BASIC LIFE SUPPORT (BLS)

BLS is transportation by air or ground ambulance to facilitate the provision of medically necessary supplies and services. The ambulance must be staffed by an individual qualified, at least as an EMT, in accordance with State and local laws.

BEHAVIORAL HEALTH COMMUNITY NETWORK (BHCN)

A public or private provider organization, under contractual affiliation through the provider enrollment process, with the State of Nevada, the DHHS, the DHCFP which operates under ~~medical and clinical supervision~~ Clinical Supervision and utilizes practices consistent with professionally recognized standards of good practice and are considered to be effective by the relevant scientific community. The BHCN provides outpatient mental health services and may provide Rehabilitative Mental Health (RMH) services for persons with mental, emotional or behavioral disorders.

BENEFIT

Benefit means a service authorized by the Managed Care plan.

BEREAVEMENT COUNSELING

Counseling services provided to the recipient's family after the recipient's death.

BILLING AUTHORIZATION

Billing Authorization is a notification sent to a provider giving authorization to bill for services within a specified time frame.

BONE ANCHORED HEARING AID (BAHA)

A BAHA system is a small titanium implant placed in the bone behind the ear where it osseointegrates. The vibrations from the sound processor are transmitted to the implant via a percutaneous abutment.

BUDGET AUTHORITY

The participant direction opportunity through which a waiver participant exercises choice and control over a specified amount of waiver funds (participant-directed budget).

BURDEN OF PROOF

At a Fair Hearing, the recipient or provider must establish by a preponderance of the evidence that the agency's denial of the request was not correct. Except where otherwise established by law or regulation, in Fair Hearings

concerning the termination, reduction or suspension of medical assistance previously received by a recipient, the agency must establish by a preponderance of the evidence that its actions were correct.
Preponderance of the evidence is that evidence which, in light of the record as a whole, leads the Hearing Officer to believe that the finding is more likely to be true than not true. Except where otherwise established by law or regulation, in provider Fair Hearings concerning claims, recoupments, suspensions, non-renewals or terminations, the agency must establish by a preponderance of the evidence that its actions were correct. In all other provider Fair Hearings, the provider must establish by a preponderance of the evidence that the agency's actions were incorrect.

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE (HCQC)

The HCQC is a state agency located within the Health Division within the DHHS. The HCQC provides both state licensure and Medicare/Medicaid certification to all health facilities in Nevada. They conduct routine surveys and investigate complaints against health facilities. The HCQC monitors the quality of care and quality of life issues related to NF residents based on state and federal regulations.

BUS

Bus is defined as public or private fixed-route, fixed-schedule, intra-city or inter-city congregate transportation.

CAPABLE

An LRI who is able to safely manage carrying out necessary maintenance, health/medical care, education, supervision, support services and/or the provision of needed ADLs and IADLs.

CAPITAL RENOVATIONS/REMODELING PROJECT

Capital Renovation/Remodeling Project [hereinafter "Project"] shall mean a series of activities and investments which materially:

1. expand the capacity;

2. reduce the operating and maintenance costs; or

3. ensure the operating efficiency and/or extend the useful economic life of a fixed asset.

Said Project may involve new construction, reconstruction and/or renovation. Allowable costs include, but are not limited to, the costs of land, buildings, machinery, fixtures, furniture and equipment. Certain cost for repairs may be included but only when such costs are incidental to and necessitated by the Project. In no event shall costs for ordinary repairs and maintenance of an ongoing nature be included in a Project.

Pursuant to the Nevada State Plan for Medicaid, the cost of such Projects may include expenditures incurred over a period not to exceed 24 months. Further, in order to be considered as part of the Fair Rental Value rate setting process for a given facility in a given rate year, the sum of the costs for all Projects submitted for consideration must exceed $1,000 per licensed bed.

CAPITATION PAYMENT

A payment the DHCFP makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical and/or transportation services under the State Plan. The DHCFP makes the payment without regard to individual utilization of services during the period covered by the payment.

CARDHOLDER

Cardholder means the person named on the face of a Medicaid and NCU card to whom or for whose benefit the Medicaid and NCU card is issued.

CARE COORDINATION

A formal process that ensures ongoing coordination of efforts on behalf of Medicaid-eligible recipients who meet the care criteria for a higher intensity of needs. Care coordination includes: facilitating communication and enrollment between the recipient and providers and providing for continuity of care by creating linkages to and monitoring transitions between intensities of services. Care coordination is a required component of case

management services and is not a separate reimbursable service.

CARE COORDINATOR

A care coordinator is a professional who assesses plans, implements, coordinates, monitors and evaluates options to meet an individual's health needs. Care coordination links persons who have complex personal circumstances or health needs that place them at risk of not receiving appropriate services to those services. It also ensures coordination of these services.

CAREGIVER

The LRI (e.g. birthparents, adoptive parents, spouses, legal guardians, paid foster parents) and/or other adults who are not (legally) responsible or paid to provide care, who participate in providing care to a recipient.

CASE MANAGEMENT

Case management is a process by which an individual's needs are identified and social and medical services to meet those needs are located, coordinated, and monitored. Case management may be targeted to certain populations and in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act.

CASE MANAGEMENT SERVICES

Case management services are services which assist an individual in gaining access to needed medical, social, educational and other supportive services and must include the following components:

1. Assessment of the eligible individual to determine service needs.

2. Development of a person-centered care plan.

3. Referral and related activities to help the individual obtain needed services.

4. Monitoring and follow-up.

Case management services involve the following activities to assist the eligible recipient in obtaining needed services:

5. Assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. The assessment activities include the following:

    a. Taking client history.

    b. Identifying the needs of the individual and completing related documentation.

c. Gathering information from other sources, such as family members, medical providers, social workers and educators (if necessary) to form a complete assessment of the eligible recipient.

6. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

   a. Specifies the goals and actions to address the medical, social, educational and other services needed by the eligible recipient.

   b. Includes activities such as ensuring the active participation of the eligible recipient and working with the recipient (or the individual's authorized health care decision maker) and others to develop those goals.

   c. Identifies a course of action to respond to the assessed needs of the eligible recipient.

7. Referral and related activities (such as scheduling appointments for the recipient) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

8. Monitoring and follow-up; activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately address the needs of the eligible individual and may be with the individual, family members, service provider or other entities or individuals. The monitoring should be conducted as frequently as necessary, and include at least one annual monitoring, to help determine whether the following conditions are met:

   a. Services are being furnished in accordance with the individual's care plan.

   b. Services in the care plan are adequate.

   c. There are changes in the needs or status of the eligible recipient.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Monitoring may involve either face-to-face or telephone contact, at least annually.

CASE MIX

Case Mix means a measure of the intensity of care and services used by similar residents in a facility. Case Mix measures the relative resources required to care for a given population of NF residents. Within and between NFs, resident needs may vary widely, from residents requiring near full-time skilled nursing assistance to residents requiring only minimal assistance.

CASE-MIX INDEX

Case-Mix Index means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

CASE RECORD DOCUMENTATION

A case record documentation shall be maintained for each recipient and shall contain the following items:

1. The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.

2. The nature, content and units of case management services received.

3. Whether the goals specified in the care plan have been achieved.

4. If an individual declines services listed in the care plan, this must be documented in the individual's case record.

5. Timelines for providing services and reassessment.

6. The need for and occurrences of coordination with case managers of other programs.

The case manager shall make available to Nevada Medicaid or Medicaid's QIO-like vendor, upon request, copies of the medical record, progress notes, care plan, case record or summary documents which reflect the ongoing need for case management services and support any additional services requested.

CENSUS INFORMATION

Census information must be based on a NF's occupancy as of midnight (00:00 hour) on the first day of every month.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicaid programs are administered by the states with the CMS, DHHS, having responsibility for monitoring state compliance with federal requirements and providing Federal Financial Participation (FFP). CMS monitors state programs to assure minimum levels of service are provided, as mandated in the 42 CFR.

CERTIFICATION OF TERMINAL ILLNESS

An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

CERTIFIED SLEEP STUDY TECHNOLOGIST

A certified sleep study technologist is an individual trained in the diagnostic techniques and evaluation of a recipient's response.

CHILD

For the purpose of hospice services, a child is defined as an individual under the age of 21.

CHILD AND FAMILY TEAM

A family-driven, child-centered, collaborative service team, focusing on the strengths and needs of the child and family. The team consists of the child recipient (as appropriate), parents, service professionals and may also consist of family members, care providers and other individuals identified as being integral to the child's environment or mental health rehabilitation.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Children with special health care needs are all children who have, or are at increased risk for physical developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally. This program is operated by the State's Health Division.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP serves children ages zero through 18 years and is designed for families who do not qualify for Medicaid and whose incomes are at or below 200% of Federal Poverty Level (FPL). NCU is the Nevada version of CHIP. NCU insurance is comprehensive health insurance covering medical, dental, vision care, mental health services, therapies and hospitalization.

CHORE SERVICES

Chore services are those tasks that exceed light housekeeping. Chore services include, but are not limited to, heavy household chores such as cleaning windows and walls, shampooing carpets, moving heavy furniture, packing and unpacking, minor home repairs and yard work.

CHRONIC MENTAL ILLNESS (CMI)

A clinically significant disorder requiring professionally qualified and supervised levels of care. Persons with CMI have mental, emotional and/or behavioral difficulties which impair their memory, orientation comprehension, calculation, learning and/or judgment. Persons with CMI are seriously limited in their capacity to perform ADL. CMI does not include any person whose capacity is diminished by epilepsy, intellectual disabilities, pervasive developmental disorders, dementia, traumatic brain injury, intoxication or dependency to alcohol or drugs, unless a co-occurring mental illness is present which contributes to the diminished capacity of the person.

CLAIM

Claim is defined as:

1. a bill for services;

2. a line item of services; or

3. all services for one recipient within a bill.

"Claim" is further defined as communication, whether oral, written, electronic or magnetic, which is used to identify specific goods, items or services as reimbursable pursuant to the plan, or which states income or expense and is or may be used to determine a rate of payment pursuant to the plan.

CLINIC SERVICES

As amended by the Deficit Reduction Act of 1984, Section 1905(a)(9) describes clinic services as "services furnished by or under the direction of a physician without regard to whether the clinic itself is administered by a physician." Regulations at 42 CFR 440.90 define clinic services as preventive, diagnostic, therapeutic, rehabilitative or palliative items or services that:

1. are provided to outpatients;

2. are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

3. except in the case of nurse-midwife services, as specified in 42 CFR 440.165, are furnished by or under the direction of a physician or dentist.

CLINICAL LABORATORY

A laboratory which uses:

1. microbiological;

2. serological;

3. immunohematological;

4. cytological;

5. histological;

6. chemical;

7. hematological;

8. biophysical;

9. toxicological; or

10. other methods for "in-vitro" examination of tissues, secretions or excretions of the human body for the diagnosis, prevention or treatment of disease or for the assessment of a medical condition.

The term does not include forensic laboratory operated by a law enforcement agency.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) PROGRAM

The CMS regulates all laboratory testing (except research) performed on humans in the United States through the CLIA. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare and Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

CLINICAL SUPERVISION

The documented oversight by a Clinical Supervisor to assure the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values set forth by state licensure, certification, and best practice. Clinical Supervision is intended to be rendered on-site and Clinical Supervisors must be available to consult with all clinical staff. Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Clinical Professional Counselors (CPC) and Qualified Mental Health Professionals (QMHP), excluding Interns, operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, including Independent Professionals, QMHPs, and Individual RMH providers, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors can supervise other LCSWs, LMFTs, CPCs, QMHPs, QMHAs and QBAs. Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are LCSWs, LMFTs, CPCs, and QMHPs, excluding Interns, may function as Clinical Supervisors over RMH services. However, Individual RMH providers, who are QMHPs, including interns, may not function as Clinical Supervisors over Outpatient Mental Health (OMH) services, such as assessments, therapy, testing and medication management. Clinical Supervisors must assure the following:~~The documented oversight by a Clinical Supervisor to assure that the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and~~

~~monitoring of the quality and effectiveness of the services provided. Clinical Supervision is intended to be rendered on-site and Clinical Supervisors must be available to consult with providers. Qualified Mental Health Professionals (QMHP) excluding Interns, Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), or Clinical Professional Counselors (CPCs), operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. An individual functioning as a Clinical Supervisor may not perform this role for more than two (2) Behavioral Health Community Networks (BHCN) simultaneously. Clinical Supervisors must assure that the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by all Qualified Mental Health Professionals (QMHP) and all paraprofessional-level staff, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors can supervise QMHPs, Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors may also function as Direct Supervisors.~~

~~Individual Rehabilitative Mental Health (RMH) providers, who are QMHPs, may function as Clinical Supervisors over RMH services. However, Independent RMH Mental Health Rehabilitative providers, who are QMHPs, may not function as Clinical Supervisors over Outpatient Mental Health (OMH) assessments or therapies. Clinical Supervisors must assure the following:~~

1. An up-to-date (within 30 days) case record is maintained on the recipient; and

2. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services); and

3. A comprehensive and progressive treatment plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP, LCSW, LMFT, or CPC; and

4. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive and age and developmentally appropriate; and

5. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, the recipient and their family/legal guardian (in the case of legal minors) sign the treatment plan, and the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment plan; and

6. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing; and

7. Only qualified providers provide prescribed services within scope of their practice under state law; and

8. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

~~1. An up to date (within 30 days) case record is maintained on the recipient;~~

~~2. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services);~~

~~3. A comprehensive and progressive Treatment Plan and/or Rehabilitation Plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP, LCSW, LMFT, or CPC;~~

~~4. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate;~~

~~5. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, that the recipient and their family/legal guardian (in the case of legal minors) sign the Treatment and/or Rehabilitation Plan(s), and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the Treatment and/or Rehabilitation Plan(s);~~

~~6. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing;~~

~~7. Only qualified providers provide prescribed services within scope of their practice under state law; and~~

~~8. Recipients receive mental and/or behavioral health services in a safe and efficient manner.~~

CLINICAL SUPPORT GUIDE

A clinical decision support guide adopted by the DHCFP to provide a standardized tool in determining appropriate services for both the adult and pediatric recipient in the area of skilled nursing and therapies, including physical therapy, occupational therapy and speech therapy.

COCHLEAR IMPLANT

A cochlear implant is a surgically implanted electronic hearing device designed to produce useful hearing sensations to a person with severe to profound nerve deafness by electrically stimulating nerves inside the inner ear. External components of the cochlear implant include a microphone, speech processor and transmitter.

CODE OF FEDERAL REGULATIONS (CFR)

The CFR is a codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal government. The Code is divided into 50 titles which represent broad areas subject to federal regulation. SNFs and NFs are required to be in compliance with the requirements in 42 CFR Part 482, Subpart B to receive payment under either Medicare or Medicaid program.

COLD-CALL MARKETING

Any unsolicited personal contact by a provider, Managed Care Organization (MCO) or any other vendor directed

specifically toward a Medicaid or NCU recipient for the purpose of marketing or selling a product or service to that individual.

COMMERCIAL TRANSPORTATION VENDOR

A transportation provider who subcontracts with the Non-Emergency Transportation (NET) broker to supply transportation services for compensation.

COMMON OWNERSHIP

An individual possesses ownership of, or equity in, a facility and in an entity serving that same facility.

COMMUNITY MENTAL HEALTH CENTER (CMHC)

Government-affiliated agency, which is defined by NRS 433.144 and operates under the guidelines of the State of Nevada, DHHS. For purposes of Nevada Medicaid's provider qualifications, a CMHC is recognized as a BHCN.

COMPANION CARE SERVICES

Non-medical care, supervision and socialization provided, in accordance with the POC, in a recipient's home or place of residence. The provider may assist or supervise the recipient with such tasks as meal preparation, laundry, essential shopping or light housekeeping tasks.

COMPARABILITY OF SERVICES

Comparability of services refers to the regulatory mandate that provides that services available to any categorically needy recipient under a state plan must not be less in amount, duration and scope than those services available to a medically needy recipient. Comparability requirements ensure that coverage of services for the categorically needy continue to be the primary objective of the Medicaid program and prevent the coverage of selected services for the medically needy from diverting resources from the categorically needy. Also, these requirements ensure that each Medicaid recipient receives fair and equitable service once determined to be a member of an eligible coverage group.

COMPOUND DRUGS

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

COMPREHENSIVE FUNCTIONAL ASSESSMENT

Comprehensive function assessments identify all of the recipients:

1. Specific developmental strengths, including individual preferences;

2. Specific functional and adaptive social skills the recipient needs to acquire;

3. Presenting disabilities and, when possible, their causes; and

4. Need for services without regard to their availability.

CONCURRENT CARE

Concurrent care allows for the provision of Private Duty Nursing (PDN) services by a single nurse to care for more than one recipient simultaneously. A single nurse may provide care for up to three recipients if care can be provided safely.

CONCURRENT REVIEW

A review of a Nevada Medicaid or Nevada Check Up eligible recipient's clinical information performed by the DHCFP's QIO-like vendor or a Managed Care Organization. The review is performed during a period of time that services are being rendered, to determine if a requested service will be authorized, based on medical necessity, appropriateness and compliance with applicable policies.

CONFIDENTIALITY

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

CONTENTS OF NOTICE

A notice must contain the following information:

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

2. The reasons for the intended action;

3. The specific regulations that support, or the change in Federal or State law that requires the action;

4. An explanation of:

a. The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

b. In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

5. An explanation of the circumstances under which services are continued if a hearing is requested.

CONTINUITY OF CARE

The hospice program assures the continuity of patient/family care in home, outpatient and inpatient settings.

CONTINUUM OF SERVICES

The range of services which must be available to the students of a school district so that they may be served in the least restrictive environment.

CONTRACT

A legal agreement entered into between the DHCFP, based on the Request for Proposals (RFP) and on the MCO's response to the RFP.

CONTRACT PERIOD

The State-certified contract period will be the defined effective and termination dates of the contract inclusive of any renewal period.

CONTRACTOR

Pursuant to the CFRs, an MCO is any entity that contracts with the State agency under the State Plan, in return for a payment to process claims, to provide or pay for medical services or to enhance the State agency's capability for effective administration of the program. For the purposes of this RFP, a contractor must be a MCO as defined in the Medicaid State Plan which holds a certificate of authority from the Insurance Commissioner for the applicable contract period and throughout the contract period, or has a written opinion from the Insurance Commissioner that such a certificate is not required, who has a risk-basis contract with the DHCFP.

COST

1. Necessary Cost: A cost incurred to satisfy an operation need of the facility in relation to providing resident care.

2. Proper Cost: An actual recorded cost, clearly identified as to source, nature and purpose, and reasonably related to resident care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

3. Reasonable Cost: A reasonable cost is one that does not exceed that incurred by a prudent and cost-conscious facility operator.

COUNSELING SERVICES

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

COVERED SERVICES

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

CREDIBLE ALLEGATION OF FRAUD

A credible allegation of fraud may be an allegation which has been verified by the State from any source, including but not limited to:

1. Fraud hotline complaints;

2. Claims data mining; or

3. Patterns identified through provider audits, civil false claims cases and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and Nevada Medicaid has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

CRIMINAL CLEARANCE

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

CRITICAL ACCESS HOSPITAL (CAH)

A Medicare certified and state licensed hospital established under the State Medicare Rural Hospital Flexibility Program.

CUEING

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

CULTURAL COMPETENCE

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

CURRENT DENTAL TERMINOLOGY (CDT)

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

CUSTODIAL CARE

Custodial care is LOC involving medical and non-medical services that are not intended to cure. This care is provided when the recipient’s medical condition remains unchanged and when the recipient does not require the services of trained medical personnel.

CUSTOM FABRICATED ORTHOSIS

Custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather or cloth in the form of sheets, parts, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending or making other modifications to a substantially prefabricated item.

MAINTENANCE DRUG

Maintenance Drug is defined as any drug used continuously for a chronic condition.

MAINTENANCE THERAPY

The repetitive services required to maintain function generally do not involve complex and sophisticated therapy procedures, and consequently the judgment and skill of a qualified therapist are not required for safety and effectiveness. As such, "maintenance" programs do not meet the requirement of being restorative or rehabilitative and are not a covered benefit by Nevada Medicaid. In certain instances the specialized knowledge and judgment of a qualified therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a therapist to determine what type of exercises will contribute the most to maintain the patient's present functional level. Establishing a home based maintenance program is typically limited to one evaluation visit.

MAMMOGRAPHY

Radiography of the soft tissues of the breast to allow identification of various benign and malignant neoplastic processes.

MANAGED CARE

A system of health care delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to quality, cost–effective health care.

MANAGED CARE ORGANIZATION (MCO)

Managed Care is a system of health care delivery that influences utilization, cost of services and measures performance. The delivery system is generally administered by an MCO, which may also be known as a HMO. An MCO or HMO is an entity that must provide its Medicaid or NCU enrollees inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, home health services, emergency services and additional contracted State Plan benefits. The MCO provides these services for a premium or capitation fee, regardless of whether the individual enrollee receives services.

MANAGED HEALTH PLAN

Provides one or more products which:

1. integrate financing and management with delivery of health care services to an enrolled population;

2. employ or contract with an organized provider network which delivers services and (as a network or individual provider) shares financial risk or has some incentive to deliver quality, cost-effective services;

and use an information system capable of monitoring and evaluating patterns of covered persons' uses of medical services and the cost of those services.

MANAGING EMPLOYER

In a self-directed care model, refers to the recipient who selects, schedules, directs, trains and discharges his or her PCA. As a managing employer, the recipient manages the day to day aspects of the employment relationship.

MARKETING

Any communication from the Provider, including its employees, affiliated providers, agents or contractors to a Medicaid or NCU recipient who is not a client of the provider that can be reasonably interpreted as intended to influence the recipient to utilize that Provider.

MARKETING MATERIALS

Materials that are produced in any medium by or on behalf of the MCO and can reasonably be interpreted as intended to market potential clients.

MATERNITY KICK PAYMENT (SOBRA)

The Maternity Kick Payment is payment made to an MCO which is intended to reimburse the health plan for costs associated specifically with covered delivery costs and postpartum care.

MAXIMUM ALLOWABLE COST (MAC)

MAC is the lower of the cost established by:

1. CMS for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927(f)(2) of the Act; or

2. The DHCFP for multiple source drugs under the State Maximum Allowable Cost (SMAC).

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

The MAC list is available online at http://www.medicaid.nv.gov/providers/rx/MACinfo.aspx.

MEDICAID BILLING NUMBER (BILLING NUMBER)

Medicaid Billing Number is an eleven digit number in one of the following forms: 12345600010 or 00000123456 and used to identify Medicaid recipients. Providers use the billing number when submitting claims for payment on services provided to Medicaid recipients.

MEDICAID ESTATE RECOVERY (MER)

MER is a federally mandated program for deceased individuals age 55 or older who are subject to estate recovery for medical assistance paid by Medicaid on their behalf.

MEDICAID INTEGRITY

Medicaid integrity involves the planning, prevention, detection and investigative/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, abuse or improper payments.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

A computer system designed to help managers plan and direct business and organizational operations.

MEDICAL CARE ADVISORY COMMITTEE (MCAC)

This is a mandated advisory committee whose purpose it is to act in an advisory capacity to the state Medicaid Administrator.

MEDICAL CARE PLAN

This plan of treatment is developed in coordination with licensed nursing personnel by a licensed physician, if the physician determines that the recipient requires 24 hour licensed nursing care. Thus, recipients with chronic but stable health problems such as epilepsy do not require medical care plans. The medical care plan must be integrated with the IPP.

MEDICAL DIRECTOR

The Medical Director must be a hospice employee who is a doctor of medicine or osteopathy. The Medical Director assumes overall responsibility for the medical component of the hospice's recipient care program. The Medical Director must be an approved Medicaid provider if he/she provides direct patient care services in order to bill for direct Medicaid reimbursement.

MEDICAL DOCUMENTATION

For the purposes of obtaining DMEPOS through Nevada Medicaid and NCU, medical documentation used to support medical necessity is part of a medical record which is completed, signed and dated by a licensed medical

professional. Clinical reports or assessments required to support medical necessity must be from a licensed/certified professional performing within their scope of practice. Information used as medical documentation cannot be compiled or composed by the recipient, their relatives or representatives.

MEDICAL EMERGENCY

Medical Emergency is the sudden onset of an acute condition where a delay of 24 hours in treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self or bodily harm to others. This is a higher degree of need than one implied by the words "medically necessary" and requires a physician's determination that it exists.

MEDICAL HOME

Refers to inclusion of a program recipient on the patient panel of a Primary Care Physician and the ability of the recipient to rely on the PCP for access to and coordination of their medical care.

MEDICAL NUTRITION THERAPY

The development and provision of a nutritional treatment or therapy based on a detailed assessment of a person's medical history, psychosocial history, physical examination and dietary history. It is used to treat an illness or condition, or as a means to prevent or delay complications from nutritionally related disease states.

~~MEDICAL SUPERVISION~~

~~The documented oversight which determines the medical appropriateness of the mental health program and services rendered. Medical supervision must be documented at least annually and at all times when determined medically appropriate based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication. Medical supervision may be secured through a current written agreement, job description or similar type of binding document. BHCNs and all inpatient mental health services are required to have medical supervision.~~

~~MEDICAL SUPERVISOR~~

~~A licensed physician with at least two years' experience in a mental health treatment setting who, as documented by the BHCN, has the competency to oversee and evaluate a comprehensive mental and/or behavioral health treatment program including rehabilitation services and medication management to individuals who are determined as SED or SMI.~~

MEDICAL TRANSPORTATION

Transportation is any conveyance of a Medicaid recipient to and from providers of medically necessary Medicaid covered services, or medical services that Medicaid would cover except for the existence of prior resources such

as Medicare, Veterans' coverage, workers' compensation or private health insurance.

MEDICARE SAVINGS PROGRAM

1. QMBs without other Medicaid (QMB Only) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. FFP equals the Federal Medical Assistance Percentage (FMAP).
2. QMBs with full Medicaid (QMB Plus) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less, resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

4. Qualified Disabled and Working Individuals (QDWIs) - These individuals no longer have Medicare Part A benefits due to a return to work. However, they are eligible to purchase Medicare Part A benefits if they have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.

5. Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2), these individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down their resources to qualify for Medicaid or meet the requirements for a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services received from Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a state option; however, states may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

MEDICOACH, MEDIVAN, MEDICAR

These interchangeable terms refer to a motor vehicle staffed and equipped to transport one or two persons in wheelchairs or on gurneys or stretchers, door-to-door.

MENTAL HEALTH SERVICES

Mental health services are those techniques, therapies or treatments provided to an individual who has an acute, clinically identifiable psychiatric disorder for which periodic or intermittent treatment is recommended, as identified in the current International Classification of Diseases (ICD) of mental disorders. These techniques, therapies or treatments must be provided by a QMHP. Mental health services are provided in a medical or in a problem-oriented format that includes an assessment of the problem, limitations, a diagnosis and a statement of treatment goals and objectives, recipient strengths and appropriate community based resources. Treatment should generally be short term and goal oriented or, in the case of chronic disorders, intermittent and supportive and rehabilitative.

MENTAL HEALTH SPECIAL CLINICS

These are public or private entities that provide:

1. outpatient services, including specialized services for children, the elderly, individuals who are experiencing symptoms relating to current ICD diagnosis or who are mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment;

2. 24-hour per day emergency care services; and

3. screening for recipients being considered for admission to inpatient facilities.

MENTALLY INCOMPETENT INDIVIDUAL

Mentally incompetent individual means an individual who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction for any purpose.

MILEAGE REIMBURSEMENT

Car mileage is reimbursement by the NET broker at a per mile rate, paid when appropriate and approved by the NET broker for the transport of an eligible recipient to a covered service.

MINIMUM DATA SET (MDS)

MDS refers to a federally required resident assessment tool. Information from the MDS is used by the Division for determining the Medicaid average CMI to adjust the direct care component of each free-standing NF's rate.

MINIMUM ESSENTIAL PERSONAL ASSISTANCE

The assistance of a person with a severe functional disability for six hours or less per day in eating, bathing, toileting, dressing, moving about and taking care of himself, as defined in NRS 426.723.

MOLDED TO PATIENT MODEL ORTHOSIS

A molded-to-patient-model orthosis is a particular type of custom fabricated orthosis in which an impression of the specific body part is made (by means of a plaster cast, CAD-CAM technology, etc.) and this impression is then used to make a positive model (of plaster or other material) of the body part. The orthosis is then molded on this positive model.

MULTIDISCIPLARY CONFERENCE (MDC)

A required gathering under IDEA; the only body that can make certain determinations, specifically about a child's eligibility for special education.

MULTIPLE SLEEP LATENCY TEST (MSLT)

The MSLT is a standardized and well-validated measure of physiologic sleepiness. The same parameters as for basic Polysomnography (PSG) are monitored. The MSLT consists of four - five twenty-minute nap opportunities offered at two-hour intervals. To insure validity, proper interpretation of the MSLT can only be made following a polysomnogram that was performed the preceding night.

MULTIPLE SOURCE DRUGS

Multiple Source Drugs is defined in §1927(k)(7) of the Social Security Act as covered outpatient drug for which there are two or more drug products which:

1. are rated as therapeutically equivalent (under the Food and Drug Administration's (FDA) most recent publication of "Approved Drug Products with Therapeutically Equivalence Evaluations");

2. except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the FDA; and

3. are sold or marketed in the State during the period.