MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 8, 2003

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF, COMPLIANCE

SUBJECT: MEDICAID MANUAL SERVICES CHANGES

MATERIAL TRANSMITTED	MATERIAL SUPERCEDED
MTL 26/03	**MTL 13/91**
CHAPTER 2400	CHAPTER 2400
REHABILITATION AND	COMPREHENSIVE OUTPATIENT
CASE MANAGEMENT SERVICES	REHABILITATION SERVICES
FOR THE PHYSICALLY DISABLED	PROGRAM

Background and Explanations

These changes should be effective September 1, 2003 to coincide with the billing process change to the Medicaid Management Information System. This chapter supercedes what was commonly referred to as the RECAMS program. This version will brings the program more in line with other Medicaid State Plan programs.

Changes are being made to the chapter to:

- Change the name of the program from RECAMS to Comprehensive Outpatient Rehabilitation (COR) services, to better reflect the services provided.
- Remove Case Management policy as a separate available service, to comply with Federal regulations.
- Standardize definitions amongst Medicaid Service Manual Chapters;
- Standardize the formatting to what is being used in all chapters.
- Expands upon and provides clarification of program and service edits already in existence;
- Expand policies for covered services, admission criteria for comprehensive rehabilitation programs, continued stay criteria and discharge criteria.
- Expand policies regarding provider qualifications, required documentation, and prior authorization procedures.
- Provide clarification of service coverage language where confusion has existed;

- Delineate process changes necessary for program compliance with the Health Insurance Portability and Accountability Act.
- Remove internal procedures which will be incorporated more appropriately into a program operations manual.

2401.1 Authority: Made corrections to the citations listed.

2401.2 Definitions

- Removed definitions that were no longer applicable.
- Added definition for; Significant Practical Improvement
- Modified the definition under case management to standardize with other Division chapters, but also removed the reference to the Social Security Act as allowing targeting of case management to a particular group, as this reference applies to the Targeted Case Management program.

Coverage and Limitations (from prior chapter)

- Removed all references to the eligibility requirement that a recipient must be determined physically disabled (or pending a determination) to comply with Federal regulations.

- Removed exclusions related to mental disorders.

- Removed policy sections for Acute Rehabilitation and Specialty Rehabilitation as these are inpatient services and are included in Chapter 200.

2403 Policy - Comprehensive day treatment program

Reorganized the chapter, making Comprehensive Day Treatment the primary policy, which will be referenced in other policies for things such as; covered services, provider responsibility, recipient responsibility and authorization process.

2403.1A Coverage and Limitations

- Added policy: Recipients who have completed comprehensive rehab for the same condition are not eligible to receive it again, except under certain circumstances, as this would constitute a duplication.
- Imposed restrictions as to when a recipient would be services in relationship to when they incurred a functional or cognitive impairment.
- Delineated (and expanded) admission criteria.
- Delineated what services must be included in a comprehensive rehabilitation program.
- Identified non-covered services, combining activities previously identified in various sections. Clarified some activities that have not been identified in the chapter previously but have been “understood” by providers as non-covered.
- Expanded our criteria for continued stay in a rehab program.

- Added discharge criteria.

2403.1B Provider responsibility;

- Expanded on the provider responsibility.
- Identified documentation requirements for providers.
- Clarified requirements regarding discharge planning.
- Provided instructions/policy regarding recipients who need to transfer to an inpatient hospital and then back to outpatient rehab.

2403.1 C Recipient responsibility:

- Modified the recipient responsibilities to comply with Federal regulations and provided HIPAA notification.

2403.1 D Authorization Process:

- Revised the policy and procedures related to securing prior authorization for services, including information about the QIO-like vendor.
- Provided the new HIPAA compliant codes, changed the required billing form from the HCFA 1500 to the UB92.

2403.2 Residential Rehabilitation Program – policy

In addition to the following changes, many of those changes identified above for covered services, admission criteria, provider responsibility, recipient responsibility and authorization procedures, apply to the residential rehab program section.

- Name changed from Transitional Living Services to Residential Rehabilitation Program, which more accurately reflects the services being provided.
- Reorganized the chapter to reflect that recipients in an RRP are actually participating fully, in a comprehensive day treatment program but receive additional therapy, trainings, supervision and personal care services around the clock in a residential home.
- Clarifies that Nevada Medicaid does not reimburse for room and board, to comply with Federal regulations.
- Modified the policy regarding therapeutic leave which is no longer available for participants of the comprehensive day treatment program.
- Imposed certain restrictions for therapeutic leave for participants of the residential rehabilitation program.

2403.3 Community reintegration services

In addition to the following changes, many of those changes identified above for covered services, admission criteria, provider responsibility, recipient responsibility and authorization procedures, apply to the Community reintegration services section.

- Changed the name from Life Skills Training to Community Reintegration Services to more accurately reflect the services provided.
- Clarified, and in some cases added, the responsibilities the providers have for documentation and service provision. These are areas that have not been well defined in the past.

COMPREHENSIVE OUTPATIENT REHABILITATION (COR) SERVICES

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2400 INTRODUCTION

2400.1 COMPREHENSIVE OUTPATIENT REHABILITATION (COR) SERVICES

Rehabilitation services are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury. The Comprehensive Outpatient Rehabilitation (COR) services program provides coverage for community based comprehensive medical rehabilitation programs for eligible recipients under the rehabilitative services option of the Medicaid State Plan.

The COR services program may utilize administrative case-management activities to coordinate Medicaid covered rehabilitation services to assist in the transition of eligible recipients through the rehabilitation continuum. Services provided under the COR program are time-limited and include Comprehensive Day Treatment programs, Residential Rehabilitation Programs and Community Re-integration services.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

2401 AUTHORITY

a. Rehabilitation services are an optional Medicaid benefit under the Social Security Act 1905(a)(13). The citation which interprets and implements this section of the Act is found in the 42 Code of Federal Regulations (CFR), Part 440.130.

b. Nevada Medicaid provides limited coverage under the Rehabilitative services option of State Plan for Medical Assistance. Attachment 3.1-A page 6. OMB NO.: 0938-0193.

2402 DEFINITIONS

2402.1 ACQUIRED BRAIN INJURY (ABI)

Refers to impaired brain functioning due to a medically verifiable incident including but not limited to a cerebral vascular accident, a ruptured aneurysm, anoxia, or hypoxia and brain tumors. Not all acquired brain injuries require or meet criteria for comprehensive rehabilitation services.

2402.2 HABILITATION

Defined by Section 1915(c)(5) of the Social Security Act (the Act) is "services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings." Under Federal law and policy, habilitation services cannot be offered under the State Plan to non-institutionalized persons. Therefore, this is not a covered benefit of the COR Program.

2402.3 SIGNIFICANT PRACTICAL IMPROVEMENT

A generally measurable and substantial increase in the patient's level of functional independence and competence compared to when treatment was initiated.

2402.4 TRAUMATIC BRAIN INJURY (TBI)

Defined by the Brain Injury Association of America "…is an insult to the brain, not of a degenerative or cognitive nature, but caused by an external force, that may produce a diminished or altered state of consciousness, which results in an impairment of cognitive abilities or functioning. It can also result in a disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and can cause partial or total functional disability or psychosocial maladjustment.

Title 38 of NRS, as amended, define TBI as"…a sudden shock or damage to the brain or its covering which is not a degenerative nature and produces an altered state of consciousness or temporarily or permanently impairs the mental, cognitive, behavioral, or physical functioning of the brain. Title 38 further states that the term does not include:

a. A cerebral vascular accident
b. An aneurysm; or
c. A congenital defect.

2403 POLICY

2403.1 COMPREHENSIVE DAY TREATMENT (CDT) PROGRAM

Comprehensive day treatment is an outpatient, non-residential program for individuals whose illness or injury, or exacerbation or deterioration has resulted in a functional, and/or cognitive impairment of such a complex nature that requires a comprehensive, interdisciplinary team approach to achieve his or her rehabilitation potential.

2403.1A COVERAGE AND LIMITATIONS

Reimbursement is available for CDT programs which have been prior authorized by Nevada Medicaid's QIO-like vendor. Programs must include physical rehabilitative services ordered by a physiatrist, as a reasonable and medically necessary part of the recipient's treatment plan; be consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and furnished at a safe, efficient and cost-effective level.

1. ADMISSION CRITERIA FOR COMPREHENSIVE DAY TREATMENT

   a. The recipient has Medicaid eligibility for services;

   b. The recipient has not previously completed a comprehensive day treatment program for the same condition, unless a substantial intervening event has occurred that would require an abbreviated program to maintain community placement. The decision to impose such an exception is the sole determination of DHCFP, and requires supporting medical rationale;

   c. The recipient's functional or cognitive impairment is the result of an illness or injury within the past 90 days, or 90 days from the original inpatient hospitalization or, 90 days from Medicaid eligibility determination, or has a chronic illness or injury with recent exacerbation, or complication which resulted in a change in function, or has a more remote injury with recent improvement in condition and/or advancement in technology;

   d. The recipient requires at least minimal to moderate cueing or physical assistance of another to perform self- care or mobility skills;

   e. The recipient does not have ongoing acute medical or psychiatric problems that would preclude participation in an intensive rehabilitation program;

   f. To upgrade the level of function, the recipient requires a comprehensive interdisciplinary team approach including (but not limited to) the following:

1. Coordinated direction by a physician specializing in Rehabilitative Medicine;

2. At least 2 different disciplines of therapy indicated (physical therapy, occupational therapy, speech/language pathology or psychology); and

3. Has a need for rehabilitative nursing or case management services in addition to therapy and medical coordination by a rehabilitation medicine physician.

4. Documentation is made available, upon request, to support that the rehabilitation goals cannot be safely and adequately carried out at a less intensive level such as isolated therapeutic modalities.

g. The recipient must be medically stable as for intensive rehabilitation as evidenced by the absence of medical conditions requiring acute medical interventions (e.g., acute infectious process, uncontrolled irregular heartbeat, unstable diabetes mellitus, etc):

h. The recipient is willing, and demonstrates capacity for endurance for at least 3 hours of comprehensive rehabilitation therapy per day, five days per week;

i. The recipient has a prognosis and potential to increase his or her functional independence towards a realistic goal of returning to independent or assisted living after discharge, achievable within a reasonable period of time as determined by DHCFP, or its QIO-like vendor;

j. The recipient has sufficient mental alertness and is able to actively participate in a complete therapy program on a daily basis;

k. The recipient is responsive to verbal or visual stimuli and can consistently follow single step commands in a meaningful way; and

l. The recipient's premorbid functional abilities indicate a significant potential for rehabilitation.

2. COVERED SERVICES

a. Comprehensive Day Treatment programs are provided as Full Day – 6 hours per day of rehabilitative services or as Half Day – a minimum of 3 hours per day. All programs provide CDT five days per week and may occur in the recipient's home, (even if that home is currently a nursing facility), outpatient settings of acute care or rehabilitation hospitals, or in other community based settings.

b. Comprehensive day treatment programs must meet the following service requirements, when the specialty area is included in the individual plan of care/treatment plan:

1. Physician: Physician services require that the physician have special knowledge and clinical skills and experience in the field of rehabilitation or other related fields. The recipient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The physician must order rehabilitative therapy services, determining the composition of the team, the plan of care and the duration of the rehabilitation program; collaborate with the team to identify the specific discipline to carry out the plan of care; participate on a regular basis in treatment conferences, and consult with team disciplines as needed in providing a comprehensive approach of the treatment plan.

2. Rehabilitative Nursing: rehabilitative nursing services require nurses that have education, training, and/or experience which provide special knowledge and clinical skills to diagnosis nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability. Implementation of the rehabilitation plan shall be carried out pursuant to the Practice Act governing nursing.

3. Physical Therapy: Only a licensed physical therapist has the knowledge, training and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and where appropriate, recommended to the physician a plan shall be carried out pursuant to the Practice Act governing physical therapy.

4. Occupational Therapy: Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and where appropriate, recommend to the physician a plan of care/treatment plan. Implementation of the rehabilitation plan shall be carried out pursuant to the Practice Act governing occupational therapy.

5. Speech-Language Pathology services: Only a licensed speech-language pathologist (SLP) has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether a speech therapy program could reasonably be

expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. Implementation of the rehabilitation plan shall be carried out pursuant to the Practice Act governing speech-language pathology.

6. Case Management: Case management service must be provided by a licensed nurse or social worker, or Certified Case Manager (CCM), or other licensed individual eligible to apply for certification or who is working under the direct supervision of a CCM, who has the education, skills abilities and experience to perform case management services for individuals participating in comprehensive rehabilitation. The case manager may also need language skills, cultural sensitivity, and acquired knowledge and expertise unique to a geographic area. The case manager coordinates and implements individualized plans of care in conjunction with recipient's families or legal guardians physicians and others involved in the care

c. In addition to the specialty-specific requirements noted above, all of the following guidelines must be met:

1. All practitioners and providers of services shall be required to meet current state and Federal licensing and/or certification requirements and be licensed accordingly.

2. The services shall be directly and specifically related to an active written plan of care/treatment plan approved by the primary physician after any needed consultation with the licensed/certified therapy provider (RN, PT, OTR, SLP) who is experienced in rehabilitation;

3. The services shall be of a level of complexity and sophistication, or the condition of the recipient shall be of a nature that the services can only be performed by the licensed/certified therapy provider, or rehabilitation technician under the direct supervision of the licensed/certified provider (RN, PT, OTR, SLP) who is experienced in rehabilitation.

4. The services shall be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

5. The services shall be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative services, which can only be provided in an intensive rehabilitative setting.

d. Service requirements for specialized services/therapies performed part as of a comprehensive rehabilitation program and identified in the plan of care.

1. Cognitive Rehabilitation Therapy:

The provision of cognitive rehabilitation is included as a component of a comprehensive rehabilitation program for the severely neurologically impaired individual such as those with traumatic brain injury (TBI). Other diagnoses that may require cognitive remediation include, but are not limited to, severe cerebral vascular accident (CVA), anoxic injuries, and intracranial hemorrhage. For these diagnoses, as well as with TBI, major impairments exist in arousal or alerting, perception, selective attention, discrimination, orientation, organization, recall and high level thought processes, including convergent thinking, deductive reasoning, inductive reasoning, divergent thinking, and multiprocess reasoning. Cognitive rehabilitation services are those services furnished a recipient that meet all of the following conditions:

a. The services must be directly and specifically related to an active written plan of care/treatment plan signed by the primary care physician after any needed consultation with a clinical psychologist, or physician experienced in working with the neurologically impaired.

b. The services must be of a level of complexity and sophistication, or the condition of the recipient must be of a nature that the services can only be performed under the direction of a clinical psychologist or licensed physician experienced in cognitive rehabilitation.

c. Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and psychologists with experience in working with the neurologically impaired when provided under a plan of care/treatment plan recommended and coordinated by a physician or clinical psychologists licensed by the State where services are rendered. The plan of care/treatment plan must be prepared with the assistance and input of any specialist who may be called upon to

provide services pursuant to the plan. Supervision of, or by, the occupational therapist, speech-language pathologist, or the psychologist must be consistent with the applicable Practice Act;

d. The cognitive rehabilitation services must be an integrated part of the total recipient care plan and must relate to information processing deficits that are a consequence of related neurological event.

e. The cognitive rehabilitation services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning memory, discrimination, and behavior; and

f. The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary in establishing a safe and effective maintenance program required in connection with a specific diagnosis. Once established a maintenance program is not a covered benefit under the COR program.

2. Therapeutic Recreation: Therapeutic recreation services are included as a component of a comprehensive rehabilitation program when all of the following conditions are met:

a. The services must be directly and specifically related to an active written plan of care/treatment plan ordered by a licensed physician;

b. The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a therapeutic recreation specialist certified with the National Council for Therapeutic Recreation at the professional level;

c. The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and

effective maintenance program required in connection with a specific diagnosis; and

d. The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency and duration of the services must be reasonable, as determined by the DHCFP or its QIO-like vendor.

3. Prosthetic/Orthotic Services: Prosthetic services furnished to a recipient include prosthetic devices that replace all or part of an external body part and services necessary to design the device, including measuring, fitting, and instructing the recipient in its use. Refer to MSM Chapter 1300 for further information and program requirements.

4. Durable Medical Equipment: required for in home use or to facilitate the recipient's discharge home or to a community placement (not to an extended care facility) may be covered under the DME and supplies program (Refer to MSM Chapter 500 for DME coverage guidelines for recipients who reside in or will be discharged to an extended care facility).

3. NON-COVERED SERVICES

The following are not covered benefits under the COR services program and therefore are not reimbursable by Nevada Medicaid;

a. Maintenance therapy is the point at which the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain function at the level to which it has been restored;

b. Duplicative services are not considered medically justified and will not be covered by Nevada Medicaid. An inquiry or referral for services does not indicate the necessity for services. If the Medicaid recipient is receiving services from another provider, it is the responsibility of the evaluating provider to determine if additional services are appropriate and request prior authorization as indicated;

c. Time spent conducting a team conference is included in the established all-inclusive rate and is not a separately billable service;

d. Pre-Admission screenings completed in order to determine the appropriateness of the recipient for a particular program is considered a cost of doing business and is not a reimbursable visit;

e. Admissions or continued stays for evaluation or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services;

f. Admissions solely for the convenience of the recipient, their family or the provider, are not covered services;

g. Pain management services, i.e. relaxation techniques, stress management and biofeedback programs; or

h. Habilitation.

4. CONTINUED STAY CRITERIA FOR COMPREHENSIVE DAY TREATMENT

For continued comprehensive day treatment services, prior authorization must be submitted to Nevada Medicaid's QIO-like vendor a minimum of five (5) days but no greater than ten (10) days prior to the expiration of the current authorization period. To be considered for continued stay, supporting documentation must be provided, including the most recent team conference report, which demonstrates that the recipient continues to meet admission criteria and continues to:

a. Demonstrate an ability to actively participate in all therapies;

b. Have documented progression toward written goals;

c. Need coordination by a rehabilitation medicine physician; and

d. Need at least two therapies and either skilled nursing or case management services.

If continuation of services is determined to medically appropriate, a new length of stay will be assigned. Concurrent review will continue in this manner until the discharge of the recipient is indicated. Services provided without prior authorization are not reimbursable.

5. DISCHARGE CRITERIA

A comprehensive day treatment program is a medically prescribed treatment for improving or restoring functions and must be considered for termination, regardless of

the approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation treatment can be achieved in a less intensive setting.

A maintenance program and/or habilitation services are not a covered benefit and services provided once this level has been reached will not be reimbursed. Specifically, if no further progress is observed, discharge would be required. A recipient in a comprehensive day treatment program must be considered for discharge, when any one of the following conditions is met:

a. Care needs exceed outpatient rehabilitation and transfer to an inpatient hospital is indicated;

b. Functional plateau reached for two weeks as indicated by a lack of significant practical improvement toward established goals such that the amount of assistance required has not decreased:

c. Inability to participate in three or more hours of therapy five days a week as evidenced by:
   1. Participation less than 5 days per week or
   2. More than two episodes of medical instability this admission.

d. No longer requires the active direction of the interdisciplinary team by a rehabilitation medicine physician;

e. The specialized knowledge and skills of the interdisciplinary team are no longer required for safe and effective provision of such rehabilitation services;

f. Achieves goals in one or more therapies and can safely progress to a non-comprehensive outpatient setting;

g. Lack of attendance and/or participation in therapies for more than three (3) consecutive visits;

h. No further potential for improvement is demonstrated. The recipient has reached his or her maximum progress and a safe and effective maintenance program has been developed;

i. There is limited motivation on the part of the recipient or caregiver which has impacted the rehabilitation progress for two weeks;

j. The established goals serve no purpose to increase functional or cognitive capabilities towards independent or assisted living; or

k. Skilled nursing and/or case management issues are resolved.

2403.1B PROVIDER RESPONSIBILITY

1. PROVIDER ENROLLMENT

a. Each provider of COR services must enroll as a Provider Type 55 and enter into the agreement with Nevada Medicaid, through its fiscal agent and must submit required licenses, registrations, certificates, etc., upon request, to determine that conditions of participation, as stated in Medicaid Services Manual 100, are met.

b. Comprehensive Outpatient Rehabilitation providers must hold current accreditation, in good standing, by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission on the Accreditation of Health Organizations (JCAHO) as long as the JCAHO accreditation includes a special designation meeting criteria as a comprehensive physical rehabilitation program.

c. Providers must comply with all IRS, FICA, and OSHA, Local, State, and Federal regulations and applicable statutes.

2. INTERDISCIPLINARY TEAM

a. All services provided must be under the direction of an interdisciplinary team consisting of at least:
   1. The primary care physician, an occupational therapist and/or a physical therapist and/or a speech-language pathologist, and a rehabilitation nurse or case manager.
   2. Any other appropriate support staff

b. All practitioners and providers of services must meet current state and federal licensing and/or certification requirements.

c. Comprehensive day treatment services require that the recipient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. This physician must have special knowledge and clinical skills and experience in the field of rehabilitation.

d. Rehabilitation Aides may provide personal assistance services, supervisory care, direction and guidance to assist recipients, following written plan of care/treatment plans and clinical protocols under the direct supervision of the licensed/certified therapy provider.

Rehabilitation aides must have:

1. A high school diploma or GED;
2. Some post-secondary educational experience is desired;
3. a minimum of two positive, verifiable employment experiences;
4. two years of related experience is desired
5. Job experience that demonstrates the ability to teach, work independent of constant supervision, and demonstrate regard and respect for recipients and co-workers;
6. have verbal and written communication skills;
7. the ability to handle many details at the same time;
8. the ability to follow through with designated tasks;
9. knowledge of the philosophy and principles of independent living for people with disabilities.

Supporting Qualifications include:

1. dependability, able to work with minimal supervision;
2. demonstrates problem solving ability;
3. the ability to perform the functional tasks of the job;
4. ability to identify emergency situations and act accordingly including CPR certification, which may be obtained outside the agency.

3. DOCUMENTATION REQUIREMENTS

a. Initial Evaluation and Proposed Treatment Plan.

The intent of comprehensive interdisciplinary rehabilitation is to increase the individual's functional abilities and to decrease the level of assistance needed for independent living, therefore the initial evaluation must measure the patient's starting functional abilities and level of assistance required. The initial evaluation must contain all of the following information and be signed by the treating physician to be considered for authorization:

1. Origin and rationale of referral, including a copy of the order;
2. The principal and significant associated diagnosis;
3. Brief history including the date of onset of illness or injury;
4. Current medical status and confirmation of medical stability for intensive rehabilitation;
5. Current and pre-morbid functional status, including baseline evaluation, prognosis and potential for significant practical improvement;
6. Indication of medical necessity;
7. Identified barriers;
8. Corresponding therapeutic short and long-term goals that are functional, objective and measurable;

9. The composition of the team, the plan of care and the duration of the rehabilitation program;
10. Summary of any previous rehabilitative therapy received and results of such therapy;
11. Anticipated time for completion of the comprehensive day treatment program;
12. If the recipient is to participate in any group therapy sessions, documentation must include:
    a. The description of the purpose of the group;
    b. Number of patients and staff members in group;
    c. The minimum ratio of staff to patients;
    d. Duration on each session; and
    e. The number of group sessions anticipated per week.
13. A viable, written discharge plan with appropriate post placement resources, including the identified support system that will facilitate community re-entry in a non-institutional setting.

The proposed plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g, 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." Include specific procedures, frequencies and duration of specific modalities.

b. Documentation for continuing stay

1. The continuing stay documentation must be submitted to the QIO-like vendor a minimum of five (5) days, but not greater than ten (10) days, prior to the expiration of the current authorization, and demonstrate that the recipient continues to meet the Continued Stay Criteria as identified in Section 2403.1A4 of this Chapter.

2. The following documentation must be maintained in the recipient's file and provided to DHCFP or the QIO-like vendor immediately, upon request.

    a. Ongoing documentation of discharge planning and appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge. Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the program, an extended period of time for discharge action is not reasonable after established goals have been reached, or a determination made that further progress is unlikely, or that care in a less intensive setting is appropriate.

b. Documentation that bi-weekly conferences are held (or alternative intervals if prior authorized) by the rehabilitation team to assess the individual's progress and the barriers impeding progress, consider possible resolutions to such barriers and reassess the validity of the rehabilitation goals initially established.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. The decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the clinical record and made available upon request.

c. Improvement of Function

Rehabilitative therapy designed to improve function must be based on a realistic expectation that the therapy will result in a significant practical improvement in a recipient's level of functioning within a reasonable period of time.

Where a valid expectation of improvement exists at the time the rehabilitative therapy program is implemented, the services would be reimbursable even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the recipient is not going to improve.

d. Readmission to Rehabilitation

When a recipient requires transfer to an acute care setting for more than 3 consecutive business days, the provider must discharge the recipient from the comprehensive day treatment program. When the recipient is medically stable and appropriate to continue the comprehensive program, the recipient may be re-admitted from the acute care setting to continue the intensive rehabilitation.

For all re-admissions over 3 consecutive business days, each rehabilitation treatment team member must re-evaluate the recipient's functional status and record the findings in the recipient's medical record. In addition, each team member must review the current plan of care/treatment plan.

Upon review of the plan of care/treatment plan, the member must document whether or not changes to the current plan are necessary. This review of the plan of care must be signed and dated. The treating physician is responsible for documenting a re-admission note to review the events leading to the transfer and the appropriateness for the recipient to continue with the intensive rehabilitation program.

For all re-admissions over 3 consecutive business days, whether or not plans of care have changed, pre-authorizations through Nevada Medicaid's QIO-like vendor is required.

e. Any monies paid by DHCFP for COR services, are subject to full recoupment if all of the required supporting documentation is determined to be missing or inadequate upon retrospective review or audit.

2403.1C RECIPIENT RESPONSIBILITY

1. Medicaid recipients are required to maintain and provide a valid Medicaid eligibility card to their service providers and to notify their providers of any changes to the type of eligibility, or other insurance benefits that may be in effect such as Medicare.

2. Medicaid recipients are expected to comply with and participate in their rehabilitation plan, including making and keeping medical appointments.

3. The recipient is responsible to notify the provider of changes in medical status, service needs address, and location.

4. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), protected health information may be disclosed for the purposes of treatment, payment, or health care operations without a signed Authorization for Disclosure from the participant or designated representative. However, most other disclosures require authorization. Additional details about allowable uses and disclosures are available to participants in the DHCFP Notice of Privacy Practices, which is provided to all new enrollees.

   Additionally, in accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the Department of Human Resources 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.

2403.1D AUTHORIZATION PROCESS

The purpose of prior-authorization is to validate that the service being requested is medically necessary and meets Nevada Medicaid criteria for reimbursement.

1. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

2. Prior authorizations are specific to a recipient, a provider, a service code, and established quantity of units, and for specific dates of service.

3. Prior authorizations of comprehensive outpatient rehabilitation services must be obtained through the Nevada Medicaid's QIO-like vendor. All requests for prior-authorization, as well as any information submitted in response to pending letters, must be direct to the QIO-like vendor listed in the reference section at the end of this Chapter.

4. Prior authorization is required for all services and must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

2403.2 RESIDENTIAL REHABILIATION PROGRAM (RRP)

Residential rehabilitation programs (formerly Transitional Living Services) are a covered benefit when medically necessary services are furnished in a safe, efficient and cost-effective setting to Medicaid eligible recipients who require time limited outpatient rehabilitation services 24 hours per day in a normalized living environment.

2403.2A COVERAGE AND LIMITATIONS

Reimbursement is available for time limited Residential Rehabilitation Programs which have been prior authorized by Nevada Medicaid's QIO-like vendor. Programs must include a comprehensive day treatment program as discussed in Section 2403.1 of this Chapter, and a 24-hour residential component for those eligible recipients who are not ready to return to independent, or supported independent, living due to their functional or cognitive impairments.

1. Admission Criteria

In addition to the admission criteria required for a CDT, as identified in Section 2403.1A1, of this Chapter, the following criteria apply for residential rehabilitation programs:

a. Eligible recipients are unable to return to independent living due to a significant cognitive or physical impairment which requires intensive, short-term specialized intervention to reintegrate into the community;

b. An intensive residential rehabilitation program consisting of an interdisciplinary coordinated team approach is required, based on supporting medical rational, to improve the recipient's ability to function as independently as possible;

c. The recipient has a viable discharge plan with appropriate post placement resources, including a support system identified that will facilitate community re-entry and a realistic expectation and plan for non-institutional living post-discharge; and

d. Documentation is made available, upon request, to support that the rehabilitation goals cannot be safely and adequately carried out at a less intensive level such as comprehensive day treatment programs or isolated therapeutic modalities.

2. COVERED SERVICES

a. A residential rehabilitation program includes a medically necessary comprehensive day treatment program component focused on community reintegration and then continues training, therapy, supervision and personal care assistance in a 24 hour supervised residential setting.

b. The comprehensive day treatment (CDT) component of the RRP must meet all requirements outlined in Section 2403.1 of this Chapter.

c. The residential component of the RRP must provide continued training, supervision and personal care services appropriate in amount and frequency to meet the needs of the recipient in a safe and therapeutic environment 24 hours per day, 7 days per week.

d. The interdisciplinary team must establish an individual rehabilitation plan which is developed and updated for each resident and which reinforces the strategies and techniques learned in the CDT component.

e. Nevada Medicaid does not reimburse for costs associated with room and board in the residential setting. Arrangements for reimbursement of such costs must be made with the recipient, or their family, prior to the program admission.

f. Payment for therapeutic leave of absence (LOA) may be made in a residential rehabilitation program if properly documented, and prior authorized subject to the following conditions:

1. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to the community living.
2. The recipient's primary physician authorizes the therapeutic leave of absence and the plan of care provides for such absences.

The RRP therapeutic LOA is to be reimbursed the lesser of billed charges or the established RRP per diem rate for a maximum of 2 days per month. For this purpose, a month is any continuous 31 day period.

3. CONTINUED STAY CRITERIA FOR RESIDENTIAL REHABILITATION PROGRAM

For continued residential rehabilitation services, prior authorization must be submitted to Nevada Medicaid's QIO-like vendor a minimum of 5 days prior to the expiration of the current authorization period. To be considered for continued stay, supporting documentation must be provided including the most recent team conference report, which demonstrates that the recipient continues to meet CDT admission criteria and continues to:

a. Demonstrate the ability to actively participate in all therapies within the CDT and those activities identified in the residential care plan;

b. Have documented progression toward written goals;

c. Need for coordination by a rehabilitation physician;

d. Need for at least two therapies and either skilled nursing or case management services; and

e. Need 24-hour rehabilitation services as described in 2403.2A1c.

If continuation of services is determined to be medically appropriate, a new length of stay will be assigned. Concurrent review will continue in this manner until the discharge of the recipient is indicated. Services provided without prior authorization are not reimbursable.

4. DISCHARGE CRITERIA

A recipient in a residential rehabilitation component of a comprehensive rehabilitation program must be considered for discharge, regardless of the authorized length of stay or program completion. A maintenance program or habilitation services are not a covered benefit and services provided once this level has been reach will not be reimbursed.

A recipient receiving services under the residential rehabilitation component must be discharged from services or decelerated to the comprehensive day treatment program when any one of the following conditions is met:

a. Care needs require the skill of a licensed nurse and therefore exceed the scope of outpatient residential rehabilitation, or transfer to an inpatient hospital or skilled nursing facility is indicated;

b. The recipient no longer meets the criteria for a CDT program;

c. The specialized knowledge and skills of the interdisciplinary team are no longer required for safe and effective provision of rehabilitation services 24 hours per day;

d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three consecutive days;

c. The recipient has reached his or her residential goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;

d. There is limited motivation on the part of the recipient or caregiver which is impacting the rehabilitation progress for over one week; or

e. The established residential goals serve no purpose to increase functional or cognitive capabilities towards independent or assisted living.

2403.2B PROVIDER RESPONSIBILITY

In addition to the policies discussed in Section 2403.1B "Provider Responsibility" of this Chapter, the following policies apply to the Residential Rehabilitation Program.

1. Providers must maintain compliance with all regulatory requirements for a residential rehabilitation provider for the State in which they operate;

2. Providers must maintain either CARF or JCAHO accreditation as a residential facility to be in good standing;

3. The provider shall provide qualified rehabilitation aides as defined in Section 2403.1B.2c, at the appropriate staffing ratios as determined by applicable licensure, certification and/or accreditation requirements;

4. Providers establish, maintain and update an emergency plan specific to the recipient, including appropriate emergency information on-site for each recipient at all times;

5. Providers must establish a mechanism for residents or their families to report, without retribution, any complaints or occurrences that may compromise the safety or well being of the residents within the home; and

6. Providers must establish and enforce policies to ensure the safety and well being of all residents of the facility.

2403.2C RECIPIENT RESPONSIBILITY

In addition to the policies discussed in Section 2403.1C "Recipient Responsibility" of this Chapter, the following policies apply to residents of the Residential Rehabilitation Program:

1. Recipients and their guests must comply with all reasonable and necessary posted "house rules" as established by the provider, in order to maintain a safe and therapeutic environment for all residents.

2. Recipients should notify the provider and Nevada Medicaid of any occurrences that may compromise the safety or well being of residents within the home.

2403.2D AUTHORIZATION PROCESS

The policies discussed in Section 2403.1D "Authorization Process" of this Chapter, apply to the Residential Rehabilitation Program.

2403.3 COMMUNITY RE-INTEGRATION SERVICES (CRS)

Community reintegration services are designed to provide temporary assistance and support to those recipients with significant neurological impairment, incorporating those skills developed during a comprehensive rehabilitation program into their daily lives as they become reintegrated into their community.

Appropriate services are intended to enable the individual to function with greater independence, to prevent additional disabilities or an increase in the severity of an existing disability, without which the individual would require institutionalization.

2403.3A COVERAGE AND LIMITATIONS

Reimbursement is available for CRS which have been prior authorized by Nevada Medicaid's QIO-like vendor. Services must be ordered by a physician with special knowledge, clinical skills and experience in rehabilitation or other related fields, as a reasonable and medically necessary

part of the recipient's treatment plan and must be determined safe, efficient and cots-effective by the DHCFP or its QIO-like vendor.

1. Admission Criteria

   a. The recipient must be eligible for services under Nevada Medicaid and must have behaviors which are manageable in the community environment;

   b. Eligible recipients have successfully progressed through the comprehensive physical rehabilitation continuum, but due to a significant cognitive impairment, requires specialized transition assistance to fully reintegrate into the community;

   c. Community reintegration services are required, based on supporting medical rational, to ensure the recipient's ability to function as independently as possible in the community; and

   d. Documentation is provided, to support that the reintegration goals cannot be safely and adequately carried out utilizing more informal supports, such as willing family members and neighbors;

   e. The recipient has a viable written discharge plan, established by the multidisciplinary rehabilitation team, with appropriate resources in place, including the support system that will facilitate the community reintegration process and a realistic expectation of successful non-institutional living.

   f. The medical condition is stable and compatible with an active reintegration program.

   g. The recipient has sufficient mental alertness, and is able, to actively participate in a complete reintegration program on a daily basis.

   h. There is a valid expectation of significant practical improvement in the individual's capacity for independent living, achievable within a reasonable period of time.

2. Covered Services

   a. Community reintegration services are a covered benefit for recipients admitted within 14 days of completing a formal comprehensive rehabilitation program or from the date determined to be eligible for Nevada Medicaid;

   b. Services may be provided in the recipient's residence (non-institutional setting), work environment, or other appropriate community-based setting;

c. Rehabilitation aides must assist the recipient in utilizing those skills taught by the interdisciplinary rehabilitation team and involve coaching, advising, supporting and cueing recipients in instrumental activities of daily living such as; household management; behavioral management; safety; navigating in their immediate community using public transportation and socialization skills.

3. Service Limitations

a. Services must be provided in accordance with reintegration action plan under the direction of a comprehensive outpatient rehabilitation provider, as defined in Section 2403.1B subsections 1 and 2;

b. Community reintegration services are limited to a maximum of 20 hours per week, and must be prior authorized.

4. Non Covered Services

a. Maintenance Therapy – is defined as the point where the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative aide are not required to carry out an activity or a home program to maintain function at the level to which it has been restored. Services in this category are non-covered.

b. Duplicative Services are not considered medically justified and will not be covered by Nevada Medicaid. An inquiry or referral for services does not indicate the necessity for services.

c. Community reintegration services solely for vocational, educational or convenience purposes or for developmental or behavioral concerns is not covered services within this program.

5. Continuing Stay Criteria

a. All rehabilitative services must be part of, and specifically related to, an active treatment program prescribed by a physician experienced in rehabilitation and be a part of a written plan of care/treatment plan that the physician reviews periodically, but not less than every 30 days;

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of best medical practice;

b. The re-integration action plan must incorporate the written discharge plan established during the comprehensive rehabilitation program, identifying formal

and informal resources that are currently in place, as well as the identified support system that will be facilitating the community re-entry.

1. The action plan must also contain:

   a. Identified barriers; and corresponding short and long-term goals that are functional, objective and measurable;

   b. Specific services to be provided, including the frequency, duration and modalities to be implemented; and

   c. The proposed reintegration action plan must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis."

c. Ongoing documentation of discharge planning including appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge. Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the program, an extended period of time for discharge action is not reasonable after established goals have been reached, or a determination made that further progress is unlikely.

d. The recipient must demonstrate the ability and willingness to actively participate in goal oriented interventions developed with the interdisciplinary rehabilitation team. This shall be evidenced by regular attendance in interventions that are a part of the reintegration action plan and documented progression toward the established goals;

e. Documentation must reflect that the community reintegration activities are reduced as the recipient's level of independence increases.

2. Discharge Criteria

Community reintegration services must be considered for termination regardless of the pre-authorized length of stay when any one of the following conditions are met:

a. No further potential for improvement is demonstrated. The specialized knowledge and skills of a qualified rehabilitative aide is no longer required for the safe and effective provision of such rehabilitation services;

b. The recipient has reached his or her maximum progress and a safe and effective maintenance program has been established;

c. There is limited motivation on the part of the recipient or caregiver;

d. The recipient has an unstable condition that affects his or ability to participate in community reintegration activities; or

e. The established goals serve no purpose to increase functional or cognitive capabilities.

2403.3B PROVIDER RESPONSIBILITY

In addition to the policies discussed in Section 2403.1B1 "Provider Enrollment" of this Chapter, the following policies apply to Community Re-integration Services.

1. Community reintegration services must be provided by a rehabilitation aide, employed by a COR authorized provider (provider type 55) and meeting those minimum qualifications described in Section 2403.1 of this Chapter.

2. Community reintegration services require that the recipient must be under the care of a physician who is legally authorized to practice in Nevada and who is action within the scope of his or her license. This physician has special knowledge and clinical skills and experience in the field of rehabilitation or other related fields.

3. A reintegration action plan must be developed which incorporates the written discharge plan established during the comprehensive rehabilitation program, identifying available formal and informal resources, as well as the identified support system that will be facilitating the community re-entry.

4. Documentation must reflect that the community reintegration activities are reduced as the recipient's level of independence increases.

5. Services maybe authorized on a monthly basis and must be submitted with supporting documentation.

2403.3C RECIPIENT RESPONSIBILITY

The policies discussed in Section 2403.1C "Recipient Responsibility" of this Chapter, apply to Community Re-integration Services.

2403.3D AUTHORIZATION PROCESS

The policies discussed in Section 2403.1D "Authorization Process" of this Chapter, apply to Community Re-integration Services.

2404 HEARINGS

Please reference Nevada Medicaid Services Manual, Chapter 3100, for Medicaid Hearing Process.

2405 REFERENCES AND CROSS-REFERENCES

2405.1 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following chapters:

Chapter 100	Eligibility, Coverage and Limitations
Chapter 500	Nursing Facility Services
Chapter 1300	DME, Prostheses and Disposable Supplies
Chapter 1900	Medical Transportation
Chapter 3100	Medicaid Hearings
Chapter 3300	Surveillance and Utilization Review
Chapter 3600	Managed Care Organization
Chapter 3700	Nevada Check Up

2405.2 PROVIDER RELATIONS UNITS

Provider Relations Department
First Health Services Corporation
PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

2405.3 PRIOR AUTHORIZATION DEPARTMENTS

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

2405.4 PHARMACY POINT-OF-SALE DEPARTMENT

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

2405.5 WELFARE ELIGIBILITY OFFICES

Welfare District Offices:

Carson City	(775) 684-0800
Elko	(775) 753-1187
Ely	(775) 289-1650
Fallon and Lovelock	(775) 423-3161
Hawthorne	(775) 945-3602
Henderson	(702) 486-1201
Las Vegas – Belrose	(702) 486-1600
Las Vegas – Charleston	(702) 486-4701
Las Vegas – Owens	(702) 486-1800
Las Vegas – Cannon Center	(702) 486-3554
Las Vegas – Southern Professional Development Center	(702) 486-1401
Pahrump	(775) 751-7400
Reno – Bible Way (Investigations & Recovery)	(775) 688-2261
Reno – Kings Row	(775) 448-5000
Reno – Northern Professional Development Center	(775) 856-8438
Tonopah	(775) 482-6626
Winnemucca	(775) 623-6557
Yerington	(775) 463-3025

2405.6 STATE OFFICES

State offices in Carson City may be telephoned long distance free of charge (within Nevada only) by dialing 1-800-992-0900 and asking the State Operator for the specific office:

a. Nevada Division of Health Care Financing and Policy Nevada Medicaid Office
1100 E. William Street Suite 102
Carson City, Nevada 89701
Telephone: (775) 684-3600

b. Nevada State Health Division Bureau of Licensure and Certification
1550 E. College Parkway, Suite 158
Carson City, Nevada 89706
Telephone: (775) 687-4475

c. NEVADA MEDICIAD DISTRICT OFFICES (NMDO):

Carson City	(775) 684-0826
Reno	(775) 688-2811
Las Vegas	(702) 486-1540
Elko	(775) 753-1191
Fallon	(775) 423-6730