MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 10, 2009

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF OF COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 – MEDICAID PROGRAM

BACKGROUND AND EXPLANATIONS

Changes and modifications in policy language were made to section 105, Medicaid Billing and Payment, to clarify provider responsibilities in submitting claims for reimbursement, filing appeals for denied claims and billing Medicaid recipients. In addition, typographical and numbering/lettering sequence errors were corrected. Changes are effective upon approval of the public hearing.

MATERIAL TRANSMITTED **MTL 32/09** CHAPTER 100 –MEDICAID PROGRAM	MATERIAL SUPERSEDED **MTL 08/07** CHAPTER 100 –MEDICAID PROGRAM
Sec. 105.1.a Added "I"	Deleted "i"
Added "and"	
Sec. 105.1.b Added "I"	Deleted "i"
Sec. 105.1.c Added "I"	Deleted "i"
Sec. 105.2.b Added "; or"	Deleted "."
Sec. 105.2.c Added "; or"	Deleted "."
Sec. 105.1.5 Added "Refer to"	Deleted "See"

Sec. 105.1.6

Added "Refer to"	Deleted "See"

Sec. 105.1.7

Added "04"	Deleted "92"

Sec. 105.2B

Added "To be considered timely, claims must be received by the fiscal agent within"	Deleted "The Medicaid timely filling period is"
Added "For out-of-state providers or when a third party resource exists, t"	Deleted "T"
Added "Stale date criteria are strictly adhered to whether the claim is initially received or being appealed for a stale date override."	Deleted "for out of state provider claims, and when a third party resource exists"
Added "required"	Deleted "180 day"
Added "the"	

Sec. 105.2C

Added "for"	Deleted "'s Provider Services Unit"
Added "f'	Deleted "on"
Added "a"	Deleted "F"
Added "Claim appeals must be postmarked no later than thirty (30) days from the date of the Remittance Advice (RA) listing the claim as denied. Appeal requests for subsequent same service claim submissions will not be considered."	Deleted "A" Deleted "'s Provider Relations Unit" Deleted "See"
Added "Refer to"	Deleted ".2"

Sec. 105.2C.1.a

Added "A letter addressing the specific reason for the appeal, which includes the provider name and NPI/API, the ICN of the claim, the recipient's name and Medicaid ID number, the date of service, and the name and phone number of the person to be contacted regarding the appeal; and"	Deleted "A copy of the RA showing denial,"

Sec. 105.2C.1.b

Added "appeal request"	Deleted "A copy of the original signed

	claim," Deleted "position"
Sec. 105.2C.1.c Added "A copy of the Remittance Advice showing the denied claim; and"	
Sec. 105.2C.1.d Added "An original signed paper claim that may be used for processing should the appeal be approved."	Deleted "A cover letter addressing the specific reason for the appeal, provider name and number, the ICN of the claim, recipient's name and ID number, date of service, procedure code and the name and phone number of the person to be contacted regarding the appeal."
Sec. 105.2C.2 Added "by the fiscal agent"	

Sec. 105.2C.3
Added "fiscal agent"
 	
Added "clarification"
 	
Added ", the fiscal agent will send"
 	
Added ", along"
 	
Added "the"
 	
Added ","
 	
Added "of"
	Deleted "Stale date criteria are strictly adhered to whether the claim is initially received or being appealed for a stale date override."
	
	Deleted "Medical Review Unit"
	
	Deleted "Only i"
	
	Deleted "statement"
	
	Deleted "is"
	
	Deleted "sent"
	
	Deleted "Nevada"
	
	Deleted ","
	
	Deleted "Unit"

Sec 105.2C.4 Added "Providers must exhaust the fiscal agent's appeal process prior to pursuing a Fair Hearing with the Division." Added "Section 108 for contract information for filing an appeal and"	Deleted "for additional information"

Added "for additional information"

Sec. 105.3.2
Added "signed"

Sec. 105.3.8
Added "Providers are prohibited from billing Medicaid or the recipient when no service has been provided. This includes billing a deposit for a scheduled appointment or for a missed appointment."

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MEDICAID PROGRAM

100 INTRODUCTION

The mission of the Nevada Division of Health Care Financing and Policy (Nevada Medicaid) is to: purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and 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 (HHS), Division of Health Care Financing and Policy, and to establish program policies and procedures.

100.1 AUTHORITY

The Medicaid program in Nevada is authorized to operate under the Department of Health and Human Services (HHS), Division of Health Care Financing and Policy (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. 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 Service Manual along with the Medicaid Operations Manual 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.

1. Eligibility for Medicaid assistance is regulated by Section 1901(a) of the Social Security Act, 42 Code of Federal Regulations (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 Social Security Act, 42 Code of Federal Regulations (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 information on applicants and recipients is regulated by 42 CFR 431, Subpart F; Nevada Revised Statute (NRS) 422.290; and Nevada Medicaid State Plan Section 4.3. Penalties for the unauthorized disclosure of confidential information are found in NRS 193.170.

5. Disclosure of information is regulated by 42 CFR 455.106, Sections 11289(b)(9) and 102 (a)(38) of the Social Security Act, and Nevada Medicaid State Plan Section 4.31.

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

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

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

9. Nevada Medicaid assistance is authorized pursuant to State of Nevada Revised Statues (NRS), Title 38, Public Welfare, Chapter 422, Administration of Welfare Programs.

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

11. Assignment of insurance benefits by insurance carriers is authorized pursuant to State in Nevada Revised Statutes (NRS), Title 57, Insurance, based on the type of policy.

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

13. “Advance Directives” are regulated by 42 CFR 489, Subpart I.

14. Worker’s compensation insurance coverage is required for all providers pursuant to (NRS) Chapter 616A through 616B.

15. Section 1902(a)(68) of the Social Security Act establishes providers as ‘entities’ and the requirement to educate their employees, contractors, and agents on false claims recovery, fraud, and abuse.

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

17. Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations 45 CFR 160 and 164.

18. HIPAA Security Regulations 45 CFR 142.

19. HIPAA Standards for Electronic Transaction 45 CFR 160 and 162.

101 OVERVIEW OF PROGRAMS

Health care coverage for low-income individuals and families, in Nevada, is provided through Medicaid and Nevada Check Up. For purposes of this manual, Medicaid and Nevada Check Up are referred to as Medicaid. However, there are some differences in coverage between the two programs. Please refer to Chapter 3700 for an explanation of these differences.

1. Medicaid

Medicaid applicants must apply for and meet the criteria of the appropriate assistance program. Every person has the right to apply for assistance. A deceased person may have an application filed on his or her behalf.

Requests for medical assistance under the TANF-Related Medicaid (TRM), Child Health Assurance Program (CHAP), Medicaid for the Aged, Blind, and Disabled (MAABD) programs and the Child Welfare Services (as provided by NRS 432.075 are processed at one of the local Nevada Division of Welfare and Supportive Services (DWSS) offices depending on the applicant's residence. Eligibility is established based on regulations stated in the DWSS policy manuals. Inquiries are made at the nearest DWSS office and may be made verbally, in writing, in person, or by a representative. District Office staff will assist with applications if necessary. DWSS policy manuals are located on their website at www.welfare.state.nv.us.

Children may also be covered by Medicaid through child welfare programs authorized through the Division of Children and Family Services (DCFS).

2. Nevada Check Up

The Nevada Check Up program is Nevada's name for the federal Title XXI benefits administered under the State Children's Health Insurance Program (SCHIP). Nevada Check Up provides low-cost, health care coverage to uninsured children who do not meet the conditions of Medicaid eligibility. Applicants must apply for and meet the criteria for this program. The services for Nevada Check Up recipients generally duplicate the services outlined for Nevada Medicaid and the program uses the Nevada Medicaid Provider Panel. Refer to chapter 3700 for description of program differences.

101.1 STATE PLAN SERVICES UNDER 1915(i) OF THE SOCIAL SECURITY ACT

Section 6086 of the Deficit Reduction Act of 2005, established a new optional benefit under the State Plan that provides home and community-based services to certain Medicaid recipients, statewide, without requiring a Home and Community-Based waiver.

Nevada Medicaid has adopted this State Plan option effective July 1, 2007. This Home and Community-Based Service (HCBS) supplemental benefit package is available to individuals who:

- are Medicaid recipients;
- have been determined to meet the needs-based criteria; and
- *do not* require a level of care equal to the care provided in a long term care hospital, nursing facility, or a 1915(i) Home and Community Based Waiver

There is no waiting list for enrollment in HCBS, and no annual limit on the number of recipients that can be enrolled for services.

101.1A NEEDS-BASED CRITERIA

To qualify for HCBS, any given recipient must demonstrate that they meet the minimum total score of two boxes checked out of the following categories:

1. Functional impairment to include Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs);
2. Cognitive/Behavioral Impairment;
3. Medically related risk factors;
4. Impairment requiring the recipient to require supervision;
5. Substance Related Impairment;
6. Multiple Social Services System involvement.

The level of care assessment to establish needs-based criteria must be completed by a physician or other licensed practitioner of the healing arts, and must be re-evaluated at least every 12 months. The examination is based on:

- An objective face-to-face evaluation;
- Consultation with the individual and others as appropriate;
- An examination of the individual's relevant history, medical records, care and support needs, and preferences;
- Objective evaluation of the inability to perform, or need for significant assistance in at least two categories as mentioned above.

At no time will there be allowed circumstances creating a conflict of interest with regard to the assessment and eligibility determination.

Individual determined eligible for these Home and Community-Based Services (HCBS) are referred to their local Medicaid District Office to obtain a list of service providers to choose from based on their specific needs.

101.1B INDIVIDUAL SERVICE PLAN

Recipients eligible for Home and Community Based Services (HCBS) have an individualized plan of care developed by their Medicaid service provider.

The service provider must obtain a written statement confirming the recipient was offered a choice of providers.

The service provider will ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process, and understands the needed services and elements of the Plan.

The Plan must:

- identify the necessary HCBS to be furnished to the individual;
- takes into account the extent of, and need for, any family or other supports for the individual;
- prevent the provision of unnecessary or inappropriate care;
- be guided by best practices and research on effective strategy for improved health and quality of life outcomes; and
- be reviewed at least annually and as needed when there is significant change in the recipient's circumstances.

All Plans must be approved by the Nevada Medicaid's fiscal intermediary, and/or Quality Improvement Organization (QIO)-like vendor, and maintained by the service provider for a minimum of three years.

The Division of Health Care Financing and Policy (DHCFP) staff will review a representative's sample of participant service plans annually to ensure State Plan requirements are met.

101.1C COVERED SERVICES

Services provided under HCBS include:

- Adult Day Health Care
- Habilitation for Comprehensive Outpatient Services
- Psychosocial Rehabilitation for Chronic Mental Illness (CMI)
- Partial Hospitalization Program (PHP) for (CMI)
- Intensive Outpatient Program (IOP) for (CMI)

All services are administered by qualified Medicaid providers. The State does not make payment to legally responsible individuals, other relatives, or legal guardians who furnish State Plan Home and Community Based Services (HCBS).

101.2 OUT OF STATE SERVICES

Nevada Medicaid may authorize payment for both mandatory and optional services if determined to be medically necessary.

Section 1902(i)(16) of the Social Security Act requires the out-of-state service equal in amount, duration and scope to in-state service be reimbursed for eligible Nevada residents who are absent from the state when;

1. Needed because of a medical emergency.

2. Recipients' health would be in danger by travel back to Nevada.

3. Nevada Medicaid determines, on the bases of medical advice, that the needed medical service or necessary supplementary resources are readily available in another state; or

4. Provided to the children in out-of-state placement for whom Nevada makes adoption assistance or foster care maintenance payments.

5. It is general practice for a recipient in a particular locality to use medical resources in another state;

   a. Nevada residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the Division of Health Care Financing and Policy (DHCFP) refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation.

      The primary catchment areas are:

      1. Arizona: Bullhead City, Kingman
      2. California: Bishop, Needles, South Lake Tahoe, Susanville, Truckee, Bridgeport, Loyalton, Markleeville
      3. Idaho: Boise, Mountain Home, Twin Falls
      4. Utah: Cedar City, Orem, Provo, Salt Lake City, St. George, Wendover

(Note: The portion of Wendover that lies inside the Nevada border is officially called West, Wendover, Nevada 89883)

b. The same services that are covered within the state of Nevada are available for payment for any qualified provider, in the catchment area, who is or will be enrolled with the plan.

Nevada Medicaid does not pay for medical services rendered by health care providers outside of the United States.

101.3 NEVADA MEDICAID AND NEVADA CHECK UP CARD

Medicaid and Nevada Check Up recipients are issued a plastic identification card upon approval for benefits, through the State Medicaid Management Information System (MMIS). The card is issued with his or her full eleven-digit billing number, last name, first name, sex, and date of birth. The card does not identify the category of eligibility nor does it carry photographic or other individual identifying information, and it does not guarantee eligibility for benefits. The recipient is not responsible to return the card when the case is closed and they may use the same card for any subsequent eligibility.

101.3A ELIGIBILITY VERIFICATION AND CARD USE

1. Information regarding the recipient, category of eligibility, managed care, recipient restrictions, and third party payers is accessible, for any of the most recent 60 months, through the fiscal agent's Eligibility Verification System (EVS), by phone using the Voice Response Unity (VRU), or by using a swipe card vendor. Providers may contact the Fiscal Agent to receive information about enrolling for EVS system access and alternative sources of eligibility verification.

   a. EVS will identify individuals eligible for full Medicaid, full Medicare, full Medicaid and Medicare coverage, and Qualified Medicare Beneficiary (QMB) coverage. Note: Medicaid pays only the deductibles and co-insurance for QMB recipients up to Medicaid allowable amounts.

2. Eligibility is determined on a month to month basis. Providers must always verify recipient eligibility prior to providing services, as well as the identity of the individual through a driver's license, Social Security card, or photo identification. Recipients must be prepared to provide sufficient personal identification to providers, and shall not allow any individual to use their card to obtain medical services.

3. Newly approved Medicaid recipients may present a Notice of Decision from the Welfare Division as proof of eligibility, prior to the EVS update.

4. Individuals may have more than one active billing number on file at the same time; e.g., a child may be eligible through Child Welfare services and have a Welfare case at the same time. When this happens, the Division's Provider Support Unit can advise the provider which number to use for billing.

5. Medicaid and Nevada Check Up have contracts with managed care organizations to provide medical coverage to eligible categories of individuals in Clark and Washoe County. Nevada Medicaid and Nevada Check Up reimburse managed care providers a capitated monthly rate for each enrollee and cannot reimburse any other provider independently for covered, contracted services. Refer to chapter 3600 for detailed information about the Managed Care program.

6. Recipients enrolled in a Medicaid managed care plan must be sure to seek services only from plan providers. Recipients should notify their providers as soon as they become eligible for managed care. Refer to chapter 3600 on Managed Care.

7. In most cases, managed care eligibility begins the first of the month after the date of approval. Medicaid prior medical months are covered under Fee-For Service (FFS). Refer to chapter 3600 for additional information on managed care.

101.3B CHILD WELFARE RECIPIENTS

Payment for emergent or necessary medical services or care provided to a child who is in the custody of a Public Child Welfare Agency may be covered by Nevada Medicaid or guaranteed by the custodial public agency. A child eligible for coverage through one of these sources will receive a Medicaid number and card.

If a child requires medical care before a Medicaid number and/or a Medicaid card is issued, the custodial agency may prepare a letter verifying demographic information including the child's name, date of birth, Social Security number, and the services requested. (If a Medicaid number has been assigned but a card has not yet been issued, the letter should also contain the Medicaid number.) The letter must be signed by an authorized staff member of the Public Child Welfare Agency in whose custody the child is placed and must be printed on the agency's official letterhead.

101.3C RESTRICTIONS

1. Certain recipients who have inappropriately used medical services may have their access to Medicaid services restricted by Medicaid Staff.

2. Before any non-emergency service is provided to a recipient, whose benefits have been restricted, phone authorization must be obtained from the Quality Improvement Organization (QIO)-like vendor. Providers will be asked to document the necessity of all

services provided which are not emergencies. If approval is granted, a specific authorization number will be issued to the provider. This number must then appear on the provider's claim for payment of the service dispensed. Claims submitted for a recipient whose benefits have been restricted without an authorization number or documentation of an emergency will not be paid.

102 PROVIDER ENROLLMENT

All individuals/entities providing services to Medicaid recipients under the Fee for Service or Medicaid managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered, and 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.

Medicaid may reimburse a provider who meets the following conditions:

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

2. Completes the Nevada Medicaid Provider Application and Contract; and,

3. Received notice from the Nevada Medicaid Program that the credentials have been met and the provider agreement as been accepted.

A provider may request enrollment in the Nevada Medicaid Program by contacting the Provider enrollment Unit of the fiscal agent. See Section 108.2 for contact information.

The effective date of the provider contract is the date received or the requested effective date as long as the provider meets all State and Federal requirements as of that date. The effective date may be retroactive for up to one year to encompass dates on which the provider furnished services to a Medicaid recipient.

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.

102.1 CONDITIONS OF PARTICIPATION

1. In order to enter into a provider contract with the Medicaid program, the provider or any person who has ownership or control interest in the provider or who is an agent or managing employee of the provider must not:

   a. Have been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, State Children's Health Insurance Program (Nevada Check Up), or the Title XX services program.
   b. Have been terminated for cause, excluded or be under any form of suspension from Medicare, Medicaid, State Children's Health Insurance Program (Nevada Check Up), or the Title XX services program.

2. The fiscal agent will not enroll any person or entity convicted of a felony 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. Such persons are not eligible providers. Detailed information about each service area may be found in the corresponding chapters within this manual. The following list, though not exhaustive, provides examples of crimes which indicate a provider is not eligible and inconsistent with the best interests of the recipients under the State plan:

   a. Murder, voluntary manslaughter, mayhem, or kidnapping;
   b. Sexual assault, sexual seduction or any sexually related crime;
   c. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission;
   d. Dueling or challenges to fight;
   e. False imprisonment or involuntary servitude;
   f. Assault or battery;
   g. Criminal neglect of patients per the Nevada Revised Statutes (NRS) 200.495; p. Any offense involving arson, fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
   h. Abuse or neglect of children per NRS 200.508 through 200.5085;
   i. Abuse, neglect, exploitation or isolation of older persons;
   j. Harassment, stalking, or hazing;
   k. Any offense against a minor under NRS 200.700 through 200.760;
   l. Any offense against public decency and good morals under a provision NRS 201.015 through NRS 201.56;
   m. Any offense against the executive power of the State in violation of NRS 197;
   n. Any offense against the legislative power of the State in violation of NRS 198;
   o. Any offense against public justice in violation of NRS 199
   p. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or
   q. Any other felony involving the use of a firearm or other deadly weapon, within the immediately preceding 7 years.

3. The Fiscal Agent will not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program that has been found guilty of fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of convictions for fraud or abuse, within the previous seven (7) years.

4. The Fiscal Agent will not enroll a public institution unless it is a medical institution. The Fiscal Agent will never enroll a penal or correctional institution. Individuals and/or recipients are ineligible for Medicaid at the time they are incarcerated, until their release regardless of there status on Employment Verification System (EVS).

5. 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 Nevada Revised Statutes (NRS).

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

7. The provider is responsible for understanding the requirements of their provider type as stated in the Nevada Medicaid Services Manual. The provider should also be familiar with Chapter 3100, Hearings, and Chapter 3300, Surveillance, Utilization and Review.

102.2 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 within the state of Nevada must have a business location within Nevada and must be licensed by the appropriate licensing authority in Nevada.

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

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

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

3. 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 who are provided services to Medicare crossover recipient's only.

A provider outside of the State of Nevada who furnishes goods and services authorized to be provided under the Nevada medical assistance program to eligible Nevada residents visiting in

the state and urgently requiring care and services shall be exempt from the enrollment process so 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 actually rendered.

102.3 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 Licensing and Certification. 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 provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, State Children's Health Insurance Program (Nevada Check Up), or the Title XX services program.

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.

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

6. Name and address of each person with an ownership or control interest in the discloser, or in any subcontractor in which discloser has direct or indirect ownership of 5% or more;

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

8. Name of any other disclosing entity in which a person with an ownership or control interest in the discloser also has ownership or controlling interest.

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

9. 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

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

102.3A PROVIDER DISCLOSURE

If discrepancies are found to exist during the pre-enrollment period, the Division of Health Care Financing and Policy (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 DHCFP and/or the Fiscal Agent, may result in denial of the application.

The Fiscal Agent may deny enrollment to any applicant that, at the time of application, is under investigation pursuant to Subpart A (commencing with Section 455.12) of 42 CFR 455. The Fiscal Agent will not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges.

The Fiscal Agent may complete a background check on applicants for the purpose of verifying the accuracy of information provided in the application and in order to prevent fraud and abuse. The background check may include, but is not limited to, the following: a) onsite inspection prior to enrollment; b) review of business records; and c) data searches.

102.4 DISPOSITION OF CONTRACT FOR NEW PROVIDERS

The fiscal agent will review the completed provider application, copies of required licenses, registrations, certificates, etc., to determine if the applicant meets all of the conditions of participation as stated in the Nevada Medicaid Services Manual for the specified provider type and Nevada Medicaid Services Manual Chapter 100 all inclusive.

102.4A CERTIFICATION STATEMENT

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

"I UNDERSTAND IN ENDORSING OR DEPOSITING THIS CHECK that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws."

I AGREE TO ACCEPT MEDICAID PAYMENTS AS PAYMENT IN FULL for services rendered and under NO CONDITION, except for lawful patient liability, contact the patient or members of the patient's family for additional sums."

"I ACKNOWLEDGE THAT I HAVE EXAMINED THE REMITTANCE ADVICE THAT ACCOMPANIED THIS CHECK AND THAT THE ITEMS COVERED REPRESENT AMOUNTS DUE ME AND THAT THE SERVICES LISTED THEREON HAVE BEEN RENDERED BY ME."

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

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

With regard to submission of claims for payment,

I CERTIFY THAT ALL INFORMATION IS TRUE, ACCURATE, AND COMPLETE; and

With regard to remittance and receipt of payment whether by check or electronic transmission.

I AGREE TO ACCEPT MEDICAID PAYMENTS AS PAYMENT IN FULL for services rendered and under NO CONDITION, except for lawful patient liability, contact the patient or members of the patient's family for additional sums."

"I ACKNOWLEDGE THAT I HAVE EXAMINED THE REMITTANCE ADVICE THAT ACCOMPANIED THIS PAYMENT AND THAT THE ITEMS COVERED REPRESENT AMOUNTS DUE ME AND THAT THE SERVICES LISTED THEREON HAVE BEEN RENDERED BY ME."

102.4B CONTRACT APPROVAL

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

An enrollment approval letter, which will include the provider's individual provider number(s), will be returned to the provider. If the provider has been approved to provide more than one type of medical service, the provider numbers will be identified for each service type.

102.4C CONTRACT DENIAL

1. The Division of Health Care Finance and Policy (DHCFP) will refuse to enter into a contract with an applicant for provider enrollment in the Medicaid program if the provider:

a. Does not meet the conditions of participation as stated in this Chapter, all inclusive; and/or,
b. Does not meet all of the professional credentialing requirements or other conditions of participation as required by the Nevada Medicaid Services Manual for the specified provider type; and/or,
c. Has been terminated for cause, excluded or suspended, leading to revocation of an agreement or contract with a provider by any other governmental or State program; and/or,
d. Fails to submit information requested by the Fiscal Agent; and/or,
e. Submits false information.

2. The Fiscal Agent Provider Enrollment Unit will notify the provider by U.S. mail of the contract denial. The letter will include:

a. The basis of the denial citing the appropriate Medicaid policy, Federal regulation and/or state law; and,
b. The provider's right to a fair hearing, in accordance with Nevada Revised Statute 422.306.

103 PROVIDER RULES AND REQUIREMENTS

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

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

2. A Medicaid provider who accepts a Medicaid recipient for treatment accepts the responsibility to make sure the recipient receives all medically necessary services. This includes making appropriate referrals to other Medicaid providers, ensuring ancillary services are delivered by a Medicaid provider, and ensuring the recipient receives all medically necessary services at no cost to the recipient.

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

103.1 MEDICAL NECESSITY

A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability.
The determination of medical necessity is made on the basis of the individual case and takes into account:

1. Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
2. Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
3. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
4. Services are provided for medical or mental/behavioral reasons rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider.

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

103.2 AUTHORIZATION

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

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

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

1. Some services covered by Nevada Medicaid require prior authorization for payment. When the provider learns that a patient has been approved for Medicaid, authorization, as appropriate, must be requested for services provided and/or being provided.

   For Medicaid recipients who have been discharged, but are approved retroactively the provider has 90 days from the date of the eligibility decision to submit a request for authorization, with the complete medical record, to the QIO-like vendor. For recipients still in the hospital when the date of decision is determined, the facility is responsible for initiating the admission and concurrent process within five working days.

2. For Medicare and Medicaid dual eligible's there is no requirement to obtain Medicaid prior authorization for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's prior authorization guidelines. Prior authorizations (PA) are not necessary for recipients who are eligible for QMB only since Medicaid pays only the co-pay and deductible. If Medicare benefits are exhausted (i.e. inpatient) a PA from Medicaid's QIO-like vendor must be obtained within 30 days of the receipt of the Medicare Explanation of Benefits (EOB).

3. Medicaid Eligibility may be determined for up to three months prior to an application for assistance. Services provided during a period of retroactive eligibility are evaluated on a case-by-case basis. Provider can verify eligibility through the Electronic Verification System (EVS). Covered services that meet the definition of "emergency services" reimbursed. A retrospective review for services which require prior authorization by Medicaid (QIO)-like vendor will determine authorization for payment based on clinical information that supports medical necessity and/or appropriateness of the settings.

4. If prior authorization (PA) is required, it is the responsibility of the provider to request before providing services. Waiting until the claim is due before security an approved PA will not override the stale date. The PA number is required on the claim. See the Appropriate Services Manual Chapter for program specific retro-authorization policy.

103.3 PROVIDER REPORTING REQUIREMENTS

Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery.

103.3A CONDITIONS OF REPORTING

1. All changes must be reported in writing 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 verification of a change in the Federal Employee Identification Number (FEIN).

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 Division of Health Care Financing & Policy (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:

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

2. Ensure policies are adopted by any contractor or agent acting on their behalf;

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

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

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

6. Provide requested re-certification within required timeframes to ensure ongoing compliance.

103.4A COVERAGE AND LIMITATIONS

1. The Division of Health Care Financing and Policy (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.

2. The DHCFP will issue a letter advising an entity of the regulations and require the entity to:
   a. Submit a certification stating they are in compliance with the requirements; and
   b. Sign a provider agreement, or Managed Care Contract Amendment incorporating this requirement; and
   c. Provide copies of written policies developed for educating their staff on false claims, fraud and abuse, and whistleblowers protections under law; and
   d. Provide documentation of employees having received the information.

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

4. The Division of Health Care Financing and Policy (DHCFP) is authorized to take administrative action for non-compliance through non-renewal of provider or contract, or suspension or termination of provider status.

103.5 SAFEGUARDING INFORMATION ON APPLICANTS AND RECIPIENTS

Federal and state regulations (including the Health Insurance Portability and Accountability Act of 1996 (HIPAA of 1996) restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the Medicaid program. The information to be safeguarded 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 without a signed Authorization for Disclosure from the participant or designated representative. However, most other disclosures require authorization. Additional details about allowable uses and disclosures are available to participants in the Division of Health Care Financing and Policy (DHCFP) Notice of Privacy Practices, which is provided to all new Medicaid enrollees.

DHCFP has implemented detailed policies and procedures to ensure that privacy rules and security safeguards are observed and practiced by its staff. The DHCFP HIPAA Privacy Rule manual is available for reference in hard copy form in District Offices and on the DHCFP Intranet website.

Additionally, in accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the Department of Human Resources (DHHS) in the performance of official duties and with local governments that help the Department carry out official duties as long as the disclosure is related to treatment, payment, or health care options.

The Nevada Revised Statutes state the unauthorized disclosure of confidential information is a misdemeanor, punishable by up to six months in jail and/or up to $1,000 fine.

103.5A MEDICAL AND PSYCHOLOGICAL INFORMATION

1. 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

2. 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.

3. Information may be released to the Federal Department of Health and Human Services (HHS) for purposes directly related to the furtherance of any of the Medicaid programs.

4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 Division of Health Care Financing and Policy (DHCFP) business associates; to recipient's personal representatives; as required by law; for the good of public health; etc.)

5. 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).

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

103.6 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 (FPP). The Division of Health Care Financing and Policy's (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 Division of Health Care Financing's (DHCFP) nondiscrimination policies. In addition, hospitals, nursing facilities and Intermediate Care Facility for the Mentally Retarded (ICF/MRs) will be reviewed by Medicaid periodically to assure they follow requirements specific to them.

Requirements for compliance:

1. Hospitals, nursing facilities ICF/MR must designate on 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.
2. 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:

   a. Admissions;
   b. Access to and provisions of services; or
   c. 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.

3. 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).

7. 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 and ICF/MRs, which do not have a TDD, must have access to a TDD at no cost or inconvenience to the patient or staff member wishing to use it.

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

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).

8. 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 Division for Aging Services Long Term Care Ombudsman or to the Division of Health Care Finance & Policy (DHCFP).

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

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

10. Disabled persons, or organizations representing disabled persons, must be consulted at least once to complete a Transitional Plan or self-evaluation (per 45 CFR 84.6(C)), to assure the facility does not have physical barriers which would inhibit or restrict disabled persons, and if it does, a plan of correction which would eradicate such barriers.

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

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

    a. Identify the non-English languages that must be accommodated among the population served and identify the points of contact where language assistance is needed;
    b. Develop and implement a written policy that ensures accurate and effective communication;
    c. Take steps to ensure staff understands the policy and is capable of carrying it out; and
    d. Annually review the LEP program to determine its effectiveness.

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

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

103.7 ADVANCED DIRECTIVE

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

103.7A ADMINISTRATION OF ADVANCED DIRECTIVES

1. Hospitals, nursing facilities, home health agencies, Personal Care Attendants (PCA) providers, and hospices must maintain written policies and procedures concerning

advance directives, and provide written information to all adult individuals (age 18 or older) upon admission or service delivery concerning:

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

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

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

1. Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
2. Identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and
3. Describe the range of medical conditions or procedures by the conscience objection.

2. Document in the individual's medical records whether or not the individual has an advanced directive.

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

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

5. Provide for the education of staff concerning its policies and procedures on advance directives (at least annually).

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

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

103.8 MUTUAL AGREEMENT IN PROVIDER CHOICE

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

104 THIRD PARTY LIABILITY – OTHER HEALTH CARE COVERAGE'S

Medicaid is generally the payer of last resort whenever any other resource is responsible for payment of health care services. Other Health Care Cover (OHC) includes, but is not limited to: Medicare, worker's compensation insurance, private or group insurance, and any self-insured plans.

Recipients who have major medical insurance cannot participate in the Nevada Check Up program. If a provider discovers a participant in Nevada Check Up has major medical insurance, they must report to Division of Health Care Financing and Policy (DHCFP).

1. Providers should question all patients carefully regarding possible prior resources. If coverage has lapsed, or if insurance is discovered when none is indicated on the Electronic Verification System (EVS), Voice Response Unit (VRU), or swipe card, an explanatory note attached to the claim will enable the fiscal agent to update its Third Party Liability (TPL) file.

2. Providers are required to bill a recipient's OHC prior to billing Medicaid.

3. Medicaid Managed Care is not considered (OHC). Providers should refer recipients enrolled in a Medicaid Managed Care plan to the plan identified by the Fiscal Agent's EVS or swipe card vendor unless the provider is authorized to provide services under the plan.

4. If the provider does not participate in a recipient's OHC plan, the provider must refer the recipient to the OHC. Nevada Medicaid will deny payment for OHC services if the recipient elects to seek treatment from a provider not participating in the OHC plan. If the Medicaid recipient is informed by a provider not authorized by the OHC that both the OHC and Medicaid may deny payment for the services, and the recipient then voluntarily elects to receive Medicaid covered services from a provider who does not participate in the recipient's OHC plan, the recipient assumes the responsibility to pay for the services personally.

5. The provider must inform the recipient, or responsible adult, before services are provided that they will be financially responsible for the cost of services. If the recipient chooses to continue with the service, the provider must secure a written and signed statement at the time of the agreement which includes the date, type of services, cost of service, and the fact that the recipient, or responsible adult, has been informed. Medicaid will not pay for the services and agrees to accept full responsibility for the payment. This agreement may not be in the form of a blanket authorization secured only once (for example, at the time of consent for all treatment). It must be specific to each incident or arrangement for which the recipient, or responsible adult, accepts financial responsibility.

6. A Medicaid provider cannot refuse to provide Medicaid covered services to a Medicaid eligible recipient due to potential third party liability (TPL) coverage.

7. Providers are required to bill Medicare for services provided to Medicare beneficiaries and must accept assignment if the recipient is a Medicare beneficiary and eligible for Medicaid, including Medicare/Medicaid (dual eligible) and Qualified Medicare Beneficiaries (QMBs).

8. If providers are unable to pursue Third Party Liability (TPL), assistance may be requested within one year from the date of service through the Fiscal Agent's Third Party Liability Unit. See Cross Reference Section 108.3 of this chapter. Providers are requested to contact the Fiscal Agent's Third Party Liability Unit within four weeks after date of service or date of discovery of TPL matters. In many instances this prompt action will result in additional insurance recoveries.

9. Providers should not release itemized bills to Medicaid patients. This will help prevent prior resources from making payment directly to the patient. Providers are encouraged to accept assignment whenever possible to lessen insurance problems by receiving direct payments.

104.1 PAYMENT LIMITS AND EXCEPTIONS

The total combined payment of other insurance and Medicaid cannot exceed the Medicaid maximum allowable. In all instances, Medicaid payment, even a zero paid amount, is considered payment in full and no additional amount may be billed to the recipient, his or her authorized representative, or any other source.

Medicare recipients covered by Medicaid as "Qualified Medicare Beneficiaries" (QMB) are entitled to have Medicaid pay their Medicare premiums, co-insurance and deductible amounts for regular Medicare benefits. Some individuals may have this coverage as well as full Medicaid benefit coverage.

Some QMB only recipients may have a Health Management Organization (HMO) for their Medicare benefits. Any services provided to a QMB only recipient by the HMO which exceed the standard Medicare benefit package (i.e., prescription drugs) will not have co-payments and deductible amounts paid by Medicaid for those added benefits.

Co-pays and/or deductibles, set forth by the other health care cover (OHC), cannot be collected from a Medicaid recipient for a Medicaid covered service. Rather, the provider must bill Medicaid for the co-pay and/or deductible. In no instance will Medicaid's payment be more than the recipient's co-pay and/or deductible. Medicaid can make payments only where there is a recipient legal obligation to pay, such as a co-pay and/or deductible. EXCEPTION: Medicaid

pays only co-payments and deductibles for regular Medicare benefits, even if provided through a Medicare HMO.

Nevada Medicaid is not liable for payment of services if the recipient elects to seek treatment from a provider outside other health care cover (OHC) network, or if the provider fails to follow the requirements of the other health care (OHC). Exceptions to Medicaid liability policy for OHC coverage are: The service(s) is/are not covered by the OHC plan;

1. The service(s) is/are not covered by the OHC plan;

2. The service is an emergency and participating provider is more than 25 miles away; or

3. The recipient resides outside the service area of the OHC and accesses the nearest Nevada Medicaid provider.

Providers who have entered into an OHC agreement agree to accept payment specified in these agreements and must bill Medicaid for recipient co-pay and/or deductible. In no instance can the provider bill Medicaid for an amount that exceeds the patient's legal obligation to pay under the OHC agreement.

It is not necessary to bill the OHC if it is known the specific service provided is not a covered benefit under the OHC policy. In this instance, note on the claim the date, phone number, and name of the person from whom the coverage information on the insurance was obtained and submit the claim to the Medicaid fiscal agent.

After receiving payment or a denial letter from the other health coverage, send the completed claim, explanation of benefits (EOB), computer screen print-out, or denial letter to the fiscal agent. All attached documents must reflect the name of the patient, date of service, service provided, the insurance company, the amounts billed, approved, and paid.

Providers must bill Medicaid for all claims, regardless of the potential for tort actions, within the specified time frame from the date of service or date of eligibility determination, whichever is later. Time frames are according to the Medicaid stale date period when no third party resource has been identified; or 365 days, when a third party resource exists.

Not all medical benefit resources can be discovered prior to claims payment. Therefore, a post payment program is operated. In these instances, Medicaid payment is recovered from the provider and the provider is required to bill the OHC resource. If OHC has been identified by the Medicaid system and the other resource has not been billed and the service(s) is/are a covered benefit of the OHC, the payment will be denied. The insurance carrier information will appear on the Medicaid remittance advice to enable the provider to bill the OHC.

Exceptions to the Third Party Liability rule are:

a. Indian/Tribal Health Services (IHS),
b. Children with Special Health Care Needs and
c. State Victims of Crime.

Medicaid is primary payer to these three programs; however, this does not negate the provider's responsibility to pursue OHC.

104.2 SUBROGATION

In certain trauma situations, there may be a source of medical payments other than regular health insurance. This source could be through automobile insurance, homeowner's insurance, liability insurance, etc. A provider may elect to bill or file a lien against those sources, or Medicaid may be billed.

Nevada Medicaid will allow providers who accept(ed) a Medicaid payment for services directly related to injuries or accidents to subsequently return that payment to Medicaid in order to seek reimbursement directly from a liable third party.

1. Medicaid will not enter into an arrangement with providers to represent or act on behalf of Medicaid in pursuit of recovery. Medicaid will continue to utilize its own legal staff to pursue recovery.

2. Medicaid will pursue its own liens against tort settlements/judgments for those payments made by Medicaid to providers who do not repay them to pursue liens of their own. Although one provider may return a payment and pursue its own lien, other(s) may choose to accept Medicaid's payment in full. In these latter situations, Medicaid will pursue its own liens through established subrogation policies. However, the amount of Medicaid's lien will be limited to the total amount of all payments made by Medicaid which were not repaid by providers.

3. Providers have the option to pursue liens on tort actions on a case-by-case basis.

4. Providers are prohibited from pursuing money that has been awarded to a Medicaid beneficiary. The provider is entitled to reimbursement from a tort judgment or settlement only when the settlement distinguishes a set amount of money for medical expenses, and only if this amount is above the amount owed to Medicaid. The provider lien must be against the tort feasor and not the general assets of the beneficiary.

In the case of tort liens, on or before 24 months from the date of injury, the provider may return the payment the provider received from Medicaid for the claims related to that injury. Repayment of the Medicaid payment is a waiver by the provider of any further claims against

Medicaid based on claims for that injury. Once a Medicaid payment is returned for the purpose of pursuing a tort lien, the provider's claim against Medicaid is ended. Providers who return Medicaid payments to pursue liens will not be allowed to bill Medicaid again at a later date in an effort to secure the entire previously paid Medicaid amount, or for payment above the lien recovery amount to secure a minimum of Medicaid's allowable. Repayment to Medicaid must be made prior to any action being taken by the provider to purse the lien. Pursuit of a lien before returning the Medicaid payments violates federal regulation and the terms of the provider's agreement. In no event may a provider delay returning Medicaid payment until after a settlement or judgment is received.

104.3 HEALTH INSURANCE PREMIUM PAYMENTS (HIPP)

Nevada Medicaid may pay insurance premiums through Employer-Based Group Health Plans for individuals and families when it is cost effective for the agency. In determining cost-effectiveness, the fiscal agent uses a formula as set forth in the State Plan or considers whether the individual has catastrophic illness or condition (e.g., AIDS or AIDS-related conditions, Down syndrome, cerebral palsy, cystic fibrosis, fetal alcohol syndrome, etc.)

Nevada Check Up participants are not eligible for HIPP.

105 MEDICAID BILLING AND PAYMENT

Medicaid payment must be made directly to the contracted person, entity, or institution providing the care or service unless conditions under #2 below are met. Federal regulations prohibit factoring or reassignment of payment.

1. A provider may use a billing agent to complete Medicaid billing only if the compensation for this service:

   a. Is related to the actual cost of processing the billing; and

   b. Is not related on a percentage or other basis to the amount that is billed or collected; and

   c. Is not dependent on the collection of the payment.

2. Medicaid payment for an individual practitioner may be made to:

   a. The employer of a practitioner if the practitioner is required, as a condition of employment, to turn over his fees to his employer; or

   b. The group if the practitioner and the group have a contract in place under which the group submits the claims, or

   c. The facility in which the services is provided, if the practitioner has a contract under which the facility submits the claims, or

   d. A foundation, plan or similar organization operating an organized health care delivery system if the practitioner has a contract under which the organization submits the claims. An “organized health care delivery system” may be a public or private health maintenance organization (HMO).

105.1 MEDICAID PAYMENTS TO PROVIDERS

1. As specified in federal regulations and the terms of all provider agreements, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. This includes, but is not limited to, situations where the provider’s claim is denied by Medicaid for failure to bill timely, accurately, or when Medicaid payment equates to zero because a third party’s payment exceeds Medicaid’s allowable amount.

2. Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims

editor program employs a nationally recognized, standardized method of processing claims for professional services using clinical logic based on CPT, HCPCS, ICD-9-C, AMA, CMS, and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.

3. If an individual is pending Medicaid, it is requested the provider await an eligibility decision before billing for the service. If the provider decides not to wait for the decision, he or she may request payment from the recipient while the decision is pending. Once the recipient is found eligible for Medicaid, and the date of service for which payment was collected is covered, the provider must return the entire amount collected to the recipient before billing Medicaid. The payment subsequently received from Medicaid is payment in full and no additional payment may be requested from the recipient, and no part of the payment made by the recipient may be retained by the provider.

4. Providers are to bill their usual and customary fees unless otherwise specified in Medicaid policy. For exceptions, refer to individual chapters. Billings are submitted according to established Medicaid policies.

5. Appropriate billings must include the current year procedure codes and ICD-9-CM diagnostic codes or Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.

6. Claims for payment are to be sent to Nevada Medicaid's fiscal agent on an appropriate billing form. Claims may be submitted either through electronic media or by paper. Refer to Section 108 of this chapter for addresses and other information.

7. It is the provider's responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid time frames. All claims must be of sufficient quality to allow electronic imaging and optical character recognition (OCR) therefore, corrections are not allowed. All paper claims must be submitted on the original applicable CMS-1500 or UB04 claim forms. Facsimiles, photocopies, or laser-printed claim forms may not be scanned and are unacceptable.

   Those claims not meeting this criterion will be returned from the fiscal agent to the provider. The claims will not be stamped as received and there will be no record of receipt.

8. Nevada Medicaid will neither accept nor reimburse professional billings for services rendered by other than the provider under whose name and provider number the claims is submitted (e.g., a claim for an office visit submitted by a physician when a psychologist

or other personnel actually provided the service). Individuals who do not meet Medicaid criteria for provider numbers must not have their services billed as through a physician/dentist to the Medicaid program for payment.

9. Medical residents do not meet Medicaid criteria for provider status. No service provided by a medical resident is to be submitted by another licensed physician/dentist to the Medicaid program for payment.

10. Payments are made only to providers. (Recipients who provide transportation for themselves and/or other recipients may be reimbursed as providers under certain circumstances.) A provider cannot request payment from Medicaid recipients assuming Medicaid will reimburse the recipient. Optional reimbursement to a patient is a characteristic of the Medicare Program, not the Medicaid program.

11. Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services (HHS), or the state Medical Fraud Control Unit (MFCU).

12. When payment appears to be unduly delayed, a duplicate billing labeled “duplicate” or “tracer” may be submitted. Failure to indicate “duplicate” or “tracer” may be interpreted as a fraudulent practice intended to secure improper double payment.

    Group practices should make certain that rebilling shows the same service codes, the same physician’s name and the same Medicaid provider number. If it should be necessary to alter the billing to show different codes or descriptors, a copy of the previous claim should be attached to the revised billing.

105.1A EXTENDED SERVICES

Services or treatment provided over an extended period of time require interim billing so that claims will be received no later that the stale date

1. The discharge date or the last day of the month which service was provided, whichever comes first, is considered the date of service for inpatient/residential claims. Each interim monthly billing must be received no later than the stale date.

2. Physicians, individual practitioners and clinics providing prolonged or extended treatment should submit interim billings for each calendar month; e.g., therapists whose services have been prior authorized for several months; and home health agencies authorized for ongoing, long-term care.

3. A global payment will be paid to the delivering obstetrician when the pregnant woman has been seen seven or more times by the delivering obstetrician and must be billed following the delivery. The delivery date is considered the date of service in this instance. Bill all other obstetrical claims as follows:

   a. Prenatal laboratory panels must be billed before the stale date under rules of clinical laboratory services;

   b. Prenatal visits (three or fewer) must be itemized and submitted before the stale date;

   c. Prenatal visits (four to seven or more) must be billed using appropriate obstetrical codes and submitted before the stale date; and,

   d. If delivery is performed by someone other than the prenatal provider, prenatal care is billed as above before the stale date.

105.2 REIMBURSEMENT

Nevada Medicaid reimburses qualified enrolled providers for services provided within program limitations to Medicaid-eligible persons. Reimbursement rates and methodologies are established by the Rates Unit at the Division of Health Care Financing and Policy (DHCFP). Rates and methodologies are based on, but not limited to, federal regulations and fee studies prior to billed charges. Providers may appeal their rate of payment to DHCFP, submit appropriate documentation, and receive administrative review. Refer to chapter 700 in this manual for specific information

105.2A LIMITATIONS

1. Medicaid pays global or per diem rates to facilities.

2. Most individual practitioners are paid computer-generated maximum allowable amounts that are the result of multiplying a specific dollar amount times the relative unit value assigned to a specific procedure code. Procedure code value lists and/or dollar factors are available on the DHCFP website at http://dhcfp.nv.gov.

3. Reimbursement for most providers is Medicaid's maximum allowable amount or billed charges, whichever is less.

105.2B BILLING TIME FRAMES (STALE DATES)

Providers must bill Medicaid for all claims within the specific time frame set by Medicaid. To be considered timely, claims must be received by the fiscal agent within 180 days from the date of

service or the date of eligibility decision, whichever is later. For out-of-state providers or when a third party resource exists, the timely filing period is 365 days.

Stale date criteria are strictly adhered to whether the claim is initially received or being appealed for a stale date override.

In order to submit claims for which eligibility was determined after the date of service within the required time frame, providers should query the Electronic Verification System (EVS) every 30 days until the determination of eligibility is obtained.

105.2C DISPUTED PAYMENT

The Fiscal Agent is responsible for research and adjudication of all disputed payments. This includes claims for which the provider is requesting an override even though the claim has not been previously submitted and denied.
Requests for adjustments to paid claims, including zero-paid claims, must be received by the fiscal agent no later than the Medicaid stale date period.

Providers can request an appeal of denied claims through the fiscal agent. Claim appeals must be postmarked no later than thirty (30) days from the date of the Remittance Advice (RA) listing the claim as denied. Appeal requests for subsequent same service claim submissions will not be considered.

Refer to Section 108 for contact information.

1. Providers who request an appeal must provide the following:

   a. A letter addressing the specific reason for the appeal, which includes the provider name and NPI/API, the ICN of the claim, the recipient's name and Medicaid ID number, the date of service, and the name and phone number of the person to be contacted regarding the appeal; and

   b. Documentation to thoroughly support the appeal request, and

   c. A copy of the Remittance Advice showing the denied claim; and

   d. An original signed paper claim that may be used for processing should the appeal be approved.

2. A Notice of Decision will be sent by the fiscal agent to the provider advising them of the appeal decision.

3. Claims appealed due to a provider's dissatisfaction with reimbursement for specific procedure codes are first researched by the fiscal agent. If there is a need for policy clarification or a question of policy change, is the fiscal agent will send the appeal, along with the full documentation of research, to Medicaid's Chief of Compliance.

4. Providers must exhaust the fiscal agent's appeal process prior to pursuing a Fair Hearing with the Division.

Refer to Section 108 for contact information for filing an appeal and Chapter 3100 for additional information on Fair Hearings.

105.3 BILLING MEDICAID RECIPIENTS

1. A provider may bill a recipient when a Medicare/Medicaid patient elects not to use lifetime reserve days for hospital inpatient stays. In these cases, the patient must be informed that, due to this election, Medicaid coverage will not be available.

2. When a service is provided by a Medicaid provider, which is not a Medicaid covered service, the recipient is only responsible for payment if a signed written agreement is in place prior to the service being rendered.

3. When all of the criteria under a. and b. below are met, a patient may be billed for all or a portion of an acute hospital admission.

   a. Preadmission Denial – The Quality Improvement Organization (QIO)-like vendor issues a denial for the admission as not being medically necessary or not a Medicaid benefit; and

      1. The physician chooses to admit the patient, nonetheless; and

      2. The recipient is notified in writing before services are rendered that he or she will be held responsible for incurred charges; and

      3. A document signed by the recipient or designee acknowledging the responsibility is accepted by a recipient.

   b. Denial of a portion of the admission – The QIO-like vendor issues a denial for a portion of the admission as no longer medically necessary for acute care; and

      1. The recipient is furnished with the denial notice prior to services being rendered which are to be billed; and

      2. The physician orders the discharge of the patient; and

3. No requested administrative days have been approved by The Quality Improvement Organization (QIO)-like vendor; and

4. The recipient refuses to leave.

4. Recipients may not be billed for acute hospital admissions or a portion of the stay if certain conditions exist. The following are examples and may be all inclusive:

   a. The admitting physician fails to acquire a prior authorization from the QIO-like vendor in cases other than emergency, except when the hospital admission comes directly from the emergency department.

   b. The QIO-like vendor has reduced the level of care from acute to an administrative level.

   c. The hospital and patient receive a retrospective denial by the QIO-like vendor after service has been rendered.

   d. In any case where the hospital neglects to follow Medicaid policies, courts have upheld the position that hospitals should be knowledgeable of rules and regulations and may not look to Medicaid or the recipient for payment when the rules or regulations are not followed.

5. If the payment for services is made by the recipient's other health care coverage directly to the recipient or his or her parent and/or guardian, he or she is responsible to submit the payment to the provider. If the recipient, or his or her guardian, fails to do so, the provider may bill the recipient for the services, but may not collect more than the exact dollar amount paid by the OHC for services rendered.

6. Providers may bill Medicaid recipients when the recipient does not disclose Medicaid eligibility information at the time the service is provided. As a rule, all providers seek payment source information from recipients/patients before services are rendered. Any recipient not declaring their Medicaid eligibility or pending eligibility, and thus denying the provider the right to reject that payment source, is viewed as entering into a "private patient" arrangement with the provider.

7. If a provider has billed a Medicaid recipient erroneously, the provider must refund the money to the recipient and bill Medicaid for the amount. Medicaid claims showing a "patient paid" amount, when the recipient was not responsible for payment, will be returned to the provider. Once the refund has been made to the recipient, the claim may be resubmitted with a copy of the refund check and the fiscal agent will process the claim for payment.

8. Providers are prohibited from billing Medicaid or the recipient when no service has been provided. This includes billing a deposit for a scheduled appointment or for a missed appointment.

106 CONTRACT TERMINATIONS AND NON-RENEWAL (Per 42CFR 1002)

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

The Medicaid provider contract allows for termination of the contract by either party upon 90 days prior written notification of the other party.

106.1 CONDITIONS OF CONTRACT TERMINATIONS AND NON-RENEWAL

If the Division of Health Care Financing and Policy (DHCFP) decide to terminate or not renew a provider contract, an advance Notice of Intent to terminate must be mailed no less than 20 days from the intended action date.

1. The DHCFP shall terminate or not renew a provider's contract when deemed necessary and includes but is not limited to the following reasons:

    a. Determination the provider falsifies the application for a Medicaid contract; and/or
    b. Fraud or abuse of such a nature and extent that immediate and permanent action is deemed necessary; and/or
    c. Termination, exclusion or suspension of an agreement or contract by any other governmental or state program; and/or
    d. Provider no long meets the conditions of participation as stated in Chapter 100 all inclusive of the Nevada Medicaid Services Manual; and/or
    e. Provider no longer meets all of the professional credentialing requirements or other conditions of participation as required by the Nevada Medicaid Services Manual for the specified provider type; and/or
    f. Fails to submit information requested.

106.1A PROCEDURES FOR TERMINATION AND NON-RENEWAL

If DHCFP decides to terminate or not renew a provider contract in the Nevada Medicaid Program:

1. The Chief of the Nevada Medicaid Compliance Unit will send Notice of Intent to Terminate or Non-renew to the provider by certified letter. The notice must include:

    a. Description of proposed action;
    b. The effective date of the proposed action;
    c. Basis for the proposed action, citing the appropriate Medicaid policy, federal regulation and/or state law;

d. The effect of the action on the provider's participation in the Nevada Medicaid Program;
e. The provider's right to a fair hearing, in accordance with Nevada Revised Statute (NRS) 402.306.

2. A provider whose contract is terminated or non-renewed may request a fair hearing pursuant to Nevada Medicaid Services Manual Section 104.2A and Chapter 3100, Section 3105.

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

106.2 ADMINISTRATIVE CONTRACT TERMINATIONS

Administrative contract terminations are not based on a disciplinary action. An administrative closure is required to ensure accurate statistics within the agency.

If the Division of Health Care Financing and Policy (DHCFP) decide to terminate or suspend/exclude a provider contract, an advance Notice of Intent to Terminate must be mailed no less than 20 days prior to the intended action date.

A Provider contract can be terminated for administrative reasons when deemed necessary and includes:

1. Death of the provider; and/or,
2. Loss of contact; and/or,
3. No payments made to provider within the prior two years; and/or,
4. When the sole issue is a change in federal law.

106.2A PROCEDURES FOR ADMINISTRATIVE CONTRACT TERMINATIONS

1. The Fiscal Agent Provider Enrollment unit will notify the provider by U.S. mail of the contract termination. The letter will include:

a. The effective date of the intended action;
b. Basis for the proposed action, citing the appropriate Medicaid policy;
c. The effect of the action on the provider's participation in the Nevada Medicaid Program; and,
d. The provider's right to a fair hearing in accordance with Nevada Revised Statute 422.306.

2. A provider whose contract is terminated for administrative reasons may request a fair hearing pursuant to Nevada Medicaid Services Manual, Section 104.2A and Chapter 3100, Section 3105.

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

106.3 MEDICAID AGENCY ACTION AFTER PROGRAM REVIEWS

The Division of Health Care Financing and Policy (DHCFP) may recommend and/or take corrective action against a provider as the result of an investigation conducted by Nevada Medicaid Surveillance Utilization and Review (SUR) staff, program compliance reviews conducted by the Nevada Medicaid program staff, or by fiscal agent staff. Refer to Chapter 3300 of the Medicaid Services Manual for Medicaid Provider Investigations.

106.3A CORRECTIVE ACTIONS

1. In determining appropriate action to be taken, the following will be considered:

   a. Corrective action necessary to eliminate the problem(s);
   b. Seriousness of the problem(s);
   c. Number of current and past violations;
   d. Past sanctions applied; and
   e. Other available services

2. DHCFP may take one or a combination of the possible corrective actions such as:

   a. Educational contact may be used when minor errors are detected and may be in the form of a telephone call, on-site visit, or a letter by Nevada Medicaid staff or provider services staff of the fiscal agent. Educational contact is made for the purpose of instructing a provider in correct billing procedures or program benefit limitations, and to correct identified errors in billing or requests for services not covered by Medicaid.
   b. Warning letters may be prepared by a DHCFP Chief in cases where an investigation or program compliance review has revealed a violation occurred but the extent of the violation is not substantial enough to warrant stronger administrative action or referral for civil/criminal action. Warning letters are intended to assist the provider in rectifying the problem and will include notice of potential consequence if the problem reoccurs.
   c. The agency may impose special requirements on a Medicaid provider as a condition of participation. These include, but are not limited to the following:

1. All services provided to Medicaid recipients must be prior authorized by the Division of Health Care Financing and Policy (DHCFP) Office to be eligible for Medicaid reimbursement.
2. Selected provider services must be prior authorized to be eligible for Medicaid reimbursement;
3. Medical records must be submitted with all claims; and/or
4. Second opinion from an independent peer must be obtained to confirm the need for the service to be eligible for Medicaid reimbursement.

If corrective action is initiated against a provider, the provider is required to cooperate and comply with the terms of the corrective action plan.

If the provider disagrees with the action recommended, they may request a hearing pursuant to Chapter 3100 of this manual.

106.3B TERMINATION AND SUSPENSION/EXCLUSION OF MEDICAID PROVIDER ENROLLMENT AS A RESULT OF PROGRAM REVIEW

Termination means ending the Medicaid agreement between Nevada Medicaid and the provider permanently or for an indefinite period of time.

Suspension/Exclusion means cancellation of the Medicaid agreement between Nevada Medicaid and the provider for a period of not less than one year.

1. A provider may be suspended/excluded from the Medicaid program if found to be providing items or services at a frequency or amount not medically necessary or of a quality that does not meet professionally recognized standards of health care in a significant number of cases.

2. Exclusion/suspension may be applied to any person who has ownership or control interest in the provider or who is an agent or managing employee of the provider. All persons affected by the exclusion must be notified in the original notice of exclusion.

3. Nevada Medicaid will not reimburse the provider for services rendered to Medicaid recipients after the Medicaid agreement has been terminated, suspended/excluded or not renewed.

4. A provider whose contract is terminated, suspended/excluded or not renewed may request a fair hearing pursuant to Nevada Services Manual, Chapter 3100.

106.3C PROCEDURES FOR TERMINATION AND SUSPENSION/EXCLUSION AS RESULT OF PROGRAM REVIEW

If the Division of Health Care Financing and Policy (DHCFP) decide to terminate or suspend/exclude a provider contract in the Nevada Medicaid Program:

The Division will send a notice of the intended action to the provider by certified letter. The notice must include:

1. Description of proposed action;

2. The effective date of the proposed action;

3. Basis for the proposed action, citing the appropriate Medicaid policy, federal regulation and/or state law;

4. The effect of the action on the provider's participation in the Nevada Medicaid Program;

5. The provider's right to a fair hearing in accordance with Nevada Revised Statute (NRS) 422.306.

107 REINSTATEMENT RIGHTS

A Medicaid provider who has been previously terminated, excluded, or suspended may be reinstated upon request and completion of provider enrollment requirements as outlined in Section 102 of this Chapter.

Exception: A provider who voluntarily terminates enrollment can be reinstated within 120 days of the termination date by completing a Provider Reinstatement Request. This process does not require a new application or contract.

107.1 CONDITIONS OF REINSTATEMENT

1. If a termination was for administrative reasons (e.g., loss of contact, failure to return updated agreement, failure to provide requested information to determine whether conditions of participation are met, etc.) Nevada Medicaid may reinstate the provider upon receipt of a completed updated agreement, information request form and/or any other information requested to determine conditions of participation are met.

2. If termination, suspension, exclusion, or non-renewal was due to fraud, abuse, falsification of information, etc., the length of the sanction will be in accordance to the letter of notification.

3. If the provider has been suspended, excluded or terminated from Medicare or at the direction of the Secretary of Health and Human Services (HHS), Nevada Medicaid will not reinstate the provider until HHS notifies Nevada Medicaid to do so and the provider completes all enrollment applications and contracts.

4. If HHS notifies Nevada Medicaid it has reinstated a provider under Medicare, Nevada Medicaid may reinstate effective the date of Medicare reinstatement, unless a longer period of suspension, exclusion or termination was established by Nevada Medicaid in accordance with the state's authority and procedures.

5. Nevada Medicaid may grant reinstatement only if it is reasonably certain the fraudulent and/or abusive acts which led to the adverse action by Nevada Medicaid will not be repeated. Factors which will be considered include but are not limited to:

    a. Whether the provider has been convicted in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid program which were not considered in the development of the Medicaid suspension, exclusion or termination; and
    b. Whether the state or local licensing authorities have taken any adverse action against the provider for offenses related to participation in the Medicare or

Medicaid program which was not considered in the development of the Medicaid suspension, exclusion or termination.

6. If Nevada Medicaid approves the request for reinstatement, it must give written notice to the suspended, excluded or terminated provider and to all others who were notified of the adverse action and specify the date on which Medicaid program participation may resume.

7. If Nevada Medicaid denies the request for reinstatement, it will give written notice to the suspended, excluded or terminated provider.

8. The provider may submit a written request for enrollment at any time after the date specified in the notice of suspension, exclusion or termination.

108 REFERENCES AND CROSS-REFERENCES

NEVADA MEDICAID PROVIDER SUPPORT UNIT

The Provider Support Unit is responsible for assisting providers with questions regarding verification of eligibility. The Unit may be reached by writing to 1100 E. William, Suite 102, Carson City, NV 89701, by calling (775) 684-3700 or toll free within the state of Nevada at 1-800-992-0900, Extension 43700, or by faxing (775) 684-3772.

108.2 FISCAL AGENT CONTACT INFORMATION

PROVIDER RELATIONS UNITS

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno NV 89520-3026
Toll Free within Nevada (877) nev-fhsc (638-3472)

PRIOR AUTHORIZATION DEPARTMENTS

First Health Services Corporation
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond VA 23261-5042
(800) 884-3238

TPL UNIT

HMS Recovery Unit
PO Box 11707
Reno NV 89510-17074
(775) 335-1040

108.3 FIELD OFFICES

Carson City	(775) 684-0800
Elko	(775) 753-1187
Ely	(775) 289-1650
Fallon and Lovelock	(775) 423-3161
Hawthorne	(775) 945-3602
Henderson	(702) 486-1201
Las Vegas – Belrose	(702) 486-1600
Las Vegas – Charleston	(702) 486-4701
Las Vegas – Owens	(702) 486-1800
Las Vegas – Cannon Center	(702) 486-3554
Las Vegas – Southern Professional Development Center	(702) 486-1401
Pahrump	(775) 751-7400
Reno – Bible Way (Investigations & Recovery)	(775) 688-2261
Reno – Kings Row	(775) 448-5000
Reno – Northern Professional Development Center	(775) 856-8438
Tonopah	(775) 482-6626

109 GLOSSARY

ACT

Refers to the Social Security Act which governs Title XIX of the Social Security Act governs the federal Medicaid program.

ACTION

Action means a denial, termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determination by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by the State with regard to preadmission screening and resident review (PSARR II) requirements of section 1919 (e)(17) of the Social Security Act. It includes changes in types, amount of service, or a change in level of care.

ACTIVITIES OF DAILY LIVING

Activities of daily living (ADL) are self-care activities routinely performed on a daily basis, such as bathing, dressing, and toileting, transferring, and eating.

ADMISSION

Nevada Medicaid considers a recipient admitted to the Residential Treatment Center (RTC) as an inpatient when 1) the physician writes the order for admission; 2) and when the admission has been certified by Nevada Medicaid's Quality Improvement Organization (QIO)-like vendor.

ADVANCED PRACTITIONER OF NURSING (APN)

Advanced Practitioner of Nursing means a registered nurse who: 1) has specialized skills, knowledge and experience; 2) and has been authorized by the Board of Nursing to provide services in addition to those that other registered nurses are authorized to provide (NRS 632.012).

AMERICAN DENTAL ASSOCIATION (ADA)

The ADA is a national professional association of dentists committed to the public's oral health, ethics, science and professional advancement the purpose of which is to lead a unified profession through initiatives in advocacy, education, research and the development of standards.

APPROPRIATE

Refers to the Division of Health Care Financing and Policy's ability to provide coverage for

medically necessary services to a recipient based on regulations and the Division's available resources and utilization control procedures.

ASSESSMENT

An assessment is a process that is conducted by Nevada Medicaid and/or its contractors to evaluate the medical necessity of an individual's request for a Nevada Medicaid covered service. (NOTE: the definition of assessment may differ in intent between some program chapters)

BENEFIT

Benefit means a service authorized by the Managed Care plan.

CARDHOLDER

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

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.

* Definitions in other chapters are more program specific.

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.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicaid programs are administered by the states with the Centers for Medicare and Medicaid, Department of Health and Human Services, 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 Code of Federal Regulations (42 CFR).

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.

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 Activities of Daily Living (ADL). CMI does not include any person whose capacity is diminished by epilepsy, mental retardation, 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 42CFR 440.165, are furnished by or under the direction of a physician or dentist.

CODE OF FEDERAL REGULATIONS (CFR)

The Code of Federal Regulations (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. Skilled Nursing Facilities (SNF) are required to be in compliance with the requirements in 42 CFR Part 482, Subpart B to receive payment under either Medicare or Medicaid services.

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.

CONFIDENTIALITY

Confidentiality pertains to all safeguards required to protect all information which concerns Medicaid 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 Nevada Revised Statutes (NRS) Chapter 422, and 42 CFR 431.

COVERED SERVICES

Covered services are those services for which Nevada Medicaid reimburses providers.

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 a level of care 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.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (DSM-IV)

Published by the American Psychiatric Association (APA), the DSM-IV's primary purpose is to provide clear descriptions of diagnostic categories to enable clinicians to diagnose, communicate about, study and treat people with various mental disorders.

DISTRICT OFFICES

The Nevada Division of Welfare & Supportive Services (DWSS) District Office staff interfaces with the Medicaid program by advising the Medicaid applicant and recipient of all aspects of Medicaid eligibility at the time of application for assistance and at the time of eligibility redetermination. This responsibility extends to foster parents and to adoptive parents whose children are subject to an Adoption Assistance Agreement (AAA), particularly those children who are living out of state.

The Nevada Medicaid District Office staff assists Medicaid recipients in locating Medicaid providers, arranging for medical services, if appropriate, and acting as liaison between recipients and providers and the Medicaid office. Certain District Office staff are also assigned case management responsibilities. District Office staff also have a responsibility to report suspected fraud or abuse of the program by recipients or providers.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment is defined as equipment, devices, and gases which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of disability, illness or injury.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Early and Periodic Screening, Diagnosis, and Treatment Services is a preventive health care program, the goal of which is to provide to Medicaid-eligible children under the age of 21 the most effective, preventive health care through the use of periodic examinations, standard immunizations, diagnostic services, and treatment services which are medically necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. 42 U.S.C. Section 1396.d (a)(4)(B). Nevada’s program is named Healthy Kids.

ELECTRONIC VERIFICATION OF SERVICES (EVS)

Electronic Verification of Services (EVS) is a means to verify an individual's eligibility for services covered by the State of Nevada's Medicaid program, via an Internet access account.

ELIGIBILITY

The term eligibility is used to reference a person's status to receive Medicaid program benefits.

ELIGIBILITY NOTICE OF DECISION

Eligibility Notice of Decision is the notification sent to an individual by the Nevada State Division of Welfare & Supportive Services giving eligibility decisions regarding their application for Medicaid services.

ELIGIBILITY STAFF

Eligibility staff are state employees who are responsible for determining financial and/or categorical need for Medicaid, and Nevada Check-Up.

ENTITY

A governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organizations, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments under a State Plan, approved under Title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

EXPERIMENTAL SERVICES

Experimental services are drugs and services and will not be considered medically necessary for the purpose of the medical assistance program. Experimental services are not paid by Nevada Medicaid.

EXPLANATION OF BENEFITS (EOB)

Statement from a third party payer/health plan to a beneficiary that lists the services that have been provided, the amount that was billed for each service, and the amount that was paid.

FACTOR

Means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable.

FAMILY PLANNING SERVICES

Section 1905(a)(4)(C) of the Social Security Act requires states to provide family planning services and supplies (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies. Section 1902(a)(10)(A) specifies family planning services be made available to categorically needy Medicaid recipients while §1902(a)(10)(C) indicates the services may be provided to medically needy Medicaid recipients at the State's option.

The term "family planning services" is not defined in the law or in regulations. However, Congress intended that emphasis be placed on the provision of services to "aid those who voluntarily choose not to risk an initial pregnancy," as well as those families with children who desire to control family size. In keeping with congressional intent, these services may be defined as narrowly as services which either prevent or delay pregnancy, or they may be more broadly defined to also include services for the treatment of infertility. However, the Medicaid definition must be consistent with overall state policy and regulation regarding the provision of family planning services.

FEDERAL FINANCIAL PARTICIPATION (FFP)

The amount of federal money a state receives for expenditures under its Medicaid program.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

Means an entity as defined in 42 CFR 405.240(b). An FQHC is located in a rural or urban area that has been designated as either a shortage is or an area that has a medically underserved population and has a current provider agreement with DHCFP.

FEE FOR SERVICE

One method of payment reimbursement whereby the State of Nevada may reimburse Medicaid providers for a service rendered to a recipient.

FISCAL AGENT

The program's fiscal agent is an entity under contract to the DHCFP with responsibility for the prompt and proper processing of all claims for payment of covered services in accordance with policies and procedures established by Nevada Medicaid. In addition, the fiscal agent may:

1. Provide the auditing function for providers under cost reimbursement;

2. Perform a pre-payment review on all claims;

3. Trace, identify and apply any and all prior resources, including third-party liability and subrogation;

4. Supply provider education and provider services; and

5. Other administrative services.

FULL TIME

Working at least 30 hours per week for wages/salary or attending school at least 30 hours per week.

FUNCTIONAL ABILITY

Functional ability is a measurement of the ability to perform Activities of Daily Living (ADLs) on a continuum from dependent to independent. This includes, but is not limited to personal care, grooming, self-feeding, and transferring from bed to chair, ambulation or wheelchair mobility, care, grooming, self-feeding, and transferring from bed to chair, ambulation or wheelchair mobility, functional use of the extremities with or without the use of adaptive equipment, effective speech or communication, or adequate function of the respiratory system for ventilation and for gas exchange to supply the individual's usual activity level.

FUNCTIONAL ASSESSMENT

An assessment process that identifies the ability/inability of an individual to perform Activity of Daily Living (ADLs) such as personal hygiene, mobility, toileting, etc., and Instrumental Activities of Daily Living (IADLs) such as shopping, and light housekeeping. This assessment identifies an applicant's/recipient's unmet needs and provides a mechanism for determining service hours based on medical necessity. The functional assessment is designed to evaluate both the environment in which services are provided and the availability of support systems. This assessment is used to develop the applicant's/recipient's service plan.

FUNCTIONAL IMPAIRMENT

Functional impairment is a temporary or permanent disability (resulting from an injury or sudden trauma, aging, disease, or congenital condition) which limits a person's ability to perform one or more Activities of Daily Living (ADLs) or IADLs including, but not limited to, dressing, bathing, grooming, mobility, eating, meal preparation, shopping, cleaning, communicating, and performing cognitive tasks such as problem solving, processing information, and learning.

GENDER, NUMBER AND TENSE

Except as otherwise expressly provided herein, the masculine gender includes the feminine gender. The singular number includes the plural number, and the plural number includes the singular. The present tense includes the future tense. The use of masculine noun or pronoun in conferring a benefit or imposing a duty does not exclude a female person from that benefit or duty. The use of a feminine noun or pronoun in conferring a benefit or imposing a duty does not exclude a male person from that benefit or duty.

HABILITATION

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996, better known as HIPAA, is a law to improve the efficiency and effectiveness of the health care system. HIPAA included a series of "administrative simplification: procedures that establish national standards for electronic health care transactions, and requires health plans (i.e. Medicaid and Nevada Check Up) and health care providers that process claims and other transactions electronically to adopt security and privacy standards in order to protect personal health information.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A Health Maintenance Organization, by Nevada Medicaid standards, is an entity that must provide its Medicaid-eligible enrollees inpatient hospital, outpatient hospital, laboratory, x-ray, family planning, physician, and home health services. The HMO provides these services for a premium or capitation fee, whether or not the individual enrollee receives services.

HEALTHY KIDS

The Early & Periodic Screening, Diagnosis & Treatment (EPSDT) program. See definition above.

HOME AND COMMUNITY-BASED SERVICES

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

HOME HEALTH AGENCY (HHA)

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

HOME HEALTH SERVICES

Home health services are a mandatory benefit for individuals entitled to nursing facility services under the state's Medicaid plan. Services must be provided at a recipient's place of residence and must be ordered by a physician as part of a plan of care that the physician reviews every sixty days. Home health services must include nursing services, as defined in the state's Nurse Practice Act, that are provided on a part-time or intermittent basis by a home health agency, home health aide services provided by a home health agency, and medical supplies, equipment, and appliances suitable for use in the home. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services States may choose to provide. To participate in the Medicaid program, a home health agency must meet the conditions of participation for Medicare.

HOSPICE SERVICES

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

HOSPITAL

A hospital is an inpatient medical facility licensed to provide services at an acute level of care for the diagnosis, care and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a "hospital" must meet the requirements for participation in Medicare as a hospital. It is not an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.

IMMEDIATE FAMILY

An immediate relative means any of the following: 1) husband or wife, 2) natural or adoptive parent, child or sibling, 3) stepparent, stepchild, stepbrother or stepsister, 4) father-in-law, mother-in-law, daughter-in-law, or sister-in-law, 5) grandparent or grandchild, and 6) spouse of grandparent or child.

INDIAN HEALTH CARE SERVICES

The Indian Health Service (IHS) is the primary source of medical and other health services for American Indian and Alaska Native people living on federal Indian reservations and in other communities served by the IHS. IHS services are services that the United States Government provides to federally recognized American Indian tribes and Alaska Native villages based on a special government-to-government relationship. This relationship is the result of treaties between the federal government and Indian tribes and federal legislation. The IHS delivery system includes over 500 health care facilities, including 51 hospitals, operated directly by the IHS or by Indian tribes or tribal organizations under agreements (contracts, grants, or compacts) authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended).

INPATIENT HOSPITAL SERVICES

"Inpatient hospital services" are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that (a) is maintained primarily for the care and treatment of patients with disorders other than tuberculosis; (b) is licensed as a hospital by an officially designated authority for state standard-setting; (c) meets the requirements for participation in Medicare; and (d) has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30, 42 CFR 456.50-456.145 and 42 CFR 440.10

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental activities of daily living (IADL’s) capture more complex life activities than ADLs and include light housekeeping, laundry, meal preparation and grocery shopping.

INSTITUTIONAL STATUS

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

INSTITUTIONS FOR MENTAL DISEASES (IMDs)

Institution for Mental Diseases (IMD) is defined as a hospital, nursing facility or institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such (42 CFR 432.1009). In Nevada, IMDs are commonly referred to as "psychiatric hospitals". Nevada Medicaid only reimburses for services to IMD/psychiatric hospital patients who are of age 65 or older or under the age of 21.

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)

ICD refers to the diagnostic codes required on claims for Medicaid payment.

LEGALLY RESPONSIBLE ADULT

Those individuals who are legally responsible to provide medical support including spouses of recipient's, legal parents of minor recipients (including adoptive parents and stepparents) and legal guardians.

LICENSURE

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

LOCK-OUT

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

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.

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)

Medicaid Estate Recovery (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.

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 EMERGENCY

Medical Emergency is a situation 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 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

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only) - These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (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. Federal Financial Participation (FFP) equals the Federal Medical Assistance Percentage (FMAP).

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.

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.

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.

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.

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 Diagnostic and Statistical Manual (DSM-IV) of mental disorders. These techniques, therapies, or treatments must be provided by a qualified mental health professional. 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 DSM-IV 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.

NEVADA DIVISION OF WELFARE AND SUPPORTIVE SERVICES (DWSS)

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

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

NEVADA MEDICAID OFFICE (NMO)

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

NEVADA REVISED STATUTES (NRS)

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

NOTICE OF ACTION (NOA)

A Division of Aging Services (DAS) document that reports to Nevada Medicaid a denial, termination, suspension, or reduction of Medicaid eligibility or covered services.

NOTICE OF DECISION (NOD)

A Division of Health Care Financing and Policy document which provides federal due process notice to a recipient of a denial, termination, suspension, or reduction of Medicaid covered services or Waiver program eligibility.

NURSING FACILITY SERVICES FOR INDIVIDUALS AGE 21 AND OLDER

Nursing facilities are institutions, which primarily provide:

1. skilled nursing care and related services for residents who require medical or nursing care; rehabilitation services for the rehabilitation of injured, disabled or sick persons; or on a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services, above the level of room and board, which can be made available to them only through institutional facilities.

Nursing facility services for individuals age 21 and older is a mandatory Medicaid benefit.

OCCUPATIONAL THERAPY (OT)

Occupational therapy means “the application of purposeful activity in the evaluation, teaching and treatment, in groups or on an individual basis, of patients who are handicapped by age, physical injury or illness, psychosocial dysfunction, developmental or learning disability, poverty or aspects of culture, to increase their independence, alleviate their disability and maintain their health.”

OUTPATIENT SERVICES

Outpatient services are those medically necessary services provided for the diagnosis and/or treatment of an illness or disease for which the patient will not require care in a facility for more than 24 hours.

PART TIME

Working at least 15 hours per week for wage/salary or attending school at least 15 hours per week.

PATIENT LIABILITY

"Patient Liability" is that portion of a recipient's income that must be paid toward the cost of care.

PERSONAL CARE AID (PCA)

Personal Care Aid (PCA) is an individual who provides assistance with personal care service to recipients with functional deficits. Assistance is limited to the performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

PERSONAL CARE AID PROGRAM

Personal Care Aid Program services are provided to eligible recipients whose chronic health problems cause them to be functionally limited in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Personal care services may be furnished to an

individual who is not an inpatient or a resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR) or institution for mental disease.

PERSONAL CARE SERVICES

Personal care services are an optional Medicaid benefit provided to individuals who are not inpatients or residents of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease. Personal care services must be:

1. authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the State;

2. provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

3. furnished in a home or other location.

These services may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability.

PERSONS WITH CONDITIONS RELATED TO MENTAL RETARDATION

Persons with conditions related to mental retardation are individuals who have severe chronic disabilities that meet all of the following:

1. The condition is attributable to cerebral palsy or epilepsy, or any disability other than mental illness, found to be closely related to mental retardation. This condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires services or treatment similar to those required by persons with mental retardation;

2. The condition is manifested before the individual reaches age 22;

3. The condition is likely to continue indefinitely; and

4. The condition results in substantial functional limitations in three or more of the following areas of major life activity:

    a. self-care; understanding and use of language;
    b. learning;
    c. mobility;
    d. self-direction; or,
    e. capacity of independent living.

PERSON WITH MENTAL RETARDATION

An individual is considered mentally retarded if he or she demonstrates significant below-average general intellectual functioning resulting in, or associated with, concurrent impairments in adaptive behaviors that are manifested during the developmental period prior to age 18 years.

PHYSICAL DISABILITY

A physical disability is defined as the inability to perform one or more substantial gainful activities by reason of any medically determinable physical impairment or combination of impairments which can be expected to result in death or to last for a continuous period of not less than 12 months. Disabling impairments must result from anatomical or physiological abnormalities, which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques, and must be established by competent medical evidence.

To be considered for services under Medicaid, individuals must be determined as blind or disabled by the Social Security Administration or Nevada Medicaid Office or be pending a determination of disability, and be Medicaid eligible or pending Medicaid. Certain aged individuals may also be considered for services if they have sustained a traumatic injury requiring comprehensive rehabilitation services. Children may be considered for medically necessary rehabilitation services (not habilitation) as a result of Healthy Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Medicaid eligibility alone does not establish that the recipient is eligible for rehabilitation and case management services.

PHYSICAL THERAPY (PT)

Physical therapy is defined as “The treatment of disorders with physical agents and methods, as massage, manipulation, therapeutic exercise, cold, heat (including short-wave, microwave, and ultrasonic diathermy) hydrotherapy, electrical stimulation, and light, to assist in rehabilitating patients and in restoring normal function following an illness or injury.”

PHYSICIAN ASSISTANT

A physician assistant is a person who is a graduate of an academic program approved by the Board of Medical Examiners or who is by general education or practical training and experience determined to be satisfactory by the board and who is qualified to perform medical services under the supervision of a supervising physician. A separate Medicaid provider agreement is required.

PLAN OF CARE AND MEDICAL EVALUATION

The plan of care is established and periodically reviewed and evaluated by a physician. It must include: diagnoses; symptoms; complaint(s) and/or complications indicating the need for admission; a description of the functional level of the resident; written objectives; orders (as

appropriate) for medications; treatment; diet; supplemental nourishment; restorative and special procedures recommended for the health and safety of the resident; any test and observations and necessary frequency to monitor resident status (i.e., vital signs, weight, fecal occult blood, blood sugar, or electrolytic levels, etc.); and plans for continuing care (including provisions for review and necessary modification of the plan) and discharge.

The written plan of care must include:

1. The recipient's problems and needs;
2. Measurable objectives to meet the recipient's entire medical needs;
3. Activities (approaches) recommended meeting the objectives;
4. Any recommendations for therapy or referrals to other providers of service needed to meet the objectives; and
5. Target or review dates by which the objectives are to be reviewed or achieved.

(NOTE: the definition of Plan of Care may differ in intent between some service program chapters)

PRIMARY CARE CASE MANAGEMENT (PCCM)

Primary Care Case Management refers to an alternative health care case management system allowed for State Medicaid programs under the statutory authority provided by section 1915(a)(1) and 1915(a)(1)(A) of the Social Security Act. These systems, in general, provide for health care financing and delivery structures, which increase the responsibility of primary care physicians for the overall management of their patient's care, and make the physicians more aware of the financial implications of their health delivery decisions. In establishing this increased responsibility, recipients are restricted to their care manager as long as they are enrolled, except in an emergency, for obtaining primary care and for authorization to receive certain other services.

PRIOR AUTHORIZATION

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

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

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

PRIOR RESOURCES

Prior resources are any non-Medicaid coverage, public or private, which can be used to pay for medical services. These resources and benefits are payable before Medicaid benefits are paid.

PRIVATE DUTY NURSING SERVICES

Private duty nursing is an optional Medicaid service which states may elect to provide. Chapter 42 CFR 440.80 defines private duty nursing services as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or nursing facility, and are provided through an agency:

1. by a registered nurse or a licensed practical nurse;

2. under the direction of the recipient's physician; and

3. at the state's option, to a recipient in one or more of the following locations:

    a. his or her own home;
    b. a hospital; or
    c. a nursing facility.

PROCEDURE CODE

A code used for billing purposes which identifies services rendered.

PROVIDER

Means a person who has applied to participate or who participates in the plan as a provider of goods or services; or a private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation or person, who contracts to provide or provides goods or services that are reimbursed by or are a required benefit of the plan.

PROVIDER EXCLUSION

Refers to an action taken by the federal Office of the Inspector General (OIG) of the United States Department of Health and Human Services, which prohibits individual practitioners and/or providers from participating in providing services under and submitting claims for such services for reimbursement from any and all federally funded health care programs. An

exclusionary action by the OIG is immediate grounds for termination of a state Medicaid Provider Agreement and offers no opportunity for hearing with Nevada Medicaid.

QUALITY IMPROVEMENT ORGANIZATION (QIO-like vendor-like vendor)

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

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

REASONABLE PROMPTNESS/TIMELINESS

All service request determinations will be issued with reasonable promptness by Nevada Medicaid. Reasonable promptness means Nevada Medicaid will take action to approve, deny, terminate, reduce or suspend service(s) within 21 business days from the date the request for service is received by Nevada Medicaid.

RECIPIENT

A person who receives benefits pursuant to the Medicaid State Plan.

RECORDS
Medical, professional or business records relating to the treatment or care of a recipient, to goods or services provided to a recipient, or to rates paid for such goods or services, and records required to be kept by the plan.

REHABILITATION SERVICES

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

REQUEST FOR HEARING

A clear, written request from either a provider or Medicaid recipient to the Division for a hearing relating to a sanction and/or adverse determination. In the case of a provider sanction or adverse determination, it is a request made after all Division remedies have been exhausted by the provider.

RESIDENTIAL TREATMENT CENTER (RTC)

Residential Treatment Center (RTC) is a facility designed as medical model in therapeutic mental health, as self-contained environment which provides 24 hour-secured (locked) inpatient care, as treatment and supervision for children and as adolescents 20 years of age and younger. This setting provides an integrated and comprehensive array of services to meet the child's or adolescent's needs including, but are not limited to, treatment services (psychotherapies), educational services, psychological testing and evaluation, and a clinical treatment milieu designed to meet the individual needs of the child or adolescent who cannot effectively be helped within his/her home, substitute family, or in a less restrictive environment. RTCs specialize in treating children and adolescents with mental disorders including personality disorders, depression, hyperactivity, academic failure, mild learning disabilities, and/or substance abuse disorders, as well as other clinical and behavioral psychopathologies. Recipients admitted to RTCs generally have experienced failed placements in the home, school, and community, and have exhausted all local resources. They need a highly structured environment with a therapeutic program in a residential setting with 24-hour supervision. All patients are provided individual, group and family therapies. An RTC may exist as free standing facility or as a unit within a psychiatric hospital. Nevada Medicaid reimburses only RTCs licensed by the State Health Division's Bureau of Licensure and Certification and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

RESIDENCE

A recipient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, or a relative's home.

RESPITE

Respite is the short-term, temporary care provided to people with disabilities in order to allow responsible adults primary care giver a break from the daily routine of providing care for the recipient. Respite is not covered under State Plan Services.

SANCTION

A sanction refers to an action taken either by Nevada Medicaid or the OIG against a provider or provider applicant.

SERIOUS MENTAL ILLNESS (SMI)

Serious Mental Illness (SMI) exists in an individual who is:

1. 18 years of age and older;

2. who currently or at any time during the past year (continuous 12 month period), have had a diagnosable mental, behavioral, or emotional disorder that meets the coding and definition criteria specified within Diagnosis and Statistical Manual of Mental Health Disorders (DSM IV) criteria;

3. that resulted in functional impairment which substantially interferes with or limits with one or more major life activities;

4. functional impairment addresses the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health-illness and is viewed from the individual's perspective within the environmental complex.

   Functional impairment is defined as difficulties that substantially interfere with or limit with an adult from achieving or maintaining housing, employment, education, relationships or safety. The determination for adults with Serious Mental Illness (SMI) is made by a licensed mental health professional (psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family therapist, or psychiatric nurse with a master's degree).

SEVERE EMOTIONAL DISTURBANCE (SED)

Children with a severe emotional disturbance (SED) are persons:

1. from birth up to age of 18; and

2. who currently or at any time during the past year (continuous 12-month period):

   a. have diagnosable mental behavioral or diagnostic criterion specified that meets the coding and definition criteria specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This excludes substance abuse or addictive disorders, irreversible dementias as well as mental retardation and V codes, unless they co-occur with another serious mental illness that meets DSM-IV criteria;
   b. that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities and;

3. These disorders include any mental disorder (including those of biological etiology) listed in DSM-IV "V" codes, substance use, and developmental disorders, which are excluded, unless they concur with another diagnosable serious emotional disturbance.

All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and have a functional impairment, defined as difficulties that substantially interfere with or limit with a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit, treatment, or other support services are included in this definition

SKILLED NURSING (SN)

Skilled Nursing (SN) means assessments, judgments, interventions, and evaluations of intervention, which require the training and experience of a licensed nurse. SN care includes, but is not limited to performing assessments to determine the basis for action or the need for action, monitoring fluid and electrolyte balance, suctioning of the airway, central venous catheter care, mechanical ventilation, and tracheotomy care.

SKILLED SERVICES

Skilled services are inherently complex and are required to provide safe and effective services from a nurse or therapist with specialized trainings and credentials.

SPEECH THERAPY (ST)

Speech therapy is an optional Medicaid benefit which Nevada Medicaid covers when medically necessary for eligible recipients. Speech therapy services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. Any necessary supplies and equipment are included.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

State Children's Health Insurance Program (SCHIP) serves children ages 0 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 (FFP). Nevada Check Up is the Nevada version of SCHIP. Nevada Check Up insurance is comprehensive health insurance covering medical, dental, vision care, mental health services, therapies, and hospitalization.

STATE PLAN (The Plan)

The State Plan is a comprehensive statement submitted by Nevada Medicaid to CMS describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, and other applicable official issuances of the Department of Health and Human Services (HHS). The State Plan contains all information necessary for the Department to determine whether the plan can be approved, as a basis for Federal Financial Participation in the state program.

The State Plan consists of written documents furnished by the state to cover each of its programs under the Act including the medical assistance program (Title XIX). After approval of the original plan by HHS, all relevant changes, required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted currently so HHS may determine whether the plan continues to meet federal requirements and policies. Determinations regarding State Plans (including plan amendments and administrative practice under the plans) originally meet or continue to meet the requirements for approval are based on relevant federal statutes and regulations.

SUPPORTED LIVING ARRANGEMENT (SLA)

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

TARGETED CASE MANAGEMENT

Targeted case management is an optional service that refers to the identification of a “target” group to whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination thereof. These services are defined as “services which assist an individual eligible under the plan in gaining access to needed medical, social, educational and other services.” The intent of these services is to allow states to reach beyond the usual bounds of the Medicaid program to coordinate a broad range of activities and services necessary to the optimal functioning of a Medicaid recipient.

THIRD PARTY LIABILITY

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

UTILIZATION CONTROL

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

VENTILATOR DEPENDENT RECIPIENT

Ventilator dependent recipient refers to a recipient who receives mechanical ventilation for life support at least six hours per day.

110 NEVADA MEDICAID PROVIDER TYPES

10 - Outpatient Surgery
11 - Hospital, Inpatient
12 - Hospital, Outpatient
13 - Psychiatric Hospital, Inpatient
14 - Mental Health, Outpatient/Public
16 - Intermediate Care Facility/MR
17 - Special Clinics
18 - Nursing Facility/Skilled Level
19 - Nursing Facility/Intermediate Level
20 - Physician/Osteopath
21 - Podiatrist
22 - Dentist
23 - Hearing Aid Dispenser & Related Supplies
24 - Certified Registered Nurse Practitioner, Nurse
25 - Optometrist
26 - Psychologist
27 - Radiology & Noninvasive Diagnostic Centers
28 - Pharmacy
29 - Home Health Agency - (persons 21 years old and older)
30 - Personal Care Aide (Home Care) Provider Agency
32 - Ambulance - Air or Ground
33 - Durable Medical Equipment (DME), Disposables, Prosthetics
34 - Therapy - Physical, Occupational, Respiratory, Speech and Audiology
35 - Transportation
36 - Chiropractor
37 - Intravenous Therapy (TPN)
38 - Home and Community Based Waiver - MR Services
39 - Adult Day Health Care
40 - Primary Care Case Management (PCCM) Services
41 - Optician/Optical Businesses
42 - Out-Patient Psych Hosp/Private & Comm Mental Health Cntrs/Private
43 - Laboratory - Pathology/Clinical
44 - Swing-bed (Acute Hospitals)
45 - End Stage Renal Disease (ESRD) Facility
46 - Ambulatory Surgery Centers (Medicare Certified)
47 - Indian Health Services (IHS) & Tribal Clinics
48 - Senior Waiver
49 - IHS Transportation
51 - IHS Hospital (InPatient)
52 - IHS Hospital (OutPatient)
54 - Case Management (DHR)

55 - Transitional Rehabilitative Center
56 - Medical (Rehabilitation Center or Specialty) Hospital - Inpatient
57 - Adult Group Care Waiver
58 - Physically Disabled Waiver
60 - School Based Services
61 - Mental Health Rehab Treatment Services / Residential
62 - Health Maintenance Organization (HMO)
63 - Residential Treatment Center (RTC)
64 - Hospice
65 - Hospice, Long Term Care
68 - Intermediate Care Facilities for Mentally Retarded / Private
72 – Nurse Anesthetist
74 – Nurse Midwife
75 – Critical Access Hospital (CAH), Inpatient
76 – Audiologist
77 – Physician's Assistant
78 – Indian Health Service Hospital, Inpatient (Non-Tribal)
79 – Indian Health Service Hospital Outpatient (Non-Tribal)
80 – IHS Travel (Non-Tribal)
82 – Mental Health Rehabilitative Treatment Services / Non-Residential
83 – Personal Care Aide – Intermediary Service Organization
84 – Personal Care Aide – Independent Contractor