

**MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER**

March 10, 2016

**TO:** CUSTODIANS OF MEDICAID SERVICES MANUAL

**FROM:** LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

**SUBJECT:** MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL AND  
SUBSTANCE ABUSE SERVICES

**BACKGROUND AND EXPLANATION**

Revisions to Medicaid Services Manual (MSM) Chapter 400, Mental Health and Alcohol and Substance Abuse Services are being proposed to revise the provider qualifications for the Substance Abuse Agency Model (SAAM) providers. The proposed changes will remove the requirement for SAAM providers to be funded through the Division of Public and Behavioral Health. Additional revisions allow SAAM providers to provide up to two (2) assessments per calendar year without a prior authorization.

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 March 11, 2016.

**MATERIAL TRANSMITTED**

CL 29713  
CHAPTER 400 – MENTAL HEALTH AND  
ALCOHOL AND SUBSTANCE ABUSE  
SERVICES

**MATERIAL SUPERSEDED**

MTL 21/15  
CHAPTER 400 – MENTAL HEALTH AND  
ALCOHOL AND SUBSTANCE ABUSE  
SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
<b>Attachment B, Policy #4-04, C.3</b>	<b>Definitions</b>	Deleted “A” and replace with “the”.

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>Attachment B, Policy #4-04, D.2.a</b>	<b>Provider Requirements</b>	Removed Language that indicates funding is required as a provider qualification.
<b>Attachment B, Policy #4-04, G</b>	<b>Supervision Requirements</b>	Removed Language that indicates funding is required as a provider qualification.
<b>Attachment B, Policy #4-04, H.7.n</b>	<b>Coverage and Limitations</b>	Removed Language that indicates funding is required as a provider qualification.
<b>Attachment C, Page 4</b>	<b>Coverage and Limitations Level 1</b>	Added language to allow up to two (2) assessments per calendar year without a prior authorization.
<b>Attachment C, Page 5</b>	<b>Coverage and Limitations Level 2.1 and 2.5</b>	Added language to allow up to two (2) assessments per calendar year without a prior authorization.
<b>Attachment C, Page 6</b>	<b>Coverage and Limitations Level 3.3 – 3.5</b>	Added language to allow up to two (2) assessments per calendar year without a prior authorization.

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5. Recovery is supported by peers and allies;
6. Recovery is supported through relationship and social networks;
7. Recovery is culturally-based and influenced;
8. Recovery is supported by addressing trauma;
9. Recovery involves individual, family, and community strengths and responsibility; and
10. Recovery is based on respect.

### C. DEFINITIONS

1. Co-Occurring Capable (COC) programs - are those that “address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning” (The ASAM Criteria 2013, p. 416.)
2. Co-Occurring Enhanced (COE) programs - have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse treatment to clients and “are designed to routinely (as opposed to occasionally) deal with patients who have mental health or cognitive conditions that are more acute or associated with more serious disabilities.”  
  
(The ASAM Criteria, 2013, p. 29) Enhanced-level service “place their primary focus on the integration of service for mental and substance use disorders in their staffing, services and program content.” (The ASAM Criteria, 2013, p. 417).
3. Recovery - **A**the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
4. Substance abuse - as defined in DSM-V (5<sup>th</sup> edition, Text Revision; APA 2013) is a “ cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA 2013, p. 483)
5. Substance dependence - is more serious than abuse. This maladaptive pattern of substance abuse includes such features as increased tolerance for the substance, resulting in the need for ever greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems.
6. Integrated interventions - are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or integration, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques. Some examples include:

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- a. Integrated screening and assessment process;
- b. Dual recovery mutual self-help meetings;
- c. Dual recovery groups (in which recovery skills for both disorders are discussed);
- d. Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance use disorder problems;
- e. Group interventions for persons with the triple diagnosis of mental disorder, substance abuse disorder, and trauma, or which are designed to meet the needs of persons with co-occurring disorder and another shared problem such as homelessness or criminality; and
- f. Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder.

Integrated interventions can be part of a single program or can be used in multiple program settings.

7. Quadrant of Care Model as developed by the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD):
  - a. Category I: Less Severe mental disorder/less severe substance disorder.
  - b. Category II: More severe mental disorder/less severe substance disorder.
  - c. Category III: Less severe mental disorder/more severe substance disorder.
  - d. Category IV: More severe mental disorder/more severe substance disorder.

This assessment assists the provider in integrating care, defining and guiding treatment options for recipients with co-occurring disorders.

#### D. PROVIDER REQUIREMENTS

1. In order to be recognized and reimbursed as a Prevention and Early Intervention Level 0.5 by the DHCFP, the providers must be:
  - a. Recognized health care clinicians and systems by the U.S. Preventive Services Task Force (USPSTF) within their scope of practice; and
  - b. Certified providers under the Nevada Administrative Code (NAC) 458.103 scope of practice.
2. In order to be recognized and reimbursed as a Substance Abuse Treatment Clinic for Levels I-III by the DHCFP, the provider must:

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- a. Be certified ~~and receiving funding from~~ by the Division of Public and Behavioral Health as an alcohol and drug abuse program under NAC 458.103; and
  - b. Provide Integrated Interventions; and
  - c. Be a Co-Occurring Capable Program; or
  - d. A Co-Occurring Enhanced Program.
3. In order to be recognized and reimbursed as a Substance Abuse Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management Program by the DHCFP the provider must be Licensed by the Nevada Division of Public and Behavioral Health as:
    - a. An acute care general hospital with a psychiatric unit; or
    - b. A free standing psychiatric hospital (patients ages 22-64 in an IMD are not covered).
    - c. A licensed chemical dependency specialty hospital with acute care medical and nursing staff (patients ages 22 – 64 in an IMD are not covered).
    - d. Have Medicare certification.

#### E. QUALITY IMPROVEMENT

The DHCFP requires providers who are receiving funds from the DHCFP to be deemed compliant by the Division of Public and Behavioral Health, Nevada Revised Statutes (NRS) and NAC. Qualification is based upon the Division of Public and Behavioral Health's Substance Abuse Prevention and Treatment Agency (SAPTA) Certification tool. The certification tool reviews the program for areas such as, but not limited to, compliance with federal and state regulations, quality improvement, applications of policies and procedures, health and safety of the recipients, clinical documentation requirements, and staff/training documentation. Non-compliance will result in the DHCFP provider **termination and/or suspension without cause** depending on severity of infraction.

This does not apply to level 4 providers or physicians providing level 0.5 services. They are governed by separate licensing boards.

#### F. DOCUMENTATION REQUIREMENTS

All program levels require individualized progress notes in the recipient's medical records that clearly reflect implementation of the treatment plan and the recipient's response to the therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Treatment plan reviews are conducted at specified times as documented on the treatment plan.

1. Treatment Plan-A written individualized plan that is developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and licensed professional within the scope of their practice under state law. The treatment plan is based on a comprehensive assessment and includes:

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- a. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);
  - b. Documentation supporting ASAM Criteria assessment dimensions and levels of care;
  - c. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;
  - d. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;
  - e. Discharge criteria specific to each goal; and for
  - f. High-risk recipients accessing multiple government-affiliated and/or private agencies/ evidence of care by those involved with the recipient's care.
2. The recipient, or their legal representative, must be fully involved in the treatment planning process, choice of providers, and indicate an understanding of the need for services and the elements of the treatment plan. Recipient's, family's (when appropriate) and/or representative's participation in treatment planning must be documented on the treatment plan.
  3. Temporary, but clinically necessary, services do not require an alteration of the treatment plan, however, must be identified in a progress note. The note must indicate the necessity, amount scope, duration and provider of the service.
  4. Progress Note - Reference section 403.2B(3).
  5. Discharge Plan - Reference section 403.2B(4).
  6. Discharge Summary - Reference Section 403.2B(5).
  7. Required Signatures for Treatment Plan:
    - a. Clinical Supervisor;
    - b. Recipient and their family/legal guardian (in the case of legal minors); and
    - c. The individual responsible for developing the plan.

#### G. SUPERVISION REQUIREMENTS

Clinical Supervisor – A licensed professional operating within the scope of their practice under state law may function as a Clinical Supervisor. A Clinical Supervisor must have the specific education, experience, training, credentials, and licensure to coordinate and oversee an array of services for behavioral health. The Clinical Supervisor will have administrative and clinical oversight of the program and must ensure that services provided are medically necessary, clinically appropriate, and follow an evidence based model recognized by the Health Division. The designated supervisor must be approved by the program operator of a SAPTA certified ~~and funded~~ network per NAC 458.103.

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If the Clinical Supervisor will supervise interns, they are required to have the appropriate additional licensure needed per the Board of Examiners in addition to their professional licensure. Supervision must be within the scope of their practice and field.

#### H. COVERAGE AND LIMITATIONS

The DHCFP reimburses for integrated interventions in a substance abuse medical treatment delivery model provided by qualified Medicaid providers. Patients are assessed as meeting diagnostic criteria for substance-related disorders (including substance use disorder or substance-induced disorders) and/or mental health disorders as defined in the current International Classification of Diseases (ICD).

1. Screening - A brief systematic process to determine the possibility of a co-occurring disorder.
  - a. The following screens are covered within the DHCFP program. Screens must be a nationally accepted screening instrument through SAMHSA/CSAT Treatment Improvement Protocols or other Peer Supported Literature. Below is a list of recognized tools:
    1. Clinical Institute Withdrawal Assessment (CIWA)
    2. Michigan Alcohol Drug Inventory Screen (MADIS)
    3. Michigan Alcoholism Screening Test (MAST)
    4. Modified Mini
    5. Problem Behavior Inventory (PBI)
    6. Substance Abuse Subtle Screening Inventory (SASSI)
    7. Substance Use Disorder (SUDDS)
    8. Recovery Attitude and treatment Evaluator (RAATE)
    9. Treatment Intervention Inventory (TII)
    10. Western Personality Interview (WPI)
2. Assessment - A Comprehensive Co-occurring Assessment is an individualized examination which establishes the presence or absence of mental health and substance abuse disorders, determines the recipient's readiness for change, and identifies the strengths or problem areas that may affect the recipient's treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

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3. Level of Care Determination and Authorization Requirements

- a. The DHCFP utilizes the ASAM Criteria, for individuals presenting with substance use disorder(s) to determine appropriate placement in a level of care. In addition, the DHCFP utilizes medical necessity as defined in Medicaid Services Manual (MSM) Chapter 100, Section 103.1. The process considers assessment and documentation of the following six dimensions:
  1. Dimension 1: Acute Intoxication and/or Withdrawal Potential
  2. Dimension 2: Biomedical Conditions and Complications
  3. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
  4. Dimension 4: Readiness to Change
  5. Dimension 5: Relapse, Continued Use, or Continued Problem Potential
  6. Dimension 6: Recovery/Living Environment
- b. The DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients.
- c. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request.
- d. Reference Attachment C for authorization requirements for Substance Abuse Agency Model.

4. Treatment Services – The DHCFP covers the below levels based upon the ASAM patient placement criteria. Reference Attachment C for the coverage and utilization management requirements.

- a. Level 0.5 Early Intervention/Prevention
- b. Level 1 Outpatient Services
- c. Level 2.1 Intensive Outpatient Program
- d. Level 2.5 Partial Hospitalization
- e. Level 3 Outpatient Services provided in a Licensed Level 3 environment
- f. Level 4 Medically Managed Intensive Inpatient Treatment

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5. Pharmaceutical coverage - For coverage and limitations of Narcotic Withdrawal Therapy Agents (Opioid Dependent Drugs) refer to Chapter 1200 of the MSM.
6. Opioid Use Treatment
  - a. Provided in a Nevada licensed entity through SAPTA as an Opioid Use Disorder Treatment Program.
  - b. Coverage of the service:
    1. Requires diagnosis of Opioid Use Disorder; and
    2. Requires documentation as meeting the assessment criteria of all six dimensions of opioid treatment program in The ASAM Criteria.
  - c. The following service is covered for Opioid Treatment Program:
    1. Medication assessment, prescribing, administering, reassessing and regulating dose levels appropriate to the individual, supervising withdrawal management from opioids, opioid use disorder treatment, overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders;
  - d. Opioid use disorder treatment program is required to perform:
    1. Linkage with or access to psychological, medical and psychiatric consultation;
    2. Linkage with or access to emergency medical and psychiatric care through affiliations with more intensive levels of care;
    3. Linkage with or access to evaluation and ongoing primary medical care;
    4. Ability to conduct or arrange for appropriate laboratory and toxicology tests;
      - a. Availability of physicians to evaluate, prescribe and monitor use of methadone and levo-alpha-acetylmethadol (LAAM), and of nurses and pharmacists to dispense and administer methadone or LAAM; and
      - b. Ability to assist in arrangements for transportation services for patients who are unable to drive safely or who lack transportation.
7. Non-Covered Services - the following services are not covered under the substance abuse services program for the DHCFP:
  - a. Services for recipients without an assessment documenting diagnostic criteria for substance-related disorder (including substance use disorder or substance-induced disorders) or mental health disorder as defined in the current ICD;

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- b. Services for marital problems without a covered, current ICD diagnosis;
- c. Services for parenting skills without a covered, current ICD diagnosis;
- d. Services for gambling disorders without a covered, current ICD diagnosis;
- e. Custodial services, including room and board;
- f. More than one provider seeing the recipient in the same therapy session;
- g. Services not authorized by the QIO-like vendor if an authorization is required according to policy;
- h. Respite;
- i. Services for education;
- j. Services for vocation training;
- k. Habilitative services;
- l. Phone consultation services;
- m. Services for individual ages 22-64 in an Institution for Mental Disease (IMD);
- ~~n. Services provided by agencies not receiving funding by Nevada Division of Public and Behavioral Health (DPBH) for Levels I-III under NAC458.103;~~
- ~~o.n.~~ Services provided under Nevada State Certification Level 2WM – 3.7 Withdrawal Management programs;
- ~~p.o.~~ Counseling services for Opioid Treatment Programs; and
- ~~q.p.~~ Care Coordination and treatment planning.

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention	<ol style="list-style-type: none"> <li>1. Screening services recommended by the U.S. Preventive Services Task Force:                             <ol style="list-style-type: none"> <li>a. Depression screening in adults and adolescents.</li> <li>b. Alcohol screening in adults, including pregnant women.</li> <li>c. Tobacco use counseling and interventions for pregnant women.</li> </ol> </li> <li>2. Must be direct visualization. Self-screens and over the phone are non-covered.</li> </ol>	<p>A. DEPRESSION SCREENING</p> <p><u>Adults:</u> Many formal screening tools are available, including instruments designed specifically for older adults. (See Policy, page 4) Asking two simple questions about mood and anhedonia ("Over the past two weeks, have you felt down, depressed, or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?") may be as effective as using more formal instruments (2). There is little evidence to recommend one screening method over another; therefore, clinicians may choose the method most consistent with their personal preference, the patient population being served, and the practice setting.</p> <p>All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (that is, those from the updated <i>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</i>) to determine the presence or absence of specific depressive disorders, such as MDD or dysthymia. The severity of depression and comorbid psychological problems (for example, anxiety, panic attacks, or substance abuse) should be addressed.</p>	<p>No prior authorization required.</p> <p>Limited to one screen per 90 days per disorder.</p>

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention (Continued)		<p><u>Adolescents:</u> Instruments developed for primary care (Patient Health Questionnaire for Adolescents [PHQ-A] and the Beck Depression Inventory-Primary Care Version [BDI-PC]) have been used successfully in adolescents. There are limited data describing the accuracy of using MDD screening instruments in younger children (7-11 years of age).</p> <p><b>B. ALCOHOL SCREENING</b></p> <p><u>Adults/Pregnant Women:</u> The USPSTF considers three tools as the instruments of choice for screening for alcohol misuse in the primary care setting: the Alcohol Use Disorders Identification Test (AUDIT), the abbreviated AUDIT-consumption (AUDIT-C), and single question screening (for example, the NIAAA recommends asking, “How many times in the past year have you had five [for men] or four [for women and all adults older than 65 years] or more drinks in a day?”). Of available screening tools, AUDIT is the most widely studied for detecting alcohol misuse in primary care settings; both AUDIT and the abbreviated AUDIT-C have good sensitivity and specificity for detecting the full spectrum of alcohol misuse across multiple populations.</p>	

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention (Continued)		<p>AUDIT comprises ten questions and requires approximately two to five minutes to administer. AUDIT-C comprises three questions and takes one to two minutes to complete. Single-question screening also has adequate sensitivity and specificity across the alcohol-misuse spectrum and requires less than one minute to administer.</p> <p>C. TOBACCO</p> <p><u>Pregnant Women</u>                      Various primary care clinicians may deliver effective interventions. There is a dose-response relationship between quit rates and the intensity of counseling (that is, more or longer sessions improve quit rates). Quit rates seem to plateau after 90 minutes of total counseling contact time. Helpful components of counseling include problem-solving guidance for smokers (to help them develop a plan to quit and overcome common barriers to quitting) and the provision of social support as part of treatment. Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone "quit lines."</p>	

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Outpatient Services			
Level 1 Outpatient Services	<ol style="list-style-type: none"> <li>1. Medication management</li> <li>2. 24 hour crisis intervention services face to face or telephonically available seven days per week</li> <li>3. Behavioral Health/Substance Abuse Covered Screens</li> <li>4. Comprehensive biopsychosocial Assessment</li> <li>5. Individual and group counseling</li> <li>6. Individual, group, family psychotherapy</li> <li>7. Peer Support Services</li> </ol>	<p>A clinic model that meets the certification requirement NAC 458.103 for alcohol and drug abuse programs.</p> <p>The entity will provide medical, psychiatric, psychological, services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens, up to two (2) assessments per calendar year, and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p>

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## SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Level 2 2.1 Intensive Outpatient Treatment	<p>An evidenced-based/best practice model providing a minimum amount of skilled structured programming hours per week. During the day, before or after work setting, evening, and/or weekend. Provides a milieu “real world” environment. The milieu is a combination of skilled treatment services.</p> <ol style="list-style-type: none"> <li>1. Medical and psychiatric consultation</li> <li>2. Psychopharmacological consultation</li> <li>3. Medication management</li> <li>4. 24 hour crisis intervention services face to face or telephonically available seven days per week</li> <li>5. Comprehensive biopsychosocial assessments</li> <li>6. Behavioral Health/Substance Abuse Covered Screens</li> <li>7. Individual and group counseling</li> <li>8. Individual, group, family psychotherapy</li> <li>9. Self-help/recovery groups</li> </ol>	<p>Frequencies and intensity are appropriate to the objectives of the treatment plan.</p> <p>Requires a comprehensive interdisciplinary program team approach of appropriately credentialed addiction treatment professionals, including addiction – credentialed physicians who assess and treat substance-related disorders. Some staff are cross trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and interactions with substance-related disorders.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens, up to two (2) assessments per calendar year, and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p>
2.5 Partial Hospitalization	<ol style="list-style-type: none"> <li>1. Outpatient hospital setting.</li> <li>2. All level 2.1 services in addition need the direct access to psychiatric, medical and/or laboratory services.</li> </ol>	<p>Same as above, in addition psychiatric and medical management.</p> <p>Intensity of service required is higher than can be provided in Intensive Outpatient Treatment.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens, up to two (2) assessments per calendar year, and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p>

## SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Level 3 Residential 3.3-.5 Managed Residential	<p>Medical, psychiatric, psychological, services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation.</p> <ol style="list-style-type: none"> <li>1. 24 hour crisis intervention services face to face or telephonically available seven days per week</li> <li>2. Medication management</li> <li>3. Behavioral Health/Substance Abuse Covered Screens</li> <li>4. Comprehensive biopsychosocial Assessment</li> <li>5. Individual and group counseling</li> <li>6. Individual, group, family psychotherapy</li> <li>7. Peer Support Services</li> </ol>	<p>A clinic model that meets the certification requirement NAC 458.103 for alcohol and drug abuse programs. Room and board is not a reimbursable service through the Division of Health Care Financing and Policy (DHCFP) outpatient program.</p> <p>The entity will provide medical, psychiatric, psychological, services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens, up to two (2) assessments per calendar year, and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p> <p>Intensity of service is dependent upon individual and presenting symptoms.</p>

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Detoxification Services			
Inpatient Services			
Level 4 Medically Managed Intensive Inpatient and Withdrawal Management Services	<p>Inpatient substance abuse services are those services delivered in freestanding substance abuse treatment hospitals or general hospitals with a specialized substance abuse treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance abuse professionals and a structured multi-disciplinary clinical approach to treatment. These hospitals provide medical detoxification and treatment services for individuals suffering from acute alcohol and substance abuse conditions.</p> <p>Services provided in:</p> <ol style="list-style-type: none"> <li>1. An acute care general hospital with a psychiatric unit,</li> <li>2. A free standing psychiatric (patients ages 22-64 are non-covered), and</li> <li>3. A licensed chemical dependency specialty hospital with acute care medical and nursing staff.</li> </ol>	Reference 403.10.	Prior Authorization required. Reference Inpatient section 403.10.

MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

March 10, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL  
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE  
SUBJECT: MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 600 – PHYSICIAN SERVICES

**BACKGROUND AND EXPLANATION**

A revision to Medicaid Services Manual (MSM) Chapter 600, Physician Services, is being proposed to update policy related to Temporomandibular Joint (TMJ) services in the Physician Office Services section. Services for TMJ issues are non-covered. Language is being added to clarify that palliative and emergency treatments for TMJ conditions are covered services.

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 March 11, 2016.

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<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>603.2</b>	<b>Physician Office Services</b>	TMJ related services are listed under “Non-covered Physician services.” A coverage exception is being added in cases of palliative and emergency treatment for TMJ conditions.

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- b. prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.
  - c. When medical care is unavailable for Nevada recipients residing near state borders (catchments areas) the contiguous out-of-state physician/clinic is considered the Primary Care Physician (PCP). All in-state benefits and/or limitations apply.
  - d. All service physicians must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. (See MSM Chapter 100.)
5. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The EPSDT program provides preventative health care to recipients (from birth through age 20 years) eligible for medical assistance. The purpose of the EPSDT program is the prevention of health problems through early detection, diagnosis, and treatment. The required screening components for an EPSDT examination are to be completed according to the time frames on a periodicity schedule that was adopted by the American Academy of Pediatrics and the DHCFP. See MSM Chapter 1500, Healthy Kids.

## 603.2 PHYSICIAN OFFICE SERVICES

Covered services are those medically necessary services when the physician either examines the patient in person or is able to visualize some aspect of the recipient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of X-rays, electrocardiogram (ECG) and electroencephalogram (EEG) tapes, tissue samples, etc.

Telehealth services are also covered services under the DHCFP. See MSM Chapter 3400 for the complete coverage and limitations for Telehealth.

### a. Consultation Services

A consultation is a type of evaluation and management service provided by a physician and requested by another physician or appropriate source, to either recommend care for a specific condition or problem or determine whether to accept responsibility for ongoing management of the patient's entire care. A consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that are ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or appropriate source. When a consultant follows up on a patient on

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a regular basis, or assumes an aspect of care on an ongoing basis, the consultant becomes a manager or co-manager of care and submits claims using the appropriate hospital or office codes.

1. When the same consultant sees the same patient during subsequent admissions, the physician is expected to bill the lower level codes based on the medical records.
  2. A confirmatory consultation initiated by a patient and/or their family without a physician request is a covered benefit. Usually, requested second opinions concerning the need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) third opinion will be covered if the first two opinions disagree.
- b. New and Established Patients
1. The following visits are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility:
    - a. Minimal to low level visits - Most patients should not require more than nine office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a three month period. No prior authorization is required.
    - b. Moderate visits - Generally, most patients should not require more than 12 office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a 12 month calendar year. No prior authorization is required.
    - c. High severity visits - Generally, most patients should not require more than two office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a 12 month period. Any exception to the limit requires prior authorization.
  2. Documentation in the patient's medical record must support the level of service and/or the medical acuity which requires more frequent visits and the resultant coding. Documentation must be submitted to Medicaid upon request. A review of requested reports may result in payment denial and a further review by Medicaid's Surveillance and Utilization Review (SUR) subsystem.
  3. Medicaid does not reimburse physicians for telephone calls between physicians and patients (including those in which the physician gives advice or instructions

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4. to or on behalf of a patient) except documented psychiatric treatment in crisis intervention (e.g. threatened suicide).
5. New patient procedure codes are not payable for services previously provided by the same physician or another physician of the same group practice, within the past three years.
6. Some of the procedures or services listed in the Current Procedural Terminology (CPT) code book are commonly carried out as an integral component of a total service or procedure and have been identified by the inclusion of the term “separate procedure”. Do not report a designated “separate procedure” in addition to the code for the total procedure or service of which it is considered an integral component. A designated “separate procedure” can be reported if it is carried out independently or is considered to be unrelated or distinct from other procedures/services provided at the same time.
7. Physical therapy administered by a Physical Therapist (PT) on staff or under contract in the physician’s office requires a prior authorization before rendering service.

If the physician bills for physical therapy, the physician, not the PT, must have provided the service.

A physician may bill an office visit in addition to physical therapy, on the same day in the following circumstances:

- a. A new patient examination which results in physical therapy on the same day;
- b. An established patient with a new problem or diagnosis; and/or
- c. An established patient with an unrelated problem or diagnosis.

Reference MSM Chapter 1700 for physical therapy coverage and limitations.

8. Physician administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200 for coverage and limitations.
9. Non-Covered Physician services
  - a. Investigational or experimental procedures not approved by the Food and Drug Administration (FDA).

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- b. Reimbursement for clinical trials and investigational studies.
- c. Temporomandibular Joint (TMJ) related services **with the exception for palliative and emergency treatment only(see MSM Chapter 1000 Dental).**

1. Referrals

When a prior authorization is required for either in-state or out-of-state services, the referring physicians are responsible for obtaining a prior authorization from the QIO-like vendor. If out-of-state services are medically necessary, the recipient must go to the nearest out-of-state provider for services not provided in-state. It is also the responsibility of the referring physician to obtain the authorization for a recipient to be transferred from one facility to another, either in-state or out-of-state.

2. Hospice

Physicians are responsible for obtaining prior authorization for all services not related to the morbidity that qualifies the recipient for Hospice. Physicians should contact Hospice to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200 for coverage and limitations.

3. Home Health Agency (HHA)

HHA services provide periodic nursing care along with skilled and non-skilled services under the direction of a qualified physician. The physician is responsible for writing the orders and participating in the development of the plan of care. Reference MSM Chapter 1400 for coverage and limitations.

4. Laboratory

Reference MSM Chapter 800 for coverage and limitations for laboratory services.

5. Diagnostic Testing

Reference MSM Chapter 300 for coverage and limitations for diagnostic services.

603.2A AUTHORIZATION PROCESS

Certain physician services require prior authorization. There is no prior authorization requirement for allergy testing, allergy injections or for medically necessary minor office procedures unless specifically noted in this chapter. Contact the QIO-like vendor for prior authorization information.

MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

March 10, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL  
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE  
SUBJECT: MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 1900 - TRANSPORTATION

**BACKGROUND AND EXPLANATION**

Revisions to Medicaid Services Manual (MSM) Chapter 1900 - Transportation are being proposed to clarify and define policies as stipulated by contract between the Division of Health Care Financing and Policy (DHCFP) and the transportation broker that provides mandatory, non-emergency transportation (NET) for Medicaid recipients to obtain medical services.

Accessibility to medical services was fundamental to the chapter modifications which included identifying other possible drop off locations in lieu of an emergency room and the provision for recipient transportation to pharmacies. To further enhance accessibility to Medicaid services, policy was added to include per diem reimbursement for recipients and escorts that arrived at a medical facility by emergency transportation. Emergency transportation was clarified as emergency, scheduled emergency and specialty care transportation and the type of authorization required to utilize each service - alleviating confusion for both the broker and providers. Further clarification and revision was required to identify the per diem rates allowed for recipients and their escorts during travel periods, to include the reimbursement of lodging if the recipient had extenuating circumstances that would not allow them to cancel their lodging in a timely manner. Additionally, the chapter was revised to reimburse both parents for travel expenses, if their child is less than 12 months of age and in a medical facility.

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 March 11, 2016.

**MATERIAL TRANSMITTED**

CL  
TRANSPORTATION

**MATERIAL SUPERSEDED**

MTL 17/11  
TRANSPORTATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
<b>1900</b>	<b>Introduction</b>	Nevada Medicaid was deleted and replaced with the Division of Health Care Financing and Policy (DHCFP)
<b>1901</b>	<b>Authority</b>	DHCFP NET Services Brokerage Contract was deleted  Added Health Insurance Portability and Accountability Act (HIPPA) of 1996 (P.L. 104-191)
<b>1903</b>	<b>Policy</b>	Original language addressed emergency transportation only; added language to include specialty care and scheduled emergency transportation.
<b>1903.1</b>	<b>Emergency Medical Transportation</b>	Added reference to the MSM chapter addendum.
<b>1903.1A</b>	<b>Coverage and Limitation, Emergency Medical Transportation</b>	Language was added to clarify that emergency transportation may deliver recipients to destinations other than an emergency room if the facility has the type of physician required to treat the recipient and added that emergency transport cannot be used in lieu of NET.  Updated emergency transportation provider enrollment criteria/process.  Clarified that provider claims are to be submitted to the FFS fiscal agent or the appropriate MCO.  Changed “Fiscal Agent for all” to “FSS fiscal agent or to the appropriate MCO”  Identified that routine or special supplies are included in the rates given to emergency transportation providers.
<b>1903.1B</b>	<b>Authorization Process</b>	Added language that a specialty care (SCT) or scheduled emergency transportation provider may need to obtain a Letter of Agreement from the DHCFP’s Rates Unit to transport Medicaid Fee for Service (FFS) or Nevada Check Up (NCU) Fee for Service recipients.  Identified prior or post authorization required for Medicaid managed care or Nevada Check Up managed care recipients for specialty care, out-of-state and scheduled emergency transportation. In-state specialty care transport does not require prior authorization.  Added language to the use of International

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Classification of Diseases (ICD) billing codes and current electronic data interchange (EDI) standards for claim submissions.

**1903.1C**                      **Specialty Care  
Transport**

Deleted language that stated SCT did not require prior authorization and that SCT is defined as a type of emergency transportation.

Revised and moved language regarding prior authorization for out-of-state travel and SCT not requiring authorization, to 1903.1B. Authorization Process.

**1903.1D**                      **Scheduled  
Emergency**

Added clarifying language that scheduled emergency transport will be provided by an emergency transportation provider in coordination with the DHCFP or the MCO.

Expanded on what exceeds the capabilities of NET – the requirement of medical personnel and/or attachment to medical apparatus that would be considered basic or advanced life support.

Changed ‘examples of scheduled emergencies’ from what ‘may’ be handled by the NET to what ‘must’ be handled by NET.

Added language that transportation of a live organ donor will be provided, regardless of the donor’s Medicaid or NCU eligibility.

Clarified that reimbursement requests are to be submitted to the NET broker and not the DHCFP.

Corrected statement on reimbursement for meals and lodging, which is not based on the DHCFP policy but on U.S General Services Administration (GSA) rates or actual costs, whichever is less. Mileage will be reimbursed at the current Internal Revenue Services’ (IRS) rate for medical miles driven.

Added language that recipients and escorts are entitled to meals and lodging reimbursement when travel status lasts over specific time periods. Recipients and escorts that arrive by emergency transportation are also entitled

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to reimbursement of meals and lodging.

**1903.1F**

**Recipient  
Responsibility**

Replaced Champus with Tricare.

**1904**

**Non-Emergency  
Transportation**

Added language to identify transportation will be provided to certain Medicaid covered waiver services such as Intensive Supported Living Arrangements (ISLA), Jobs and Day Training (JDT), and/or Adult Day Care.

Added required pick up timeframe for Hospital discharge not to exceed 8 hours; out-of-state and long distance transport will be handled as soon as possible.

Replaced IHS with Indian Health Programs. Added language that clarified that transportation provided by the Indian Health Programs does not need prior authorization from the NET broker and claims are paid at twice the IRS medical transport rate.

Added that All NET claims from the Indian Health Programs are to be submitted to the NET broker.

Deleted “Public” and “Paratransit-Private” from list of transportation services and added Stretcher accommodating vehicle.

Clarified language regarding NET level of care which does not exceed EMT-Basic.

**1904.1**

**Assessment and  
Authorization  
Process**

Replace IHS with Indian Health Programs and corrected section reference.

Replaced ‘appropriate’ level of service with ‘required’ level of service.

Corrected language to reflect that the recipient receives a level of service assessment from the public paratransit agency.

Added language that if a recipient resides outside the parameter of a paratransit agency, the NET broker will provide transportation to and from the recipient’s primary care physician (PCP) at the level of service

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requested; the primary care physician can either complete their own assessment form or one from the broker to indicate the recipient's transportation level.

Deleted language that the broker will mail an application to the recipient and that Medicaid will schedule an assessment.

Added language that the Regional Transportation Commission has 21 days to notify the recipient of the results of the assessment and the NET provider will continue to provide transport at the requested level during that time. If the recipient is dissatisfied with the results, the NET broker will reassess the recipient and provide results within 48 hours. If the decision negatively impacts the recipient, the broker will provide a NOD to the recipient.

Deleted "Until the higher level of transportation is either approved or denied by the Medicaid District Office" and replaced with, "If the recipient requests a hearing, until the higher level of transportation is either approved or denied by the State Fair Hearing process..."

Replaced, "and will provide a copy of new listings to the Medicaid District Office's daily," with "sent to the paratransit service agencies."

Deleted language that the Medicaid Office will maintain lists of assessments; provide broker with recipient's authorization status; and a description of what the assessments should include.

Deleted language that the Medicaid Office would conduct a reassessment and replaced it with language that states that this is the responsibility of the NET broker.

Deleted language that provides for NET to the Medicaid District Office for an assessment.

Deleted the necessity that documentation is required to partake in NET services for medical appointments, prior to the assessment.

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Added that rides will be provided at level requested. In order to travel outside the paratransit area, deleted language: demonstrate a medical necessity and replaced with: to access the nearest appropriate provider.

Deleted language that the NET broker would state the medical condition and the treatment of recipients.

Clarified that only provider information will be supplied to the transportation companies.

Deleted language that the Medicaid District Office will complete assessments and determine the level of service.

Added language that the broker will provide the recipient authorization status and level of service.

Replaced 'states' with 'provides evidence' and added the broker will re-evaluate the recipient and refer to RTC for an assessment.

Changed language from the recipient will not receive a higher level of service prior to assessment, to reflect that they will be provided the level of NET services requested until an evaluation is completed.

Deleted language that recipients will not receive requested level of service for routine appointments.

Deleted redundant language; "Recipients may be reassessed for a greater level of service if they can document a significant change in their condition or circumstance..."

Clarified, that an LRI, that cannot provide transportation, can request transportation services from the broker.

**1904.2**

**Coverage and Limitations**

Deleted language describing Free Transportation as the recipient having a vehicle or that the LRI is capable of providing transportation.

Revised Free Transportation to include when the recipient is capable of providing their own

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transportation or able to obtain it from another source.

Removed language that required the recipient or LRI to provide documentation that they are either unable or incapable of providing transportation.

Added language that the broker may not deny transportation to a recipient based on an LRI's unwillingness to provide transportation

Added clarifying language that children may accompany a recipient and the broker is to provide additional bus tickets if necessary. If more than one child will be in attendance, the transportation provider must be notified.

Added language that recipients do not have to ride fixed route public transit if their appointments are outside of the service area.

Replaced 'qualified' with 'required' to ride public transit.

Moved and combined language appearing later in this section regarding freedom of choice when selecting medical providers and that NET may be used to access the nearest appropriate provider.

Defined 'appropriate' provider to include prior relationships and appointment availability. The DHCFP will assist the broker in making these determinations.

Removed verbiage regarding the 26<sup>th</sup> mile or the 51<sup>st</sup> mile mileage reimbursement.

Added language that the NET broker may negotiate a different mileage rate due to limited transportation availability and cost effectiveness.

Clarified that prior authorization must be obtained from the NET broker for reimbursement.

Deleted redundant language that prior authorization must be obtained from the NET broker.

Removed statement regarding Title XXI NCU recipients

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who are no longer under the responsibility of DHCFP.

Clarified NET services for residents are the responsibility of the skilled nursing facilities.

Added language that the examples of circumstances provided for NET, are not all inclusive.

Deleted language regarding NET for out-of-state nursing home admittance.

Added transportation is provided to urgent care clinics.

Added transportation is provided to and from pharmacies for medical necessities.

Clarified that the broker will allow ‘at least’ one escort and that recipients under 18 do not require an escort when obtaining family planning products.

Clarified that a physician’s statement may also determine the need for an escort(s).

Deleted language that the NET broker may not charge for an escort’s transportation.

Added language that the broker will cover the costs of the escort(s) travel expenses including transportation, lodging, and meals during travel status of the recipient and while the recipient is receiving medical services.

Added ‘products’ to family planning services.

Clarified that if a delay of a child’s transport may be medically detrimental, a Consent and Release of Liability Form must be signed by a facility case worker.

Added that minor children may be transported on a case by case basis as determined by the DHCFP.

Deleted that NET services may be authorized to transport a minor child with a mental disability to a facility by ambulance.

Deleted that foster or adoptive parents must demonstrate

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a need for public assistance to receive NET.

Clarified that foster/adoptive parents may receive reimbursement for travel expenses at GSA and/or IRS rates, when obtaining medical services for foster/adopted children.

Added that the foster/adoptive parents may also schedule NET services.

Replaced “QIO-like vendor or contracted” to “FSS fiscal agent or the contracted MCO”.

Replaced ‘utilization management’ with ‘fiscal’ agent.

Deleted that recipients are only eligible for out-of-area services if those services are not available locally.

Changed ‘may’ to ‘will’ be granted and added that those detained in a juvenile detention facility are an exception to the 14 day NET broker notification requirement.

Replaced ‘DHCFP travel policy’ with ‘GSA rates’.

Replaced ‘three’ with ‘twelve’ months.

Clarified that multiple trips may be authorized but are limited to no more than 5 trips that may be authorized at one time.

Deleted that multiple trip authorization was for mileage reimbursement only.

Revised age of children that may have two parents as escorts, from ‘three months’ to ‘less than twelve months’.

Deleted language referencing bonding between parents and child.

Replaced ‘QIO-like vendor’ with ‘the DHCFP’s fiscal agent’ throughout the chapter.

Added references to MSM Chapter 400.

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Deleted that a maximum of 24 days per year is allowed for therapeutic absences.

Added language that states that transportation must fall within the maximum allowable therapeutic leave requests which are described in MSM Chapter 1600.

Deleted verbiage regarding residential group care.

Clarified that there may be more than one escort; changed child under three months to under twelve months; replaced DHC FP policy with GSA rates.

If lodging has been reserved and must be cancelled, any charges incurred by the recipient, will be reimbursed by the NET broker. Documentation of why the cancellation was unavoidable must be submitted to the broker. Disputes will be resolved by the DHC FP.

Replaced IHS with Indian Health Programs throughout the chapter.

Deleted language regarding TPL.

Corrected reference from 1903.2A (6) to 1904.21.

Added language that recipients requiring any type of medical care, medical supervision, physical monitoring, the attachment to medical intravenous therapy, EMT-intermediate or paramedic services, etc. during transport are not eligible for non-emergency transportation.

Deleted extra attendant and excise tax.

Deleted “State” and added “DHC FP”.

**1904.3**

**Net Broker Responsibility**

Deleted language that defines who the prohibition of ownership applies to.

Added language that the broker will work cooperatively with the DHC FP and the Regional Transportation Centers for handling ride cancellations.

Clarified language that the NET broker and the paratransit agencies will assess for requested higher

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levels of service.

Deleted the prohibition of recipients not being able to access a higher level of service if their level of service is unavailable.

Deleted that the Medicaid District office will determine maximum level of service.

Deleted “QIO-like vendor” and replaced with “fiscal agent”.

Changed reference from 45 CFR 160 to 45 CFR 164.

Added reference to the consideration of an existing provider relationship and access to care, along with referencing section 1904.2A (2d).

Added ‘appropriate’ to define Medicaid providers.

Deleted the statement that a referral from a physician to a provider that is not the closest, does not automatically authorize the recipient NET services to that provider. Deleted that the NET broker must obtain a written justification for the exception.

Clarified that the list of Medicaid providers will be provided ‘quarterly’.

Changed ‘will refund’ to ‘may be required to’ refund capitation.

Deleted statement that if we use historical costs to determine rates, inappropriate rides will be disqualified.

Change the transportation wait time from ten (10) to fifteen (15) minutes.

Deleted reference to: NRS 450B.180.

Added NRS 484B.157.

Replaced ‘rear’ with ‘side’ view mirrors.

Added language that if the insurance amount per NAC

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		<p>706.191 increases, the amount that is greater of either the Code or the Chapter will be the amount of required coverage.</p> <p>Changed “Administrator of Nevada Medicaid” to “DHCFP”.</p> <p>Changed “Administrator” to “fiscal agent”.</p> <p>Clarified that transportation providers are to provide evidence of or status changes to, insurance policies to the DHCFP.</p> <p>Changed reference from 103.12A to Chapter 100.</p> <p>Added language that when the NET broker submits claims for services outside of capitation, the ICD and EDI standards must be utilized.</p>
1904.4	<b>Recipient Responsibility NET</b>	<p>Added clarifying language under free transportation, that a recipient may provide medical documentation to signify that they or their LRI are unable to utilize public transit.</p> <p>Added language urging recipient to schedule rides not less than five (5) days and no more than 30 days prior to travel.</p> <p>Deleted language that recipients are to contact public paratransit to cancel rides.</p> <p>Deleted reference to section 603.3.</p> <p>Deleted reference to Specialty Care Transport and added ‘scheduled’ emergency. Changed reference from 1903.1 to 1903.1D.</p> <p>Deleted language referencing the lifting of recipients up or down stairs.</p> <p>Deleted “contacting the DHCFP Business Lines Unit at (775) 684-3692”.</p>
1904.7	<b>Enrollment and Disenrollment</b>	<p>Added DHCFP Website for reference.</p>

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
	<b>Requirements and Limitations</b>	
<b>1905.1</b>	<b>Notice of Decision</b>	<p>Changed CFR reference from 42 CFR 438.10 (h) to 42 CFR 438.10 (g).</p> <p>Added language to include transportation to hearings.</p>
<b>1905.2</b>	<b>Recipient Grievances and Provider Disputes</b>	<p>Changed “TTY” to “TDD”.</p>

<b>DRAFT</b>	<b>MTL-17/HCL</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1900
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

1900 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP/~~Nevada Medicaid~~) and its contractors assure the availability of emergency and ~~Non-Emergency T~~ransportation (NET) services for Medicaid recipients, to provide access to covered medically necessary services by all eligible, Title XIX Medicaid recipients. Transportation services are provided to and from Medicaid medical providers pursuant to 42 ~~Code of Federal Regulations (CFR)~~ Part 431.53 and the respective State of Nevada Title XIX State Plan.

The DHCFP/~~Nevada Medicaid~~ and its contractors ~~also~~ assure the availability of emergency and scheduled emergency services for Nevada Check Up (NCU) recipients, to provide access to emergency services by all eligible, Title XXI Children’s Health Insurance Program (CHIP/NCU) recipients. Emergency and scheduled emergency transportation services are provided to NCU recipients pursuant to the State of Nevada Title XXI ~~s~~State ~~p~~Plan.

The DHCFP has comprehensive risk-based contracts with ~~M~~managed ~~C~~are ~~O~~rganizations (MCOs), which are contractually required to cover all the emergency transportation needs of their enrollees and are prohibited from requiring prior or post authorization for emergency services, including emergency transportation services originating through “911”. Emergency transportation services provided for Fee for Service (FFS) recipients do not require prior or post authorization. ~~and are covered under the FFS reimbursement program option.~~ NET services are provided to all Medicaid recipients through the contracted NET broker and must be authorized by the broker. This chapter provides details about covered services, how to access services, and the entities responsible for reimbursing providers and, in some instances, recipients.

All transportation providers, including the DHCFP’s contracted NET broker, must comply with all applicable Nevada Revised Statutes (NRS), ~~the~~ Nevada Administrative Code (NAC), the Code of Federal Regulations (CFR~~s~~), the United States Codes, and the Social Security Act, which ~~assure~~~~ensures~~ program and operational compliance. Additionally, pursuant to Medicaid Services Manual (MSM) Chapter 100 transportation providers, the DHCFP’s NET broker and members of the NET broker’s provider network may not discriminate unlawfully against recipients on the basis of race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions). Nondiscrimination and Civil Rights regulations extend to job applicants and employees of service providers as well.

<b>DRAFT</b>	<b>MTL-23/10CL</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1901
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1901 AUTHORITY

The rules set forth below are intended to supplement, and not duplicate, supersede, supplant or replace other requirements that are otherwise generally applicable to Medicaid programs as a matter of federal statute, laws and regulations. Nevada's ~~Non-Emergency Transportation~~ (NET) broker is not a ~~Prepaid Ambulatory Health Plan~~ (PAHP). In the event that any rule set forth herein is in conflict with any applicable federal law or regulation, such federal law or regulation shall control. Such other applicable requirements include, but are not limited to:

- a. 42 Code of Federal Regulations (CFR) Part 431.53 for assurance of medically necessary transportation to providers;
- b. 42 CFR 434.6 of the general requirements for contracts; and Part 2 of the State Medicaid Manual, Centers for Medicare and Medicaid Services (CMS) Publication 45-2;
- c. 45 CFR 92.36 (b)-(f) for procurement standards for grantees and sub grantees;
- d. The Deficit Reduction Act of 2006 (Pub. L. No. 109-171) for provision that the states may use state plan authority to operate a transportation brokerage system;
- e. The requirement that certain entities be excluded from participation, as set forth in §1128 and §1902(p) of the Social Security Act and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- f. Section 1932(b)(2)(D) of the Social Security Act for limits on amount paid to non-contracting providers of emergency services;
- g. Confidentiality and privacy requirements as set forth in 45 CFR Parts 160 and 164;
- h. The requirement of freedom of choice for family planning services and supplies, as set forth in 42 CFR 431.51 and as defined in Section 1905(a)(4)(C) and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- i. The respective State of Nevada Title XIX and Title XXI State Plans;
- j. Nevada Revised Statutes (NRS) Chapter 422 and Chapter 706; and
- ~~k. — DHCFP NET Services Brokerage Contract.~~
- k. The Health Insurance Portability and Accountability Act (HIPPA) of 1996 (P.L. 104-191).

These rules are issued pursuant to the provisions of NRS Chapter 422. The Nevada State Department of Health and Human Services (DHHS), acting through the DHCFP, has been

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designated as the single state agency responsible for administering the Nevada Medicaid program under delegated federal authority pursuant to 42 CFR 431. Accordingly, to the extent that any other state agency rules are in conflict with these rules, the rules set forth herein shall control.

DRAFT

<b>DRAFT</b>	<b>MTL-17/11CL</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1902
MEDICAID SERVICES MANUAL	Subject: RESERVED

1902      RESERVED

DRAFT

<b>DRAFT</b>	<b>MTL-17/11CL</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1903
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1903 POLICY

The Division of Health Care Financing and Policy (DHCFP) and its contractors, assures the availability of medically necessary emergency, **specialty care, scheduled emergency** and ~~Non-Emergency Transportation~~ (NET) services for eligible Title XIX Medicaid recipients. These transportation services are provided to and from **the** DHCFP Fee-for-Service (FFS) medical providers and Managed Care Organization (MCOs) network and non-network providers pursuant to 42 CFR Part 431, § Part 438, and the respective State of Nevada Title XIX State Plan.

The DHCFP/~~Nevada Medicaid~~ and its contractors assure the availability of emergency, **specialty care**, and scheduled emergency ~~services for transportation for~~ Nevada Check Up (NCU) recipients, to provide access to emergency services by all eligible, Title XXI Children’s Health Insurance Program (CHIP/NCU) recipients. Emergency ~~and scheduled emergency~~ transportation services are provided to NCU recipients pursuant to the State of Nevada Title XXI ~~s~~State ~~p~~Plan.

1903.1 EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation does not require prior authorization. Claims must be submitted to **either** the DHCFP’s FFS ~~F~~fiscal ~~A~~agent or the recipient’s ~~NCU or Medicaid~~ MCO; ~~if applicable,~~ for processing. According to the Centers for Medicare and Medicaid Services (CMS), emergency response to “911” calls normally result in a ~~B~~basic ~~L~~Life ~~S~~support (BLS) or ~~A~~advanced ~~L~~Life ~~S~~support ~~L~~Level 1 (ALS-1) service level. Note that emergency medical transportation providers who submit claims coded as ~~A~~advanced ~~L~~Life ~~S~~support ~~L~~Level 2 (ALS-2) must present supporting documentation to verify that the transport included the type of care described in the ALS-2 definition in ~~Section 1902~~ **the MSM chapter addendum.**

1903.1A COVERAGE AND LIMITATIONS, EMERGENCY MEDICAL TRANSPORTATION

1. Emergency transportation is provided for eligible recipients; ~~whether that are covered by~~ FFS or **an** MCO.
2. The DHCFP has contracts with MCOs that are contractually obligated to cover emergency medical transportation services for their enrollees by applying the prudent layperson standard. For MCO enrolled recipients, claims for emergency transportation are to be submitted to the MCO in which the recipient is enrolled.
- ~~2.3.~~ **Emergency transportation (ambulances) may deliver the recipient to appropriate medical destinations other than a hospital emergency room. Recipients may be transported from any point of origin to the nearest hospital, critical access hospital (CAH), dialysis facility, appropriate specialty clinic (e.g. substance abuse agency, federally qualified health center, rural health clinic, Indian health program), or a physician’s office (when the ambulance must stop in route due to the dire medical need of the recipient). Ambulances may also transport skilled nursing facility (SNF) residents when the required level and type of care**

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for the recipient's illness or injury cannot be met by the SNF, to the nearest supplier of medically necessary services. The hospital or CAH must have available the type of physician specialist needed to treat the recipient's condition. However, the utilization of emergency transportation may not be used in lieu of non-emergency transportation.

4. Emergency medical transportation providers must submit all appropriate documentation to the MCOs or to the FFS fiscal agent to register as an emergency medical transportation provider in addition to documentation that demonstrates the appropriate level of service personnel are employed (i.e. BLS, ALS, etc.).
- 3.5. Providers are to submit claims for reimbursement of emergency medical transportation to the ~~Fiscal Agent for all~~ FFS fiscal agent or to the appropriate MCO. ~~recipients~~. Neither the DHCFP nor its contractors will reimburse the following individual services in connection with emergency medical transportation:
  - a. Response with "Non-transport";
  - b. Routine or special supplies, including oxygen, defibrillation, IV's, intubation, ECG monitoring, ~~extra attendant~~, or air transport excise taxes (agreed upon rates between the DHCFP and specific transportation providers are all inclusive);
  - c. Ambulance charges for waiting time, stairs, plane loading;
  - d. Deadheading (an empty trip to or from a destination); or
  - e. Transportation of deceased persons.

#### 1903.1B AUTHORIZATION PROCESS

No prior or post authorization is required for emergency medical transportation that originates with a "911" call.

Other transportation ~~treated as an emergency~~ such as specialty care and scheduled emergency transportation does not require prior or post authorization if the recipient is enrolled in FFS Medicaid FFS or in NCU FFS, from Medicaid's fiscal agent. However, the transportation company may be required to obtain a Letter of Agreement from the DHCFP's Rates Unit, for both in-state and out-of-state transport.

~~but~~ Prior or post authorization may be required if the recipient is enrolled in a contracted Medicaid ~~or NCU-MCO~~ or NCU MCO, from the recipient's MCO provider. Recipients that are members of a Medicaid MCO or NCU MCO require prior authorization for specialty care, out-of-state transportation and all scheduled emergency transportation services. The transportation

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provider must contact the MCO for direction before providing the service. In-state specialty care transport does not require prior authorization.

1. ~~Providers-Transportation vendors~~ must submit claims for service to the DHCFP's ~~Fiscal Agent or the contracted MCO~~ using the ~~appropriate-current~~ nationally ~~devised~~ recognized International Classification of Diseases (ICD) billing codes and current electronic data interchange (EDI) standards. ~~for all FFS recipients or to the responsible contracted MCO for managed care enrollees.~~

#### 1903.1C SPECIALTY CARE TRANSPORT

Specialty ~~C~~care ~~T~~ransport (SCT) is hospital-to-hospital transportation of a critically injured or ill recipient by a ground or air ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the ~~emergency medical technician (EMT) - Intermediate or paramedic.~~ ~~Specialty Care Transport (SCT) is considered an emergency service and does not require prior authorization when the recipient is covered under FFS Medicaid or NCU. SCT is defined as a type of emergency transportation due to the necessary Level of Care (LOC) and is not covered under the NET program.~~

~~If the recipient is a member of a Medicaid or NCU MCO, prior authorization may be required for out-of-state travel. The transportation provider must contact the MCO for direction before providing the service. In-state Specialty Care Transportation is considered an emergency service and does not require prior authorization when the recipient is covered under an MCO.~~

SCT is not covered by the NET program due to the necessary level of care during transport.

Provider and recipient responsibilities in situations involving SCT are ~~the same as for emergency medical transportation and are~~ referenced in Sections 1903.1E and 1903.1F.

#### 1903.1D SCHEDULED EMERGENCIES

Scheduled ~~E~~mergency ~~T~~ransportation may be arranged by a hospital, physician or an emergency transportation provider or it may be scheduled by the DHCFP's NET broker.

In determining whether scheduled emergency transportation should be the responsibility of the DHCFP's NET broker, distance or cost is not the deciding factor. In-transit care needs and time-critical factors take precedence. The following guidelines provide general direction.

1. When the recipient's care needs during transit exceed the capabilities of a NET provider, scheduled emergencies will be ~~treated as emergencies provided by an emergency transportation vendor.~~ This will be done in coordination with either the DHCFP or the responsible MCO.

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Examples of exceeding the capabilities of a NET provider include:

- a. Transportation of a critically ill recipient to a location where an organ transplant will occur;
- b. Hospital-to-hospital transfer of a seriously injured or ill recipient when medically necessary tests or treatment are not available at the dispatching hospital and the recipient's care needs during transit ~~requires the attendance of medical personnel and/or the attachment to medical apparatus that would be included in a basic life support or advanced life support vehicle (ambulance); exceed the scope of service of an Emergency Medical Technician Basic (EMT Basic); and or~~
- c. Facility-to-facility transfer of a ~~s~~ Seriously ~~m~~ Mentally ~~i~~ ill (SMI) adult or a ~~s~~ Severely ~~e~~ Emotionally ~~d~~ Disturbed (SED) child who qualified health care professionals deem is an imminent danger to self or others and who requires significant chemical or physical restraints and/or the attendance of security personnel during transit.

Scheduled emergency transportation provided under the above circumstances does not require prior authorization ~~from Medicaid's fiscal agent~~ when the recipient is covered under Medicaid FFS ~~Medicaid~~ or NCU FFS. However, if the recipient is a member of a Medicaid ~~or NCU MCO or an NCU MCO~~, prior authorization ~~may be~~ is required. The provider responsible for arranging the transportation must contact the MCO for direction before providing the service.

~~Sections 1903.1E and 1903.1F set forth provider and recipient responsibilities when scheduled emergency transportation is treated as an emergency.~~

2. When the recipient's care needs during transit are within the scope of services provided by the DHCFP's NET broker, the NET broker will make every effort to fulfill the transportation request within the required timeframe. Prior authorization ~~for transportation~~ by the NET broker will be required. ~~If the request for scheduled emergency transportation exceeds the level of NET services that the NET broker is capable of providing, the service will be treated as an emergency. Questions of the levels of NET will be decided by the DHCFP.~~

Examples of scheduled emergencies that, ~~time permitting, may~~ **must** be handled by the NET broker include:

- a. Transportation of a medically stable recipient to a location where an organ transplant will occur;

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- b. Hospital-to-hospital transfer of a medically stable recipient; ~~and~~
- c. Hospital to mental health facility transfer with a qualified ~~escort~~ attendant(s) of an ~~SMI seriously mentally ill~~ adult, an individual with dementia, or an ~~SED severely emotionally disturbed~~ child who is not a danger to self or others but whom, during transit, may need minimal chemical or physical restraints that are within the scope of service of an ~~escort~~ attendant(s) who is qualified as an EMT-Basic. This is in accordance with NRS 433.; or
- d. Transportation of a live organ donor, regardless of whether the donor is a Medicaid or NCU recipient.

Provider and recipient responsibilities when scheduled emergency transportation is handled by the DHCFP's NET broker are found in Sections 1903.~~2B1E~~ and 1903.~~2C1F~~.; ~~and the authorization process is described in Section 1903.2D.~~

- 3. Due to the nature of some scheduled emergencies (e.g., time-critical air transportation to another city for organ transplant), it is occasionally necessary for a recipient, or an individual on behalf of a recipient, to pay for transportation costs from personal funds. When this occurs, a reimbursement request may be submitted to the ~~DHCFP NET broker~~. ~~The person who submits the request must provide a letter that explains why expenses were handled in this manner.~~ Documentation that the transportation was medically necessary (e.g., a hospital admitting form) and original receipts for out-of-pocket costs must be attached. ~~Reimbursement for lodging and meals will be based on the lesser of actual costs or the U.S General Services Administration (GSA) rates. Mileage will be reimbursed at the current Internal Revenue Services' (IRS) rate for medical miles driven.~~
  - a. Reimbursable expenses include ground and/or air transportation, lodging and meals for the recipient and ~~one attendant~~escort(s), if necessary. Reimbursement for lodging, meals and mileage, and other necessary items are reimbursed in accordance with ~~the current DHCFP travel policy~~ GSA rates or the actual cost, ~~whichever is less~~. Recipients and escorts must present receipts for reimbursement. Recipients and escorts must use low cost accommodations such as the Ronald McDonald House whenever available and reimbursement will not be authorized or reimbursed for higher costs unless the recipient can demonstrate to the NET broker that the low-cost accommodations in the area were unavailable at the time the recipient required them. ~~Recipients and escorts are entitled to be reimbursed by the NET broker for meals and lodging when travel status to obtain medical services lasts over specific time periods, regardless if the transportation utilized by the recipient was non-emergent or emergent (e.g. air ambulance).~~

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1903.1E PROVIDER RESPONSIBILITY

The transportation provider is solely responsible for verifying program eligibility, ~~and~~ enrollment and assessed levels of NET service for each recipient. Whenever possible, this should be done prior to rendering emergency transportation services. Information concerning eligibility and enrollment verification is located in ~~Section 103.5,~~ Chapter 100, of the Nevada Medicaid Services Manual (MSM).

The provider must ensure the confidentiality of recipient medical records and other information, such as the health, social, domestic and financial circumstances learned or obtained in providing services to recipients.

The provider shall not release information related to a recipient without first obtaining the written consent of the recipient or the recipient’s legally authorized representative, except as required by law. Providers meeting the definition of a “covered entity” as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

The DHCFP expects that providers will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable.

1903.1F RECIPIENT RESPONSIBILITY

The recipient or legally authorized representative shall:

1. Provide the emergency transportation provider with a valid Medicaid/NCU Identification card at the time the service is rendered, if possible, or as soon as possible thereafter.
  - a. Recipients shall provide the emergency transportation provider with accurate and current medical information, including diagnosis, attending physician, medication regime, etc., at the time of request, if possible;
  - b. Recipients shall notify the emergency transportation provider of all third party insurance information, including the name of other third party insurance, such as Medicare, ~~Champus~~Tricare, Workman’s Compensation, or any changes in insurance coverage at the time of service, if possible, or as soon as possible thereafter;
  - c. Recipients shall not refuse service of a provider based solely or partly on the provider’s race, creed, religion, sex, marital status, color, age, disability, and/or national origin; ~~and~~

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- d. **Recipients shall participate** in and cooperate fully with the NET **broker's** eligibility and level of service assessment.

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1904 NON-EMERGENCY TRANSPORTATION (NET) SERVICES

The DHCFP has contracted with a NET broker to provide transportation to ~~only~~ medically necessary Medicaid covered services—~~statewide~~ including certain Medicaid covered waiver services such as Intensive Supported Living Arrangements (ISLA), Jobs and Day Training (JDT), and/or Adult Day Care. Although ride scheduling will only be accommodated during customary business hours, transportation may be scheduled for confirmed after—hours medical appointments. After—hours, weekend and holiday rides that are not prior authorized may be reimbursed only when the recipient requires urgent medical care. The transportation must be to an emergency care facility, such as an emergency room or after hour’s clinic. ~~The transportation broker provides services on a statewide and out-of-state basis. Transportation services for a Medicaid eligible recipient as a result of a hospital discharge must be provided as soon as possible and in any event is not to exceed an eight (8) hour time span. Out-of-state and long distant transport will be handled and provided as soon as possible.~~

All NET services require prior authorization by the DHCFP’s NET broker with the exception of NET services provided by ~~Indian Health Services (IHS) clinics~~ Indian Health Programs. ~~Several tribes and/or Indian Health Programs offer ambulance and/or van services for both emergency and NET. Indian Health Programs and tribal community health representatives (CHRs) may provide NET services to recipients who are eligible for NET services in private vehicles to medically necessary, covered services and are reimbursed at a per mile rate that is double the IRS medical mileage rate. The Indian Health Programs’ NET services do not require prior authorization. All Indian Health Program claims for reimbursement for non-emergency transportation services are submitted to the NET Broker for adjudication and payment.~~ The NET broker is required to authorize the least expensive alternative conveyance available consistent with the recipient’s medical condition and needs. Examples of NET services may include the following:

- a. Charter air flight;
- b. Commercial air;
- c. Rotary wing;
- d. Fixed wing;
- e. Ground ambulance;
- f. Bus, local city;
- g. Bus, out of town;
- h. Paratransit—~~Public~~;

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i. ~~Paratransit Private;~~

j.i. Private vehicle; ~~and~~

j. Taxi; ~~and a-~~

k. ~~Stretcher accommodating vehicle.~~

NET never originates from a “911” call. NET ~~seldom requires the recipient’s care needs during transit to~~ is utilized by recipients whose level of care needs do not exceed the scope of service of an EMT-Basic.

#### 1904.1 ASSESSMENT AND AUTHORIZATION PROCESS

- A. With the exception of services provided by **Indian Health Programs**~~HHS~~ (see **Section 19043.2A (14)**), the need for NET services must be assessed as specified in this section, and authorized by the NET broker.
- B. The goal of the combined assessment and authorization processes is to determine the ~~appropriaterequired~~ level of non--emergency ~~medical~~ transportation services.
- C. Assessment and prior authorization to use NET:
  1. Recipients wishing to use NET services will be assessed for the proper level of transportation prior to being authorized access to NET.
    - a. Otherwise appropriate requests for lower levels of ground transportation, i.e. mileage reimbursement, public bus or public paratransit, will be assessed and authorized by the NET broker. ~~without intervention from the Medicaid District Office.~~
    - b. If the request is for a greater level of ground transportation than mileage reimbursement, public bus or public paratransit, the NET broker should use due diligence in questioning the recipient to see if a lower level transport is acceptable and sufficient for their medical condition. If the recipient agrees to the lower level, then that transport will be authorized by the NET broker. ~~without intervention from the Medicaid District Office.~~
    - c. If the recipient does not believe the lower level transport is appropriate or acceptable, then they will be referred to ~~the Medicaid District Office~~ the public paratransit services agency for a level of service needs evaluation.

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If the recipient resides outside the parameter of a paratransit agency, the NET broker will provide transportation to and from the recipient's primary care physician (PCP) at the level of service requested. The PCP will provide documentation and/or a NET broker form that will identify the correct level of transportation service based on the recipient's medical needs.

- d. If the recipient has ~~not~~ been authorized for NET, and has been assessed by the public paratransit service, the Regional Transportation Commission (RTC) has 21 days to notify the recipient of the results of the assessment. Until the assessment has been reviewed and submitted to the recipient, the transportation broker will continue to provide transportation at the level of service requested by the recipient. In the event the recipient has been denied the use of paratransit services, and is now receiving a lower level of transportation service than requested, the recipient must inform the transportation broker of their dissatisfaction, if applicable, with the level of service assigned. The transportation broker will then review the assessment as well as the recipient's medical documents and determine if the recipient is eligible for the broker's paratransit or curb-to-curb services. The transportation broker will notify the recipient of their determination within 48 hours of review. If the decision negatively impacts the recipient, the transportation broker will also provide the recipient with the broker will, within 48 hours, mail the recipient an application form for NET assessment by the Medicaid District Office and refer the recipient to the Medicaid agency NET contact, who will schedule an assessment. a Notice of Decision (NOD).
- e. If the recipient requests a hearing, ~~U~~ntil the higher level of transportation is either approved or denied by the ~~Medicaid District Office~~ State Fair Hearing process, the NET broker will provide rides at the requested level of service.
- f. The NET broker will maintain a list of all assessment referrals sent to the paratransit service agencies and will provide a copy of new listings to the Medicaid District Office's daily.
- g. ~~The Medicaid District Office will maintain a list of all assessments and the level of transportation that has been authorized. The Medicaid District~~

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~~Office will provide the NET broker with written documentation regarding the recipient's authorization status and level of service.~~

- ~~h. The reports of member requests/assessments that are exchanged between the Medicaid District Office and the NET broker must include enough information for the recipient to be easily identified, and it should clearly indicate which Medicaid District Office is responsible for the assessment. This may be as simple as "Las Vegas District Office" and "Other District Office".~~
- ~~g. i.——If the NET broker believes that a recipient is receiving unnecessarily expensive transportation, and that it is unlikely their Medicaid District Office assessment will qualify them for this method of transportation, then the broker is expected to contact the appropriate Medicaid District Office and ask for that assessment to be given a high priority conduct a reassessment to determine the correct level of transportation needed.~~
- ~~h. j.——When recipients contact the NET broker requesting a ride, they will be screened for prior authorization and will **only** be permitted to ride within the level of service authorized.~~
- ~~i. k.——If the recipient requires NET prior to the time of the assessment including a ride to the Medicaid District Office assessment paratransit service agency for an or to a paratransit assessment, the NET broker will authorize the rides at the level requested. Rides to medical services require documentation that there is a medical necessity to receive services prior to the time the assessment is scheduled.~~
1. Recipients within the service areas of Clark County, Washoe County, and Carson City's public transit systems and who require transportation above the level of fixed route, must receive an assessment disqualifying them from public paratransit prior to being authorized for a higher level of service.
- a.2. Once a recipient has been referred to the Pparatransit service agency for an assessment, the recipient has five (5) days in which to contact the Pparatransit service agency to schedule an assessment. The Pparatransit service agency has up to 45 days to complete an assessment. The level of service requested by the recipient will be provided until an assessment has been completed. Failure to complete the Pparatransit assessment within 45 days will result in the recipient being placed on a fixed route bus service for

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all NET ~~transportation~~, unless the recipient can show in writing, that ~~P~~paratransit service agency was unable to complete an assessment within the 45 days.

- h.j. Recipients may be authorized for mileage reimbursement or private commercial transportation in addition to use of public transit if, ~~they must travel outside during the assessment, they demonstrate a medical necessity to travel outside~~ the public transit system service area to access the nearest appropriate provider.
  - k. ~~n.~~ For authorization other than the public transit, the NET ~~B~~broker will ~~supply explicitly state~~ the name of the provider, the provider's location, ~~the medical condition, the treatment,~~ and the frequency of the transit that the recipient is permitted, ~~to the transportation company.~~
  - ~~o.~~ ~~When the Medicaid District Office has completed the NET assessment, the assessor will determine the level of service for qualified recipients to access NET.~~
  - l. ~~p.~~ Recipients who submit evidence from an assessment showing they do not qualify for public paratransit may be qualified for a higher level of service.
  - m. ~~q.~~ The ~~Medicaid District Office will provide the~~ NET broker will provide with written documentation ~~regarding to~~ the recipient's ~~regarding the recipient's~~ authorization status and level of service.
2. If the recipient ~~states provides evidence~~ that they are unable to ride at the level of service assigned due to a significant change in condition or circumstance, the recipient will be ~~referred to the Medicaid District Office for re-evaluation. This referral will include a verbal explanation of the process accompanied by the mailing of an application form for a NET assignment re-evaluated by the broker who may direct the recipient to the RTC for an assessment.~~
- a. Recipients contesting their assessed level of service will ~~not~~ be authorized NET at the requested level, pending an evaluation. ~~provided with NET at a higher service level prior to reassessment unless they can provide medical evidence that inability to access medical care during the re-evaluation period will result in serious exacerbation of their medical condition or unacceptable risk to their general health. Recipients will not be provided the higher level of NET for routine medical appointments.~~

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- b. Recipients are required to ride the least expensive transport within a level of service and will not be placed on a higher cost transport because of personal preference or convenience.
  - c. Recipients may be reassessed for a greater level of service if ~~they can document a significant change in their condition or circumstance or demonstrate that~~ they no longer have access to the assigned transportation level of service.
- D. A ~~Legally Responsible Individual (LRI)~~ who is unable to provide transportation for a recipient to obtain medical services, may request ~~assistance with transportation to a covered medical service~~ on behalf of an eligible recipient, ~~from the NET broker in the event the recipient is unable to submit a request to the NET broker for his or her own travel.~~
- E. The NET broker must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider and/or the ~~DHCFP Medicaid District Office~~ when appropriate.
- F. The NET broker and the ~~DHCFP Medicaid District Office~~ must provide standard authorization decisions within reasonable ~~timeliness frames~~. If the broker determines, or a provider indicates, ~~that~~ the standard service authorization timeframe could seriously jeopardize the recipient's condition or circumstance, the NET broker must make an expedited authorization decision and provide notice as expeditiously as the recipient's health condition requires.

1904.2 COVERAGE AND LIMITATIONS

- A. NET for Medicaid eligible ~~program~~ recipients to and from ~~Medicaid~~~~DHCFP~~ medical providers ~~offer~~ covered medically necessary services is provided under the following terms:
- 1. The recipient is unable to provide his/her own transportation:
    - a. Free Transportation: Recipients must use free transportation when it is available. Free transportation ~~is available when a vehicle is registered to the recipient or a LRI where the recipient lives and the recipient or LRI is able and capable of providing transportation~~ includes, but is not limited to, when the recipient is able and capable of providing their own transportation or when an LRI, another individual or an agency is willing to provided transportation to the recipient to obtain eligible Medicaid services.

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~~b. Recipients or LRIs must provide documentation to demonstrate that they are unable or incapable of providing transportation to a recipient.~~

b. The NET broker may not deny transportation to a Medicaid recipient based on an LRI's unwillingness to provide transportation.

c. Recipients should make every reasonable effort to find day care for their children when they use non-emergency transportation services; however, this may not always be possible. When appropriate care for a child cannot be obtained, the child may accompany the recipient. The broker must provide bus tickets for minor children unless the child is able to accompany the recipient at no additional cost. More than one child may accompany the recipient if the transportation provider is notified in advance. This provision abides by the intent of 42 CFR 440.170.

2. The least expensive form of transportation is utilized in accordance with the recipient's medical condition and needs:.

Public Transit: Recipients who do not have free transportation available and live within the service area of the Clark County, Washoe County, or Carson City public transit systems must use public transit where possible and cost-effective.

a. Recipients are deemed to live within the public transit system service area when they reside within three quarters (3/4) mile of a transit stop. If the recipient qualifies for public paratransit service and this is available in the area where the recipient resides, the recipient is deemed to live within the public transit area, whether or not the recipient resides within three quarters (3/4) mile of the transit stop.

b. Recipient's who do not have free transportation available must ride fixed-route public transit unless they reside outside the service area; or their medical appointment is outside of the service area; they are assessed to be medically unable to board, disembark, or ride buses; or public transit buses cannot accommodate the recipient's wheelchair or other medical equipment that must accompany the recipient in transit.

c. Recipients who reside within the service area of the public transit system and are assessed to be unable to ride fixed-route buses will be referred for assessment for public paratransit services. If qualified for public paratransit services, the recipient will be ~~qualified~~ required to ride only public transit services, unless traveling to a destination that is outside the public transit system service area. If traveling outside of the paratransit service area, the recipient's transport must be authorized by the NET broker.

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d. A recipient who requires frequent travel on fixed route transit ~~or public paratransit~~ will be provided with a multiple-ride pass, ~~where~~ when this is cost effective. Recipients who are issued passes by the NET broker may use them for purposes other than accessing medical services, as long as this does not incur additional costs to the Medicaid program.

1. If a recipient who is qualified for public transit level of service requires transport to a medical appointment that is not accessible by public transit, the recipient must receive specific authorization for the transport from the NET broker, who will require evidence of medical necessity for the trip and verify that the recipient is accessing the nearest appropriate provider. **Recipients have freedom of choice when selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider. The nearest health care provider or facility is not always the most appropriate. The NET broker should consider existing relationships between the recipient and their medical provider, or appointment availability, when the provider is within a reasonable distance. The DHCFP will assist the NET broker in making these decisions.** The NET broker will assign the recipient to ride with the least expensive transportation provider available.

~~b.~~2. Recipients are required to comply with all policy and rules of the public transit system. Recipients who are suspended from service by public transit agencies because of recipient misbehavior, persistent no-shows, or failure to cancel rides in a timely manner are ineligible for other NET services unless they can provide medical evidence that **their** inability to access medical care during the suspension period will result in serious exacerbation of their medical condition or **pose an** unacceptable risk to their general health. Recipients who have been suspended will not be provided NET for routine medical appointments. Recipients who have been suspended must exhaust the public transit system appeal process before being assessed for another level of service. Recipients who are suspended indefinitely from public transit will be suspended indefinitely from access to NET, except in cases where they can provide medical evidence that **their** inability to access medical care will result in serious exacerbation of their medical condition or **pose an** unacceptable risk to their general health.

3. **Mileage Reimbursement:** under certain circumstances, recipients, their LRI or volunteer drivers may receive mileage reimbursement for driving a recipient to medical services.

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- a. Recipients assigned to ride only free transportation or their LRIs may be authorized to receive mileage reimbursement ~~if traveling more than 25 miles one-way to access medical services or more than 50 miles in one week. Reimbursement~~ if traveling to access medical services. Compensation will be at the ~~Internal Revenue Service (IRS)~~ rate for medical/moving mileage reimbursement ~~and will be calculated starting at the 26<sup>th</sup> or 50<sup>th</sup> mile, respectively.~~
- b. Recipients who are assigned to public fixed-route transit or paratransit may receive mileage reimbursement if they are traveling outside the transit system service area and mileage reimbursement is the least expensive mode of transportation.
- c. Volunteer drivers (private citizens who do not contract with the NET broker) who are not LRIs, nonprofit organizations, or ~~HHS~~ Indian Health Programs may receive mileage reimbursement for driving a recipient~~s~~ to medical services, ~~where~~ ~~when~~ this is the least expensive mode of transportation. Friends, families and neighbors may fall into this category. Reimbursement will be at twice the current IRS rate for medical/moving mileage reimbursement, as found on the IRS website at <http://www.irs.gov>. Mileage reimbursement is provided to the driver for the vehicle's miles actually driven from the point of where a recipient has been picked up and does not exceed twice the IRS medical/moving rate ~~unless a different rate is negotiated by the NET broker due to limited transportation availability and cost effectiveness.~~ In cases of disputes over actual mileage, MapQuest or other geo-mapping software will be used as the final determining factor.
- d. Recipients must have prior authorization ~~to receive from the NET broker services~~ for drivers to be eligible for mileage reimbursement.
- ~~e. The destination utilizes the nearest appropriate Medicaid health care provider or medical facility. Recipients have freedom of choice when~~

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~~selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider.~~  
~~f. Prior authorization has been obtained from the contracted NET broker.~~

B. Eligibility

The eligibility functions for Title XIX Medicaid ~~recipients-determinations~~ are the responsibility of the Division of Welfare and Supportive Services (DWSS).

~~The eligibility functions for the Title XXI NCU recipients are the responsibility of the DHCFP.~~

Title XXI NCU recipients are not eligible for NET services.

Title XIX recipients who are Medicaid eligible solely for the purpose of payment of Medicare premiums, co-insurance, deductibles, or co-pays i.e., Qualified Medicare Beneficiaries (QMB's), Specified Low Income Medicare Beneficiaries (SLMB's), ~~and~~ Qualified Individuals (QI-1s), ~~and~~ "not qualified" non-citizens are not eligible for NET services. Residents of skilled nursing facilities ~~(Medical Assistance to the Aged, Blind and Disabled (MAABD) Institutional and County Indigent eligibility categories)~~ are not eligible to receive NET services. ~~Medically necessary~~ are entitled to NET services through the facility; NET costs are included in the nursing facilities' rate structures. Other Title XIX recipients are eligible for NET services in order to access medically necessary covered services.

Medicaid recipients are eligible for NET services only from the date of determination forward. No payment will be made for NET provided while a recipient's Medicaid application ~~was~~ is pending. Retroactive eligibility does not apply to NET services.

Special payment arrangements may be made with the NET broker for special circumstances where it is in the best interest of the DHCFP to provide NET transportation to certain Medicaid recipients. These decisions will be made exclusively by the DHCFP; however the payment rate will be determined mutually by the DHCFP and the NET broker. ~~One example is the transfer of the resident from one skilled nursing facility to another skilled nursing facility where the two parties agree to a cost plus payment arrangement. Similarly, if~~ the DHCFP decides to 'carve out' an eligibility group from non-emergency transportation they may contract ~~with the NET broker~~ to provide service on an individual basis at a cost plus payment model.

C. Examples of circumstances for which NET will be provided to eligible recipients include, ~~but are not limited to the following:~~

1. A transplant candidate to be evaluated for services not available in Nevada;

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~~2. A recipient who is being admitted to an out-of-state nursing facility. When a recipient is being admitted to an out-of-state nursing facility, the discharging facility must contact the DHCFP out-of-state coordinator for authorization prior to the admission. Please refer to the MSM Chapter 500;~~

- ~~2.~~ 3. The transport from an acute general hospital to an acute psychiatric hospital; ~~and~~
- ~~3.~~ 4. Transportation to/from a routine Medicaid-reimbursable medical or dental appointment;
- ~~4.~~ Transportation to an urgent care clinic; and
- ~~5.~~ Transportation to/from pharmacies for medical necessities.

Each of these examples assume that the **LOC level of care** required during transit does not exceed the scope of services of an EMT-Basic and that required timeframes allow the NET broker to make appropriate arrangements.

D. The NET broker must allow **at least** one escort, who must be **at least a minimum of 18** years of age (or any age if the escort is the parent of a minor child) to accompany a recipient or group of recipients when escort services are determined medically necessary; ~~or~~ **for those recipients who are minor children; or for individuals that have been adjudicated incompetent.** A Medicaid recipient who is physically disabled or developmentally disabled may be authorized to be accompanied by an escort(s) during the assessment to access NET services. A person under the age of 18 must be accompanied by one escort unless that person is married, legally emancipated, or obtaining family planning services **and/or family planning products.**

- ~~1.~~ During the ~~Medicaid District Office~~ NET assessment, the assessor **or a physician's statement** will determine whether the recipient requires an escort(s) and specify the circumstances under which an escort(s) may accompany the recipient while ~~riding-utilizing NET services at the time of the assessment.~~

E. The NET broker **will cover the costs of an escort(s) to accompany the recipient, if necessary, including the expense of the escort's transportation, lodging and up to three (3) meals per day while they are in a travel status during typical meal times.** ~~may not charge for transport of an escort when the services of the escort are required for a minor child or when the services of the escort are determined to be medically necessary.~~ Escort travel is a covered expense during the transport of the recipient to a medical facility; while the recipient is receiving medical services and during the return transport to the escort's/recipient's residence. Should the recipient be detained for further treatment, NET services will continue to be provided to the escort(s).

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F. NET services may not be authorized for minor children unless a parent (regardless of the parent's age) or LRI accompanies the child. Exceptions include but are not limited to:

1. A minor child transported for the purpose of obtaining family planning services and/or products.
2. If a delay of Aa minor child transported from one facility to another for treatment is medically detrimental, and the parent or LRI is not available, Aa Consent and Release of Liability form must always be signed by the parent or LRI facility case worker prior to the transport.
3. ~~A minor child with a mental disability receiving NET to a facility by ambulance where a paramedic or EMT is present and, per the judgment of appropriate medical personnel, it would be detrimental to the child if the parent or LRI is present in the vehicle. A Consent and Release of Liability form must be signed by the parent or LRI prior to the transport.~~ Other specific exceptions may be made on a case by case basis by the DHCFP.

In addition and pursuant to Nevada MSM Chapter 3500, an escort(s) services are is available to accompany a recipients who requires approved Ppersonal Ccare Sservices (PCS) ein route to, or at, a destination to obtain Nevada Medicaid covered, medically necessary services when an LRI is unable to accompany them. An escort(s) may be a parent or legal guardian, caretaker, LRI, friend or a Ppersonal Ccare Aattendant (PCA) who accompanies the recipient.

~~Pursuant to 42 CFR 440.250 and the Nevada State Plan, Aan adoptive parent under the auspices of an Adoption Assistance Program (AAP) agreement and or a foster parent of a program eligible child are is reimbursed for any travel expenses incurred when obtaining Medicaid eligible medical services for a foster/adopted child such as mileage (utilizing the IRS rate for medical/moving mileage reimbursement), transportation, meals, and lodging through the NET broker, up to GSA rates.pursuant to the NET broker's guidelines for the costs of transporting children in out of home placement to medically necessary covered services. Foster and adoptive parents are required to demonstrate a need for public assistance with transportation.~~ The agency thatholding maintains custody of a foster child or the adoptive/foster parents must coordinate the medical transportation services through the NET broker.

G. ~~F.~~ Pursuant to federal regulations, eligible FFS program recipients may obtain covered medically necessary services, with limitations, from any facility, pharmacy, physician, therapist, agency or provider participating under a signed agreement with Nevada Medicaid. Eligible MCO enrollees may obtain covered medically necessary services from a provider who is a member of a contracted MCO's network of providers

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or from a provider who has an agreement with a contracted MCO to provide services to a recipient as an out-of-network provider.

- H.** ~~G.~~—In those situations in which a recipient has requested out-of-town or out-of-state covered medical services which are determined to be available in the recipient’s community, a referral and justification by the local primary care provider is first required. This referral must then be authorized by the DHCFP’s ~~QIO-like vendor or contracted FFS fiscal agent or the contracted~~ MCO before the NET broker may authorize services. ~~depending on unique circumstances.~~ NET services will not be authorized in those instances in which a recipient has requested out-of-town and/or out-of-state medical services until such time as the NET broker can confirm that authorization and justification for such services has been obtained.

The same provision applies to FFS ~~or MCO~~ recipients who wish to utilize a health care provider or medical facility that is located within the boundaries of his/her city but is not the nearest appropriate health care resource.

- I.** Out-of-Area and Air Travel: Recipients may be eligible to receive NET for out-of-town, out-of-state or airline travel if certain conditions are met.
1. Recipients must receive prior authorization for out-of-area medical services from the DHCFP’s ~~utilization management fiscal~~ agent or their MCO prior to requesting authorization for transportation.
  - ~~2. Recipients are only eligible for NET to out-of-area services if no comparable services are available in the area.~~
  2. Recipients must request authorization for out-of-area and airline NET a minimum of 14 days prior to the travel date.
    - a. Exceptions to the 14 calendar day requirement may be granted if the recipient has a medical necessity to travel and could not have known 14 days in advance, as in the case of a donor organ becoming available for a transplant surgery that must occur out of the area.
    - b. Exceptions to the 14 day requirement ~~may will~~ be granted for recipients who are discharged to or from an out-of-area acute-care facility; ~~or an out-of-state nursing facility; or otherwise detained in a juvenile detention facility.~~
    - c. Other exceptions may be granted from time to time if they are in the best financial interest of the State.

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3. ~~4.~~—Recipients are required to travel by the least expensive mode of transportation available that will accommodate their medical requirements.
4. ~~5.~~—Recipients are required to make use of any low-cost accommodations available for out-of-area travel, such as Ronald McDonald houses, and will not be authorized or reimbursed for higher costs unless the recipient can demonstrate to the NET broker that the low-cost accommodations in the area were unavailable at the time the recipient required them.
5. ~~6.~~—Recipients may incur higher costs for accommodations if they demonstrate that this will reduce the overall cost of out-of-area travel.
6. ~~7.~~—Out-of-area costs for lodging, meals, and other necessary items are reimbursed by the NET broker in accordance with the current ~~DHCFP travel policy with the GSA rates with the following~~ exceptions: ~~Transportation, including of mileage, which is reimbursed-compensated~~ according to the terms of this Chapter. For all ~~reimbursement-except travel expenses excluding~~ mileage, the recipient, ~~escort(s) and live organ donor will be~~ is reimbursed at actual costs up to limits set by ~~DHCFP travel policy the GSA and~~ ~~†~~The recipient, ~~or~~ escort(s), ~~and/or donor~~ must submit receipts documenting expenditures to the NET broker if ~~receive-requesting~~ reimbursement. ~~When †Two parents may accompany a child under threetwelve (12) months old, and they will receive a single reimbursement for lodging. Each parent will not receive an individual reimbursement.~~ Meals will be reimbursed for both parents.
7. ~~8.~~—Recipients and their escorts are not reimbursed for the cost of meals if free meals are available at meal time.
8. ~~9.~~—Recipients must submit their request for reimbursement within 60 calendar days after completing the out-of-area trip.
9. ~~10.~~—Recipients who have recurring requirements to receive out-of-area trips for a single treatment or multiple treatments for the same diagnoses, may have ~~up to five multiple~~ trips a month authorized but no more than five (5) trips may be authorized at ~~the one same time. for mileage reimbursement only.~~

H.J. Transportation services and per diem are covered for new parent(s) to care for a newborn ~~up to 3 less than twelve (12) months of age receiving treatment on an inpatient basis in a facility. This transportation may be authorized when needed to encourage bonding between parent and child, and to promote confidence in the ability to care for the newborn.~~

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**K.** ~~J.~~—NET services may be authorized for a recipient residing in an inpatient treatment facility to allow the resident to attend a therapeutic home visit, in-state or out-of-state, when such visits are part of the resident’s treatment plan. It is the responsibility of the inpatient treatment facility to obtain transportation for eligible recipients for all therapeutic home visits by calling the NET broker. NET services are not available to family members to visit a recipient residing in an inpatient treatment facility. The NET broker may authorize NET services for therapeutic home visits within the following criteria:

1. Acute care:

The ~~QIO-like vendor~~-DHCFP’s fiscal agent must prior authorize absences beyond eight hours. No prior authorization is required for absences of less than eight hours in duration; per MSM Chapter 400.

2. Acute rehabilitation:

The ~~QIO-like vendor~~-DHCFP’s fiscal agent must authorize all absences, per MSM Chapter 400;.

3. Intermediate Care Facility for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities (ICF/IID):

~~At the facility’s request, a maximum 24 days per calendar year is allowed for therapeutic leaves of absence;~~Transportation must fall within the maximum allowable therapeutic leave requests which are described in MSM Chapter 1600.

4. Residential Treatment Center:

At the facility’s request and as ordered by the attending physician, a maximum of three (3) 72 hour home therapeutic passes per calendar year is allowed. Please refer to MSM Chapter 400, ~~Mental Health and Alcohol/Substance Abuse Services.~~

~~5.—Residential Group Care:~~

~~A maximum of 25 days per calendar year is allowed for therapeutic home passes. Duration of each pass may be no more than 72 hours.~~

**L.** ~~K.~~—Per 42 CFR 440.170, the costs of meals and lodging may also be covered for ~~one more than one attendant~~ escort, if ~~more than one an attendant~~ escort is required to ensure that the recipient receives required medical services. As noted in Section 19034.2AE (8) above, the cost of meals and lodging may be covered for two ~~attendants~~-parents when

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~~those attendants are~~ they ~~parents~~ are seeking medical services for ~~of~~ a child ~~under three~~ (~~3~~) less than twelve (12) months of age. Costs of meals and lodging for an ~~attendant/attendants~~ ~~escort(s)~~ will be covered when traveling to and from services or while the recipient is receiving medical care when such travel requires the ~~attendant/attendants~~ ~~escort(s)~~ to be away from their legal or primary residence over night or as long as medically necessary. Costs will not exceed a per diem rate set forth ~~in~~ ~~DHCFP policy~~ by GSA rates.

M. If the recipient has already reserved lodging and unforeseen circumstances arise that result in the unavoidable cancellation of the approved trip, then the recipient may request reimbursement of any charges incurred as a result of the cancelled lodging. The recipient must submit documentation to the NET broker demonstrating why the cancellation was unavoidable. The recipient must make a good faith effort to avoid unnecessary cancellation charges. Disputes must be provided to the DHCFP for final determination.

~~K.N.~~ Eligible program recipients who live out-of-state may obtain NET services similarly to those eligible recipients who reside within the State of Nevada. Such out-of-state recipients may include foster children, children placed in an adoptive home under the auspices of an Adoption Assistance Program (AAP) agreement, or children in ~~R~~esidential ~~T~~reatment ~~C~~enters (RTCs). Authorization of NET services for eligible recipients residing out-of-state is the same as for those eligible recipients who reside within Nevada.

O. ~~M.~~—Nevada residents living near the state line or border may be geographically closer to out-of-state providers than to in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the DHCFP refers to as the “primary catchment areas.” Such services are treated the same as those provided within the state borders for purposes of authorization and transportation.

The primary catchment areas are listed in the MSM Chapter 100., ~~Medicaid Program:~~

P. ~~N.~~—Several tribes and/or ~~IHS~~ Indian Health Programs ~~services~~ offer ambulance and/or van services for both emergency and NET. Community ~~H~~health ~~R~~epresentatives (CHRS) may provide NET services to recipients who are eligible for NET services in private vehicles to medically necessary covered services and are reimbursed at a per mile rate that is double the IRS medical/moving mileage rate. The Indian Health Programs’ ~~IHS~~ NET services do not require prior authorization. All ~~IHS~~ claims for reimbursement by the Indian Health Programs for non-emergency transportation services are submitted to the NET broker for adjudication and payment.

~~N.Q.~~ If a recipient is transferred to/from an out of state nursing facility or ~~Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/MRIID)~~ facility during a month

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where they were eligible for NET, and capitation was paid for them, then that transfer is a covered benefit. If the transfer happens in a month after their initial admission, where no capitation has been paid, then the NET broker will arrange the transportation and will be reimbursed on the mutually agreed upon cost plus payment model.

~~Ø.R.~~ Medicaid and NCU funds may not be used to pay for transportation services that are otherwise available without charge to both Medicaid and non-Medicaid recipients. In addition, Medicaid is generally the payor of last resort except for certain Federal programs such as Title V Maternal and Child Health Block Grant funded services or special education related health services funded under the Individuals with Disabilities Education Act (IDEA).

~~P.S.~~ The following are non-covered NET services:

1. When one or more eligible recipients make the same trip in a private vehicle or van, reimbursement is made for only one recipient;
2. Transportation to or from any non-covered service; ~~except for exclusion due to Third Party Liability (TPL) coverage under the Medicaid program;~~
3. Travel to visit a recipient in an inpatient treatment facility, except in the case of a parent or parents visiting a newborn that is in a facility ~~[(see 19034.21A)-(6)];~~
4. Transportation between hospitals for outpatient or inpatient care or services (e.g., MRI, CAT scan, etc.); exceptions may be granted when services to treat the recipient's condition are not available at the originating hospital and/or are not part of the all-inclusive prospective rate; ~~or if the recipient is transferring to a hospital closer to home following an out-of-area hospital stay;~~
- 5.4. "Deadheading," this refers to a provider's return trip when the eligible recipient travels only one way of a two-way trip;
- 6.5. The cost of renting an automobile for private vehicle transport;
- 7.6. A non-transport charge for a recipient who did not show up for their scheduled ride;
- 8.7. Wages or salary for ~~attendants~~ escort(s);
- 9.8. Charges for waiting time, stairs, plane loading; ~~and/or~~
- 10.9. Routine or special supplies including: oxygen; Special services such as: defibrillation; IVs; intubation; ~~or ECG monitoring;~~ ~~or extra attendant;~~ ~~or, air~~

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~~transport-exercise-tax~~; Recipients requiring any type of medical care, medical supervision, physical monitoring, attachment to medical intravenous therapy, EMT-intermediate or paramedic services, etc. during transport, are not eligible for non-emergency transportation.

10. ~~11.~~—Transportation of a recipient in a personal care attendant’s private vehicle is not a reimbursable service;
- ~~9.11.~~ Transportation from a nursing facility to a medical appointment; and
- ~~10.12.~~ ~~Stretcher, b~~Basic life support (BLS), and advanced life support (ALS) transports. ~~are beyond the scope of NET broker and are not NET broker covered services.~~

Stretcher is a covered NET service. Claims for stretcher transport should be submitted to the ~~State~~ DHCFP’s fiscal agent.

#### 1904.3 NET BROKER RESPONSIBILITY

- A. The NET broker provides all or most services ancillary to transporting Medicaid recipients, but provides transportation only through subcontracting or non-contract arrangements with third parties.
  1. ~~The~~ NET broker shall not hold ownership in any NET provider with whom the broker sub-contracts or arranges NET through, ~~as a non-contractual relationship. This prohibition applies to the corporation, if the broker is incorporated, and to owners, officers, or employees of the broker.~~
  2. The broker will submit all subcontracts or other documentation pertaining to the terms and conditions for ~~the~~ provision of NET services by third parties to ~~the~~ DHCFP for approval.
  3. The broker shall advise ~~the~~ DHCFP in writing of all financial relationships and transactions between itself and ~~a~~ NET providers (for instance, loans, grants, etc.) that are not included in the NET instrument, specifying the nature of the relationship and the terms and conditions governing ~~it~~them. Such relationships and transactions are not permitted without written approval of the DHCFP administrator.
  4. ~~The NET broker will work cooperatively with the DHCFP and the Regional Transportation Center for handling ride cancellations.~~
- B. Commercial Transportation Vendors: The NET broker may subcontract with various private vendors to provide transportation to Medicaid recipients.

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1. The NET broker shall directly facilitate transportation for recipients requiring bus ~~passtickets~~, public paratransit and mileage reimbursement. Recipients who request higher levels of service will need to be assessed for ~~the~~ level of service by the ~~Medicaid District Office~~ NET broker, and if necessary, the appropriate paratransit services agency.
2. Recipients may not be assigned to ride with a commercial vendor if they have been prior authorized for a lesser level of service, unless the authorized level of service does not provide access to necessary medical care that complies fully with Medicaid's NET policy. For instance, if a recipient is authorized for a bus ~~passticket~~, but the bus does not pass within 3/4 of a mile of the provider's office, then the NET broker may authorize a higher level of transportation.
3. Recipients must be assigned to the least expensive commercial vendor who provides the level of service and geographic access required.
4. Where there is public transit available in a rural county, and that provider is capable of offering the level of service required by the recipient, commercial vendors may not be used for the convenience of the recipient or the NET broker.
- ~~5. Recipients may not be assigned to higher level of service than they are authorized by the assessment to use because the lower level of service is unavailable at the time of the medical appointment unless the recipient provides documentation that inability to access medical care at the appointed time will result in serious exacerbation of their medical condition or unacceptable risk to their general health.~~
- ~~6. When the recipient is authorized for use of commercial vendors, the Medicaid District Office will stipulate the maximum level of service that the recipient is authorized to access.~~

- C. Using monthly enrollment downloads from the DHCFP or systems maintained by the DHCFP's ~~QIO-like vendor~~ fiscal agent, the NET broker is solely responsible for verifying program eligibility for each recipient prior to authorizing and scheduling the NET service. The NET broker must also verify the existence of an appointment and that the appointment is a Medicaid covered service, which may require contacting the health care provider, the DHCFP's ~~QIO-like vendor~~ fiscal agent, or the contracted MCO, before authorizing transportation.
- D. Neither the NET broker nor its providers shall release information related to a recipient without the written consent of the recipient or the recipient's legal or authorized representative, except as required by law or except to verify medical appointments in accordance with policy. The NET broker and any of its providers meeting the definition

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of a “covered entity” as defined in the HIPAA Privacy Regulations (45 CFR 1604) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

- E. The DHCFP expects that the NET broker and its provider network will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable, in accordance with NRS 200.508 and 200.509-1.
- ~~F.~~ Pursuant to 42 CFR 438.100(c), the NET broker shall ensure that each recipient is free to exercise his or her rights and that by the exercise of those rights, no adverse affect will result in the way the NET broker treats the recipient.
- F. Recipients have freedom of choice when selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider **(taking existing relationships between the providers and recipients into account as well as access to care) according to section 1904.2A (2d) of this chapter.**
1. The NET broker will be responsible for verifying that the recipient is using the nearest **appropriate** Medicaid provider for the applicable services.
  2. The NET broker will develop written procedures, approved by DHCFP for verifying that the nearest **appropriate** Medicaid provider is being used.
  3. The procedures shall include an exception procedure that specifies the conditions under which the recipient may access a provider other than the nearest, if exception to the requirement might, in some cases, be appropriate.
  - ~~4. The recipient must use the nearest appropriate provider when utilizing NET. Referral by a physician to a provider who is not the nearest appropriate provider is not an authorized exception to the nearest appropriate provider requirement. The NET broker procedure will include a requirement that exceptions to the nearest appropriate provider requirement include a written justification that can be provided to DHCFP upon request.~~
  4. ~~5.~~ The DHCFP will provide the NET broker with a **quarterly** list of Medicaid providers and their addresses, including ~~fee for service—FFS~~ providers and providers within each **HMCO**’s network ~~quarterly~~.
  5. ~~6.~~ DHCFP will periodically review rides to verify that the NET broker has transported to the nearest appropriate provider.
  6. ~~7.~~ **Whenre** the DHCFP determines that a recipient has employed NET to access a provider other than the provider located nearest to the recipient’s

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residence and there is no justification documented, the NET broker ~~will~~ **may be required to** refund the capitation payment for that recipient for all months that the recipient accessed a geographically inappropriate provider.

- G.** ~~H.~~—A transportation provider must wait at least ~~ten~~ **fifteen (15)** minutes after the scheduled pick-up time before “no-showing” the recipient at the pick-up location. The NET broker or contracted transportation providers shall not charge recipients for transportation services or for no shows.
- H.** ~~I.~~—Recipients who are repeated no-shows or fail to cancel in a timely manner for rides provided by its commercial vendors may be subject to suspensions of services. Recipients who receive a suspension will have the right ~~of~~ **a State Fair Hearing**.
- I.** ~~J.~~—Access to transportation services shall be at least comparable to transportation resources available to the general public. Capacity shall include all of the modes of transportation listed in Section 1904 of this chapter.
- J.** ~~K.~~—The NET broker shall ensure all drivers of vehicles transporting program recipients meet the following requirements:
1. All drivers, at all times during their employment, shall be at least 18 years of age ~~(NRS 450B.180)~~ and have a current valid driver’s license from the State of Nevada to operate the transportation vehicle to which they are assigned.
  2. Drivers shall have no more than one chargeable accident and two moving violations in the last three years. Drivers shall not have had their driver’s license, commercial or other, suspended or revoked in the previous five years. Drivers shall not have any prior convictions for substance abuse, sexual abuse or crime of violence. Approval of any such driver who has been convicted of a felony shall be obtained from the DHCFP before employment by the vendor.
  3. All drivers shall be courteous, patient and helpful to all passengers and be neat and clean in appearance.
  4. No driver or attendant shall use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time. The transportation provider shall not use drivers who are known abusers of alcohol or known consumers of narcotics or drugs/medications that would endanger the safety of recipients.
  5. All drivers and attendants shall wear or have visible, easily readable proper organization identification.

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6. At no time shall drivers or attendants smoke while in the vehicle, while involved in recipient assistance, or in the presence of any recipient.
7. Drivers shall not wear any type of headphones or use cell phones, except for dispatch purposes, at any time while on duty. Drivers shall not use cell phones while operating vehicles.
8. Drivers shall assist passengers in the process of being seated and confirm that all seat belts are fastened properly and ~~that~~ wheelchairs and wheelchair passengers are properly secured.
9. Drivers shall provide necessary assistance, support, and oral directions to passengers. Such assistance shall include assistance with recipients of limited mobility, and movement, ~~and including the~~ storage of mobility aids and wheelchairs.
10. The NET broker shall provide, or ensure that its subcontractors provide, classroom and behind-the-wheel training for all drivers within 30 days of beginning service under this agreement. Driver training shall, at a minimum, include defensive driving techniques, wheelchair securement and lift operation, cultural and disability sensitivity training, passenger assistance techniques, first aid, and general customer service. The training curriculum is subject to ~~the~~ DHCFP's approval.

~~L.~~ **K.** The NET broker shall ensure that all transportation providers maintain all vehicles adequately to meet the requirements of the contract. Vehicles and all components shall comply with or exceed State, Federal, and ~~the~~ manufacturer's safety, ~~and~~-mechanical, ~~operating~~ and maintenance standards for the vehicles. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations. All vehicles shall meet the following requirements:

1. The transportation provider shall provide and use a two-way communication system linking all vehicles used in delivering the services under the contract with the transportation provider's major place of business. Pagers are not an acceptable substitute.
2. All vehicles shall be equipped with adequate heating and air-conditioning.
3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position when required by law. Each vehicle shall utilize child safety seats when transporting children as prescribed by NRS ~~484B.157~~.
4. All vehicles shall have a functioning speedometer and odometer.

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5. All vehicles shall have two (2) exterior ~~rear~~ side view mirrors, one on each side of the vehicle.
6. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.
7. The interior and exterior of the vehicle shall be clean and the exterior free of broken mirrors or windows, excessive grime, major dents or paint damage that detract from the overall appearance of the vehicles.
8. The vehicle shall have passenger compartments that are clean, free from torn upholstery, ~~or~~ floor, or ceiling covering;; damaged or broken seats;; protruding sharp edges; and ~~shall also~~ be free of dirt, oil, grease or litter.
9. All vehicles shall have the transportation provider's name, vehicle number, and the NET broker's toll free and local phone number prominently placed within the interior of each vehicle. This information and the complaint procedures shall be available in written form in each vehicle for distribution to recipients on request.
10. Smoking is prohibited in all vehicles while transporting program recipients. All vehicles shall have the following signs posted in all vehicle interiors, easily visible to the passengers:

"NO SMOKING"

"ALL PASSENGERS MUST USE SEAT BELTS"

11. All vehicles shall include a vehicle information packet containing vehicle registration, insurance card and accident procedures and forms.
12. All vehicles shall be provided with a fully equipped first aid kit.
13. Each vehicle shall contain a current map of the applicable ~~S~~state(s) with sufficient detail to locate recipients and medical providers.

All vehicles shall have a minimum of \$1,500,000 combined single limit insurance coverage for vehicles at all times during the contract period in accordance with State regulations and contract requirements. ~~This is per~~ (NAC 706.191). ~~If NAC 706.191 minimum insurance coverage is amended, the amount that is greater of either the Code or this Chapter will be the mandated amount of coverage.~~

14. Any vehicle or driver found out of compliance with the contract requirements, or any State or Federal regulations shall be removed from service immediately until

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the NET broker verifies correction of deficiencies. Any deficiencies and actions taken shall be documented and become a part of the vehicle's and the driver's permanent records.

15. The NET broker shall develop and implement an annual inspection process in addition to the applicable State vehicle inspection requirements to verify that vehicles used by ~~subcontracted~~ transportation ~~subcontracted~~ providers meet the above requirements and that safety and passenger comfort features are in good working order (e.g., brakes, tire, tread, signals, horn, seat belts, air conditioning/heating, etc.).
- L.** The NET broker shall ensure adequate oversight of subcontracted transportation providers and ensure that providers comply with all applicable State and Federal laws, regulations and permit requirements. This duty includes, but is not limited to verification that each provider maintains at all times:
1. Insurance which complies with the standards at 49 C.F.R. 387 subpart B, N.A.C. §191(1-3), and which provides for notice of the status of the policy to the ~~Administrator of Nevada Medicaid-DHCFP~~ upon expiration, termination, or at any time requested by the ~~Administrator DHCFP~~;
  2. An alcohol and substance abuse testing program which complies with the standards ~~at~~ of 49 C.F.R. Part 382;
  3. Criminal background checks conducted periodically that assure the criteria ~~at~~of MSM ~~§Chapter 1030.12A~~ are met;
  4. Signage on all vehicles identifying those operating under any exemption from Nevada Transportation Authority (NTA) regulation;
  5. Documentation in each vehicle of any exemption from NTA regulation; ~~and~~
  6. Current provider agreements with Nevada Medicaid.

As a contracted agent of the Director of the Department of Health and Human Services (DHHS), subject to the requirements of NRS § 422.2705 and NRS § 706.745: ~~T~~he NET broker may utilize the services of motor carriers that are exempt from certain certification requirements of the NTA of the Department of Business and Industry. Prior to exercising this option, the NET broker shall, with the assistance of the NTA, establish and utilize an inspection program designed to ensure that vehicles used by these motor carriers, and their operations, are safe. The NET broker shall also require these same motor carriers to submit proof of a liability insurance policy, certificate of insurance or surety which is substantially

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equivalent in form and is in the same amount or in a greater amount than the policy, certificate or surety required by the Department of Motor Vehicles (DMV) pursuant to NRS 706.291 for a similar situated motor carrier. The NET broker shall certify the transportation providers meet insurance requirements, vehicle safety standards, and driver background and drug tests cited in this chapter before a letter of exemption will be issued by DHCFP for that transportation provider.

- M. The NET broker is encouraged and expected to use recipient vouchers and/or volunteer programs to provide the most cost efficient transportation service to the recipient if such transportation is appropriate to meet the needs of the recipient. The broker shall verify and document ~~that~~ vehicles and drivers used in reimbursement and volunteer programs ~~that~~ comply with appropriate State operating requirements, driver's licensure, vehicle registration and insurance coverage **requirements**.
- N. The NET broker will be available as a resource to the DHCFP's ~~QIO-like vendor-fiscal agent~~ or contracted MCO when medically necessary covered services must be provided outside a recipient's community. The NET broker will advise the ~~QIO-like vendor-fiscal agent~~ or contracted MCO regarding such factors as distance and transportation availability.
- O. ~~The NET broker must submit claims for service outside of capitation to the DHCFP utilizing the nationally recognized International Classification of Diseases (ICD) and current electronic data interchange (EDI) standards, as approved by the Centers of Medicare and Medicaid Services (CMS).~~

#### 1904.4 RECIPIENT RESPONSIBILITY (NET)

The recipient or LRI shall:

- a. Use personal transportation or transportation of a LRI whenever possible;
- b. Explore alternative resources first, and when such a resource exists at no cost to the recipient, use the alternative transportation resource;
- c. If free transportation is not available, use public transportation when residing within 3/4 of a mile of a bus stop ~~(unless medical documentation is provided to support the recipient's or LRI's physical or mental condition that prohibits the recipient from utilizing public transport)~~;
- d. Participate in the assessment process to determine the appropriate level of service needed for transportation. The recipient must follow through when referred for a public paratransit evaluation;

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- e. If eligible for ~~P~~paratransit services, the recipient is required to access available ~~P~~paratransit programs;
- f. Make and keep all appointments and travel schedules, and ~~tele~~phone to cancel when an unforeseen event makes it impossible to keep an appointment;
- g. Recipients (or their LRI) ~~who are not using public transit or their representatives~~ are responsible to schedule rides by contacting the NET broker;
- h. Recipients are urged to schedule rides (except out-of-the-area travel) not less than five days and no more than 30 days prior to travel;
  - ~~1. Recipients must schedule rides (except out-of-the-area travel) not less than five and not more than 30 days prior to travel.~~
  - ~~2. Recipients assigned to public paratransit are responsible to contact the public transit authority to schedule rides.~~
- ~~g.i.~~ Recipients are required to be ready and available to ride from 15 minutes before the scheduled ride to 30 minutes after the scheduled time;
  - ~~1. Recipients using public paratransit will contact public transit system to cancel rides, including late rides, according to the transit system rules.~~
  - 1. ~~2.~~ Recipients who are using commercial transportation vendors will follow the NET broker policy concerning late rides.
- ~~j.~~ ~~i.~~ Notify the NET broker immediately when an urgent service need for NET transportation is discovered;
- ~~k.~~ ~~j.~~ Notify the NET broker of all third party insurance information, including the name of other third party insurance, or any changes in insurance coverage at the time of service, if possible, or in a timely manner thereafter;
- l. ~~k.~~ Not refuse service of a provider based solely or partly on the provider's race, color, national origin, sex, religion, disability or age; ~~and~~
- m. ~~l.~~ Provide car seats, wheelchairs, other devices or equipment, and any extra physical assistance, not required of providers, necessary to make the trip.

1904.5

GEOGRAPHIC AREA

The NET broker provides services statewide and in catchments areas. The NET broker provides services to and from out--of--state facilities.

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1904.6 SPECIAL REQUIREMENTS FOR SELECTED COVERED NET SERVICES

A. Out-of-Network Providers

The NET broker generally uses transportation providers who have executed a contract to be part of the NET broker’s network. However, occasionally it may be necessary for enrolled recipients to obtain NET services from an out-of-network provider (e.g., the recipient needs specialized transportation for which the NET broker has no such specialist in its network), **in which case** the broker must:

1. Arrange transportation with out-of-network providers with respect to services and payment;
2. Offer the opportunity to the out-of-network provider to become part of the network; and
3. Negotiate a contract to determine the rate prior to services being rendered.

B. Family Planning Services

Pursuant to policies set forth in ~~Section 603.3~~, Chapter 600 of the Nevada MSM, the NET broker will authorize NET services to family planning services for any eligible recipient to any qualified provider.

C. Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs.

Transplant services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. When a transplant recipient’s care needs during transit are within the scope of the NET broker, transportation should be prior authorized and provided through the NET broker. When the recipient’s care needs during transit exceed the capabilities of the NET broker (~~e.g., Specialty Care Transport is required~~) and/or the timeframe for transport is less than four hours, transportation may be treated as **an-a scheduled** emergency. (Refer to Section 1903.1D for guidance ~~regarding Emergency Medical Transportation~~.)

D. Paratransit Transportation

Paratransit transportation may be provided based on assessed medical need. When **P**paratransit transportation is indicated, such transportation services shall be “curb to curb” or “door-to-door”, whichever service is necessary for the recipient. **All P**paratransit providers are responsible for assisting riders into and out of their vehicles, ~~but are not responsible for lifting recipients using a wheelchair or gurney up or down stairs.~~

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1904.7 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of DHCFP and the DWSS. The NET broker shall accept each recipient who is enrolled in or assigned to the NET broker by DHCFP and/or its enrollment sections.

Pursuant to ~~the~~ State of Nevada’s Medicaid State Plan §3.1 for NET Services, eligible recipients do not have the option of disenrolling from the NET broker, nor does the NET broker have the option of disenrolling any eligible recipient. Copies of the State of Nevada Medicaid State Plan §3.1 for NET Services are available ~~upon request by contacting the DHCFP Business Lines Unit at (775) 684-3692 on the DHCFP’S website at <https://dhcfnv.gov>.~~

“Pending” Medicaid recipients (those whose applications for assistance have been submitted but not adjudicated) are not eligible for transportation services provided by the NET broker.

The NET broker is not financially responsible for any services rendered during a period of retroactive eligibility.

1904.8 INFORMATION REQUIREMENTS

The NET broker must have written information about its services and access to services available upon request to recipients. This written information must ~~also~~ be available in English and Spanish. The NET broker must make free, oral, Spanish interpretation services available to each recipient, if necessary. ~~The B~~broker may supply telephone interpretation services for other non-English languages. ~~The~~ DHCFP must approve all materials distributed to recipients.

- a. The NET broker’s written material must use an easily understood format. The NET broker must also develop appropriate alternative methods for communicating with people with vision or hearing impairments and must accommodate recipients with a physical disability in accordance with the requirements of the ADA. All recipients must be informed that this information is available in alternative formats and how to access those formats.

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1905 NET GRIEVANCES, APPEALS AND PROVIDER DISPUTES

1905.1 NOTICE OF DECISION

The NET broker may take action on a recipient's request for transportation based on **the** DHCFP's coverage policy and guidelines as set forth in the Nevada MSM. The request may be approved, denied, or limited (i.e. denied in part, or reduced) based on these eligibility and coverage policies. The broker shall notify each recipient in writing of the reason for any action which is taken to deny or otherwise limit a recipient's request, within five business days of such action; such notification is called a Notice of Decision (NOD).

Pursuant to 42 CFR 438.10 (**hg**), the NOD shall include information regarding the recipient's right to a State Fair Hearing (see Chapter 3100 of the Nevada MSM), the method for obtaining a State Fair **h**Hearing, and the rules that govern the recipient's right to representation. The broker must also provide a NOD to the requesting provider, if applicable.

The NOD must include the following information:

- a. The action the broker or its network provider has taken or intends to take;
- b. The reasons for the action;
- c. The recipient's right to request a State Fair Hearing;
- d. The method of obtaining a State Fair Hearing;
- e. The rules that govern representation at a State Fair Hearing;
- f. The right of the recipient to request a State Fair Hearing and how to do so;
- g. The right to request to receive benefits while the hearing is pending and how to make this request; and
- h. That the recipient may be held liable for the cost of those benefits if the hearing decision upholds the broker's action.

The NET broker shall provide any reasonable assistance to recipients in filing a State Fair Hearing, **including transportation to the hearing, if necessary.**

The NET broker is required to maintain records of all grievances received and NODs provided, which the State will review as part of the State's contract monitoring and management oversight.

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1905.2 RECIPIENT GRIEVANCES AND PROVIDER DISPUTES

The NET broker must have a process with which to address recipient grievances and provider disputes. **The** DHCFP will refer all recipient grievances and provider disputes to the NET broker for resolution. The NET broker must provide information about its recipient grievance process to all providers and subcontractors, at the time they enter into a contract.

The NET broker is required to dispose of each recipient grievance and provide notice as expeditiously as the recipient's health condition requires or no more than 90 days from the date the grievance is received by the NET broker or a network provider. The NET broker shall attempt to respond verbally to **the** recipient, authorized representative, **the** DHCFP or provider grievances and disputes within 24 hours of receipt of the grievance or dispute. The NET broker shall issue an initial response or acknowledgement to written grievances and disputes in writing within 72 hours.

In addition, the NET broker must:

- a. Provide recipients any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate **TYDD** and interpreter capability;
- b. Acknowledge receipt of each recipient grievance;
- c. Ensure that the individuals who make decisions on recipient grievances were not involved in any previous level of review or decision-making; and
- d. Notify the recipient of the disposition of grievances in written format. The written notice must include the results of the resolution process and the date it was completed.