropathies associated with pernicious anemia.

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

004.02(E) DECUBITUS AND SKIN DISORDERS. Covered when specific physician, certified nurse midwife, nurse practitioner, or nurse specialist orders indicate that skilled care is necessary, or that skilled nursing care is necessary, requiring prescribed medications and treatment.

004.02(F) DRESSINGS. Medicaid covers application of dressings when aseptic technique and prescription medications are used.

004.02(G) COLOSTOMY, ILEOSTOMY, AND GASTROSTOMY. These services are ~~C~~covered during immediate postoperative time when maintenance care and control by the patient or family is being established. This includes the initial teaching. General maintenance care is not covered.

004.02(H) ENTEROSTOMAL THERAPY. Medicaid recognizes enterostomal therapy visits as a skilled nursing service.

004.02(I) ENEMAS AND REMOVAL OF IMPACTIONS. Medicaid covers enemas and removal of impactions when the complexity of the patient's condition establishes that the skills of a nurse are required.

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

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

004.02(L) CASTS. Casts are covered if the physician's order evidences more complexity than routine or general supportive care.

004.02(M) DRAW OR COLLECTION OF LABORATORY SPECIMENS. Medicaid covers the collection of specimens only if based on the client's medical condition home health services are medically necessary and appropriate services to be provided in the home.

004.02(N) OBSERVATION AND EVALUATION. Medicaid 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) ~~A recent acute episode~~ An episode in the previous 60 days;
(ii) A recent acute episode; ~~A well-documented history of noncompliance without nursing intervention; or~~
(iii) A well-documented history of noncompliance without nursing intervention; or
(iv) A significant ~~high~~ probability that complications would arise without the skilled supervision of the treatment program on an intermittent basis.

004.02(O) TEACHING AND TRAINING ACTIVITIES. Medicaid limits postpartum visits for teaching and training to two visits. The Department covers up to two visits of skilled nursing services for teaching or training purposes. The necessity of further visits must be justified by additional documentation evidencing extenuating circumstances that create the need beyond two visits. Medicaid covers skilled nursing visits for teaching or training that require the skills or knowledge of a nurse. 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 teaching or 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;
(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(P) OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH, HEARING, AND LANGUAGE THERAPY. Medicaid covers occupational therapy, physical therapy, and speech, hearing, and language therapy as a home health agency service only when the services meet the requirements in accordance with 471 NAC 14 and 23.

004.02(Q) DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND MEDICAL SUPPLIES (DMEPOS). Durable medical equipment, prosthetics, orthotics, and medical supplies provided by a home health agency or any skilled nursing services must meet all requirements outlined in 471 NAC 7. The Department covers medically necessary durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) which meets program guidelines when ordered by a physician, certified nurse midwife, nurse practitioner, and nurse specialist.

004.02(R) 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. Clients are authorized 56 hours a week for a maximum of 12 hours a day in a 24 hour period.

004.02(R)(i) EXTENDED-HOUR NURSING SERVICES FOR ADULTS. Clients are authorized 56 hours a week for a maximum of 12 hours a day in a 24 hours period. Clients are only authorized 56 hours a week. Changes in the client's condition or schedule of the caregiver may require a reevaluation of the approved nursing hours. The Department will authorize the following service:

(1) Those on a ventilator may qualify for additional hours based on medical necessity as deemed appropriate by the Department.

004.02(R)(ii) EXTENDED-HOUR NURSING SERVICES FOR CHILDREN. Children must have documented medical needs, which 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 or as approved by The Department. Children who seek Early and Periodic Screening, Diagnosis & Treatment (EPSDT) services and are deemed to have a medical necessity are not limited to certain hours as outlined in 471 NAC 33. 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. If a parent works from home they can request home health services for a child with disabilities during their working hours.

004.02(R)(iii) NURSING COVERAGE AT NIGHT. Caregivers or families may be eligible for night hours if the client requires 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 be 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 and 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 or 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.

004.03 NON-COVERED SERVICES.

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

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

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

004.03(D) DRESSINGS. Medicaid does not cover visits made to dress non-infected closed postoperative wounds or chronic controlled conditions.

004.03(E) 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.

004.03(F) SUPERVISORY VISITS. Skilled nursing visits required for the supervision of licensed practical nurse (LPN) or aide services may not be billed as a skilled nursing visit. The cost of supervision is included in the payment for the licensed practical nurse (LPN) or aide service.

005. BILLING AND PAYMENT FOR HOME HEALTH AGENCIES.

005.01 BILLING.

005.01(A) GENERAL BILLING REQUIREMENTS. Providers must comply with all applicable billing requirements codified in 471 NAC 2 and 471 NAC 3. In the event the individual billing requirements in 471 NAC 2 and 471 NAC 3 conflict with billing requirements outlined in this chapter, the individual billing requirements in this chapter will govern.

005.01(B) SPECIFIC BILLING REQUIREMENTS.

005.01(B)(i) BILLING INSTRUCTIONS. The provider must bill Medicaid, using the appropriate claim form or electronic format, in accordance with the billing instructions. The signed plan of care must be submitted with the claim. Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes used by Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule. Durable medical equipment and medical supplies are billed under the home health agency provider number.

005.01(B)(ii) PRIVATE DUTY NURSING. 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-82-N: Private Duty Nurse Claim Form. The signed plan of care must be submitted with the claim.

~~005.01(B)(ii) SUPERVISORY VISITS. Skilled nursing visits required for the supervision of licensed practical nurse (LPN) or aide services may not be billed as a skilled nursing visit. The cost of supervision is included in the payment for the licensed practical nurse (LPN) or aide service.~~

005.02 PAYMENT.

005.02(A) GENERAL PAYMENT REQUIREMENTS. Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC 2 and 471 NAC 3. Providers must comply with all applicable billing requirements codified in 471 NAC 2 and 471 NAC 3. In the event the individual payment regulations in 471 NAC 3 conflict with payment regulations outlined in this chapter, the individual payment regulations in this chapter will govern.

005.02(B) SPECIFIC PAYMENT REQUIREMENTS. Medicaid pays for medically prescribed and Department-approved home health agency services provided by Medicare-certified home health agencies.

005.02(B)(i) REIMBURSEMENT. Durable medical equipment and medical supplies are reimbursed according to the payment methodology outlined in 471 NAC 7. Medicaid pays for covered home health agency services and nursing 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~~.~~; or

(3) 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) 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. Medicaid does not make payment for services denied by Medicare for lack of medical necessity. Medicaid may cover services denied by Medicare for other reasons if the services are within the scope of Medicaid. Claims submitted to the Department for services provided to Medicare-eligible clients must be accompanied by documentation, which verifies the services are not covered by Medicare. To be covered by Medicaid, these services must be provided in accordance with all requirements in limitations outlined in this chapter.

005.02(B)(iii) 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. 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.

005.02(B)(iv) NURSING SERVICES, REGISTERED NURSE (RN) AND LICENSED PRACTICAL NURSE (LPN), FOR ADULTS AGE 21 AND OLDER. In addition to the requirements and limitations outlined in ~~471 NAC 13~~ this chapter, Medicaid 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 must not exceed the average ventilator per diem of all Nebraska nursing facilities, which are providing that service. This average will be computed using nursing facility's ventilator interim rates that 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 service will not be changed by the Department for purposes of the Nebraska Medicaid Case Mix System. A record modification may replace an existing record in the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) data base, but the Department will not replace the existing record in the Nebraska Medicaid Case Mix system. The record modification will be processed by the Department as an original record. This means that the Department will process the record in the usual manner if the record is not already in the Case Mix system. The Department will reject the record as a duplicate if the record has already been accepted into the Case Mix system. The Department will inactivate a discharge or re-entry tracking record but not an assessment. ~~must not exceed the average case mix per diem for the Extensive Special Care 2 case mix reimbursement level. 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.

005.02(B)(v) EXTENDED HOME HEALTH HIGH-TECH RATES. High-tech hourly rates are approved when clients require:

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

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 13 - (Repealed)

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. 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.