MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 22, 2018

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 clarify policy regarding the terms "Applicant" and "Provider," National Provider Identifier (NPI) number, provider Change of Ownership, Site Visits, Sanctions and Sanction Tiers, and updates are being made to Fiscal Agent and MCO references. Proposed updates will also include language for applicants who are prohibited from enrollment consideration and Provisional Enrollment criteria.

These proposals will include changes to Section 100 – Introduction, to include the meanings of "Applicant" and "Provider" and to relocate specific Code of Federal Regulations (CFR) citings from Section 102 to this section; Section 102 – Provider Enrollment, which will add Provisionally Enrolled providers to the "Moderate" risk category, outlining the conditions for Provisional Enrollment and the effect of non-compliance, and to clarify policy such as NPI requirements, terminations for provider convictions of State or Federally funded assistance programs other than Medicaid/Medicare, the purpose of and method for site visits, and the criteria under which an applicant will be prohibited from enrollment consideration; Section 103 – Provider Rules and Requirements, to list examples of changes which providers shall report and to update the language for Intermediate Care Facilities/Individuals with Intellectual Disabilities (ICF/IID); and Section 106 – Contract Terminations, to inform providers that terminating from Fee-for-Service will also terminate provider from Medicaid Managed Care Organization(s), add to the conditions warranting Immediate Termination and Advance Notice of Termination, align sanction periods, and to restructure the 3-Tier Sanction format to a 4-Tier Sanction format.

Further revisions are proposed to MSM Chapter 100, Section 108 – References, to list changes to Fiscal Agent and MCO information.

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: All Medicaid enrolled providers.

Financial Impact on Local Government: None.

These changes are effective February 23, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 31442 Medicaid Program	MTL 14/17, 19/15, Medicaid Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
100	**Introduction**	Moved last paragraph in this section to the first paragraph and added clarification of "Nevada" DHHS and added "Nevada Division of Health Care Financing and Policy" to clarify DHCFP.
100(B)	**Introduction**	New sub-section to identify who an "Applicant" is with Nevada Medicaid and to include examples of an "Applicant."
100(C)	**Introduction**	New sub-section to identify who a "Provider" is with Nevada Medicaid and to include examples of a "Provider."
100.1(A)(17)	**Authority**	Moved "42 CFR §455.450" from Section 102.2(A) to keep all Authority citing's together.
100.1(A)(18)	**Authority**	Moved "42 CFR §455.432" and "42 CFR §455.434" from Sections 102.3(A)(2)(b) and 102.3(A)(3)(c), respectively, to keep all Authority citing's together.
102(A)(1)	**Provider Enrollment**	Added "maintains their NPI in "Active" status in the NPPES Registry and updates all data elements, per NPPES guidelines, when changes occur."
102(B)	**Change of Ownership (CHOW)**	New sub-section to address ownership changes and provide examples.
102(C)	**CHOW Enrollment**	New sub-section to address CHOW Enrollment parameters.
102(D)	**Prohibited from Enrollment Consideration**	New sub-section to address a sit-out period for applicants who, prior to enrollment, are found to have "provided false, untrue or misleading/deceptive information and/or who have omitted relevant information" on their enrollment application. These applicants will serve a 12 month sit-out from the date of application denial.
102.1(A)	**Request for Enrollment, Re-Enrollment and Revalidation**	This sub-section has been relocated here from Section 102.7(B).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.1(A)(3)	**Request for Enrollment, Re-Enrollment and Revalidation**	Added "or" at the end of this bullet.
102.2	**Conditions of Participation – All Providers and Applicants**	Added "and Applicants" in the section title and the first line of the first paragraph.
102.2(A)	**Conditions of Participation – All Providers and Applicants**	Moved "42 CFR §455.450" to Section 100.1(A)(17), Authority and removed the word "Per."
102.2(A)(2)(k)	**Conditions of Participation – All Providers and Applicants**	Added this bullet which includes the Moderate Categorical Risk level "Provisionally Enrolled providers."
102.2(B)	**Conditions of Participation – All Providers and Applicants**	Added "or applicant" in the first and last line of the first paragraph.
102.2(B)(9)	**Conditions of Participation – All Providers and Applicants**	Added parenthesis: "NCU" and "or any other State or Federally funded assistance program;"
102.2(B)(12)	**Conditions of Participation – All Providers and Applicants**	Added "or any other State or Federally funded assistance program;"
102.2(B)(15)	**Conditions of Participation – All Providers and Applicants**	Added "or applicant" in the first line after the word "provider."
102.2(I)	**Conditions of Participation – All Providers and Applicants**	Added this sub-section to identify when a site visit is conducted and some parameters for site visits

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.2(J)	**Conditions of Participation – All Providers and Applicants**	Added this sub-section to read: "In addition to any other authority it may have, the DHCFP may exclude an individual or entity (applicant or provider) from participation in the Medicaid program for any reason for which the secretary could exclude that individual or entity from participation in Medicare."
102.3(A)(2)(b)	**Enhanced Provider Screening**	Removed "on" from "on-site" and "in accordance with 42 CFR §455.432," relocating the CFR reference to Section 100.1(A)(18).
102.3(A)(3)(c)	**Enhanced Provider Screening**	Relocated "42 CFR §455.434" to Section 100.1(A)(18), removing the word "and."
102.3A	**Provisional Enrollment**	This section is new and addresses the criteria for applicants and re-validating providers to be provisionally enrolled, the criteria under which an active provider would be elevated to a provisionally enrolled status, the time frame for provisional enrollment, the consequence to a provider who does not "not meet provisional enrollment requirements," that "backdating for provisionally enrolled providers shall not be permitted," and that "revalidation date shall be the first day of full enrollment."
102.7(A)(1)	**Provider Disclosure**	Removed "a criminal" and replaced with the word "any" to describe an offense for which there is a conviction. Removed "person's" and replaced with "individual's or entity's."
102.7(A)(3)	**Provider Disclosure**	Removed "criminal" before the word "offense." Added "and/or applicants," removed "criminal," replaced "convictions" with "those," updated Section "102.2A" with "102.2(B)," added "and/or applicants" in the last line and replaced the last word "charge" with "conviction."
102.7(A)(4)	**Provider Disclosure**	In the last sentence, added "and/or applicants" after the word "providers" and added "regarding the investigation" at the end of the sentence.
102.7(A)(8)	**Provider Disclosure**	Added "and/or applicant's" after the word "provider's" in the first line.
102.7(B)	**Provider Disclosure**	Moved this section to Section 102.1(A).
102.7(C)	**Provider Disclosure**	Deleted this section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
103.3(B)	**Provider Reporting Requirements**	Added this bullet to list changes after enrollment which providers shall be required to report.
103.3A(3)	**Conditions of Reporting**	Added definition of FEIN to read: "…verification of a change in the Federal Employer Identification Number (FEIN)."
103.8	**Non-Discrimination and Civil Rights Compliance**	In the second paragraph, removed "…the Mentally Retarded (ICF/MRs)" and replaced with "Individuals with Intellectual Disabilities (ICF/IID)."
103.8(A)	**Non-Discrimination and Civil Rights Compliance**	Replaced "MRs" with "IIDs."
103.8(D)	**Non-Discrimination and Civil Rights Compliance**	Removed "ICF/MRs" and replaced with "ICF/IIDs."
106	**Contract Terminations**	Added fourth paragraph which states "Individuals/entities enrolled with Nevada Medicaid who are terminated or who voluntarily terminate must be terminated by all Medicaid Managed Care Organization(s)."
106.2(A)(2)	**Conditions of Contract Terminations**	Added "or expired" at the end of the bullet.
106.2(A)(14)	**Conditions of Contract Terminations**	Added this bullet to include "The provider is convicted of any offense related to the participation in any Social Services program administered by any State or the Federal Government, including but not limited to Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance to Needy Families (TANF)."
106.2(A)(15)	**Conditions of Contract Terminations**	Added this bullet to include "The seller and/or buyer having 5% or more direct or indirect ownership of any active provider entity/group is found to have sold, transferred or purchased the provider entity/group in anticipation of (or following) a conviction, imposition of a civil money penalty or assessment or imposition of an exclusion."
106.2(B)(6)	**Conditions of Contract Terminations**	Removed "and/or" at the end of this bullet.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
106.2(B)(7)	**Conditions of Contract Terminations**	Added "and/or" at the end of this bullet.
106.2(B)(8)	**Conditions of Contract Terminations**	Added this bullet which states "The provider's NPI number is deactivated and/or the provider's data elements in NPPES are no longer current."
106.3	**Sanction Periods**	Second paragraph, added a second sentence which states "Sanctions also apply to individual owners and agents/ managing employees when the group/entity meets any of the criteria listed in this section." Also, added a third paragraph which states "If an entity is excluded, the length of the individual owner's exclusion will be for the same period as the sanctioned entity. If an individual owner is excluded, the entity will also be excluded and the length of the entity's exclusion will be for the same period as the sanctioned owner."
106.3(1)(b)	**Sanction Periods**	Removed "criminal" to describe: felony and added at the end of the sentence "or any other State or Federally funded assistance program."
106.3(1)(c)	**Sanction Periods**	Added at the end of the bullet "or any other State or Federally funded assistance program."
106.3(2)	**Sanction Periods**	Renamed this sub-section to state "Tier 2 – Ten Year Sanction.
106.3(2)(b)(2)	**Sanction Periods**	Removed the word "robbery."
106.3(2)(b)(6)	**Sanction Periods**	Added "and/or" at the end of this bullet.
106.3(2)(b)(7)	**Sanction Periods**	Removed "within the immediately preceding seven years."
106.3(2)(b)(8)	**Sanction Periods**	Added bullet to include a sanction for any program related misdemeanor conviction of a provider.
106.3(3)	**Sanction Periods**	Renamed this sub-section to state "Tier 3 – Three Year Sanction."
106.3(3)(a)	**Sanction Periods**	Removed "denied enrollment" and replaced with "terminated at Revalidation."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
106.3(3)(f)	**Sanction Periods**	Added bullet which states "It is reported or discovered that the provider falsified information on and/or supplied false information/documentation with the Enrollment Application, unless a higher sanction tier is applicable; and/or."
106.3(3)(g)	**Sanction Periods**	Added bullet which states "It is reported or discovered that the provider omitted information on the Enrollment Application, unless a higher sanction tier is applicable."
106.3(4)	**Sanction Periods**	Added "Tier 4 – Twelve Month Sanction."
106.3(4)(a)	**Sanction Periods**	Removed the word "or."
106.3(4)(b)	**Sanction Periods**	Reworded to state "Provider has a restriction placed on their professional license which is incompatible with the mission of the DHCFP."
106.3(4)(c)	**Sanction Periods**	Added bullet which states "Provider failed to successfully meet Provisional Enrollment conditions of participation."
106.3(4)(d)	**Sanction Periods**	Added bullet which states "Provider failed to report/provide required information in the time frame set forth in the Enrollment Application, Provider Contract and/or the MSM (all inclusive), such as:" and lists examples which include CHOWs, updated licenses, indictment, arrest or criminal charges/convictions, investigation, failure to consent to enhanced provider screening.
108	**References**	Update information for Fiscal Agent from HP Enterprise Services to DXC Technology, TPL from Emdeon to HMS – NV Casualty Recovery, Amerigroup Community Care phone number, and added necessary information for Silver Summit (Centene).
108	**References**	Updates made to Welfare (DWSS) Field Offices phone numbers and added new Welfare offices.

100 INTRODUCTION

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

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

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

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

3. restrain the growth of health care costs; and

4. 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.~~

B. For the purposes of this chapter, individuals and/or entities that have never been enrolled with Nevada Medicaid as a provider who submit an initial enrollment application and former Nevada Medicaid providers who submit a re-enrollment application are considered applicants. The term "Applicant" includes:

1. individuals;

2. groups and/or entities;

3. owners having 5 ~~percent~~% direct or indirect ownership or controlling interest in a group and/or entity; and/or

4. authorized agents, authorized users or managing employees acting with authority on behalf of an individual, group, entity and/or owner.

C. For the purposes of this chapter and the *Nevada Medicaid and Nevada Check Up Provider Contract*, individuals and/or entities actively enrolled with Nevada Medicaid are considered providers. The term "Provider" includes:

1. individual providers;

2. groups and/or entity providers;

3. owners having 5% direct or indirect ownership in a group and/or entity; and/or

4. authorized agents, authorized users or managing employees acting with authority on behalf of an individual, group, entity and/or owner.

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 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 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.

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.

17. Provider Categorical Risk Levels are assigned, in part, under 42 CFR §424.518.

18. Enhanced provider screening can be found under 42 CFR §455.432 for ~~S~~site ~~V~~visits and 42 CFR §455.434 for ~~C~~criminal ~~B~~background ~~C~~checks.

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 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;

c. the past, present or future payment for the provision of health care to the individual; or

d. identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

b. Information which does not meet the requirements of de-identified data defined in 45 CFR 164 § 514(b). This includes all elements of dates (such

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/Atypical Provider Number (API) number on the application and requests for payment, maintains their NPI in "Active" status in the NPPES Registry and updates all data elements, per NPPES guidelines, when changes occur;

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

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

4. Receives notice from Nevada Medicaid that the credentialing requirements have been met and the provider agreement has been accepted.

B. CHANGE OF OWNERSHIP (CHOW)

A CHOW typically occurs when a Medicaid provider is purchased or leased by another organization. The following list indicates examples (not all inclusive) of a CHOW:

1. Partnership: In the case of a partnership, the removal, addition or substitution of a partner as permitted by applicable State law.

2. Unincorporated sole proprietorship: Transfer of title and property to another party.

3. Corporation: The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation.

4. Leasing: The lease of all or part of a provider facility.

5. Sale/Transfer: The sale, gifting, purchase or transfer of an existing provider or the assets of an existing provider to an individual, relative~~,~~ and/or group.

C. CHOW enrollment:

1. is not guaranteed,

2. is considered a new enrollment, and

3. must meet all enrollment requirements for the specified provider type.

Providers or applicants having (or formerly holding) a direct or indirect ownership or control interest who purchase, sell and/or transfer such interest in an entity to a family member or a member of the person's household in anticipation of (or following):

1. a conviction;

2. an imposition of a civil money penalty or assessment; and/or

3. an imposition of an exclusion

shall be terminated or have enrollment denied and will serve, at minimum, a Tier 4 – Twelve-Month Sanction, unless a higher tier sanction is applicable.

D. PROHIBITED FROM ENROLLMENT CONSIDERATION

Applicants who are found to have provided false, untrue~~,~~ or misleading/deceptive information and/or who have omitted relevant information are prohibited from enrollment consideration for a period of twelve consecutive months from the date of application denial. Examples may include, but are not limited to:

1. criminal conviction(s);

2. information regarding direct or indirect ownership or controlling interest of 5% or more; and/or

3. falsified documentation.

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 all types of enrollment 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. 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.

A. 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.

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

1. on-site inspection prior to enrollment;

2. review of business records;

3. data searches; and/or

4. provisional enrollment.

102.2 CONDITIONS OF PARTICIPATION – ALL PROVIDERS AND APPLICANTS

As a condition of new or continued enrollment, providers and applicants 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 five 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 §455.450, t~~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.

c. End-stage renal disease facilities.

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.

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

h. Portable x-ray suppliers.

i. Revalidating home health agencies.

j. Revalidating Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers.

k. Provisionally enrolled providers.

3. High categorical risk:

   a. Newly enrolling home health agencies.

   b. Newly enrolling DMEPOS suppliers.

B. The Fiscal Agent shall not enroll any provider or applicant (individual or entity having a person with a five percent or greater direct or indirect ownership interest in the provider, including management personnel) who has been convicted of a felony or 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 or applicant 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 NRS Section 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;

9. Conviction of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, CHIP~~,~~ (NCU)~~, or~~ the Title XX services program or any other State of Federally funded assistance 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. Is on the Office of the Inspector General (OIG) or Excluded Parties List System (EPLS) exclusion list;

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

15. The Fiscal Agent shall not enroll a provider or applicant who has been convicted within the preceding ten years of (not all inclusive);

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

    b. 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. any offense involving the use of a firearm or other deadly weapon.

C. The Fiscal Agent shall not enroll a public institution unless it is a medical institution. The Fiscal Agent 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 provider's 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).

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, Nevada 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

I. Site visits shall be conducted on all providers and/or applicants designated as "Moderate" or "High" categorical risk. The purpose of the site visit is to verify that the information submitted to the Fiscal Agent or the DHCFP is accurate, the facility is operational and to determine compliance with Federal and State enrollment requirements. Site visits may be:

1. conducted pre- or post-enrollment;

2. announced and/or unannounced; and/or

3. conducted as needed in conjunction with a Corrective Action Plan.

J. In addition to any other authority it may have, the DHCFP may exclude an individual or entity (applicant or provider) from participation in the Medicaid program for any reason for which the secretary could exclude that individual or entity from participation in Medicare.

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; and

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

2. Moderate categorical risk:

   a. provider meets the "Limited" screening requirements; and

   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; and

   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 five 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 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 five 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 five 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:

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.

102.3A PROVISIONAL ENROLLMENT

A. At the discretion of the DHCFP, the Fiscal Agent may provisionally enroll applicants who meet one or more of the following conditions:

1. The applicant is part of an approved repayment program for an outstanding debt owed to:

a. any State or the Federal Government;

b. Medicare;

c. Medicaid; and/or

d. a Managed Care Organization (MCO).

2. The applicant discloses a conviction which would not automatically preclude the applicant from enrollment.

3. The applicant is under investigation by any law enforcement, regulatory or state agency at the time of application.

4. The applicant has an open or pending court case which is reported on the enrollment application.

5. The applicant has been denied malpractice insurance or has ever had any professional business or accreditation license/certificate denied, suspended, surrendered, restricted or revoked.

6. All applicants for a provider type for which a moratorium was lifted in the preceding 12 months.

B. The DHCFP may elevate an active provider to provisionally enrolled status if one or more of the following occurs:

1. The outcome of an open or pending court case or investigation by any law enforcement, regulatory or state agency reported on the enrollment application indicates a conviction for an offense not listed in MSM Chapter 100, Section 102.2(B).

2. The provider's Categorical Risk level is elevated to "Moderate" or "High" after enrollment has occurred.

3. The provider's license required for enrollment with Medicare and/or Medicaid (in Nevada or any other State) is restricted by the issuing Board or agency.

4. A Change of Ownership is reported and any of the purchasing and/or new owners/officers report any conditions noted in Section 102.3A, all inclusive.

5. Preliminary information is discovered where conditions under Section 102.3A would not warrant termination but would require provisional enrollment.

C. At the discretion of the DHCFP, the Fiscal Agent may provisionally enroll a re-validating

provider who meets one or more of the following:

1. The provider is part of an approved repayment program for an outstanding debt owed to:

   a. any State or the Federal Government;

   b. Medicare;

   c. Medicaid; and/or

   d. a Managed Care Organization (MCO).

2. The provider discloses a conviction which would not automatically preclude the provider from enrollment.

3. The provider is under investigation by any law enforcement, regulatory or state agency at the time of re-validation.

4. The provider has an open or pending court case.

5. The provider has been denied malpractice insurance or has ever had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked.

D. Provisional enrollment will be for a period not less than 30 days and not more than 24 consecutive months for each enrollment application. During the provisional enrollment period, the provider shall be required to comply with all requirements within the MSM, including, but not limited to, the following:

1. Permit ~~S~~site ~~V~~visits (announced or unannounced);

2. Provide any and all requested information regarding billing, billing practices and/or policies and procedures in a complete and accurate manner by due date;

3. Attend provider training recommended by the DHCFP;

4. Cooperate and comply with all terms of a corrective action plan by the due date; and/or

5. Cooperate and comply with all quality of care compliance reviews.

E. Providers who fail to meet provisional enrollment requirements will be terminated "for

cause" and serve a Tier 4 – Twelve-Month Sanction, unless termination criteria require a higher level of sanction.

F. Backdating for provisionally enrolled providers shall not be permitted.

G. Revalidation date shall be the first day of full enrollment.

102.4 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.

102.5 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.

102.6 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.

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, CHIP, NCU or the Title XX services program.

A. Documents subject to disclosure include:

1. survey reports, including a statement of deficiencies;

2. official notifications of findings based on the survey;

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

4. ownership and contract information specified below; and

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:

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 five percent or more;

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

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:

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

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

102.7 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 five 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:

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

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

4. 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 Enrollment Unit for consideration on a case-by-case basis. Providers and/or applicants must provide information, documentation and explanation, regarding the investigation;

5. any current open/pending court cases;

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

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

8. if the provider's and/or applicant'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.A. 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.~~

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

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

~~2.1. review of business records;~~

~~3.1. data searches; and~~

~~4.1. 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.~~

102.8 DISPOSITION OF CONTRACT FOR PROVIDERS

The Fiscal Agent and/or the DHCFP will review the completed provider application 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.

102.9 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

103.3 PROVIDER REPORTING REQUIREMENTS

A. Medicaid providers 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 all required documentation. Failure to do so may result in termination of the contract at the time of discovery.

B. Within five working days, providers are required to report changes which may affect enrollment status. All changes are to be reported on the form prescribed in the online *Provider Enrollment Booklet*. Below are examples of changes effective after enrollment which shall be reported (not all inclusive):

1. change to licensure status;
2. indictment, arrest, criminal charge and/or conviction;
3. open and/or pending court case;
4. change in familial association with regard to ownership, managing employee and/or authorized user or agent;
5. enrollment/disenrollment in another State's Medicaid program;
6. enrollment/disenrollment with Medicare;
7. denial of malpractice insurance;
8. open investigation by any law enforcement, regulatory or state agency; and/or
9. provider becomes a state or government employee.

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 Federal Employer Identification Number (FEIN). The provider must also complete/submit an initial enrollment application.

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.

103.5 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;

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.

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

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.

103.6 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).

103.7 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.

103.8 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 Facilit~~ies~~iesy for ~~the Mentally Retarded (ICF/MRs)~~ Individuals with Intellectual Disabilities (ICF/IID) will be reviewed by Medicaid periodically to assure they follow requirements specific to them. Requirements for compliance:

A. Hospitals, nursing facilities and ICF/~~MRs~~ IIDs 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~~IIDs, 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.

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.

106 CONTRACT TERMINATIONS

Termination means termination of the Medicaid Contract between Nevada Medicaid and the actively enrolled provider.

A provider whose contract is terminated 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.

Individuals/entities enrolled with Nevada Medicaid who are terminated or who voluntarily terminate must be terminated by all Medicaid ~~Managed Care Organization~~MCO(s).

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

A. Immediate Terminations

The DHCFP may decide to immediately terminate 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 or expired.

3. The DHCFP is notified the provider is placed on the 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.

8. Identity of the provider cannot be proven.

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

10. The Provider, or any person with a five 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 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 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.

14. The provider is convicted of any offense related to the participation in any Social Services program administered by any State or the Federal Government, including, but not limited to, Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance to Needy Families (TANF).

15. The seller and/or buyer having 5% or more direct or indirect ownership of any active provider entity/group is found to have sold, transferred or purchased the provider entity/group in anticipation of (or following) a conviction, imposition of a civil money penalty or assessment or imposition of an exclusion.

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

2. The provider no longer meets the conditions of participation as stated in Chapter

100 all-inclusive of the Nevada MSM.

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.

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

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.

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

7. An administrative contract termination has been performed~~.~~; and/or

~~7.~~8. The provider's NPI number is deactivated and/or the provider's data elements in NPPES are no longer current.

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 apply to entities when individuals meet the criteria below who have a five percent or greater ownership or control interest, or are an agent or managing employee. Sanctions also apply to individual owners and agents/managing employees when the group/entity meets any of the criteria listed in this section. A person who assists to submit prior authorization requests or claims is an agent for purposes of MSM Chapter 100.

If an entity is excluded, the length of the individual owner's exclusion will be for the same period as the sanctioned entity. If an individual owner is excluded, the entity will also be excluded and the length of the entity's exclusion will be for the same period as the sanctioned owner.

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 CHIP (NCU), ~~or~~ the Title XX services program or any other State of Federally

funded assistance 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 or any other State of Federally funded assistance 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;

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 DHHS or Medicare notifies the DHCFP that the provider may be reinstated.

2. Tier 2 – ~~Seven~~ Ten 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. Any other felony involving the use of a firearm or other deadly weapon within the immediately preceding seven years.

8. Provider has been convicted of a misdemeanor offense related to that person's involvement in any program established under Medicare, Medicaid, Children's CHIP (NCU), the Title XX services programs or any other State or Federally funded assistance program.

3. Tier 3 – ~~Twelve Month~~Three Year Sanction

a. Provider was ~~denied enrollment~~ terminated at revalidation 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. It is reported or discovered that the provider falsified information on and/or supplied false information/documentation with the Enrollment Application, unless a higher sanction tier is applicable; and/or

g. It is reported or discovered that the provider omitted information on the Enrollment Application, unless a higher sanction tier is applicable.

4. Tier 4 – Twelve Month Sanction

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

b. Provider has a ~~restricted~~ restriction placed on their professional license which is incompatible with the mission of the DHCFP;~~.~~

c. Provider failed to successfully meet Provisional Enrollment conditions of participation;

d. Provider failed to report/provide required information in the time frame set forth in the Enrollment Application, Provider Contract and/or the MSM (all inclusive), such as:

1. Change of Ownership (CHOW);

2. indictment, arrest, criminal charge and/or conviction of any provider, owner, agent and/or authorized user (unless a higher tier sanction is applicable); and/or

3. result(s) of a pending legal case or investigation (as reported on the Enrollment Application or Change Form) resulted in a "for cause" termination not listed in Tier 1, Tier 2 or Tier 3.

e. Provider failed to consent and submit to Enhanced Provider Screening requirements, such as a site visit and/or FCBC.

f. Provider fails to provide required and/or requested information specific to participation for their provider type, or a provider voluntarily terminates without providing required and/or requested information specific to participation for their provider type.

~~4.~~5. Immediate Re-Application

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

108 REFERENCES

FISCAL AGENT CONTACT INFORMATION

PROVIDER RELATIONS UNITS (Enrollment/Claims Issues/Questions)

~~HP Enterprise Services~~DXC Technology
PO Box 30042
Reno, NV 89520-3042
Toll Free within Nevada (877) 638-3472

ELECTRONIC BILLING

~~HP Enterprise Services~~DXC Technology
EDI Coordinator
P.O. Box 30042
Reno, NV 89520-3042

Telephone: (877) 638-3472 (select option for "Electronic Billing")
Fax: (775) 335-8594
E-mail: http://medicaid.nv.gov

PRIOR AUTHORIZATION FOR DENTAL AND PERSONAL CARE AIDE

Mailing Address:
"Dental PA" or "PCA PA"
P.O. Box 30042
Reno, NV 89520-3042
Telephone: (800) 648-7593
Fax: (775) 784-7935

PRIOR AUTHORIZATION FOR ALL OTHER SERVICE TYPES (except Pharmacy)

Telephone: (800) 525-2395
Fax: (866) 480-9903

PHARMACY

Clinical Call Center
Pharmacy prior authorization requests
Telephone: (877) 638-3472
Fax: (855) 455-3303

Technical Call Center
General pharmacy inquiries
Telephone: (866) 244-8554

THIRD PARTY LIABILITY (TPL) UNIT

~~Emdeon TPL Unit~~
~~P.O. Box 148850~~
~~Nashville, TN 37214~~
~~Phone: (855) 528-2596~~
~~Fax (855) 650-5753~~
HMS – NV Casualty Recovery
PO Box 844648
Los Angeles, CA 90084-4648

~~Email: TPL-NV@Emdeon.com~~

MANAGED CARE ORGANIZATIONS

AMERIGROUP Community Care

Physician Contracting
Phone: ~~(702) 228-1308, ext. 59840~~(877) 269-5685

Provider Inquiry Line
(for eligibility, claims and pre-certification)
Phone: (800) 454-3730

Notification/Pre-certification
Phone: (800) 454-3730
Fax: (800) 964-3627

Claims Address:
AMERIGROUP Community Care
Attn: Nevada Claims
P.O. Box 61010
Virginia Beach, VA 23466-1010

HEALTH PLAN OF NEVADA (HPN)
Phone: (800) 962-8074
Fax: (702) 242-9124

Claims Address:
Health Plan of Nevada

P.O. Box 15645
Las Vegas, NV 89114

SILVER SUMMIT (CENTENE)

Physician Contracting
Phone: (844) 366-2880
Email: NetworkManagement@SilverSummitHealthPlan.com

Provider Inquiry Line (for eligibility, claims and pre-certifications)

Phone:

Medical/Behavioral Health: (844) 366-2880
Pharmacy: (844) 366-2880
Pharmacy (Prior Authorization): (855) 565-9520
Vision: (855) 896-8572

Claims Address:

Medical/Behavioral Health:
P. O. Box 5090
Farmington, MO 63640

Pharmacy:
5 River Park Place E, Suite 210
Fresno, CA 93720

Vision:
Attn: Claims Processing
P. O. Box 7548
Rocky Mount, NC 27804

FIELD OFFICES

Carson City	(775) 684-~~72000~~800
Elko/Winnemucca	(775) 753-~~1187~~1233
Ely	(775) 289-1650
Fallon and Lovelock	(775) 423-3161
Hawthorne	(775) 945-3602
Henderson	(702) 486-~~1201~~1001
Las Vegas – Belrose	(702) 486-1646
Las Vegas – Cambridge	(702) 486-1646

Las Vegas – Cannon Center	(702) 486-1646
Las Vegas – Charleston	(702) 486-1646
Las Vegas – Craig Road	(702) 631-3386
Las Vegas – Decatur	(702) 486-5000
Las Vegas – Durango	(702) 631-3212
Las Vegas – Flamingo	(702) 486-~~1646~~9400
Las Vegas – Nellis	(702) 486-~~1646~~4828
Las Vegas – Owens	(702) 486-~~1800~~1899
Las Vegas – Southern Investigations & Recovery	(702) 486-1875
Las Vegas – Spring Mountain	(702) 631-3077
Pahrump	(775) 751-7400
Reno – Bible Way (Investigations & Recovery)	(775) 688-2261
Reno – ~~Kings Row~~District Office	(775) 684-7200
Sparks	(775) 824-7400
Yerington	(775) 463-~~3028~~0800