

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 14, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
MSM ADDENDUM – DEFINITIONS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Addendum Section L was made to the definition of Legally Responsible Individual (LRI) to correct an error that occurred when the definition was moved and consolidated from MSM Chapter 3500 to the MSM Addendum in 2011.

These changes are effective December 1, 2013.

MATERIAL TRANSMITTED

MTL 17/13
MSM ADDENDUM – DEFINITIONS

MATERIAL SUPERSEDED

MTL 08/11
MSM ADDENDUM - DEFINITIONS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section L	Addendum	Added comma to clarify the original intent of the LRI definition.

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24-HOUR CARE AT HOME

In the absence of the primary caregiver due to medical need of the caregiver or of a family member, a recipient under 21 years of age may receive 24-hour care at home through an Early Periodic Screening and Diagnostic Testing (EPSDT) screening referral. Please refer to Chapter 900.

1915(i) HOME AND COMMUNITY-BASED SERVICES (HCBS) UNIVERSAL NEEDS ASSESSMENT TOOL (UNIVERSAL NEEDS ASSESSMENT)

The “1915(i) HCBS Universal Needs Assessment Tool” is a needs based assessment that is completed by an independent third party. It is person-centered and focuses on the level of support needed, not deficits in skill.

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ABLE

An able parent and/or legal guardian of a minor child, is a Legally Responsible Individual (LRI) who has the option to be present in the home during the time necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are needed.

ABLE CAREGIVER

An able caregiver is a LRI who has the option to be present in the home during the time necessary maintenance, health/medical care, education, supervision, support services, and/or provision of ADLs and IADLs are needed.

ABUSE

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid or Nevada Check Up (NCU) programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid or NCU programs. (42 Code of Federal Regulations (CFR) 455.2)

ACCESS

A recipient's ability to obtain medical care. The ease of access is determined by components such as:

1. the availability of medical services and their acceptability to the recipient;
2. the location of health care facilities;
3. transportation;
4. hours of operation; and
5. cost of care.

ACCOMMODATIONS

Supports or services provided to help a student access the general curriculum and facilitate learning.

ACQUIRED BRAIN INJURY (ABI)

ABI refers to impaired brain functioning due to a medically verifiable incident including, but not limited to:

1. a cerebral vascular accident;

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2. a ruptured aneurysm;
3. anoxia; or
4. hypoxia and brain tumors.

Not all acquired brain injuries require or meet criteria for comprehensive rehabilitation services.

ACT

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

ACTION

An action is a termination, suspension, reduction or denial of Medicaid covered services or disenrollment from NCU. An action also means determinations by Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) to transfer or discharge residents and adverse determinations made by the State with regard to the Pre-Admission Screening And Resident Review (PSARR II) requirements of section 1919(e)(17) of the Social Security Act. It includes changes in types, amount of service or a change in Level Of Care (LOC).

ACTIVE TREATMENT

All services provided by the facility directly or under contract are part of the active treatment program including:

1. evaluations;
2. Individual Program Plan (IPP);
3. training and habilitation;
4. behavior modification;
5. recreation and social services;
6. psychological and psychiatric services;
7. nutrition services;
8. medical services;
9. dental services;

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10. preventive health services;
11. nursing services;
12. pharmacy services;
13. physical and occupational therapy;
14. speech therapy and audiology services;
15. transportation; and
16. vocational or pre-vocational services.

Active treatment includes:

17. aggressive consistent implementation of a program of specialized and generic training;
18. treatment; and
19. health and related services.

Active treatment is directed toward acquiring the behaviors necessary for the recipient to function with as much self-determination and independence as possible and preventing or slowing the regression or loss of current optimal functional status.

A continuous Active Treatment Program consists of needed interventions and services in sufficient intensity and frequency to support the achievement of IPP objectives.

Active treatment does not include services to maintain generally independent recipients who are able to function with little supervision or without a continuous active treatment program.

ACTIVITIES OF DAILY LIVING (ADLs)

ADLs are self-care activities routinely performed on a daily basis, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.

For purposes of evaluation, the ADLs are defined as:

- Bathing/Dressing/Grooming: Includes bathing (washing oneself in a bathtub or shower, or by sponge bath. It also includes the individual's ability to get into and out of the shower or tub), dressing, undressing, grooming and personal hygiene.

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- Toileting: Includes getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene. Also includes the routine maintenance of incontinence.
- Transferring: Includes moving into or out of a chair, bed or wheelchair.
- Mobility: Includes walking and getting around with the use of assistive devices or with assistance.
- Eating: Putting food into the body from a cup, plate, feeding tube or intravenously. Does not include the preparation of food which is an Instrumental Activity of Daily Living (IADL).

ACTUAL ACQUISITION COST (AAC)

AAC is the actual price paid by the pharmacy for a drug.

ADAPTIONS

Any procedure intended to meet an educational situation with respect to individual differences in ability or purpose.

ADMINISTRATION FEE

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

ADMINISTRATIVE ACTION

Administrative Action is an action taken by the Division of Health Care Financing and Policy (DHCFP) which includes but is not limited to:

1. the recovery of improper payments;
2. issuance of educational letters;
3. issuance of warning letters;
4. issuance of recoupment/recovery letters;
5. special claims reviews or on-site audits;
6. requests for provider corrective action plans;
7. requests for provider self audits;
8. referral to appropriate civil agencies (licensing bodies);
9. referral to the Medicaid Fraud Control Unit (MFCU);

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10. denial of provider applications;
11. suspension and termination of provider status; and
12. other actions as stated in policy 3303.3A.

See the Social Security Act Sections: 1128, 1128A, 1128B, and 1903.

ADMINISTRATIVE AUTHORITY

Has the administrative authority over four HCBS waivers:

1. Assisted Living (AL)
2. Elderly in Adult Residential Care (WEARC)
3. Frail Elderly at home (CHIP); and
4. Persons with Mental Retardation or Related Conditions (MRRC).

DHCFP issues policy rules and regulations related to waivers in addition to overseeing the performance of the operating agency.

ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities include activities such as collecting data for eligibility verification, evaluating the recipient's LOC, developing a Plan Of Care (POC) or a service plan, and performing reassessments of the recipient's needs at mandated intervals or as needed. Administrative case management activities may not be billed as direct service case management activities.

ADMINISTRATIVE COSTS

There are two separate cost components in administrative costs:

1. Non-Medical Administrative Costs: Those costs (both direct and indirect) necessary to administer the Medicaid managed care program.
 - a. Direct Expenses: Those expenses that can be charged directly as a part of the overall administrative costs; and,
 - b. Indirect Expenses: Those elements of costs necessary in the performance of administering the program that are of such a nature that the amount applicable to the program cannot be determined

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accurately or readily (i.e., rent, heat, electrical power, salaries and benefits of management personnel which are allocated to different programs, etc.).

2. Medical Administrative Costs

Costs, either direct or indirect, related to recipient medical care management (i.e., development of physician protocols for disease management, utilization review activities, case management costs, and medical information management systems).

DHCFP will review Medical Administrative Costs for reasonability and in the context of the benefit received by the client and DHCFP (i.e., is the cost of developing physician protocols for disease management less than or equal to the fiscal and health outcome benefit received).

3. Non-Medical Costs

The following are not considered administrative costs. They are, however, included in the overall percentage of non-medical costs, and will be reviewed for reasonableness by DHCFP:

- a. Profit: The percentage of profit which the Contractor anticipates receiving after expenses (net income, revenues less expenses, divided by total revenues received from DHCFP); and
- b. Risk and contingencies: That amount which the Contractor anticipates setting aside (as a percentage of the revenues received) for potential unknown risks and contingencies.

ADMINISTRATIVE CUT-OFF DATE

A date each month selected by DHCFP. Changes made to the Medicaid recipient eligibility system prior to this date are effective the next month and are shown on the recipient's Medicaid card. Changes made to the computer system after this date become effective the first day of the second month after the change was made.

ADMINISTRATIVE DAYS

The primary purpose and function of administrative days is to assist hospitals which, through no fault of their own, cannot discharge a recipient who no longer requires acute level services due to lack of, or a delay in, an alternative appropriate setting.

ADMISSION

Nevada Medicaid considers a recipient admitted to the inpatient facility as an inpatient when the:

1. physician writes the order for admission; and

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2. admission has been certified by Nevada Medicaid's Quality Improvement Organization (QIO)-like vendor.

ADULT

For purpose of hospice services, an adult is defined as an individual 21 years of age or older.

ADULT COMPANION SERVICES

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the participant with such tasks as meal preparation, laundry and shopping. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. This service is provided in accordance with a goal in the POC and is not purely diversional in nature.

ADULT DAY CARE

Adult Day Care provides socialization in a safe environment for frail, socially isolated, physically or cognitively impaired seniors in order for them to remain in the community. Services are provided for four (4) or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting. Adult Day Care services include, supervision, monitoring of general well-being and social interaction through scheduled activities and peer contact.

Adult Day Care does not provide elements of health care, which differentiate Adult Day Care from Adult Day Health Care (ADHC).

ADULT DAY CARE FACILITY

Adult Day Care Facility is defined by Nevada Revised Statutes (NRS) 449.004 as an establishment operated and maintained to provide care during the day, temporary or permanent, for aged or infirm persons, but does not include halfway houses for recovering alcoholics or drug abusers. The emphasis is social interaction in a safe environment. Adult Day Care Facilities are required by NRS to be licensed by the Bureau of Health Care Quality and Compliance (HCQC), Nevada State Health Division. Refer to Medicaid Services Manual (MSM) Chapter 2200.

ADULT DAY HEALTH CARE (ADHC) FACILITY

ADHC Facilities provide medical services on a regularly scheduled basis as specified in the POC. Services must be provided in a non-institutional community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. The inclusion of health in a day care setting should indicate they provide elements of health care and are not just a model of socialization for seniors. Facilities providing these services are licensed by HCQC, Nevada State Health Division. ADHC Facilities meet the criteria set forth by Medicaid for reimbursement for Adult Day Health Services.

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ADVANCED PRACTITIONER OF NURSING (APN)

APN means a Registered Nurse (RN) who has:

1. specialized skills, knowledge and experience; and
2. been authorized by the Board of Nursing to provide services in addition to those that other RNs are authorized to provide (NRS 632.012).

ADVANCED LIFE SUPPORT (ALS) ASSESSMENT

ALS Assessment is performed by an ALS crew as part of an emergency response that was necessary due to the recipient's reported condition at the time of dispatch and was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the recipient requires an ALS level of service.

ADVANCED LIFE SUPPORT (ALS) INTERVENTION

ALS Intervention is a procedure that is, in accordance with State and local laws, beyond the scope of practice of an Emergency Medical Technician (EMT)-Basic.

ADVANCED LIFE SUPPORT LEVEL 1 (ALS-1)

ALS-1 is transportation by ground or air ambulance and the provision of medically necessary supplies and services, including the provision of an ALS assessment or at least one ALS intervention, which must be performed by personnel trained to the level of an EMT-Intermediate or paramedic, in accordance with State and local laws.

ADVANCED LIFE SUPPORT LEVEL 2 (ALS-2)

ALS-2 is transportation by ground or air ambulance and the provision of medically necessary supplies and services, including:

1. at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or
2. the provision of at least one of the ALS-2 procedures defined by the Centers for Medicare and Medicaid Services (CMS).

These procedures must be performed by personnel trained to the level of an EMT-Intermediate or paramedic, in accordance with State and local laws, and may include:

3. manual defibrillation/cardioversion;

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4. endotracheal intubation;
5. central venous lines;
6. cardiac pacing;
7. chest decompression;
8. surgical airway; and
9. intraosseous line.

ADVANCE NOTICE OF ACTION (NOA)

A written notice mailed to the individual when DHCFP or the Health Plan propose to take an Action at least 10 days before the Date Of Action (DOA). Advance Notice of Action (NOA) and Notice Of Decision (NOD) may be used interchangeably.

ADVERSE DETERMINATION

Adverse determination means a determination made in accordance with sections 1919(b)(3)(f) or 1919(e)(7)(B) of the Act that the individual does not require the level of services provided by a NF or that the individual does or does not require specialized services.

AGE/SEX RATES

A set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories.

AGING AND DISABILITY SERVICES DIVISION (ADSD)

A State agency that is part of Nevada's Department of Health and Human Services (DHHS) and is the operating agency for the Home and Community-Based Waiver (HCBW) WEARC, the AL waiver and the HCBW for the Frail Elderly.

AIR AMBULANCE

Air ambulance means an aircraft (fixed or rotary wing) specially designed, constructed, modified, or equipped to be used for the transportation of injured or sick persons. Air Ambulance does not include any commercial aircraft carrying passengers on regularly scheduled flights.

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ALL INCLUSIVE RATE

The daily rate which is paid to a facility during the course of a covered Medicaid stay. This daily rate is to include services and items such as, but not limited to, nursing services, dietary services, activity programs, laundry services, room/bed maintenance services, medically related social services, routine personal hygiene supplies, active treatment program and day training programs.

AMBULANCE

Ambulance is defined as a medical vehicle that is specially designed, constructed, staffed, and equipped to provide basic, intermediate, or advanced services for one or more sick or injured person or persons whose medical condition may require special observation during transportation or transfer.

AMBULATORY SURGICAL CENTERS (ASCs)

ASC's are any distinct entities that operate exclusively for the purpose of providing outpatient surgical services to recipients not requiring inpatient hospitalization. They must have an agreement with the CMS to participate in Medicare as an ASC, and meets the conditions set forth in 42 CFR 416, Part B and Part C. Ambulatory Surgery services may be provided in either a freestanding or hospital-based ASC.

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY (AAPD)

AAPD is the membership organization representing the specialty of pediatric dentistry. Their members work in private offices, clinics and hospital settings and serve as primary care providers for millions of infants, children, adolescents and patients with special health care needs. In addition, AAPD members serve as the primary contributors to professional education programs and scholarly works concerning dental care for children. (Refer to Appendix A)

AMERICAN DENTAL ASSOCIATION (ADA)

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

AMOUNT

The number and frequency of treatment sessions provided.

ANKLE-FOOT ORTHOSES

Ankle-foot orthoses extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics, which are shoe inserts that do not extend above the ankle.

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ANNUAL

For the purpose of annual Level of Care (LOC) assessments for Home and Community-Based Waivers (HCBW), annual means in the same month each year.

ANNUAL GOAL

A statement in a student's Individualized Education Program (IEP) that describes what a child with a disability can reasonably be expected to accomplish within a 12-month period in the student's special education program. There should be a direct relationship between the annual goals and the present levels of educational performance.

APPEAL

A request for review of an action as "action" is defined in 42 CFR 438.

APPLICANT

An individual who is applying for waiver services.

APPROPRIATE

Refers to the DHCFP's ability to provide coverage for medically necessary services to a recipient based on regulations and the Division's available resources and utilization control procedures.

ASSESSMENT

An assessment is a written evaluation that is conducted by Nevada Medicaid and/or its contractors to evaluate the medical necessity of an individual's request for a Nevada Medicaid covered service.

(NOTE: the definition of assessment may differ in intent between some program chapters. For specific types of assessments refer to the specific chapters.)

ASSESSMENT REFERENCE DATE (ARD)

The ARD is the common date on which all MDS observation periods end. The ARD is the last day of the MDS observation period and controls what care and services are captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. The ARD is located on the MDS 2.0, Section A3a.

ASSISTED LIVING (AL) FACILITY

An AL Facility is a residential facility that provides AL services to low or moderate income individuals who are 65 years of age or older. The facility must qualify as affordable housing for a period of at least 15 years and must be certified by the Housing Division of the Department of Business and Industry pursuant to NRS 319.147.

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ASSISTED LIVING (AL) SERVICES

AL Services, as specified in the AL Waiver, include an array of services offered which are determined necessary to allow the recipient to remain in a community setting. AL services include homemaker, chore, augmented personal care, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, transportation, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. Also included is 24-hour on-site response staff to meet scheduled or unpredictable needs, and to provide supervision, safety, and security.

ASSISTIVE COMMUNICATION DEVICE (ACD)

ACD is Durable Medical Equipment (DME) which helps speech, hearing and verbally impaired individuals communicate.

AT RISK RECIPIENT

The At Risk Recipient is a recipient for whom the absence of Personal Care Services (PCS) would likely result in medical deterioration, medical complications or might jeopardize the recipient's personal safety if PCS is not received within 24 hours.

ATTENDANCE RECORD

The attendance record is documentation by a facility, indicating the time the recipient arrived at the facility and the time the recipient left the facility. The recipient and a facility staff member must sign each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. An authorized representative may sign on behalf of the recipient.

ATTENDANT CARE (AC)

1. HCBW for Persons with Physical Disabilities (WIN):

For the purposes of the WIN waiver, AC is defined as extended State plan Personal Care Attendant (PCA) service may include assistance with eating, bathing, dressing, personal hygiene, ADLs, shopping, laundry, meal preparation and accompanying the recipient to appointments as necessary to enable the individual to remain in the community. The service may include hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. This service may include an extension of task completion time allowed under the state plan with documented medical necessity.

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2. HCBW WEARC:

For purposes of the WEARC waiver, AC is defined as assistance for the functionally impaired individual with basic self care needs and ADLs which are determined necessary to allow the individual to remain in a community setting. This assistance may include, but is not limited to, PCS, homemaker, chore, AC, companion services, medication oversight (to the extent permitted under State Law), therapeutic social and recreational programming and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. It includes 24-hour in home supervision to meet scheduled or unpredictable needs. This care is over and above the mandatory service provision required by regulation for residential facilities for groups.

ATTENDING PHYSICIAN

A physician who is a doctor of medicine or osteopathy and is identified by the recipient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the recipient's medical care. Attending physicians who provide services to Medicaid Hospice recipients must be contracted Medicaid providers.

AUDIOGRAM

An audiogram is a means of recording the results of a hearing test.

AUDIOLOGIST

Audiologist means any person who engages in the practice of Audiology (NRS 637B030). An Audiologist must be licensed by the Board of Examiners for Audiology and Speech Pathology and meet the requirements of NRS 637.160.

The practice of audiology consists of rendering services for the measurement, testing, appraisal, prediction, consultation, counseling, research or treatment of hearing and hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing.

AUDIOLOGY TESTING

Audiology testing is evaluation/testing performed by an audiologist licensed by the appropriate licensure board of the state to determine extent of hearing impairments that affect the student's ability to access education. Audiology testing includes hearing and/or hearing aid evaluations, hearing aid fitting or reevaluation and audiograms.

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AUDITORY BRAINSTEM IMPLANT

Auditory Brainstem Implant is similar to a cochlear implant, but the electrode is implanted in the brainstem, rather than the cochlear in the ear. The brainstem electrode is placed next to the cochlear nuclei. The electrode is connected to an external microphone and processor which allows the patient to identify sound.

AUGMENTED PERSONAL CARE (provided in a licensed residential facility for groups)

Assistance for the functionally impaired individual with basic self care needs and ADLs such as personal care services, homemaker, chore, companion services, medication oversight (to the extent permitted under State Law), therapeutic social and recreational programming and services that ensure that the residents of the facility are safe, secure and adequately supervised. This service includes 24-hour in home supervision to meet scheduled or unpredictable needs.

AUGMENTED PERSONAL CARE SERVICES (PCS)

There are three levels of augmented PCS. The service level provided by an assisted living facility is based on the recipient's functional needs to ensure his/her health, safety and welfare in the community. ADSD determines the service level and PAs for services as an administrative function of the AL Waiver.

AUTHORIZATION

The word authorization is used synonymously with Prior Authorization (PA) of payment. EPSDT services and adult emergency services (emergency extractions and palliative care) do not require PA. All orthodontia services require a PA. A PA is required for partials and/or full dentures provided to recipients residing in NFs or receiving Hospice services. PA of payment for procedures does not confirm eligibility for Medicaid benefits. Medicaid allows post-service authorization of payment in special circumstances involving life-threatening health complications and NF recipients.

AUTHORIZATION NUMBERS

Authorization numbers are the assigned numbers issued by Nevada Medicaid's QIO-like vendor for authorizing medically necessary services. Authorization numbers are used for submitting claims to DHCFP's fiscal agent for reimbursement. An approved authorization does not confirm a recipient's eligibility or guarantee claims payment.

AUTHORIZED REPRESENTATIVE

An authorized representative is an individual who has been designated by a recipient as having authority to act on behalf of the recipient. A written and signed request sent to DHCFP, to allow representation by a designated person as their legal representative. The request would include the designated person's name and relationship to the requestor.

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BASIC LIFE SUPPORT (BLS)

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

BEHAVIORAL HEALTH COMMUNITY NETWORK (BHCN)

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

BENEFIT

Benefit means a service authorized by the Managed Care plan.

BEREAVEMENT COUNSELING

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

BILLING AUTHORIZATION

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

BONE ANCHORED HEARING AID (BAHA)

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

BUDGET AUTHORITY

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

BURDEN OF PROOF

At a Fair Hearing, the recipient or provider must establish by a preponderance of the evidence that the agency's denial of the request was not correct. Except where otherwise established by law or regulation, in Fair Hearings concerning the termination, reduction or suspension of medical assistance previously received by a recipient, the agency must establish by a preponderance of the evidence that its actions were correct.

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

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE (HCQC)

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

BUS

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

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CAPABLE

A capable parent and/or legal guardian of a minor child, is a LRI who is physically and cognitively capable of carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

CAPABLE CAREGIVER

A capable caregiver is a LRI who is physically capable of carrying out necessary maintenance, health/medical care, education, supervision, support services, and/or the provision of needed ADLs and IADLs.

CAPITAL RENOVATIONS/REMODELING PROJECT

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

1. expand the capacity;
2. reduce the operating and maintenance costs; or
3. ensure the operating efficiency and/or extend the useful economic life of a fixed asset.

Said Project may involve new construction, reconstruction and/or renovation. Allowable costs include, but are not limited to, the costs of land, buildings, machinery, fixtures, furniture and equipment. Certain 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.

CAPITATION PAYMENT

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

CARDHOLDER

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

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CARE COORDINATION

A formal process that ensures ongoing coordination of efforts on behalf of Medicaid-eligible recipients who meet the care criteria for a higher intensity of needs. Care coordination includes: facilitating communication and enrollment between the recipient and providers and providing for continuity of care by creating linkages to and monitoring transitions between intensities of services. Care coordination is a required component of case management services and is not a separate reimbursable service.

CARE COORDINATOR

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

CAREGIVER

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

CASE MANAGEMENT

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

CASE MANAGEMENT SERVICES

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

1. Assessment of the eligible individual to determine service needs.
2. Development of a person-centered care plan.
3. Referral and related activities to help the individual obtain needed services.
4. Monitoring and follow-up.

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

5. Assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. The assessment activities include the following:
 - a. Taking client history.
 - b. Identifying the needs of the individual and completing related documentation.
 - c. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible recipient.
6. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
 - a. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible recipient.
 - b. Includes activities such as ensuring the active participation of the eligible recipient and working with the recipient (or the individual's authorized health care decision maker) and others to develop those goals
 - c. Identifies a course of action to respond to the assessed needs of the eligible recipient.
7. Referral and related activities (such as scheduling appointments for the recipient) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
8. Monitoring and follow-up; activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately address the needs of the eligible individual and may be with the individual, family members, service provider or other entities or individuals. The monitoring should be conducted as frequently as necessary, and include at least one annual monitoring, to help determine whether the following conditions are met:
 - a. Services are being furnished in accordance with the individual's care plan.
 - b. Services in the care plan are adequate.
 - c. There are changes in the needs or status of the eligible recipient.

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

CASE MIX

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

CASE-MIX INDEX

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

CASE RECORD DOCUMENTATION

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

1. The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.
2. The nature, content, and units of case management services received.
3. Whether the goals specified in the care plan have been achieved.
4. If an individual declines services listed in the care plan, this must be documented in the individual's case record.
5. Timelines for providing services and reassessment.
6. The need for and occurrences of coordination with case managers of other programs.

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

CENSUS INFORMATION

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

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CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

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

CERTIFICATION OF TERMINAL ILLNESS

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

CERTIFIED SLEEP STUDY TECHNOLOGIST

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

CHILD

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

CHILD AND FAMILY TEAM

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

CHIP serves children ages 0 through 18 years and is designed for families who do not qualify for Medicaid and whose incomes are at or below 200% of Federal Poverty Level (FPL). NCU is the Nevada version of CHIP. NCU insurance is comprehensive health insurance covering medical, dental, vision care, mental health services, therapies, and hospitalization.

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CHORE SERVICES

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

CHRONIC MENTAL ILLNESS (CMI)

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

CLAIM

Claim is defined as:

1. a bill for services;
2. a line item of services; or
3. all services for one recipient within a bill.

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

CLINIC SERVICES

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

1. are provided to outpatients;
2. are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and
3. except in the case of nurse-midwife services, as specified in 42 CFR 440.165, are furnished by or under the direction of a physician or dentist.

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CLINICAL LABORATORY

A laboratory which uses:

1. microbiological;
2. serological;
3. immunohematological;
4. cytological;
5. histological;
6. chemical;
7. hematological;
8. biophysical;
9. toxicological; or
10. other methods for “in-vitro” examination of tissues, secretions, or excretions of the human body for the diagnosis, prevention or treatment of disease or for the assessment of a medical condition.

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

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) PROGRAM

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

CLINICAL SUPERVISION

Qualified Mental Health Professionals (QMHP), operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials, and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors must assure that the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided. Clinical Supervisors can supervise QMHPs, Qualified Mental Health Associates (QMHA), and Qualified Behavioral Aides (QBA). Clinical Supervisors may also function as Direct Supervisors.

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

1. An up to date (within 30 days) case record is maintained on the recipient;
2. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services);
3. A comprehensive and progressive Treatment Plan and/or Rehabilitation Plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP;
4. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate;
5. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, that the recipient and their family/legal guardian (in the case of legal minors) sign the Treatment and/or Rehabilitation Plan(s), and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the Treatment and/or Rehabilitation Plan(s);
6. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing;
7. Only qualified providers provide prescribed services within scope of their practice under state law; and
8. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

CLINICAL SUPPORT GUIDE

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

COCHLEAR IMPLANT

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

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CODE OF FEDERAL REGULATIONS (CFR)

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

COLD-CALL MARKETING

Any unsolicited personal contact by a provider, Managed Care Organization (MCO) or any other vendor directed specifically toward a Medicaid or NCU recipient for the purpose of marketing or selling a product or service to that individual.

COMMERCIAL TRANSPORTATION VENDOR

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

COMMON OWNERSHIP

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

COMMUNITY MENTAL HEALTH CENTER (CMHC)

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

COMPANION CARE SERVICES

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

COMPARABILITY OF SERVICES

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

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COMPOUND DRUGS

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

COMPREHENSIVE FUNCTIONAL ASSESSMENT

Comprehensive function assessments identify all of the recipients:

1. Specific developmental strengths, including individual preferences;
2. Specific functional and adaptive social skills the recipient needs to acquire;
3. Presenting disabilities and, when possible, their causes; and
4. Need for services without regard to their availability.

CONCURRENT CARE

Concurrent care allows for the provision of Private Duty Nursing (PDN) services by a single nurse to care for more than one recipient simultaneously in the recipient's residence.

CONCURRENT REVIEW

Concurrent review is performed for patients who are Medicaid eligible at the time of inpatient admission. Review is conducted to certify length of stay, medical necessity and appropriateness.

CONFIDENTIALITY

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

CONTENTS OF NOTICE

A notice must contain the following information:

1. A statement of what action the State, or NF intends to take;
2. The reasons for the intended action;
3. The specific regulations that support, or the change in Federal or State law that requires the action;

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4. An explanation of:
 - a. The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
 - b. In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
5. An explanation of the circumstances under which services are continued if a hearing is requested.

CONTINUITY OF CARE

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

CONTINUUM OF SERVICES

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

CONTRACT

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

CONTRACT PERIOD

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

CONTRACTOR

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

COST

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

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2. Proper Cost: An actual recorded cost, clearly identified as to source, nature and purpose, and reasonably related to resident care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
3. Reasonable Cost: A reasonable cost is one that does not exceed that incurred by a prudent and cost-conscious facility operator.

COUNSELING SERVICES

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

COVERED SERVICES

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

CRIMINAL CLEARANCE

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

CRITICAL ACCESS HOSPITAL (CAH)

Nevada Medicaid utilizes Medicare criteria when defining a CAH. Pursuant to section 1820 (a) of the Social Security Act, a state may designate a facility as a CAH if the facility:

1. located in a county in a rural area more than a 35-mile drive from a hospital and is certified by the state as being a necessary provider of health care services to residents in that area;
2. makes necessary 24-hour emergency care services that a state determines are necessary for ensuring access to emergency care services in each area serviced by a CAH;
3. provides not more than 15 acute care inpatient beds for providing inpatient care for a period that does not exceed 96 hours per patient (unless a longer period of time is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions); and
4. meets staff requirements as defined in section 1861 (e) and 1861 (mm)(1) of the Act.

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CUEING

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

CULTURAL COMPETENCE

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

CURRENT DENTAL TERMINOLOGY (CDT)

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

CUSTODIAL CARE

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

CUSTOM FABRICATED ORTHOSIS

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

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DAILY RECORD

The daily record is documentation completed by a provider, indicating the type of service provided and the time spent. The documentation will include the recipient's initials with a full signature of the recipient on each daily record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the Individual Support Plan (ISP). The direct service staff will initial after the daily services are delivered, with a full signature of the direct service staff on each daily record.

Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation of services provided and the time spent providing those services.

If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file, or have the ability to make available upon request.

DATE OF ACTION (DOA)

Is the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the determination made by a State with regard to the PASARR requirements of Section 1919(e)(7) of the Social Security Act.

DAY HABILITATION

Day Habilitation services provide meaningful day and individualized activities that support the recipient's definition of a meaningful day. Day habilitation services enable the recipient to increase or maintain their capacity for independent functioning and decision making.

DAYS

Refers to calendar days, unless otherwise specified.

DENIED SERVICE

Any medical service requested by a provider for a Medicaid or NCU recipient for whom the Contractor denies approval for payment.

DENTAL CONSULTANT

Identifies and promotes best practices and advances education for consistent, evidence based plan and claims evaluations.

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DENTAL DIRECTOR

The Contractor's director of dental services, who is required to be a Doctor of Dental Science or a Doctor of Medical Dentistry and licensed by the Nevada Board of Dentistry, designated by the Contractor to exercise general supervision over the provision of dental services by the Contractor.

DENTAL HYGIENIST

Any person who practices dental hygiene as defined in NRS 631.040.

DENTAL RELATED SERVICES

These may include radiology, physician, anesthesiologist, outpatient facility and pharmacy related to a covered medically necessary dental services or procedures.

DENTAL SERVICES

Dental services are any diagnostic, preventive or corrective procedures that include:

1. treatment of the teeth and associated structures of the oral cavity for disease, injury or impairment that may affect the oral or general health of persons up to age 21 years old; and
2. dentures, emergency extractions and Palliative care for 21 years old and over.

DENTIST

A dentist is a person licensed to practice dentistry or dental surgery as defined in NRS 631.215.

DENTURES

Dentures include both complete and partial prostheses replacing missing teeth.

DEPARTMENT OF JUSTICE (DOJ) PRICING

In 2000, the US DOJ and the National Association of Medicaid Fraud Control Units (NAMFCU) determine 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 programs 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.

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DIAGNOSIS

Diagnosis means determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical and developmental examination, and laboratory tests.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM) DIAGNOSIS

The determination of a recipient's mental or emotional disorder as described in the DSM of Mental Disorders, published by the American Psychiatric Association (APA). The principal Axis I diagnosis provides the clinical basis for treatment and must be reassessed annually for recipients under age 18. It is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment, and is entered on a written individualized Treatment Plan. A DSM "V" code condition except 995.54 (Physical Abuse of Child-Victim), 995.53 (Sexual Abuse of Child – Victim) and 995.54 (Neglect of Child – Victim), substance use disorder or mental retardation may not be considered the principal diagnosis, although these conditions or disorders may co-occur with the diagnosable mental disorder.

DIAGNOSTIC AND STATISTICAL MANUAL (DSM) OF MENTAL DISORDERS

The latest text revision of the DSM of Mental Disorders published by the APA.

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

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

DIAGNOSTIC CLASSIFICATION: 0-3 (DC:0-3)

The determination of a mental or emotional disorder for a childbirth through 48 months of age as described in the latest text version of the Manual for DC:0-3 published by the National Center for Clinical Infant Programs. The principal Axis I diagnosis or the Axis II PIR-GAS score of 40 or less provides the clinical basis for treatment and must be reassessed every 6 months for children under age 4. The DC:0-3 diagnosis may be used in place of the DSM Axis I Diagnosis to determine eligibility for and provide mental health services to recipients under 4 years of age.

DIRECT CARE COMPONENT

Direct care component means the portion of Medicaid reimbursement rates that are attributable to the salaries and benefits of RNs, Licensed Practical Nurses (LPNs), certified nursing assistants, rehabilitation nurses, and contracted nursing services.

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DIRECT SERVICE CASE MANAGEMENT

Direct service case management assists individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

DIRECT SERVICES

Direct services assist in the acquisition, retention and improvement of skills necessary for the person to successfully reside in the community. Direct services are individualized hours that are not shared. Direct services providers participate in the ISP meetings.

DIRECT SUPERVISION

QMHP or QMHA may function as Direct Supervisors. Direct Supervisors must have the practice specific education, experience, training, credentials, and/or licensure to coordinate an array of mental and/or behavioral health services. Direct Supervisors assure servicing providers provide services in compliance with the established treatment/rehabilitation plan(s). Direct Supervision is limited to the delivery of services and does not include Treatment and/or Rehabilitation Plan(s) modification and/or approval. If qualified, Direct Supervisors may also function as Clinical Supervisors. Direct Supervisors must document the following activities:

1. Their face-to-face and/or telephonic meetings with Clinical Supervisors.
 - a. These meetings must occur before treatment begins and periodically thereafter;
 - b. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and
 - c. This supervision may occur in a group and/or individual settings.
2. Their face-to-face and/or telephonic meetings with the servicing provider(s).
 - a. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;
 - b. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and
 - c. This supervision may occur in group and/or individual settings;
3. Assist the Clinical Supervisor with Treatment and/or Rehabilitation Plan(s) reviews and evaluations.

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DIRECT SUPPORTS

Direct supports are the hours allocated in the participant's ISP for protective oversight. Protective oversight is supervision hours provided to ensure the health, safety and welfare of an individual who cannot be left alone for an extended period of time. Direct support is funded to individuals residing in a non-family host home that may not have a second person or 24-hour homes which require that the hours be shared with two or more individuals unless the person requires the one to one direct hours as a result of medical or clinical necessity, as determined by the Regional Center Psychologist and Regional Center Nurse.

DISABILITY

Disability means (with respect to a person):

1. a physical or mental impairment that substantially limits one or more of the major life activities of the person;
2. a record of such an impairment; or
3. being regarded as having such and impairment.

DISABILITY DETERMINATION

DHCFP's physician consultant and medical professional staff make up the disability determination team. The team reviews medical documentation and determines if the applicant qualifies as physically disabled.

DISCHARGE CRITERIA

The diagnostic, behavioral, and functional indicators that must be met to complete service provision as documented in the Treatment Plan and/or Rehabilitative Plan. Discharge criteria are developed as part of the discharge planning process, which begins on the date of admission to services.

DISCHARGE PLAN

A written component of the Treatment Plan and/or Rehabilitation Plan which ensures continuity of care and access to needed support services upon completion of the Treatment Plan and/or Rehabilitation Plan goals and objectives. A Discharge Plan must identify:

1. the anticipated duration of the overall services;
2. discharge criteria;
3. required aftercare services;

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4. the identified agency(ies) or Independent Provider(s) to provide the aftercare services; and
5. a plan for assisting the recipient in accessing these services.

DISCHARGE SUMMARY

Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the mental health Treatment and/or Rehabilitation Plan(s). The Discharge Summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven (7) calendar days of the transfer. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan, and the Discharge Plan.

DISENROLLMENT

Process of terminating individuals or groups from enrollment with a Managed Care Plan. Except where expressly required by federal or state regulations, disenrollment may not occur mid-month. Under most circumstances, requests for disenrollment are effective the first day of the month following receipt of the request, provided that the request is within policy/contract guidelines and is submitted before the administrative cutoff date.

DISPENSING FEE

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

DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies are those items which are not reusable, and are primarily and customarily used to serve a medical purpose, and generally are not useful to a person in the absence of an illness or injury.

DISTRICT OFFICES

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

The Nevada Medicaid District Office staff assists Medicaid recipients in locating Medicaid providers, arranging for medical services, if appropriate, and acting as liaison between recipients and providers and the Medicaid

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office. Certain District Office staff are also assigned case management responsibilities. District Office staff also have a responsibility to report suspected fraud or abuse of the program by recipients or providers.

DRUG USE REVIEW (DUR) BOARD

A DUR program that consists of prospective DUR, the application of explicit predetermined standards, and an educational program. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and that they are not likely to result in adverse medical results. (CFR 456 I.B) The board consists of pharmacists and physicians.

DRUGS

Refer to MSM Chapter 1200 (Prescription Services) for covered pharmaceuticals.

DURABLE MEDICAL EQUIPMENT (DME)

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

DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR (DME MAC)

The CMS utilize four insurance companies to process DME, Prosthetic, Orthotic, and disposable medical supply claims for Medicare in four distinct jurisdictions. Nevada is in Jurisdiction D. This was formerly referred to as Durable Medical Equipment Regional Carrier (DMERC).

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

Aggregate term used under the Medicare program and by some Medicaid programs, which incorporates all DME, prosthetics, orthotics, and disposable medical supplies. The acronym is pronounced “demipose”.

DURATION

The length of time to provide a service and the anticipated or actual time of treatment.

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EAR IMPRESSIONS

All custom made hearing aids and ear molds are made from a cast of the ear. The cast is referred to as an ear impression.

EAR MOLDS

Ear molds form the connection between the ear and hearing aid.

EARLY

Early means as soon as possible in the child's life after the child is determined eligible.

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

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

EPSDT excludes females, under age 21, whose Medicaid eligibility benefit is for pregnancy-related services only.

ELECTION PERIOD

A time period for which hospice care may be provided when elected by a recipient and the recipient is deemed appropriate as evidenced by a certification of terminal illness signed by an attending physician and/or a hospice physician.

ELECTION STATEMENT

A signed statement by a terminally ill recipient or his or her representative indicating the election of hospice care and filed by the individual with a particular hospice which maintains the certification statement.

ELECTRODIAGNOSTIC TESTING/NEUROPHYSIOLOGICAL STUDIES

The neurologic system controls and manages most body functions needed for survival through the central nervous system, peripheral nervous system and the sensory organs. A sequence of tests may be essential to complete neurological evaluation. The outcome of the physical examination will dictate what tests or sequence of testing is required to confirm the diagnosis or promote disease management.

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ELECTRONIC VERIFICATION OF SERVICES (EVS)

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

ELIGIBILITY

The term eligibility is used to reference to a recipient's status of being approved to receive Medicaid program benefits.

An individual's Medicaid eligibility status should not be confused with authorization for the services a provider has requested. Conversely, providers who receive written Prior Authorization of payment for services must still check the recipient's monthly Medicaid/Managed Care eligibility status.

ELIGIBILITY NOTICE OF DECISION (NOD)

Eligibility NOD is the notification sent to an individual by the Nevada State DWSS giving eligibility decisions regarding their application for Medicaid services.

ELIGIBILITY STAFF

Eligibility staff are state employees who are responsible for determining financial and/or categorical need for Medicaid and NCU.

EMERGENCY CARE

Emergency dental services do not require PA. For those persons under 21 years of age, emergency care involves those services necessary to control bleeding, relieve significant pain and/or eliminate acute infection, and those procedures required to prevent pulpal death and/or the imminent loss of teeth. For persons 21 years and older, emergency care consists of emergency extractions and palliative care.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

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EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation is ground or air ambulance, as medically necessary, to transport a recipient with an emergency medical condition. A ground or air ambulance resulting from a “911” communication is included as emergency medical transportation.

EMERGENCY SERVICES

Emergency services means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. The Contractor must not require the services to be prior or post-authorized.

EMPLOYEE

An employee of the agency or organization who is appropriately trained and assigned to the hospice unit. “Employee” also refers to a volunteer under the jurisdiction of the hospice.

EMPLOYER AUTHORITY

The participant direction opportunity by which the waiver participant exercises choice and control over individuals who furnish waiver services authorized in the service plan.

EMPLOYER OF RECORD

Refers to the ISO that provides all fiscal and supportive tasks related to PCA employment in the self-directed option. The employer of record ensures compliance with legal requirements related to employment (e.g., manages payroll and taxes and processes employment documents) and the supportive requirements (e.g., assist with training materials, training, background checks, etc.).

ENCOUNTER

A covered service or group of services delivered by a provider to a recipient during a visit, or as a result of a visit (e.g., pharmacy) between the recipient and provider.

ENCOUNTER DATA

Data documenting a contact or service delivered to an eligible recipient by a provider for any covered service.

ENROLLEE

A Medicaid or NCU recipient who is enrolled in a managed care program.

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ENTITY

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

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Physical adaptations to the home, which must be identified in the individual's POC, and are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

ESCORT/ATTENDANT

An escort is defined as an individual whose presence is required to assist a recipient during transit and while at location for Medicaid-reimbursable services. Escorts will be transported at no additional expense and are allowed for members who have been approved through an assessment process to receive ambulatory assistance (e.g., blind, mentally retarded, deaf, physically disabled, or under 21 years of age) during transit.

ESCORT SERVICE

A PCA who accompanies a recipient into the community to provide authorized PCA en route to or while obtaining Medicaid or NCU covered services.

ESSENTIAL COMMUNITY PROVIDERS

A healthcare provider that:

1. has historically provided services to underserved populations and demonstrates a commitment to serve low-income, underserved populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves underserved patients within its clinical capability; and
2. waives charges or charges for services on a modified sliding fee scale based on income and does not restrict access or services because of a client's financial limitations.

ESSENTIAL MEDICATIONS

Essential medications are those which are medically necessary to counteract severe pain and/or to sustain life, limb, or eyesight. Restorative, rehabilitative, preventive, and maintenance medications must have appropriate corresponding diagnoses in the resident's chart to be considered medically necessary.

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ESSENTIAL SHOPPING

Essential shopping is shopping to meet the recipient's health care or nutritional needs. Essential shopping includes brief occasional trips in the local community to shop for food, medical necessities, and household items required specifically for the health and care of the recipient.

ESTIMATED ACQUISITION COST (EAC)

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

EXCEPTION TO ADVANCE NOTICE

Pursuant to 42 CFR §431.213, the agency may mail a notice not later than the DOA if:

1. The agency has factual information confirming the death of a recipient;
2. The agency receives a clear written statement signed by a recipient that:
 - a. He/She no longer wishes services; or
 - b. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
3. The recipient has been admitted to an institution where he/she is ineligible under the plan for further services;
4. The recipient's whereabouts are unknown and the post office returns agency mail directed to him/her indicating no forwarding address (see §431.231(d) of this subpart for the procedure if the recipient's whereabouts become known);
5. The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
6. A change in the level of medical care is prescribed by the recipient's physician;
7. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or
8. The DOA will occur in less than 10 days, in accordance with §483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of §483.12(a)(5)(i).

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Pursuant to 42 CFR §431.214, the agency may shorten the period of advance notice to 5 days before the DOA if:

9. The agency has facts indicating that action should be taken because of probable fraud by the recipient; and
10. The facts have been verified, if possible, through secondary sources.

EXISTING PROVIDER-RECIPIENT RELATIONSHIP

This relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through State records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.

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.

EXPERIMENTAL SERVICES

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

EXPLANATION OF BENEFITS (EOB)

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

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

An independent entity which performs annual external reviews of the quality of services furnished under State contracts with MCO to render Medicaid services.

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FACTOR

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

FAMILY

An individual who is a LRI for a child. Family for both children and adults may also include siblings and/or other individuals identified by the recipient or legal guardian as integral in their home/community environment or mental health stabilization.

FAMILY INVOLVEMENT

The family's active input, guidance and participation in treatment planning, implementation, monitoring, and follow up. Family involvement must be documented on the Treatment Plan anytime there is a LRI for a child and when a recipient identifies a family member as being integral to their mental health stabilization. Required family involvement in treatment planning must be documented on the Treatment Plan when the plan is reviewed every 90 days and at anytime the plan is revised. If is deemed clinically appropriate, family involvement may occur for adult recipients.

FAMILY MEMBER

42 CFR 440.167(b) and State Medicaid Manual Section 4480: D define family member, for the purposes of PCS, as a LRI.

FAMILY PLANNING SERVICES

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

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

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FEDERAL FINANCIAL PARTICIPATION (FFP)

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

FEDERAL UPPER LIMIT (FUL)

Under the authority of 45 CFR, Part 19, the Pharmaceutical Reimbursement Board of the U.S. DHHS 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 multiple source drugs which and 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>.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

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

FEE FOR SERVICE (FFS)

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

FINANCIAL MANAGEMENT SERVICES (FMS)

FMS is a critical support and important safeguard for participants self-directing their waiver services. The FMS acts as the fiscal agent and manages payroll and employment tasks, and pays invoices for goods and services listed in the individual budget. The FMS also ensures service providers meet the qualifications and training requirements, submit background checks, purchase worker's compensation insurance and submit required quality management and utilization reports. FMS are an administrative activity.

FISCAL AGENT

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

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In addition, the fiscal agent may:

1. provide the auditing function for providers under cost reimbursement;
2. perform a pre-payment review on all claims;
3. trace, identify and apply any and all prior resources, including third-party liability and subrogation;
4. supply provider education and provider services; and
5. other administrative services.

FRAUD

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)

FREE APPROPRIATE PUBLIC EDUCATION (FAPE)

A federal statutory requirement that children and youth with disabilities receive a public education appropriate to their needs at no cost to their families.

FULL TIME (F/T)

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

FUNCTIONAL ABILITY

Functional ability is defined as a measurement of the ability to perform ADLs progressing from dependence to independence. This includes, but may not be limited to: personal care, grooming, self-feeding, transferring from bed to chair, ambulation or wheelchair mobility, functional use of the extremities with or without the use of adaptive equipment, effective speech or communication and adequate function of the respiratory system for ventilation and gas exchange to supply the individual's usual activity level.

FUNCTIONAL ASSESSMENT

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

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FUNCTIONAL IMPAIRMENT

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

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GENDER, NUMBER AND TENSE

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

GENERAL PUBLIC

General Public is defined as the patient group accounting for the largest number of non-Medicaid prescriptions from a pharmacy. This excludes patients who purchase or receive prescriptions through third party payers such as Blue Cross, Aetna, PAID, PCS, etc. If a pharmacy discounts prices to specified customers, (e.g. 10% discount to senior citizens) these lower prices should be excluded from usual and customary calculations unless they represent more than 50% of the store's prescription volume.

GEOGRAPHIC SERVICE AREA

The MCO can elect to offer health care services to recipients residing in any or all towns, cities, and/or counties in Nevada for which the MCO has been certified by the Nevada State Insurance Commissioner. The MCO must meet the requirements of NAC 695C.160.

GOALS

Goals are components of Treatment and/or Rehabilitation Plans. Goals are outcome driven. Goals are created during the treatment/rehabilitation planning process and must include the involvement and agreement of the recipient and their family/legal guardian (in the case of legal minors). Treatment/rehabilitation goals are written statements that specify anticipated treatment/rehabilitation outcomes and provide indicators of treatment/rehabilitation success. Goals must be specific, measurable (observable), achievable, realistic, and time-limited. Goals must clearly address specific behaviors and/or problems and they must evolve in conjunction with the recipient's functional progress.

GRIEVANCE

Any oral or written communications made by an enrollee, or a provider acting on behalf of a recipient with the recipient's written consent, to any of the Contractor's employees or its providers expressing dissatisfaction with any aspect of the Contractor's operations, activities or behavior, regardless of whether the communication requests any remedial actions.

GROUP CARE FACILITIES

An establishment that furnishes food, shelter, assistance and limited supervision to a person with mental retardation or with a disability or a person who is aged or infirm as defined in NRS 449.17. These are group

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homes that have provider agreements with Medicaid. These facilities are licensed by the Health Division's HCQC as Residential Facilities for Groups.

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HABILITATION SERVICES

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

HANDICAPPING LABIOLINGUAL DEVIATION INDEX (HLD)

The HLD is a scoring tool used by orthodontic providers to determine "medically necessary handicapping malocclusion" for orthodontia. A score of 26 or higher is required for Nevada Medicaid to consider reimbursement for orthodontics.

HEALTH CARE PLAN

An arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, and at least part of the arrangement consists of arranging for, or the provision of, health care services paid for by, or on behalf of, the recipient on a periodic prepaid basis (according to NRS 695C.030.4).

HEALTH CARE PROFESSIONAL

A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified register nurse anesthetist, and certified nurse midwife) licensed clinical social worker, registered respiratory therapist, and certified respiratory therapy technician. States may, at their sole discretion, expand this list to include other health care professionals.

HEALTH CARE PROVIDER

A qualified medical professional licensed in accordance with state regulation.

HEALTH CARE RECORDS

Health care records refer to any reports, notes, orders, photographs, x-rays or other recorded data or information whether maintained in written, electronic or another form which is received or produced by a physician of health care, or any person employed by him/her, and contains information relating to the medical history, examination, diagnosis or treatment of the recipient.

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HEALTH CARE SERVICES

Any services included in the furnishing to any natural person of medical or dental care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person any other services for the purpose of preventing, alleviating, curing or healing human illness or injury (according to NRS 695C.030.5).

HEALTH EDUCATION

Health education means the guidance, including anticipatory, offered to assist in understanding what to expect in terms of a child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

HEALTH MAINTENANCE ORGANIZATION (HMO)

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

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)

HEDIS consists of a standardized set of measures to assess and continuously improve the performance of MCOs and allow comparison of Contractors.

HEALTHY KIDS

Health Kids is the Nevada name for EPSDT. Please refer to definition for EPSDT.

HEARING

A hearing is an orderly, readily available proceeding before a hearing officer, which provides for an impartial process to determine the correctness of an agency action.

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HEARING OFFICER

The Hearing Officer is an impartial fact-finder who may or may not be an employee of the DHCFP. The Hearing Officer is an individual who has not been directly involved in the investigation or initial determination of the action in question.

HEARING PREPARATION MEETING (HPM)

An informal discussion facilitated by DHCFP, in attempt to resolve a dispute.

HOME AND COMMUNITY-BASED SERVICES (HCBS)

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

HOME ENVIRONMENT

The residence of the recipient whether it is the natural environment or a substitute setting.

HOME HEALTH AGENCY (HHA)

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

HOME HEALTH AIDE

A home health aide is an attendant certified by the State Board of Nursing who provides care to individuals under the supervision of a RN and in accordance with the Nurse Practice Act.

HOME HEALTH SERVICES

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

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may choose to provide. To participate in the Medicaid program, a HHA must meet the conditions of participation for Medicare.

HOMEBOUND

Recipients are considered homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation, or the assistance of another person, or if leaving the home is medically contraindicated. Nevada Medicaid does not require beneficiaries of HHA service to be homebound.

HOMEMAKER SERVICES

Services consisting of light housekeeping tasks including cleaning, laundry, essential shopping, and meal preparation.

HOSPICE

A public or private organization or subdivision primarily engaged in providing care to terminally ill individuals is Medicare certified, is licensed as a hospice in the State of Nevada by Nevada's HCQC, and has an approved provider agreement with the DHCFP.

HOSPICE HOME CARE

Formally organized services designed to provide and coordinate hospice interdisciplinary team services to recipient/family in the place of residence.

HOSPICE PROGRAM

A coordinated program of home and/or inpatient care, available 24 hours a day, that utilizes an interdisciplinary team of personnel trained to provide services to a patient/family unit experiencing a life limiting disease with a terminal prognosis.

HOSPICE SERVICES

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

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HOSPITAL

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

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IMPROPER PAYMENT

An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with:

1. the Medicaid or NCU policy governing the service provided;
2. fiscal agent billing manuals;
3. contractual requirements;
4. standard record keeping requirements of the provider discipline; and
5. federal law or state statutes.

An improper payment can be an overpayment or an underpayment. Improper payments include, but are not limited to:

6. improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits;
7. payments for ineligible recipients;
8. payments for ineligible, non-covered or unauthorized services;
9. duplicate payments;
10. payments for services that were not provided or received;
11. payments for unbundled services when an all-inclusive bundled code should have been billed;
12. payments not in accordance with applicable pricing or rates;
13. data entry errors resulting in incorrect payments; payments where the incorrect procedure code was billed (up-coding);
14. payments over Medicaid allowable amounts;
15. payments for non-medically necessary services;
16. payments where an incorrect number of units were billed;
17. submittal of claims for unauthorized visits; and

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18. payments that cannot be substantiated by appropriate or sufficient medical or service record documentation.

Improper payments can also be classified as fraud and/or abuse.

INCAPABLE CAREGIVER

A caregiver who is unable to safely manage required care due to:

1. cognitive limitations (unable to learn care tasks, memory deficits),
2. documented physical limitations (unable to render care such as inability to lift patient),
3. significant health issues with health or emotional, as documented by the caregiver's treating physician, that prevents or interferes with the provision of care.

INDEPENDENT CLINICAL LABORATORY

A clinical laboratory independent of an attending or consulting physicians' office or of a hospital that, at least, meets the requirements to qualify as an emergency hospital as defined in 1861 of the Social Security Act.

INDEPENDENT CONTRACTOR (IC)

An individual who independently contracts with the DHCFP to provide PCS to a recipient under the Self-Directed Care model. The independent contractor holds a Medicaid provider number and receives all payments from Medicaid and must meet the conditions of participation as stated in MSM Chapter 100, Chapter 2300, Chapter 2600 and in a specific provider agreement for waiver services.

INDIAN HEALTH CARE SERVICES

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

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INDIVIDUAL BUDGET

An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity. Also referred as the “Participant-Directed Budget”.

INDIVIDUAL PROGRAM PLAN (IPP)

An IPP is developed for each recipient by an IDT utilizing Person-Centered-Planning. The plan is based on accurate, comprehensive, functional assessments to identify the recipient’s needs. It includes specific, measurable objectives to meet the recipient’s needs and written programs to implement the objectives.

INDIVIDUAL PROVIDERS

Refers to an individual contracting with the DHCFP to provide AC, Homemaker, Chore, or Respite services to Nevada Medicaid recipients. The individual provider holds a Medicaid provider number and receives all payments from Medicaid. The individual provider must meet the conditions of participation as stated in MSM, Chapter 100 and Chapter 2300, and in a specific provider agreement for waiver services.

INDIVIDUAL SUPPORT PLAN (ISP)

ISP is a document and working tool that identifies:

1. the recipient’s interests;
2. personal goals;
3. health and welfare needs; and
4. agreed upon support services that are to be provided through the waiver by contracted providers.

The ISP also identifies natural supports and state plan services. The ISP is developed by the Regional Service Coordinators (Case Managers), in partnership with the recipient and their support team, who utilize approved assessment tools to identify the recipient’s interests, personal goals, health status and current skills in order to determine the level and type of service and supports required to adequately address health and welfare needs, promote skill acquisition and independence and facilitate achievement of personal goals.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

A written plan for every student receiving special education services that contain information such as the student’s special learning needs and the specific education services required for the student. The document is periodically reviewed and updated at least annually.

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INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

The federal law that mandates that a free and appropriate public education is available to all school-age children with disabilities.

INFORMED CONSENT

A hospice must demonstrate respect for a recipient's rights by ensuring that an informed consent form specifying the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the recipient or designated representative.

INHERENT COMPLEXITY

A service that by nature of its difficulty requires the skills of a trained professional to perform, monitor, or teach. This definition is used by HHA's to determine the need for skilled services and the type of provider.

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.

INPATIENT HOSPITAL SERVICES

"Inpatient hospital services" are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that:

1. is maintained primarily for the care and treatment of patients with disorders other than tuberculosis;
2. is licensed as a hospital by an officially designated authority for state standard-setting;
3. meets the requirements for participation in Medicare; and
4. has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of 42 CFR 482.30, 42 CFR 456.50-456.145 and 42 CFR 440.10

INPATIENTS

Inpatients are those individuals receiving room, board, and medical care in a general or specialty hospital or NF. Individuals living in Adult Group or Child Care Facilities are not considered inpatients. Persons who are bedfast and receiving home health care in a private residence are not considered inpatients.

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INSTITUTIONAL STATUS

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

INSTITUTIONS FOR MENTAL DISEASES (IMDs)

A hospital, NF or institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMDs is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such (42 CFR 435.1009). In Nevada, IMDs are commonly referred to as “psychiatric hospitals.”

Nevada Medicaid only reimburses for services to IMD/psychiatric hospital patients who are age 65 or older, or under age 21.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient’s level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of Needs Determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient’s clinical status.

These components include:

1. A comprehensive assessment of the recipient’s level of functioning;
2. The clinical judgment of the QMHP; and
3. A proposed Treatment and/or Rehabilitation Plan.

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INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved LOC utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse. Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.
2. Intensity of Need for Children:

Child and Adolescent Service Intensity Instrument (CASII)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	• Significant Life Stressors and/or V-code Diagnosis that does not meet SED criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Outpatient Services	• DSM Axis I Diagnosis that does not meet SED criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less.
Level III Intensive Outpatient Services	• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED Determination
Levels IV Intensive Integrated Services	• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED Determination
Level V Non-secure, 24 hour Services with Psychiatric Monitoring	• DSM Axis I Diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED determination; and • Requires specialized treatment (e.g., sex offender treatment, etc).

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Level VI Secure, 24 hour, Services with Psychiatric Management	• DSM Axis I Diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR - GAS score of 40 or less; and • SED determination; and • Requires inpatient/secured LOC.
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3. Intensity of Needs for Adults:

Level of Care Utilization System for Adults (LOCUS)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	• DSM Axis I diagnoses, including “V” codes, that do not meet SMI criteria (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Low Intensity Community Based Services	• DSM Axis I diagnoses, including “V” codes that do not meet SMI criteria (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level III High Intensity Community Based Services (HCBS)	• DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination
Levels IV Medically Monitored Non-Residential Services	• DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination
Level V Medically Monitored Residential Services	• DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc).
Level VI Medically Managed Residential Services	• DSM Axis I diagnosis (excluding “V” codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.

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INTERDISCIPLINARY GROUP

A group of qualified individuals with expertise in meeting the special needs of hospice recipients and their families. This group must consist of but is not limited to the following:

1. Physician;
2. RN;
3. Social worker; and
4. Pastoral or other counselor.

INTERDISCIPLINARY TEAM (IDT)

The IDT is comprised of professionals, and when appropriate paraprofessionals and non-professionals, who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the recipient's needs and design appropriate services and specialized programs responsive to these needs.

The IDT, which evaluates the recipient and develops, reviews, and revises the POC, must include:

1. a physician;
2. a RN;
3. at least one member of the IDT must be a QMRP; and
4. other professionals, as appropriate, to develop and review the plan. The other professions which may be represented on the IDT include a:
 - a. physical or occupational therapist;
 - b. social worker;
 - c. recreation therapist;
 - d. educator or vocational counselor;
 - e. speech - language pathologist;
 - f. dietician;
 - g. psychologist;

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- h. psychiatrist;
- i. dentist;
- j. pharmacist; or
- k. Direct care staff.

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

An ISO is an entity that contracts with DHCFP to provide PCS under the Self-Directed Care model. The ISO acts as an employer of record, providing both fiscal and supportive intermediary services such as administrative, limited program and specific payroll responsibilities for the delivery of PCS.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)

An institution (or distinct part of an institution), which is primarily for the diagnosis, treatment, or rehabilitation for persons with mental retardation or a related condition. In a protected residential setting, an ICF/MR facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health and rehabilitative services to help individuals function at their home.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) LEVEL OF CARE (LOC)

ICF/MR means an establishment operated and maintained to provide 24-hour personal and medical supervision for a person who does not have illness, disease, injury or other condition that would require the degree of care and treatment which a hospital or facility for skilled nursing is designed to provide. Persons in this facility must have a diagnosis of mental retardation or a condition related to mental retardation. This LOC identifies if an individual's total needs are such that they could be routinely met on an inpatient basis in an ICF/MR.

INTERMEDIATE CARE SERVICES FOR THE MENTALLY RETARDED

Health and rehabilitative services provided to a mentally retarded person or person with a related condition. The services are certified as needed and provided in a licensed inpatient facility.

INTERMITTENT SERVICES

Social Security Act section 1814(a)(2)(c) and 1835(a)(2)(a) defines intermittent services as to skilled nursing and home health aide care that is either provided or needed on fewer than seven (7) days per week, or less than eight (8) hours each day for a period of 21 days or less and 28 or fewer hours each week.

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INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)

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

INTERPERIODIC

Interperiodic means at intervals other than those indicated in the periodicity schedule.

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KICKBACKS

The offering or receiving of any payments or incentives by/from a provider for referring patients, including illegal cash reimbursements, vacations, merchandise, or personal services. (NRS 422.560)

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LEAD CASE MANAGER

The Lead Case Manager is only used if a recipient is included in more than one target group at a given time. The Lead Case Manager is a case manager, and represents Severely Emotionally Disturbed (SED) children and adolescents or Seriously Mentally Ill (SMI) adults. The Lead Case Manager coordinates the recipient's care and services with another case manager. The lead case manager is responsible for coordinating the additional case management services, whether or not, chronologically, the lead case manager was the original or the subsequent case manager.

LEAST RESTRICTIVE SETTING

The least confining, most normative environment possible, which is individualized to the recipient and does not subject the individual to unnecessary health or safety risks. Services are delivered with the least amount of intrusion, disruption, or departure from the individual's typical patterns of living that most support the person's level of independence, productivity, and inclusion in the community.

LEGAL BLINDNESS

Legal blindness is defined in state law as:

1. Visual acuity with correcting lenses of worse than 20/200 in the better eye; or
2. Field of vision subtending an angle of less than 20 degrees in the better eye.

LEGAL REPRESENTATIVE FOR SELF-DIRECTED SKILLED CARE

For the purposes of Self-Directed Skilled Care, a Legal Representative has the meaning defined in Section 6 of NRS 629.091.

1. "Parent", "Guardian" or any other person legally responsible for a minor child with a disability who is under the age of 18 years; or
2. A parent, spouse, guardian or adult child of a person aged 18 and older with a disability who suffers from a cognitive impairment.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support including: spouses of recipients, legal guardians, and parents of minor recipients, including: stepparents, foster parents and adoptive parents.

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LEGEND DRUGS

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

LEVEL I IDENTIFICATION SCREENING

Level I Identification screening is the initial screening assessment conducted in the PASRR program. It is used to identify individuals suspected of serious mental illness, mental retardation and/or related conditions. Every NF applicant, regardless of payer source, must be screened prior to admission to a NF.

LEVEL OF CARE (LOC) - HOSPICE

The LOC determines the reimbursement for each day the recipient is enrolled in a hospice benefit. Each day of hospice care is classified into one of four levels:

1. Routine Home Care – A day on which an individual who has elected to receive hospice care is in a place of residence, this includes individuals residing in a NF and is not receiving continuous care as defined.
2. Continuous Home Care – A day on which an individual who has elected to receive hospice care is not an inpatient facility and receiving hospice care consisting predominantly of nursing care.
3. Inpatient Respite Care – A day on which an individual who has elected hospice care receives care in an approved facility on a short-term basis only when necessary to relieve the family members or other persons caring for the individual at home.
4. General Inpatient Care – A day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

LEVEL OF CARE (LOC) SCREENING

The process that is used to determine if an individual’s total needs and condition are such that they require the level of services offered in a NF. The LOC instrument documents the requirement that the individual have at least three (3) functional deficits and would require imminent placement in a NF (within 30 days) if HCBW services or other supports were not available. The LOC screening instrument and procedures utilized for admission to NFs are the same as utilized for admission into a 1915(c) HCBW.

LICENSURE

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

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LIGHT HOUSEKEEPING

Light housekeeping means performing or helping the recipient to perform minor cleaning tasks. Examples of light housekeeping tasks include, but are not limited to, changing bed linens, washing dishes, vacuuming and dusting.

LOCAL EDUCATION AGENCY (LEA)

A public elementary or secondary school, or unit school district, or special education cooperative or joint agreement.

LOCK-OUT

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

LONG-TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL

LTAC facilities are hospitals that specialize in acute care for medically complex patients, i.e., multi-system complications and/or failures that require extended hospitalization, specialized programs and aggressive clinical and therapeutic interventions. Specialty hospitals generally do not provide surgical, obstetric or psychiatric services. LTAC hospitals must comply with state and federal licensing requirements. This applies to both free-standing and hospital based units.

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MAINTENANCE DRUG

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

MAINTENANCE THERAPY

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

MAMMOGRAPHY

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

MANAGED CARE

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

MANAGED CARE ORGANIZATION (MCO)

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

MANAGED HEALTH PLAN

Provides one or more products which:

1. integrate financing and management with delivery of health care services to an enrolled population;
2. employ or contract with an organized provider network which delivers services and (as a network or individual provider) shares financial risk or has some incentive to deliver quality, cost-effective services; and

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

MANAGING EMPLOYER

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

MARKETING

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

MARKETING MATERIALS

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

MATERNITY KICK PAYMENT (SOBRA)

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

MAXIMUM ALLOWABLE COST (MAC)

MAC is the lower of the cost established by:

1. CMS for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927(f)(2) of the Act; or
2. DHCFP for multiple source drugs under the State Maximum Allowable Cost (SMAC).

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

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

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MEDICAID BILLING NUMBER (BILLING NUMBER)

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

MEDICAID ESTATE RECOVERY (MER)

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

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

MEDICAL CARE ADVISORY COMMITTEE (MCAC)

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

MEDICAL CARE PLAN

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

MEDICAL DIRECTOR

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

MEDICAL DOCUMENTATION

For the purposes of obtaining DMEPOS through Nevada Medicaid and NCU, medical documentation used to support medical necessity is part of a medical record which is completed, signed and dated by a licensed medical professional. Clinical reports or assessments required to support medical necessity must be from a licensed/certified professional performing within their scope of practice. Information used as medical documentation cannot be compiled or composed by the recipient, their relatives or representatives.

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MEDICAL EMERGENCY

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

MEDICAL HOME

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

MEDICAL SUPERVISION

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

MEDICAL SUPERVISOR

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

MEDICAL TRANSPORTATION

Transportation is any conveyance of a Medicaid recipient to and from providers of medically necessary Medicaid covered services, or medical services that Medicaid would cover except for the existence of prior resources such as Medicare, Veterans' coverage, workers' compensation, or private health insurance.

MEDICARE SAVINGS PROGRAM

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

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2. QMBs with full Medicaid (QMB Plus) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less, resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.
3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.
4. Qualified Disabled and Working Individuals (QDWIs) - These individuals no longer have Medicare Part A benefits due to a return to work. However, they are eligible to purchase Medicare Part A benefits if they have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.
5. Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2), these individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down their resources to qualify for Medicaid or meet the requirements for a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services received from Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a state option; however, states may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

MEDICOACH, MEDIVAN, MEDICAR

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

MENTAL HEALTH AND DEVELOPMENTAL SERVICES (MHDS)

MHDS is a State agency that is part of the Nevada DHHS. MHDS is the operating agency for the HCBW for Persons with Mental Retardation and Related Conditions.

MENTAL HEALTH SERVICES

Mental health services are those techniques, therapies, or treatments provided to an individual who has an acute, clinically identifiable psychiatric disorder for which periodic or intermittent treatment is recommended, as

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identified in DSM-IV of mental disorders. These techniques, therapies, or treatments must be provided by a QMHP. Mental health services are provided in a medical or in a problem-oriented format that includes an assessment of the problem, limitations, a diagnosis, and a statement of treatment goals and objectives, recipient strengths and appropriate community based resources. Treatment should generally be short term and goal oriented or, in the case of chronic disorders, intermittent and supportive and rehabilitative.

MENTAL HEALTH SPECIAL CLINICS

These are public or private entities that provide:

1. outpatient services, including specialized services for children, the elderly, individuals who are experiencing symptoms relating to DSM-IV diagnosis or who are mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment;
2. 24-hour per day emergency care services; and
3. screening for recipients being considered for admission to inpatient facilities.

MENTAL RETARDATION

Mental retardation means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period prior to age 18. A diagnosis of mental retardation is made based on commonly used standardized tests of intelligence and standardized adaptive behavior instruments.

MENTALLY INCOMPETENT INDIVIDUAL

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

MILEAGE REIMBURSEMENT

Car mileage is reimbursement at a per mile rate, paid when appropriate and approved by the NET broker for the transport of an eligible recipient to a covered service. Reimbursement will be at the Internal Revenue Service (IRS) rate for medical/moving mileage reimbursement unless otherwise agreed to in writing by DHCFP.

MINIMUM DATA SET (MDS)

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

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MINIMUM ESSENTIAL PERSONAL ASSISTANCE

The assistance of a person with a severe functional disability for six (6) hours or less per day in eating, bathing, toileting, dressing, moving about and taking care of himself, as defined in NRS 426.723.

MOLDED TO PATIENT MODEL ORTHOSIS

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

MULTIDISCIPLINARY CONFERENCE (MDC)

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

MULTIPLE SLEEP LATENCY TEST (MSLT)

The MSLT is a standardized and well-validated measure of physiologic sleepiness. The same parameters as for basic Polysomnography (PSG) are monitored. The MSLT consists of 4-5 twenty-minute nap opportunities offered at two-hour intervals. To insure validity, proper interpretation of the MSLT can only be made following a polysomnogram that was performed the preceding night.

MULTIPLE SOURCE DRUGS

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

1. are rated as therapeutically equivalent (under the Food and Drug Administration's (FDA) most recent publication of "Approved Drug Products with Therapeutically Equivalence Evaluations");
2. except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the FDA; and
3. are sold or marketed in the State during the period.

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NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

The NCPDP, Inc. is a not-for-profit Standards Developmental Organization representing the pharmacy services industry.

NATIONAL DRUG CODE (NDC)

The NDC is a unique three segment number assigned to each medication listed under Section 510 of the U.S. Federal Food, Drug, and Cosmetic Act. The first segment identifies the drug manufacturer, the second segment identifies the product, and the third segment identifies the package size.

NEUROLOGY

Neurology is the branch of medicine dealing with the nervous system.

NEVADA DIVISION OF WELFARE AND SUPPORTIVE SERVICES (DWSS)

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

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

NEVADA HEALTH NETWORK (NHN)

DHCFP's official name for its collective Managed Care Programs.

NEVADA MEDICAID OFFICE (NMO)

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

NEVADA REVISED STATUTES (NRS)

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

NON-DIRECT CARE COMPONENT

Non-direct care component means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

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NON-EMERGENCY TRANSPORTATION (NET)

NET is any conveyance service that can be scheduled ahead of time which is necessary to convey an eligible program recipient to and from covered medical services. The recipient has the duty to use the least expensive alternative conveyance and the nearest appropriate Medicaid health care provider or medical facility.

Conditions exist for non-emergency medical transportation when a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would not place the health of the individual in serious jeopardy or cause serious impairment to a bodily organ or part.

NON-EMERGENCY TRANSPORTATION (NET) BROKER

The NET broker contracts with individual transportation companies and volunteer drivers who provide transportation for Nevada Medicaid and NCU recipients. The NET broker manages, authorizes, and coordinates NET services for Medicaid recipients. The NET broker also provides various utilization management reports to the DHCFP for Quality Assurance (QA) purposes. The NET broker does not perform the transportation services. The NET Broker may not have an ownership interest in a subcontractor for whom the broker is setting reimbursement rates.

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.

NOTICE OF DECISION (NOD)

A DHCFP document which provides federal due process notice to a recipient of a reduction, suspension, termination or denial of Medicaid covered services or Waiver program eligibility.

NURSING FACILITY (NF)

NF is a general NF, free-standing or hospital-based, which is licensed and certified by the Health Division, HCQC, and provides both skilled and intermediate nursing services.

NURSING FACILITY (NF) SERVICES FOR INDIVIDUALS AGE 21 AND OLDER

NFs are institutions, which primarily provide:

1. skilled nursing care and related services for residents who require:
 - a. medical or nursing care;

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

2. NF services for individuals age 21 and older is a mandatory Medicaid benefit.

NURSING FACILITY (NF) TRACKING FORM

The NF Tracking Form is the form used as a notification for all NF admissions, service level updates, new or retro-eligibility determinations, Hospice enrollment or disenrollment, Medicaid Managed Care disenrollment, discharges and deaths. The information provided on this form is used in determining how and when a NF will be paid for services rendered.

NURSING SERVICES

Nursing services, as provided by a HHA, are intermittent skilled and non-skilled services, which are based on a physician's order, administered by a RN or a LPN, or certified home health aide under the supervision of a RN employee of the certified HHA.

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OBJECTIVES

Objectives are benchmarks to measure progress towards treatment and/or rehabilitation goals. Objectives specify the steps that must be taken/achieved in order to reach treatment and/or rehabilitation goals. Objectives must be specific, measurable (observable), achievable, realistic, and time-limited. Objectives must clearly address specific behaviors and/or problems and they must evolve in conjunction with the recipient's functional progress.

OCCUPATIONAL THERAPIST

Occupational therapist means a person who is licensed pursuant to NRS 640A to practice occupational therapy prescribed by a physician. The prescribed service must be of such a level of complexity and sophistication that only a qualified occupational therapist can provide it.

OCCUPATIONAL THERAPY

Occupational Therapy means "the application of purposeful activity in the evaluation, teaching and treatment, in groups or on an individual basis, of patients who are handicapped by age, physical injury or illness, developmental or learning disability. Intervention techniques are necessary to increase their independence, alleviate disability and promote optimal health."

OCCUPATIONAL THERAPY ASSISTANT (OTA)

OTA means a person who is licensed under the provision of NRS 640A.060 to practice occupational therapy under the direct supervision of a qualified occupational therapist within the scope of practice allowed by state law. The qualified OTA is not recognized as an independent Medicaid provider.

OCULAR SERVICES

Ocular services include refractive examinations with a prescription for corrective lenses, and fitting and provision of corrective lenses. Ocular services also include the medical diagnostic examination of the eyes performed by either an optometrist (within their scope of services) or an ophthalmologist.

OCULARIST

Ocularist refers to a person skilled in measuring, fitting, and dispensing prosthetic eyes.

OMNIBUS BUDGET RECONCILIATION ACT (OBRA) 90 DRUG REBATE

Created by the OBRA of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the DHHS for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). The law was amended by the Veterans Health Care Act of 1992 which also requires a drug manufacturer to enter into discount pricing agreements with the Department of

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Veterans Affairs and with covered entities funded by the Public Health Service in order to have its drugs covered by Medicaid.

OPHTHALMOLOGIST

Ophthalmologist refers to a physician, licensed by the state in which he/she practices, who limits his/her practice to the science dealing with the structure, functions, and diseases of the eye. In addition to the use of medication and surgical techniques, the provider may prescribe optical instruments and corrective lenses, and may or may not dispense such items.

OPTICIAN

Optician refers to a person licensed by the state in which the provider operates as a maker or dealer in optical items and instruments (to include spectacle lenses) and who may construct such items and instruments to prescription. The provider does not perform ocular examinations, but may dispense optical aids to the patient.

OPTOMETRIST

Optometrists are licensed by the state and skilled in the art and science of examining the eye for visual defects or faults of refraction and in prescribing, fitting, and adapting corrective lenses and/or exercises to correct such faults or defects. Optometrists may construct correctional eyeglasses and dispense such aids. The optometrist may also prescribe or direct the use of pharmaceutical agents to treat an abnormality of the eye or its appendages; remove a foreign object from the eye; or order laboratory tests to assist in the diagnosis of an abnormality of the eye or its appendage.

ORTHOSIS

An orthosis (brace) is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. An orthosis can be either prefabricated or custom-fabricated.

OUT-OF-NETWORK PROVIDER

These are certain types of providers with whom formal contracts may not be in place with the Contractor. However, the Contractor benefit package includes Medicaid services for which the Contractor will reimburse for specific services. The Contractor must, at a minimum, pay qualified out-of-network providers for family planning, emergency services, out-of-network obstetrical and gynecological providers for recipients within the last trimester of pregnancy, and prior-authorized specialty services rendered to its recipients at the rate paid by DHCFP according the Medicaid FFS rate schedule.

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OUTPATIENT SERVICES

Outpatient services are those medically necessary services provided for the diagnosis and/or treatment of an illness or disease for which the patient will not require care in a facility for more than 24 hours. Services are provided in variety of settings that include, but are not limited to: the office/clinic, home, institution and outpatient hospital.

OVERPAYMENT

Any payments made by Medicaid for goods or services provided which are later determined to be excessive, based upon fraudulent claims, or the result of improper billing practices.

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PALLIATIVE CARE

Care that relieves or alleviates significant dental pain or bleeding or infection. See section 1003.9 for list of accepted dental codes for persons 21 years of age and older.

PALLIATIVE SERVICES

Comfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness. Palliative or symptomatic therapy is treatment directed toward controlling symptoms and maintaining comfort.

PARATRANSIT

Paratransit is a shared-ride program providing transportation for eligible people with disabilities of all ages who are unable to use fixed-route, fixed-schedule conventional public transportation. Paratransit services may be designated “curb to curb,” or “door-to-door.”

PARENT

1. natural, adoptive, or foster parent of a child (unless a foster parent is prohibited by State Law from serving as a parent);
2. a guardian, but not the State if the child is a ward of the State;
3. an individual acting in the place of a natural or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives; or
4. an individual who is legally responsible for the child’s welfare.

PART TIME

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

PARTICIPANT-DIRECTED BUDGET

An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity, sometimes called the individual budget, as identified in the ISP.

PARTICIPANT DIRECTION

The opportunity for a waiver participant to exercise choice and control in identifying, accessing and managing waiver services and other supports in accordance with their needs and personal preferences.

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PATIENT LIABILITY (PL)

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

PAYMENT AUTHORIZATION REQUEST (PAR)

A PAR also referred to as a request for Prior or Post Authorization, is a request a provider or recipient submits to the NET broker for payment of transportation to a Medicaid-reimbursable service. The NET broker may require verification that the DHCFP's QIO-like vendor or contracted MCO has authorized the medical service.

PERFORMANCE INDICATORS

Performance indicators are preset criteria which involve the recipient or provider and show the outcomes and impact level of Contract performance on specified sets of the population.

PERIOD OF CRISIS

A period in which the recipient requires continuous care to achieve palliation or management of acute medical symptoms.

PERIODIC

Periodic means at intervals established for screening by medical, dental, and other health care providers to detect disease or disability that meet reasonable standards of medical practice. The procedures performed and their frequency will depend upon the child's age and health history.

PERM REVIEW ERRORS

These are payment errors discovered during the course of PERM medical record, processing or eligibility reviews.

PERSON-CENTERED TREATMENT PLANNING

Joint planning with a recipient and their family (when appropriate) of treatment services and interventions for the amelioration of symptoms of mental health needs which prohibit effective functioning. Recipient and family involvement in treatment planning must be documented on the Treatment Plan and/or Rehabilitation Plan, when the plan is reviewed every 90 days and at anytime the plan is revised.

PERSON WITH MENTAL RETARDATION OR A RELATED CONDITION

42 CFR, Section 483.102(b)(3) states an individual is considered mentally retarded if he or she has a level of retardation (mild, moderate, severe or profound). A person with mental retardation demonstrates significant sub-

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average general intellectual functioning resulting in, or associated with, concurrent limitations in two or more adaptive skills areas which are manifested during the developmental period prior to age 18 years.

As defined in 42 CFR, Section 435.1009, "persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:

Attributable to:

1. Cerebral palsy or epilepsy; or any other condition, other than mental illness, closely related to mental retardation, resulting in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requiring similar treatment and services.
2. Manifested before the person reaches age 22 years.
3. Likely to continue indefinitely.
4. Results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care;
 - b. Understanding and use of language;
 - c. Learning;
 - d. Mobility;
 - e. Self-direction; or
 - f. Capacity for independent living.

PERSONAL CARE ATTENDANT (PCA) SERVICES

Services provided to eligible recipients whose chronic health problems cause them to be functionally limited in performing ADL and IADLs. PCS may be furnished to an individual who is not an inpatient or resident of a hospital, NF, ICF/MR or IMD.

PERSONAL CARE REPRESENTATIVE (PCR)

A PCR is an individual who is directly involved in the day-to-day care of a recipient and is available to direct care in the home. This individual acts on behalf of the recipient for both skilled and unskilled services when the recipient is unable to direct his or her own personal care service(s). A PCR must be a responsible adult.

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Services must be done in the presence of the LRI if the recipient is unable to direct their own care, as in the case of a minor child or a cognitively impaired adult in accordance with NRS 629.091.

PERSONAL CARE SERVICES (PCS)

Services performed in accordance with a written service plan approved by the DHCFP, or its designee, developed in conjunction with the recipient, or the representative, and based on the needs of the recipient being served as determined by a functional assessment. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task, and relates to the performance ADLs and IADLs.

PCS may be provided in the home, or locations outside the home, including employment sites, or wherever the need for PCS occurs. The time authorized for services is documented in the approved service plan, regardless of the location of services.

PCS is an optional state plan service.

PERSONAL CARE SERVICES (PCS) FUNCTIONAL ASSESSMENT (FA)

The PCS FA is an assessment process that identifies the ability/inability of a recipient to perform ADLs and IADLs. The FA also evaluates the environment in which services are provided and the availability of support systems.

PERSONAL CARE SERVICES (PCS) PROVIDER AGENCY

An entity that contracts with DHCFP to provide PCS under a standard agency-based care delivery model. The Provider Agency is the managing employer providing the administrative, payroll, supervision and program responsibilities for the delivery of PCS.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

An electronic medical alert device, worn as a necklace, wristwatch or belt clip, that allows an individual at high risk of falling to secure help in case of an emergency by pushing a button on the device which dials the phone remotely. This system alerts the person or agency designated by the individual that an emergency has occurred and that the individual needs emergency assistance.

PERSONAL NEEDS ALLOWANCE

Personal Needs Allowance is the amount of money deducted from the recipient's monthly income when the cost of care is calculated. The personal needs allowance is \$35.00 per month and is intended for the exclusive use of the recipient as he/she desires for personal items such as clothing, cigarettes, hair styling, etc.

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PHARMACEUTICALS

Pharmaceuticals are any drug, compound, mixture, or preparations which the U.S. FDA 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.

PHARMACY AND THERAPEUTICS (P & T) COMMITTEE

P & T Committee is established under NRS. The P&T Committee is comprised of physicians and pharmacist to:

1. identify the prescription drugs that are included or excluded on the preferred drug list for Title XIX and Title XXI programs;
2. identify the therapeutic classes for review and clinical analysis; and
3. review at least annually the therapeutic classes on the preferred drug list.

PHYSICAL DISABILITY

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

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

PHYSICAL EVALUATION

An evaluation completed by a physician to evaluate an individual's complete medical history.

PHYSICAL THERAPIST

Physical therapist means a person who is licensed in accordance with NRS 640 to provide rehabilitative services to promote the highest potential of restorative function for individuals. The level of complexity and

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sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or PTA under their supervision.

PHYSICAL THERAPY

Physical Therapy means the specialty in the field of health which is concerned with prevention of disability and/or physical rehabilitation of persons having congenital or acquired disabilities due to illness or injury.

PHYSICAL THERAPY ASSISTANT (PTA)

A qualified PTA is a graduate of a program approved by the Physical Therapy Board, and is licensed as a PTA under the provision of NRS 640.260. The qualified PTA is not recognized as a Medicaid provider. Services must be provided under the direct supervision of a qualified physical therapist within the scope of practice allowed by the state law.

PHYSICIAN ASSISTANT

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

PHYSICIAN OFFICE LABORATORY

A clinical laboratory set up for the sole purpose of performing diagnostic tests for recipients in connection with the physician's practice.

PHYSICIANS IN TEACHING HOSPITALS

Medicaid adheres to Medicare rules in effect beginning July 1, 1996 as they relate to a physician in a teaching hospital responsible for supervising residents. The physician does not have to meet the definition of "attending physician" in order to be considered rendering billable services but rather the physician must be present during the "key portion" of the service or procedure provided by the resident. Physicians in teaching hospitals must be enrolled Medicaid physicians.

PICTURE DATE

Picture Date is a "snapshot" of residents' MDS data in Nevada's free-standing NFs and is collected for rate-setting purposes. A CMI report is generated based on the picture date which is the first day of each calendar quarter (January 1, April 1, July 1 and October 1).

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PLAN OF CARE (POC)

A written document identifying the recipient's health and welfare needs, along with goals and interventions to meet the identified needs. It specifies the amount, duration, frequency and type of provider for all services, as well as other ongoing community support services that may meet the assessed needs of the recipient, regardless of the funding source.

PLAN OF CORRECTION

A detailed written plan describing the actions and/or procedures to remedy deviation from the stated standard(s) or contractual and/or legal mandates.

POINT OF SALE (POS)

POS 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.

POLYSOMNOGRAM/POLYSOMNOGRAPHY (PSG)

PSG is the continuous measurement and recording of physiological activities during sleep. During PSG several parameters are recorded to establish a diagnosis or rule out sleep apnea, narcolepsy, and other sleep disorders. The studies are also performed to evaluate a patient's response to therapy, such as Continuous Positive Airway Pressure (CPAP). PSG is distinguished from sleep studies by the inclusion of sleep staging which is defined to include a 1-4 lead electroencephalogram (EEG), an electro-oculogram (EOG) and a submental electromyogram (EMG). Sleep must be recorded and staged, and must be attended.

POST-STABILIZATION SERVICES

Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

PRACTITIONER OF RESPIRATORY CARE

Practitioner of respiratory, per NRS 630.023, care means a person who is certified to engage in the practice of respiratory care by the National Board for Respiratory Care or its successor organization and licensed by the board of medical examiners.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

PASRR is a federally mandated program to determine whether NF applicants and residents require NF services and specialized services. Congress developed the PASRR program to prevent inappropriate admission and retention of people with mental disabilities in NFs.

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PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) LEVEL II

PASRR Level II is the evaluation conducted when the Level I Identification screen indicates the individual may have a mental illness, mental retardation or related condition. PASRR Level II determines whether the individual requires NF services and specialized mental health services.

PREFABRICATED ORTHOSIS

Pre-fabricated orthosis is one which is manufactured in quantity without a specific patient in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

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.

PREGNANCY RELATED SERVICES

Pregnancy related services are those medically necessary Medicaid covered dental services provided to women to promote the woman and child's systemic well being. Pregnancy related dental services offer expanded dental services in addition to the adult dental services described in MSM Chapter 1000. These expanded services require PA. Refer to the fee schedule, provider type 22, for a list of covered pregnancy related services.

PREPAID BENEFIT PACKAGE

The set of health care-related services for which plans will be capitated and responsible to provide.

PRESENT LEVELS OF EDUCATIONAL PERFORMANCE

An evaluation and a summary statement which describes the student's current achievement in the areas of need; an IEP required component.

PRIMARY CARE CASE MANAGEMENT (PCCM)

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

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enrolled, except in an emergency, for obtaining primary care and for authorization to receive certain other services.

PRIMARY CARE PROVIDER (PCP)

Physicians who practice general medicine, family medicine, general internal medicine, general pediatrics, or osteopathic medicine. Physicians who practice obstetrics and gynecology may function as PCPs for the duration of the health plan member's pregnancy.

PRIMARY CARE SITE (PCS)

A location, usually a clinic, where a recipient chooses to access primary health care. The recipient's medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the recipient's medical needs.

PRIMARY CAREGIVER

The person designated by the recipient or representative. This person may be family, an individual who has personal significance to the recipient but no blood or legal relationship, such as a neighbor, friend, significant other, or other person. The primary caregiver assumes responsibility for care of the recipient as needed. If the recipient has no designated primary caregiver the hospice may, according to individual program policy, make an effort to designate a primary caregiver. The primary caregiver is not eligible for Medicaid reimbursement.

PRIMARY DIAGNOSIS

The primary diagnosis is the diagnosis based on the condition that is most relevant to the current POC. Primary diagnosis is the first listed diagnosis for claims submission.

PRIOR AUTHORIZATION (PA)

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

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

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

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PRIOR RESOURCES

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

PRIVATE DRIVERS

Individual(s) who provide transportation of an eligible recipient to a covered service and without compensation. A private driver may be a relative, friend, neighbor or other individual willing and qualified to provide the transportation. Since there is no compensation and no contract with the NET broker, no authorization is needed for a private driver to provide the transportation. Private drivers differ from “Volunteer Drivers” in that volunteer drivers are not contracted with the NET broker but may be compensated.

PRIVATE DUTY NURSING (PDN) SERVICES

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

1. by a RN or a LPN;
2. under the direction of the recipient's physician; and
3. at the state’s option, to a recipient in one or more of the following locations:
 - a. his or her own home;
 - b. a hospital; or
 - c. an NF.

PROCEDURE CODE

A code used for billing purposes which identifies services rendered.

PROFESSIONAL MANAGEMENT RESPONSIBILITY

The hospice retains professional management responsibility for services including those provided by another individual or entity and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of CFR 418.56 and in accordance with the recipient’s POC.

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PROGRAM POLICY

Program policy refers to all relevant doctrine including federal regulations, NRS, Medicaid and NCU State Plan, Medicaid and NCU Services Manual and Bulletins and Medicaid's interpretation of its policy.

PROGRESS

The movement toward treatment goals utilizing established criteria as written in the Treatment Plan.

PROGRESS MONITORING

A method of monitoring a student's achievements that enables the IEP team to discern whether changes need to be made in the IEP.

PROGRESS NOTE

The written documentation of the treatment, services or services coordination provided which reflects the progress, or lack of progress towards the goals and objectives of the Treatment and/or Rehabilitation Plan(s). All progress notes reflecting a billable Medicaid mental health service must be sufficient to support the services provided and must document the amount, scope, duration and provider of the service. Progress notes must be completed at least monthly and at anytime there is a substantial change in the recipient's clinical status.

PROSPECTIVE DRUG UTILIZATION REVIEW (PRO-DUR)

PRO-DUR encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening.

PROSTHETIC DEVICES

Prosthetic devices are replacement, corrective, or supportive devices prescribed by a physician (or other licensed practitioner of the healing arts within the scope of his practice as defined by state law) to:

1. artificially replace a missing portion of the body;
2. prevent or correct physical deformity or malfunction; or
3. support a weak or deformed portion of the body (as defined by 42 CFR 440.120(c)).

For Nevada Medicaid's DMEPOS program purposes, dentures and eyeglasses are not included as a prosthetic device.

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PROVIDER

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

PROVIDER DISPUTE

A request to the Contractor by any provider who provides services to Medicaid or NCU recipients for the Contractor to review and make a decision to change or uphold a Contractor decision regarding, but not limited to:

1. quality of plan service;
2. policy and procedure issues;
3. denied claims;
4. claim processing time; or
5. other disputes.

PROVIDER EXCLUSION

Refers to an action taken by the federal Office of the Inspector General (OIG) of the United States DHHS, which prohibits individual practitioners and/or providers from participating in providing services under and submitting claims for such services for reimbursement from any and all federally funded health care programs. An exclusionary action by the OIG is immediate grounds for termination of a state Medicaid Provider Agreement and offers no opportunity for hearing with Nevada Medicaid.

PROVIDER RESPONSIBILITY

In order to assure that services are rendered to the qualifying recipient, providers should take steps to verify the eligibility and identity of the recipients. Such steps may include checking for valid Medicaid and NCU eligibility and check the recipient's identification.

PRUDENT LAYPERSON

A person who possesses an average knowledge of health and medicine, who could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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PSYCHOLOGICAL TESTING

The administration, evaluation and scoring of standardized tests which may include the evaluation of:

1. intellectual functioning;
2. mental health strengths and needs;
3. diagnosis(ses);
4. psychodynamics;
5. mental health risks;
6. insight;
7. motivation; and
8. other factors influencing treatment and outcomes.

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QUALIFIED MEDICARE BENEFICIARY (QMB)

QMB's without other Medicaid (QMB Only) – these individuals are entitled to Medicare Part A, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any Medicare Part B premiums, and to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Medicare does not cover dental services.

QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)

A QMRP is a person who has one or more years experience in working with persons with mental retardation and is from one of the following professions:

1. A psychologist with a master's degree from an accredited program. A psychologist who is hired or subcontracted with after July 1, 1986 must be certified by the Nevada State Board of Psychological Examiners.
2. A doctor of medicine or osteopathy licensed in Nevada.
3. A professional dietician who is eligible for registration by the American Dietetics Association.
4. A social worker licensed by the Nevada State Board of Examiners for Social Workers.
5. An occupational therapist who has a current registration issued by the American Occupational Therapy Association or another comparable body.
6. A physical therapist who has a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners.
7. A speech pathologist or audiologist who is licensed by the State of Nevada Board of Audiology and Speech Pathology and has a current certificate of clinical competence issued by the American Speech and Hearing Association or another comparable body.
8. An RN licensed in Nevada.
9. A professional recreation specialist who has a Bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.
10. A human services professional who has at least a Bachelor's degree in a human services field (including but not limited to: sociology, special education, rehabilitation counseling, and psychology).

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QUALIFIED PERSONAL CARE ASSISTANT (PCA)

A PCA who is in compliance with all requirements at the time services were provided and reimbursed by Medicaid.

QUALIFIED RECIPIENTS

Medicaid recognizes a qualified recipient to be one who is currently eligible for full Medicaid services and meets the criteria of coverage and limitations for services.

QUALIFYING SERVICE

Qualifying service refers to a service that meets the DHCFP's requirements for "skilled care" or authorized home health aide services to be admitted for reimbursed HHA services, a recipient must require medically necessary skilled nursing services, physical therapy services, speech therapy services, occupational therapy services, respiratory therapy services, dietician service or certified home health aide.

QUALITY ASSURANCE (QA)

A structured, internal monitoring and evaluation process designed to improve quality of care. QA involves the identification of quality of care criteria, which establishes the indicators for program measurements and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

QUALITY IMPROVEMENT

A continuous process that identifies problems in organizational systems, including health care delivery systems which tests solutions to those problems and constantly monitors the solutions for improvement.

QUALITY IMPROVEMENT ORGANIZATION (QIO)-LIKE VENDOR

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

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

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RADIOLOGIC TECHNOLOGIST

A Radiological Technologist is an individual trained in the use of radioactive materials and operation of associated equipment designed for purposes of diagnosis and treatment of the human body.

RADIOLOGIST

A Radiologist is a physician who specializes in radiological medicine.

RADIOLOGY

Radiology is the branch of medicine concerned with radioactive substances. Various techniques of visualization using radiant energy are used for diagnosis and treatment of disease.

RADIOLOGY LABORATORY

A radiology laboratory is a certified place of business requiring specialty certified equipment. The diagnostic tests (radiological studies) are provided by or under the direction of a physician or other practitioner of the healing arts within the scope of practice as defined by state law. Radiological services can be provided in an office or similar facility, hospital outpatient department or clinic, and a laboratory or with portable equipment.

RADIONUCLIDE STUDIES

Radionuclide studies are performed in a department of nuclear medicine. Radionuclide imaging is used mainly to allow visualization of organs and regions within organs that cannot be seen on a simple X-ray. Included but not limited in this definition are the Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET), etc.

REASONABLE PROMPTNESS/TIMELINESS

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

RECIPIENT

A person who receives benefits pursuant to the Medicaid or NCU State Plan and/or Waiver Programs.

RECIPIENT RESPONSIBILITY

Recipients are responsible for the following:

1. Keep appointment or call 24 hours before if unable to make appointment;

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2. Be on time for appointment;
3. Relay any current or past dental provider and/or previous dental procedure received by recipient or recipient's children within the past five years;
4. Bring Medicaid/Managed Care card and identification;
5. If possible, find childcare for children not being seen by dentist; and
6. Follow dentist's advice and recommendations.

RECORDS

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

RECOUPMENT/RECOVERY

Recoupment or recovery is an administrative action by the DHCFP or its fiscal agent to initiate re-payment of an overpayment, with or without advance official notice. Recoupment or recovery can be made by reducing future payments to a provider or by direct reimbursement from the provider.

REEVALUATIONS

Revaluations must be completed for each recipient within 365 days, or more often as needed, to determine if the recipient continues to need the LOC provided and would, but for the provisions of waiver services, otherwise be institutionalized in an ICF/MR according to 42 CFR 441.302(c)(2)(iii).

REFERENCE LABORATORY

A reference laboratory is an independent clinical laboratory that receives a specimen from another Medicaid approved laboratory for testing.

REFERRAL

The recommendation by a physician, dentist and/or Contractor, and in certain instances, the recommendation by a parent, legal guardian and/or authorized representative, for a covered recipient to receive medically necessary care from a different provider.

REFERRING LABORATORY

A referring laboratory is a laboratory that receives a specimen to be tested and refers the specimen to another laboratory for performance of the laboratory test.

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REHABILITATION PLAN

1. A comprehensive, progressive, and individualized written Rehabilitative Plan must include all the prescribed Rehabilitation Mental Health (RMH) services. RMH services include:
 - a. Basic Skills Training (BST);
 - b. Program for Assertive Community Treatment (PACT);
 - c. Day Treatment;
 - d. Peer-to-Peer Support;
 - e. Psychosocial Rehabilitation (PSR); and
 - f. Crisis Intervention (CI).

The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the recipient to their best possible functional level. The plan must ensure the transparency of coverage and medical necessity determinations, so that the recipient, their family (in the case of legal minors), or other responsible individuals would have a clear understanding of the services that are made available to the recipient. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible - while sustaining overall health. All prescribed services must be medically necessary, clinically appropriate, and contribute to the rehabilitation goals and objectives.

2. The Rehabilitation Plan must include recovery goals. The plan must establish a basis for evaluating the effectiveness of the RMH care offered in meeting the stated goals and objectives. The plan must provide for a process to involve the beneficiary, and family (in the case of legal minors) or other responsible individuals, in the overall management of the RMH care. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress.
3. The reevaluation of the plan must involve the recipient, the recipient's family (in the case of legal minors), or other responsible individuals. The reevaluation of the plan must include a review of whether the established goals and objectives are being met and whether each of the services prescribed in the plan has contributed to meeting the stated established goals and objectives. If it is determined that there has been no measurable reduction of disability and/or function level restoration, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, objectives, services, and/or methods. The plan must identify the rehabilitation goals and objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities.

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4. Rehabilitation goals and objectives are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal and objectives as defined in the rehabilitation plan. The plan must be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative mental and/or behavioral health services to an individual with the individual's condition(s). The written rehabilitation plan must ensure that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. Rehabilitation plans are living documents and therefore must evolve in concert (show progressive transformations in the amount, duration, and scope of services provided) with the recipient's functional progress. The rehabilitation plan must also demonstrate that the services requested are not duplicative (redundant) of each other. The written rehabilitation plan must:
- a. be based on a comprehensive assessment of an individual's rehabilitation needs including DSM or DC:0-3 diagnoses and presence of a functional impairment in daily living;
 - b. ensure the active participation of the individual, individual's family (in the case of legal minors), the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review and modification of these goals and services;
 - c. be approved by a QMHP, working within the scope of their practice under state law;
 - d. be signed by the individual responsible for developing the plan;
 - e. specify the individual's rehabilitation goals and objectives to be achieved, including recovery goals for persons with mental health related disorders;
 - f. identify the RMH services intended to reduce the identified physical impairment, mental and/or behavioral health related disorder;
 - g. identify the methods that would be used to deliver services;
 - h. indicate the frequency, amount and duration of the services;
 - i. indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service;
 - j. specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than every 90 days or more frequently if needs change;
 - k. document that the individual, the individual's family (in the case of legal minors), or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and

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- l. document that the services have been determined to be rehabilitative services consistent with the regulatory definition.
5. Temporary, but clinically necessary, services do not require an alteration to Rehabilitation Plans; however, temporary services must be identified in progress notes. These progress notes must indicate the medical necessity, amount, scope, duration, and provider(s) of the service(s).
6. At a minimum, Rehabilitation Plans must include all of the following headings:
 - a. Recipient's Full Name:
 - b. Recipient's 11-Digit Medicaid Billing Number:
 - c. Intensity of Needs Determination: See Intensity of Needs Determination definition.
 - d. SED/SMI Determination: See Severe Emotional Disturbance (SED) and Serious Mental Illness (SMI) definitions.
 - e. Measurable Goals and Objectives: See Goals and Objectives definitions.
 - f. Prescribed Services:
 1. Identify the specific mental health service or services (i.e., family therapy, individual therapy, basic skills training, day treatment, etc.) to be provided;
 2. Identify the daily amount, service duration, and therapeutic scope for each service to be provided; and
 3. Identify the provider or providers that are anticipated to provide each service.
 - g. Rehabilitation Plan Evaluation and Recipient Progress: A QMHP must evaluate the Rehabilitation Plan at a minimum, every 90-days or more often when rehabilitation needs change. Rehabilitation Plan reviews must demonstrate the recipient's progress towards functional improvements towards established goals and objectives.
 - h. Discharge Criteria and Plan: Rehabilitation Plans must include discharge criteria and plans. See Discharge Criteria and Discharge Plan definitions. and
 - i. Required Signatures:
 1. Clinical Supervisor,
 2. Recipient and their family/legal guardian (in the case of legal minors),

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3. The individual responsible for developing the plan.

REHABILITATION SERVICES

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

REHABILITATION (REHAB) SPECIALTY HOSPITAL

A rehab hospital provides post-acute related services to recipients having, but not limited to, head and spinal cord injury, traumatic brain injury, cerebrovascular accident (CVA), wound care needs, cardiac-related disorders, respiratory failure and ventilator dependency. Rehabilitation hospitals generally do not provide surgical, obstetrical or psychiatric services. Rehab hospitals must meet state and federal licensing criteria. This applies to free-standing and hospital based units.

REINSURANCE

Insurance purchased by a Contractor, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents.

RELATED CONDITION

Persons with conditions related to mental retardation are persons who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required by a person with mental retardation. It is manifested before the person reaches age 22. It is likely to continue indefinitely. It results in substantial functional limitations in three or more of the following areas of major life activity:

1. Self Care;
2. Understanding and use of language;
3. Learning;
4. Mobility;
5. Self-direction; and/or

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6. Capacity for independent living.

RELATED SERVICES

IDEA requires that school districts provide whatever related services (other than medical care, which is not for diagnostic purposes) a child needs in order to benefit from his or her special education program.

REPRESENTATIVE

An individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated.

REQUEST FOR HEARING

A clear, written request to DHCFP for a hearing relating to a sanction and/or adverse determination.

RESIDENCE

Recipient's residence is wherever he/she makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, a group home, a foster home, a supported living arrangement and other non-institutional settings. An institution may not be considered a recipient's home if the institution meets the requirements of 1861(e)(1) or 1819(a)(1) of the Social Security Act. Included in this group are hospitals, SNFs, licensed certified day centers, schools and correction facilities.

RESIDENT ASSESSMENT INSTRUMENT (RAI)

RAI is a comprehensive assessment of a resident's needs. At a minimum it includes the MDS and utilization guidelines which include the Resident Assessment Protocols (RAPs).

RESIDENT ASSESSMENT INSTRUMENT (RAI) USER'S MANUAL

RAI User's Manual is the Long Term Care Resident Assessment Instrument User's Manual issued by the CMS covering the MDS, Resident Assessment Protocols and Utilization Guidelines.

RESIDENT ASSESSMENT PROTOCOLS (RAPs)

RAPs are structured, problem oriented frameworks for organizing MDS information, and examining additional clinically relevant information about a resident. RAPs are used as the basis of individualized care planning.

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RESIDENT LISTING REPORT

Resident Listing Report is a report based on data obtained from the CMS MDS repository and used to ensure accurate input for the payment system. Each free-standing NF is asked to provide input for appropriate corrections to the report on a quarterly basis in conjunction with the rate setting process.

RESIDENT PERSONAL FUNDS

Resident Personal Funds are funds entrusted to a NF by a resident which are in the possession and control of the NF and are held, safeguarded, managed and accounted for by the facility in a fiduciary capacity for the resident.

RESIDENT PHYSICIAN

A resident physician is authorized to practice only in a specific hospital setting while he or she participates in a Graduate Medical Education (GME) program. A resident is not enrolled as a Medicaid physician. Refer to definition for Physician's in Teaching Hospitals.

RESIDENTIAL FACILITY FOR GROUPS

An establishment that furnishes food, shelter, assistance and limited supervision to a person with mental retardation or with a disability or a person who is aged or infirm as defined in NRS 449.17. These facilities are licensed by the Health Division's HCQC as a residential facility for groups and have provider agreements with Medicaid.

RESIDENTIAL TREATMENT CENTER (RTC)

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

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RESOURCE UTILIZATION GROUPS

Resource Utilization Groups (RUG-III) is a classification system which uses information from the MDS assessment to classify NF residents into a series of groups representing the residents' relative direct care resource requirements. The MDS assessment data is used to calculate the RUG-III Classification necessary for payment. 108 MDS assessment items are used in the RUG-III Classification system to evaluate the resident's clinical condition.

RESPIRATORY THERAPY

Practice of respiratory care is defined by NRS 630.021 to include:

1. therapeutic and diagnostic use of medical gases, humidity and aerosols and the maintenance of associated apparatus;
2. the administration of drugs and medications to the cardiopulmonary system;
3. the provision of ventilator assistance and control;
4. postural drainage and percussion, breathing exercises and other respiratory rehabilitation procedures;
5. cardiopulmonary resuscitation and maintenance of natural airways and the insertion and maintenance of artificial airways;
6. carrying out the written orders of a physician, physician assistant, certified RN anesthetist or an APN relating to respiratory care;
7. techniques for testing to assist in diagnosis, monitoring, treatment and research related to respiratory care, including the measurement of ventilatory volumes, pressures and flows, collection of blood and other specimens, testing of pulmonary functions and hemodynamic and other related physiological monitoring of the cardiopulmonary system; and
8. training relating to the practice of respiratory care.

The practice of respiratory care must be performed under the direction of, or pursuant to, a prescription from a licensed physician or an APN per NRS 640B.030.6.

RESPIRE

Respite refers to the short-term, temporary care provided to people with disabilities or chronic medical conditions in order to allow LRIs a break from the daily routine of providing care for the recipient.

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RESPIRE SERVICE

Refers to those services provided to eligible recipients who are unable to care for themselves. These services are furnished on a short-term basis due to the absence or need for relief of those persons normally providing the care. This service provides general assistance with ADLs and IADLs, and provides supervision for recipients with functional impairments in their home or place of residence (community setting). Services may be for 24-hour periods, and the goal is relief of the primary caregiver.

RESTORATIVE CARE

Therapy services are considered to be “restorative” when there is an expectation that the patient’s condition will improve in a reasonable (and generally predictable) period of time. Medically necessary, restorative therapy services are eligible for coverage by Nevada Medicaid.

1. If an individual’s expected potential for improvement in function (restoration) would be insignificant in relation to the extent and duration of therapy services required to achieve such potential the therapy would not be considered reasonable and/or medically necessary.
2. If at any point in the treatment of an illness it is determined that the expectations will not materialize, the services will no longer be considered reasonable and medically necessary; and they, therefore, may be excluded from coverage.
3. As a general rule, failure to progress towards goals after a reasonable time period would no longer qualify as restorative.

Please refer to Chapter 1500 in the MSM, Section 1503.6A for a description of the scope of medical services available for children under age 21 described in 42 U.S.C. 1396d(a).

RETROSPECTIVE REVIEW

Retrospective review is performed for patients who are not Medicaid eligible when inpatient services were rendered, but become Medicaid eligible after services are rendered and/or after discharge. A review is conducted to certify length of stay, medical necessity, and appropriateness.

REVENUE CODE

Revenue code is the code used on billing forms which identifies a specific accommodation, ancillary service or billing calculation.

REVIEW AND REVISION OF IEP

An annual meeting to review each eligible individual’s IEP and revise its provisions if appropriate.

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REVOKED ELECTION

The recipient elects to discontinue hospice care and resumes eligibility for all Medicaid covered services. This recipient must sign a statement indicating his/her desire to discontinue hospice care.

RISK CONTRACT

Means under which the contractor assumes risk for the costs of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

ROUTINE SUPPLIES

Routine supplies are items used in small quantities for the recipient during the course of most HHA visits.

RURAL HEALTH CLINIC (RHC)

RHC, defined in 42 CFR 491.2, is a clinic that is located in a rural area designated as a shortage area. It is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

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SANCTION

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

SCHEDULED EMERGENCY TRANSPORTATION

Scheduled emergency transportation is transportation to covered medically necessary, provider directed services scheduled on behalf of the recipient, usually with less than 48 hours notice. An example of a scheduled emergency is transportation for a medically stable recipient on an organ transplant list who receives notification an organ available from a donor and the recipient must be present at the transplant facility within the timeframe determined by the surgeon or the transplant coordinator. (See also Urgent Services.)

SCHOOL OF MEDICINE

The facility referred to in MSM Chapter 1200 shall mean the University of Nevada School of Medicine, Reno and Las Vegas.

SCOPE

The extent or range of the intervention or services provided to a recipient.

SCREENING

Screening means to examine methodically in order to determine a child's health status and to make appropriate diagnosis and treatment referrals.

SELF DETERMINATION

Self determination is defined as freedom for individuals, who as a result of their disability and vulnerability have often been oppressed, segregated and isolated within society. It is defined by a set of guiding principles that assure freedom, choice and self-direction in their lives.

SELF-DIRECTED MODEL (SD)

The Self-Directed model is a delivery option designed to allow recipients more autonomy and responsibility in the provision of PCS. The option is utilized by accessing services through an ISO.

SELF-DIRECTED SKILLED SERVICES

Specific medical, nursing, or home health services that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care. Such services may be provided for

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a person with a disability by a personal care assistant without obtaining any license required for a provider of health care or his assistance, under very specific circumstance pursuant to NRS 629.091.

SERIOUS MENTAL ILLNESS (SMI)

Persons who are 18 years of age and older who currently or at any time during the past year (continuous 12 month period):

1. have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified in the DSM (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with a serious mental illness that meets DSM criteria); and
2. have a functional impairment which substantially interferes with or limits one or more major life activity such as psychological, social, occupational or educational and may include limiting an adult from achieving or maintaining housing, employment, education, relationships or safety.
3. SMI determinations are made by a QMHP within the scope of their practice under state law and expertise.

SERVICE AREA

The geographic area served by the Contractor as approved by State regulatory agencies and/or as detailed in the certificate of authority issued by the Nevada State Department of Insurance (DOI).

SERVICE AUTHORIZATION REQUEST (SAR)

A managed care enrollee's request for the provision of a service. The request may be made by the enrollee, a provider, or some other entity or individual acting on behalf of the enrollee. A SAR may be made either in writing or orally.

SERVICE LEVELS

Service levels are various measurable requirements that pertain to the delivery system structure of the contract and are used for evaluating contract performance and compliance.

SERVICE PLAN

The service plan is an authorization tool that is developed by the facility using the Physician Evaluation Form and the Universal Needs Assessment Tool. The service plan addresses the delivery of services, provides guidelines for monitoring recipient's progress and identifies the title of the staff that will be providing the specific services identified in the POC. The service plan requires pre-approval for services to be provided, authorization for new treatment, and is part of the PA process.

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SEVERE EMOTIONAL DISTURBANCE (SED)

1. Persons from birth through 48 months who currently or at any time during the past year (continuous 12-month period) have a:
 - a. DC:0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or
 - b. DC:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is “Disturbed”); or
2. Persons from 4 to age 18 who currently or at any time during the past year (continuous 12-month period) have a:
 - a. Diagnosable mental or behavioral disorder or diagnostic criteria that meets the coding and definition criteria specified in the DSM (excluding substance abuse or addictive disorders, irreversible dementias, mental retardation, developmental disorders, and V codes, unless they co-occur with a serious mental disorder that meets DSM criteria); and have a:
 - b. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent, and persistent features are included, however may vary in term of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.
3. SED determinations are made by a QMHP within the scope of their practice under state law and expertise.

SEVERE FUNCTIONAL DISABILITY (SFD)

As defined by NRS 426.721 to 731, severe functional disability means:

1. Any physical or mental condition pursuant to which a person is unable, without substantial assistance from another person, to eat, bathe, and toilet themselves.
2. A traumatic brain injury.

SHORT-TERM OBJECTIVES/BENCHMARK

An IEP must contain a statement of annual goals, including a description of short term objectives or benchmarks that are measurable and outcome oriented. Goals should be related to the child’s unique needs to enable the child with a disability to participate and function in the general curriculum.

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SIGNIFICANT CHANGE OF CONDITION OR CIRCUMSTANCE

A significant change in condition may be demonstrated by, for example, a recent hospitalization (within past 14 days), a physician's visit (within past seven days) resulting in an exacerbation of previous disabling condition, or a new diagnosis not expected to resolve within 30 days.

A significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI. The primary care giver is no longer capable or able to provide transportation or the recipient has moved to a new geographical location where currently authorized modes of transportation are not available (no public transportation, for instance).

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.

SINGLE SOURCE DRUG

Single Source Drug is defined in SS 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 FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application."

SITTERS

Sitters refer to individual services to watch or supervise a recipient in the absence of a LRA or primary caregiver.

SKILLED NURSING (SN)

SN means assessments, judgments, interventions, and evaluations of intervention, which require the training and experience of a licensed nurse. SN care includes, but is not limited to:

1. performing assessments to determine the basis for action or the need for action;
2. monitoring fluid and electrolyte balance;
3. suctioning of the airway;
4. central venous catheter care;
5. mechanical ventilation; and
6. tracheotomy care.

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SKILLED SERVICES

Skilled services are health care services that are inherently complex and require the specialized training of a licensed nurse or therapist to provide safely and effectively.

SLEEP STUDY

Sleep studies refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six (6) or more hours attended by a technologist. In order for a sleep study to be considered reasonable and necessary it must be an observed study.

SLOT

The number of available openings which may be offered to eligible recipients during each fiscal year. The number of slots available is determined by the level of legislative funding approved per fiscal year and through an agreement with CMS.

SPECIAL CHILDREN’S CLINIC (SCC)

Clinics operating to serve children, from birth to their third birthday, providing early intervention services for children with known or suspected developmental delays or disabilities. These clinics receive Title V funding.

SPECIAL EDUCATION

Specifically designed instruction, provided at no cost to the parent, to meet the unique needs of a child with disabilities, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

SPECIALTY CARE TRANSPORTATION (SCT)

SCT is hospital-to-hospital transportation of a critically injured or ill recipient by a ground or air ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Intermediate or paramedic. SCT is necessary when a recipient’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training). SCT’s are not covered under NET, nor do they require PA. An example of SCT is the transfer of a newborn from a critical care neonatal unit to a hospital where immediate heart surgery may be performed.

SPEECH GENERATING DEVICE (SGD)

SGDs, also commonly known as “Augmentative and Alternative Communication” (AAC) devices are electronic aids, devices, or systems that correct expressive communication disabilities that preclude an individual from

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meaningfully participating in ADLs. SGDs are covered as DME. Requests for SGDs must provide the information required.

SPEECH THERAPY (ST)

Speech and language pathology services medically necessary for diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), with or without the presence of a communication disability. This may include the following:

1. Abnormal development of a person's ability to communicate;
2. Disorders and problems concerning a person's ability to communicate;
3. Deficiencies in a person's sensory, perceptual, motor, cognitive and social skills necessary to enable him to communicate; and
4. Abnormal sensorimotor functions of a person's mouth, pharynx and larynx.

STATE PLAN (The Plan)

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

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

STATEMENT OF UNDERSTANDING/CHOICE (SOU)

This form is used to inform applicants of their right to choose between HCBW services or institutional placement and their right to request a Fair Hearing. The form must be signed by the applicant or his/her authorized representative if the applicant is not capable to sign the document.

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STEP THERAPY

The process of beginning drug therapy for a medical condition with the safest and most effective lower risk drug therapy and progressing to other drug regimens only if medically necessary. Step therapy protocols are developed at a therapeutic class level, and approved through the DUR Board based upon clinical practice guidelines, without consideration of the cost of prescription drugs. Step therapy guidelines may be implemented through a PA process, prospective DUR edits, and/or provider educational programs.

STRETCHER

A type of transportation where the recipient must be transported in a prone position on a gurney or a stretcher. Stretcher transport is not a covered NET broker service.

STUDENT THERAPIST

Outpatient student therapists are persons in training, supervised by a qualified therapist. The student is not recognized as a Medicaid provider.

SUBCONTRACTOR

Third party, not directly employed by the primary contractor, that provides services identified in the primary contract not including third parties who provide support or incidental services to the contractor.

SUPPLEMENTAL OMNIBUS BUDGET RECONCILIATION ACT OF 1996 (SOBRA)

Legislation of the OBRA of 1986.

SUPPLEMENTAL REBATES

Supplemental rebates are drug rebates collected from the manufacturer above the rebates collected under the OBRA 90 Drug Rebate Program. Section 927(a)(1) of the Social Security Act provides that “the Secretary may authorize a State to enter directly into agreements with a manufacturer.” Per CMS, SMDL #02-014, “States may enter separate or supplemental drug rebate agreements as long as such agreements achieve drug rebates equal to or greater than the drug rebates set forth in the Secretary’s national rebate agreement with drug manufacturers, which is published at 56 F.R.7049 (1991).

SUPPORT BROKER

The Support Broker assists the participant in the development and management of their services including; budget management, monitoring of expenditures, personnel management and ISP development. These supports are provided in a manner that is flexible, responsive to and directed by the individual participant. A support broker is employed by the support broker agency contracted by MHDS. This is an administrative activity.

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SUPPORT SERVICES

Specifically designed instruction and activities, which augment, supplement, or support the educational program.

SUPPORTED LIVING ARRANGEMENT (SLA)

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

SWING-BED HOSPITAL

A swing-bed hospital is any hospital that meets the following criteria:

1. the hospital has a Medicare swing-bed provider agreement;
2. has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units;
3. the hospital is located in a rural area, including all areas not delineated as “urbanized” areas by the Census Bureau, based on most recent census;
4. the hospital does not have in effect a 24-hour nursing waiver;
5. the hospital has not had swing-bed approval terminated within two years previous to application; and
6. The facility is substantially in compliance with the SNF requirements contained in 42 CFR, subpart B, part 483.

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TAMPER-RESISTANT PRESCRIPTION PADS

Effective October 1, 2008, pursuant to CMS SMDL # 07-012 a tamper-resistant prescription pad must contain all of the following three characteristics:

1. One or more industry-recognized feature(s) designed to prevent unauthorized copying of a complete or blank prescription form;
2. One or more industry-recognized feature(s) designed to prevent the erasure or modification of information written on the prescription by the prescriber; and
3. One or more industry-recognized feature(s) designed to prevent the use of counterfeit prescription forms.

TARGET GROUP – CHILD PROTECTIVE SERVICES (CPS)

CPS are provided to:

1. children and young adults who are Medicaid recipients and abused or neglected or suspected to be at risk thereof as evidenced by being in the care of the Division of Child and Family Services (DCFS), Clark County Department of Family Youth Services or Washoe County Department of Social Services.
2. families who are abused or neglected or suspected to be at risk thereof as evidenced by being in the care of DCFS, Clark County Department of Family Services or Washoe County Department of Social Services.

TARGET GROUP – DEVELOPMENTALLY DELAYED INFANTS AND TODDLERS UNDER AGE 3

Developmentally delayed infants and toddlers are children ages birth through two years determined eligible for early intervention services through the identification of a “developmental delay,” a term which means:

1. A child exhibits a minimum of fifty percent (50%) delay of the child’s chronological age in any one of the areas listed below or a minimum of 25% delay of the child’s chronological age in any two of the areas listed below. Delays for infants less than 36 weeks gestation shall be calculated according to their adjusted age.
2. The delay(s) must be defined in one or more of the following areas:
 - a. Cognitive development;
 - b. Physical development, including vision and hearing;
 - c. Communication development;

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- d. Social or emotional development; or
 - e. Adaptive development.
3. Children also are eligible who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delays.
 4. Informed clinical opinion must be used in determining eligibility for services as a result of a development delay.

TARGET GROUP – JUVENILE PROBATION SERVICES (JPS)

JPS are covered services provided to:

1. juveniles on probation (referred or under the supervision of juvenile caseworkers) for Washoe County JPS and Clark County Department of Juvenile Justice Services.
2. family member(s) who are Medicaid eligible whose children are on probation.

TARGET GROUP – NON-SERIOUSLY MENTALLY ILL (NON-SMI) ADULTS

Adults, who are non-SMI, excluding dementia and mental retardation, are recipients 18 years of age and older with significant life stressors and have a:

1. DSM Axis I diagnosis, including V-codes, that does not meet SMI criteria.
2. LOCUS score of Level I or II.

TARGET GROUP – NON-SEVERELY EMOTIONALLY DISTURBED (NON-SED) CHILDREN AND ADOLESCENTS

Children and adolescents, who are Non-SED, excluding dementia and mental retardation, are recipients with significant life stressors and have:

1. A DSM Axis I diagnosis that does not meet SED criteria.
2. V-code DSM diagnosis that does not meet SED criteria.
3. CASII Level of 0, 1, 2, or above.
4. DC:03 Axis I diagnosis or DC:03 Axis II PIR-GAS score of 40 or less.

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TARGET GROUP – PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS (MRRC)

Persons with MRRC are persons who are significantly sub-average in general intellectual functioning (IQ of 70 or below) with concurrent related limitations in two or more adaptive skill areas, such as communication, self-care, social skills, community use, self-direction, health and safety, functional academics, leisure and work activities.

Persons with related conditions are individuals who have a severe chronic disability. It is manifested before the person reaches age 22 and is likely to continue indefinitely. The disability can be attributable to cerebral palsy, epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a mentally retarded person and requires treatment or services similar to those required by these persons.

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

1. Self care.
2. Understanding and use of language.
3. Learning.
4. Mobility.
5. Self-direction.
6. Capacity for independent living.

TARGET GROUP -- SERIOUS MENTAL ILLNESS (SMI) ADULTS

Adults with a SMI are persons:

1. 18 years of age and older; and;
2. Who currently, or at any time during the past year (continuous 12 month period);
 - a. have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the Diagnosis and Statistical Manual of Mental Disorders (DSM-IV) (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with another serious mental illness that meets DSM-IV criteria);

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- b. that resulted in functional impairment which substantially interferes with or limits one or more major life activities;
3. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health-illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

TARGET GROUP -- SEVERE EMOTIONAL DISTURBANCE (SED)

Children from birth through 48 months who currently or at any time during the past year (continuous 12 month period) have a:

1. DC:0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or
2. CD:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or

Children with a SED are persons age 4 to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

1. Diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the DSM. This excludes substance abuse or addictive disorders, irreversible dementias, as well as mental retardation and V codes, unless they co-occur with another serious mental illness that meets DSM criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities, and
2. These disorders include any mental disorder (including those of biological etiology) listed in DSM or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however they vary in terms of severity and disabling effects; and
3. Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

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TARGETED CASE MANAGEMENT (TCM)

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

THERAPEUTIC LEAVE OF ABSENCE (LOA)

Therapeutic LOA includes therapeutic or rehabilitative home and community visits with relatives and friends. Therapeutic leave also includes leave used in preparation for discharge to community living. Therapeutic leave days are considered overnight stays. Therapeutic leave does not apply when a resident is out on pass for short periods of time for visits with family/friends, to attend church services or other social activities. Therapeutic leave does not include hospital emergency room visits or hospital stays.

THIRD PARTY LIABILITY (TPL)

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

TRAUMATIC BRAIN INJURY (TBI)

A traumatic brain injury is a medically verifiable incident of 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.

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TREATMENT

1. EPSDT

Medically necessary services or care provided to prevent, correct or improve disease or abnormalities detected by screening and diagnostic procedures.

2. Behavioral Health

A planned, medically appropriate, individualized program of interactive medical, psychological, rehabilitative procedures, therapeutic interventions and/or services designed to rehabilitate, relieve or minimize mental, emotional or behavioral disorders.

TREATMENT PLAN

A written individualized plan that is developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and a QMHP within the scope of their practice under state law. When RMH services are prescribed, the provider must develop a Rehabilitation Plan (see definition). The Treatment Plan is based on a comprehensive assessment and includes:

1. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);
2. Intensity of Needs Determination;
3. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;
4. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;
5. Discharge criteria specific to each goal; and for
6. High-risk recipients accessing services from multiple government-affiliated and/or private agencies, evidence of care coordination by those involved with the recipient's care.

The recipient, or their legal representative, must be fully involved in the treatment planning process, choice of providers, and indicate an understanding of the need for services and the elements of the Treatment Plan. Recipient's, family's (when appropriate) and/or legal representative's participation in treatment planning must be documented on the Treatment Plan.

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Temporary, but clinically necessary, services do not require an alteration of the Treatment Plan, however, must be identified in a progress note. The note must indicate the necessity, amount, scope, duration and provider of the service.

TRAINING AND HABILITATION SERVICES

Training and habilitation services are those services which are intended to aid the intellectual, sensorimotor, and emotional development of an individual.

These services include instruction in self-help skills, social skills, and independent living activities with the goal, when feasible, of enabling individuals to function in community living situations.

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URGENT SERVICES

With respect to NET services, an urgent service consists of transportation to a covered medically necessary, provider directed service which is scheduled on behalf of the recipient with less than 5 business days notice. A recipient must have a medical need to see the provider in less than 5 business days in order to schedule an urgent transport.

ULTRASONOGRAPHY

Ultrasonography is a noninvasive procedure for visualizing soft-tissue structures of the body by recording the reflection of ultrasonic waves directed into the tissues.

UNAVAILABLE

Time constraints of primary caregivers, which limit their availability to provide care due to verified employment or attendance at school.

UNBUNDLING

Unbundling is the billing of separate procedure codes rather than one all-inclusive code, when an all-inclusive code is required to be billed.

UNDERPAYMENT

This is an amount paid by the DHCFP, to a provider, which is less than the amount that is allowable for services furnished under applicable policy, rate or regulation.

UNIT DOSE

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

UNIVERSAL NEEDS ASSESSMENT

The Universal Needs Assessment is a needs based assessment that is completed by an independent third party. It is person-centered and focuses on the level of support needed, not deficits in skill.

UP-CODING

Up-coding is billing using procedure codes that overstate the level or amount of health care or other service provided.

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URBAN

A geographic area of service in a county having a population of 30,000 or more and has a radius of not more than 25 miles between recipients and the MCOs network providers and hospitals.

USUAL CHARGE

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

UTILIZATION

The extent to which the recipients of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. It is usually expressed as the number of services used per year or per 100 or one 1,000 persons eligible for the service.

UTILIZATION CONTROL

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

UTILIZATION MANAGEMENT AGENCY

The state's fiscal agent or QIO-like vendor. The utilization review/control requirements of 42 CFR 456, are deemed met if a State Medicaid agency contracts with a Medicare certified QIO-like vendor, designated under Part 475, to perform review/control services.

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VENTILATOR DEPENDENT RECIPIENT

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

VISIT

A visit is an episode of personal contact with the recipient by staff of the HHA for the purpose of providing a covered home health service. A visit is initiated with the delivery of a covered HHA service and ends at the conclusion of the delivery of covered HHA service.

VOLUNTEER

An individual who agrees to provide services to a hospice program without monetary compensation.

A volunteer is referred to as an “employee” under the jurisdiction of the hospice.

VOLUNTEER DRIVER

Volunteer drivers (private citizens who do not contract with the NET broker) who are not LRIs, nonprofit organizations, or IHS, may receive mileage reimbursement for driving a recipient to medical services, where this is the least expensive mode of transportation.

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WAIT LIST

A list of Waiver applicants who have been prescreened, determined eligible and are waiting for a funded waiver slot.

WHEELCHAIR LIFTS AND TIE DOWNS

Wheelchair lifts are mechanical devices that raise a person seated in a wheelchair, or a person who cannot traverse steps, from ground level to a vehicle's floor level. Tie downs lock a wheelchair in place so it does not move during transit.

WOUND

A wound is impaired tissue integrity that may involve the epidermis, dermis, subcutaneous tissue and may extend down to underlying fascia and supporting structures. The wound may be aseptic or infected.

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X-RAY

X-ray studies (also known as radiographs or roentgenograms) are used to examine the soft and bony tissues of the body. X-rays can penetrate most substances and are used to investigate the integrity of certain structures, to therapeutically destroy diseased tissue, and to make photographic images for diagnostic purposes as in radiography and fluoroscopy.

	MTL 08/11
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: Y
MEDICAID SERVICES MANUAL	Subject: ADDENDUM

< RESERVED FOR FUTURE USE >

	MTL 08/11
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: Z
MEDICAID SERVICES MANUAL	Subject: ADDENDUM

< RESERVED FOR FUTURE USE >