7. Home Health Care Services:

a. Home health care services include the following services and items:
   1. physical therapy – 1 unit per 15 minutes,
   2. occupational therapy – 1 unit per 15 minutes,
   3. speech therapy – 1 unit per 15 minutes,
   4. family planning education – 1 unit per visit,
   5. skilled nursing services (RN/LPN visits) 1 unit per 60 minutes or 1 unit per 15 minutes for brief visits or 1 unit per 15 minutes for extended visits (after 1st hour),
   6. home health aide services – 1 unit per 60 minutes or 1 unit per 30 minutes for extended visits (after 1st hour),
   7. durable medical equipment, prosthetics, orthotics, and
   8. disposable medical supplies.

b. Reimbursements for Home Health Care services, listed above in a.1. through a.6, provided by Home Health Agencies (HHA) are the lower of a) billed charges, or b) a fixed fee schedule which includes the rate for each of the home health services and a rate for "mileage" as an add-on. The agency's rates were set as of July 1, 2000 and are effective for services on or after July 1, 2000.

   A pediatric enhancement for services listed above in a.1, 2, 3, and 5 is effective for services on or after July 1, 2009.

c. Durable Medical Equipment, Prosthetics and Orthotics

   1. Reimbursement for purchase of Durable Medical Equipment, Prosthetics and Orthotics is the lower of: a) usual and customary charge, or b) a fixed fee schedule.

   2. Reimbursement for rental of Durable Medical Equipment, Prosthetics and Orthotics is the lower of: a) usual and customary charge, or b) a fixed fee schedule.

   The agency's rates were set as of August 1, 2011 and are effective for services on or after August 1, 2011.

d. Disposable supplies:

   1. If a supply item is billed through point of sale (POS), using a National Drug Code (NDC) number, reimbursement is the lower of: a) usual and customary charge, or b) gross amount due or c) Wholesale Acquisition Cost (WAC) + 8% as indicated on the current national drug data base utilized in Point-of-Sale plus a handling fee. For drugs without a WAC acquisition cost will be reimbursed plus a handling fee.

   2. All other supplies billed outside POS, using Healthcare Common Procedure Coding System (HCPCS) codes and/or Current Procedural Terminology (CPT) codes are reimbursed the lower of: a) billed charge, or b) fixed fee schedule. The Agency's rates were set as of August 1, 2011 and are effective for services on or after August 1, 2011.

12. a. Nevada Medicaid will meet all reporting and provision of information requirements of section 1927(b)(2) and the requirements of subsections (d) and (g) of section 1927.

The State assures that the State will not provide reimbursement for an innovator multi-source drug, subject to the Federal Upper Limits (42 CFR 447.332(a)), if, under applicable State law, a less expensive non-innovator multi-source drug could have been dispensed.

1. Payment for multi-source drugs shall be the lowest of (a) Federal Upper Limit (FUL) as established by the Centers for Medicare and Medicaid Services (CMS) for listed multi-source drugs plus a dispensing fee; (b) State Maximum Allowable Cost (MAC) plus dispensing fee; (c) Estimated Acquisition Cost (EAC) plus a dispensing fee; (d) the pharmacist's usual and customary charge; (e) Department of Justice pricing less 15% plus dispensing fee or (f) billed charge.

2. Payment for covered drugs other than multi-source drugs subject to the Federal Upper Limits shall not exceed the lower of (a) EAC plus a dispensing fee; (b) the pharmacist's usual and customary charge to the general public; or (c) providers actual charge to Medicaid agency.

3. Estimated Acquisition Cost (EAC) is defined by Nevada Medicaid as Wholesale Acquisition Cost (WAC) + 2% as indicated on the current national drug data base utilized in Point-of-Sale. For drugs without a WAC acquisition, cost will be reimbursed.

4. The FUL for multi-source drugs for which an upper limit has been set does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient, and the statement "brand medically necessary" appears on the face of the prescription.

5. A generic drug may be considered for MAC pricing if there are 2 or more therapeutically equivalent, multi-source, non-innovator drugs with a significant cost difference. The SMAC will be based on drug status (including non-rebateable, rebateable, obsolete, therapeutic equivalency ratings) marketplace availability and cost. The obsolete drug status will be taken into account to ensure that the MAC pricing is not influenced by the prices listed for obsolete drugs. The SMAC will be based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department.

6. The State's dispensing fees are defined as (a) those given to outpatient retail pharmacists at a rate of $4.76 per prescription; (b) those given to Home Infusion Therapy providers for intravenous antibiotic therapeutic classes at $22.40 per day. All other pharmaceuticals given by Home Infusion Therapy providers receive dispensing fees in accordance with retail pharmacists; (c) those given to pharmacists for intravenous antibiotic therapeutic classes in a nursing facility at $16.80 per day. All other pharmaceuticals given by Long Term Care pharmacists receive dispensing fees in accordance with retail pharmacists.

7. There is no co-payment requirement on medications for beneficiaries.