MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 13, 2009

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 700 – RATES AND COST CONTAINMENT

BACKGROUND AND EXPLANATIONS

One definition is being added to the Medicaid Services Manual (MSM), Chapter 700 – Rates and Cost Containment. The addition clarifies and further defines the treatment of Capital Renovation/Remodeling Projects. The definition is consistent with the State Plan, Attachment 4.19-D, Page 5d.1. The clarification is needed as such projects may include expenditures that could be considered part of the Fair Rental Value in the rate setting process. The Pharmaceutical Definition heading is being removed. One paragraph that addresses inpatient hospital services is being removed from 703.2. Its inclusion in Chapter 700 is redundant because it is already found in the Introduction to Chapter 200 (page 1). Changes are effective upon approval of the public hearing.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 30/09	**MTL 26/07, 19/09**
CHAPTER 700 – RATES AND COST CONTAINMENT	CHAPTER 700 – RATES AND COST CONTAINMENT

Sec. 702
Added new section and definition for "702.3 CAPITAL RENOVATIONS/REMODELING PROJECT - Capital Renovation/Remodeling Project [hereinafter "Project"] shall mean a series of activities and investments which materially (a) expand the capacity, (b) reduce the operating and maintenance costs or (c) ensure the operating efficiency and/or extend the useful economic life of a fixed asset. Said Project may involve new construction, reconstruction and/or renovation. Allowable costs include, but are not limited to the costs of land, buildings, machinery, fixtures, furniture

and equipment. Certain costs for repairs may be included but only when such costs are incidental to and necessitated by the Project. In no event shall costs for ordinary repairs and maintenance of an ongoing nature be included in a Project.

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

Sec. 703.2

Deleted "Inpatient services are a federally mandated Medicaid benefit. A hospital is an inpatient medical facility licensed as such to provide services at an acute level of care for diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases, a Nursing Facility, or an Intermediate Care Facility for the Mentally Retarded, regardless of name or licensure."

Sec. 705.1

Added "Medicaid Program"

Added "ies"

Added "Prescribed Drugs"

Added ", Disposable Supplies and Supplements"

Added "Program"

Added "Services"

Deleted "Eligibility Coverage & Limitations (Overview of Medicaid)"

Deleted "Diagnostic Testing and"

Deleted "y Services"

Deleted "Services"

Deleted "Prescription Services (Rx)"

Deleted "Durable Medical Equipment ( )"

Added "(COR)"

Added "Program Integrity"

Added "Program"

Deleted "(HHA) Services"

Deleted "(EPSDT)"

Deleted "(ICF/MR)"

Deleted "Services"

Deleted "(Recams)"

Deleted "Targeted"

Deleted "(TCM)"

Deleted "2900 Mental Health Rehabilitative Services"

Deleted "Services"

Deleted "Surveillance & Utilization Review"

Deleted "Aide"

Deleted "(PCA)"

Deleted "(MCO)"

DIVISION OF HEALTH CARE FINANCING AND POLICY

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700 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) establishes the methods and standards for provider reimbursements for Medicaid services in accordance with the Code of Federal Regulations (CFR, Title 42, Part 447) and in consultation with providers and a public hearings process. The methods and standards for rate determinations are described in Nevada's approved State Plan under Title XIX of the Social Security Act (i.e. the Medicaid State Plan.)

Providers should consult the Medicaid State Plan, Section 4.19 – Payment for Services, for methods and standards for reimbursement. The following is a brief summary of the detail attachments to Section 4.19:

1. Attachment 4.19-A describes methods and standards for reimbursing inpatient hospitals, residential treatment centers, Indian Health Service and Tribal 638 Health Facilities.

2. Attachment 4.19-B describes the methods and standards for reimbursing medical services provided by licensed professionals in various settings and those items ancillary to licensed medical services, such as laboratory and x-ray, pharmaceuticals, dentures, prosthetic devices, eyeglasses, medical supplies, appliances and equipment, and transportation.

3. Attachment 4.19-C describes the methods and standards for reimbursing reserved beds in various institutions excluding acute care facilities.

4. Attachment 4.19-D describes the methods and standards for long-term care facilities including hospital-based and freestanding nursing facilities, intermediate care facilities for the mentally retarded and swing beds in hospitals.

701 AUTHORITY

701.1 FEE TO INCREASE QUALITY OF NURSING CARE

NRS 442.3755 to NRS 422.379

701.2 COST REPORTS

CFR, Title 42, Part 413-Principles of Reasonable Cost Reimbursement, Section 413.24

1. Title XIX of the Social Security Act, Nevada State Plan for Medicaid, Attachment 4.19-D, Page 6, Section C.

701.3 MEDICAID RATE(S) APPEAL

The authority for provider rate(s) appeals exists under The Code of Federal Regulations (CFR, Title 42, Chapter IV, Part 447 – Payments for Services, Section 447.253 (e) – Other requirements). This section states, “The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.”

702 DEFINITIONS

702.1 ADMINISTRATION FEE

The administration fee is the dollar amount established for administering covered pharmaceuticals.

702.2 ACTUAL ACQUISITION COST (AAC)

Actual Acquisition Cost (AAC) is the actual price paid by the pharmacy for a drug.

702.3 CAPITAL RENOVATIONS/REMODELING PROJECT

Capital Renovation/Remodeling Project [hereinafter "Project"] shall mean a series of activities and investments which materially (a) expand the capacity, (b) reduce the operating and maintenance costs or (c) ensure the operating efficiency and/or extend the useful economic life of a fixed asset. Said Project may involve new construction, reconstruction and/or renovation. Allowable costs include, but are not limited to, the costs of land, buildings, machinery, fixtures, furniture and equipment. Certain costs for repairs may be included but only when such costs are incidental to and necessitated by the Project. In no event shall costs for ordinary repairs and maintenance of an ongoing nature be included in a Project.

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

702.4 COMPOUND DRUGS

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

702.5 DEPARTMENT OF JUSTICE (DOJ) PRICING

In 2000, the US Department of Justice (DOJ) and the National Association of Medicaid Fraud Control Units (NAMFCU) determined that some drug manufacturers were reporting inaccurate Average Wholesale Prices (AWPs) for some of their products. As a result, the DOJ and the NAMFCU compiled new pricing data gathered from several wholesale drug catalogs for approximately 400 national drug codes. The State Medicaid program had the option to implement this revised pricing from the investigation. Nevada Medicaid chose to implement the pricing algorithm at the time of its inception. The pricing is reflective of the data file from the First Data Bank.

702.6 DISPENSING FEE

The dispensing fee is the dollar amount established for dispensing covered pharmaceuticals.

702.7 ESTIMATED ACQUISITION COST (EAC)

Estimated Acquisition Cost (EAC) is defined by Nevada Medicaid as Average Wholesale Price as indicated on the current listing provided by the First Data Bank less 15 percent (AWP - 15%). EAC is based upon the original package or container size from which the prescription is dispensed.

702.8 EXPERIMENTAL

A drug prescribed for a use that is not a medically accepted indication. The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

702.9 FEDERAL UPPER LIMIT (FUL)

Under the authority of 45 CFR, Part 19, the Pharmaceutical Reimbursement Board of the U.S. Department of Health and Human Services has determined the maximum allowable ingredient costs. These limits apply to all Medicaid prescriptions unless exempted as "Medically necessary" by the prescriber. The FUL for multi-source drugs for which an upper limit has been set does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient, and the statement "brand medically necessary" appears on the face of the prescription.

The upper limit for multiple source drugs meets the criteria set forth in federal regulations. The FUL price list will be updated approximately every six months. This listing is now available at: http://www.cms.hhs.gov/FederalUpperLimits.

702.10 INNOVATOR MULTI-SOURCE DRUG

An innovator multi-source drug was the original single-source drug before generic drug introduction into the market. The remainder of the manufacturers produce, only generic (multi-source) drugs.

702.11 LEGEND DRUGS

Legend pharmaceuticals are those bearing the insignia "Rx only" on the label, and/or bearing the statement "Caution: Federal law prohibits dispensing without a prescription."

702.12 MAINTENANCE DRUG

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

702.13 MAXIMUM ALLOWABLE COST (MAC)

Maximum Allowable Cost (MAC) is the lower of (1) the cost established by the Center for Medicare and Medicaid Services (CMS) for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927(f)(2) of the Act, or (2) the cost established by DHCFP for multiple source drugs under the State Maximum Allowable Cost (SMAC).

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

The MAC list is available online at http://nevada.fhsc.com.

702.14 MULTIPLE SOURCE DRUGS

Multiple Source Drugs is defined in §1927 (k) (7) of the Social Security Act as, "covered outpatient drug for which there are two or more drug products which (I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutically Equivalence Evaluations"), (II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and (III) are sold or marketed in the State during the period."

702.15 NON-LEGEND DRUGS

Non-legend pharmaceuticals are those not bearing the insignia "Rx only" on the label, and/or "Caution: Federal law prohibits dispensing without a prescription." Non-legend pharmaceuticals may also be known as "over-the-counter" drugs.

702.16 PHARMACEUTICALS

Pharmaceuticals are any drug, compound, mixture, or preparations which the U.S. Food and Drug Administration have approved for medical use.

Controlled pharmaceuticals are those pharmaceuticals listed in the schedule of substances, controlled by the Drug Enforcement Administration and/or the State Board of Pharmacy.

702.17 POINT OF SALE (POS)

Point of Sale is a computerized claims adjudication system allowing pharmacies real-time access to recipient eligibility, drug coverage, pricing and payment information, and prospective drug utilization review across all network pharmacies.

702.18 PREFERRED DRUG LIST (PDL)

The PDL is a listing of preferred outpatient drugs within specific therapeutic categories that have been identified, reviewed, and approved by the Pharmacy and Therapeutics Committee.

702.19 SINGLE SOURCE DRUG

Single Source Drug is defined in section 1927(k)(7) of the Social Security Act as, “a covered outpatient drug which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.”

702.20 UNIT DOSE

A unit dose drug is that quantity of a drug which is packaged as a single dose by the manufacturer.

702.21 USUAL CHARGE

A pharmacy may not charge Medicaid more than the general public.

703 POLICY

703.1 PHARMACEUTICAL REIMBURSEMENT

703.1A DRUG PRICING - RETAIL PHARMACY, HOME INFUSION THERAPY AND LONG TERM CARE FACILITIES

1. Legend and non-legend drugs, with the exception of compound drugs, shall be reimbursed at the lowest of (a) Federal Upper Limit (FUL) as established by the Centers for Medicare and Medicaid Services (CMS) for listed multi-source drugs plus a dispensing fee; (b) State Maximum Allowable Cost (SMAC) plus dispensing fee; (c) Estimated Acquisition Cost (EAC), which is equal to AWP less 15%, plus a dispensing fee; (d) Department of Justice pricing less 15% plus dispensing fee; (e) Usual and customary charge; or (f) Billed charge.

2. Reimbursement for all compound pharmaceuticals, providing at least one covered drug is included in therapeutic quantity, are paid using the NCPDP Multi-Ingredient Compound claim functionality. Drug coverage edits will be performed at the individual ingredient level. Reimbursement for topical compound claims and non-antibiotic IV therapy claims will be based on the reimbursement policy stated in 703.1 A (1) Reimbursement for IV antibiotic therapy claims will be reimbursed based on the Home Infusion Therapy policy. For detailed billing instructions, please refer to the Pharmacy Billing Manual at http://nevada.fhsc.com.

703.1B DRUG PRICING - PHYSICIAN ADMINISTERED DRUGS AND HOSPITAL BASED OUTPATIENT CLINICS

1. Legend and non-legend drugs, with the exception of compound drugs, shall be reimbursed at the lowest of (a) Estimated Acquisition Cost (EAC), which is equal to Average Wholesale Price (AWP) less 15%; (b) Usual and customary charge; (c) Billed charge; or (d) Federal Upper Limit (FUL); or (e) State Maximum Allowable Cost (SMAC); or (f) Department of Justice pricing less 15%.

2. Reimbursement for all compound pharmaceuticals, providing at least one covered drug is included in therapeutic quantity is reimbursed according to 703.1.A (1).

   These providers are reimbursed for administering pharmaceuticals; therefore, they are not allowed a dispensing fee.

703.1C AMBULATORY SURGICAL CENTERS, INPATIENT MEDICAL/SURGICAL AND PSYCHIATRIC HOSPITALS.

These providers are reimbursed an all-inclusive rate; therefore, they are not separately reimbursed for pharmaceuticals or pharmaceutical administration fees.

703.1D DISPENSING FEES

The State's dispensing fees are defined as (a) those given to outpatient retail pharmacists at a rate of $4.76 per prescription; (b) those given to Home Infusion Therapy providers for intravenous antibiotic therapeutic classes at $22.40 per day. All other pharmaceuticals given by Home Infusion Therapy providers receive dispensing fees in accordance with retail pharmacists; (c) those given to pharmacists for intravenous antibiotic therapeutic classes in a nursing facility at $16.80 per day. All other pharmaceuticals given by Long Term Care pharmacists receive dispensing fees in accordance with retail pharmacists.

703.1E CO-PAYMENTS

There is no co-payment requirement on medications for recipients. Medicaid does pay co-pays for dual eligible’s, with the exception of those with an eligibility code of 5 or S.

703.2 INPATIENT HOSPITAL SERVICES

Inpatient hospital services, which have been authorized for payment at the acute level by a quality improvement organization (QIO-like vendor), as specified in the contract between the QIO-like vendor and DHCFP, are reimbursed by all-inclusive, prospective per diem rates by type of admission/service. The all-inclusive prospective rates cover routine and ancillary services furnished by the hospital, including direct patient care for professional services furnished to inpatients by hospital-staffed physicians and practitioners. For specific rate methods and standards for inpatient hospital services, refer to the State Plan, Section 4.19, Attachment A.

703.3 FEE TO INCREASE QUALITY OF NURSING CARE

The Division of Health Care Financing and Policy (DHCFP) established the following policy to assess and collect fees to increase the quality of nursing care. NRS 422.3775 states: *"Each nursing facility that is licensed in this State shall pay a fee assessed by the Division to increase the quality of nursing care in this State."*

1. Reporting Requirements:

    a. Each nursing facility shall file with DHCFP each month a report setting forth the total number of days of care it provided to non-Medicare patients during the preceding month, the total gross revenue it earned as compensation for services provided to patients during the preceding month, and any other information required by the Division.

2. Payment of Fee:

    a. DHCFP shall annually establish a rate per non-Medicare patient day that is equivalent to 5.5 percent, or a percentage not to exceed any limitation provided under federal law or regulation, of the total annual accrual basis gross revenue for services provided to patients of all nursing facilities licensed in this state.
    b. DHCFP shall calculate the fee owed by each nursing facility by multiplying the total number of days of care provided to non-Medicare patients by the rate in 2.a.
    c. The monthly report and fee assessed pursuant to this section are due 30 days after the end of the month for which the fee was assessed.

3. Failure to Pay, or Late Payment of, Fee:

    a. DHCFP may assess a penalty of one percent of the fee for each day a fee is past due up to 10 days. DHCFP may assess interest at the rate of 1.5 percent of the fee per month or fraction thereof for any past due fee. In the event a facility has not submitted the required monthly report, DHCFP may estimate the fee due for purposes of assessing penalties and interest.
    b. DHCFP may withhold past due fees, penalties, and interest from a facility's Medicaid claims payments until such past due amounts are paid in full.

703.4 COST REPORTS

The Division of Health Care Financing and Policy (DHCFP) established the following policy to collect Medicare/Medicaid Cost Reports. (A Medicare/Medicaid Cost Report is the standard Medicare Cost Report with the required Medicaid sections completed.)

DHCFP adopts Medicare deadlines for the Medicare/Medicaid cost reports. These requirements are found in the Code of Federal Regulations (CFR, Title 42, Part 413 – Principles of Reasonable Cost Reimbursement, Section 413.24). This section states, *"Due dates for cost reports. (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period."*

The authority to collect Medicaid Cost Reports exists under Title XIX of the Social Security Act, Nevada State Plan for Medicaid, Attachment 4.19. Cost and other statistical information within the cost report must be reported in compliance with allowable and non-allowable cost definitions contained in the Medicare/Medicaid provider reimbursement manual (commonly referred to as CMS Publication 15).

1. Hospital Cost Reporting Requirements:

    a. Hospital (including hospital-based nursing facility) annual Medicare/Medicaid cost reports are to be filed with the Medicaid program (DHCFP) following the cost report filing deadlines adopted in 42 CFR 413.24. If a facility requests an extension from the Medicare program, they must also request an extension from the DHCFP. Extension requests approved by Medicare will automatically be approved by the DHCFP, once the DHCFP receives evidence of Medicare approval from the facility.

2. Free Standing Cost Reporting Requirements:

    a. Free-standing nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must complete and file an annual Medicare/Medicaid cost report with the DHCFP.

    b. Cost reports are to be received by DHCFP by the last day of the third month following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame a request for a 30 day extension can be requested from the DHCFP prior to the original cost report due date. Reasonable extension requests will be granted.

    c. Minimum Direct Care Staffing Requirement: In the event that a nursing facility does not incur direct care cost, at least equal to 94% of the direct care median, the Department will have the option to recoup, from future payments to that provider, an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing. Any penalties collected shall accrue to the State General fund and shall be used to offset Medicaid expenses.

3. Failure to File, or Late Filing of, Cost Reports

   a. Facilities failing to file a Medicare/Medicaid cost report in accordance with these provisions may have their Medicaid payments suspended, or be required to pay back to the Medicaid program all payments received during the fiscal year period for which they were to provide a cost report. Facilities may also be subject to an administrative fine of up to $500 per day for each day the required cost reports are delinquent.

   b. DHCFP may withhold any amounts due under 3.a. (above) from a facility's Medicaid claims payments until such amounts are paid in full.

704 MEDICAID RATE(S) APPEAL

The following appeal procedure applies to reimbursement rates paid to providers for providing services under the State Plan for Medicaid to Medicaid recipients enrolled in the fee-for-service Medicaid program. Appeals are only applicable to individual providers. General rates, as determined by procedures set forth in the State Plan, cannot be appealed.

1. Appeals must be submitted in writing to the address below and clearly marked as a Rate appeal.

   To ensure receipt of the Appeal, certified mail or other commonly accepted delivery methods which clearly show the date of receipt are encouraged.

   Appeal address: Administrator DHCFP, 1100 E. William Street, Suite 101, Carson City, Nevada 89701.

2. The appeal must contain the following information:

   a. The name, address and telephone number of the person who has authority to act on behalf of the provider/appellant; and
   b. The specific rate(s) to be reviewed;
   c. The basis upon which the provider believes relief should be granted including supporting documentation:
      1. Claims documentation showing costs for Medicaid services not fully compensated by Medicaid payments is necessary, but not sufficient to form a basis for relief.
      2. The documentation should show that payments received from Medicaid for the appealed rate fail to compensate for costs attributable to providing services to Medicaid patients as well as for the rates in aggregate for the provider.
      3. The documentation must show how the specific circumstances of services provided to Medicaid recipients relative to other like-providers result in higher costs not adequately or appropriately considered in the development of the existing rate(s);
   d. The relief requested, including the methodology used to develop the relief requested.
      Actual costs from the most recent prior year(s), or costs from part of the current year, may be used in developing the methodology for the relief request, so long as it is not a cost reimbursement methodology;
   e. Any other information the provider believes to be relevant to the review.

3. The Administrator, or his designee, may consider the following factors in deciding whether to grant rate relief:

a. Whether there are circumstances related to the appellant when compared to other providers that cause the appellant to have higher Medicaid costs in the rate category reviewed;
b. Whether the circumstances relating to the provider are adequately considered in the rate-setting methodology set forth in the State Plan;
c. The extent to which comparable health care services are available and accessible for all people in the geographic area served by the appellant/provider;
d. Whether Medicaid payments are sufficient to meet Medicaid costs in the appealed rate(s);
e. The total Medicaid payments to the provider and all Medicaid payments for the appealed rate(s):
In the case of hospitals, this includes total Medicaid costs to the hospital for inpatient care and the hospital's Medicaid costs for the appealed rate(s);
f. Audit review information, if any;
g. Information and data used to set the existing or appealed rate;
h. Such other information or documentation as the Administrator, or his designee, deems relevant; and
i. That the basis for relief results in uncompensated Medicaid costs to the provider, both in the appealed rate(s) and in aggregate Medicaid payments under the State Plan.

4. The Administrator, or his designee, shall review the appeal and supporting documentation and issue a written decision within 90 calendar days of receipt of a properly submitted appeal. The Administrator, or his designee, may request any additional information from the provider, including independent verification by an unrelated third party of the provider's claims. If the Administrator, or their designee, requests additional information or verification, the period in which the Administrator or his designee must issue a decision is extended to 90 calendar days from the receipt of the requested information.

5. The decision on the appeal shall set forth Findings of Fact and Conclusions of Law.

6. The decision will be sent in writing by certified mail, return receipt requested, to the person designated in 704.2.a.

7. The Administrator's decision may be appealed to the District Court in and for Carson City of the State of Nevada pursuant to NRS 422.306(3). Such appeal shall be filed within 30 calendar days from the date the decision of the Administrator is received.

705 REFERENCES AND CROSS REFERENCES

705.1 PROVIDER SPECIFIC INFORMATION

See Medicaid Service Manual for Policy Resources – Chapters are as follows:

100	Medicaid Program
200	Hospital Services
300	Radiology Services
400	Mental Health and Alcohol/Substance Abuse Services
500	Nursing Facilities
600	Physician Services
700	Rates and Cost Containment
800	Laboratory Services
900	Private Duty Nursing
1000	Dental
1100	Ocular Services
1200	Prescribed Drugs
1300	DME, Disposable Supplies and Supplements
1400	Home Health Agency
1500	Healthy Kids Program
1600	Intermediate Care Facility for the Mentally Retarded
1700	Therapy
1800	Adult Day Health Care
1900	Transportation Services
2400	Comprehensive Outpatient Rehabilitation (COR) Services
2500	Case Management
2800	School Based Child Health Services
3100	Hearings
3200	Hospice
3300	Program Integrity
3500	Personal Care Services Program
3600	Managed Care Organizations

705.2 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS
Provider Relations Department
First Health Services Corporation
PO Box 30042
Reno, NV 89520-3042
Toll Free within Nevada (877) NEV-FHSC (638-3472)

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

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