MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 28, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 – MEDICAID PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program are being proposed to include information to and add requirements for providers who are subject to enhanced provider screening per Section 6401 of the Affordable Care Act (ACA), which includes Fingerprint-based Criminal Background Check (FCBC). These proposals cite the Authority for this screening, list the categorical risk level for provider types, include enrollment requirements for each categorical risk level, provide elevation of risk level examples, inform providers and individuals of their cost responsibility associated with FCBC, advise providers of non-compliance consequences with FCBC requirements and/or instructions and state the criteria under which FCBC results obtained through a provider's Medicare enrollment may be used by Nevada Medicaid.

Further changes to MSM Chapter 100 are proposed to include revisions to provider contract time frames, clarification to provider exclusions from Nevada Medicaid participation, meaning of Enrollment, Re-Enrollment, Revalidation, Denials, and Terminations, and to add information regarding provider disclosures and the resulting contract termination as a result of false or misleading information submitted to the DHCFP.

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.

Entities Financially Affected: Provider Type 29 – Home Health Agency (HHA) and Provider Type 33 – Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS). These provider types will be responsible for all costs associated with the "capture" or "roll" of fingerprints.

Financial Impact on Local Government: At this time, the DHCFP will be impacted as a portion of the FCBC cost, mainly the Federal/State Criminal Background Check, will be the responsibility of the agency per clarification from the Center for Medicare and Medicaid Services (CMS). The exact dollar amount of this impact cannot be determined at this time. There is no anticipated financial impact on city and county governments.

These changes are effective June 29, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 30976 MSM CH 100 – MEDICAID PROGRAM	MTL 19/15, 08/17 MSM CH 100 – MEDICAID PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 100	**Introduction**	Added the word "and" for clarification to include the DHCFP.
Section 100.1(A)	**Authority**	Added bullet "A" which states "Below is a list (not all inclusive) of specific Authorities:" as an introduction.
Section 100.1(A)(16)	**Authority**	Added bullet 16 which states "Section 6401(b) of the ACA amended Section 1902 of the Social Security Act (SSA) to require states to comply with procedures established by the Secretary of Health and Human Services for screening providers and suppliers. Section 6401(c) of the ACA amended Section 2107(e) of the SSA to make the provider and supplier screening requirement under section 1902 applicable to the Children's Health Insurance Program (CHIP). CMS implemented these requirements with federal regulations at 42 Code of Federal Regulations 455 subpart E" to include Authority for enhanced provider screening and FCBC.
Section 102	**Provider Enrollment**	Removed "Overview of Programs" from the subject header and replaced with "Provider Enrollment."
Section 102(A)(3)	**Provider Enrollment**	Removed the word "and," adding "if applicable, FCBC process; and" to include the FCBC requirement for enrollment.
Section 102(A)(4)	**Provider Enrollment**	Changed the tense of this sentence and added "credentialing requirements" for clarification and to form a complete sentence.
Section 102.1	**Request for Enrollment, Re-Enrollment, and Revalidation**	Include "Re-Enrollment, and Revalidation" in this section's title added introductory paragraph which states "A request for enrollment means an applicant, who has never been a Nevada Medicaid provider, submits an initial enrollment application; Re-enrollment means a

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		former Nevada Medicaid provider, whose contract was terminated or deactivated and who is now eligible to "re-enroll," submits an initial enrollment application, and, Revalidation means an active Nevada Medicaid provider, who must validate their current enrollment to extend their agreement with Nevada Medicaid, submits a revalidation application;"added the words "including re-enrollment or re-validation," to clarify "enrollment" and remove "who request enrollment" as unnecessary language; add "otherwise eligible" to clarify when a retroactive enrollment date may be allowed; replace "The Provider Contract expires 36 months from the date the DHCFP approves enrollment" with "All approved Provider Contracts, unless otherwise withdrawn or terminated, shall expire 60 months from enrollment date, with the exception of DME Contracts which shall expire 36 months from enrollment date, unless withdrawn or terminated" to align with 42 CFR §455.414 and include backdated application enrollment dates.
Section 102.2	**Conditions of Participation – All Providers**	Added paragraphs to include provider conditions of enrollment based on screening and FCBC requirements, including risk levels, providers adjusted to "High" risk, and "High" risk providers adding a person with 5 percent or more ownership interest in the provider.
Section 102.2(A)(1)	**Conditions of Participation – All Providers**	Added to list the "Limited" categorical risk providers.
Section 102.2(A)(2)	**Conditions of Participation – All Providers**	Added to list the "Moderate" categorical risk providers.
Section 102.2(A)(3)	**Conditions of Participation – All Providers**	Added to list the "High" categorical risk providers.
Section 102.2(B)	**Conditions of Participation – All Providers**	Reworded the first sentence as follows: "The Fiscal Agent shall not enroll any provider (individual or entity having a person with a 5 percent or greater direct or indirect ownership interest in the provider, including management personnel) who has been convicted of a felony or misdemeanor," replacing the word "will" with "shall" and removing the words "entity" replacing with "provider"

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		and "gross" when referring to misdemeanors, for consistency and clarification. Also, added the words "and/or offenses" to clarify the list of either crimes and/or offenses which would indicate a provider is not eligible for participation.
Section 102.2(B)(9)	**Conditions of Participation – All Providers**	Added this bullet to include "Conviction of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, CHIP, Nevada Check-Up (NCU), or the Title XX services program" as an example of a crime for which a provider is not eligible to participate in the Nevada Medicaid program. Bullet 102.2(B)(2) stated the same language and was removed.
Section 102.2(B)(10)	**Conditions of Participation – All Providers**	Added bullet which reads "Any entity or individual who has an existing overpayment with an outstanding balance with the DHCFP and has not entered into a State approved re-payment plan" to include an example for which a provider is not eligible to participate in the Nevada Medicaid program.
Section 102.2(B)(11)	**Conditions of Participation – All Providers**	New bullet added to this section, moved from 102.2(B)(1).
Section 102.2(B)(12)	**Conditions of Participation – All Providers**	New bullet added to this section, moved from 102.2(B)(3).
Section 102.2(B)(13)	**Conditions of Participation – All Providers**	New bullet added to this section, moved from 102.2(B)(4).
Section 102.2(B)(14)	**Conditions of Participation – All Providers**	New bullet added to this section, moved from 102.2(B)(4).
Section 102.2(B)(15)	**Conditions of Participation – All Providers**	New bullet added to this section, moved from 102.2(B)(9) and reworded to state "The Fiscal Agent shall not enroll a provider who has been convicted within the preceding ten years of (not all inclusive):" and changed "seven years" to "10" in keeping with 42 CFR §455.416(b).

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Section 102.2(B)(15)(c)	**Conditions of Participation – All Providers**	Removed the word "felony" and replace with "offense" for clarification and consistency.
Section 102.2(C)	**Conditions of Participation – All Providers**	Replaced the word "will" with "shall" in two instances for clarification and consistency.
Section 102.3	**Enhanced Provider Screening**	Added new section regarding Federally mandated provider screening based on categorical risk level and FCBC.
Section 102.3(A)(1)	**Enhanced Provider Screening**	Listed the screening requirements for the "Limited" risk category.
Section 102.3(A)(2)	**Enhanced Provider Screening**	Listed the screening requirements for the "Moderate" risk category.
Section 102.3(A)(3)	**Enhanced Provider Screening**	Listed the screening requirements for the "High" risk category.
Section 102.3(B)	**Enhanced Provider Screening**	Listed the reason(s) an enrolled provider might have their risk level elevated to "High."
Section 102.3(C)	**Enhanced Provider Screening**	Informed elevated risk level providers and "High" risk out of state providers of the requirement to consent and submit fingerprints per instruction provided by the DHCFP.
Section 102.3(D)	**Enhanced Provider Screening**	Informed "High" risk providers adding any new person with ownership interest of the FCBC requirement.
Section 102.3(E)	**Enhanced Provider Screening**	Informed providers of their cost responsibility for FCBC.
Section 102.3(F)	**Enhanced Provider Screening**	Informed of the criteria under which the DHCFP may accept individual provider FCBC screening from Medicare.
Section 102.6(B)(1)	**Facility Disclosure**	Replaced the "%" sign with the word "percent" for consistency.
Section 102.7(A)	**Provider Disclosure**	Replaced the "%" sign with the word "percent" for consistency.

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Section 102.7(A)(3)	**Provider Disclosure**	Replaced the word "Support" with "Enrollment" to correctly identify the DHCFP unit as Provider Enrollment.
Section 102.7(A)(4)	**Provider Disclosure**	Replaced the word "Support" with "Enrollment" to correctly identify the DHCFP unit as Provider Enrollment.
Section 102.7(A)(8)	**Provider Disclosure**	Included the requirement for providers to disclose "if a provider's license(s) required for enrollment with Nevada Medicaid has ever been suspended, surrendered, and/or revoked by any licensing Board or State."
Section 102.7(D)	**Provider Disclosure**	Removed this section which stated "Once agency program staff has completed an evaluation of the provider, enrollment will be granted or denied. Providers will be notified via US mail of the determination."
Section 102.8	**Disposition of Contract for Providers**	Removed "New" from the section title, capitalized "Fiscal Agent" for consistency, removed "copies of required licenses, registrations, certificates, etc.," as these required documents are part of the application, and added the word "specialty" to further clarify the conditions of participation for "specified provider type/specialty."
Section 102.9(D)(2)	**Certification Statement**	Added this bullet which reads "Under penalty of perjury, certifies as "true" information on the enrollment application and/or Change Form to become enrolled in, maintain enrollment in and/or update enrollment information with the Nevada Medicaid program; and" as further attestation by the provider on the enrollment application.
Section 102.9(D)(3)(a)	**Certification Statement**	With regard to submission of claims for payment, added "and that I am responsible for any and all claims submitted by employees and other person(s) acting on my behalf."
Section 102.9(D)(4)	**Certification Statement**	With regard to remittance and receipt of payment, added "the provider agrees and acknowledges:" to clarify the provider's understanding.
Section 102.9(D)(4)(b)	**Certification Statement**	Reworded bullet to read "that they have examined the remittance advice that accompanied the payment, the

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		payment represents amounts due, and the services listed thereon have been rendered by the provider" for clarification.
Section 102.10	**Contract Approval**	Removed "or Re-Enrollment" from section title.
Section 102.11	**Contract Denial**	Removed "or Re-Enrollment" from title and added verbiage which states "Denial means denial of an enrollment application submitted to Nevada Medicaid from any applicant, including an individual, entity, or group."
Section 102.11(A)(4)	**Contract Denial**	Added "DHCFP and/or" to include the DHCFP as a source from which information may be requested.
Section 102.11(A)(6)	**Contract Denial**	Added bullet which states "fails to consent to the FCBC process and/or submit FCBC forms and fingerprints as requested and instructed by the Fiscal Agent and/or the DHCFP" and is consistent with Section 106, Contract Terminations.
Section 102.11(B)	**Contract Denial**	Added "or the DHCFP" and replaced "Providers" with "Individuals and/or entities" for additional clarification.
Section 103(B)	**Provider Rules and Requirements**	Restructured and reworded section, adding bullets to emphasize provider responsibilities to recipients.
Section 103(B)(4)	**Provider Rules and Requirements**	Added bullet which states "Claims submitted are only for services actually rendered."
Section 103.1	**Medical Necessity**	Added "Medical Necessity is a" and remove "that is" to form a complete sentence.
Section 103.3	**Provider Reporting Requirements**	Reworded to state Medicaid providers (and any pending contract approval) are required to report, in writing "on the form prescribed in the online *Provider Enrollment Information Booklet*" within five working days, any change "and/or correction to" address, addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. "Change in ownership, including but not limited to, the removal, addition, and/or substitution of a partner, must be reported within five working days by completing and submitting an initial enrollment application along with

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		all required documentation." (Text ("removed"), text "added.")
Section 103.3A(1)	**Conditions of Reporting**	Added verbiage in quotations so the sentence now states: All changes, "with the exception of change in ownership," must be reported in writing "on the form prescribed in the online *Provider Enrollment Information Booklet*" and require the signature of the provider.
Section 103.3A(3)	**Conditions of Reporting**	Added verbiage in quotations so the sentence now states: If there is a change in ownership, the provider must provide a copy of the bill of sale, copies of new licenses/certifications, and"/or" verification of a change in the Federal Employe"r" Identification Number (FEIN). "The provider must also complete/submit an initial enrollment application."
Section 106	**Contract Terminations**	Removed "and Non-Renewal" from the title, added "actively enrolled" to clarify provider, and removed "Non-renewal means Nevada Medicaid will refuse to renew a Medicaid contract with the provider when the previous agreement expires." Also, removed "non-renewed" verbiage from two sentences in this section and from the "Subject" header.
Section 106.2	**Conditions of Contract Terminations**	Removed "and Non-Renewal" from the section title.
Section 106.2(A)	**Conditions of Contract Terminations**	Removed "or not renew" for consistency and added "is discovered, or reported:" when referring to how the DHCFP might learn of an occurrence which might result in immediate termination.
Section 106.2(A)(7)	**Conditions of Contract Terminations**	Added "and all sub-sections" for clarification.
Section 106.2(A)(8)	**Conditions of Contract Terminations**	Removed the word "or" to allow for additional bullet points.

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Section 106.2(A)(10)	**Conditions of Contract Terminations**	Added new bullet point which states "The Provider, or any person with a 5 percent or greater direct or indirect ownership interest in the Provider, fails to consent to FCBC and/or to submit sets of fingerprints in the form and manner as instructed by the Fiscal Agent and/or the DHCFP" to include the effect of a Provider's failure to comply with FCBC.
Section 106.2(A)(11)	**Conditions of Contract Terminations**	Moved to Immediate Termination (for accuracy) from Section 106.2(B)(2) and reworded to state "Credible allegations of fraud, waste, or abuse of such a nature and extent have been discovered and/or reported that immediate and permanent action is deemed necessary."
Section 106.2(A)(12)	**Conditions of Contract Terminations**	Moved to Immediate Termination (for accuracy) from Section 106.2(B)(8), as "The provider has been convicted of a misdemeanor and/or felony that is incompatible with the mission of the DHCFP" requires an immediate action. Also, removed "gross misdemeanor" and added "and/or" for clarification.
Section 106.2(A)(13)	**Conditions of Contract Terminations**	Added bullet which states "The DHCFP becomes aware that the provider failed to provide required information and/or provided false information on the enrollment application."
Section 106.2(B)(1)	**Conditions of Contract Terminations**	Removed this bullet as this item is addressed in 106.2(A)(13).
Section 106.2(B)(2)	**Conditions of Contract Terminations**	Moved "Fraud or abuse of such a nature and extent that immediate and permanent action is deemed necessary" to Section 106.2(A)(11).
Section 106.2(B)(1)	**Conditions of Contract Terminations**	Re-numbered from 106.2(B)(3) to the first bullet in this sub-section and added verbiage which states "is reported or discovered" to form a complete sentence and for consistency.
Section 106.2(B)(6)	**Conditions of Contract Terminations**	Re-numbered from 106.2(B)(7) and removed "and/or," allowing for additional bullet points and information regarding termination reasons.

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Section 106.2(B)(8)	**Conditions of Contract Terminations**	Moved "The provider has been convicted of a misdemeanor, gross misdemeanor or felony that is incompatible with the mission of the DHCFP" to Section 106.2(A)(12).
Section 106.3	**Sanction Periods**	Replaced second paragraph with the following: "Sanctions apply to entities when individuals meet the criteria below who have a 5 percent or greater ownership or control interest, or are an agent or managing employee. A person who assists to submit prior authorization requests or claims is an agent for purposes of MSM Chapter 100."
Section 106.3(1)(d)(10)	**Sanction Periods**	Moved from Section 106.3(2)(b)(7) to this section as "A violation of any federal or state law regulating the possession, distribution, or use of any controlled substance or any dangerous drug as defined in Chapter 454 of NRS" constitutes a permanent sanction.

100 INTRODUCTION

The mission of the Nevada Division of Health Care Financing and Policy (DHCFP) (Nevada Medicaid) is to:

a. purchase and provide quality health care services to low-income Nevadans in the most efficient manner;

b. promote equal access to health care at an affordable cost to the taxpayers of Nevada;

c. restrain the growth of health care costs; and

d. review Medicaid and other State health care programs to maximize potential federal revenue.

The purpose of this chapter is to provide an overview and description of the Nevada Medicaid program administered under the authority of the Department of Health and Human Services (DHHS) and the DHCFP and to establish program policies and procedures.

100.1 AUTHORITY

The Medicaid program in Nevada is authorized to operate under the DHHS and the DHCFP per Nevada Revised Statutes (NRS) Chapter 422. Nevada Medicaid has a federally approved State Plan to operate a Medicaid program under Title XIX of the Social Security Act (SSA). Regulatory and statutory oversight of the program is found in Chapter 42 of the Code of Federal Regulations (CFRs) as well as Chapter 422 of the NRS.

This Medicaid Services Manual (MSM) along with the Medicaid Operations Manual (MOM) is the codification of regulations adopted by Nevada Medicaid based on the authority of NRS 422.2368, following the procedure at NRS 422.2369. These regulations supplement other Medicaid program requirements including laws, all applicable Federal requirements and requirements in the Nevada State Plan for Medicaid. The regulations provide the additional conditions which limit Medicaid providers' program participation and payment. The regulations also provide additional limitations on services provided to Medicaid recipients. The Division administrator has authority under NRS 422.2356 to establish policies and exceptions to policy for administration of the programs under Medicaid.

A. Below is a list (not all inclusive) of specific Authorities:

1. Eligibility for Medicaid assistance is regulated by Section 1901(a) of the SSA, 42 CFR, Part 435, and Nevada Medicaid State Plan Section 2.1.

2. Payment for Medicaid services is regulated by Sections 1902(a) and 1923 of the

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SSA, 42 CFR, Part 447, and Nevada Medicaid State Plan Sections 4.19 and 4.21.

3. Provider contracts/relations are regulated by 42 CFR 431, Subpart C; 42 CFR Part 483 and Nevada Medicaid State Plan Section 4.13.

4. Safeguarding and disclosure of information on applicants and recipients is regulated by 42 United States Code (USC) 1396a(a)(7), and the associated regulations: 42 CFR 431, Subpart F; the Health Insurance Portability and Accountability Act (HIPAA) and associated regulations: 45 CFR 160, 162 and 164 and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009; Nevada Medicaid State Plan Section 4.3, and NRS 422.290. Penalties for unauthorized use or disclosure of confidential information are found within the HITECH Act and NRS 193.170.

5. Prohibition against reassignment of provider claims is found in 42 CFR 447.10 and Nevada Medicaid State Plan Section 4.21.

6. Exclusion and suspension of providers is found in 42 CFR 1002.203 and Nevada Medicaid State Plan 4.30.

7. Submission of accurate and complete claims is regulated by CFR 42 CFR 455.18 and 444.19.

8. Nevada Medicaid assistance is authorized pursuant to State of NRS, Title 38, Public Welfare, Chapter 422, Administration of Welfare Programs.

9. Third Party Liability (TPL) policy is regulated by Section 1902 of the SSA, 42 CFR, Part 433, Subpart D, and the Nevada Medicaid State Plan Section 4.22.

10. Assignment of insurance benefits by insurance carriers is authorized pursuant to State in NRS, Title 57, Insurance, based on the type of policy.

11. Subrogation of medical payment recoveries is authorized pursuant to NRS 422.293.

12. "Advance Directives" are regulated by 42 CFR 489, Subpart I.

13. Worker's compensation insurance coverage is required for all providers pursuant to NRS Chapter 616A through 616B.

14. Section 1902(a)(68) of the SSA establishes providers as 'entities' and the requirement to educate their employees, contractors and agents on false claims recovery, fraud and abuse.

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15. Offering gifts and other inducements to beneficiaries is prohibited pursuant to Section 1128A(a)(5) of the SSA, enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

16. Section 6401(b) of the Affordable Care Act (ACA) amended section 1902 of the SSA to require states to comply with procedures established by the Secretary of Health and Human Services for screening providers and suppliers. Section 6401(c) of the ACA amended section 2107(e) of the SSA to make the provider and supplier screening requirement under section 1902 applicable to the Children's Health Insurance Program (CHIP). The Centers for Medicare & Medicaid Services (CMS) implemented these requirements with federal regulations at 42 CFR 455 subpart E.

100.2 CONFIDENTIAL INFORMATION

All individuals have the right to a confidential relationship with the DHCFP. All information maintained on Medicaid and CHIP applicants and recipients ("recipients") is confidential and must be safeguarded.

Handling of confidential information on recipients is restricted by 42 CFR § 431.301 – 431.305, The Health Insurance Portability and Accountability Act (HIPAA) of 1996, the HITECH Act of 2009, NRS 422.290, and the Medicaid State Plan, Section 4.3.

Any ambiguity regarding the definition of confidential information or the release thereof will be resolved by the DHCFP, which will interpret the above regulations as broadly as necessary to ensure privacy and security of recipient information.

A. Definition of Confidential Information

For the purposes of this manual, confidential information includes:

1. Protected Health Information (PHI)

   a. All *individually identifiable health information* held or transmitted by the DHCFP or its business associates, in any form or media, whether electronic, paper or oral.

      1. "Individually identifiable health information" is information, including demographic data, that relates to:

         a. the individual's past, present or future physical or mental health or condition;

         b. the provision of health care to the individual;

102 PROVIDER ENROLLMENT

All individuals/entities providing services to Medicaid recipients under the FFS or Medicaid Managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered. All healthcare providers who are eligible to obtain a National Provider Identifier (NPI) number must provide this NPI to Medicaid at the time of their provider enrollment application. To obtain a NPI or further information regarding NPI, see the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov.

A. Medicaid may reimburse a provider who meets the following conditions:

1. Provides their NPI/API number on the application and requests for payment;

2. Meets all of the professional credentialing requirements or other conditions of participation for the provider type;

3. Completes the Nevada Medicaid Provider Application~~, and~~ Contract~~,~~ and if applicable, Fingerprint-based Criminal Background Check process; and

4. Receive~~sd~~ notice from Nevada Medicaid that the credential~~s~~ing requirements have been met and the provider agreement has been accepted.

Prior to receiving reimbursement, providers must meet the participation standards specified for the program service area for which they are applying, and comply with all federal, state and local statutes, rules and regulations relating to the services being provided.

Providers who provide services outside of the United States will not receive reimbursement per MSM 101.1.e.2.

A moratorium may be implemented at the discretion of the federal DHHS or the DHCFP. A new enrollment application is required for enrollment after it is lifted.

102.1 REQUEST FOR ENROLLMENT, RE-ENROLLMENT, AND REVALIDATION

A request for enrollment means an applicant, who has never been a Nevada Medicaid provider, submits an initial enrollment application; Re-enrollment means a former Nevada Medicaid provider, whose contract was terminated or deactivated and who is now eligible to "re-enroll," submits an initial enrollment application; and, Revalidation means an active Nevada Medicaid provider, who must validate their current enrollment to extend their agreement with Nevada Medicaid, submits a revalidation application.

A provider may request enrollment, including re-enrollment and revalidation, in the Nevada Medicaid Program by completing the Enrollment Application and providing the required

verifications for their requested provider type. However, the DHCFP is not obligated to enroll all eligible providers, and ~~who request enrollment.~~ all types of ~~E~~enrollment ~~is~~ are at the discretion of the DHCFP. For additional information regarding enrollment, the provider may contact the Provider Enrollment Unit of the Fiscal Agent. Refer to Section 108 for contact information.

The effective date of the provider contract is the date received. Exceptions may be allowed for up to six months of retroactive enrollment to encompass dates on which the otherwise eligible provider furnished services to a Medicaid recipient. ~~The Provider Contract expires 36 months from the date the DHCFP approves enrollment.~~ All approved Provider Contracts, unless otherwise withdrawn or terminated, shall expire 60 months from enrollment date, with the exception of Durable Medical Equipment (DME) Contracts which shall expire 36 months from enrollment date, unless withdrawn or terminated.

If the provider does not meet all State and Federal requirements at the time of the initial request for participation, the effective date of the provider contract will be the date all requirements are met. If the Provider is serving a sanction period, they are not eligible for enrollment.

102.2 CONDITIONS OF PARTICIPATION – ALL PROVIDERS

As a condition of new or continued enrollment, providers shall consent and submit to criminal background checks, including fingerprinting, when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for the provider.

The DHCFP and/or Fiscal Agent shall screen all initial applications, applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "Limited," "Moderate" or "High." This screening also applies to providers who the DHCFP has adjusted to the highest level of risk after enrollment and providers deemed "High" risk who add a person(s) with 5 percent or more direct or indirect ownership interest in the provider. If a provider could be placed within more than one risk level, the highest level of screening is applicable, and the DHCFP has the authority to adjust a provider's risk level to ensure the fiscal integrity of the Medicaid program.

A. Per 42 CFR §424.518, the following indicates categorical risk levels for providers:

1. Limited categorical risk:

a. Physician or non-physician practitioners, including nurse practitioners, Certified Registered Nurse Anesthetists (CRNAs), occupational therapists, speech/language pathologists, and audiologists, and medical groups or clinics.

b. Ambulatory surgical centers.

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c. End-stage renal disease facilities.

~~a.~~d. Federally qualified health centers.

e. Histocompatibility laboratories.

f. Hospitals, including critical access hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities.

g. Health programs operated by an Indian Health Program or an urban Indian organization that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act.

h. Mammography screening centers.

i. Mass immunization roster billers.

j. Organ procurement organizations.

k. Pharmacies newly enrolling or revalidating via the CMS-855B application.

l. Radiation therapy centers.

m. Religious non-medical health care institutions.

n. Rural Health Clinics.

o. Skilled nursing facilities.

2. Moderate categorical risk:

a. Ambulance service suppliers.

b. Community mental health centers.

c. Comprehensive outpatient rehabilitation facilities.

d. Hospice organizations.

e. Independent clinical laboratories.

f. Independent diagnostic testing facilities.

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g. Physical therapists enrolling as individuals or as group practices.

h. Portable x-ray suppliers.

i. Revalidating home health agencies.

j. Revalidating DMEPOS suppliers.

3. High categorical risk:

a. Newly enrolling home health agencies.

b. Newly enrolling DMEPOS suppliers.

B. The F~~f~~iscal A~~a~~gent ~~will~~ shall not enroll any ~~entity~~ provider (individual or entity having a person with a 5 percent or greater direct or indirect ownership interest in the provider, including management personnel) who has been convicted of a felony or ~~gross~~ misdemeanor under Federal or State law for any offense which the State agency determines is inconsistent with the best interest of recipients under the State plan. The following list, though not exhaustive, provides examples of crimes and/or offenses which indicate a provider is not eligible for participation:

1. Murder, voluntary manslaughter or mayhem;

2. Sexual assault, sexual seduction or any sexually related crime;

3. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission of the crime;

4. Abuse or neglect of a child or contributory delinquency;

5. False imprisonment, involuntary servitude or kidnapping;

6. Abuse, neglect, exploitation or isolation of any older persons or vulnerable persons, including a violation of any provisions of Nevada Revised Statute (NRS) Sections 200, or a law of any other jurisdiction that prohibits the same or similar conduct;

7. Any offense involving assault or battery, domestic or otherwise;

8. Conduct hostile or detrimental to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;

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9. Conviction of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (CHIP), Nevada Check-Up (NCU), or the Title XX services program;

10. Any entity or individual who has an existing overpayment with an outstanding balance with the DHCFP and has not entered into a State approved re-payment plan;

11. ~~i~~Is on the Office of the Inspector General (OIG) or Excluded Parties List System (EPLS) exclusion list;

12. ~~h~~ Has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU) or Title XX services program;

13. Uses a financial institution outside of the country (excluding Guam, Puerto Rico, Mariana Islands and American Samoa); or

14. Is serving a sanction period.

~~9.~~15. ~~Within the preceding seven years, the fiscal agent shall not enroll a provider who has been convicted of (not all inclusive):~~ The Fiscal Agent shall not enroll a provider who has been convicted within the preceding ten years of (not all inclusive);

a. ~~A~~any offense involving arson, fraud, theft, embezzlement, burglary, fraudulent conversion or misappropriation of property;

b. ~~A~~a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in Chapter 454 of the NRS;

c. ~~A~~any ~~felony~~ offense involving the use of a firearm or other deadly weapon~~;~~.

~~B. The Fiscal Agent will not enroll any provider who:~~

~~14. is on the Office of the Inspector General (OIG) or EPLS exclusion list;~~

~~15. has been convicted of a criminal felony offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (CHIP) (NCU) or the Title XX services program;has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU) or Title XX services program;~~

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~~16. use a financial institution outside of the country (excluding Guam, Puerto Rico, Mariana Islands and American Samoa); or~~

~~5. is serving a sanction period.~~

C. The Fiscal Agent ~~will~~ shall not enroll a public institution unless it is a medical institution. The Fiscal Agent ~~will~~ shall never enroll a penal or correctional institution.

D. All providers must provide and maintain workers compensation insurance as required by law and provided proof of insurance as required through 616D, inclusive, of the NRS.

E. All Nevada Medicaid providers must comply with information reporting requirements of the Internal Revenue Code (26 U.S.C. 6041) which requires the filing of annual information (1099) showing aggregate amount paid to providers service identified by name, address, Social Security Number (SSN) or Federal Identification Number (FEIN). A FEIN is the preferred identifier, but a SSN may be used by those self-employed individuals in a sole proprietorship who do not have a FEIN.

F. The provider is responsible for understanding the requirements of their provider type as stated in the Nevada MSM. The provider should also be familiar with Chapter 3100 – Hearings and Chapter 3300 – Surveillance, Utilization and Review (SUR~~s~~).

G. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with the DHCFP Operations Service Manuals, state and federal statutes and regulations at a minimum of six years from the date of payment for the specified service. Electronic health records must include a verifiable date of service time stamp, record who is making the entry and who actually saw the patient.

H. Any provider who is providing services to foster children, in any setting, must submit to a full, fingerprint-based criminal history and Child Abuse and Neglect Screening (CANS) in order to comply with the Adam Walsh Child Protection Act of 2006.

These reports are legally mandated and maintained by the Nevada Division of Child and Family Services (DCFS), Central Office, 4126 Technology Way, 1st Floor, Carson City, NV 89706. Names of individuals are checked against names in the central registry to identify any substantiated perpetrators of abuse. CANS employer information is limited to provision of the substantiated status of a report and is released only by the Nevada DCFS (NRS 432.100). Information may be released to an employer under NRS 432.100(3).

The completion of a request form and Authorization to Release Information must be submitted to:

Nevada Division of Child and Family Services
Attn: Child Abuse and Neglect Records Check
4126 Technology Way, 1st Floor
Carson City, NV 89706

For additional information and authorization forms please contact:
Nevada Division of Child and Family Services
(775) 684-7941

102.3 ENHANCED PROVIDER SCREENING

A. CATEGORICAL RISK

Providers shall be placed in one of the following risk levels and submit to the necessary screening (not all inclusive) for each risk level as follows:

1. Limited categorical risk:

   a. provider meets applicable federal regulations and/or state requirements for the provider type.

   b. provider's license(s) is current, including in states other than Nevada.

   c. there are no current limitations or restrictions on the provider's license.

   d. provider initially and continues to meet enrollment criteria for their provider type.

2. Moderate categorical risk:

   a. provider meets the "limited" screening requirements.

   b. on-site visits, whether announced or unannounced, for any and all provider locations in accordance with 42 CFR §455.432.

3. High categorical risk:

   a. provider meets the "limited" and "moderate" screening requirements.

   b. provider consents to a criminal background check.

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c. provider submits a set of fingerprints in accordance with 42 CFR §455.434 and instructions from the DHCFP.

B. RISK LEVEL ADJUSTMENT

Once enrolled, providers or any person with a 5 percent or more direct or indirect ownership interest in the provider, may have their categorical risk level adjusted from "limited" or "moderate" to "High" for the following reason and/or reasons (not all inclusive):

1. A payment suspension on the individual or entity was imposed based on a credible allegation of fraud, waste or abuse. The provider's risk remains "high" for 10 years beyond the date of the payment suspension.

2. A provider (individual or entity) incurs a Medicaid overpayment.

3. The DHCFP or the Centers for Medicare and Medicaid Services (CMS) in the previous six months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

C. Within 30 days of notification, providers and/or individuals or any person with 5 percent or more direct or indirect ownership interest in the provider whose risk level is elevated to "High" and any out of state provider required to submit to FCBC shall consent to and provide proof of fingerprint capture and submission per the instructions provided by the DHCFP.

D. Approved providers whose categorical risk level is "High" shall complete the FCBC requirements for any new person(s), having 5 percent or more direct or indirect ownership, who is added and/or not previously screened.

E. Providers subject to FCBC will be responsible for all costs associated with fingerprint collection.

F. Providers screened and placed in the "High" risk category by the Fiscal Agent or the DHCFP may be found to have met the FCBC requirements when the provider enrolled with Medicare. The DHCFP may rely upon Medicare's screening if all of the following are verified:

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1. The date of Medicare's last screening of the provider occurred within the last five years.

2. The provider's Medicaid enrollment information is a "positive match" with the Medicare enrollment record.

102.~~3~~4 OUT OF STATE PROVIDER PARTICIPATION

Out of state providers may request enrollment in the Nevada Medicaid program. Provider types that require Medicare and/or national certification, as defined in Federal regulations, must have the required certifications. In addition, all providers must meet all licensure, certification or approval requirements in accordance with state law in the state in which they practice. Additional conditions of participation may apply depending on where the services are provided.

Out of state providers requesting enrollment to provide ongoing services to Nevada Medicaid recipients must meet one of the following criteria:

A. The provider is providing a service which is not readily available within the state; and

B. The provider is providing services to Medicaid recipients in a catchment (border) area; or

C. The provider is providing services to Medicare cross over recipients only.

Nevada Medicaid does not enroll providers to provide mail order delivery of pharmaceutical or durable medical equipment or gases, except those providing services to Medicare crossover recipient's only.

102.~~3A5~~ EMERGENCY SERVICES OUTSIDE THE STATE OF NEVADA

A provider outside of the State of Nevada who furnishes authorized goods and services under the Nevada medical assistance program to eligible Nevada residents visiting another state and urgently requiring care and services shall be exempt from the full enrollment process as long as that provider is properly licensed to provide health care services in accordance with the laws of the provider's home state and enrolled as a Medicaid provider in the provider's home state to furnish the health care services rendered. Refer to the billing manual for needed documentation.

102.~~4~~6 FACILITY DISCLOSURE

Section 1902(a)(36) requires Nevada Medicaid to make available, for inspection and copying by the public, pertinent findings from surveys made by the State survey agency, the Bureau of Health Care Quality and Compliance (BHCQC). Such surveys are made to determine if a health care organization meets the requirements for participation in the Medicare/Medicaid program.

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Federal regulations require the disclosure by providers and fiscal agents of ownership and control information and information on a facility's owners and other persons convicted of criminal offenses against Medicare, Medicaid, Children's Health Insurance Program (CHIP), NCU or the Title XX services program.

A. Documents subject to disclosure include:

~~a.~~1. survey reports, including a statement of deficiencies;

~~b.~~2. official notifications of findings based on the survey;

~~c.~~3. written plans of correction submitted by the provider to the survey agency;

~~d.~~4. ownership and contract information specified below; and

~~e.~~5. reports of post-certification visits and summaries of uncorrected deficiencies.

Within the context of these requirements, the term "provider" or "discloser" excludes an individual practitioner or group of practitioners unless specifically mentioned.

B. At the time of a periodic survey or renewal of a contract to participate in the program, providers and fiscal agents must disclose:

~~f.~~1. name and address of each person with an ownership or control interest in the discloser, or in any subcontractor in which discloser has direct or indirect ownership of 5 percent or more;

~~g.~~2. whether any of the persons named is related to another as spouse, parent, child or sibling; and

~~h.~~3. name of any other disclosing entity in which a person with an ownership or controlling interest in the discloser also has ownership or controlling interest.

C. Within 35 days of the date of request by the Secretary of Department of Health and Human Services (DHHS), or the Medicaid agency, a provider must submit full and complete information about:

~~i.~~1. ownership of any contractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

~~j.~~2. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of request.

102.~~4A~~7 PROVIDER DISCLOSURE

A. In order to enter into a provider contract with the Medicaid or NCU programs, the provider or any person who has ownership or a controlling interest of 5~~%~~ percent or more, or who is an agent or managing employee of the provider must disclose any information listed below including, but not limited to the following:

~~A.~~1. c~~C~~onviction of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, CHIP (NCU) or Title XX services program since the inception of the programs;

~~B.~~2. ~~D~~denial of enrollment or termination for cause, exclusion or any form of suspension from Medicare, Medicaid, CHIP (NCU), any federal health care program or Title XX services program since the inception of the programs;

3. ~~C~~conviction of any criminal offense. Providers reporting criminal convictions other than convictions listed in 102.2.A are not automatically precluded from enrollment. The Fiscal Agent will forward these applications to the DHCFP Provider ~~Support~~ Enrollment Unit for consideration on a case by case basis. Providers must provide information, documentation and explanation regarding their charge;

~~C.~~4. ~~A~~any current or previous investigation by any law enforcement, regulatory agency, or state agency, or restricted professional license. The Fiscal Agent will forward these applications to the DHCFP Provider ~~Support~~ Enrollment Unit for consideration on a case by case basis. Providers must provide information, documentation and explanation;

~~D.~~5. Any current open/pending court cases;

~~E.~~6. Any current or previous affiliation with a provider, supplier or other State that has uncollected debt with no attempt to resolve; ~~or~~

~~A.~~7. ~~I~~if billing privileges have ever been denied or revoked with a federal or state health care program; or

~~7.~~8. if the provider's license(s) required for enrollment with Medicare and/or Nevada Medicaid has ever been suspended, surrendered and/or revoked by any licensing Board or State.

B. If discrepancies are found to exist during the pre-enrollment period, the DHCFP and/or the Fiscal Agent may conduct additional inspections prior to enrollment. Failure to provide complete and accurate information, or to resolve discrepancies as prescribed by the DHCFP and/or the Fiscal Agent, may result in denial of the application.

The Fiscal Agent may complete additional screenings on applicants for the purpose of verifying the accuracy of information provided in the application and in order to prevent fraud and abuse.

~~A.~~ The screening may include, but is not limited to, the following:

~~B.~~1. on-site inspection prior to enrollment;

~~C.~~2. review of business records;

~~D.~~3. data searches; and

~~E.~~4. provisional enrollment.

C. Should a provider be granted provisional enrollment, the provisional enrollment will be for a period not less than 30 days, but not to exceed 365 days. During the provisional period, agency program staff may complete on-site visits (announced or unannounced), audits or reviews focusing on, but not limited to:

1. billing practices;

2. policy and procedure; or

3. quality of care compliance reviews.

~~Once agency program staff has completed an evaluation of the provider, enrollment will be granted or denied. Providers will be notified via US mail of the determination.~~

102.~~5~~8 DISPOSITION OF CONTRACT FOR ~~NEW~~ PROVIDERS

The ~~f~~Fiscal ~~a~~Agent and/or the DHCFP will review the completed provider application ~~copies of required licenses, registrations, certificates, etc.,~~ to determine if the applicant meets all of the conditions of participation as stated in the Nevada MSM for the specified provider type/specialty and Nevada MSM Chapter 100, all inclusive.

Provisional licensure will be allowed based on Nevada State Board requirements of the specific specialties within the scope of practice for licensed professionals. Provisional licensure will apply only to licensed level professionals. Credentialed and paraprofessional level providers do not meet the requirement for provisional licensure.

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102.~~5A~~9 CERTIFICATION STATEMENT

The following reminder to providers of Medicaid regulations appears on the endorsement side of every Medicaid payment:

A. "I understand in endorsing or depositing this check that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws."

B. "I agree to accept Medicaid payments as payment in full for services rendered and under no condition, except for lawful patient liability, contact the patient or members of the patient's family for additional sums."

C. "I acknowledge that I have examined the remittance advice that accompanied this check and that the items covered represent amounts due to me and that the services listed thereon have been rendered by me."

D. By signing the enrollment application, the provider attests to the following:

1. That payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws; and

2. Under penalty of perjury, ~~C~~certifies as "true" information on the enrollment application and/or Change Form to become enrolled in, maintain enrollment in and/or update enrollment information with the Nevada Medicaid program.

~~2.~~3. With regard to submission of claims for payment:

a. I certify that all information is true, accurate and complete and that I am responsible for any and all claims submitted by employees and other person(s) acting on my behalf. ~~;and~~

~~a.~~4. With regard to remittance and receipt of payment, the provider agrees and acknowledges: ~~whether by check or electronic transmission.~~

a. ~~"I agree~~ to accept Medicaid payments as payment in full for services rendered and under no condition, except for lawful patient liability, contact the patient or members of the patient's family for additional sums; and

~~d~~.b ~~"I acknowledge~~ that ~~I~~they have examined the remittance advice that accompanied the~~is~~ payment, ~~and that~~ the payment ~~items covered~~ represents amounts due, ~~to me~~ and ~~that~~ the services listed thereon have been rendered by the provider. ~~by me.~~

102.~~5B~~10 CONTRACT ~~OR RE-ENROLLMENT~~ APPROVAL

If conditions of participation are met, Nevada Medicaid will obtain the necessary signatures to bind the contract.

An enrollment approval letter, which will include the provider's NPI/API, will be sent to the provider. If the provider has been approved to provide more than one type of medical service, the provider type will be identified for each service type.

102.~~5C~~11 CONTRACT ~~OR RE-ENROLLMENT~~ DENIAL

Denial means denial of an enrollment application submitted to Nevada Medicaid from any applicant, including an individual, entity or group.

A. The DHCFP will refuse to enter into a contract with an applicant for provider enrollment in the Medicaid program if the provider:

1. does not meet the conditions of participation as stated in this Chapter, all inclusive;

2. does not meet all of the professional credentialing requirements or other conditions of participation as required by the Nevada MSM for the specified provider type;

3. has been terminated for cause, excluded or suspended, leading to revocation of an agreement or contract with a provider by any other governmental or State program;

4. fails to submit information requested by the DHCFP and/or Fiscal Agent;

5. submits false information~~.~~;

6. fails to consent to the FCBC process and/or submit FCBC forms and fingerprints as requested and instructed by the Fiscal Agent and/or the DHCFP.

B. The Fiscal Agent or the DHCFP Provider Enrollment Unit will notify the provider ~~by U.S. mail~~ of the contract denial. ~~Providers~~Individuals and/or entities who have their enrollment denied do not have appeal or hearing rights.

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103 PROVIDER RULES AND REQUIREMENTS

Under a program such as Medicaid, providers of medical services have responsibilities that may not exist in a private patient relationship. The provider accepts a degree of responsibility not only to the recipient but also to the paying agency, which, in the end, is the community as a whole.

A. If the provider has knowledge of over-utilization, inappropriate utilization, use of the Nevada Medicaid card by a person not listed on the card, unreasonable demands for services or any other situation that the provider feels is a misuse of medical services by a recipient, he shall inform the Nevada Medicaid office.

B. A Medicaid provider who accepts a Medicaid recipient for treatment accepts the responsibility to make ~~sure~~ certain the recipient receives all medically necessary Medicaid covered services. This includes, but is not limited to, the following assurances:

1. ~~making appropriate r~~Referrals to other Medicaid providers are appropriate.

2. ~~ensuring a~~Ancillary services are delivered by an actively enrolled Medicaid provider.

3. ~~and ensuring the r~~Recipient(s) receives all medically necessary Medicaid covered services at no cost to the recipient(s).

4. Claims submitted are only for services rendered.

C. In addition, when the services require a Prior Authorization (PA) and a PA number is obtained; the provider must give that number to other relevant providers rendering service to the recipient.

D. All Medicaid providers who accept Medicaid reimbursement for treatment accept responsibility for understanding and comprehending their provider contract and all chapters of the MSM that pertain to their individual provider type and services they provide. This applies to all institutions and medical groups as well.

103.1 MEDICAL NECESSITY

Medical Necessity is a health care service or product ~~that is~~ provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to:

A. diagnose, treat or prevent illness or disease;

B. regain functional capacity; or

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C. reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:

~~A.~~D. the ~~T~~type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.

~~A.~~E. the ~~L~~level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.

~~B.~~F. that ~~S~~services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.

~~C.~~G. that ~~S~~services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

103.2 AUTHORIZATION

Titles XI and XVIII of the Act provide the statutory authority for the board objectives and operations of the Utilization and Quality Control Quality Improvement Organization (QIO) program. The Peer Review Improvement Act of the Tax Equity and Fiscal Responsibility Act of 1982 established Utilization and Quality Control QIO.

QIOs operate under contract with the Secretary of Health and Human Services (HHS) to review Medicaid services, once so certified by CMS. They may also contract with Medicaid agencies and private insurers. The utilization review/control requirements of 42 CFR 456 are deemed met if a state Medicaid agency contract with a Medicare certified QIO, designated under Part 475 to perform review/control services (42 CFR 431.630).

PA review is conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid's policy, prior to the delivery of service.

G. It is the provider's responsibility to submit the necessary paperwork to support the PA request. PA requests submitted lacking the required information for the service/item will be denied with a Notice of Decision (NOD) to the recipient.

103.3 PROVIDER REPORTING REQUIREMENTS

Medicaid providers ~~and any pending contract approval,~~ are required to report in writing on the form prescribed in the online *Provider Enrollment Information Booklet* within five working days, any change and/or correction to ~~in ownership,~~ address, ~~or~~ addition or removal of practitioners or any other information pertinent to the receipt of Medicaid funds. Change in ownership, including but not limited to the removal, addition and/or substitution of a partner, must be reported within five working days by completing and submitting an initial enrollment application along with all required documentation. Failure to do so may result in termination of the contract at the time of discovery.

103.3A CONDITIONS OF REPORTING

1. All changes, with the exception of change in ownership, must be reported in writing on the form prescribed in the online *Provider Enrollment Information Booklet* and require the signature of the provider. If the provider is a business, the change must include the signature of the owner or administrator. Medicaid will not change any provider record without proper signatures. Annual 1099 forms reflect the information in Medicaid's records and may be incorrect if changes are not reported timely.

2. Medicaid payments are mailed only to the address furnished by the provider and listed in the Medicaid computer system. Correct address and other information are necessary to assure receipt of all checks and policy publications from Nevada Medicaid. Address changes are required even when only a suite number change as the US Postal Service will not deliver mail to a different suite number. Returned mail may be used by Medicaid to close provider numbers due to "loss of contact".

3. When there is a change in ownership, the contract may be automatically assigned to a new owner, as well as the payment amounts that may be due or retrospectively become due to, or from Nevada Medicaid, by the prior owners. The assigned contract is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.

   If there is a change in ownership, the provider must provide a copy of the bill of sale, copies of new licenses/certifications and/or verification of a change in the FEIN. The provider must also complete/submit an initial enrollment application.

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4. For a change in name only, the provider must provide copies of new license/certifications and verification of change in FEIN. For a change in FEIN, the provider must provide verification from the Treasury Department of the new number.

103.4 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

The DHCFP is required to ensure entities receiving annual payments from Medicaid of at least $5,000,000 have written policies for educating their staff on federal and state regulations pertaining to false claims and statements, the detection and prevention of fraud and abuse, and whistleblowers protections under law for reporting fraud and abuse in Federal health care programs. (1396a(a)(68) of Title 42, United States Code).

These providers are required to:

A. adhere to federal and state regulations, and the provider agreement or contract, to establish written policy of dissemination to their staff;

B. ensure policies are adopted by any contractor or agent acting on their behalf;

C. educate staff on the regulations. Dissemination to staff should occur within 30 days from the date of hire, and annually thereafter;

D. provide signed Certification Form, signed provider agreement, copies of written policy and employee handbook, and documentation staff has been educated, within the required timeframes;

E. maintain documentation on the education of staff, and make it readily available for review by state or federal officials; and

F. provide requested re-certification within required timeframes to ensure ongoing compliance.

103.~~4A~~5. COVERAGE AND LIMITATIONS

A. The DHCFP has a program to identify providers that fit the criteria of being an entity and will identify additional or new providers fitting the criteria at the beginning of each federal fiscal year.

B. The DHCFP will issue a letter advising an entity of the regulations and require the entity to:

1. submit a certification stating they are in compliance with the requirements;

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2. sign a provider agreement or Managed Care Contract Amendment incorporating this requirement;

3. provide copies of written policies developed for educating their staff on false claims, fraud and abuse and whistleblowers protections under law; and

4. provide documentation of employees having received the information.

~~A.~~C. Re-certification of existing entities will be done annually for ongoing compliance.

~~B.~~D. The DHCFP is authorized to take administrative action for non-compliance through non-renewal of provider or contract or suspension or termination of provider status.

103.~~5~~6 SAFEGUARDING INFORMATION ON APPLICANTS AND RECIPIENTS

Federal and state regulations including HIPAA of 1996, the HITECH Act of 2009 and confidentiality standards within 42 CFR § 431.301 – 431.305 restrict the use or disclosure of information concerning applicants and recipients. The information providers must safeguard includes, but is not limited to, recipient demographic and eligibility information, social and economic conditions or circumstances, medical diagnosis and services provided and information received in connection with the identification of legally liable third party resources.

In accordance with HIPAA, protected health information may be disclosed for the purposes of treatment, payment or health care operations. Most other disclosures require a signed Authorization for Disclosure from the participant or designated representative. Details about allowable uses and disclosures are available to participants in the DHCFP Notice of Privacy Practices, which is provided to all new Medicaid enrollees.

For penalties associated with impermissible use and disclosure of recipient information, see Section 100.2(d).

103.~~5A~~7 MEDICAL AND PSYCHOLOGICAL INFORMATION

A. Any psychological information received about an applicant or recipient shall not be shared with that person. This ruling applies even if there is a written release on file from his or her physician. If the applicant/recipient wishes information regarding his or her psychological condition, he or she must discuss it with his or her physician.

B. Medical information, regardless of source, may be shared with the applicant or recipient upon receipt of their written request. However, any other agency needing copies of medical information must submit a Medicaid release stating what information is requested and signed by the applicant or recipient in question or their authorized representative.

The exception to this policy is in the case of a fair hearing. Agency material presented at a fair hearing constituting the basis of a decision will be open to examination by the applicant/recipient and/or his or her representative.

C. The HIPAA of 1996 Privacy Rules permit the disclosure of a recipient's health information without their authorization in certain instances (e.g. for treatment, payment, health care operations or emergency treatment; to make appointments to the DHCFP business associates; to recipient's personal representatives; as required by law; for the good of public health; etc.)

D. The HIPAA Privacy Rules assure the recipient certain rights regarding their health information (e.g. to access/copy, to correct or amend, restrict access, receive an accounting of disclosures and confidential communications).

E. A provider may not disclose information concerning eligibility, care or services given to a recipient except as specifically allowed by state and federal laws and regulations.

103.~~6~~8 NON-DISCRIMINATION AND CIVIL RIGHTS COMPLIANCE

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act (ADA) of 1990, prohibit discrimination on the basis of race, color, national origin, religion, sex, age, disability (including AIDS or related conditions) or any other class status protected by federal or state law or regulation by programs receiving Federal Financial Participation (FFP). The DHCFP service providers must comply with these laws as a condition of participation in the Nevada Medicaid program in offering or providing services to the Division's program beneficiaries or job applicants and employees of the service providers.

All service providers are required to follow and abide by the DHCFP's non-discrimination policies. In addition, hospitals, nursing facilities and Intermediate Care Facility for the Mentally Retarded (ICF/MRs) will be reviewed by Medicaid periodically to assure they follow requirements specific to them. Requirements for compliance:

A. Hospitals, nursing facilities and ICF/MRs must designate an individual as having responsibility for civil rights coordination, handling grievances and assuring compliance with all civil rights regulations. This person will serve as coordinator of the facility's program to achieve nondiscrimination practices, as well as be the liaison with Medicaid for Civil Rights compliance reviews.

B. Notices/signs must be posted throughout a facility, as well as information contained in patient and employee handouts, which notifies the public, patients and employees that the

facility does not discriminate with regards to race, color, national origin, religion, gender, age or disability (including AIDS and related conditions) in:

1. admissions;

2. access to and provisions of services; or

3. employment.

There must, also, be posted a grievance procedure to assure patients and employees of the facility are provided notice of how to file a grievance or complaint alleging a facility's failure to comply with applicable civil rights and non-discrimination laws and regulations.

C. Medical facilities may not ask patients whether they are willing to share accommodations with persons of a different race, color, national origin, religion, age or disability (including AIDS and related conditions) or other class protected by federal law. Requests for transfers to other rooms in the same class of accommodations must not be honored if based on discriminatory considerations. (Exceptions due to valid medical reasons or compelling circumstances of the individual case may be made only by written certification of such by the attending physician or administrator).

D. Medical facilities must have policies prohibiting making improper inquiries regarding a person's race, color, national origin, religion, sex, age or disability (including AIDS and related conditions) prior to making the decision to admit the person. Supervisory staff must be aware of this policy and enforce it.

Admission to a facility and all services rendered and resources routinely used by all persons in the facility (e.g., nursing care, social services, dining area, beauty salon, barber shop, etc.) must be provided without regard to race, color, national origin, religion, sex, age or disability (including AIDS and related conditions). An acute hospital must have a Telecommunications Device (TTY or TDD) for use by patients and staff who are deaf to assure that its emergency room services are made equally available. All other hospitals, Nursing Facilities (NF) and ICF/MRs, which do not have a TDD, must have access to a TDD at no cost or inconvenience to the patient or staff member wishing to use it.

The facility must assure equal availability of all services to persons with Limited English Proficiency (LEP), hearing and sight-impaired patients and persons with other communication limitations. For example, when a provider determines that a particular non-English language must be accommodated; vital documents must be available at no charge. With regard to sight-impaired individuals, the provider's library or other reading service must be made equally available through Braille, Large Print books or Talking books.

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The facility must include assurances of nondiscrimination in contracts it maintains with non-salaried service providers and consultants (e.g., physicians, lab or x-ray services, and respiratory, occupational or physical therapists).

E. Displacement of a resident after admission to a facility on the basis of a change in payment source is prohibited. A Medicaid participating facility cannot refuse to continue to care for a resident because the source of payment has changed from private funds to Medicaid. A facility must not terminate services to a resident based on financial rather than medical reasons when payment changes from private funds to Medicaid.

A facility must not require a Medicaid-eligible resident or his or her legal guardian to supplement Medicaid coverage. This includes requiring continuation of private pay contracts once the resident becomes Medicaid eligible, and/or asking for contributions, donations, or gifts as a condition of admission or continued stay. Complaints regarding alleged economic discrimination should be made to the Aging and Disability Services Division (ADSD) Long Term Care Ombudsman or to the DHCFP.

F. Medical facilities must have policies that prevent making improper inquiries regarding race, color, national origin, religion, sex, age or disability (including AIDS and related conditions) prior to making a decision to employ a person. Supervisory personnel must be knowledgeable with regard to these policies and practices and must enforce them.

The facility must assure that educational institutions which place students with the facility do not discriminate regarding the selection or treatment of minority groups, disabled (including AIDS and related conditions) or other protected classes of students. Facilities must also assure they do not discriminate in their selection and placement of student interns.

G. All service providers (including medical facilities) must maintain a list of in-house and/or community based sign language interpreters. This list must be reviewed and revised, if necessary, at least annually. Facilities must also have policies outlining how persons with hearing impairments are identified as needing interpretation services, and how these services can be accessed at no cost to them.

H. All service providers (including medical facilities) must provide persons who have LEP with access to programs and services at no cost to the person. Services providers must:

1. identify the non-English languages that must be accommodated among the population served and identify the points of contact where language assistance is needed;

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2. develop and implement a written policy that ensures accurate and effective communication;

3. take steps to ensure staff understands the policy and is capable of carrying it out; and

4. annually review the LEP program to determine its effectiveness.

Service providers in need of additional guidance should refer to the LEP policy guidance document provided by the CMS and the U.S. Office of Civil Rights (OCR). Among other things, the document explains the criteria for identifying languages that must be accommodated and includes methods of providing language assistance. A link to the policy document is available via the Division's Civil Rights web pages accessible from its Internet website: www.dhcfp.nv.gov.

I. The facility must maintain, in systematic manner, and provide upon request to Medicaid, information regarding race, color, national origin, and disability of patients and employees.

103. ~~7~~9 ADVANCED DIRECTIVE

An Advanced Directive (AD) is a written instruction by an individual, 18 years of age or older and done in advance of a serious illness or condition. The AD allows the individual to direct health care decisions in the event they become incapacitated. It may be in the form of a Living Will or Durable Power of Attorney, and includes provisions allowing the individual to make decisions regarding the use or refusal of life sustaining treatment.

103.~~7A~~10 ADMINISTRATION OF ADVANCED DIRECTIVES

A. Hospitals, NF, home health agencies, Personal Care Attendants (PCA) providers and hospices must maintain written policies and procedures concerning ADs and provide written information to all adult individuals (age 18 or older) upon admission or service delivery concerning the:

~~a.~~1. individual's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate ADs.

~~b.~~2. written policies of the service provider respecting implementation of such rights, including a clear and precise statement of limitation if the service provider cannot implement an AD on the basis of conscience.

At a minimum, a service provider's statement of limitations must:

a. clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

b. identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and

c. describe the range of medical conditions or procedures by the conscience objection.

~~2~~.B. Document in the individual's medical records whether or not the individual has an AD.

~~3~~.C. Service providers cannot apply conditions to provisions of care or otherwise discriminate against an individual based on whether or not they have executed an AD.

~~4~~.D. Ensure compliance with the requirements of state law regarding ADs, and inform individuals any complaints concerning AD requirements may be filed with the state survey and certification agency.

~~5~~.E. Provide for the education of staff concerning its policies and procedures on ADs (at least annually).

~~6~~.F. Provide for community education regarding issues concerning ADs (at least annually). At a minimum, education presented must define what constitutes an AD, emphasize an AD is designed to enhance an individual's control over medical treatment, and describe applicable state law concerning ADs. A provider must be able to document its community education efforts.

Nevada Medicaid is responsible for monitoring/reviewing service providers periodically to determine whether they are complying with federal and state AD requirements.

103.~~8~~11 MUTUAL AGREEMENT IN PROVIDER CHOICE

Any individual eligible for Medicaid has free choice of provider from among those who have signed a participating contract. Such choice is a matter of mutual agreement between the recipient and provider and in no way abrogates the right of the professional to accept or reject a given individual as a private patient or to limit his or her practice as he or she chooses.

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106 CONTRACT TERMINATIONS ~~AND NON-RENEWAL~~

Termination means termination of the Medicaid Contract between Nevada Medicaid and the actively enrolled provider. ~~Non-renewal means Nevada Medicaid will refuse to renew a Medicaid contract with the provider when the previous agreement expires.~~

A provider whose contract is terminated ~~or non-renewed~~ may request a fair hearing in accordance with NRS 422.306 and MSM Chapter 3100. Refer to Chapter 3100, Section 3105 of the MSM for additional information on how to request a hearing.

Nevada Medicaid will not reimburse the provider for services rendered to Medicaid recipients on or after the Medicaid contract has been terminated~~,~~ or suspended ~~or non-renewed~~.

106.1 TERMINATION FOR CONVENIENCE

The Medicaid provider contract can be terminated for convenience by either party upon 90 days' prior written notification of the other party.

106.2 CONDITIONS OF CONTRACT TERMINATIONS ~~AND NON-RENEWAL~~

A. Immediate Terminations

The DHCFP may decide to immediately terminate ~~or not renew~~ a provider contract if any of the following occurs, is discovered or reported:

1. The provider is convicted of a criminal offense related to the participation in the Medicare/Medicaid program.
2. The provider's professional license, certification, accreditation or registration is suspended or revoked.
3. The DHCFP is notified the provider is placed on the Office of Inspector General (OIG)'s Exclusion List (42 CFR 1002).
4. The provider is deceased.
5. The DHCFP has determined that the quality of care of services rendered by the provider endangers the health and safety of one or more recipients.
6. Mail is returned from the post office and a forwarding address is not provided.
7. The provider has failed to disclose information listed in MSM Chapter 100, Section 102 and all sub sections.~~;~~

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8. Identity of the provider cannot be proven.~~; or~~

9. The provider has been terminated for cause by a MCO contracted with the DHCFP.

10. The Provider, or any person with a 5 percent or greater direct or indirect ownership interest in the Provider, fails to consent to FCBC and/or to submit sets of fingerprints in the form and manner as instructed by the Fiscal Agent and/or the DHCFP.

11. Credible allegations of ~~F~~fraud, waste or abuse of such a nature and extent have been discovered and/or reported that immediate and permanent action is deemed necessary;

12. The provider has been convicted of a misdemeanor ~~gross misdemeanor~~ and/or felony that is incompatible with the mission of the DHCFP.

13. The DHCFP becomes aware that the provider failed to provide required information and/or provided false information on the enrollment application.

B. Advance Notice of Termination

An advance notice of Intent to terminate must be mailed no less than 20 days from the intended action date if the DHCFP determines to terminate the contractual relationship. Advance notice is required for the following reasons (not all inclusive):

~~1. The provider falsified the application for a Medicaid contract;~~

~~2. Fraud or abuse of such a nature and extent that immediate and permanent action is deemed necessary;~~

~~3.~~1. Termination, exclusion or suspension of an agreement or contract by any other governmental, state or county program is reported or discovered.~~;~~

~~4.~~2. The provider no longer meets the conditions of participation as stated in Chapter 100 all-inclusive of the Nevada MSM.

~~5.~~3. The provider no longer meets all of the requirements or other conditions of participation as required by the Nevada MSM for the specified provider type.

~~6.~~4. The provider fails to submit requested information by the required due date.

~~7.~~5. The provider is under investigation by a law enforcement or state agency for conduct that it is deemed incompatible with the mission of the DHCFP.

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~~8.6.~~ ~~The provider has been convicted of a misdemeanor, gross misdemeanor or felony that is incompatible with the mission of the DHCFP;~~

6. The Division has determined that the results of any investigation, audit, review or survey necessitate termination; and/or

~~9.~~7. An administrative contract termination has been performed.

106.3 SANCTION PERIODS

Providers who are terminated or denied from Nevada Medicaid for cause will serve a sanction period that begins with the effective date of the termination or denial. Sanctioned providers will not be reimbursed for any services provided on or after the date of termination. Providers who have not been permanently sanctioned from the Nevada Medicaid program may resubmit a new Provider Enrollment Application at the end of the sanction.

~~Sanctions may be applied to any person who has ownership or controlling interest in the provider or who is an agent or managing employee of the provider.~~ Sanctions apply to entities when individuals meet the criteria below who have a 5 percent or greater ownership or control interest, or are an agent or managing employee. A person who assists to submit prior authorization requests or claims is an agent for purposes of MSM Chapter 100.

1. Tier 1 - Permanent Sanction

   a. Provider is on the OIG exclusion list.

   b. Provider has been convicted of a criminal felony offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (CHIP) (NCU) or the Title XX services program.

   c. Provider has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU) or the Title XX services program.

   d. Provider has been convicted of any offense listed below:

      1. Murder, voluntary manslaughter, mayhem or kidnapping;

      2. Sexual assault, sexual seduction or any sexually related crime;

      3. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission;

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4. False imprisonment or involuntary servitude;

5. Criminal neglect of patients per the NRS 200.495;

6. Abuse or neglect of children per NRS 200.508 through 200.5085;

7. Abuse, neglect, exploitation or isolation of older persons;

8. Any offense against a minor under NRS 200.700 through 200.760;

9. Any offense against public decency and good morals under a provision NRS 201.015 through NRS 201.56;

10. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS.

The DHCFP may choose to allow re-enrollment if the United States Department of Health and Human Services (DHHS) or Medicare notifies the DHCFP that the provider may be reinstated.

2. Tier 2 – Seven Year Sanction

a. Provider has been terminated due to quality of care issues or inappropriate and/or fraudulent billing practices as identified as a result of an investigation, audit, review or survey.

b. Provider has been convicted of any offense listed below:

1. Assault or battery;

2. Any offense involving arson, fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;

3. Harassment or stalking;

4. Any offense against the executive power of the State in violation of NRS 197;

5. Any offense against the legislative power of the State in violation of NRS 198;

6. Any offense against public justice in violation of NRS 199;

~~7.~~ ~~A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or~~

~~8.~~7. Any other felony involving the use of a firearm or other deadly weapon within the immediately preceding seven years.

3. Tier 3 – Twelve Month Sanction

a. Provider was denied enrollment due to omitting information regarding criminal background or ownership and/or supplying false information on the Provider Enrollment Application;

b. Provider was terminated as a result of an investigation, audit, review or survey not related to quality of care or inappropriate fraudulent billing practices;

c. Provider was terminated due to not meeting the conditions of participation as stated in Chapter 100 all-inclusive of the Nevada MSM or other conditions of participation as required by the Nevada MSM for the specified provider type;

d. Provider was terminated due to being under investigation by a law enforcement or state agency for conduct that it is deemed incompatible with the mission of the DHCFP;

e. Provider was terminated due to conviction of a misdemeanor, gross misdemeanor or felony, not listed in Tier 1 or Tier 2, which is incompatible with the mission of the DHCFP;

f. Provider has failed to follow through with their DHCFP approved corrective action plan; or

g. Provider has a restricted professional license.

4. Immediate Re-Application

Providers whose contracts have been terminated for the following reasons may reapply at any time:

a. Loss of contact;

b. No payments made to provider within the prior 24 months;

c. When the sole issue is a change in federal law and the law has been repealed; or

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