

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 12, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER - ADDENDUM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter Addendum are being proposed to update, delete or add definitions.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective May 13, 2016.

MATERIAL TRANSMITTED

CL 30017
ADDENDUM

MATERIAL SUPERSEDED

MTL 23/15
ADDENDUM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section A	Administrative Days	Updated language
	Ambulatory Surgical Centers (ASCs)	Updated language
Section C	Concurrent Review	Updated language
	Critical Access Hospital (CAH)	Updated language
Section D	Dialysis	Added definition

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section E	End Stage Renal Disease (ESRD)	Added definition
Section H	Hemodialysis	Added definition
	Hospital	Updated language
Section I	Informed Sterilization Consent Form Meeting Federal Requirements	Added definition
	Inpatient	Moved definition above Inpatient Hospital Services
	Inpatient Rehabilitation Hospital	Updated language – moved from Rehab Hospital
	Intermediate Administrative Days	Added definition
Section L	Leave of Absence (LOA)	Added definition
	Level I Trauma Center	Added definition
	Long-Term Acute Care (LTAC) Specialty Hospital	Updated language
Section N	Newborn/Neonate	Added definition
Section O	Observation Services	Added definition
	Outpatient Hospital	Added definition
Section R	Rehabilitation (Rehab) Specialty Hospital	Moved to Section I – Inpatient Rehabilitation Hospital
	Retrospective Review	Updated language

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Rollover Admission	Added definition
Section S	Skilled Administrative Days	Added definition
	Swing Bed	Added definition
	Swing Bed Hospital	Updated language
Section T	Therapeutic Leave of Absence (LOA)	Updated language
Section U	Utilization Review	Added definition

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b. Indirect Expenses: Those elements of costs necessary in the performance of administering the program that are of such a nature that the amount applicable to the program cannot be determined accurately or readily (i.e., rent, heat, electrical power, salaries and benefits of management personnel which are allocated to different programs, etc.).

2. Medical Administrative Costs

Costs, either direct or indirect, related to recipient medical care management (i.e., development of physician protocols for disease management, utilization review activities, case management costs, and medical information management systems).

DHCFP will review Medical Administrative Costs for reasonability and in the context of the benefit received by the client and DHCFP (i.e., is the cost of developing physician protocols for disease management less than or equal to the fiscal and health outcome benefit received).

3. Non-Medical Costs

The following are not considered administrative costs. They are, however, included in the overall percentage of non-medical costs, and will be reviewed for reasonableness by DHCFP:

- a. Profit: The percentage of profit which the Contractor anticipates receiving after expenses (net income, revenues less expenses, divided by total revenues received from DHCFP); and
- b. Risk and contingencies: That amount which the Contractor anticipates setting aside (as a percentage of the revenues received) for potential unknown risks and contingencies.

ADMINISTRATIVE CUT-OFF DATE

A date each month selected by DHCFP. Changes made to the Medicaid recipient eligibility system prior to this date are effective the next month and are shown on the recipient's Medicaid card. Changes made to the computer system after this date become effective the first day of the second month after the change was made.

ADMINISTRATIVE DAYS

~~The primary purpose and function of administrative days is to assist hospitals which, through no fault of their own, cannot discharge a recipient who no longer requires acute level services due to lack of, or a delay in, an Inpatient hospital days reimbursed at a lower per diem rate when a recipient's status does not meet an acute level of care and if discharged, alternative appropriate setting. placement in an alternative appropriate setting is not available despite a hospital's documented, comprehensive discharge planning efforts. Reference the Skilled Administrative Days and Intermediate Administrative Days definitions.~~

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AGING AND DISABILITY SERVICES DIVISION (ADSD)

A State agency that is part of Nevada’s Department of Health and Human Services (DHHS) and is the operating agency for the Home and Community-Based Waiver (HCBW) WEARC, the AL waiver and the HCBW for the Frail Elderly.

AIR AMBULANCE

Air ambulance means an aircraft (fixed or rotary wing) specially designed, constructed, modified, or equipped to be used for the transportation of injured or sick persons. Air Ambulance does not include any commercial aircraft carrying passengers on regularly scheduled flights.

ALL INCLUSIVE RATE

The daily rate which is paid to a facility during the course of a covered Medicaid stay. This daily rate is to include services and items such as, but not limited to, nursing services, dietary services, activity programs, laundry services, room/bed maintenance services, medically related social services, routine personal hygiene supplies, active treatment program and day training programs.

AMBULANCE

Ambulance is defined as a medical vehicle that is specially designed, constructed, staffed, and equipped to provide basic, intermediate, or advanced services for one or more sick or injured person or persons whose medical condition may require special observation during transportation or transfer.

AMBULATORY SURGICAL CENTERS (ASCs)

~~ASC’s are any distinct entities that operate exclusively for the purpose of providing outpatient surgical services to recipients not requiring inpatient hospitalization. They must have an agreement with the CMS to participate in Medicare as an ASC, and meets the conditions set forth in 42 CFR 416, Part B and Part C. Ambulatory Surgery services may be provided in either a~~ A Medicare certified freestanding or hospital-based ASC medical facility operating exclusively for the purpose of providing surgical services when the expected duration of services does not exceed 24 hours following admission and the individual does not require hospitalization.

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY (AAPD)

AAPD is the membership organization representing the specialty of pediatric dentistry. Their members work in private offices, clinics and hospital settings and serve as primary care providers for millions of infants, children, adolescents and patients with special health care needs. In addition, AAPD members serve as the primary contributors to professional education programs and scholarly works concerning dental care for children. (Refer to Appendix A)

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COMPOUND DRUGS

Compound means to form or make up a composite product by combining two or more different ingredients.

COMPREHENSIVE FUNCTIONAL ASSESSMENT

Comprehensive function assessments identify all of the recipients:

1. Specific developmental strengths, including individual preferences;
2. Specific functional and adaptive social skills the recipient needs to acquire;
3. Presenting disabilities and, when possible, their causes; and
4. Need for services without regard to their availability.

CONCURRENT CARE

Concurrent care allows for the provision of Private Duty Nursing (PDN) services by a single nurse to care for more than one recipient simultaneously in the recipient's residence.

CONCURRENT REVIEW

~~Concurrent-A review is performed for patients who are of a Nevada Medicaid or Nevada Check Up eligible recipient's clinical information performed by the DHCFP's QIO-like vendor or a Managed Care Organization. The review is performed during a period of time that services are being rendered, to determine if a requested service will be authorized, based onat the time of inpatient admission. Review is conducted to certify length of stay, medical necessity, and appropriateness, and compliance with applicable policies.~~

CONFIDENTIALITY

Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid and NCU applicants and recipients, Medicaid providers and any other information which may not be disclosed by any party pursuant to federal and state law, and Medicaid Regulations, including, but not limited to: NRS Chapter 422, and 42 CFR 431, 45 CFR 160 and 164 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191).

CONTENTS OF NOTICE

A notice must contain the following information:

1. A statement of what action the State, or NF intends to take;

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COST

1. Necessary Cost: A cost incurred to satisfy an operation need of the facility in relation to providing resident care.
2. Proper Cost: An actual recorded cost, clearly identified as to source, nature and purpose, and reasonably related to resident care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
3. Reasonable Cost: A reasonable cost is one that does not exceed that incurred by a prudent and cost-conscious facility operator.

COUNSELING SERVICES

A short-term structured intervention with specific aims and objectives to promote the student's social, emotional, and academic growth within the school environment.

COVERED SERVICES

Covered services are those for which Nevada Medicaid may reimburse when determined to be medically necessary, and which meet utilization control procedures as provided in the State Plan, MSM, and Provider Bulletin/Medicaid Policy News.

CRIMINAL CLEARANCE

A criminal background check must be completed as a condition of employment. All providers and employees of both Divisions must have a State and Federal Bureau of Investigation (FBI) criminal history clearance obtained from the Central Repository for Nevada Records of Criminal History through the submission of fingerprints and receiving the results.

CRITICAL ACCESS HOSPITAL (CAH)

~~Nevada Medicaid utilizes Medicare criteria when defining a CAH. Pursuant to section 1820 (a) of the Social Security Act, a state may designate a facility as a CAH if the facility~~A Medicare certified and state licensed hospital established under the State Medicare Rural Hospital Flexibility Program that meets all of the following criteria:

1. ~~Currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1999; or is a health clinic or health center that was downsized from a hospital;~~
2. ~~located in a county in a rural area or treated as rural;~~

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- ~~2.3. located more than a 35-mile drive from any other hospital ~~and is certified by the state as being a necessary provider of health care services to residents in that area~~ or in a mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles;~~
- ~~3.4. makes necessary 24-hour emergency care services that a state determines are necessary for ensuring access to emergency care services in each area serviced by a CAH complies with all CAH Conditions of Participation, including the requirement to make 24-hour emergency care services 7 days per week available;~~
- ~~4.5. provides-maintains not more than 125 acute-care inpatient beds for providing inpatient care for a period that does not exceed 96 hours per patient (unless a longer period of time is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions); and~~
- ~~5.6. meets staff requirements as defined in section 1861(e) and 1861(mm)(1) of the Act maintains an annual average length of stay of 96 hours per patient for acute inpatient care.~~

In addition to the 25 inpatient beds, a CAH may also operate a psychiatric and/or rehabilitation distinct part unit, not exceeding 10 beds per unit.

CUEING

Any spoken instructions or physical guidance which serves as a signal to do something. Cueing is typically used when caring for individuals who have a cognitive impairment.

CULTURAL COMPETENCE

An approach to the delivery of mental health services grounded in the assumption that services are more effective provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The Surgeon General defines cultural competence in the most general terms as "the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values." In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

CURRENT DENTAL TERMINOLOGY (CDT)

Refers to the coding system used for dental procedures developed by the American Dental Association and used by Nevada Medicaid.

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DIAGNOSIS

Diagnosis means determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical and developmental examination, and laboratory tests.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM) OF MENTAL DISORDERS

The latest text revision of the DSM of Mental Disorders published by the American Psychiatric Association (APA).

DIAGNOSTIC CLASSIFICATION: 0-3 (DC:0-3)

The determination of a mental or emotional disorder for a childbirth through 48 months of age as described in the latest text version of the Manual for DC:0-3 published by the National Center for Clinical Infant Programs.

DIALYSIS

A process of removing waste products from the body by diffusion from one fluid compartment to another across a semi-permeable membrane.

DIRECT CARE COMPONENT

Direct care component means the portion of Medicaid reimbursement rates that are attributable to the salaries and benefits of RNs, Licensed Practical Nurses (LPNs), certified nursing assistants, rehabilitation nurses, and contracted nursing services.

DIRECT SERVICE CASE MANAGEMENT

Direct service case management assists individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

DIRECT SERVICES

Direct services assist in the acquisition, retention and improvement of skills necessary for the person to successfully reside in the community. Direct services are individualized hours that are not shared. Direct services providers participate in the ISP meetings.

DIRECT SUPERVISION

QMHP or QMHA may function as Direct Supervisors. Direct Supervisors must have the practice specific education, experience, training, credentials, and/or licensure to coordinate an array of mental and/or behavioral health services. Direct Supervisors assure servicing providers provide services in compliance with the

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3. being regarded as having such and impairment.

DISABILITY DETERMINATION

The DHCFP's physician consultant and medical professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies as physically disabled.

DISCHARGE CRITERIA

The diagnostic, behavioral, and functional indicators that must be met to complete service provision as documented in the Treatment Plan and/or Rehabilitative Plan. Discharge criteria are developed as part of the discharge planning process, which begins on the date of admission to services.

DISCHARGE PLAN

A written component of the Treatment Plan and/or Rehabilitation Plan which ensures continuity of care and access to needed support services upon completion of the Treatment Plan and/or Rehabilitation Plan goals and objectives. A Discharge Plan must identify:

1. the anticipated duration of the overall services;
2. discharge criteria;
3. required aftercare services;
4. the identified agency(ies) or Independent Provider(s) to provide the aftercare services; and
5. a plan for assisting the recipient in accessing these services.

DISCHARGE SUMMARY

Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the mental health Treatment and/or Rehabilitation Plan(s). The Discharge Summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan, and the Discharge Plan.

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EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation is ground or air ambulance, as medically necessary, to transport a recipient with an emergency medical condition. A ground or air ambulance resulting from a “911” communication is included as emergency medical transportation.

EMERGENCY SERVICES

Emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The Contractor must not require the services to be prior or post-authorized.

EMPLOYEE

An employee of the agency or organization who is appropriately trained and assigned to the hospice unit. “Employee” also refers to a volunteer under the jurisdiction of the hospice.

EMPLOYER AUTHORITY

The participant direction opportunity by which the waiver participant exercises choice and control over individuals who furnish waiver services authorized in the service plan.

EMPLOYER OF RECORD

Refers to the ISO that provides all fiscal and supportive tasks related to PCA employment in the self-directed option. The employer of record ensures compliance with legal requirements related to employment (e.g., manages payroll and taxes and processes employment documents) and the supportive requirements (e.g., assist with training materials, training, background checks, etc.).

ENCOUNTER

A covered service or group of services delivered by a provider to a recipient during a visit, or as a result of a visit (e.g., pharmacy) between the recipient and provider.

ENCOUNTER DATA

Data documenting a contact or service delivered to an eligible recipient by a provider for any covered service.

END STAGE RENAL DISEASE (ESRD)

Irreversible and permanent destruction of normal kidney function resulting in kidney failure that requires a regular course of dialysis or a kidney transplant.

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HEARING OFFICER

The Hearing Officer is an impartial fact-finder who may or may not be an employee of the DHCFP. The Hearing Officer is an individual who has not been directly involved in the investigation or initial determination of the action in question.

HEARING PREPARATION MEETING (HPM)

An informal discussion facilitated by DHCFP, in attempt to resolve a dispute.

HEMODIALYSIS

A process of cleansing blood of waste products (e.g. urea, creatinine) as the blood passes through an artificial kidney machine, diffuses across a man-made membrane into a specific cleansing solution (a dialysate solution) and returns to an individuals' body.

HOME AND COMMUNITY-BASED SERVICES (HCBS)

Section 1915(c) of the Act authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid statutory requirements to enable states to cover a broad array of HCBS as an alternative to institutionalization. These waivers include state wideness, comparability and categorical eligibility of institutional Medicaid which allows states to offer a wide array of services, defined by the state, to those recipients who may otherwise require institutionalization.

HOME ENVIRONMENT

The residence of the recipient whether it is the natural environment or a substitute setting.

HOME HEALTH AGENCY (HHA)

A HHA is a health care provider licensed, certified, or authorized by state and federal laws to provide health care services in the home. A HHA provides skilled services in the home. A HHA provides skilled services and non-skilled services to recipients on an intermittent and periodic basis. The HHA must meet the conditions of participation as stated in the MSM, Chapter 100 and 1400. To participate in the Medicaid program, a HHA must meet the conditions of participation of Medicare.

HOME HEALTH AIDE

A home health aide is an attendant certified by the State Board of Nursing who provides care to individuals under the supervision of a RN and in accordance with the Nurse Practice Act.

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HOSPICE SERVICES

Hospice services are an optional benefit provided under Nevada Medicaid. A hospice is a public agency or private organization, or a subdivision of either, that primarily engaged in providing care to terminally ill individuals. A participating hospice must meet the Medicare conditions of participation for hospices and have a valid provider agreement. In order to be eligible to elect hospice care under Nevada Medicaid, an individual must be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less.

HOSPITAL

A hospital (other than tuberculosis or psychiatric) is an state-licensed, Medicare-certified inpatient medical facility primarily engaged in providing, by or under the supervision of, a physician or dentist, licensed to provide services at an acute LOC for the diagnosis, care, and treatment or rehabilitation of sick, injured, or disabled individuals, and is not of human illness primarily for the care and treatment of patients with disorders other than mental diseases. For purposes of Medicaid, a "hospital" must meet the requirements for participation in Medicare as a hospital. It is not an Institution for Mental Diseases (IMD), a NF, or an ICF/MR, regardless of name or licensure.

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INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

The federal law that mandates that a free and appropriate public education is available to all school-age children with disabilities.

INFORMED CONSENT

A hospice must demonstrate respect for a recipient's rights by ensuring that an informed consent form specifying the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the recipient or designated representative.

INFORMED STERILIZATION CONSENT FORM MEETING FEDERAL REQUIREMENTS

A signed consent form that meets all of the federal requirements specified in 42 CFR 441.250 through 441.259 and in 42 CFR 482.24 (c) (4) (v).

INHERENT COMPLEXITY

A service that by nature of its difficulty requires the skills of a trained professional to perform, monitor, or teach. This definition is used by HHA's to determine the need for skilled services and the type of provider.

INNOVATOR MULTI-SOURCE DRUG

An innovator multi-source drug was the original single-source drug before generic drug introduction into the market. The remainder of the manufacturers produce, only generic (multi-source) drugs.

INPATIENT

An inpatient is an individual receiving room, board, and medical care in an acute, critical access, psychiatric, or specialty hospital or nursing facility.

INPATIENT HOSPITAL SERVICES

Services ordered by a physician or dentist primarily for the care and treatment of individuals with disorders other than mental illness, admitted to a Medicare-certified and state licensed hospital that has a utilization review plan in effect that meets the requirements of 42 CFR 482.30, 42 CFR 456.50, and 42 CFR 440.10. Inpatient hospital services do not include skilled nursing services furnished in a swing-bed.

~~INPATIENT~~

~~An inpatient is an individual receiving room, board, and medical care in an acute, critical access, psychiatric, or specialty hospital or nursing facility.~~

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INPATIENT REHABILITATION HOSPITAL

A Medicare certified, state licensed, free standing or hospital based facility that provides intensive services to restore optimal function following an accident or injury (e.g. head and spinal cord injury, traumatic brain injury, cerebrovascular accident (CVA), cardiac-related disorders.) Rehabilitation hospitals generally do not provide surgical, obstetrical or psychiatric services.

INSTITUTIONAL STATUS

For purposes of Medicaid eligibility, please refer to the Welfare Division Eligibility Manual and cross references in Chapter 500 of the MSM.

INSTITUTIONS FOR MENTAL DISEASES (IMDs)

A hospital, NF or institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMDs is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such (42 CFR 435.1009). In Nevada, IMDs are commonly referred to as “psychiatric hospitals.”

Nevada Medicaid only reimburses for services to IMD/psychiatric hospital patients who are age 65 or older, or under age 21.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient’s level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of Needs Determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient’s clinical status.

These components include:

1. A comprehensive assessment of the recipient’s level of functioning;
2. The clinical judgment of the QMHP; and

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- f. dietician;
- g. psychologist;
- h. psychiatrist;
- i. dentist;
- j. pharmacist; or
- k. Direct care staff.

INTERMEDIATE ADMINISTRATIVE DAYS

Inpatient hospital days reimbursed at a lower per diem rate when a recipient's status does not meet an acute level of care and the recipient cannot be discharged due to social reasons (e.g., a stable newborn is waiting for adoption) despite comprehensive documented discharge efforts.

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

An ISO is an entity that contracts with DHCFP to provide PCS under the Self-Directed Care model. The ISO acts as an employer of record, providing both fiscal and supportive intermediary services such as administrative, limited program and specific payroll responsibilities for the delivery of PCS.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)

An institution (or distinct part of an institution), which is primarily for the diagnosis, treatment, or rehabilitation for persons with mental retardation or a related condition. In a protected residential setting, an ICF/MR facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health and rehabilitative services to help individuals function at their home.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) LEVEL OF CARE (LOC)

ICF/MR means an establishment operated and maintained to provide 24-hour personal and medical supervision for a person who does not have illness, disease, injury or other condition that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide. Persons in this facility must have a diagnosis of mental retardation or a condition related to mental retardation. This LOC identifies if an individual's total needs are such that they could be routinely met on an inpatient basis in an ICF/MR.

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LEAD CASE MANAGER

The Lead Case Manager is only used if a recipient is included in more than one target group at a given time. The Lead Case Manager is a case manager, and represents Severely Emotionally Disturbed (SED) children and adolescents or Seriously Mentally Ill (SMI) adults. The Lead Case Manager coordinates the recipient's care and services with another case manager. The lead case manager is responsible for coordinating the additional case management services, whether or not, chronologically, the lead case manager was the original or the subsequent case manager.

LEAST RESTRICTIVE SETTING

The least confining, most normative environment possible, which is individualized to the recipient and does not subject the individual to unnecessary health or safety risks. Services are delivered with the least amount of intrusion, disruption, or departure from the individual's typical patterns of living that most support the person's level of independence, productivity, and inclusion in the community.

LEAVE OF ABSENCE (LOA)

Absences for special circumstances (e.g., an absence for a few hours due to the death of an immediate family member or for a therapeutic reason such as a trial home visit to prepare for independent living.) Reference therapeutic leave of absences.

LEGAL BLINDNESS

Legal blindness is defined in state law as:

1. Visual acuity with correcting lenses of worse than 20/200 in the better eye; or
2. Field of vision subtending an angle of less than 20 degrees in the better eye.

LEGAL REPRESENTATIVE FOR SELF-DIRECTED SKILLED CARE

For the purposes of Self-Directed Skilled Care, a Legal Representative has the meaning defined in Section 6 of NRS 629.091.

1. "Parent", "Guardian" or any other person legally responsible for a minor child with a disability who is under the age of 18 years; or
2. A parent, spouse, guardian or adult child of a person aged 18 and older with a disability who suffers from a cognitive impairment.

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LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents and adoptive parents.

LEGEND DRUGS

Legend pharmaceuticals are those bearing the insignia “Rx only” on the label, and/or bearing statement “Caution: Federal law prohibits dispensing without a prescription.”

LEVEL I IDENTIFICATION SCREENING

Level I Identification screening is the initial screening assessment conducted in the PASRR program. It is used to identify individuals suspected of serious mental illness, mental retardation and/or related conditions. Every NF applicant, regardless of payer source, must be screened prior to admission to a NF.

LEVEL I TRAUMA CENTER

A hospital meeting the Level I Trauma Center criteria described in the most recent version of the Resources for Optimal Care of the Injured Patient and published by the Committee on Trauma of the American College of Surgeons, having a full range of specialists and equipment immediately available on a twenty-four (24) hour basis to provide the highest level of definitive and comprehensive care for acutely injured patients of all ages and serving as a regional resource, responsible for research, professional and community education, prevention, and consultative community outreach services and programs statewide.

LEVEL OF CARE (LOC) - HOSPICE

The LOC determines the reimbursement for each day the recipient is enrolled in a hospice benefit. Each day of hospice care is classified into one of four levels:

1. Routine Home Care – A day on which an individual who has elected to receive hospice care is in a place of residence, this includes individuals residing in a NF and is not receiving continuous care as defined.
2. Continuous Home Care – A day on which an individual who has elected to receive hospice care is not an inpatient facility and receiving hospice care consisting predominantly of nursing care.
3. Inpatient Respite Care – A day on which an individual who has elected hospice care receives care in an approved facility on a short-term basis only when necessary to relieve the family members or other persons caring for the individual at home.
4. General Inpatient Care – A day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

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LEVEL OF CARE (LOC) SCREENING

The process that is used to determine if an individual's total needs and condition are such that they require the level of services offered in a NF. The LOC instrument documents the requirement that the individual have at least three (3) functional deficits and would require imminent placement in a NF (within 30 days) if HCBW services or other supports were not available. The LOC screening instrument and procedures utilized for admission to NFs are the same as utilized for admission into a 1915(c) HCBW.

LICENSURE

Licensure means the act or practice of granting licenses, as to practice a profession.

LIGHT HOUSEKEEPING

Light housekeeping means performing or helping the recipient to perform minor cleaning tasks. Examples of light housekeeping tasks include, but are not limited to, changing bed linens, washing dishes, vacuuming and dusting.

LOCAL EDUCATION AGENCY (LEA)

A public elementary or secondary school, or unit school district, or special education cooperative or joint agreement.

LOCK-OUT

Lock-out refers to a provider sanction that suspends the Medicaid agreement between Nevada Medicaid and the provider for a set period of time.

LONG-TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL

~~LTAC facilities are hospitals that specialize in acute care for medically complex patients, i.e., multi-system complications and/or failures that require extended hospitalization, specialized programs and aggressive clinical and therapeutic interventions. Specialty hospitals generally do not provide surgical, obstetric or psychiatric services. LTAC hospitals must comply with state and federal licensing requirements. This applies to both free-standing and hospital based units.~~

A Medicare-certified and state-licensed free-standing or hospital-based facility that provides comprehensive, long-term acute care for medically complex recipients having an acute illness, injury, or exacerbation of a disease process or multi-system complications and/or failures (e.g. ventilator care and/or weaning, wound care, treatment of complex infections or neurological conditions).

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NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

The NCPDP, Inc. is a not-for-profit Standards Developmental Organization representing the pharmacy services industry.

NATIONAL DRUG CODE (NDC)

The NDC is a unique three segment number assigned to each medication listed under Section 510 of the U.S. Federal Food, Drug, and Cosmetic Act. The first segment identifies the drug manufacturer, the second segment identifies the product, and the third segment identifies the package size.

NEUROLOGY

Neurology is the branch of medicine dealing with the nervous system.

NEVADA DIVISION OF WELFARE AND SUPPORTIVE SERVICES (DWSS)

The Nevada DWSS provides eligibility determinations and services enabling Nevada families, the disabled and elderly to receive temporary cash and/or medical assistance, in an effort to achieve their highest level of self sufficiency.

DWSS also administers the Food Stamp and Temporary Assistance to Needy Families (TANF) programs. DWSS determines eligibility for the Child Health Assurance Program (CHAP) and the Medical Assistance to the Aged, Blind and Disabled (MAABD) program.

NEVADA HEALTH NETWORK (NHN)

DHCFP's official name for its collective Managed Care Programs.

NEVADA MEDICAID OFFICE (NMO)

The NMO is responsible for policy, planning and administration of the Nevada Medicaid program; AKA Division, DHCFP.

NEVADA REVISED STATUTES (NRS)

The NRS are the statutory laws of Nevada of a general nature enacted by the Legislature, with such laws arranged in an orderly manner by subject, and updated after every regular legislative session.

NEWBORN/ NEONATE

A designation that begins at birth and lasts through the 28th day of life.

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OBJECTIVES

Objectives are benchmarks to measure progress towards treatment and/or rehabilitation goals. Objectives specify the steps that must be taken/achieved in order to reach treatment and/or rehabilitation goals. Objectives must be specific, measurable (observable), achievable, realistic, and time-limited. Objectives must clearly address specific behaviors and/or problems and they must evolve in conjunction with the recipient's functional progress.

OBSERVATION SERVICES

A well-defined set of specific, clinically appropriate outpatient services, including ongoing short term treatment, assessment and reassessment furnished in an appropriate location of the hospital when a recipient's medical needs do not meet acute care guidelines and/or to assess the need for inpatient admission.

OCCUPATIONAL THERAPIST

Occupational therapist means a person who is licensed pursuant to NRS 640A to practice occupational therapy prescribed by a physician. The prescribed service must be of such a level of complexity and sophistication that only a qualified occupational therapist can provide it.

OCCUPATIONAL THERAPY

Occupational Therapy means "the application of purposeful activity in the evaluation, teaching and treatment, in groups or on an individual basis, of patients who are handicapped by age, physical injury or illness, developmental or learning disability. Intervention techniques are necessary to increase their independence, alleviate disability and promote optimal health."

OCCUPATIONAL THERAPY ASSISTANT (OTA)

OTA means a person who is licensed under the provision of NRS 640A.060 to practice occupational therapy under the direct supervision of a qualified occupational therapist within the scope of practice allowed by state law. The qualified OTA is not recognized as an independent Medicaid provider.

OCULAR SERVICES

Ocular services include refractive examinations with a prescription for corrective lenses, and fitting and provision of corrective lenses. Ocular services also include the medical diagnostic examination of the eyes performed by either an optometrist (within their scope of services) or an ophthalmologist.

OCULARIST

Ocularist refers to a person skilled in measuring, fitting, and dispensing prosthetic eyes.

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planning, emergency services, out-of-network obstetrical and gynecological providers for recipients within the last trimester of pregnancy, and prior-authorized specialty services rendered to its recipients at the rate paid by DHCFP according the Medicaid FFS rate schedule.

OUTPATIENT HOSPITAL

A Medicare certified, state licensed hospital that furnishes medically necessary diagnostic and therapeutic services to a sick or injured individual registered or accepted for care in the hospital, but not formally admitted as an inpatient and not requiring inpatient services.

OUTPATIENT SERVICES

Outpatient services are those medically necessary services provided for the diagnosis and/or treatment of an illness or disease for which the patient will not require care in a facility for more than 24 hours. Services are provided in variety of settings that include, but are not limited to: the office/clinic, home, institution and outpatient hospital.

OVERPAYMENT

Any payments made by Medicaid for goods or services provided which are later determined to be excessive, based upon fraudulent claims, or the result of improper billing practices.

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3. The individual responsible for developing the plan.

REHABILITATION SERVICES

Rehabilitation services are an optional Medicaid benefit that must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under state law, for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functional level. Nevada Medicaid provides for physical rehabilitation services and mental health rehabilitation services under separate programs within the plan.

~~REHABILITATION (REHAB) SPECIALTY HOSPITAL~~

~~A rehab hospital provides post-acute related services to recipients having, but not limited to, head and spinal cord injury, traumatic brain injury, cerebrovascular accident (CVA), wound care needs, cardiac related disorders, respiratory failure and ventilator dependency. Rehabilitation hospitals generally do not provide surgical, obstetrical or psychiatric services. Rehab hospitals must meet state and federal licensing criteria. This applies to free-standing and hospital based units.~~

REINSURANCE

Insurance purchased by a Contractor, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents.

RELATED CONDITION

Persons with conditions related to mental retardation are persons who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required by a person with mental retardation. It is manifested before the person reaches age 22. It is likely to continue indefinitely. It results in substantial functional limitations in three or more of the following areas of major life activity:

1. Self Care;
2. Understanding and use of language;
3. Learning;
4. Mobility;
5. Self-direction; and/or

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RESPIRE SERVICE

Refers to those services provided to eligible recipients who are unable to care for themselves. These services are furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care. This service provides general assistance with ADLs and IADLs, and provides supervision for recipients with functional impairments in their home or place of residence (community setting). Services may be for 24-hour periods, and the goal is relief of the primary caregiver.

RESTORATIVE CARE

Therapy services are considered to be “restorative” when there is an expectation that the patient’s condition will improve in a reasonable (and generally predictable) period of time. Medically necessary, restorative therapy services are eligible for coverage by Nevada Medicaid.

1. If an individual’s expected potential for improvement in function (restoration) would be insignificant in relation to the extent and duration of therapy services required to achieve such potential the therapy would not be considered reasonable and/or medically necessary.
2. If at any point in the treatment of an illness it is determined that the expectations will not materialize, the services will no longer be considered reasonable and medically necessary; and they, therefore, may be excluded from coverage.
3. As a general rule, failure to progress towards goals after a reasonable time period would no longer qualify as restorative.

Please refer to Chapter 1500 in the MSM, Section 1503.6A for a description of the scope of medical services available for children under age 21 described in 42 U.S.C. 1396d(a).

RETROSPECTIVE REVIEW

~~A Retrospective review is performed for patients who are by the DHCFP’s QIO-like vendor or MCO regarding recipients not Medicaid eligible until when inpatient after services were rendered, but become Medicaid eligible after services are rendered and/or after discharge to determine if a requested service will be authorized based on .-A review is conducted to certify length of stay, medical necessity, and appropriateness, and compliance with applicable policies.~~

REVENUE CODE

Revenue code is the code used on billing forms which identifies a specific accommodation, ancillary service or billing calculation.

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REVIEW AND REVISION OF IEP

An annual meeting to review each eligible individual's IEP and revises its provisions if appropriate.

REVOKED ELECTION

The recipient elects to discontinue hospice care and resumes eligibility for all Medicaid covered services. This recipient must sign a statement indicating his/her desire to discontinue hospice care.

RISK CONTRACT

Means under which the contractor assumes risk for the costs of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

ROLLOVER ADMISSION

A direct inpatient admission initiated through an emergency room or outpatient observation as part of one continuous episode of care (encounter) at the same facility when a physician writes an acute inpatient admission order.

ROUTINE SUPPLIES

Routine supplies are items used in small quantities for the recipient during the course of most HHA visits.

RURAL HEALTH CLINIC (RHC)

RHC, defined in 42 CFR 491.2, is a clinic that is located in a rural area designated as a shortage area. It is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

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A significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI. The primary care giver is no longer capable or able to provide transportation or the recipient has moved to a new geographical location where currently authorized modes of transportation are not available (no public transportation, for instance).

SIGNIFICANT PRACTICAL IMPROVEMENT

A generally measurable and substantial increase in the patient's level of functional independence and competence compared to when treatment was initiated.

SINGLE SOURCE DRUG

Single Source Drug is defined in SS 1927(k)(7) of the Social Security Act as, "a covered outpatient drug which is produced or distributed under an original new drug application approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application."

SITTERS

Sitters refer to individual services to watch or supervise a recipient in the absence of a LRA or primary caregiver.

SKILLED ADMINISTRATIVE DAYS

Inpatient hospital days reimbursed at a lower per diem rate when a recipient's status does not meet an acute level of care and if discharge is ordered, alternative appropriate placement is not available, despite documented evidence of comprehensive discharge planning efforts (e.g., a recipient is waiting for nursing or psychiatric facility placement or home equipment set-up availability).

SKILLED NURSING (SN)

SN means assessments, judgments, interventions, and evaluations of intervention, which require the training and experience of a licensed nurse. SN care includes, but is not limited to:

1. performing assessments to determine the basis for action or the need for action;
2. monitoring fluid and electrolyte balance;
3. suctioning of the airway;
4. central venous catheter care;
5. mechanical ventilation; and

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SUPPORT BROKER

The Support Broker assists the participant in the development and management of their services including; budget management, monitoring of expenditures, personnel management and ISP development. These supports are provided in a manner that is flexible, responsive to and directed by the individual participant. A support broker is employed by the support broker agency contracted by MHDS. This is an administrative activity.

SUPPORT SERVICES

Specifically designed instruction and activities, which augment, supplement, or support the educational program.

SUPPORTED LIVING ARRANGEMENT (SLA)

SLA services are provided to adults and children in homes shared with other recipients or in a home where the individual rents a room, including adults who rent rooms from their family and is defined in Chapter 2100.

SWING-BED

A CMS certified bed in a rural or critical access hospital that can be used to provide either acute hospital inpatient or post-acute skilled nursing services, as needed.

SWING-BED HOSPITAL

~~A swing bed CMS certified rural or critical access hospital is any hospital that meets the following criteria: has a Medicare swing-bed provider agreement, and is state-licensed to allow either acute or post acute skilled nursing/skilled rehabilitation services to be provided in a specific number of certified beds, as needed.~~

- ~~1. the hospital has a Medicare swing bed provider agreement;~~
- ~~2. has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units;~~
- ~~3. the hospital is located in a rural area, including all areas not delineated as “urbanized” areas by the Census Bureau, based on most recent census;~~
- ~~4. the hospital does not have in effect a 24-hour nursing waiver;~~
- ~~5. the hospital has not had swing bed approval terminated within two years previous to application; and~~
- 6.1. The facility is substantially in compliance with the SNF requirements contained in 42 CFR, subpart B, part 483.

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THERAPEUTIC LEAVE OF ABSENCE (LOA)

Acute Hospital or Medical Rehabilitation Specialty Hospital: A leave of absence for a therapeutic reason, such as, a diagnostic test or procedure that must be performed at an alternate facility or a trial home visit to prepare for independent living.

Nursing Facility: An LOA for therapeutic or rehabilitative home and community visits or in preparation for discharge to community living that involves overnight stays. Therapeutic leave does not apply when a resident is out on pass for short periods of time for visits with family/friends, to attend church services, or other social activities. Therapeutic leave does not include hospital emergency room visits or hospital stays.

~~Therapeutic LOA includes therapeutic or rehabilitative home and community visits with relatives and friends. Therapeutic leave also includes leave used in preparation for discharge to community living. Therapeutic leave days are considered overnight stays. Therapeutic leave does not apply when a resident is out on pass for short periods of time for visits with family/friends, to attend church services or other social activities. Therapeutic leave does not include hospital emergency room visits or hospital stays.~~

THIRD PARTY LIABILITY (TPL)

Means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State (Medicaid) Plan.

TRAUMATIC BRAIN INJURY (TBI)

A traumatic brain injury is a medically verifiable incident of the brain not of a degenerative or cognitive nature, but caused by an external force, that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or functioning. It can also result in a disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and can cause partial or total functional disability or psychosocial maladjustment.

TREATMENT

1. EPSDT

Medically necessary services or care provided to prevent, correct or improve disease or abnormalities detected by screening and diagnostic procedures.

2. Behavioral Health

A planned, medically appropriate, individualized program of interactive medical, psychological, rehabilitative procedures, therapeutic interventions and/or services designed to rehabilitate, relieve or minimize mental, emotional or behavioral disorders.

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URBAN

A geographic area of service in a county having a population of 30,000 or more and has a radius of not more than 25 miles between recipients and the MCOs network providers and hospitals.

USUAL CHARGE

A pharmacy may not charge Medicaid more than the general public.

UTILIZATION

The extent to which the recipients of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. It is usually expressed as the number of services used per year or per 100 or one 1,000 persons eligible for the service.

UTILIZATION CONTROL

"Utilization Control" refers to the federally mandated methods and procedures that may include utilization review to safeguard against unnecessary or inappropriate utilization of care and services to Medicare and Medicaid recipients (42 CFR 456.50-456.145).

UTILIZATION MANAGEMENT AGENCY

The state's fiscal agent or QIO-like vendor. The utilization review/control requirements of 42 CFR 456, are deemed met if a State Medicaid agency contracts with a Medicare certified QIO-like vendor, designated under Part 475, to perform review/control services.

UTILIZATION REVIEW

A process to evaluate the medical necessity, appropriateness, location of service, level of care and length of stay, when applicable, and the efficiency and efficacy of health care services or procedures requested or provided. Utilization review is a cost containment program that promotes the delivery of quality health care in a cost efficient manner.