

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 28, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR /*Cody L. Phinney*/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES ADDENDUM –
SECTIONS B, C, D, M

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Addendum – Sections B, C, D, and M are being proposed to reflect the proposed changes to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services.

Entities Financially Affected: This proposed change may affect Medicaid-enrolled providers delivering Medical Supervision to BHCNs. Those provider types include, but are not limited to, Physician, M.D., Osteopath, D.O., Provider Type 20.

Financial Impact on Local Government: unknown at this time.

These changes are effective April 29, 2020.

MATERIAL TRANSMITTED
MTL 11/20 MSM ADDENDUM

MATERIAL SUPERSEDED
MTL 10/17, 23/15, 22/17 MSM ADDENDUM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section B	Behavioral Health Community Network (BHCN)	Removed medical supervision from the operation of a BHCN.
Section C	Clinical Supervision	Clarified definition of Clinical Supervision.
Section D	Direct Supervision	Clarified definition of Direct Supervision.
Section M	Medical Supervision	Removed Medical Supervision and Medical Supervisor 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 Medicaid Services Manual (MSM) 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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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;
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

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

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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/ambulation and eating.

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.

ADAPTIVE BEHAVIOR

Adaptive behavior is the collection of conceptual, social and practical skills that are learned and performed by people in their everyday lives.

- Conceptual skills: language and literacy; money, time and number concepts; and self-direction.
- Social skills: interpersonal skills, social responsibility, self-esteem, gullibility, naïveté (i.e., lack of wariness), social problem solving and the ability to follow rules/obey laws and to avoid being victimized.

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- Practical skills: activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money and use of the telephone.

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 review 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);
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

The DHCFP has administrative authority over three Home and Community Based Services (HCBS) Waivers:

1. HCBS Waiver for the Frail Elderly;

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2. HCBS Waiver for Persons with Physical Disabilities; and
3. HCBS Waiver for Individuals with Intellectual Disabilities and Related Conditions.

The DHCFP issues policy rules and regulations related to the 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 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).

The DHCFP will review Medical Administrative Costs for reasonability and in the context of the benefit received by the client and the 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 the DHCFP:

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- a. Profit: The percentage of profit which the Contractor anticipates receiving after expenses (net income, revenues less expenses, divided by total revenues received from the 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 the 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

Inpatient hospital days reimbursed at a lower per diem rate when a recipient's status does not meet an acute level of care and if discharged, placement in an alternative appropriate setting is not available despite a hospital's documented, comprehensive discharge planning efforts. Reference the Skilled Administrative Days and Intermediate Administrative Days definitions.

ADMISSION

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

1. physician writes the order for admission; and
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 or more hours per

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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 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.

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

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an Emergency Medical Technician (EMT).

ADVANCED LIFE SUPPORT LEVEL 1 (ALS-1)

ALS-1 is the service level of 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 Advanced Emergency Medical Technician (AEMT) or paramedic, in accordance with State and local laws.

ADVANCED LIFE SUPPORT LEVEL 2 (ALS-2)

ALS-2 is the service level of 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 AEMT-Intermediate or paramedic, in accordance with State and local laws, and may include:

1. manual defibrillation/cardioversion;
2. endotracheal intubation;
3. central venous lines;
4. cardiac pacing;
5. chest decompression;
6. surgical airway; and
7. intraosseous line.

ADVANCE NOTICE OF ACTION (NOA)

A written notice mailed to the individual when the 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.

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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 Services (HCBS) Waivers which includes the HCBS Waiver for the Frail Elderly, HCBS Waiver for Individuals with Intellectual Disabilities and Related Conditions and the HCBS Waiver for Persons with Physical Disabilities.

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.

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)

A Medicare certified freestanding or hospital-based medical facility operating exclusively for the purpose of providing surgical services when the expected duration of services does not exceed 24 hours following admission and the individual does not require hospitalization.

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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.

ANNUAL

For the purpose of annual Level of Care (LOC) assessments for HCBS Waivers, 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.

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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.

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

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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. HCBS Waiver for Persons with Physical Disabilities:

For the purposes of the HCBS Waiver for Persons with Physical Disabilities, 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.

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 637B.030). 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.

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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.

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 Prior Authorizations (PAs) for services as an administrative function of the AL Waiver.

AUTHORIZATION

The word authorization is used synonymously with 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 the DHCFF's fiscal agent for reimbursement. An approved authorization does not confirm a recipient's eligibility or guarantee claims payment.

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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 the 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.

AVAILABLE

Available refers to an LRI who is physically present in the recipient's home or is physically present with the recipient while in settings outside the home (including employment sites) at the time necessary maintenance, health/medical care, education, supervision, support services and/or assistance with ADLs and IADLs is needed by a Medicaid recipient.

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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, 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, the DHHS, the DHCNP which operates under **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

An LRI who is able to safely manage 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 cost 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 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.

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

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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, who 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.

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.

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- 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.

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.

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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.

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.

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CERTIFIED SLEEP STUDY TECHNOLOGIST

A certified sleep study technologist is an individual trained in the diagnostic techniques and evaluation of a recipient's 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 zero 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.

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, intellectual disabilities, 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.

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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.

CLINICAL LABORATORY

A laboratory which uses:

1. microbiological;
2. serological;
3. immunohematological;
4. cytological;
5. histological;

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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

The documented oversight by a Clinical Supervisor to assure the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values set forth by state licensure, certification, and best practice. Clinical Supervision is intended to be rendered on-site. Clinical Supervisors are accountable for all services delivered and must be available to consult with all clinical staff related to delivery of service, at the time the service is delivered. Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Clinical Professional Counselors (CPC) and Qualified Mental Health Professionals (QMHP), **excluding Interns**, 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 assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, including Independent Professionals, QMHPs, and Individual RMH providers, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). **Clinical Supervisors can supervise other LCSWs, LMFTs, CPCs, QMHPs, QMHAs and QBAs.** Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are **who are LCSWs, LMFTs, CPCs, and QMHPs, excluding Interns**, may function as Clinical Supervisors over RMH services. However, **Individual RMH providers, who are QMHPs, including Interns**, may not function as Clinical Supervisors over Outpatient Mental Health (OMH) services, such as **assessments, therapy, testing and medication management.** Clinical Supervisors must assure the following:

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1. An up to date (within 30 days) case record is maintained on the recipient; **and**
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); **and**
3. A comprehensive and progressive **treatment plan** is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a **QMHP, LCSW, LMFT, or CPC**; **and**;
4. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate; **and**
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 plan**, and the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the **treatment plan**; **and**
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; **and**
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 the 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.

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.

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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.

COMPOUND DRUGS

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

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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. A single nurse may provide care for up to three recipients if care can be provided safely.

CONCURRENT REVIEW

A review of a Nevada Medicaid or Nevada Check Up eligible recipient's clinical information performed by the DHCFP's QIO-like vendor or a Managed Care Organization. The review is performed during a period of time that services are being rendered, to determine if a requested service will be authorized, based on medical necessity, appropriateness and compliance with applicable policies.

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 the 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 the 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 Individuals with Intellectual Disabilities (ICF/IID).
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.

CREDIBLE ALLEGATION OF FRAUD

A credible allegation of fraud may be an allegation which has been verified by the State from any source, including but not limited to:

1. Fraud hotline complaints;
2. Claims data mining; or
3. Patterns identified through provider audits, civil false claims cases and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and Nevada Medicaid has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.

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)

A Medicare certified and state licensed hospital established under the State Medicare Rural Hospital Flexibility Program.

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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 providing those services. The documentation must be initialed by the recipient and the individual providing the services, on a daily basis, after services are delivered. The daily record must also be signed by the recipient and the individual providing the services. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this must be clearly documented in the recipient's Plan of Care (POC) or Individual Support Plan (ISP).

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 them 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) OF MENTAL DISORDERS

The latest text revision of the DSM of Mental Disorders published by the American Psychiatric Association (APA).

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.

DIALYSIS

A process of removing waste products from the body by diffusion from one fluid compartment to another across a semi-permeable membrane.

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.

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

Direct Supervision – Independent Professionals, QMHPs and/or QMHAs may function as Direct Supervisors **within the scope of their practice**. Direct Supervisors must have the practice-specific education, experience, training, credentials and/or licensure to coordinate an array of **OMH and/or RMH** services. Direct Supervisors assure servicing providers provide services in compliance with the established treatment plan(s). Direct

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Supervision is limited to the delivery of services and does not include treatment 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 plan reviews and evaluations.

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

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3. being regarded as having such and impairment.

DISABILITY DETERMINATION

The 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;
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 calendar days of the transfer. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan and the Discharge Plan.

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DISENGROLLMENT

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 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,

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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 DENTAL 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 (including labor and delivery) manifesting itself by the sudden onset of acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in either placing an individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, resulting in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or serious physical harm to another.

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

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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 service delivery 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.

END STAGE RENAL DISEASE (ESRD)

Irreversible and permanent destruction of normal kidney function resulting in kidney failure that requires a regular course of dialysis or a kidney transplant.

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

An escort is defined as an individual whose presence is needed to assist the recipient or to perform an approved task en route to or while obtaining Medicaid reimbursable services.

ESCORT SERVICE

A service that may be authorized for PCS recipients who require a PCA to perform an approved PCS task en route to or while obtaining Medicaid reimbursable 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.

ESSENTIAL SHOPPING

Essential shopping is shopping to meet the recipient's health care or nutritional needs. Essential shopping includes

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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% (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).

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

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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 any time 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 the 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.

FOR CAUSE

For cause terminations are terminations related to fraud, integrity or quality issues which run counter to the overall success of the Medicaid Program.

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.

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FUNCTIONAL ASSESSMENT SERVICE PLAN (FASP)

The FASP is an assessment tool used by an enrolled and trained physical or occupational therapist, to complete an in-home assessment, to identify the ability/inability of a recipient to perform ADLs and IADLs. This assessment identifies an applicant's/recipient's unmet needs and provides a mechanism for determining the appropriate amount of personal care service hours, based on the recipient's needs and functional ability. The FASP also evaluates the environment in which services are provided and the availability of support systems.

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.

FURNISHED

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual (either as an employee or in his or her own capacity), a provider or other supplier of services.

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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 intellectual disabilities or with a physical disability or a person who is aged or infirm. The term includes, without limitation,

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an assisted living facility as defined in NRS 449.017. These are entities that have provider agreements with Medicaid and are licensed by the Bureau of Health Care Quality and Compliance (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 registered 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.

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).

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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)

An 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.

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.

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HEARING PREPARATION MEETING (HPM)

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

HEMODIALYSIS

A process of cleansing blood of waste products (e.g. urea, creatinine) as the blood passes through an artificial kidney machine, diffuses across a man-made membrane into a specific cleansing solution (a dialysate solution) and returns to an individuals' body.

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)

An HHA is a health care provider licensed, certified or authorized by state and federal laws to provide health care services in the home. An HHA provides skilled services in the home. An 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 Chapters 100 and 1400. To participate in the Medicaid program, an 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 an HHA, home health aide services provided by an 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 may

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choose to provide. To participate in the Medicaid program, an 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 (other than tuberculosis or psychiatric) is a state-licensed, Medicare-certified inpatient medical facility primarily engaged in providing services, by or under the supervision of a physician or dentist, for the diagnosis, care, and treatment or rehabilitation of sick, injured or disabled individuals, and is not primarily for the care and treatment of mental disease.

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IMMEDIATE RELATIVE

An immediate relative means as any of the following:

1. husband or wife;
2. natural or adoptive parent, child or sibling;
3. stepparent, stepchild, stepbrother or stepsister;

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);

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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
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 physical or mental health), 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 personal care services or skilled services to a recipient where no Personal Care Services (PCS) Agency or Intermediary Service Organization (ISO) is available. 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 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 recognize 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

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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).

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.

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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.

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.

INDIVIDUAL WITH INTELLECTUAL DISABILITY (IID) OR A RELATED CONDITION

42 CFR, Section 483.102(b)(3) states an individual is considered to have intellectual disability if he or she has a level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual Disability's Manual on Classification in Intellectual Disability (1983).

A person with an intellectual disability demonstrates significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age 18.

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, found to be closely related to intellectual disability, resulting in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled 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;

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- e. Self-direction; or
- f. Capacity for independent living.

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.

INFORMED STERILIZATION CONSENT FORM MEETING FEDERAL REQUIREMENTS

A signed consent form that meets all of the federal sterilization consent form requirements specified in 42 CFR 441.250 through 441.259 and in 42 CFR 482.24 (c)(4)(v).

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

An inpatient is an individual receiving room, board and medical care in an acute, critical access, psychiatric or specialty hospital or nursing facility.

INPATIENT HOSPITAL SERVICES

Services ordered by a physician or dentist primarily for the care and treatment of individuals with disorders other than mental illness, admitted to a Medicare-certified and state licensed hospital that has a utilization review plan in effect that meets the requirements of 42 CFR 482.30, 42 CFR 456.50, and 42 CFR 440.10. Inpatient hospital services do not include skilled nursing services furnished in a swing-bed.

INPATIENT REHABILITATION HOSPITAL

A Medicare certified, state licensed, free standing or hospital based facility that provides intensive services to restore optimal function following an accident or injury (e.g. head and spinal cord injury, traumatic brain injury, cerebrovascular accident (CVA), cardiac-related disorders). Rehabilitation hospitals generally do not provide surgical or obstetrical services.

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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 meal preparation, laundry, light housekeeping and essential shopping.

INTELLECTUAL DISABILITY

A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18. A diagnosis of intellectual disability is made based on commonly used standardized tests of intelligence and standardized adaptive behavior instruments.

INTELLECTUAL FUNCTIONING

Also called intelligence, refers to general mental capacity, such as learning, reasoning, problem solving and so on. An IQ test score of around 70 or as high as 75 indicates a limitation in an individual’s intellectual functioning.

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.

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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.

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. an 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;

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- d. educator or vocational counselor;
- e. speech-language pathologist;
- f. dietician;
- g. psychologist;
- h. psychiatrist;
- i. dentist;
- j. pharmacist; or
- k. Direct care staff.

INTERMEDIATE ADMINISTRATIVE DAYS

Inpatient hospital days reimbursed at a lower per diem rate when a recipient’s status does not meet an acute level of care and the recipient cannot be discharged due to social reasons (e.g. a stable newborn is waiting for adoption) despite comprehensive documented discharge efforts.

INTERMEDIARY SERVICE ORGANIZATION (ISO)

An ISO is an entity acting as an intermediary between Medicaid recipients, who elect the Self-Directed (SD) service delivery model and the Personal Care Assistants (PCAs) who provide those services. In the SD service delivery model, the recipient is the managing employer of the PCA and the ISO is the employer of record, providing both fiscal and supportive services.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

An institution (or distinct part of an institution), which is primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or a related condition. In a protected residential setting, an ICF/IID 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 INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) LEVEL OF CARE (LOC)

ICF/IID 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

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a diagnosis of intellectual disability or a condition related to an intellectual disability. This LOC identifies if an individual's total needs are such that they could be routinely met on an inpatient basis in an ICF/IID.

INTERMEDIATE CARE SERVICES FOR THE INTELLECTUALLY DISABLED

Health and rehabilitative services provided to an individual with intellectual disabilities 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 Sections 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 days per week, or less than eight hours each day for a period of 21 days or less and 28 or fewer hours each week.

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.

LEAVE OF ABSENCE (LOA)

Absences for special circumstances (e.g. an absence for a few hours due to the death of an immediate family member or for a therapeutic reason such as a trial home visit to prepare for independent living). Reference therapeutic leave of absences.

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.

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.

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

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identify individuals suspected of serious mental illness, intellectual disability and/or related conditions. Every NF applicant, regardless of payer source, must be screened prior to admission to a NF.

LEVEL I TRAUMA CENTER

A hospital meeting the Level I Trauma Center criteria described in the most recent version of the Resources for Optimal Care of the Injured Patient and published by the Committee on Trauma of the American College of Surgeons, having a full range of specialists and equipment immediately available on a twenty-four hour basis to provide the highest level of definitive and comprehensive care for acutely injured patients of all ages and serving as a regional resource, responsible for research, professional and community education, prevention and consultative community outreach services and programs statewide.

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 functional deficits and would require imminent placement in a NF (within 30 days) if HCBS Waiver 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) HCBS Waiver.

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

A Medicare-certified and state-licensed free-standing or hospital-based facility that provides comprehensive, long-term acute care for medically complex recipients having an acute illness, injury or exacerbation of a disease process or multi-system complications and/or failures (e.g. ventilation care and/or weaning, wound care, treatment of complex infections or neurological conditions).

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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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- 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:

- CMS for multiple source drugs that meet the criteria set forth in 42 CFR 447.332 and 1927(f)(2) of the Act; or
- The 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 INTEGRITY

Medicaid integrity involves the planning, prevention, detection and investigative/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, abuse or improper payments.

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

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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.

MEDICAL EMERGENCY

Medical Emergency is the sudden onset of an acute condition 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 NUTRITION THERAPY

The development and provision of a nutritional treatment or therapy based on a detailed assessment of a person's medical history, psychosocial history, physical examination and dietary history. It is used to treat an illness or condition, or as a means to prevent or delay complications from nutritionally related disease states.

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).
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.

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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 SERVICES

Mental health services are those techniques, therapies or treatments provided to an individual who has an acute, clinically identifiable psychiatric disorder for which periodic or intermittent treatment is recommended, as identified in the current International Classification of Diseases (ICD) 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:

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

MENTALLY INCOMPETENT INDIVIDUAL

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

MILEAGE REIMBURSEMENT

Car mileage is reimbursement by the NET broker 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.

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.

MINIMUM ESSENTIAL PERSONAL ASSISTANCE

The assistance of a person with a severe functional disability for six 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

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basic Polysomnography (PSG) are monitored. The MSLT consists of four - five 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)

The 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, the 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.

NEWBORN/NEONATE

A designation that begins at birth and lasts through the 28th day of life.

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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.

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 Medicaid services. The recipient has the duty to use the least expensive alternative conveyance and the nearest appropriate Medicaid health care provider or medical facility.

NON-EMERGENCY TRANSPORTATION (NET) BROKER

The NET broker contracts with individual transportation companies and volunteer drivers who provide NET for Nevada Medicaid recipients. The NET broker manages, authorizes and coordinates NET services for Medicaid recipients. 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;
 - b. rehabilitation services for the rehabilitation of injured, disabled or sick persons; or

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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.

OBSERVATION SERVICES

A well-defined set of specific, clinically appropriate outpatient services, including ongoing short term treatment, assessment and reassessment furnished in an appropriate location of the hospital when a recipient’s medical needs do not meet acute care guidelines and/or to assess the need for inpatient admission.

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.

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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 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,

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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 the DHCFP according the Medicaid FFS rate schedule.

OUTPATIENT HOSPITAL

A Medicare certified, state-licensed hospital that furnishes medically necessary diagnostic and therapeutic services to a sick or injured individual registered or accepted for care in the hospital, but not formally admitted as an inpatient and not requiring inpatient services.

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.

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 any time the plan is revised.

PERSONAL ASSISTANT

A person who, for compensation and under the direction of:

1. A person with a disability;
2. A parent or guardian of, or any other person legally responsible for, a person with a disability who is under the age of 18 years; or
3. A parent, spouse, guardian or adult child of a person with a disability who suffers from a cognitive impairment, performs services, in accordance with NRS 629.091, for the person with a disability to help the person with a disability maintain independence, personal hygiene and safety.

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PERSONAL CARE ATTENDANT (PCA)

A person who is employed by or retained pursuant to a contract, by an agency to provide personal care services in the home, for the purpose of providing personal care services (PCS) to client/recipient.

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.

PERSONAL CARE SERVICES (PCS)

PCS are services that provide eligible Medicaid recipients with direct hands-on assistance or cueing to perform tasks that relate to the performance of ADLs and IADLs. Services must be performed in accordance with a written service plan approved by the DHCFP, or its designee, developed in conjunction with the recipient, their LRI or PCR, and based on the needs of the recipient as determined by a Functional Assessment Service Plan (FASP). PCS are an optional Medicaid State Plan benefit under the Social Security Act.

PERSONAL CARE SERVICES (PCS) PROVIDER AGENCY

An entity, that is licensed by the Bureau of Health Care Quality and Compliance (HCQC), to provide personal care services in the home, and which contracts with the DHCFP to provide covered, medically necessary PCS to eligible Medicaid recipients under the Provider agency service delivery model. The Provider Agency employs the PCAs who provide the recipients approved 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.

PHARMACEUTICALS

Pharmaceuticals are any drug, compound, mixture or preparations which the U.S. FDA have approved for medical use.

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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 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

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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).

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.

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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.

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, intellectual disability or related condition. PASRR Level II determines whether the individual requires NF services and specialized mental health services.

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PRE-FABRICATED 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 Sections 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 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

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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.

PRIOR RESOURCES

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

PRIVATE DUTY NURSING (PDN) SERVICES

PDN is an optional Medicaid service which states may elect to provide. Chapter 42 CFR 440.80 defines PDN

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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.

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,

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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 any time 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.

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

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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.

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 INTELLECTUAL DISABILITY PROFESSIONAL (QIDP)

A QIDP is a person who has one or more years' experience in working with persons with intellectual disability 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 Dietetic 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).

QUALIFIED RECIPIENTS

Medicaid recognizes a qualified recipient to be one who is currently eligible for full Medicaid services and meets

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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

Reevaluations 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/IID 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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REGISTERED DIETITIANS

A person licensed to engage in the practice of dietetics or to provide nutrition services, including, without limitation, medical nutrition therapy, and is registered as a dietitian by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics. Licensure is required in Nevada through the Department of Public and Behavioral Health (DPBH). Nutrition services are practiced within dietetics and include the assessment, evaluation, diagnosis, counseling, intervention, monitoring and treatment of a person which requires substantial specialized judgment and skill based on the knowledge, application and integration of the principles derived from the sciences of food, nutrition, management, communications, biology, behavior, physiology and social science to achieve and maintain proper nourishment and care of a person.

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.

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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.

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 current ICD 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;

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- 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
 - 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

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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),
 - 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.

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 intellectual disability 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 intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required by a person with intellectual disability. 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;

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4. Mobility;
5. Self-direction; and/or
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 the 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 an intellectual disability or with a physical disability or a person who is aged or infirm. The term includes, without limitation, an assisted living facility as defined in NRS 449.017. These facilities are licensed by the 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.

RESOURCE UTILIZATION GROUPS

Resource Utilization Groups (RUG-III) is a classification system which uses information from the MDS

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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.

RESPITE

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.

RESPITE 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.

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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

A review performed by the DHCFP’s QIO-like vendor or MCO regarding recipients not Medicaid eligible until after services are rendered, and/or after discharge to determine if a requested service will be authorized based on medical necessity, appropriateness, and compliance with applicable policies.

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 revises its provisions if appropriate.

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.

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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.

ROLLOVER ADMISSION

A direct inpatient admission initiated through an emergency room or outpatient observation as part of one continuous episode of care (encounter) at the same facility when a physician writes an acute inpatient admission order.

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 is 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. The non-emergency transportation broker may provide this service if the recipient is medically stable and the broker is able to meet the prescribed time frame. (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 (SD) SERVICE DELIVERY MODEL

The Self-Directed service delivery model is a delivery option that allows for the self-direction of Personal Care Services and/or Skilled Services to allow recipients who have the ability and desire to manage their own care, more autonomy and responsibility in the provision of their services. This option is only available by accessing services through an ISO.

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SELF-DIRECTED (SD) SKILLED SERVICES

SD Skilled Services are skilled services provided to a recipient by an unlicensed personal care assistant, where a provider of healthcare can authorize an unlicensed personal care assistant to provide certain specific medical, nursing or home health services, subject to a number of conditions. Services must be provided in the presence of the parent or guardian, or any other person legally responsible for the recipient, if the recipient is unable to direct their own care, as in the case of a minor child or a disabled and/or cognitively impaired adult in accordance with 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 current ICD (excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disability, unless they co-occur with a serious mental illness that meets current ICD 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.

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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.

SEVERE EMOTIONAL DISTURBANCE (SED)

1. Children with SED are persons up 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 meet the coding and definition criteria specified in the current ICD (excluding substance abuse or addictive disorders, irreversible dementias, intellectual disability, developmental disorders and Z codes, unless they co-occur with a serious mental disorder that meets ICD 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.
2. 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

An exacerbation of a previous disabling condition resulting in a hospitalization (within past 14 days) or a physician’s visit (within past seven days) or a new diagnosis not expected to resolve within eight weeks.

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 §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 legally responsible individual (LRI) or primary caregiver.

SKILLED ADMINISTRATIVE DAYS

Inpatient hospital days reimbursed at a lower per diem rate when a recipient’s status does not meet an acute level of care and if discharge is ordered, alternative appropriate placement is not available, despite documented evidence of comprehensive discharge planning efforts (e.g. a recipient is waiting for nursing or psychiatric facility placement or home equipment set-up availability).

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

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6. tracheotomy care.

SKILLED SERVICES

Skilled services are specific medical, nursing or home health services that are inherently complex and require the technical or professional skill and specialized training that the State statute or regulation mandates must be performed by a health care professional licensed or certified by the State.

SLEEP STUDY

Sleep studies refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for six 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 advanced emergency medical technician (AEMT) or paramedic. SCT is necessary when a recipient's condition requires ongoing care that must be furnished by one or more health professionals during transport. SCT is not a service provided by the NET broker, and may require a prior authorization from the recipient's managed care organization, if applicable. 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.

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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 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 HCBS Waiver 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 TRANSPORT

A type of transportation where the recipient must be transported in a prone position on a gurney or a stretcher. Stretcher transport is 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).”

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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.

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 MSM Chapter 2100.

SWING-BED

A CMS certified bed in a rural or critical access hospital that can be used to provide either acute hospital inpatient or post-acute skilled nursing services, as needed.

SWING-BED HOSPITAL

A CMS certified rural or critical access hospital that has a Medicare swing-bed provider agreement, and is state-licensed to allow either acute or post-acute skilled nursing/skilled rehabilitation services to be provided in a specific number of certified beds, as needed.

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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 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;
 - d. Social or emotional development; or

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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 services are:

1. Covered services provided to juveniles on probation (referred or under the supervision of juvenile caseworkers) within all counties of Nevada.
2. Covered services provided to 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 intellectual disabilities, are recipients 18 years of age and older with significant life stressors and have a:

1. A current International Classification of Diseases (ICD) diagnosis, from the current Mental, Behavioral, Neurodevelopmental Disorders section including Z-codes 55-65, R45.850 and R45.851, which 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 intellectual disability, are recipients with significant life stressors and have:

1. A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section that does not meet SED criteria.
2. Z-codes 55-65, R45.850 and R45.851 as listed in the current ICD which does not meet SED criteria.
3. CASII Level of 0, 1, 2 or above.

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TARGET GROUP – INDIVIDUALS WITH INTELLECTUAL DISABILITY OR RELATED CONDITIONS (IIDRC)

Persons with IIDRC 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 intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectually disabled 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);
3. have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the current ICD Mental, Behavioral, Neurodevelopmental Disorders section (excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disability, unless they co-occur with another serious mental illness that meets current ICD criteria) that resulted in functional impairment which substantially interferes with or limits one or more major life activities;
4. Have a functional impairment addressing the ability to function successfully in several areas such as

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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 with a SED are persons up 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 current ICD. This excludes substance abuse or addictive disorders, irreversible dementias, as well as intellectual disability and Z codes, unless they co-occur with another serious mental illness that meets current ICD 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 disorder from the Mental, Behavioral, Neurodevelopmental Disorders section (including those of biological etiology) listed in the current ICD manual (and subsequent revisions), with the exception of “Z” 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.

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)

Acute Hospital or Medical Rehabilitation Specialty Hospital: A leave of absence for a therapeutic reason, such as, a diagnostic test or procedure that must be performed at an alternate facility or a trial home visit to prepare for independent living.

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Nursing Facility: An LOA for therapeutic or rehabilitative home and community visits or in preparation for discharge to community living that involves 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.

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.

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.

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

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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.

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.

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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 five business days' notice. A recipient must have a medical need to see the provider in less than five 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.

UTILIZATION REVIEW

A process to evaluate the medical necessity, appropriateness, location of service, level of care and length of stay, when applicable, and the efficiency and efficacy of health care services or procedures requested or provided. Utilization review is a cost containment program that promotes the delivery of quality health care in a cost efficient manner.

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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 via an endotracheal tube or a tracheotomy.

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.

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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.

WASTE

Waste includes practices that, directly or indirectly, result in unnecessary costs to the Medicaid Program, such as overusing services or misuse of resources.

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.

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