MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 8, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 – MEDICAID PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program are being proposed for provisional licensure as allowed by state board requirements for specialty.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: All Nevada Medicaid Provider Types.

Financial Impact on Local Government: Unknown at this time.

These changes are effective December 9, 2016.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 26/16 Chapter 100 – Medicaid Program	MTL 19/15 Chapter 100 – Medicaid Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.5	**DISPOSITION OF CONTRACT FOR NEW PROVIDERS**	The Division of Health Care Financing and Policy (DHCFP) is proposing clarifying language in MSM Chapter 100 for provisional licensure to allow for provisional license based on state board requirements of the specific specialties within the scope of practice. Provisional licensure will apply only to licensed level professionals. Credentialed and paraprofessional level providers do not meet the requirement for provisional licensure.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MEDICAID PROGRAM

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

100 INTRODUCTION

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

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

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

c. restrain the growth of health care costs; and

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

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

100.1 AUTHORITY

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

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

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

b. Payment for Medicaid services is regulated by Sections 1902(a) and 1923 of the Social Security Act, 42 CFR, Part 447, and Nevada Medicaid State Plan Sections 4.19 and 4.21.

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

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

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

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

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

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

i. 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.

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

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

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

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

n. 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.

o. 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).

100.2 CONFIDENTIAL INFORMATION

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

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

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

a. Definition of Confidential Information

For the purposes of this manual, confidential information includes:

1. Protected Health Information (PHI)

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

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

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

b the provision of health care to the individual;

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

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

b. Information which does not meet the requirements of de-identified data defined in 45 CFR 164 § 514(b). This includes all elements of dates (such as date of service, data dispensed, claim paid date) and identifiers (including internal control numbers (ICN)).

2. Information on social and economic condition or circumstances.

3. Division/Department evaluation of personal information.

4. Any information received for verifying income eligibility and amount of medical assistance payments.

5. Any information received in connection with the identification of legally liable third party resources.

6. Medicaid Provider Numbers or other identifiers defined by NRS 603A.040.

b. Limitations on Use and Disclosure

Disclosures of identifiable information are limited to purposes directly related to State Plan administration. These activities include, but are not limited to:

1. Establishing eligibility;

2. Determining the amount of medical assistance; payment activities as defined by HIPAA;

3. Determining third party liability;

4. Providing services (medical and non-medical) for recipients; treatment as defined by HIPAA;

5. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan;

6. Health care operations as defined by HIPAA, which includes, but is not limited to: quality assessment and improvement activities, including case management and care coordination, competency assurance activities, medical reviews, audits, fraud and abuse detection, rate setting, business management and general administration;

7. For public interest and benefit activities within limits set under HIPAA, including, but not limited to: disclosures required by law, public health activities, health oversight activities, judicial and administrative proceedings, essential government functions, to comply with worker's compensation laws, and to avoid serious threats to the health and safety of recipients and others.

8. Per authorizations (as defined by HIPAA) from the recipient or their designated representative.

c. Release of Information

Except as otherwise provided in these rules, no person shall obtain, disclose or use, or authorize, permit or acquiesce the use of any client information that is directly or indirectly derived from the records, files, or communications of the DHCFP, except for purposes directly connected with the administration of the Plan or as otherwise provided by federal and state law.

1. Disclosure is permitted for purposes directly connected with the administration of Medicaid between covered entities (as defined by HIPAA) for the purposes of treatment, payment, and health care operations and may, in certain circumstances, be done in the absence of an authorization or agreement. Such situations include, but are not limited to: verifying information with Medicaid program staff in other states to verify eligibility status, disclosure to Medicare staff for coordination of benefits, or communications with providers for payment activities.

2. Access to confidential information regarding recipients will be restricted to those persons or agencies whose standards of confidentiality are comparable to those of the DHCFP.

   a. Those standards of confidentiality will be outlined in appropriate agreements which the DHCFP may require, including business associate agreements and limited data set use agreements (as defined by HIPAA) data sharing agreements, and other agreements deemed necessary by the DHCFP.

3. In accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the 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 operations.

4. The DHCFP will make reasonable efforts to follow HIPAA's "minimum necessary" standard when releasing confidential information.

5. Detailed policies and procedures are found in the DHCFP HIPAA Privacy and Security Manuals, available for reference in hard copy form in the District Office and on the DHCFP Intranet.

d. Penalties

Penalties for inappropriate use and disclosure of confidential information are:

1. The HITECH Act imposes civil and criminal penalties depending upon the nature and scope of the violation, which range from $100 to $1.5 million dollars and up

to ten years in prison. This is enforced by the Office for Civil Rights. State Attorneys General have the authority to bring civil actions on behalf of state residents for violations of HIPAA Privacy and Security Rules.

2. Penalties under Nevada state law are found at NRS 193.170.

e. Ownership

All recipient information contained in the DHCFP records is the property of the DHCFP, and employees of the DHCFP shall protect and preserve such information from dissemination except as provided within these rules.

101 OVERVIEW OF PROGRAMS

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

a. 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 Temporary Assistance for Needy Families (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.dwss.nv.gov.

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

b. Nevada Check Up (NCU)

The NCU program is Nevada's name for the federal Title XXI benefits administered under the Children's Health Insurance Program (CHIP). NCU 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 NCU recipients generally duplicate the services outlined for Nevada Medicaid and the program uses the Nevada Medicaid Provider Panel. Refer to the NCU Manual for a description of program differences.

c. State Plan Services under 1915(c) of the Social Security Act

Section 1915(c) State Plan of the Social Security Act known as Home and Community-Based Waiver (HCBW) services which permits the option to waive certain Medicaid statutory requirements in order to offer an array of Home and Community-Based Services (HCBS) to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. Each 1915(c) waiver is designed to provide

eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

d. State Plan Services under 1915(i) of the Social Security Act

Section 6086 of the Deficit Reduction Act of 2005, established a new benefit of the Social Security Act called 1915(i) State Plan HCBS which allows states to provide traditional 1915(c) services as a covered state plan benefit. 1915(i) services are available to certain Medicaid recipients who meet the needs based criteria and who reside in the community.

101.1 OUT OF STATE SERVICES

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

Section 1902(a)(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:

a. needed because of a medical emergency.

b. recipients' health would be in danger by travel back to Nevada.

c. 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

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

e. it is general practice for a recipient in a particular locality to use medical resources in another state:

1. 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 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. Refer to the billing manual for a list of catchment areas.

2. 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.

101.2 NEVADA MEDICAID AND NCU CARD

Medicaid and NCU 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/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.

101.2A 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 Unit (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.

   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 (NOD) from the DWSS 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 NCU have contracts with managed care organizations to provide medical coverage to eligible categories of individuals in Clark and Washoe County. Nevada

Medicaid and NCU reimburse managed care providers a capitated monthly rate for each enrollee and cannot reimburse any other provider independently for covered, contracted services. Refer to Medicaid Services Manual (MSM) 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 MSM 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 MSM Chapter 3600 for additional information on Managed Care.

101.2B 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.

101.2C 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 QIO-like vendor. Providers will be asked to document the necessity of all services provided which are not emergent. 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 for 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 (FFS) or Medicaid Managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered. All healthcare providers who are eligible to obtain a National Provider Identifier (NPI) number must provide this NPI to Medicaid at the time of their provider enrollment application. To obtain a NPI or further information regarding NPI, see the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov.

Medicaid may reimburse a provider who meets the following conditions:

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

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

c. Completes the Nevada Medicaid Provider Application and Contract; and

d. Received notice from Nevada Medicaid that the credentials have been met and the provider agreement has been accepted.

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

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

A moratorium may be implemented at the discretion of the federal Department of Health and Human Services (DHHS) or the Division of Health Care Financing and Policy (DHCFP). A new enrollment application is required for enrollment after it is lifted

102.1 REQUEST FOR ENROLLMENT

A provider may request enrollment in the Nevada Medicaid Program by completing the Enrollment Application and providing the required verifications for their requested provider type. However, the DHCFP is not obligated to enroll all eligible providers who request enrollment. Enrollment is at the discretion of the DHCFP. For additional information regarding enrollment, the provider may contact the Provider Enrollment Unit of the Fiscal Agent. Refer to Section 108 for contact information.

The effective date of the provider contract is the date received. Exceptions may be allowed for up to six months of retroactive enrollment to encompass dates on which the provider furnished

services to a Medicaid recipient. The Provider Contract expires 36 months from the date the DHCFP approves enrollment.

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

102.2 CONDITIONS OF PARTICIPATION – ALL PROVIDERS

A. The fiscal agent will not enroll any person or entity convicted of a felony or gross misdemeanor under Federal or State law for any offense which the State agency determines is inconsistent with the best interest of recipients under the State plan. The following list, though not exhaustive, provides examples of crimes which indicate a provider is not eligible for participation:

1. Murder, voluntary manslaughter or mayhem;

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

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

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

5. False imprisonment, involuntary servitude or kidnapping;

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

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

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

9. Within the preceding seven years the fiscal agent shall not enroll a provider who has been convicted of (not all inclusive):

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

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

c. Any felony involving the use of a firearm or other deadly weapon;

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

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

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

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

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

5. is serving a sanction period.

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

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

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

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

G. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with the DHCFP Operations Service Manuals, state and federal statutes, and regulations at a minimum of six years from the date of payment for the specified service.

Electronic health records must include a verifiable date of service time stamp, record who is making the entry and who actually saw the patient.

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

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

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

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

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

102.3 OUT OF STATE PROVIDER PARTICIPATION

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

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

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

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

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

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

102.3A EMERGENCY SERVICES OUTSIDE THE STATE OF NEVADA

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

102.4 FACILITY DISCLOSURE

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

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

Documents subject to disclosure include:

a. survey reports, including a statement of deficiencies;

b. official notifications of findings based on the survey;

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

d. ownership and contract information specified below; and

e. 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:

f. 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;

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

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

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

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

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

102.4A PROVIDER DISCLOSURE

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

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

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

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

4. Any current or previous investigation by any law enforcement, regulatory agency, or state agency, or restricted professional license. The Fiscal Agent will forward these applications

to the Provider Support Unit for consideration on a case by case basis. Providers must provide information, documentation and explanation;

5. Any current open/pending court cases;

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

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

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

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

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

a. onsite inspection prior to enrollment;

b. review of business records;

c. data searches; and

d. provisional enrollment.

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

1. billing practices;

2. policy and procedure; or

3. quality of care compliance reviews.

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

102.5 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 MSM for the specified provider type and Nevada MSM Chapter 100 all inclusive.

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

102.5A CERTIFICATION STATEMENT

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

1. "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."

2. "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."

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

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

    a. 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

    b. With regard to submission of claims for payment:

        1. I certify that all information is true, accurate and complete; and

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

3. "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."

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

102.5B CONTRACT OR RE-ENROLLMENT APPROVAL

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

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

102.5C CONTRACT OR RE-ENROLLMENT DENIAL

1. The 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;

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

   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;

   d. fails to submit information requested by the Fiscal Agent;

   e. submits false information.

2. The Fiscal Agent Provider Enrollment Unit will notify the provider by U.S. mail of the contract denial. Providers who have their enrollment denied do not have appeal or hearing rights.

103 PROVIDER RULES AND REQUIREMENTS

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

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

b. A Medicaid provider who accepts a Medicaid recipient for treatment accepts the responsibility to make sure 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.

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

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

103.1 MEDICAL NECESSITY

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:

a. Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.

b. 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.

c. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.

d. Services are provided for medical or mental/behavioral reasons rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider.

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

103.2 AUTHORIZATION

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

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

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

a. Some services covered by Nevada Medicaid require PA 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 from an inpatient facility, and are approved for Medicaid eligibility 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 eligibility date of decision is determined, the facility is responsible for initiating the admission and concurrent review authorization within ten working days.

b. For Medicare and Medicaid dual eligibles there is no requirement to obtain Medicaid PA for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's PA guidelines. PA are not necessary for recipients who are eligible for Qualified Medicare Beneficiary (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).

c. 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 of Services (EVS). Covered services that meet the definition of "emergency services" reimbursed. A retrospective review for services which require prior authorization by Medicaid's QIO-like vendor will determine authorization for payment based on clinical information that supports medical necessity and/or appropriateness of the settings.

d. If PA is required, it is the responsibility of the provider to request before providing services. Waiting until the claim is due before securing an approved PA will not override the stale date. The PA number is required on the claim. See the appropriate MSM chapter for program specific retro-authorization policy.

e. Once an approved PA request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.

f. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period, or both) of the current authorization, the provider is responsible for the submission of a new PA request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period, so the newly authorized service may start immediately following the expiration of the existing authorization. Exception: the 15-day recommendation does not apply to concurrent, inpatient hospital stay authorizations.

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

103.3 PROVIDER REPORTING REQUIREMENTS

Medicaid providers, and any pending contract approval, are required to report, in writing 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

a. 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.

b. 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".

c. 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).

d. 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 and 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:

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

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

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

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

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

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

103.4A COVERAGE AND LIMITATIONS

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

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;

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

   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 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 Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and confidentiality standards within 42 CFR § 431.301 – 431.305 restrict the use or disclosure of information concerning applicants and recipients. The information providers must safeguard includes, but is not limited to: recipient demographic and eligibility information, social and economic conditions or circumstances, medical diagnosis and services

provided, and information received in connection with the identification of legally liable third party resources.

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

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

103.5A 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. The HIPAA of 1996 Privacy Rules permit the disclosure of a recipient's health information without their authorization in certain instances (e.g. for treatment, payment, health care operations, or emergency treatment; to make appointments to the DHCFP business associates; to recipient's personal representatives; as required by law; for the good of public health; etc.)

4. 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).

5. 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 (FFP). The DHCFP service providers must comply with these laws as a condition of participation in the Nevada Medicaid program in offering or providing services to the Division's program beneficiaries or job applicants and employees of the service providers.

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

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

b. Notices/signs must be posted throughout a facility, as well as information contained in patient and employee handouts, which notifies the public, patients and employees that the facility does not discriminate with regards to race, color, national origin, religion, gender, age, or disability (including AIDS and related conditions) in:

   1. admissions;

   2. access to and provisions of services; or

   3. employment.

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

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

circumstances of the individual case may be made only by written certification of such by the attending physician or administrator).

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

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

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

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

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

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

f. Medical facilities must have policies that prevent making improper inquiries regarding race, color, national origin, religion, sex, age or disability (including AIDS and related

conditions) prior to making a decision to employ a person. Supervisory personnel must be knowledgeable with regard to these policies and practices and must enforce them.

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

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

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

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

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

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

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

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

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

103.7 ADVANCED DIRECTIVE

An Advanced Directive (AD) is a written instruction by an individual, 18 years of age or older, and done in advance of a serious illness or condition. The AD allows the individual to direct health

care decisions in the event they become incapacitated. It may be in the form of a Living Will or Durable Power of Attorney, and includes provisions allowing the individual to make decisions regarding the use or refusal of life sustaining treatment.

103.7A ADMINISTRATION OF ADVANCED DIRECTIVES

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

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

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

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

        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 AD.

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 AD.

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

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

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

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

103.8 MUTUAL AGREEMENT IN PROVIDER CHOICE

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

104 THIRD PARTY LIABILITY (TPL) – OTHER HEALTH CARE COVERAGE

Medicaid is generally the payer of last resort whenever there are any other responsible resources for payment of health care services. Other Health Care Coverage (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 NCU program. If a provider discovers a participant in NCU has major medical insurance, they must report to DHCFP.

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

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

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

d. 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 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.

e. The provider must inform the recipient, or responsible individual, 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 individual, 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 individual, accepts financial responsibility.

f. A Medicaid provider cannot refuse to provide Medicaid covered services to a Medicaid eligible recipient due to potential TPL coverage.

g. 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).

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

i. 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. For Medicare Services which are not covered by Medicaid, or for which Nevada does not have an established rate, Medicaid will pay the Medicare co-insurance and deductible amounts. 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 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 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 the OHC network, or if the provider fails to follow the requirements of the OHC. Exceptions to Medicaid liability policy for OHC coverage are:

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

b. the service is an emergency and the recipient is not given an option to choose/select where they are taken; or

c. 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 the recipient's 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.

After receiving payment or a denial letter from the OHC, if the provider is submitting a paper claim, they must also submit the OHC's 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.

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, the provider must 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 for processing. If the recipient's OHC is Medicare and the service is not a covered Medicare service, the provider is not required to contact Medicare.

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 TPL rule are:

d. Indian/Tribal Health Services (IHS);

e. Children with Special Health Care Needs; and

f. State Victims of Crime.

Medicaid is primary payer to these three programs; however, this does not negate the provider's responsibility to pursue OHC. For specific information on IHS billing, refer to Medicaid Services Manual (MSM) Chapter 600, Section 603.8.

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.

a. 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.

b. 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.

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

d. 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.)

NCU 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.

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

   1. related to the actual cost of processing the billing;

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

   3. not dependent on the collection of the payment.

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

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

   2. the group if the practitioner and the group have a contract in place under which the group submits the claims;

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

   4. 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

A. 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.

B. Medicaid utilizes the Centers for Medicare and Medicaid Services (CMS) developed National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate payments. The National Correct Coding Initiative (NCCI) edits are defined

as edits applied to services performed by the same provider for the same beneficiary on the same date of service. They consist of two types of edits:

1. NCCI edits, or procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and

2. Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.

C. 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 the most current CPT, HCPCS, International Classification of Diseases (ICD), American Medical Association (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.

D. 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.

E. 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.

F. Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the Health Insurance Portability and Accountability Act (HIPAA) of 1996 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.

G. 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.

H. 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 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.

I. 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.

J. 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 except by the teaching physician under the policy guidance in Medicaid Services Manual (MSM) Chapter 600.

K. 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.

L. 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).

M. 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 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.

4. Provider Preventable Conditions

   If a Provider Preventable Condition (PPC) is discovered that has caused or will cause an increase in incurred cost, the DHCFP or its agents may deny payment, or recover any payments already made, for such condition. The term "Provider Preventable Condition'' is defined as an undesirable and preventable medical condition that the patient did not have upon entering a health care facility, but acquired while in the medical custody of the facility. Known risks associated with a procedure will not be considered to be a PPC; however, any primary or secondary diagnosis code(s) caused by the care provided in the facility will be subject to this policy. Examples of PPCs include, but are not limited to:

   a. Wrong surgical or other invasive procedure performed on a patient.

   b. Surgical or other invasive procedure performed on the wrong body part.

   c. Surgical or other invasive procedure performed on the wrong patient.

   d. Foreign object retained after surgery.

   e. Air embolism.

   f. Blood incompatibility.

   g. Surgical site infection following:

      1. Coronary artery bypass graft.

      2. Bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery).

      3. Orthopedic procedures (spine, neck, shoulder and elbow).

h. State III and IV pressure ulcers.

i. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock).

j. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity).

k. Catheter-associated urinary tract infection.

l. Vascular catheter-associated infection.

m. Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery other than in pediatric and/or obstetric patients.

If a PPC is caused by one provider or facility (primary) and is then treated by a different facility or provider (secondary), payment will not be denied to the secondary provider. The DHCFP will make appropriate payments to the secondary provider and may pursue recovery of all money in full, including legal expenses and other recovery costs from the primary provider. This recoupment may be recovered directly from the primary provider, or through subrogation of the injured recipient's settlement. The anticipated costs of long-term health care consequences to the recipient may also be considered in all recoveries.

Providers can request an appeal via the fiscal agent if they disagree with an adverse determination related to a PPC. The fiscal agent’s appeal process must be exhausted before pursuing a Fair Hearing with the DHCFP. Refer to MSM Chapter 3100, Section 3105 for additional information on Fair Hearings.

Individual agreements between managed care organizations and their providers may vary from fee for service limitations.

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 30 days from the date of the initial Remittance Advice (RA) listing the claim as denied. An additional 30 days to appeal a denied claim will not be allowed when an identical claim has been subsequently submitted.

Claims that have denied due to a system error, as identified by web announcement on the Fiscal Agent website, do not need to be resubmitted or appealed.

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;

    b. Documentation to thoroughly support the appeal request;

    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 (NOD) 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 MSM Chapter 3100 for additional information on Fair Hearings.

105.3 BILLING MEDICAID RECIPIENTS

A. 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.

B. 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.

C. 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.

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

   a. The physician chooses to admit the patient, nonetheless;

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

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

2. 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

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

   b. The physician orders the discharge of the patient;

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

d. The recipient refuses to leave.

D. 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:

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

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

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

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.

E. 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.

F. 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.

G. 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.

H. 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

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.

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

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

106.1 TERMINATION FOR CONVENIENCE

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

106.2 CONDITIONS OF CONTRACT TERMINATIONS AND NON-RENEWAL

A. Immediate Terminations

The DHCFP may decide to immediately terminate or not renew a provider contract if any of the following occur:

1. The provider is convicted of a criminal offense related to the participation in the Medicare/Medicaid program;

2. The provider's professional license, certification, accreditation or registration is suspended or revoked;

3. The DHCFP is notified the provider is placed on the Office of Inspector General (OIG)'s Exclusion List (42 Code of Federal Regulations (CFR) 1002);

4. The provider is deceased;

5. The DHCFP has determined that the quality of care of services rendered by the provider endangers the health and safety of one or more recipients;

6. Mail is returned from the post office and a forwarding address is not provided;

7. The provider has failed to disclose information listed in MSM Chapter 100, Section 102;

8. Identity of the provider cannot be proven; or

9. The provider has been terminated for cause by a Managed Care Organization (MCO) contracted with the DHCFP.

B. Advance Notice of Termination

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

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

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

3. Termination, exclusion or suspension of an agreement or contract by any other governmental, state or county program;

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

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

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

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

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

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

10. An administrative contract termination has been performed.

106.3 SANCTION PERIODS

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

Sanctions may be applied to any person who has ownership or controlling interest in the provider or who is an agent or managing employee of the provider.

a. Tier 1 - Permanent Sanction

1. Provider is on the OIG exclusion list.

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

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

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

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. False imprisonment or involuntary servitude;

e. Criminal neglect of patients per the NRS 200.495;

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

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

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

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

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

b. Tier 2- Seven Year Sanction

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

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

a. Assault or battery;

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

c. Harassment or stalking;

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

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

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

g. 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

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

c. Tier 3- Twelve Month Sanction

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

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

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

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

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

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

7. Provider has a restricted professional license.

d. Immediate Re-Application

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

1. Loss of contact;

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

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

4. Provider failed to provide requested information.

106.4 PROCEDURES FOR TERMINATION AND NON-RENEWAL

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

a. A Notice of Intent to Terminate or Non-renew will be sent to the provider at the last known mailing address via U.S. mail. The notice will include:

1. a description of proposed action;

2. the effective date of the proposed action;

3. the 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 NRS 422.306; and

6. the tier and length of sanction imposed, if applicable.

106.4A ADMINISTRATIVE CONTRACT TERMINATIONS

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

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

1. death of the provider;

2. loss of contact;

3. no payments made to provider within the prior 24 months; and/or

4. when the sole issue is a change in federal law.

106.5 MEDICAID AGENCY ACTION AFTER REVIEW, AUDIT OR INVESTIGATION

The DHCFP may initiate a corrective action plan against a provider as the result of an investigation, audit and/or review.

Investigations, audits or reviews may be conducted by one or more of the following (not all inclusive):

a. U.S. DHHS;

b. U.S. Department of Justice;

c. Nevada Medicaid Surveillance Utilization and Review (SUR) staff;

d. Medicaid Fraud Control Unit (MFCU);

e. Nevada Medicaid program Provider Support staff;

f. Nevada Medicaid audit staff;

g. DHCFP Audit Contractors;

h. Fiscal agent staff;

i. Aging and Disability Services Division (ADSD) staff; or

j. Other state and/or county agencies.

Refer to MSM Chapter 3300 for information regarding SURS investigations.

106.5A 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. The 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 DHCFP or fiscal agent staff. Educational contact is made for the purpose of instructing a provider in policy compliance, correct billing procedures, 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 DHCFP staff 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 DHCFP 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. A second opinion from an independent peer must be obtained to confirm the need for the service to be eligible for Medicaid reimbursement.

d. Suspending the provider from accepting and billing for new Medicaid recipients.

If corrective action is initiated against a provider, the provider is required to cooperate and comply with the terms of the corrective action plan. Failure to cooperate and/or comply with the terms of the corrective action plan may result in the termination of the provider's contract.

If the provider disagrees with the action recommended, they may request a fair hearing. Refer to MSM Chapter 3100, Section 3105 for additional information.

106.6 SUSPENSION

Suspension means Nevada Medicaid will not reimburse payment for rendered services for a specified period of not more than one year. In addition, a provider may be suspended from accepting and billing for new Medicaid recipients as the result of an audit, review or investigation until corrective action is initiated.

a. A provider may be suspended from the Medicaid program when:

1. found to be providing items or services at a frequency or amount not medically necessary;

2. found to be providing items or services of a quality that does not meet professionally recognized standards of health care in a significant number of cases; or

3. an audit, review or investigation reveals failure to comply with program policies.

b. Suspension may be applied to any person who has ownership or controlling interest in the provider or who is an agent or managing employee of the provider. All persons affected by the exclusion must be notified in the original notice of exclusion.

c. A provider whose contract is suspended may request a fair hearing pursuant to MSM Chapter 3100. Refer to Chapter 3100 Section 3105 for additional information.

106.6A PROCEDURES FOR SUSPENSION

If the DHCFP decides to suspend a provider contract, a notice of the intended action will be mailed to the provider via U.S. mail to the last known address.

The notice will include:

1. a description of proposed action;

2. the effective date of the proposed action;

3. the length of suspension;

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

5. the effect of the action on the provider's participation in the Nevada Medicaid Program; and

6. the provider's right to a fair hearing in accordance with NRS 422.306.

107 RE-ENROLLMENT

A Medicaid provider who has been previously terminated, excluded, or suspended may be re-enrolled upon completion of the Provider Enrollment Application, Medicaid Provider Contract, submission of the required verifications and meeting all conditions of participation noted elsewhere in this Chapter. Re-enrollment is at the discretion of the Division.

A provider who voluntarily terminates enrollment is not eligible for re-enrollment for a period of 365 days from the date of termination, unless an access to care issue exists.

107.1 CONDITIONS OF RE-ENROLLMENT

A. 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 that conditions of participation are met.

B. 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 and the provider is eligible to apply for re-enrollment after serving their sanction period.

Nevada Medicaid may re-enroll the provider 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:

1. Whether the provider has been convicted in a federal, state or local court of other offenses related to participation in the Medicare or Medicaid programs which were not considered in the development of the Medicaid suspension, exclusion or termination; and

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

C. 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 re-enroll the provider until federal HHS notifies Nevada Medicaid it is permissible to do so and the provider completes all enrollment applications and contracts.

D. If Nevada Medicaid approves the request for re-enrollment, 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.

E. Nevada Medicaid Fiscal Agent will give written notice to the suspended, excluded or terminated provider of the status of their re-enrollment request.

108 REFERENCES

FISCAL AGENT CONTACT INFORMATION

PROVIDER RELATIONS UNITS (Enrollment/Claims Issues/Questions)

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

ELECTRONIC BILLING

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

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

PRIOR AUTHORIZATION FOR DENTAL AND PERSONAL CARE AIDE

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

PRIOR AUTHORIZATION FOR ALL OTHER SERVICE TYPES (except Pharmacy)

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

PHARMACY

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

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

THIRD PARTY LIABILITY (TPL) UNIT

Emdeon TPL Unit
P.O. Box 148850
Nashville, TN 37214
Phone: (855) 528-2596
Fax (855) 650-5753

Email: TPL-NV@Emdeon.com

MANAGED CARE ORGANIZATIONS

AMERIGROUP Community Care

Physician Contracting
Phone: (702) 228-1308, ext. 59840

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

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

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

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

Claims Address:
Health Plan of Nevada
P.O. Box 15645
Las Vegas, NV 89114

FIELD OFFICES

Carson City	(775) 684-7200
Elko/Winnemucca	(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) 486-1646
Las Vegas – Cambridge	(702) 486-1646
Las Vegas – Cannon Center	(702) 486-1646
Las Vegas – Charleston	(702) 486-1646
Las Vegas – Flamingo	(702) 486-1646
Las Vegas – Nellis	(702) 486-1646
Las Vegas – Owens	(702) 486-1800
Las Vegas – Southern Investigations & Recovery	(702) 486-1875
Pahrump	(775) 751-7400
Reno – Bible Way (Investigations & Recovery)	(775) 688-2261
Reno – Kings Row	(775) 684-7200
Yerington	(775) 463-3028

109 RESERVED

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