

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 10, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 - MEDICAID PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 100 are being proposed to update policy with the current International Classification of Diseases (ICD)-10 CM verbiage.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED

MTL 19/15
CHAPTER 100 - MEDICAID PROGRAM

MATERIAL SUPERSEDED

MTL 11/15
CHAPTER 100 - MEDICAID PROGRAM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
105.1C	Medicaid Payments to Providers	Deleting reference to ICD-9.
105.1F		Deleting reference to ICD-9.

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100 INTRODUCTION

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

- a. purchase and provide quality health care services to low-income Nevadans in the most efficient manner;
- b. promote equal access to health care at an affordable cost to the taxpayers of Nevada;
- c. restrain the growth of health care costs; and
- d. review Medicaid and other State health care programs to maximize potential federal revenue.

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

100.1 AUTHORITY

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

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

- a. Eligibility for Medicaid assistance is regulated by Section 1901(a) of the Social Security Act, 42 CFR, Part 435, and Nevada Medicaid State Plan Section 2.1.
- b. Payment for Medicaid services is regulated by Sections 1902(a) and 1923 of the Social Security Act, 42 CFR, Part 447, and Nevada Medicaid State Plan Sections 4.19 and 4.21.

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- c. Provider contracts/relations are regulated by 42 CFR 431, Subpart C; 42 CFR Part 483, and Nevada Medicaid State Plan Section 4.13.
- d. Safeguarding and disclosure of information on applicants and recipients is regulated by 42 United States Code (USC) 1396a(a)(7), and the associated regulations: 42 CFR 431, Subpart F; the Health Insurance Portability and Accountability Act (HIPAA), and associated regulations: 45 CFR 160, 162 and 164 and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009; Nevada Medicaid State Plan Section 4.3, and NRS 422.290. Penalties for unauthorized use or disclosure of confidential information are found within the HITECH Act and NRS 193.170.
- e. Prohibition against reassignment of provider claims is found in 42 CFR 447.10 and Nevada Medicaid State Plan Section 4.21.
- f. Exclusion and suspension of providers is found in 42 CFR 1002.203 and Nevada Medicaid State Plan 4.30.
- g. Submission of accurate and complete claims is regulated by CFR 42 CFR 455.18 and 444.19.
- h. Nevada Medicaid assistance is authorized pursuant to State of NRS, Title 38, Public Welfare, Chapter 422, Administration of Welfare Programs.
- i. Third Party Liability (TPL) policy is regulated by Section 1902 of the Social Security Act; 42 CFR, Part 433, Subpart D, and the Nevada Medicaid State Plan Section 4.22.
- j. Assignment of insurance benefits by insurance carriers is authorized pursuant to State in NRS, Title 57, Insurance, based on the type of policy.
- k. Subrogation of medical payment recoveries is authorized pursuant to NRS 422.293.
- l. “Advance Directives” are regulated by 42 CFR 489, Subpart I.
- m. Worker’s compensation insurance coverage is required for all providers pursuant to NRS Chapter 616A through 616B.
- n. Section 1902(a)(68) of the Social Security Act establishes providers as ‘entities’ and the requirement to educate their employees, contractors, and agents on false claims recovery, fraud, and abuse.
- o. Offering gifts and other inducements to beneficiaries is prohibited pursuant to Section 1128A(a)(5) of the Social Security Act, enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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100.2 CONFIDENTIAL INFORMATION

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

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

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

a. Definition of Confidential Information

For the purposes of this manual, confidential information includes:

1. Protected Health Information (PHI)

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

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

- a. the individual’s past, present or future physical or mental health or condition;
- b. .the provision of health care to the individual;
- c. the past, present, or future payment for the provision of health care to the individual; or
- d. identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

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

2. Information on social and economic condition or circumstances.

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3. Division/Department evaluation of personal information.
4. Any information received for verifying income eligibility and amount of medical assistance payments.
5. Any information received in connection with the identification of legally liable third party resources.
6. Medicaid Provider Numbers or other identifiers defined by NRS 603A.040.

b. Limitations on Use and Disclosure

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

1. Establishing eligibility;
2. Determining the amount of medical assistance; payment activities as defined by HIPAA;
3. Determining third party liability;
4. Providing services (medical and non-medical) for recipients; treatment as defined by HIPAA;
5. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan;
6. Health care operations as defined by HIPAA, which includes, but is not limited to: quality assessment and improvement activities, including case management and care coordination, competency assurance activities, medical reviews, audits, fraud and abuse detection, rate setting, business management and general administration;
7. For public interest and benefit activities within limits set under HIPAA, including, but not limited to: disclosures required by law, public health activities, health oversight activities, judicial and administrative proceedings, essential government functions, to comply with worker's compensation laws, and to avoid serious threats to the health and safety of recipients and others.
8. Per authorizations (as defined by HIPAA) from the recipient or their designated representative.

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c. Release of Information

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

1. Disclosure is permitted for purposes directly connected with the administration of Medicaid between covered entities (as defined by HIPAA) for the purposes of treatment, payment, and health care operations and may, in certain circumstances, be done in the absence of an authorization or agreement. Such situations include, but are not limited to: verifying information with Medicaid program staff in other states to verify eligibility status, disclosure to Medicare staff for coordination of benefits, or communications with providers for payment activities.
2. Access to confidential information regarding recipients will be restricted to those persons or agencies whose standards of confidentiality are comparable to those of the DHCFP.
 - a. Those standards of confidentiality will be outlined in appropriate agreements which the DHCFP may require, including business associate agreements and limited data set use agreements (as defined by HIPAA) data sharing agreements, and other agreements deemed necessary by the DHCFP.
3. In accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the DHHS in the performance of official duties and with local governments that help the Department carry out official duties as long as the disclosure is related to treatment, payment, or health care operations.
4. The DHCFP will make reasonable efforts to follow HIPAA's "minimum necessary" standard when releasing confidential information.
5. Detailed policies and procedures are found in the DHCFP HIPAA Privacy and Security Manuals, available for reference in hard copy form in the District Office and on the DHCFP Intranet.

d. Penalties

Penalties for inappropriate use and disclosure of confidential information are:

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

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

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

e. Ownership

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

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101 OVERVIEW OF PROGRAMS

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

a. Medicaid

Medicaid applicants must apply for and meet the criteria of the appropriate assistance program. Every person has the right to apply for assistance. A deceased person may have an application filed on his or her behalf.

Requests for medical assistance under the Temporary Assistance for Needy Families (TANF)-Related Medicaid (TRM), Child Health Assurance Program (CHAP), Medicaid for the Aged, Blind, and Disabled (MAABD) programs and the Child Welfare Services (as provided by NRS 432.075 are processed at one of the local Nevada Division of Welfare and Supportive Services (DWSS) offices depending on the applicant's residence. Eligibility is established based on regulations stated in the DWSS policy manuals. Inquiries are made at the nearest DWSS office and may be made verbally, in writing, in person, or by a representative. District Office staff will assist with applications if necessary. DWSS policy manuals are located on their website at: www.dwss.nv.gov.

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

b. Nevada Check Up (NCU)

The NCU program is Nevada's name for the federal Title XXI benefits administered under the Children's Health Insurance Program (CHIP). NCU provides low-cost, health care coverage to uninsured children who do not meet the conditions of Medicaid eligibility. Applicants must apply for and meet the criteria for this program. The services for NCU recipients generally duplicate the services outlined for Nevada Medicaid and the program uses the Nevada Medicaid Provider Panel. Refer to the NCU Manual for a description of program differences.

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

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

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

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

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

101.1 OUT OF STATE SERVICES

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

Section 1902(a)(16) of the Social Security Act requires the out-of-state service equal in amount, duration and scope to in-state service be reimbursed for eligible Nevada residents who are absent from the state when:

- a. needed because of a medical emergency.
- b. recipients' health would be in danger by travel back to Nevada.
- c. Nevada Medicaid determines, on the bases of medical advice, that the needed medical service or necessary supplementary resources are readily available in another state; or
- d. provided to the children in out-of-state placement for whom Nevada makes adoption assistance or foster care maintenance payments.
- e. it is general practice for a recipient in a particular locality to use medical resources in another state:
 1. Nevada residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the DHCFP refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation. Refer to the billing manual for a list of catchment areas.
 2. The same services that are covered within the state of Nevada are available for payment for any qualified provider, in the catchment area, who is or will be enrolled with the plan.

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Nevada Medicaid does not pay for medical services rendered by health care providers outside of the United States.

101.2 NEVADA MEDICAID AND NCU CARD

Medicaid and NCU recipients are issued a plastic identification card upon approval for benefits, through the State Medicaid Management Information System (MMIS). The card is issued with his/her full eleven-digit billing number, last name, first name, sex, and date of birth. The card does not identify the category of eligibility nor does it carry photographic or other individual identifying information, and it does not guarantee eligibility for benefits. The recipient is not responsible to return the card when the case is closed and they may use the same card for any subsequent eligibility.

101.2A ELIGIBILITY VERIFICATION AND CARD USE

1. Information regarding the recipient, category of eligibility, managed care, recipient restrictions, and third party payers is accessible, for any of the most recent 60 months, through the fiscal agent's Eligibility Verification System (EVS), by phone using the Voice Response Unit (VRU), or by using a swipe card vendor. Providers may contact the Fiscal Agent to receive information about enrolling for EVS system access and alternative sources of eligibility verification.

EVS will identify individuals eligible for full Medicaid, full Medicare, full Medicaid and Medicare coverage, and Qualified Medicare Beneficiary (QMB) coverage. Note: Medicaid pays only the deductibles and co-insurance for QMB recipients up to Medicaid allowable amounts.

2. Eligibility is determined on a month to month basis. Providers must always verify recipient eligibility prior to providing services, as well as the identity of the individual through a driver's license, Social Security card, or photo identification. Recipients must be prepared to provide sufficient personal identification to providers, and shall not allow any individual to use their card to obtain medical services.
3. Newly approved Medicaid recipients may present a Notice of Decision (NOD) from the DWSS as proof of eligibility, prior to the EVS update.
4. Individuals may have more than one active billing number on file at the same time; e.g., a child may be eligible through Child Welfare services and have a Welfare case at the same time. When this happens, the Division's Provider Support Unit can advise the provider which number to use for billing.
5. Medicaid and NCU have contracts with managed care organizations to provide medical coverage to eligible categories of individuals in Clark and Washoe County. Nevada

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

6. Recipients enrolled in a Medicaid managed care plan must be sure to seek services only from plan providers. Recipients should notify their providers as soon as they become eligible for managed care. Refer to MSM Chapter 3600 on Managed Care.
7. In most cases, managed care eligibility begins the first of the month after the date of approval. Medicaid prior medical months are covered under Fee-for Service (FFS). Refer to MSM Chapter 3600 for additional information on Managed Care.

101.2B CHILD WELFARE RECIPIENTS

Payment for emergent or necessary medical services or care provided to a child who is in the custody of a Public Child Welfare Agency may be covered by Nevada Medicaid or guaranteed by the custodial public agency. A child eligible for coverage through one of these sources will receive a Medicaid number and card.

If a child requires medical care before a Medicaid number and/or a Medicaid card is issued, the custodial agency may prepare a letter verifying demographic information including the child's name, date of birth, Social Security number, and the services requested. (If a Medicaid number has been assigned but a card has not yet been issued, the letter should also contain the Medicaid number.) The letter must be signed by an authorized staff member of the Public Child Welfare Agency in whose custody the child is placed and must be printed on the agency's official letterhead.

101.2C RESTRICTIONS

1. Certain recipients who have inappropriately used medical services may have their access to Medicaid services restricted by Medicaid Staff.
2. Before any non-emergency service is provided to a recipient, whose benefits have been restricted, phone authorization must be obtained from the QIO-like vendor. Providers will be asked to document the necessity of all services provided which are not emergent. If approval is granted, a specific authorization number will be issued to the provider. This number must then appear on the provider's claim for payment for the service dispensed. Claims submitted for a recipient whose benefits have been restricted without an authorization number or documentation of an emergency will not be paid.

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102 PROVIDER ENROLLMENT

All individuals/entities providing services to Medicaid recipients under the Fee-for-Service (FFS) or Medicaid Managed Care program must be enrolled as a Medicaid provider in order to receive payment for services rendered. All healthcare providers who are eligible to obtain a National Provider Identifier (NPI) number must provide this NPI to Medicaid at the time of their provider enrollment application. To obtain a NPI or further information regarding NPI, see the National Plan and Provider Enumeration System (NPPES) website at <https://nppes.cms.hhs.gov>.

Medicaid may reimburse a provider who meets the following conditions:

- a. Provides their NPI/API number on the application and requests for payment;
- b. Meets all of the professional credentialing requirements or other conditions of participation for the provider type;
- c. Completes the Nevada Medicaid Provider Application and Contract; and
- d. Received notice from Nevada Medicaid that the credentials have been met and the provider agreement has been accepted.

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

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

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

102.1 REQUEST FOR ENROLLMENT

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

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

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

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

102.2 CONDITIONS OF PARTICIPATION – ALL PROVIDERS

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

1. Murder, voluntary manslaughter or mayhem;
2. Sexual assault, sexual seduction or any sexually related crime;
3. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission of the crime;
4. Abuse or neglect of a child or contributory delinquency;
5. False imprisonment, involuntary servitude or kidnapping;
6. Abuse, neglect, exploitation or isolation of any older persons or vulnerable persons, including a violation of any provisions of Nevada Revised Statute (NRS) Sections 200, or a law of any other jurisdiction that prohibits the same or similar conduct;
7. Any offense involving assault or battery, domestic or otherwise;
8. Conduct hostile or detrimental to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
9. Within the preceding seven years the fiscal agent shall not enroll a provider who has been convicted of (not all inclusive):
 - a. Any offense involving arson, fraud, theft, embezzlement, burglary, fraudulent conversion or misappropriation of property;

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- b. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in Chapter 454 of the NRS;
 - c. Any felony involving the use of a firearm or other deadly weapon;
- B. The Fiscal Agent will not enroll any provider who:
 - 1. is on the Office of the Inspector General (OIG) or EPLS exclusion list;
 - 2. has been convicted of a criminal felony offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (CHIP) (NCU) or the Title XX services program;
 - 3. has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU) or Title XX services program;
 - 4. use a financial institution outside of the country (excluding Guam, Puerto Rico, Mariana Islands and American Samoa); or
 - 5. is serving a sanction period.
- C. The Fiscal Agent will not enroll a public institution unless it is a medical institution. The Fiscal Agent will never enroll a penal or correctional institution.
- D. All providers must provide and maintain workers compensation insurance as required by law and provided proof of insurance as required through 616D, inclusive, of the NRS.
- E. All Nevada Medicaid providers must comply with information reporting requirements of the Internal Revenue Code (26 U.S.C. 6041) which requires the filing of annual information (1099) showing aggregate amount paid to providers service identified by name, address, or Social Security Number or Federal Identification Number (FEIN). A FEIN is the preferred identifier, but a Social Security Number may be used by those self-employed individuals in a sole proprietorship who do not have a FEIN.
- F. The provider is responsible for understanding the requirements of their provider type as stated in the Nevada Medicaid Services Manual (MSM). The provider should also be familiar with Chapter 3100 – Hearings and Chapter 3300 – Surveillance, Utilization and Review (SURs).
- G. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with the DHC FP Operations Service Manuals, state and federal statutes, and regulations at a minimum of six years from the date of payment for the specified

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

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

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

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

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

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

102.3 OUT OF STATE PROVIDER PARTICIPATION

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

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

- a. The provider is providing a service which is not readily available within the state; and
- b. The provider is providing services to Medicaid recipients in a catchment (border) area; or
- c. The provider is providing services to Medicare cross over recipients only.

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

102.3A EMERGENCY SERVICES OUTSIDE THE STATE OF NEVADA

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

102.4 FACILITY DISCLOSURE

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

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

Documents subject to disclosure include:

- a. survey reports, including a statement of deficiencies;
- b. official notifications of findings based on the survey;
- c. written plans of correction submitted by the provider to the survey agency;
- d. ownership and contract information specified below; and
- e. reports of post-certification visits and summaries of uncorrected deficiencies.

Within the context of these requirements, the term "provider" or "discloser" excludes an individual practitioner or group of practitioners unless specifically mentioned.

At the time of a periodic survey or renewal of a contract to participate in the program, providers and fiscal agents must disclose:

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- f. name and address of each person with an ownership or control interest in the discloser, or in any subcontractor in which discloser has direct or indirect ownership of 5% or more;
- g. whether any of the persons named is related to another as spouse, parent, child, or sibling; and
- h. name of any other disclosing entity in which a person with an ownership or controlling interest in the discloser also has ownership or controlling interest.

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

- i. ownership of any contractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- j. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of request.

102.4A PROVIDER DISCLOSURE

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

1. Conviction of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, CHIP (NCU) or Title XX services program since the inception of the programs;
2. Denial of enrollment or termination for cause, exclusion or any form of suspension from Medicare, Medicaid, CHIP (NCU), any federal health care program or Title XX services program since the inception of the programs;
3. Conviction of any criminal offense. Providers reporting criminal convictions other than convictions listed in 102.2.A are not automatically precluded from enrollment. The Fiscal Agent will forward these applications to the DHC FP Provider Support Unit for consideration on a case by case basis. Providers must provide information, documentation, and explanation regarding their charge;

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4. Any current or previous investigation by any law enforcement, regulatory agency, or state agency, or restricted professional license. The Fiscal Agent will forward these applications to the Provider Support Unit for consideration on a case by case basis. Providers must provide information, documentation and explanation;
5. Any current open/pending court cases;
6. Any current or previous affiliation with a provider, supplier or other State that has uncollected debt with no attempt to resolve; or
7. If billing privileges have ever been denied or revoked with a federal or state health care program.

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

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

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

- a. onsite inspection prior to enrollment;
- b. review of business records;
- c. data searches; and
- d. provisional enrollment.

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

1. billing practices;
2. policy and procedure; or
3. quality of care compliance reviews.

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

102.5 DISPOSITION OF CONTRACT FOR NEW PROVIDERS

The fiscal agent will review the completed provider application, copies of required licenses, registrations, certificates, etc., to determine if the applicant meets all of the conditions of participation as stated in the Nevada MSM for the specified provider type and Nevada MSM Chapter 100 all inclusive.

102.5A CERTIFICATION STATEMENT

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

1. “I understand in endorsing or depositing this check that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.”
2. “I agree to accept Medicaid payments as payment in full for services rendered and under no condition, except for lawful patient liability, contact the patient or members of the patient’s family for additional sums.”
3. “I acknowledge that I have examined the remittance advice that accompanied this check and that the items covered represent amounts due to me and that the services listed thereon have been rendered by me.”
4. By signing the enrollment application, the provider attests to the following:
 - a. That payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws; and
 - b. With regard to submission of claims for payment:
 1. I certify that all information is true, accurate and complete; and
 2. With regard to remittance and receipt of payment whether by check or electronic transmission.
 3. “I agree to accept Medicaid payments as payment in full for services rendered and under no condition, except for lawful patient liability, contact the patient or members of the patient’s family for additional sums.”

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

102.5B CONTRACT OR RE-ENROLLMENT APPROVAL

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

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

102.5C CONTRACT OR RE-ENROLLMENT DENIAL

1. The DHCFP will refuse to enter into a contract with an applicant for provider enrollment in the Medicaid program if the provider:
 - a. does not meet the conditions of participation as stated in this Chapter, all inclusive;
 - b. does not meet all of the professional credentialing requirements or other conditions of participation as required by the Nevada MSM for the specified provider type;
 - c. has been terminated for cause, excluded or suspended, leading to revocation of an agreement or contract with a provider by any other governmental or State program;
 - d. fails to submit information requested by the Fiscal Agent;
 - e. submits false information.
2. The Fiscal Agent Provider Enrollment Unit will notify the provider by U.S. mail of the contract denial. Providers who have their enrollment denied do not have appeal or hearing rights.

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103 PROVIDER RULES AND REQUIREMENTS

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

- a. If the provider has knowledge of over-utilization, inappropriate utilization, use of the Nevada Medicaid card by a person not listed on the card, unreasonable demands for services, or any other situation that the provider feels is a misuse of medical services by a recipient, he shall inform the Nevada Medicaid office.
- b. A Medicaid provider who accepts a Medicaid recipient for treatment accepts the responsibility to make sure the recipient receives all medically necessary services. This includes making appropriate referrals to other Medicaid providers, ensuring ancillary services are delivered by a Medicaid provider, and ensuring the recipient receives all medically necessary services at no cost to the recipient.
- c. In addition, when the services require a Prior Authorization (PA) and a PA number is obtained; the provider must give that number to other relevant providers rendering service to the recipient.
- d. All Medicaid providers who accept Medicaid reimbursement for treatment accept responsibility for understanding and comprehending their provider contract and all chapters of the Medicaid Services Manual (MSM) that pertain to their individual provider type and services they provide. This applies to all institutions and medical groups as well.

103.1 MEDICAL NECESSITY

A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:

- a. Type, frequency, extent, body site and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
- b. Level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.

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- c. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
- d. Services are provided for medical or mental/behavioral reasons rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider.

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

103.2 AUTHORIZATION

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

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

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

- a. Some services covered by Nevada Medicaid require PA for payment. When the provider learns that a patient has been approved for Medicaid, authorization, as appropriate, must be requested for services provided and/or being provided.

For Medicaid recipients who have been discharged from an inpatient facility, and are approved for Medicaid eligibility retroactively, the provider has 90 days from the date of the eligibility decision to submit a request for authorization, with the complete medical record, to the QIO-like vendor. For recipients still in the hospital when the eligibility date of decision is determined, the facility is responsible for initiating the admission and concurrent review authorization within ten working days.

- b. For Medicare and Medicaid dual eligibles there is no requirement to obtain Medicaid PA for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's PA guidelines. PA are not necessary for recipients who are eligible for Qualified Medicare Beneficiary (QMB) only since Medicaid pays only the co-pay and deductible. If Medicare benefits are exhausted (i.e. inpatient) a PA from

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Medicaid's QIO-like vendor must be obtained within 30 days of the receipt of the Medicare Explanation of Benefits (EOB).

- c. Medicaid Eligibility may be determined for up to three months prior to an application for assistance. Services provided during a period of retroactive eligibility are evaluated on a case-by-case basis. Provider can verify eligibility through the Electronic Verification of Services (EVS). Covered services that meet the definition of "emergency services" reimbursed. A retrospective review for services which require prior authorization by Medicaid's QIO-like vendor will determine authorization for payment based on clinical information that supports medical necessity and/or appropriateness of the settings.
- d. If PA is required, it is the responsibility of the provider to request before providing services. Waiting until the claim is due before securing an approved PA will not override the stale date. The PA number is required on the claim. See the appropriate MSM chapter for program specific retro-authorization policy.
- e. Once an approved PA request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.
- f. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period, or both) of the current authorization, the provider is responsible for the submission of a new PA request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period, so the newly authorized service may start immediately following the expiration of the existing authorization. Exception: the 15 day recommendation does not apply to concurrent, inpatient hospital stay authorizations.
- g. It is the provider's responsibility to submit the necessary paperwork to support the PA request. PA requests submitted lacking the required information for the service/item, will be denied with a Notice of Decision (NOD) to the recipient.

103.3 PROVIDER REPORTING REQUIREMENTS

Medicaid providers, and any pending contract approval, are required to report, in writing within five working days, any change in ownership, address, or addition or removal of practitioners, or any other information pertinent to the receipt of Medicaid funds. Failure to do so may result in termination of the contract at the time of discovery.

103.3A CONDITIONS OF REPORTING

- a. All changes must be reported in writing and require the signature of the provider. If the provider is a business, the change must include the signature of the owner or administrator. Medicaid will not change any provider record without proper signatures.

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Annual 1099 forms reflect the information in Medicaid’s records and may be incorrect if changes are not reported timely.

- b. Medicaid payments are mailed only to the address furnished by the provider and listed in the Medicaid computer system. Correct address and other information are necessary to assure receipt of all checks and policy publications from Nevada Medicaid. Address changes are required even when only a suite number change as the US Postal Service will not deliver mail to a different suite number. Returned mail may be used by Medicaid to close provider numbers due to “loss of contact”.
- c. When there is a change in ownership, the contract may be automatically assigned to a new owner, as well as the payment amounts that may be due or retrospectively become due to, or from Nevada Medicaid by the prior owners. The assigned contract is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.

If there is a change in ownership, the provider must provide a copy of the bill of sale, copies of new licenses/certifications, and verification of a change in the Federal Employee Identification Number (FEIN).

- d. For a change in name only, the provider must provide copies of new license/certifications and verification of change in FEIN. For a change in FEIN the provider must provide verification from the Treasury Department of the new number.

103.4 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

The Division of Health Care Financing and Policy (DHCFP) is required to ensure entities receiving annual payments from Medicaid of at least \$5,000,000 have written policies for educating their staff on federal and state regulations pertaining to false claims and statements, the detection and prevention of fraud and abuse, and whistleblowers protections under law for reporting fraud and abuse in Federal health care programs. (1396a(a)(68) of Title 42, United States Code).

These providers are required to:

- a. adhere to federal and state regulations, and the provider agreement or contract, to establish written policy of dissemination to their staff;
- b. ensure policies are adopted by any contractor or agent acting on their behalf;
- c. educate staff on the regulations. Dissemination to staff should occur within 30 days from the date of hire, and annually thereafter;

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- d. provide signed Certification Form, signed provider agreement, copies of written policy and employee handbook, and documentation staff has been educated, within the required timeframes;
- e. maintain documentation on the education of staff, and make it readily available for review by state or federal officials; and
- f. provide requested re-certification within required timeframes to ensure ongoing compliance.

103.4A COVERAGE AND LIMITATIONS

- 1. The DHCFP has a program to identify providers that fit the criteria of being an entity, and will identify additional or new providers fitting the criteria at the beginning of each federal fiscal year.
- 2. The DHCFP will issue a letter advising an entity of the regulations and require the entity to:
 - a. submit a certification stating they are in compliance with the requirements;
 - b. sign a provider agreement, or Managed Care Contract Amendment incorporating this requirement;
 - c. provide copies of written policies developed for educating their staff on false claims, fraud and abuse, and whistleblowers protections under law; and
 - d. provide documentation of employees having received the information.
- 3. Re-certification of existing entities will be done annually for ongoing compliance.
- 4. The DHCFP is authorized to take administrative action for non-compliance through non-renewal of provider or contract, or suspension or termination of provider status.

103.5 SAFEGUARDING INFORMATION ON APPLICANTS AND RECIPIENTS

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

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

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

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

103.5A MEDICAL AND PSYCHOLOGICAL INFORMATION

1. Any psychological information received about an applicant or recipient shall not be shared with that person. This ruling applies even if there is a written release on file from his or her physician. If the applicant/recipient wishes information regarding his or her psychological condition, he or she must discuss it with his or her physician.
2. Medical information, regardless of source, may be shared with the applicant or recipient upon receipt of their written request. However, any other agency needing copies of medical information must submit a Medicaid release stating what information is requested and signed by the applicant or recipient in question or their authorized representative.

The exception to this policy is in the case of a fair hearing. Agency material presented at a fair hearing constituting the basis of a decision will be open to examination by the applicant/recipient and/or his or her representative.

3. The HIPAA of 1996 Privacy Rules permit the disclosure of a recipient's health information without their authorization in certain instances (e.g. for treatment, payment, health care operations, or emergency treatment; to make appointments to the DHC FP business associates; to recipient's personal representatives; as required by law; for the good of public health; etc.)
4. The HIPAA Privacy Rules assure the recipient certain rights regarding their health information (e.g. to access/copy, to correct or amend, restrict access, receive an accounting of disclosures, and confidential communications).
5. A provider may not disclose information concerning eligibility, care or services given to a recipient except as specifically allowed by state and federal laws and regulations.

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103.6 NON-DISCRIMINATION AND CIVIL RIGHTS COMPLIANCE

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act (ADA) of 1990, prohibit discrimination on the basis of race, color, national origin, religion, sex, age, disability (including AIDS or related conditions) or any other class status protected by federal or state law or regulation by programs receiving Federal Financial Participation (FFP). The DHCFCP service providers must comply with these laws as a condition of participation in the Nevada Medicaid program in offering or providing services to the Division's program beneficiaries or job applicants and employees of the service providers.

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

- a. Hospitals, nursing facilities and ICF/MRs must designate an individual as having responsibility for civil rights coordination, handling grievances and assuring compliance with all civil rights regulations. This person will serve as coordinator of the facility's program to achieve nondiscrimination practices, as well as be the liaison with Medicaid for Civil Rights compliance reviews.
- b. Notices/signs must be posted throughout a facility, as well as information contained in patient and employee handouts, which notifies the public, patients and employees that the facility does not discriminate with regards to race, color, national origin, religion, gender, age, or disability (including AIDS and related conditions) in:
 1. admissions;
 2. access to and provisions of services; or
 3. employment.

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

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

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

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

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

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

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

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

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

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- f. Medical facilities must have policies that prevent making improper inquiries regarding race, color, national origin, religion, sex, age or disability (including AIDS and related conditions) prior to making a decision to employ a person. Supervisory personnel must be knowledgeable with regard to these policies and practices and must enforce them.

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

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

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

1. identify the non-English languages that must be accommodated among the population served and identify the points of contact where language assistance is needed;
2. develop and implement a written policy that ensures accurate and effective communication;
3. take steps to ensure staff understands the policy and is capable of carrying it out; and
4. annually review the LEP program to determine its effectiveness.

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

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

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103.7 ADVANCED DIRECTIVE

An Advanced Directive (AD) is a written instruction by an individual, 18 years of age or older, and done in advance of a serious illness or condition. The AD allows the individual to direct health care decisions in the event they become incapacitated. It may be in the form of a Living Will or Durable Power of Attorney, and includes provisions allowing the individual to make decisions regarding the use or refusal of life sustaining treatment.

103.7A ADMINISTRATION OF ADVANCED DIRECTIVES

1. Hospitals, NF, home health agencies, Personal Care Attendants (PCA) providers and hospices must maintain written policies and procedures concerning ADs and provide written information to all adult individuals (age 18 or older) upon admission or service delivery concerning the:
 - a. individual’s rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate ADs.
 - b. written policies of the service provider respecting implementation of such rights, including a clear and precise statement of limitation if the service provider cannot implement an AD on the basis of conscience.

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

1. clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
 2. identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and
 3. describe the range of medical conditions or procedures by the conscience objection.
2. Document in the individual’s medical records whether or not the individual has an AD.
 3. Service providers cannot apply conditions to provisions of care or otherwise discriminate against an individual based on whether or not they have executed an AD.
 4. Ensure compliance with the requirements of state law regarding ADs, and inform individuals any complaints concerning AD requirements may be filed with the state survey and certification agency.

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

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

103.8 MUTUAL AGREEMENT IN PROVIDER CHOICE

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

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

Medicaid is generally the payer of last resort whenever there are any other responsible resources for payment of health care services. Other Health Care Coverage (OHC) includes, but is not limited to: Medicare, worker’s compensation insurance, private or group insurance, and any self-insured plans.

Recipients who have major medical insurance cannot participate in the NCU program. If a provider discovers a participant in NCU has major medical insurance, they must report to DHCFP.

- a. Providers should question all patients carefully regarding any other possible medical resources. If coverage has lapsed, or if insurance is discovered when none is indicated on the Eligibility Verification System (EVS), Voice Response Unit (VRU), or swipe card, an explanatory note attached to the claim will enable the fiscal agent to update the Third Party Liability (TPL) file.
- b. Providers are required to bill a recipient’s OHC prior to billing Medicaid.
- c. Medicaid Managed Care Organization (MCO) is not considered an OHC. Providers should refer recipients enrolled in a Medicaid MCO plan to the contact that is identified by the Fiscal Agent’s EVS or swipe card vendor unless the provider is authorized to provide services under the plan.
- d. If the provider does not participate in a recipient’s OHC plan, the provider must refer the recipient to the OHC. Nevada Medicaid will deny payment for OHC services if the recipient elects to seek treatment from a provider not participating in the OHC plan. If the Medicaid recipient is informed by a provider not authorized by the OHC that both the OHC and Medicaid may deny payment for the services, and the recipient then voluntarily elects to receive services from a provider who does not participate in the recipient’s OHC plan, the recipient assumes the responsibility to pay for the services personally.
- e. The provider must inform the recipient, or responsible individual, before services are provided that they will be financially responsible for the cost of services. If the recipient chooses to continue with the service, the provider must secure a written and signed statement at the time of the agreement which includes the date, type of services, cost of service, and the fact that the recipient, or responsible individual, has been informed. Medicaid will not pay for the services and agrees to accept full responsibility for the payment. This agreement may not be in the form of a blanket authorization secured only once (for example, at the time of consent for all treatment). It must be specific to each incident or arrangement for which the recipient, or responsible individual, accepts financial responsibility.

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- f. A Medicaid provider cannot refuse to provide Medicaid covered services to a Medicaid eligible recipient due to potential TPL coverage.
- g. Providers are required to bill Medicare for services provided to Medicare beneficiaries and must accept assignment if the recipient is a Medicare beneficiary and eligible for Medicaid, including Medicare/Medicaid (dual eligible) and Qualified Medicare Beneficiaries (QMBs).
- h. If providers are unable to pursue TPL, assistance may be requested within one year from the date of service through the Fiscal Agent’s TPL Unit. See Reference Section of this chapter. Providers are requested to contact the Fiscal Agent’s TPL Unit within four weeks after the date of service or TPL date of discovery. In many instances this prompt action will result in additional insurance recoveries.
- i. Providers should not release itemized bills to Medicaid patients. This will help prevent prior resources from making payment directly to the patient. Providers are encouraged to accept assignment whenever possible to lessen insurance problems by receiving direct payments.

104.1 PAYMENT LIMITS AND EXCEPTIONS

The total combined payment of other insurance and Medicaid cannot exceed the Medicaid maximum allowable. For Medicare Services which are not covered by Medicaid, or for which Nevada does not have an established rate, Medicaid will pay the Medicare co-insurance and deductible amounts. In all instances, Medicaid payment, even a zero paid amount, is considered payment in full and no additional amount may be billed to the recipient, his or her authorized representative, or any other source.

Medicare recipients covered by Medicaid as QMB are entitled to have Medicaid pay their Medicare premiums, co-insurance and deductible amounts for regular Medicare benefits. Some individuals may have this coverage as well as full Medicaid benefit coverage.

Some QMB only recipients may have a Health Management Organization (HMO) for their Medicare benefits. Any services provided to a QMB only recipient by the HMO which exceed the standard Medicare benefit package (i.e., prescription drugs) will not have co-payments and deductible amounts paid by Medicaid for those added benefits.

Co-pays and/or deductibles, set forth by the OHC, cannot be collected from a Medicaid recipient for a Medicaid covered service. Rather, the provider must bill Medicaid for the co-pay and/or deductible. In no instance will Medicaid’s payment be more than the recipient’s co-pay and/or deductible. Medicaid can make payments only where there is a recipient legal obligation to pay, such as a co-pay and/or deductible. EXCEPTION: Medicaid pays only co-payments and deductibles for regular Medicare benefits, even if provided through a Medicare HMO.

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Nevada Medicaid is not liable for payment of services if the recipient elects to seek treatment from a provider outside the OHC network, or if the provider fails to follow the requirements of the OHC. Exceptions to Medicaid liability policy for OHC coverage are:

- a. the service(s) is/are not covered by the OHC plan;
- b. the service is an emergency and the recipient is not given an option to choose/select where they are taken; or
- c. the recipient resides outside the service area of the OHC and accesses the nearest Nevada Medicaid provider.

Providers who have entered into an OHC agreement agree to accept payment specified in these agreements and must bill Medicaid for the recipient’s co-pay and/or deductible. In no instance can the provider bill Medicaid for an amount that exceeds the patient’s legal obligation to pay under the OHC agreement.

After receiving payment or a denial letter from the OHC, if the provider is submitting a paper claim, they must also submit the OHC’s Explanation of Benefits (EOB), computer screen print-out, or denial letter to the fiscal agent. All attached documents must reflect the name of the patient, date of service, service provided, the insurance company, the amounts billed, approved and paid.

It is not necessary to bill the OHC if it is known the specific service provided is not a covered benefit under the OHC policy. In this instance, the provider must note on the claim the date, phone number, and name of the person from whom the coverage information on the insurance was obtained and submit the claim to the Medicaid fiscal agent for processing. If the recipient’s OHC is Medicare and the service is not a covered Medicare service, the provider is not required to contact Medicare.

Providers must bill Medicaid for all claims, regardless of the potential for tort actions, within the specified time frame from the date of service or date of eligibility determination, whichever is later. Time frames are according to the Medicaid stale date period when no third party resource has been identified; or 365 days, when a third party resource exists.

Not all medical benefit resources can be discovered prior to claims payment. Therefore, a post payment program is operated. In these instances, Medicaid payment is recovered from the provider and the provider is required to bill the OHC resource. If OHC has been identified by the Medicaid system and the other resource has not been billed and the service(s) is/are a covered benefit of the OHC, the payment will be denied. The insurance carrier information will appear on the Medicaid remittance advice to enable the provider to bill the OHC.

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Exceptions to the TPL rule are:

- d. Indian/Tribal Health Services (IHS);
- e. Children with Special Health Care Needs; and
- f. State Victims of Crime.

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

104.2 SUBROGATION

In certain trauma situations, there may be a source of medical payments other than regular health insurance. This source could be through automobile insurance, homeowner's insurance, liability insurance, etc. A provider may elect to bill or file a lien against those sources, or Medicaid may be billed.

Nevada Medicaid will allow providers who accept(ed) a Medicaid payment for services directly related to injuries or accidents to subsequently return that payment to Medicaid in order to seek reimbursement directly from a liable third party.

- a. Medicaid will not enter into an arrangement with providers to represent or act on behalf of Medicaid in pursuit of recovery. Medicaid will continue to utilize its own legal staff to pursue recovery.
- b. Medicaid will pursue its own liens against tort settlements/judgments for those payments made by Medicaid to providers who do not repay them to pursue liens of their own. Although one provider may return a payment and pursue its own lien, other(s) may choose to accept Medicaid's payment in full. In these latter situations, Medicaid will pursue its own liens through established subrogation policies. However, the amount of Medicaid's lien will be limited to the total amount of all payments made by Medicaid which were not repaid by providers.
- c. Providers have the option to pursue liens on tort actions on a case-by-case basis.
- d. Providers are prohibited from pursuing money that has been awarded to a Medicaid beneficiary. The provider is entitled to reimbursement from a tort judgment or settlement only when the settlement distinguishes a set amount of money for medical expenses, and only if this amount is above the amount owed to Medicaid. The provider lien must be against the tort feisor and not the general assets of the beneficiary.

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In the case of tort liens, on or before 24 months from the date of injury, the provider may return the payment the provider received from Medicaid for the claims related to that injury.

Repayment of the Medicaid payment is a waiver by the provider of any further claims against Medicaid based on claims for that injury. Once a Medicaid payment is returned for the purpose of pursuing a tort lien, the provider's claim against Medicaid is ended. Providers who return Medicaid payments to pursue liens will not be allowed to bill Medicaid again at a later date in an effort to secure the entire previously paid Medicaid amount, or for payment above the lien recovery amount to secure a minimum of Medicaid's allowable. Repayment to Medicaid must be made prior to any action being taken by the provider to pursue the lien. Pursuit of a lien before returning the Medicaid payments violates federal regulation and the terms of the provider's agreement. In no event may a provider delay returning Medicaid payment until after a settlement or judgment is received.

104.3 HEALTH INSURANCE PREMIUM PAYMENTS (HIPP)

Nevada Medicaid may pay insurance premiums through Employer-Based Group Health Plans for individuals and families when it is cost effective for the agency. In determining cost-effectiveness, the fiscal agent uses a formula as set forth in the State Plan or considers whether the individual has catastrophic illness or condition (e.g., AIDS or AIDS-related conditions, Down syndrome, cerebral palsy, cystic fibrosis, fetal alcohol syndrome, etc.)

NCU participants are not eligible for HIPP.

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Medicaid payment must be made directly to the contracted person, entity, or institution providing the care or service unless conditions under #2 below are met. Federal regulations prohibit factoring or reassignment of payment.

- a. A provider may use a billing agent to complete Medicaid billing only if the compensation for this service is:
 - 1. related to the actual cost of processing the billing;
 - 2. not related on a percentage or other basis to the amount that is billed or collected; and
 - 3. not dependent on the collection of the payment.
- b. Medicaid payment for an individual practitioner may be made to:
 - 1. the employer of a practitioner if the practitioner is required, as a condition of employment, to turn over his fees to his employer;
 - 2. the group if the practitioner and the group have a contract in place under which the group submits the claims;
 - 3. the facility in which the services is provided, if the practitioner has a contract under which the facility submits the claims; or
 - 4. a foundation, plan or similar organization operating an organized health care delivery system if the practitioner has a contract under which the organization submits the claims. An “organized health care delivery system” may be a public or private Health Maintenance Organization (HMO).

105.1 MEDICAID PAYMENTS TO PROVIDERS

- A. As specified in federal regulations and the terms of all provider agreements, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. This includes, but is not limited to, situations where the provider’s claim is denied by Medicaid for failure to bill timely, accurately, or when Medicaid payment equates to zero because a third party’s payment exceeds Medicaid’s allowable amount.
- B. Medicaid utilizes the Centers for Medicare and Medicaid Services (CMS) developed National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate payments. The National Correct Coding Initiative (NCCI) edits are defined

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

1. NCCI edits, or procedure-to-procedure edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons; and
 2. Medically Unlikely Edits (MUEs) or units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.
- C. Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims editor program employs a nationally recognized standardized method of processing claims for professional services using clinical logic based on **the most current** CPT, HCPCS, **International Classification of Diseases (ICD)**, American Medical Association (AMA), CMS and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.
- D. If an individual is pending Medicaid, it is requested the provider await an eligibility decision before billing for the service. If the provider decides not to wait for the decision, he or she may request payment from the recipient while the decision is pending. Once the recipient is found eligible for Medicaid, and the date of service for which payment was collected is covered, the provider must return the entire amount collected to the recipient before billing Medicaid. The payment subsequently received from Medicaid is payment in full and no additional payment may be requested from the recipient, and no part of the payment made by the recipient may be retained by the provider.
- E. Providers are to bill their usual and customary fees unless otherwise specified in Medicaid policy. For exceptions, refer to individual chapters. Billings are submitted according to established Medicaid policies.
- F. Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant codes. Complete billing information may be obtained by contacting the Medicaid Field Representative at Medicaid's fiscal agent. Refer to Section 108 of this chapter for additional contact information.
- G. Claims for payment are to be sent to Nevada Medicaid's fiscal agent on an appropriate billing form. Claims may be submitted either through electronic media or by paper. Refer to Section 108 of this chapter for addresses and other information.

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- H. It is the provider's responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid time frames. All claims must be of sufficient quality to allow electronic imaging and OCR therefore, corrections are not allowed. All paper claims must be submitted on the original applicable CMS-1500 or UB04 claim forms. Facsimiles, photocopies, or laser-printed claim forms may not be scanned and are unacceptable.

Those claims not meeting this criterion will be returned from the fiscal agent to the provider. The claims will not be stamped as received and there will be no record of receipt.

- I. Nevada Medicaid will neither accept nor reimburse professional billings for services rendered by other than the provider under whose name and provider number the claims is submitted (e.g., a claim for an office visit submitted by a physician when a psychologist or other personnel actually provided the service). Individuals who do not meet Medicaid criteria for provider numbers must not have their services billed as through a physician/dentist to the Medicaid program for payment.
- J. Medical residents do not meet Medicaid criteria for provider status. No service provided by a medical resident is to be submitted by another licensed physician/dentist to the Medicaid program for payment except by the teaching physician under the policy guidance in Medicaid Services Manual (MSM) Chapter 600.
- K. Payments are made only to providers. (Recipients who provide transportation for themselves and/or other recipients may be reimbursed as providers under certain circumstances.) A provider cannot request payment from Medicaid recipients assuming Medicaid will reimburse the recipient. Optional reimbursement to a patient is a characteristic of the Medicare Program, not the Medicaid program.
- L. Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services (HHS), or the state Medical Fraud Control Unit (MFCU).
- M. When payment appears to be unduly delayed, a duplicate billing labeled "duplicate" or "tracer" may be submitted. Failure to indicate "duplicate" or "tracer" may be interpreted as a fraudulent practice intended to secure improper double payment.

Group practices should make certain that rebilling shows the same service codes, the same physician's name and the same Medicaid provider number. If it should be necessary to alter the billing to show different codes or descriptors, a copy of the previous claim should be attached to the revised billing.

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105.1A EXTENDED SERVICES

Services or treatment provided over an extended period of time require interim billing so that claims will be received no later than the stale date:

1. The discharge date or the last day of the month which service was provided, whichever comes first, is considered the date of service for inpatient/residential claims. Each interim monthly billing must be received no later than the stale date.
2. Physicians, individual practitioners and clinics providing prolonged or extended treatment should submit interim billings for each calendar month; e.g., therapists whose services have been prior authorized for several months; and home health agencies authorized for ongoing, long-term care.
3. A global payment will be paid to the delivering obstetrician when the pregnant woman has been seen seven or more times by the delivering obstetrician and must be billed following the delivery. The delivery date is considered the date of service in this instance. Bill all other obstetrical claims as follows:
 - a. Prenatal laboratory panels must be billed before the stale date under rules of clinical laboratory services;
 - b. Prenatal visits (three or fewer) must be itemized and submitted before the stale date;
 - c. Prenatal visits (four to seven or more) must be billed using appropriate obstetrical codes and submitted before the stale date; and
 - d. If delivery is performed by someone other than the prenatal provider, prenatal care is billed as above before the stale date.

105.2 REIMBURSEMENT

Nevada Medicaid reimburses qualified enrolled providers for services provided within program limitations to Medicaid-eligible persons. Reimbursement rates and methodologies are established by the Rates Unit at the DHCFP. Rates and methodologies are based on, but not limited to, federal regulations and fee studies prior to billed charges. Providers may appeal their rate of payment to DHCFP, submit appropriate documentation, and receive administrative review. Refer to Chapter 700 in this manual for specific information.

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105.2A LIMITATIONS

1. Medicaid pays global or per diem rates to facilities.
2. Most individual practitioners are paid computer-generated maximum allowable amounts that are the result of multiplying a specific dollar amount times the relative unit value assigned to a specific procedure code. Procedure code value lists and/or dollar factors are available on the DHCFP website at <http://dhcfnv.gov>.
3. Reimbursement for most providers is Medicaid's maximum allowable amount or billed charges, whichever is less.
4. Provider Preventable Conditions

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

- a. Wrong surgical or other invasive procedure performed on a patient.
- b. Surgical or other invasive procedure performed on the wrong body part.
- c. Surgical or other invasive procedure performed on the wrong patient.
- d. Foreign object retained after surgery.
- e. Air embolism.
- f. Blood incompatibility.
- g. Surgical site infection following:
 1. Coronary artery bypass graft.
 2. Bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery).
 3. Orthopedic procedures (spine, neck, shoulder and elbow).

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- h. State III and IV pressure ulcers.
- i. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock).
- j. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity).
- k. Catheter-associated urinary tract infection.
- l. Vascular catheter-associated infection.
- m. Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery other than in pediatric and/or obstetric patients.

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

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

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

105.2B BILLING TIME FRAMES (STALE DATES)

Providers must bill Medicaid for all claims within the specific time frame set by Medicaid. To be considered timely, claims must be received by the fiscal agent within 180 days from the date of service or the date of eligibility decision, whichever is later. For out-of-state providers or when a third party resource exists, the timely filing period is 365 days.

Stale date criteria are strictly adhered to whether the claim is initially received or being appealed for a stale date override.

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In order to submit claims for which eligibility was determined after the date of service within the required time frame, providers should query the Electronic Verification System (EVS) every 30 days until the determination of eligibility is obtained.

105.2C DISPUTED PAYMENT

The Fiscal Agent is responsible for research and adjudication of all disputed payments. This includes claims for which the provider is requesting an override even though the claim has not been previously submitted and denied.

Requests for adjustments to paid claims, including zero-paid claims, must be received by the Fiscal Agent no later than the Medicaid stale date period.

Providers can request an appeal of denied claims through the Fiscal Agent. Claim appeals must be postmarked no later than 30 days from the date of the initial Remittance Advice (RA) listing the claim as denied. An additional 30 days to appeal a denied claim will not be allowed when an identical claim has been subsequently submitted.

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

Refer to Section 108 for contact information.

1. Providers who request an appeal must provide the following:
 - a. A letter addressing the specific reason for the appeal, which includes the provider name and NPI/API, the ICN of the claim, the recipient's name and Medicaid ID number, the date of service, and the name and phone number of the person to be contacted regarding the appeal;
 - b. Documentation to thoroughly support the appeal request;
 - c. A copy of the Remittance Advice showing the denied claim; and
 - d. An original signed paper claim that may be used for processing should the appeal be approved.
2. A Notice of Decision (NOD) will be sent by the fiscal agent to the provider advising them of the appeal decision.
3. Claims appealed due to a provider's dissatisfaction with reimbursement for specific procedure codes are first researched by the fiscal agent. If there is a need for policy

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clarification or a question of policy change, is the fiscal agent will send the appeal, along with the full documentation of research, to Medicaid's Chief of Compliance.

4. Providers must exhaust the fiscal agent's appeal process prior to pursuing a Fair Hearing with the Division.

Refer to Section 108 for contact information for filing an appeal and MSM Chapter 3100 for additional information on Fair Hearings.

105.3 BILLING MEDICAID RECIPIENTS

- A. A provider may bill a recipient when a Medicare/Medicaid patient elects not to use lifetime reserve days for hospital inpatient stays. In these cases, the patient must be informed that, due to this election, Medicaid coverage will not be available.
- B. When a service is provided by a Medicaid provider, which is not a Medicaid covered service, the recipient is only responsible for payment if a signed written agreement is in place prior to the service being rendered.
- C. When all of the criteria under a. and b. below are met, a patient may be billed for all or a portion of an acute hospital admission.
 1. Preadmission Denial – The QIO-like vendor issues a denial for the admission as not being medically necessary or not a Medicaid benefit; and
 - a. The physician chooses to admit the patient, nonetheless;
 - b. The recipient is notified in writing before services are rendered that he or she will be held responsible for incurred charges; and
 - c. A document signed by the recipient or designee acknowledging the responsibility is accepted by a recipient.
 2. Denial of a portion of the admission – The QIO-like vendor issues a denial for a portion of the admission as no longer medically necessary for acute care; and
 - a. The recipient is furnished with the denial notice prior to services being rendered which are to be billed;
 - b. The physician orders the discharge of the patient;
 - c. No requested administrative days have been approved by The Quality Improvement Organization (QIO)-like vendor; and

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d. The recipient refuses to leave.

D. Recipients may not be billed for acute hospital admissions or a portion of the stay if certain conditions exist. The following are examples and may be all inclusive:

1. The admitting physician fails to acquire a prior authorization from the Quality Improvement Organization (QIO)-like vendor in cases other than emergency, except when the hospital admission comes directly from the emergency department.
2. The QIO-like vendor has reduced the level of care from acute to an administrative level.
3. The hospital and patient receive a retrospective denial by the QIO-like vendor after service has been rendered.

In any case where the hospital neglects to follow Medicaid policies, courts have upheld the position that hospitals should be knowledgeable of rules and regulations and may not look to Medicaid or the recipient for payment when the rules or regulations are not followed.

- E. If the payment for services is made by the recipient's other health care coverage directly to the recipient or his or her parent and/or guardian, he or she is responsible to submit the payment to the provider. If the recipient, or his or her guardian, fails to do so, the provider may bill the recipient for the services, but may not collect more than the exact dollar amount paid by the OHC for services rendered.
- F. Providers may bill Medicaid recipients when the recipient does not disclose Medicaid eligibility information at the time the service is provided. As a rule, all providers seek payment source information from recipients/patients before services are rendered. Any recipient not declaring their Medicaid eligibility or pending eligibility, and thus denying the provider the right to reject that payment source, is viewed as entering into a "private patient" arrangement with the provider.
- G. If a provider has billed a Medicaid recipient erroneously, the provider must refund the money to the recipient and bill Medicaid for the amount. Medicaid claims showing a "patient paid" amount, when the recipient was not responsible for payment, will be returned to the provider. Once the refund has been made to the recipient, the claim may be resubmitted with a copy of the refund check and the fiscal agent will process the claim for payment.

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- H. Providers are prohibited from billing Medicaid or the recipient when no service has been provided. This includes billing a deposit for a scheduled appointment or for a missed appointment.

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106 CONTRACT TERMINATIONS AND NON-RENEWAL

Termination means termination of the Medicaid Contract between Nevada Medicaid and the provider. Non-renewal means Nevada Medicaid will refuse to renew a Medicaid contract with the provider when the previous agreement expires.

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

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

106.1 TERMINATION FOR CONVENIENCE

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

106.2 CONDITIONS OF CONTRACT TERMINATIONS AND NON-RENEWAL

A. Immediate Terminations

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

1. The provider is convicted of a criminal offense related to the participation in the Medicare/Medicaid program;
2. The provider's professional license, certification, accreditation or registration is suspended or revoked;
3. The DHCFP is notified the provider is placed on the Office of Inspector General (OIG)'s Exclusion List (42 Code of Federal Regulations (CFR) 1002);
4. The provider is deceased;
5. The DHCFP has determined that the quality of care of services rendered by the provider endangers the health and safety of one or more recipients;
6. Mail is returned from the post office and a forwarding address is not provided;
7. The provider has failed to disclose information listed in MSM Chapter 100, Section 102;

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8. Identity of the provider cannot be proven; or
9. The provider has been terminated for cause by a Managed Care Organization (MCO) contracted with the DHCFP.

B. Advance Notice of Termination

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

1. The provider falsified the application for a Medicaid contract;
2. Fraud or abuse of such a nature and extent that immediate and permanent action is deemed necessary;
3. Termination, exclusion or suspension of an agreement or contract by any other governmental, state or county program;
4. The provider no longer meets the conditions of participation as stated in Chapter 100 all inclusive of the Nevada MSM;
5. The provider no longer meets all of the requirements or other conditions of participation as required by the Nevada MSM for the specified provider type;
6. The provider fails to submit requested information by the required due date;
7. The provider is under investigation by a law enforcement or state agency for conduct that it is deemed incompatible with the mission of the DHCFP;
8. The provider has been convicted of a misdemeanor, gross misdemeanor or felony that is incompatible with the mission of the DHCFP;
9. The Division has determined that the results of any investigation, audit, review or survey necessitate termination; and/or
10. An administrative contract termination has been performed.

106.3 SANCTION PERIODS

Providers who are terminated or denied from Nevada Medicaid for cause will serve a sanction period that begins with the effective date of the termination or denial. Sanctioned providers will not be reimbursed for any services provided on or after the date of termination. Providers who

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have not been permanently sanctioned from the Nevada Medicaid program may resubmit a new Provider Enrollment Application at the end of the sanction.

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

a. Tier 1 - Permanent Sanction

1. Provider is on the OIG exclusion list.
2. Provider has been convicted of a criminal felony offense related to that person's involvement in any program established under Medicare, Medicaid, Children's Health Insurance Program (CHIP) (NCU), or the Title XX services program.
3. Provider has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU), or the Title XX services program.
4. Provider has been convicted of any offense listed below:
 - a. Murder, voluntary manslaughter, mayhem, or kidnapping;
 - b. Sexual assault, sexual seduction or any sexually related crime;
 - c. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission;
 - d. False imprisonment or involuntary servitude;
 - e. Criminal neglect of patients per the NRS 200.495;
 - f. Abuse or neglect of children per NRS 200.508 through 200.5085;
 - g. Abuse, neglect, exploitation, or isolation of older persons;
 - h. Any offense against a minor under NRS 200.700 through 200.760;
 - i. Any offense against public decency and good morals under a provision NRS 201.015 through NRS 201.56.

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

b. Tier 2- Seven Year Sanction

1. Provider has been terminated due to quality of care issues or inappropriate, fraudulent billing practices as identified as a result of an investigation, audit, review, or survey.
2. Provider has been convicted of any offense listed below:
 - a. Assault or battery;
 - b. Any offense involving arson, fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
 - c. Harassment or stalking;
 - d. Any offense against the executive power of the State in violation of NRS 197;
 - e. Any offense against the legislative power of the State in violation of NRS 198;
 - f. Any offense against public justice in violation of NRS 199;
 - g. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS; or
 - h. Any other felony involving the use of a firearm or other deadly weapon within the immediately preceding seven years.

c. Tier 3- Twelve Month Sanction

1. Provider was denied enrollment due to omitting information regarding criminal background or ownership and/or supplying false information on the Provider Enrollment Application;
2. Provider was terminated as a result of an investigation, audit, review, or survey not related to quality of care or inappropriate, fraudulent billing practices;

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3. Provider was terminated due to not meeting the conditions of participation as stated in Chapter 100 all inclusive of the Nevada MSM or other conditions of participation as required by the Nevada MSM for the specified provider type;
4. Provider was terminated due to being under investigation by a law enforcement or state agency for conduct that it is deemed incompatible with the mission of the DHCFP;
5. Provider was terminated due to conviction of a misdemeanor, gross misdemeanor, or felony, not listed in Tier 1 or Tier 2, which is incompatible with the mission of the DHCFP;
6. Provider has failed to follow through with their DHCFP approved corrective action plan; or
7. Provider has a restricted professional license.

d. Immediate Re-Application

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

1. Loss of contact;
2. No payments made to provider within the prior 24 months;
3. When the sole issue is a change in federal law and the law has been repealed; or
4. Provider failed to provide requested information.

106.4 PROCEDURES FOR TERMINATION AND NON-RENEWAL

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

- a. A Notice of Intent to Terminate or Non-renew will be sent to the provider at the last known mailing address via U.S. mail. The notice will include:
 1. a description of proposed action;
 2. the effective date of the proposed action;
 3. the basis for the proposed action, citing the appropriate Medicaid policy, federal regulation and/or state law;

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4. the effect of the action on the provider's participation in the Nevada Medicaid Program;
5. the provider's right to a fair hearing, in accordance with NRS 422.306; and
6. the tier and length of sanction imposed, if applicable.

106.4A ADMINISTRATIVE CONTRACT TERMINATIONS

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

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

1. death of the provider;
2. loss of contact;
3. no payments made to provider within the prior 24 months; and/or
4. when the sole issue is a change in federal law.

106.5 MEDICAID AGENCY ACTION AFTER REVIEW, AUDIT OR INVESTIGATION

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

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

- a. U.S. DHHS;
- b. U.S. Department of Justice;
- c. Nevada Medicaid Surveillance Utilization and Review (SUR) staff;
- d. Medicaid Fraud Control Unit (MFCU);
- e. Nevada Medicaid program Provider Support staff;
- f. Nevada Medicaid audit staff;

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- g. DHCFP Audit Contractors;
- h. Fiscal agent staff;
- i. Aging and Disability Services Division (ADSD) staff; or
- j. Other state and/or county agencies.

Refer to MSM Chapter 3300 for information regarding SURS investigations.

106.5A CORRECTIVE ACTIONS

1. In determining appropriate action to be taken, the following will be considered:
 - a. Corrective action necessary to eliminate the problem(s);
 - b. Seriousness of the problem(s);
 - c. Number of current and past violations;
 - d. Past sanctions applied; and
 - e. Other available services.
2. The DHCFP may take one or a combination of the possible corrective actions such as:
 - a. Educational contact may be used when minor errors are detected and may be in the form of a telephone call, on-site visit, or a letter by DHCFP or fiscal agent staff. Educational contact is made for the purpose of instructing a provider in policy compliance, correct billing procedures, program benefit limitations and to correct identified errors in billing or requests for services not covered by Medicaid.
 - b. Warning letters may be prepared by DHCFP staff in cases where an investigation or program compliance review has revealed a violation occurred but the extent of the violation is not substantial enough to warrant stronger administrative action or referral for civil/criminal action. Warning letters are intended to assist the provider in rectifying the problem and will include notice of potential consequence if the problem reoccurs.
 - c. The agency may impose special requirements on a Medicaid provider as a condition of participation. These include, but are not limited to the following:

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1. All services provided to Medicaid recipients must be prior authorized by DHCFP to be eligible for Medicaid reimbursement.
 2. Selected provider services must be prior authorized to be eligible for Medicaid reimbursement;
 3. Medical records must be submitted with all claims; and/or
 4. A second opinion from an independent peer must be obtained to confirm the need for the service to be eligible for Medicaid reimbursement.
- d. Suspending the provider from accepting and billing for new Medicaid recipients.

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

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

106.6 SUSPENSION

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

- a. A provider may be suspended from the Medicaid program when:
 1. found to be providing items or services at a frequency or amount not medically necessary;
 2. found to be providing items or services of a quality that does not meet professionally recognized standards of health care in a significant number of cases; or
 3. an audit, review or investigation reveals failure to comply with program policies.
- b. Suspension may be applied to any person who has ownership or controlling interest in the provider or who is an agent or managing employee of the provider. All persons affected by the exclusion must be notified in the original notice of exclusion.

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

106.6A PROCEDURES FOR SUSPENSION

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

The notice will include:

1. a description of proposed action;
2. the effective date of the proposed action;
3. the length of suspension;
4. basis for the proposed action, citing the appropriate Medicaid policy, federal regulation and/or state law;
5. the effect of the action on the provider's participation in the Nevada Medicaid Program; and
6. the provider's right to a fair hearing in accordance with NRS 422.306.

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107 RE-ENROLLMENT

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

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

107.1 CONDITIONS OF RE-ENROLLMENT

- A. If a termination was for administrative reasons (e.g., loss of contact, failure to return updated agreement, failure to provide requested information to determine whether conditions of participation are met, etc.) Nevada Medicaid may reinstate the provider upon receipt of a completed updated agreement, information request form and/or any other information requested to determine that conditions of participation are met.
- B. If termination, suspension, exclusion, or non-renewal was due to fraud, abuse, falsification of information, etc., the length of the sanction will be in accordance to the letter of notification and the provider is eligible to apply for re-enrollment after serving their sanction period.

Nevada Medicaid may re-enroll the provider only if it is reasonably certain the fraudulent and/or abusive acts which led to the adverse action by Nevada Medicaid will not be repeated. Factors which will be considered include, but are not limited to:

1. Whether the provider has been convicted in a federal, state or local court of other offenses related to participation in the Medicare or Medicaid programs which were not considered in the development of the Medicaid suspension, exclusion or termination; and
 2. Whether the state or local licensing authorities have taken any adverse action against the provider for offenses related to participation in the Medicare or Medicaid programs which was not considered in the development of the Medicaid suspension, exclusion or termination.
- C. If the provider has been suspended, excluded or terminated from Medicare or at the direction of the Secretary of Health and Human Services (HHS), Nevada Medicaid will not re-enroll the provider until federal HHS notifies Nevada Medicaid it is permissible to do so and the provider completes all enrollment applications and contracts.

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- D. If Nevada Medicaid approves the request for re-enrollment, it must give written notice to the suspended, excluded or terminated provider and to all others who were notified of the adverse action and specify the date on which Medicaid program participation may resume.
- E. Nevada Medicaid Fiscal Agent will give written notice to the suspended, excluded or terminated provider of the status of their re-enrollment request.

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108 REFERENCES

FISCAL AGENT CONTACT INFORMATION

PROVIDER RELATIONS UNITS (Enrollment/Claims Issues/Questions)

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

ELECTRONIC BILLING

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

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

PRIOR AUTHORIZATION FOR DENTAL AND PERSONAL CARE AIDE

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

PRIOR AUTHORIZATION FOR ALL OTHER SERVICE TYPES (except Pharmacy)

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

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PHARMACY

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

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

THIRD PARTY LIABILITY (TPL) UNIT

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

Email: TPL-NV@Emdeon.com

MANAGED CARE ORGANIZATIONS

AMERIGROUP Community Care

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

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

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

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

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HEALTH PLAN OF NEVADA (HPN)

Phone: (800) 962-8074

Fax: (702) 242-9124

Claims Address:

Health Plan of Nevada

P.O. Box 15645

Las Vegas, NV 89114

FIELD OFFICES

Carson City	(775) 684-7200
Elko/Winnemucca	(775) 753-1187
Ely	(775) 289-1650
Fallon and Lovelock	(775) 423-3161
Hawthorne	(775) 945-3602
Henderson	(702) 486-1201
Las Vegas – Belrose	(702) 486-1646
Las Vegas – Cambridge	(702) 486-1646
Las Vegas – Cannon Center	(702) 486-1646
Las Vegas – Charleston	(702) 486-1646
Las Vegas – Flamingo	(702) 486-1646
Las Vegas – Nellis	(702) 486-1646
Las Vegas – Owens	(702) 486-1800
Las Vegas – Southern Investigations & Recovery	(702) 486-1875
Pahrump	(775) 751-7400
Reno – Bible Way (Investigations & Recovery)	(775) 688-2261
Reno – Kings Row	(775) 684-7200
Yerington	(775) 463-3028

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110 NEVADA MEDICAID PROVIDER TYPES

- 10 - Outpatient Surgery
- 11 - Hospital, Inpatient
- 12 - Hospital, Outpatient
- 13 - Psychiatric Hospital, Inpatient
- 14 - Mental Health, Outpatient/Public
- 16 - Intermediate Care Facility/MR
- 17 - Special Clinics
- 18 - Nursing Facility/Skilled Level
- 19 - Nursing Facility/Intermediate Level
- 20 - Physician/Osteopath
- 21 - Podiatrist
- 22 - Dentist
- 23 - Hearing Aid Dispenser & Related Supplies
- 24 - Certified Registered Nurse Practitioner, Nurse
- 25 - Optometrist
- 26 - Psychologist
- 27 - Radiology & Noninvasive Diagnostic Centers
- 28 - Pharmacy
- 29 - Home Health Agency - (persons 21 years old and older)
- 30 - Personal Care Aide (Home Care) Provider Agency
- 32 - Ambulance - Air or Ground
- 33 - Durable Medical Equipment (DME), Disposables, Prosthetics
- 34 - Therapy - Physical, Occupational, Respiratory, Speech and Audiology
- 35 - Transportation
- 36 - Chiropractor
- 37 - Intravenous Therapy (TPN)
- 38 - Home and Community Based Waiver - MR Services
- 39 - Adult Day Health Care
- 40 - Primary Care Case Management (PCCM) Services
- 41 - Optician/Optical Businesses
- 42 - Out-Patient Psych Hosp/Private & Comm Mental Health Cntrs/Private
- 43 - Laboratory - Pathology/Clinical
- 44 - Swing-bed (Acute Hospitals)
- 45 - End Stage Renal Disease (ESRD) Facility
- 46 - Ambulatory Surgery Centers (Medicare Certified)
- 47 - Indian Health Services (IHS) & Tribal Clinics
- 48 - Senior Waiver
- 49 - IHS Transportation
- 51 - IHS Hospital (InPatient)
- 52 - IHS Hospital (OutPatient)
- 54 - Case Management (DHR)

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- 55 - Transitional Rehabilitative Center
- 56 - Medical (Rehabilitation Center or Specialty) Hospital - Inpatient
- 57 - Adult Group Care Waiver
- 58 - Physically Disabled Waiver
- 60 - School Based Services
- 61 - Mental Health Rehab Treatment Services / Residential
- 62 - Health Maintenance Organization (HMO)
- 63 - Residential Treatment Center (RTC)
- 64 - Hospice
- 65 - Hospice, Long Term Care
- 68 - Intermediate Care Facilities for Mentally Retarded / Private
- 72 – Nurse Anesthetist
- 74 – Nurse Midwife
- 75 – Critical Access Hospital (CAH), Inpatient
- 76 – Audiologist
- 77 – Physician’s Assistant
- 78 – Indian Health Service Hospital, Inpatient (Non-Tribal)
- 79 – Indian Health Service Hospital Outpatient (Non-Tribal)
- 80 – IHS Travel (Non-Tribal)
- 82 – Mental Health Rehabilitative Treatment Services / Non-Residential
- 83 – Personal Care Aide – Intermediary Service Organization
- 84 – Personal Care Aide – Independent Contractor

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 3, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 - HOSPITAL SERVICES



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 200 are being proposed to specify that providers must ensure a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure, deny coverage of the one inpatient day during which sterilization is performed without a valid sterilization consent form, cover medically necessary inpatient days within the same episode of care that are not the day the sterilization procedure was performed without a valid prior authorization, and define the term, episode of care. A revision was also made to clarify coverage of non-emergency services provided in an emergency room.

These changes are effective September 4, 2015.

MATERIAL TRANSMITTED

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CHAPTER 200 - HOSPITAL SERVICES

MATERIAL SUPERSEDED

MTL 05/15
CHAPTER 200 - HOSPITAL SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
203.1B.16	Provider Responsibilities	Revised policy to: specify providers must ensure a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure; deny coverage of the one inpatient day during which sterilization is performed without a valid sterilization consent form; cover medically necessary inpatient days within the same episode of care that are not the day the sterilization procedure was performed without a valid PA, and define episode of care.
203.4A.2	Coverage and Limitations	Clarified coverage of non-emergency services provided in an emergency room for recipients with full Medicaid eligibility.

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200 INTRODUCTION

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

The Division of Health Care Financing and Policy (DHCFP) may reimburse acute hospitals for providing the following services: medical/surgical/intensive care, maternity, newborn, neonatal intensive care, trauma level I, medical rehabilitation or long-term acute care specialty, administrative skilled or intermediate days and emergency psychiatric and substance abuse treatment and acute medical detoxification.

In Nevada, hospitals are licensed by the Bureau of Health Care Quality and Compliance (HCQC) within the Nevada Division of Public and Behavioral Health (DPBH).

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU Manual, Chapter 1000.

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201 AUTHORITY

- A. In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation for states that elect to offer medical programs. The states must offer at least 11 basic required medical services. Two of these services are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20).
- B. Other authorities include:
1. Section 1861 (b) and (e) of the Social Security Act (Definition of Services)
 2. 42 CFR Part 482 (Conditions of Participation for Hospitals)
 3. 42 CFR Part 456.50 to 456.145 (Utilization Control)
 4. Nevada Revised Statutes (NRS) 449 (Classification of Hospitals in Nevada)
 5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers and Newborns)
 6. Section 2301 of the Affordable Care Act (ACA) (Federal Requirements for Birth Centers)
 7. NRS Chapter 449 (Hospitals, Classification of Hospitals and Obstetric/Birth Center Defined)
 8. Nevada Administrative Code (NAC) Chapter 449 (Provision of Certain Special Services-Obstetric Care)
 9. 42 CFR Part 440.255 Limited services available to certain aliens.
 10. NRS Chapter 422 Limited Coverage for certain aliens including dialysis for kidney failure.
 11. 42 CFR 435.406 (2)(i)(ii) (permitting States an option with respect to coverage of certain qualified aliens subject to the five-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria).
 12. 42 CFR 441, Subpart F (Sterilizations)
 13. 42 CFR 447.253 (b) (1) (ii) (B) Other requirements

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203 POLICY

203.1 INPATIENT HOSPITAL SERVICES POLICY

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

- a. is maintained primarily for the care and treatment of patients with disorders other than mental disease;
- b. is licensed as a hospital by an officially designated authority for state standard-setting;
- c. meets the requirements for participation in Medicare; and
- d. has in effect a Utilization Review (UR) plan, applicable to all Medicaid recipients, that meets the requirements of 42 CFR 482.30 and 42 CFR 456.50-456.145.

Inpatient hospital services do not include Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) services furnished by a hospital with a swing-bed approval (42 CFR 440.10).

A hospital is an inpatient medical facility licensed as such to provide services at an acute Level of Care (LOC) for the diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases (IMD), a Nursing Facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.

Out of State Acute Hospital Services

Non-emergency out-of-state acute inpatient hospital care requires prior authorization by the Quality Improvement Organization (QIO)-like vendor for Medicaid eligible recipients. Out-of-state inpatient hospital services may be authorized for specialized medical procedures not available in Nevada. The referral for out-of-state services must come from the referring/transferring Nevada physician and/or hospital. Reference Chapter 100, Out-of-State Services and Out-of-State Provider Participation.

In-State and Out-of State Acute Hospital Transfers

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, rehabilitation, specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor

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must make a determination regarding the availability of such services at the referring hospital or within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being met at the transferring facility.

It is always the receiving hospital's responsibility to confirm with the QIO-like vendor whether the transferring physician/hospital obtained authorization for a nonemergent transfer from the QIO-like vendor prior to the transfer, and prior to the receiving hospital's agreeing to accept/admit the recipient.

203.1A COVERAGE AND LIMITATIONS

1. Admission

a. Admission Criteria

Division of Health Care Financing and Policy (DHCFP) considers the recipient admitted to the hospital when:

1. a physician provides the order for admission at the time of admission or during the hospital stay, as verified by the date and time;
2. acute care services are rendered;
3. the recipient has been transferred, or is awaiting transfer to, an acute care bed from the emergency department, operating room, admitting department, or other hospital services; and
4. the admission is certified by the QIO-like vendor based on pertinent supporting documentation/submitted by the provider with the admission authorization request.

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, Critical Access, Medical Rehabilitation or Long Term Acute Care (LTAC) Specialty hospitals) or before authorization of payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. Reference 203.1B.11.c.

b. Admission Order

Physician orders for admission must be written at the time of admission or during the hospital stay and are only valid if they are signed by the physician. Admission orders written after discharge are not accepted. Verbal and telephone orders written by other allied personnel must be co-signed by the physician.

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The role of the QIO-like vendor is to determine whether an admission is medically necessary based on the medical record documentation, not to determine physician intent to admit.

c. Admission Date

The admission date must be reflected on the authorization as the date and time the admission order was written during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies the documentation most relevant to the admission determination contingent upon provision of acute care services. The QIO-like vendor makes every effort to identify the documented admission date; however, it is ultimately the hospital's responsibility to provide complete and accurate admission information.

d. Planned and Transfer Admissions

For those instances in which the admission order was written (as defined above) before the recipient arrives at the hospital (planned elective admission), a signed physician order meets the requirements for admission. For transfers from other acute care hospitals, a signed physician order (as defined above) must be contained in the accepting facility's record. The admission date and time for the authorization is based on documentation most relevant and available to the admission determination contingent upon provision of acute care services and admission certification by the QIO-like vendor. Reference 203.1B.16 regarding provider responsibilities related to in-state and out-of-state acute hospital transfers.

e. Inpatient Admission from Observation

Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order.

f. Military or Veterans' Hospitals

Inpatient hospital admission at a military or Veterans' hospital is not a Medicaid benefit.

g. Obstetric Admissions for Early Induction of Labor (EIOL) Prior to 39 Weeks Gestation

To be eligible for reimbursement, an obstetric hospital admission for EIOL prior to 39 weeks gestation must be prior authorized by the QIO-like vendor as medically necessary. Failure to obtain prior authorization from the QIO-like vendor will result in denial of claim reimbursement.

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h. Obstetric Admissions for Elective or Avoidable Scheduled Cesarean Delivery

Coverage/reimbursement of non-medically necessary obstetric admissions for elective or avoidable cesarean section (e.g. performed for the convenience of the physician or recipient) is limited to the minimum federal requirement (two days) for a normal vaginal delivery.

2. Authorization Requirements

Authorization review is conducted to evaluate medical necessity, appropriateness, location of service and compliance with the DHCFP's policy. All inpatient hospital admissions must be authorized by the QIO-like vendor for reimbursement by the DHCFP. The QIO-like vendor certifies LOC and length of stay.

Reference Medicaid Services Manual (MSM) Chapter 100, Section 103.1 regarding criteria related to medical necessity.

- a. All inpatient QIO-like vendor determinations are based on pertinent medical information documented initially by the requesting physician and provided to the QIO-like vendor by a hospital with the request for admission.
- b. Authorization refers only to the determination of medical necessity and appropriateness. Authorization does not guarantee benefit plan payment. Plan coverage is also conditional upon the recipient's eligibility and is subject to all other coverage terms and conditions of the Nevada Medicaid and Nevada Check Up (NCU) programs.
- c. Services requiring prior authorization which have not been prior authorized by the QIO-like vendor are not covered and will not be reimbursed. A prior authorization request inappropriately submitted for inpatient admission after an unauthorized, planned, elective inpatient procedure or surgery is performed, will be rejected and returned without consideration. Concurrent services related to these unauthorized admissions will also be returned without consideration, unless the services are specifically related to stabilization of an emergency medical condition that develops. Once the emergency medical condition is stabilized, no additional services related to this unauthorized elective admission will be reimbursed.
- d. A prior authorization is valid for the dates of service authorized. If the service cannot be provided for any reason during authorized service dates (e.g. a recipient has a change of condition) the prior authorization becomes invalid. A new or updated prior authorization must be obtained for reimbursement of corresponding dates of service.

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- e. Out-of-state authorization determinations are based upon several conditions such as the availability of the service within the state at other facilities and the LOC not being met at the transferring facility.
- f. Providers must submit pertinent clinical information and obtain prior authorization from the QIO-like vendor for the following services:
 - 1. Any surgery, treatment or invasive diagnostic testing unrelated to the reason for admission; or days associated with unauthorized surgery, treatment or diagnostic testing.
 - 2. Hospital admissions for EIOL prior to 39 weeks gestation.
 - 3. Hospital admissions for elective or avoidable scheduled cesarean sections.
 - 4. Antepartum admissions for the purpose of delivery when an additional elective procedure is planned (excluding tubal ligations).
 - 5. Additional inpatient days must be requested prior to or by the last day of the current/existing authorization period.
 - 6. Dental admissions. Two prior authorizations for inpatient hospitalization for a dental procedure are necessary:
 - a. The Medicaid dental consultant must prior authorize the dental procedure; and
 - b. The QIO-like vendor must authorize it is medically necessary for the recipient to be hospitalized for the performance of the dental procedure.
 - 7. An admission for a family planning procedure (e.g. a tubal ligation or vasectomy).
 - 8. Non-emergency admissions to in-state and out-of-state facilities.
 - 9. Psychiatric admissions to a free standing psychiatric hospital IMD for recipients age 65 or older or under age 21 or to a psychiatric wing of a general acute hospital, regardless of age.
 - 10. All changes in LOC and/or transfer between units (e.g. medical/surgical, intensive care, obstetrics, newborn, neonatal intensive care, trauma level 1, psychiatric/detoxification, rehabilitation, administrative, and outpatient

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observation.) Per diem reimbursement amounts are based on the LOC authorized by the QIO-like vendor.

11. Substance abuse detoxification and treatment (inpatient) admissions. This includes transfers from detoxification to treatment within the same hospital. Reference Chapter 400 for admission criteria.
 12. Swing bed admissions in rural or Critical Access Hospital. Reference Chapter 200, Attachment A, Hospital With Swing Beds.
 13. A leave of absence or therapeutic pass from an acute or Medical Rehabilitation Specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference 203.1A.3, Absences.
 14. When Third Party Liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference Chapter 100, Section 104.
 15. Non-Medicare covered days within 30 days of the receipt of the Medicare EOB indicating Part A Medicare benefits are exhausted. Reference Chapter 100, Section 103.2.
 16. Admissions resulting from EPSDT screening.
- g. Providers must submit pertinent clinical information and request authorization from the QIO-like vendor within one business day of patient admission for the following services:
1. An in-patient admission for an emergent condition including, but not limited to, any emergency admission (e.g. from a physician's office, urgent care or emergency room) or an emergency transfer from one in-state and/or out-of-state hospital to another.
 2. An obstetric admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or emergency cesarean delivery.
 3. A newborn admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or elective/avoidable cesarean delivery.
 4. When delivery of a newborn occurs immediately prior to arrival at a hospital for an obstetric/newborn admission.

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

The following criteria applies:

- a. Observation and ancillary services resulting in a direct inpatient admission provided as part of one continuous episode of care on the same calendar date and at the same facility as the inpatient admission are included in the first inpatient day per diem rate. Observation and ancillary services rendered on a calendar date preceding the rollover inpatient admission date can be billed separately.
 - b. Emergency room services resulting in a direct inpatient admission at the same facility and provided as part of one continuous episode of care are included in the first inpatient hospital day per diem rate, even if the emergency services are provided on the calendar date preceding the admission date.
6. Any newborn/neonate admission to a Neonatal Intensive Care Unit (NICU).
 7. Admission to hospitals without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit. Refer to MSM Chapter 400.
- h. Utilization Review (UR) Process

The QIO-like vendor evaluates the medical necessity, appropriateness, location of service and compliance with the DHCFP's policy related to inpatient admission requests. The QIO-like vendor reviews if services furnished or proposed to be furnished on an inpatient basis could (consistent with provision of appropriate medical care) be safely, effectively and more economically furnished on an outpatient basis, in a different type of inpatient health care facility or at a lower LOC within a general hospital. Once the QIO-like vendor is provided pertinent clinical admission information, a review of the medical information from the facility is conducted to determine the appropriate LOC and authorized time period for the length of stay.

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1. Concurrent Review

Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period that services are being provided. Initially the QIO-like vendor assigns a length of stay based on the diagnosis and condition of the recipient. For complex cases, additional days may be authorized to manage the medical condition through the concurrent review process. Additional inpatient review days must be requested prior to or by the last day of the current/existing authorization period.

2. Retrospective Review

Retrospective review is a review of clinical information to determine whether the services will be approved after the service is delivered. Retrospective review, for the purpose of this chapter, refers to cases in which eligibility is determined after services are provided. If the clinical information does not support the medical necessity or appropriateness of the setting, services are denied or reduced. The provider is notified when the QIO-like vendor's reviewer determines clinical information supports either a reduction in LOC, discharge, or denial of days.

3. Administrative Days

Reference Chapter 200, Attachment A, Policy #02-03.

4. Leave of Absence

a. Absences from an acute hospital or Medical Rehabilitation Specialty hospital are allowed:

1. in special circumstances, such as when a recipient is in the hospital on a long-term basis and needs to be absent for a few hours for a trial home visit or death of an immediate family member; or
2. up to, but not exceeding 32 hours from a Medical Rehabilitation Specialty hospital for therapeutic reasons, such as preparing for independent living.

b. Prior authorization must be obtained for a leave of absence expected to:

1. last longer than eight hours from an acute hospital; or

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2. last longer than eight hours or involving an overnight stay from a Medical Rehabilitation hospital
- c. A leave of absence from an acute inpatient hospital is not covered if a recipient does not return to the hospital by midnight of the day the leave of absence began (a reserved bed).
- d. For a therapeutic leave of absence, the following information must be documented in a recipient's medical record:
 1. A physician's order specifying the number of hours for the pass;
 2. The medically appropriate reason for the pass prior to issuance of the pass; and
 3. An evaluation of the therapeutic effectiveness of the pass when the recipient returns.

203.1B PROVIDER RESPONSIBILITIES

1. Patient Liability

- a. **Determination:** Patient Liability (PL) is determined by eligibility personnel in the local Division of Welfare and Supportive Services (DWSS) District Office. The hospital is notified of PL on the Notice of Decision (NOD) form. For questions regarding PL, please contact the local DWSS District Office.
- b. **Collection:** When a case is approved or PL changes, the recipient, facility and fiscal agent (and authorized representative, where appropriate) are notified of the amount and effective date. Collection of PL is the facility's responsibility.
 1. If the application is approved, the facility is sent a NOD indicating the amount of PL due and the effective date. The recipient and the fiscal agent are also notified. If eligibility is retroactive and the date of decision on months of eligibility more than 24 months from month of decision, a Medicaid Case Status Form (2214-EM) will be sent to the medical facility.
 2. PL for new approvals is effective the first month of eligibility for Medicaid. When a recipient's income changes, PL is adjusted beginning with the month of the change.
 3. The monthly PL is deducted from the initial claim received by the QIO-like vendor from a qualified facility. There is no prorating of PL for recipients transferring facilities within the month.

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4. If a recipient expires mid-month, the DWSS prorates PL as in number 3 above. The facility will be sent a notice indicating the adjusted PL amount.
5. No PL is taken from Medicaid recipients during periods of Medicare coverage. Beginning with the first non-Medicare covered day, hospitals must access PL at the Medicaid LOC and per diem rate for that hospital.

2. Conditions of Participation

a. To be enrolled with the DHCFP, providers must:

1. be in compliance with applicable licensure requirements.
2. be certified to participate in the Medicare program. Hospitals currently accredited by the Joint Commission or by the American Osteopathic Association (AOA) are deemed to meet all of the conditions of participation in Medicare. Centers for Medicare and Medicaid Services (CMS) makes the final determination of whether a hospital meets all Medicare criteria based on the recommendation of the state certifying agency (42 CFR Part 482).
3. have a Provider Contract with the DHCFP. Refer to Chapter 100, Section 102, Provider Enrollment.

b. Termination

The DHCFP may terminate a provider contract for failure of a hospital to adhere to the conditions of participation, reimbursement principles, standards of licensure, or to conform to federal, state, and local laws. Either party may terminate its agreement without cause at any time during the term of agreement by prior written notice to the other party.

Loss of Medicare certification results in concomitant loss of a Medicaid contract.

Refer to MSM, Chapter 100, for termination, lockout, suspension, exclusion, and non-renewal of Medicaid provider enrollment.

3. Utilization Review (UR)

Parts 456.100 through 456.145 of Section 42 CFR prescribe the requirements for a written UR plan for each hospital providing Medicaid services. The UR plan is deemed met for Medicare and Medicaid if a QIO-like vendor is conducting binding review.

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CFR 482.30 provides that hospitals participating in the Medicaid program must have in effect a UR program under a QIO-like or CMS has determined that the UR procedures established by the Medicaid program are superior to the procedures under the QIO-like vendor, and meet the UR plan requirements under 42 CFR 456.50 through 456.24

4. Quality Assurance - Hospital Medical Care Evaluation Studies

The purpose of hospital medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with recipient needs and professionally recognized standards of care. (CFR 456.141 to 456.145)

As part of the conditions of participation in the Medicaid Title XIX program, a minimum of one medical care evaluation study must be in progress at any time. Additionally, one study must be completed each year. The completed study must be submitted to the QIO-like vendor at the end of each calendar year along with the study in progress topic. (A report summarizing the study topics will be submitted to Nevada Medicaid by the QIO-like vendor.)

Hospitals may design and choose their own study topic or, at the request of Medicaid, perform a topic designed by Medicaid, and forward a copy of the completed study to the QIO-like vendor office within the specified time frames.

5. Civil Rights Compliance

As recipients of federal funding, hospitals must assure compliance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (including HIV, AIDS and AIDS-related conditions), the Age Discrimination Act of 1975, and the Americans with Disabilities Act (ADA) of 1990.

6. Patient Self-Determination Act (Advance Directives) Compliance

Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding for Medicare and/or Medicaid must comply with the Patient Self Determination Act (PSDA) of 1990, including Advance Directives. The DHCFP is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state advance directive requirements.

7. Form 3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form 3058 to their local DWSS District Office whenever a hospital admission, discharge, or death occurs.

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Failure to submit this form could result in payment delay or denial. To obtain copies of Form 3058, please contact the local DWSS.

8. Patient Rights

Pursuant to 42 CFR 482.13, a hospital must protect and promote each patient's rights. Hospitals are also required to comply with Nevada Revised Statutes (NRS) 449.730 pertaining to patient's rights.

9. Claims for Denied Admissions

After having an inpatient service authorized by the QIO-like vendor, hospitals are not permitted to submit the claim to the fiscal agent as an outpatient service. The only exception to this is if an outpatient or non-inpatient related service was truly rendered prior to the inpatient admission order by the physician but the inpatient stay was denied by the QIO-like vendor (e.g., admit from ER or rollover from observation days).

10. Hospital Responsibilities for Services

Any hospital receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for the recipient's service and treatment needs. If a hospital does not have the proper or functional medical equipment or services, and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing, evaluation, and/or treatment, it is the transferring hospital's responsibility to fund the particular services and transportation if necessary.

11. Admission Medical Record Documentation

a. Pre-Admission Authorization

The physician (or his/her staff) must obtain prior authorization from the QIO-like vendor for all non-emergency, elective, planned hospital procedures/admissions. Lack of a prior authorization for an elective procedure or admission results in an automatic denial which cannot be appealed. Reference Chapter 600.

Dental, oral and maxillofacial surgeons must also secure prior authorization from the DHCFP dental consultant to assure payment for the procedure. (Reference 203.1A.2.f.4) and Chapters 600 and 1000 regarding covered dental benefits.

b. Physician Certification

A physician's order, written prior to or at the time of admission, is required for all

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inpatient admissions. If a recipient applies for assistance while in the hospital, a physician's order for inpatient admission is required before reimbursement is authorized.

A physician, or physician's assistant or nurse practitioner acting within the scope of practice, as defined by state law and under the supervision of a physician, must re-certify for each applicant or recipient that inpatient services in a hospital are medically necessary. Re-certification must be made at least every 60 calendar days after the initial order. (42 CFR 456.60)

c. Plan of Care

Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. (42 CFR 456.80)

The plan of care must include:

1. diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. a description of the functional level of the individual;
3. any orders for medications, treatments, restorative and rehabilitative services, activities, social services, diet;
4. plans for continuing care, as appropriate; and
5. plans for discharge, as appropriate.

12. Discharge Planning

- a. The hospital must designate separate, identifiable staff whose primary responsibility is discharge planning. The discharge planners must review all Medicaid admissions.
- b. Discharge planning activities must commence within 48 hours of admission (or up to 72 hours involving weekends) for every recipient.
- c. The discharge planner formulates and records a discharge plan. The plan must specify goals and resolution dates. All alternatives to NF placement must be explored (e.g., home health services, homemaker services, placement with family, subsidized housing, meals programs, group care, etc).

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- d. The discharge planner must coordinate the discharge plan with primary care staff, the family, the physician, the placement setting (if applicable) and the recipient.
- e. The planner must be aware of and identify the LOC or level of services necessary to maintain the recipient out of the hospital setting.
- f. The plan must be updated with changes in the recipient's condition.
- g. There must be documentation that immediate action is taken regarding discharge alternatives whenever a specific discharge intervention or placement effort fails.
- h. Evaluation and reevaluation of a recipients needs must be conducted as necessary during the discharge planning process.
- i. Documentation must be explicit, thorough and recorded on the date a service is provided. There must be documented evidence of frequent attempts by the provider to discharge the recipient to an alternative appropriate setting. The frequency of documentation will depend on the barriers to discharge.
- j. Failure of a hospital to have documented evidence of comprehensive discharge planning efforts will result in non-coverage of corresponding dates of service.
- k. Significant contacts with family, the recipient, and/or ancillary personnel must be documented in the medical record.
- l. The recipient's understanding of his/her condition and situation should be described.
- m. When a recipient requires transfer to a NF, the hospital must request a Pre-Admission Screening (PASRR) from the QIO-like vendor. Each nursing home contact must be recorded by the discharge planner. Reasons why nursing facilities refuse the placement must also be documented. Placement efforts need to be concentrated on those facilities capable of handling the recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.
- n. A recipient's or recipient's family's or physician's refusal to cooperate with discharge planning efforts to either find or accept available appropriate placement at NF, RTC or other appropriate alternate setting must be documented in the recipient's medical record. Inpatient or administrative days are not reimbursed as of the date of the refusal.
- o. A discharge from the hospital is validated by a physician's discharge order. Any

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readmission following a discharge is treated as a new/separate admission, even if the readmission occurs within 24 hours of the discharge.

- p. As a condition of participation in the Medicare and Medicaid programs, hospitals must comply with all discharge planning requirements set forth in 42 CFR 482.43.

13. Financial Data and Reports

Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the DHCFP program.

All providers shall permit any representative of the single state agency to examine the records and documents necessary to determine the proper amount of payments due. These records shall include, but are not limited to, provider ownership, organization, and operation; fiscal, medical, and other record keeping systems; federal income tax status; asset acquisition, lease, sale, or other action; franchise or management arrangements; patient service charge schedules; costs of operation; amounts of income received, by source and purpose; flow of funds and working capital; statistical and other reimbursement information.

14. Medicare/Medicaid Crossovers

Concurrent review is not conducted for Medicare/Medicaid crossover admissions unless acute days have been exhausted and/or there has been a termination of Medicare benefits and the recipient is at an acute or administrative LOC. Medicaid authorization is provided for acute and administrative days only.

A provider must:

- a. notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted.
- b. attach a copy of the Medicare Explanation of Benefits (EOB) (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted when requesting a QIO-like vendor review.
- c. obtain prior authorization from DHCFP's QIO-like vendor in accordance with Section 203.1A.2.f.15.

QMB claims denied by Medicare are also denied by DHCFP.

15. Maternity/Newborn Federal Length of Stay Requirements

A provider must allow a recipient receiving maternity care or a newborn infant receiving

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pediatric care to remain in the hospital for no less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section delivery except when an attending physician makes a decision to discharge a mother or newborn infant prior to these timeframes.

16. Sterilization Consent Form

Providers must ensure a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure. Reference the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information for the specific procedures.

- a. An inpatient day during which sterilization is performed without a valid sterilization form is a non-covered service.
- b. Medically necessary inpatient days within the same episode of care, not including the day of the sterilization, may be reimbursed when the sterilization consent form was not obtained. An episode of care is defined as the admission date to date of discharge. All applicable coverage inpatient rules apply.

17. In-State or Out-of-State Hospital Transfers

a. Non Emergency Transfers

- 1. It is the responsibility of the transferring physician/facility to obtain prior authorization for nonemergent transfers between in-state and out-of-state facilities, prior to the transfer of the recipient and to give the authorization number to the receiving hospital.
- 2. A receiving hospital is responsible for verifying that the transferring hospital obtained prior authorization for a non emergency transfer, prior to agreeing to accept or admitting the recipient and prior to the transfer.

b. Emergency Transfers

A receiving hospital is responsible for obtaining authorization for an emergency transfer within one business day of the inpatient admission.

18. Admissions to Hospitals Without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit

- a. Reference MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services.

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- b. Maintain and submit to the QIO-like vendor documentation demonstrating comprehensive efforts to expeditiously transfer a recipient to an appropriate alternate setting (e.g. a freestanding psychiatric hospital or hospital with a psychiatric unit or to an alcohol/ substance abuse treatment hospital or a general hospital with a specialized alcohol/substance abuse treatment unit), upon request or when applicable.

19. Submission of Medical Documentation

- a. Providers must identify and submit all pertinent (relevant and significant) written medical information that supports an inpatient admission with an authorization request and/or with a request for a QIO-like vendor reconsideration review. This information must be provided in the format required by the QIO-like vendor. In addition, any documentation specifically requested by the QIO-like vendor must be submitted within time frames specified by the QIO-like vendor. Failure to provide all pertinent medical information in the format and within time frames required by the QIO-like vendor will result in authorization denial.
- b. Verbal information from an individual other than a recipient’s attending physician (without provision of either an attending physician’s written attestation or documentation of this information in the medical record) as part of an initial authorization or reconsideration review request, does not meet documentation submission requirements.

20. Adverse Determination

An adverse action or determination includes, but is not limited to, a denied or reduced authorization request.

- a. If a provider does not agree with the DHCFP QIO-like vendor’s adverse determination, a peer to peer review or a reconsideration review can be requested. Reference the QIO-like vendor’s/DHCFP’s Billing Manual for details.
- b. A provider must provide all additional pertinent documentation or information not provided with the authorization request supporting services requested (e.g. documentation related to severity of illness, intensity of services, a physician’s risk assessment) to the QIO- like vendor by the date of the reconsideration review. This information must be provided in the format required by the QIO-like vendor.
- c. Pertinent medical information not provided to the QIO-like vendor in the required format by the reconsideration date of decision, will not be subsequently considered by the QIO-like vendor.

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1. Verbal information provided by an individual other than a recipient's attending physician must be supported by either written attestation of this information by the attending physician or evidence of this information in the medical record specifically provided to the QIO-like vendor with the authorization or reconsideration review request.
2. If a provider disagrees with the results of the QIO-like vendor's peer to peer and/or reconsideration review, the provider may request a fair hearing through DHCFP. A provider must utilize internal grievance processes available through the QIO-like vendor

21. Adherence to Requirements

To receive reimbursement for covered services, a hospital must adhere to all conditions stated in the Provider Contract, all applicable DHCFP policies related to the specific service provided, all state and federal requirements, the QIO like vendor/DHCFP billing requirements, and current International Classification of Diseases, Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) billing guidelines.

203.2 SPECIALTY HOSPITAL

Specialty hospitals policy is consistent with the inpatient services for prior authorization and UR.

a. Medical (Rehabilitation) Hospital Services Policy

Medical (Rehabilitation) Hospitals provide intensive and acute services for the purpose of restoring an individual's capacity to function at an optimal level, following an accident or illness, contingent upon the individual's abilities and disabilities. Rehabilitation involves both retraining and relearning to bring about maximal restoration of physical, physiological, behavioral, social, and vocational function. Most commonly, rehabilitation hospitals treat persons who have suffered a head or spinal cord injury, and who must be able to tolerate and benefit from a minimum of three hours of physical, speech or occupational therapy per day.

Inpatient rehabilitation services may be provided in either a freestanding rehabilitation hospital or a rehabilitation unit of a general hospital.

1. Admissions are only permitted from either an acute hospital or NF.
2. The inpatient admission must occur within one year from the initial injury or illness or most recent surgery/hospitalization as a result of the initial illness or injury that requires inpatient rehab services.

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b. Long-Term Acute Care (LTAC) Hospital Services Policy

LTAC hospitals provide comprehensive long-term acute care designed for patients who have suffered an acute illness, injury or exacerbation of a disease process.

Most commonly, specialty or LTAC hospitals treat patients who require ventilator, wound care, or stroke-related services.

Inpatient specialty or LTAC services may be provided in either a freestanding specialty/long-term acute care hospital or a specialty/long-term acute unit of a general hospital.

Pain Management Services standing alone (e.g., relaxation techniques, stress management, coma stimulation, biofeedback) are not a DHCFP benefit.

203.3 SWING-BED SERVICES POLICY

Reference Chapter 200, Attachment A, Policy #02-04, Hospitals with Swing Beds.

203.4 OUTPATIENT HOSPITAL SERVICES POLICY

General Medical/Surgical Hospitals commonly provide several outpatient services, included but not limited to general, clinic, office, emergency room, ambulatory surgery center, and observation services.

203.4A COVERAGE AND LIMITATIONS

1. Outpatient hospital services provided by hospitals are subject to the same service limitations as other outpatient service providers. Providers must refer to Medicaid/DHCFP service manuals relevant to the specific services being provided. The following is a list of some of the chapters a hospital should reference:

- a. For physician, advanced practitioner of nursing, physician assistants, urgent care sites, and outpatient hospital clinic visits, refer to MSM Chapter 600.
- b. For radiologic services, refer to MSM Chapter 300.
- c. For pharmaceutical services, refer to MSM Chapter 1200.

This is not an all inclusive list. The MSM in its entirety needs to be reviewed.

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2. Emergency Room Services

Emergency services are defined as a case in which delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight or hearing, injury to self or bodily harm to others.

Non-emergent services provided in an emergency room are a covered service for recipients with full Medicaid eligibility. Providers are expected to follow national coding guidelines by billing at the most appropriate level for any services provided in an emergency room setting.

Laboratory and radiological services ordered during the course of emergency room services (when it is an emergency diagnosis and not a clinic diagnosis) are payable without prior payment authorization.

Charges made for stat performance of laboratory or radiological procedures ordered during a hospital's normal operating hours in the applicable department are not a DHCFP benefit.

Patients requiring mental health services while in the emergency room may receive such services if medically appropriate, but must first be stabilized. Every effort must be made to transfer the patient to a psychiatric hospital or unit, accompanied by a physician's order. Authorization from the DHCFP's QIO-like vendor is also required.

3. Observation Services

Reference Chapter 200, Attachment A, Policy #02-05, Observation Services.

203.5 AMBULATORY SURGICAL SERVICES POLICY

Ambulatory Surgical Centers refers to freestanding or hospital based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care, and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients expected to return safely home within 24 hours.

By contrast, physician office (MD-Office) services refers to a setting limited to use of local anesthesia, including private physician office, emergency room, urgent care centers, and clinic settings.

Observation/Medical short stay refers to the "ambulatory" recipient with a coexisting medical condition or some unforeseen medical situation who may remain in a hospital environment for an extended period. This extended stay, called observation or medical short stay can be used to

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assure recipient stability without an inpatient admission. The recipient may occupy any hospital unit. Observation recipients may be rolled over for inpatient admission any time the patient requires acute care services. All rollovers to inpatient care require QIO-like vendor's authorization within 24 hours of the admission/rollover. Observation stays which do not rollover to inpatient status are limited to 48 hours.

203.5A COVERAGE AND LIMITATIONS

1. The DHCFP reimburses for services provided in a freestanding ambulatory surgical center, or an ambulatory surgical setting within a general hospital. Some ambulatory surgical center services require QIO-like vendor authorization (please see Section 203.10.D of this Chapter entitled Authorization Process).
2. Ambulatory surgical services are not reimbursable when:
 - a. the recipient's medical condition or treatment needs meet acute inpatient guidelines and standards of care.
 - b. the recipient requires preoperative diagnostic testing that cannot be performed in an outpatient setting.
 - c. the recipient requires therapeutic interventions (measures) that can only be performed in an acute hospital setting.
 - d. the probability of significant, rapid onset of complications is exceptionally high. Actual manifestation of such complications would require prompt intervention/measures available only in an inpatient setting.
 - e. complications occur during or following an outpatient procedure that requires acute inpatient treatment and intervention.
 - f. services are not reasonable and medically necessary for diagnosis or treatment of a recipient when provided for the convenience of the recipient, recipient's family, or the physician.
 - g. services are ordered as inpatient by the admitting physician.
 - h. services can be provided in a less restrictive setting (e.g., physician office, emergency room, clinic, urgent care setting).
3. Higher Setting of Service Delivery

When any listed procedure is planned in a higher setting, the physician or his/her office

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staff must contact the QIO-like vendor for prior authorization of the setting. These procedures are listed in the booklet entitled "Surgical Procedures Recommended for an Ambulatory Setting (including inpatient prior authorization guidelines)."

4. Non-Covered Procedures

Reference Chapter 600.

5. Approval Process

The procedure approval process is designated to establish the medical necessity and appropriateness for:

- a. procedures to be performed in a higher care setting;
- b. procedures that would not routinely be covered by the DHCFP; and
- c. procedures to be performed outside Nevada.

The requesting physician must provide the QIO-like vendor with the medical documentation and justification to establish medical necessity and appropriateness.

203.5B PROVIDER RESPONSIBILITY

Please consult Section 203.1.B of this Chapter for service provider responsibility.

203.5C AUTHORIZATION PROCESS

The provider must contact the QIO-like vendor 48 hours prior to the procedure date.

1. Provider must submit the required authorization form or request Prior Authorization telephonically.
2. A copy of Medicaid card to confirm that the physician's office has verified the recipient's eligibility.
3. All supporting medical documentation that the requesting physician would like considered.
4. Procedure pre-approval requests:
 - a. cannot be accepted from the facility/hospital personnel.

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- b. require up to two working days to process.
- c. DOS must be within 30 days from the Prior Authorization's date of issue.

5. Retroactive Eligible Recipients

For those recipients who applied for Medicaid eligibility after services were rendered, the QIO-like vendor must be contacted for retro eligible authorization.

The QIO-like vendor reviews the information for medical necessity, appropriateness of the procedure, and compliance with Medicaid program benefits. Written notification of

the review determination is sent to the physician and facility within 30 days of receipt of all required documentation.

6. Prior Authorization Is Required When:

- a. a procedure indicated as "MD-Office" is planned for a setting other than a physician's office, emergency room, or clinic. This includes an ambulatory surgery facility, a hospital-based outpatient surgery department, or inpatient treatment at an acute care hospital.
- b. a procedure indicated as "Amb Surgical" is planned to be done on an inpatient basis.
- c. a procedure appearing on the list is planned for a recipient who is currently being treated in an acute care hospital and the procedure is unrelated to the original reason for admission. Authorization is not required if the procedure is for treatment related to the admitting diagnosis.
- d. the physician can provide compelling evidence that a non-covered procedure is not cosmetic but is medically necessary.
- e. the Medicaid coverage is secondary to any other private, non-Medicare insurance plans.
- f. a listed procedure(s) requiring prior authorization is to be performed in conjunction with a procedure(s) exempt from authorization.
- g. any procedure is to be performed out of state.
- h. any procedure that is to be performed on an inpatient basis.

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- i. a recipient is going to be rolled-over from ambulatory or observation status to an acute inpatient admission.

7. Prior Authorization is Not Required When:

- a. reference Accredited Standards Committee (ASC) Physician’s Assistant list.
- b. a procedure is covered by Medicare Part B and Medicaid (QMB eligible) is only required to pay coinsurance, up to the DHCFP allowable maximum.

203.6 NURSING FACILITY (NF) PLACEMENT SCREENING REQUIREMENTS

There are two types of Screenings required for potential NF Placements.

- a. Level of Care (LOC) – The LOC screening must be completed prior to discharge from the hospital for all DHCFP eligible individuals.
- b. Pre-Admission Screening and Resident Review (PASRR) – Please see Chapter 500.

The hospital completes the PASRR Level I Identification screening and the LOC screening forms and submits to the QIO-like vendor. The QIO-like vendor reviews and makes a determination (for both screening types – LOC or PASRR Level I Identification) and when indicated makes the referral for PASRR Level II evaluation. Magellan Medicaid Administration (MMA) sends the requestor the determination letter to confirm the completion of the screenings.

Hospital Responsibilities for Discharge to a NF must include:

- 1. making a reasonable effort to seek placement alternatives with appropriate documentation of such efforts.
- 2. complete the LOC and/or PASRR Level I Identification forms with complete, accurate, and sufficient information. Submit the forms to MMA as soon as an imminent discharge to a NF is identified.
- 3. do not discharge the patient to the NF until a determination letter (LOC for Medicaid eligible’s, PASRR Level I Identification for all payment sources, and/or PASRR Level II for all payment sources, when indicated) is received showing the individual is appropriate to be admitted to a NF.

Time Frames for Screening Process:

- 4. PASRR Screening Process:

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- a. PASRR Level I Identification screenings are completed for acute care facilities within one business day of receipt.
- b. PASRR Level II Evaluations are generally completed within one to seven business days from the time the Level I identifies Mentally Ill (MI), Mentally Retarded (MR) or related condition (RC). Administrative day reimbursement is available to acute care facilities for Medicaid recipients if discharge is delayed due to completion of Level II PASRR, when properly documented.

5. Level of Care (LOC) Screening Process:

LOC screenings are completed for acute care facilities within one business day of receipt.

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204 HEARINGS

Reference Chapter 3100 for Hearing Process.

POLICY #02-01	FREESTANDING OBSTETRIC/BIRTH CENTERS	EFFECTIVE DATE: October 10, 2012
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A. DESCRIPTION

Section 2301 of the Affordable Care Act (ACA) requires coverage of services furnished at freestanding birth centers. A freestanding birth center is described as a health facility that is not a hospital or physician's office, where childbirth is planned to occur away from the pregnant woman's residence. The birth center must be in compliance with applicable state licensure and nationally recognized accreditation organization requirements for the provision of prenatal care, labor, delivery and postpartum care. "Obstetric Center", Nevada's legal term for birth center, complies with Section 2301 of the ACA birth center requirements related to the health and safety of recipients provided services by licensed birth centers.

B. POLICY

The DHCFP birth center coverage and reimbursement is limited to medically necessary childbirth services which use natural childbirth procedures for labor, delivery, postpartum care and immediate newborn care. Birth center coverage and reimbursement are limited to women admitted to a birth center in accordance with adequate prenatal care, prospect for a normal uncomplicated birth defined by criteria established by the American College of Obstetricians and Gynecologists and by reasonable generally accepted clinical standards for maternal and fetal health.

Refer to the Maternity Care section of Medicaid Services Manual (MSM) Chapter 600-Physician Services, for comprehensive maternity care coverage provided by physicians and/or nurse midwives.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Birth center reimbursement includes childbirth services for labor, delivery, post-partum and immediate newborn care when the following pregnancy criteria are met:

- a. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed birth center protocol;
- b. Completion of at least 36 weeks gestation and not more than 42 weeks gestation.

Birth centers are not eligible for reimbursement if:

- c. The pregnancy is high-risk.
- d. There is history of major uterine wall surgery, cesarean section or other obstetrical complications which are likely to recur.
- e. The recipient is discharged prior to delivery.

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2. NON COVERED SERVICES

- a. Emergency treatment as a separately billed service provided by the birth center. For emergency treatment provided in a hospital - Refer to policy in MSM Chapter 200 – Hospital Services; and
- b. Emergency medical transportation as a separately billed service provided by the birth center. For policy related to emergency transportation – Refer to MSM Chapter 1900 - Transportation Services.

E. PROVIDER REQUIREMENTS

Freestanding obstetric/birth center must meet the following criteria:

1. Have a provider contract with the DHCFP. Refer to MSM Chapter 100, Section 102, Provider Enrollment.
2. Meet applicable state licensing and/or certification requirements in the state in which the center is located.
3. Accreditation by one of the following nationally recognized accreditation organizations:
 - a. The Accreditation Association for Ambulatory Health Care, (AAAHC) Inc.;
 - b. The Commission for the Accreditation of Birth Centers, (CABC); and
 - c. The Joint Commission, for institution-affiliated outpatient maternity care programs which principally provide a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies.
4. Informed consent: Each recipient admitted to the birth center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.
5. The birth center must have a written Memorandum of Understanding (MOU) with a backup hospital (or physician with admitting privileges) which will accept and treat any woman or newborn transferred from the center in need of emergency obstetrical or neonatal medical care.
6. The birth center must have a written MOU with ambulance service which is routinely staffed by qualified personnel to manage critical maternal and neonatal patients during transport to each backup hospital.

For billing instructions and a list of covered procedure and diagnosis codes, please refer to the QIO-like vendor's Billing Manual.

POLICY #02-02	FEDERAL EMERGENCY SERVICES PROGRAM DIALYSIS	EFFECTIVE DATE: September 1, 2013
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A. INTRODUCTION

The Nevada State Plan provides that certain non United States (U.S.) citizens, who otherwise meet the requirements for Title XIX eligibility, are restricted to receive only emergency service as defined by 42 CFR 440.255. Provision of outpatient emergency dialysis health care services through the Federal Emergency Services Program (FESP) is deemed an emergent service for this eligibility group.

B. DEFINITIONS

For the purpose of this chapter, the following definitions apply:

1. Acute – means symptoms that have arisen quickly and which are short-lived.
2. Chronic – means a health related state that is not acute.
3. Federal Emergency Service (FES) – treatment of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
 - a. Placing the FES recipient’s health in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.
4. FES recipient – means a qualified or non-qualified alien as described by 42 CFR 435.406(2)(ii) who receives services pursuant to 42 CFR 440.255(c).
5. End Stage Renal Disease (ESRD)/Dialysis services – means the method by which a dissolved substance is removed from the body of a patient by diffusion, osmosis and convection from one fluid compartment to another fluid compartment across a semipermeable membrane (i.e., hemodialysis, peritoneal dialysis and other miscellaneous dialysis procedures).
6. Stabilized – with respect to an emergency medical situation, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

C. COVERAGE AND LIMITATIONS

Outpatient dialysis services for an FES recipient with ESRD are covered as an emergency service when the recipient’s treating physician signs and completes the certification stating that in his/her medical opinion the absence of receiving dialysis at least three times per week, would reasonably be expected to result in any one of the following:

1. Placing the FES recipient’s health in serious jeopardy;
2. Serious impairment of bodily functions; or

POLICY #02-02	FEDERAL EMERGENCY SERVICES PROGRAM DIALYSIS	EFFECTIVE DATE: September 1, 2013
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3. Serious dysfunction of a bodily organ or part.

D. PRIOR AUTHORIZATION

1. Prior authorization is not required.
2. Refer to “Provider Requirements Section” for treating physician certification form requirements.

E. NON COVERED SERVICES

1. FESP – dialysis for an eligibility group not qualified under 42 CFR 435.406(2)(i)(ii).
2. Services covered prior to the coverage date of this policy.
3. Services deemed non-covered when:
4. the “Initial Dialysis Case Creation” form is not on file with the QIO-like vendor;
5. “Monthly Certification Form” is incomplete and/or missing from the FES recipient medical record.

F. PROVIDER REQUIREMENTS

1. Treating physicians must complete and sign the monthly certification form entitled, “Monthly Certification of Emergency Condition” and retain the certification in the FES recipient’s medical record. The form is found on the QIO-like vendor website.
2. For initiation of treatment, the treating physician must submit an “Initial Dialysis Case Creation” Form to the QIO-like vendor with the initial claim. The form is found on the QIO-like vendor website.
3. The DHCFP may audit FES recipient medical records to ensure compliance with this monthly requirement.
4. For billing instructions, please refer to the QIO-like vendor’s Billing Manual and/or PT45 Billing Guideline.

POLICY #02-03	ADMINISTRATIVE DAYS	EFFECTIVE DATE: MARCH 1, 2015
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A. DESCRIPTION

Administrative days are inpatient days reimbursed at a lower per diem rate when a recipient's status no longer meets an acute level of care (LOC) and placement in an alternative appropriate setting is not available despite a hospital's documented, comprehensive discharge planning efforts.

B. POLICY

The DHCFP reimburses skilled nursing or intermediate administrative days authorized by the QIO-like vendor in increments not exceeding seven calendar days per request.

At least one acute inpatient hospital day (24 hours) must immediately precede an administrative skilled nursing or intermediate LOC. Reimbursement is not available for admission directly to an administrative level of care or for admission to an administrative level of care from an outpatient setting (e.g., emergency room, observation status, a physician's office, urgent care or clinic.)

C. PRIOR AUTHORIZATION IS REQUIRED.

Retrospective authorization must be obtained when Medicaid eligibility is determined after admission, to or discharge from an inpatient bed.

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

- a. Skilled nursing administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital as a reduction in level of care for:
 1. A recipient waiting for evaluation and/or placement regarding a Nursing Facility (NF)/extended care facility, group home, residential treatment center (RTC) Institution for Mental Disease, psychiatric or alcohol/substance abuse treatment hospital or unit, or other treatment settings (e.g., hospice) for continuity of medical services.
 2. delays in discharge related to durable medical equipment availability, home equipment set up, or home health or hospice service arrangements.
 3. a newborn with medical complications (not requiring acute care services) waiting for placement.
 4. a recipient requiring medical interventions not meeting acute care criteria that prevent the recipient from leaving the hospital (e.g., monitoring laboratory results, obtaining cultures, a specific treatment/workup.)
 5. preparation for a surgery unrelated to the original reason for admission that does not meet acute care criteria.

POLICY #02-03	ADMINISTRATIVE DAYS	EFFECTIVE DATE: MARCH 1, 2015
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- b. Intermediate administrative (Intermediate Care Level) days are covered in an inpatient or critical access hospital when:
 - 1. services do not meet an acute level of care;
 - 2. the days are authorized by the QIO-like vendor; and
 - 3. a recipient cannot be discharged for social reasons (e.g., a stable newborn either waiting for adoption or for the mother to be discharged, a recipient waiting for medical assisted transportation, a recipient requiring evaluation after being a victim of crime.)

2. NON COVERED SERVICES

Administrative days are not covered when:

- a. a recipient was not approved for at least one acute inpatient hospital day immediately preceding the initial request for administrative days.
- b. the days are only for the convenience of the recipient, recipient's family or physician.
- c. a recipient, recipient's family or physician refuse to cooperate with discharge planning efforts or refuse placement at a NF, psychiatric facility or other available alternative setting.
- d. a hospital has not provided documented evidence of a comprehensive discharge plan or an acceptable reason and timeframe for an unavoidable delay, such as awaiting a specifically identified court date (e.g.,12-10-2013) for court appointed guardianship related to out-of-state NF placement.

E. PROVIDER RESPONSIBILITIES

- 1. Submit all pertinent discharge planning information to the QIO-like vendor with the prior authorization request and obtain authorization for administrative days within timeframes required by the QIO-like vendor.
- 2. Notify the QIO-like vendor when there is a reduction in LOC to administrative days.

F. DOCUMENTATION

Maintain documentation of appropriate, comprehensive discharge planning efforts in recipients' medical records. This includes, but is not limited to:

- 1. Monday through Friday placement efforts, contacts and contact results;
- 2. discharge planning notes from applicable social workers, case managers, and/or nurses;
- 3. physicians' orders and/or progress notes;

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POLICY #02-03	ADMINISTRATIVE DAYS	EFFECTIVE DATE: MARCH 1, 2015
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4. modifications to the discharge plan, whenever applicable; and
5. acceptable reasons and timeframes of unavoidable discharge planning delays.

POLICY #02-04	HOSPITAL WITH SWING BEDS	EFFECTIVE DATE: MARCH 1, 2015
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A. DESCRIPTION

A swing bed is a bed in a rural or Critical Access Hospital (CAH), certified as a swing bed by the Centers for Medicare and Medicaid Services (CMS), which can be used to provide either acute care or post-acute skilled nursing services. A recipient admitted to a swing bed for post-acute skilled nursing following discharge from acute inpatient care, does not have to change beds or locations in a facility, unless required by the facility.

B. POLICY

This policy is specific to an acute inpatient bed that provides post acute Nursing Facility (NF) services. The DHCFP reimburses post acute/NF swing bed days when: a recipient receiving acute inpatient hospital services for at least three consecutive calendar days (not including the day of discharge) requires post-acute, skilled nursing services seven days a week, and no NF placement is available or the recipient or family refuses NF placement outside the rural area. The three-day qualifying acute inpatient stay does not have to be from the same facility as the swing-bed admission. Placement in a swing bed must be on a temporary (not long term) basis.

C. PRIOR AUTHORIZATION

Prior Authorization is required, except when a recipient is Medicare and Medicaid dual eligible and Medicare benefits are not exhausted.

Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to or discharge from a swing bed.

Services not included in the per diem rate may require prior authorization. Reference the MSM Chapter applicable to the service type regarding authorization requirements.

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

- a. The DHCFP covers medically necessary, post-acute, nursing facility level of care services provided on an inpatient basis and reimbursed at a per diem rate. The per diem rate includes routine services and supplies, including a regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen, and the use of equipment and facilities.
- b. The following services are separately reimbursed when the service meets policy requirements specific to that service:
- c. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.
- d. Nutritional supplements in conjunction with tube feedings.

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POLICY #02-04	HOSPITAL WITH SWING BEDS	EFFECTIVE DATE: MARCH 1, 2015
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- e. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.
- f. Customized durable medical equipment.
- g. Emergency transportation.
- h. Physical, occupational, and speech therapy services.
- i. Physician services.
- j. Laboratory, portable x-ray and other diagnostic services.
- k. Repair of medical equipment and appliances which belong to the recipient.

2. NON COVERED SERVICES

- a. Swing bed placement when nursing facility placement is available in the rural area where the hospital is located, or in another rural or urban area acceptable to the recipient or family.
- b. Swing bed days not authorized by the QIO-like vendor.

E. PROVIDER RESPONSIBILITIES

- 1. Ensure compliance with Provider Responsibility requirements specified in Chapter 200, Section 203.1B, federal and state swing bed requirements, and the DHCFP coverage and authorization requirements.
- 2. Utilize available NF beds prior to requesting swing bed placement, unless NF placement is outside the rural area and there is documented evidence that a recipient or family objects to placement outside the rural community.
- 3. Transfer a recipient to the first available NF bed.
- 4. Reference Chapter 500 for Pre-Admission Screening and Resident Review (PASRR) and Nursing Facility Level of Care (LOC) screening requirements prior to a recipient being transferred from a swing bed to a NF bed within the hospital or at another facility.

F. DOCUMENTATION

- 1. Notify and submit required documentation to the QIO-like vendor to initiate admission and concurrent review authorizations when a recipient is retro eligible.
- 2. Submit the following documentation to the QIO-like vendor with the initial authorization request:

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- a. a history and physical or acute inpatient discharge summary indicating the need for skilled nursing services;
 - b. a physician acute hospital discharge order and swing bed admission order;
 - c. NF placement efforts with documentation regarding NF bed unavailability or recipient or family refusal of NF placement outside the rural area; and any additional documentation requested by the QIO-like vendor.
3. Submit the following documentation to the QIO-like vendor with a concurrent swing bed authorization request no less frequently than monthly (when applicable):
- a. ongoing NF placement efforts and either the reasons NF bed placement is not available or recipient or family refusal of NF placement outside the rural area;
 - b. a monthly nursing assessment summary indicating a recipient continues to meet a skilled level of care; and
 - c. any additional documentation requested by the QIO-like vendor.

POLICY #02-05	OUTPATIENT OBSERVATION SERVICES	EFFECTIVE DATE: MARCH 1, 2015
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A. DESCRIPTION

Observation services are physician ordered, clinically appropriate, short term hospital outpatient services including diagnostic assessment and treatments provided when a recipient's medical needs do not meet acute inpatient care guidelines. A recipient's condition is further evaluated to determine if inpatient admission is required or the recipient can be safely discharged. Observation services do not have to be provided in a designated hospital observation unit. Observation services can be provided in any area of a hospital, such as on an obstetric unit or an intermediate/progressive coronary care unit.

B. POLICY

Observation services are reimbursed when ordered by a physician or other clinician authorized by State licensure law and hospital staff bylaws to order services, and at an hourly basis up to 48 continuous hours.

Medically necessary ancillary services (e.g. laboratory, radiology and other diagnostics, therapy and pharmacy services) that meet the coverage and authorization requirements of the Medicaid Services Manual (MSM) applicable to the service are separately reimbursed.

Observation and ancillary services provided at the same facility and on the same calendar date as an inpatient admission, as part of one continuous episode of care, are included in the first inpatient day, per diem rate (a rollover admission). Observation hours (not exceeding the observation 48 hour limit) and ancillary services rendered on the calendar date(s) preceding the rollover inpatient admission date are separately reimbursed.

C. PRIOR AUTHORIZATION IS NOT REQUIRED for hourly outpatient observation.

Medically necessary ancillary services may require prior authorization. Reference the MSM Chapter applicable to the service type regarding authorization requirements.

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

- a. Observation begins the date and time specified on the physician's observation order, not when the recipient is placed in an observation bed. Observation ends when the 48 hour policy limit is reached or at the date and time the physician writes an order for either inpatient admission, transfer to another healthcare facility, or discharge.
- b. Observation days are covered when:
- c. A recipient is clinically unstable for discharge from an outpatient setting due to either:
- d. a variance from generally accepted, safe laboratory values;
- e. clinical signs and symptoms above or below normal range requiring an extension of monitoring and further evaluation;

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- f. an unstable presentation with vague symptoms and no definitive diagnosis; or
- g. an uncertain severity of illness or condition in which a change in status requiring medical intervention is anticipated.
- h. A significant adverse reaction occurs subsequent to: a therapeutic service (e.g., blood or chemotherapy administration, dialysis); a diagnostic procedure (e.g., cardiac catheterization); or an ambulatory surgery that does not require inpatient admission, but does require monitoring and treatment for a period of time that is beyond the time usually considered a component of the service, procedure, or surgical recovery period.
- i. The medically necessary services provided meet observation criteria, a provider is notified that inpatient admission is denied because it does not meet acute inpatient level of care criteria, a physician writes an order for observation status, and patient rights and utilization review federal requirements are met pertaining to changing an inpatient admission to outpatient observation status.

2. NON COVERED SERVICES

- a. Observation hours exceeding the 48 hour limit.
- b. Services rendered without a signed, dated physician order or documentation in the medical record that specifies the date and time observation services were initiated and discontinued.
- c. Diagnostic testing or outpatient procedures prescribed for a medically stable individual or services deemed by the DHCFP, the DHCFP's QIO-like vendor, or other authorized agency as not medically necessary or appropriate.
- d. Observation status when either a recipient's medical condition or treatment needs meet acute inpatient guidelines/standards of care or the probability of a significant, rapid onset complication is exceptionally high requiring prompt interventions available only in an inpatient setting.
- e. Services that can be safely and effectively provided in a less restrictive setting (e.g., a physician's office, emergency room, clinic, urgent care setting).
- f. Services limited to a therapeutic procedure (e.g., outpatient blood transfusion, intravenous fluids, chemotherapy administration, dialysis) when no other service is required or in the absence of a documented adverse reaction.
- g. Services that are routine preparation prior to or monitoring after a diagnostic test, treatment, procedure, or outpatient same-day surgery.
- h. Services immediately preceding an inpatient admission for elective induction of labor (EIOL) prior to 39 weeks gestation when the EIOL is not authorized as medically necessary.

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- i. Services provided solely for the convenience of a recipient, recipient's family or physician.
- j. Services provided to an individual not eligible (concurrently or retrospectively) for Medicaid or Nevada Check Up on the date of service or not covered by or performed in compliance with this or any other MSM Chapter.

E. DOCUMENTATION REQUIREMENTS

Ensure the following information is maintained in a recipient's medical record:

- 1. A physician's order, clearly indicating the dates and times that observation begins and ends.
- 2. Comprehensive documentation that supports medical necessity and describes, when applicable:
 - a. a significant complication or adverse reaction that requires services that would not normally be included in a recovery or post-procedure period; or
 - b. a high probability of a significant, rapid onset complication requiring prompt interventions available in an observation setting.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
 FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
 SUBJECT: MEDICAID SERVICES MANUAL CHANGES
 CHAPTER 300, RADIOLOGY SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 300, Radiology Services, Sections 303.6A, Coverage and Limitations, 303.7, Sleep Study Services, and 303.8, Radiopharmaceuticals and Contrast Agents, were made to clarify and eliminate duplicative and outdated language.

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

These changes are effective July 15, 2016

MATERIAL TRANSMITTED

MTL 17/16
CHAPTER 300 – RADIOLOGY SERVICES

MATERIAL SUPERSEDED

MTL 03/12
CHAPTER 300 – RADIOLOGY SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
303.7	Sleep Studies, Polysomnography, Multiple Sleep Latency Test (MSLT)	Description was minimized to include only the title.
303.7A	Coverage and Limitations	Section title was changed to Sleep Study Description was added to align with federal definition and the American Academy of Sleep Medicine (AASM) guidelines; reimbursement guidelines were moved; Coverage and Limitations was moved to section 303.7(C)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
303.7B	Provider Responsibility	Provider Responsibility language was omitted; and Prior Authorization section was added to define prior authorization requirements more clearly.
303.7C	Recipient Responsibility	Recipient Responsibility language was omitted; and Coverage and Limitations was added to define sleep study settings and physician requirement.
303.7D	Unattended Sleep Studies	Language was added for clarity of unattended/in-home sleep study services.
303.7E	Non-Covered Sleep Study Services	Language was added for clarity of non-covered sleep study services.
303.8	Radiopharmaceuticals and Contrast Agents Description	Radiopharmaceuticals and Contrast Agents Description was minimized to include on the title.
303.8A	Radiopharmaceuticals and Contrast Agents Coverage and Limitations	Coverage and Limitations was omitted; Description was added to align with the Food and Drug Administration (FDA).
303.8B	Radiopharmaceuticals and Contrast Agents Provider Responsibility	Provider Responsibility language was deleted; and Coverage and Limitations was moved to this section.

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MEDICAID SERVICES MANUAL
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300 INTRODUCTION

Diagnostic testing and Radiologic services are federally mandated the Division of Health Care Financing and Policy (DHCFP) Medicaid and Children’s Health Insurance Program (CHIP) benefits. This chapter presents policy diagnostic services provided in outpatient hospitals, diagnostic centers or mobile units.

The DHCFP reimbursement is based on the need to establish a diagnosis and to prescribe treatment. Reimbursement is also provided for progressive follow-up or staging. Diagnostic studies are rendered according to the written orders of the Physician, Physician’s Assistant, or an Advanced Practitioner of Nursing (APN), and must be directly related to the presenting symptoms.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual, Chapter 1000.

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301 REGULATORY AUTHORITY

301.1 The citation denoting the amount, duration, and scope of services are found in 42 Code of Federal Regulations (CFR), Part 435 and sections 1902 (a) (10) (A) (I) (IV), and (VI), 1902 (a) (10) (A) (ii) (XI), 1902 (a) (10) (E), 1902 (1) and (m), 1905 (p), (q) and (s), 1920, and 1925 of the Act. Title XVIII of the Social Security Act, 1862 (a) (1) (A), 411.15 et.seq. Title XVIII of the Social Security Act, 1862 (a) (7), 405.1411-1416.

301.2 The State Legislature sets forth standards of practice for licensed professionals in the following Nevada Revised Statutes (NRS):

Chapter 454 - Poisons; Dangerous Drugs and Hypodermics, (Section 454.213);

Chapter 457 – Cancer;

Chapter 630 - Physicians and Assistant;

Chapter 639 - Pharmacists and Pharmacy, (Section 639.008, 639.0095, 639.0097, 639.0105, 639.0125, and 639.0143.)

301.3 Also cited, Title XXI State Plan Attachment 1.2-B, 101.9, E (page 7) of Title XIX State Plan.

301.4 The Food and Drug Administration (FDA), Mammography Quality Standards Act (MQSA) of 1992.

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302 RESERVED

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303 MEDICAID POLICY

303.1 RADIOLOGICAL STUDIES

The Division of Health Care Financing and Policy (DHCFP) medical assistance programs will reimburse for those covered services that are considered to be medically necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body part without prior payment authorization. The investigational use for any radiological test is not a Medicaid covered benefit

303.1A COVERAGE AND LIMITATIONS

1. A licensed physician or other licensed persons working within the scope of their practice must request radiology services (e.g., Advanced Nurse Practitioner, Physician’s Assistant, Podiatrist, etc.).
2. Payment for X-rays and other radiological examinations will only be allowed for those services that are considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body part.
3. An annual screening mammography is a covered benefit without prior authorization for women age 40 and older and/or a woman between the ages of 35-39, considered a high risk for breast cancer. High risk is defined as one or more of the following conditions:
 - a. Personal history of breast cancer;
 - b. Personal history of biopsy – proven beginning breast disease;
 - c. A mother, sister or daughter had breast cancer; and/or
 - d. A woman who has not given birth prior to age 30
4. Diagnostic and/or treatment mammography’s are not restricted to age or sex and do not require prior authorization.
5. The choice of the appropriate imaging modality or combination of imaging modalities should be determined on an individual level. Prior authorization will not be required for medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), or Positron Emission Tomography (PET) scans. Always use other modalities or less expensive tests such as CT, ultrasound or standard X-ray, etc., when they will achieve the required results. Use of approved modalities for investigational/experimental reasons are not a Medicaid benefit.

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Prior authorization will not be required for initial testing and tumor staging. Other repeated testing will require prior authorization.

6. The DHCFP medical assistance programs cover certain types of X-rays and cover skeletal films for arms, legs, pelvis, vertebral column, skull, chest and abdominal films that do not involve the contrast material and electro cardiograms furnished by a portable x-ray supplier in a residence used as a recipient's home. These services must be performed under the general supervision of a physician. All licensing conditions and health and safety conditions must be met. Coverage of portable services are defined in 42 Code of Federal Regulation (CFR) 486.
7. Documentation must be available in the clinical record to support the reasonable and necessary indications for all testing.
8. The following exception requires prior authorization:

All non-emergency services referred and/or provided out-of-state.
9. See Billing Manual for Diagnostic Test prior authorization schedule.

303.1B PROVIDER RESPONSIBILITY

Providers are responsible for the following:

1. Verify program eligibility each month (e.g., Qualified Medicaid Beneficiary (QMB), Managed Care Organization (MCO), etc.) and comply with the program requirements. Example: A QMB only recipient never requires a Medicaid payment authorization.
2. The provider must allow, upon the request of proper representatives of the DHCFP, access to all records which pertain to Medicaid or Children's Health Insurance Program (CHIP) recipients for regular review, audit, or utilization review.
3. Evidence to support medical necessity for the procedures must be clearly documented in the clinical record. Duplicative testing when previous results are still pertinent is not a covered benefit.
4. The ordering physician is responsible for forwarding appropriate clinical data to the diagnostic facility.

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303.1C RECIPIENT RESPONSIBILITY

The DHCFP medical assistance program recipient must:

1. present a current Medicaid card to service providers at each encounter.
2. notify providers immediately for any change in eligibility status, e.g., pending status to eligible or fee for service to managed care.

303.1D PRIOR AUTHORIZATION

Providers must submit the following documentation to substantiate a prior authorization request: the date, place, and results of previous diagnostic tests performed. Fax or mail all information to the Quality Improvement Organization (QIO)-like vendor.

303.2 SCREENING MAMMOGRAPHY

Screening mammograms are radiological procedures furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and include a physician's interpretation of the results. The service must be at a minimum, a two-view exposure (that is, a cranio-caudal and medial lateral oblique view) of each breast.

The DHCFP pays for routine screening mammograms annually for women over age 40. For women aged 35-39, a baseline mammogram is allowed once during this period of time. All facilities providing mammography services are required to have a certificate issued by the Food and Drug Administration (FDA), assuring the mammography provider meets national quality standards in accordance with the Mammography Quality Standards Act (MQSA) of 1992.

303.2A COVERAGE AND LIMITATIONS

A doctor's prescription or referral is not necessary for the procedure to be covered. It is required that there be 365 days from the date of the last mammogram until the next mammogram.

303.3 ELECTRODIAGNOSTIC TESTING/NEUROPHYSIOLOGICAL STUDIES

A neurological evaluation must precede diagnostic testing.

a. ELECTROENCEPHALOGRAM (EEG)

Routine EEG tests measure and record the electrical impulses from the cortex of the brain. A diagnosis can only be made with correlating clinical findings.

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b. 24 HOUR ELECTROENCEPHALOGRAPHIC RECORDING

Intensive EEG recording (24 hours) is a safe and clinically effective method of diagnosis, classification, and localization for seizure disorders, and other factors precipitating individual seizures. Results can indicate which category of medication may be the most successful.

c. EEG BRAIN MAPPING

EEG brain mapping is a term commonly used for several quantitative EEG techniques. These include:

1. EEG frequency analysis;
2. topographic display;
3. statistical comparisons to a normative database; and
4. other similar computer-based calculations based on EEG or evoked potentials.

Prior authorization requests must be reviewed by a Physician Advisor highly skilled in clinical electroencephalographic testing for services which are provided by physician specialists in clinical electroencephalography. A specific correlating diagnosis has not been established.

303.3A COVERAGE AND LIMITATIONS:

EEG testing is covered when supported by sufficient information that its use was medically appropriate considering the patient's symptoms and preliminary diagnosis.

24 hour EEG recordings and EEG mapping require prior payment authorization.

303.4 ELECTROMYOGRAPHY (EMG), NERVE CONDUCTION STUDIES (NCS) DESCRIPTION:

Electromyoneurography is the combined use of electromyography (EMG) and electroneurography/NCS. These studies are done to detect neuromuscular abnormalities by measuring the nerve conduction and muscle potentials. F-wave studies assess motor nerve function along each nerve. An impulse generated at the stimulating electrode travels up the motor nerves to the motor neuron cell bodies in the spinal cord, on to the neuromuscular junction and the muscle. H-reflex studies are entirely separate from F-wave studies. H-reflex studies assess sensory and motor nerve function and their connections in the spinal cord. The EMG/NCS testing in combination with evaluating the range of motion, motor power, sensory defects, and reflexes, can differentiate between neuropathy and myopathy.

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303.4A COVERAGE AND LIMITATIONS:

1. EMG measures the electrical activity of muscles at rest and during contractions.
2. NCS - Diagnostic nerve conduction studies include amplitude which differentiates nerve conduction studies from screening studies performed with devices which only measure latency.
3. F-wave studies are usually performed in conjunction with conventional motor nerve conduction studies of the same nerve. F-wave studies assess motor nerve function along the entire extent of each selected nerve.
4. Reflex Tests - H-reflex testing is unilateral and usually involves assessment of the tibial motor nerve and the gastrocnemius-soleus muscle complex. They are not often performed in conjunction with conventional nerve conduction studies of this nerve-muscle pair. Typically only one or two H-reflex studies are performed on a patient during a given encounter.
5. Neuromuscular junction testing

COVERED DIAGNOSIS:

Carpal Tunnel Syndrome	Neuritis
Diabetic Neuropathy	Neuromuscular conditions
Disorders of the Peripheral Nervous System	Pain in Limb
Disturbance of Skin Sensation	Plexopathy
Fasciculation Joint Pain	Radiculopathy
Muscle Weakness	Spinal Cord Injury
Myopathy	Swelling and Cramps
Myositis	Trauma to Nerves
Nerve Root Compression	Weakness

See Billing Manual for prior authorization requirements.

303.5 EVOKED POTENTIALS (EPs):
SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY (SSEP)
VISUAL EVOKED POTENTIAL (VEP)
AUDITORY EVOKED POTENTIALS (AEP)

DESCRIPTION: EPs are time-locked responses of the nervous system to external stimuli. Somatosensory evoked potentials (SEPs) are one type of EP, which are generated by stimulation of afferent peripheral nerve fibers elicited by electrical, tactile, or other stimuli. "Short-latency" SEP (SSEP) refers to that portion of the waveform of an SEP normally occurring within a specific

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time lapse variable after nerve stimulation. SEP abnormalities are not disease specific, but can indicate afferent conduction impairments associated with certain disorders.

303.5A COVERAGE AND LIMITATIONS

1. The SEP study is separated into upper and lower limbs to recognize that switching from the upper to lower limbs requires an increase in work because many stimulating and recording electrodes must be moved and the patient must be stimulated many more times to perform the additional testing.
2. SEP studies performed on the trunk or head are completely separate tests from the upper and lower limb studies.
3. The visual evoked potential codes are clinical neurophysiologic studies.
4. The auditory evoked potential procedure codes can be a clinical neurophysiologic study as well as an audiology study.

COVERED DIAGNOSIS

SEP/SSEP:

Spinal Cord Lesions
Stroke
Extremity numbness and weakness

VER:

Lesions of Optic Nerve/Optic Tracts
Multiple Sclerosis (MS)

ABR:

Lesions in the Brain Stem including Tumor
Evaluate Hearing in Infants, Children, Adults
Evaluation for peripheral Hearing Loss

Cerebellopontine Angle Lesions
Infarctions
Multiple Sclerosis

See Billing Manual for prior authorization requirements.

303.6 MAGNETOENCEPHALOGRAPHY (MEG) INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING

DESCRIPTION: MEG is a highly refined noninvasive technique that measures the magnetic fields generated by active groups of nerve cells in the brain which would obviate the need for depth electrodes in the precise localization of epileptogenic foci. MEG Non-invasive use of MEG and MEG - EEG have been able to help focus subdural electrodes for a chronic intracranial presurgical evaluation in recipient's with medically intractable epilepsy and comparison of epileptic activity with normal evoked responses may help localize epileptic zones.

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Intraoperative neurophysiology/electrophysiologic monitoring of the nervous system is now widely used to help prevent complications and to identify structures during neurosurgical and other procedures. These techniques include EEG, evoked potentials, EMG and nerve conduction velocity (NCV) testing and monitoring.

303.6A COVERAGE AND LIMITATIONS:

MEG – The procedure is limited to localization of the seizure zone in medically intractable partial epilepsy for recipients being considered for surgical intervention.

Intraoperative electrophysiologic monitoring – EEG or SEP to monitor for cerebral ischemia; electrocorticography (ECoG) and SEP sensory cortex identification to define the limits of cortical resection; SEP spinal cord monitoring; Brainstem Auditory Evoke Potential (BAEP) and cranial nerve EMG monitoring during posterior fossa procedures; functional localization of cortex with direct cortical stimulation in expert hands; and EMG and compound muscle and nerve action potential measurements of various peripheral nervous system structures.

1. COVERED DIAGNOSIS:

Partial intractable epilepsy, without mention of impairment of consciousness.

See Billing Manual for prior authorization requirements.

2. DOCUMENTATION REQUIREMENTS

Documentation supporting **medical** necessity for any of the above procedures must be **clearly documented** in the **recipient's medical** record and submitted **when a** Prior Authorization (PA) **is** required.

303.7 SLEEP STUDY SERVICES

303.7A SLEEP STUDY DESCRIPTION

1. According to the U.S. Department of Health and Human Services, National Institutes of Health (NIH), sleep studies are tests that measure how well someone sleeps and how the body responds to sleep problems. Sleep studies are necessary because untreated sleep disorders can raise risk for heart disease, high blood pressure, stroke, and other medical conditions. Sleep disorders have also been linked to an increased risk of injury, such as falling in the elderly and automobile accidents.

2. The following sleep study tests are covered benefits:

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- a. Polysomnography (PSG) is the scientific evaluation of sleep that involves a physiologic recording of brain waves, oxygen level in blood, heart rate and breathing, and eye and leg movements.
 - b. The multiple sleep latency test (MSLT) is performed to measure daytime sleepiness. Also known as a daytime nap study, the MSLT is the standard tool used to diagnose narcolepsy and idiopathic hypersomnia.
3. Sleep study services are performed with physician review, interpretation, and report.

303.7B PRIOR AUTHORIZATION

1. The PSG and MSLT sleep study tests are limited to two services in a 12 month period without prior authorization. If the services exceed limitations, a prior authorization is required.
2. Prior authorization for MSLT includes authorization for a PSG performed on the preceding night to be valid.
3. Documentation supporting medical necessity for sleep study services must be clearly documented in the recipient's medical record and submitted when a prior authorization is requested.

303.7C COVERAGE AND LIMITATIONS

1. Sleep studies are covered services in the following settings:
 - a. a certified or accredited sleep disorder facility; or
 - b. an in-home (unattended) setting in conjunction with a comprehensive sleep evaluation by a physician board certified in sleep medicine.
2. A licensed physician or other licensed professional working within the scope of their practice must request the appropriate test.
3. The ordering provider is responsible for forwarding appropriate clinical data to the diagnostic facility.
4. The need for diagnostic testing is confirmed by medical evidence, e.g. recipient history, physician examination, and other laboratory tests.
5. Reference MSM Chapter 1300, Durable Medical Equipment, for coverage and limitation guidelines for the positive airway pressure device services.

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6. Polysomnography (PSM) minimum requirements include the following:
 - a. EEG;
 - b. Electro-oculography (EOG); and
 - c. EMG.

7. Additional parameters of sleep which may be monitored include:
 - a. EKG;
 - b. Airflow;
 - c. Ventilation and respiratory effort;
 - d. Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis;
 - e. Extremity muscle activity, motor activity-movement;
 - f. Extended EEG monitoring;
 - g. Penile tumescence;
 - h. Gastroesophageal reflux;
 - i. Continuous blood pressure monitoring;
 - j. Snoring; and
 - k. Body positions, etc.

8. A PSG must be recorded and staged.

9. MSLT's are covered only when symptoms suggest a diagnosis of narcolepsy.

303.7D UNATTENDED SLEEP STUDIES

1. Portable monitoring (PM) for the diagnosis of obstructive sleep apnea (OSA) should be performed only in conjunction with a comprehensive sleep evaluation.

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2. Clinical sleep evaluations following PM must be supervised and evaluated by a physician board certified in sleep medicine.
3. PM may be used as an alternative to PSG for the diagnosis of OSA in recipients with a high pretest probability to moderate to severe OSA.
4. PM should not be used for the following recipients:
 - a. with significant comorbid medical conditions that may degrade the accuracy of PM, including moderate to severe pulmonary disease, neuromuscular disorders, asthma, stroke, severe hypertension or congestive heart failure.
 - b. suspect of having other sleep disorders, including central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders or narcolepsy.
5. PM should not be used for general screening of asymptomatic recipients.
6. PM may be indicated for the diagnosis of OSA in recipients for whom in-laboratory PSG is not possible by virtue of immobility, safety, or critical illness.
7. At a minimum, the PM must record airflow, respiratory effort, and blood oxygenation. The type of biosensors used to monitor these parameters for in-laboratory PSG are recommended for use in PM.
8. Unattended sleep studies are considered medically necessary using one of the following diagnostic techniques for recipients with symptoms suggestive of OSA when the home sleep study is used as part of a comprehensive sleep evaluation:
 - a. Sleep monitoring using a Type II device, minimum of seven channels (e.g. electroencephalogram (EEG), electrooculogram (EOG), electromyogram (EMG), electrocardiogram (ECG) , airflow, respiratory effort, oxygen saturation);
 - b. Sleep monitoring using a Type III device, minimum of four monitored channels including ventilation or airflow (at least two channels of respiratory movement or airflow), heart rate or ECG, and oxygen saturation; or
 - c. Sleep monitoring using a Type IV device, measuring at least three channels. Type IV devices must allow channels that allow direct calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) as the result of measuring airflow or thoracoabdominal movement.

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9. An experienced sleep technician, sleep technologist or appropriately trained healthcare provider must perform the application of PM sensors or directly educate the recipient in correct application of the sensors.
10. Due to the known rate of false negative PM tests, in-laboratory PSG should be performed in cases where PM is technically inadequate or fails to establish the diagnosis of OSA in recipients with a high pretest probability.
11. If a PM test is technically inadequate or does not provide the expected result, in-laboratory PSG should be performed. Documentation supporting medical necessity for the repeat services must be clearly documented in the recipient's medical record.

303.7E NON-COVERED SLEEP STUDY SERVICES

1. Actigraphy and SleepStrip® are considered investigational/experimental and are not covered benefits.
2. Repeat studies are not covered when documentation for a repeat study does not indicate medical necessity (e.g. no new clinical documentation indicating the need for a repeat study).

303.8 RADIOPHARMACEUTICALS AND CONTRAST AGENTS

303.8A RADIOPHARMACEUTICALS AND CONTRAST AGENTS DESCRIPTION

1. According to the Food and Drug Administration (FDA), radiopharmaceuticals and contrast agents are used in diagnostic imaging procedures or for therapeutic purposes. Agents enhance the quality of MRI, MRA, CT scans, PET, x-ray and other modalities. Agents are also used to monitor treatment effect. Radiopharmaceuticals and contrast agents may be dispensed to the recipient in several different ways, i.e. by mouth or injection, or placed into the eye or bladder. They may also be used for nuclear medicine.

303.8B COVERAGE AND LIMITATIONS

1. The DHCFP will reimburse covered, medically necessary radiopharmaceuticals and contrast agents.

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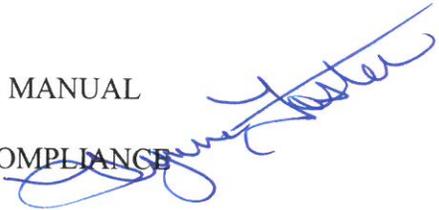
304 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM), Chapter 3100, for Hearings process and policy.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE 

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE
ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Alcohol/Substance Abuse Services are being proposed to clarify requirements for case management services and referring providers to MSM Chapter 2500 – Case Management, for further clarification of definitions, service requirements, service limitations, provider qualifications and documentation requirements. This is not a change to policy and is only providing further clarification.

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

These changes are effective April 15, 2016.

MATERIAL TRANSMITTED

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MSM 400 - MENTAL HEALTH AND
ALCOHOL/SUBSTANCE ABUSE
SERVICES

MATERIAL SUPERSEDED

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MSM 400 - MENTAL HEALTH AND
ALCOHOL/SUBSTANCE ABUSE
SERVICES

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403.4

**Outpatient Mental
Health Services**

Added language to refer providers to MSM Chapter 2500 for further clarification of case management services.

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MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

400 INTRODUCTION

Nevada Medicaid reimburses for community-based and inpatient mental health services to both children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their 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 functioning level. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, while in transit and/or in the recipient's home. All services must be documented as medically necessary and appropriate and must be prescribed on an individualized Treatment Plan.

Mental health rehabilitation assists individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.

Alcohol and substance abuse treatment and services are aimed to achieve the mental and physical restoration of alcohol and drug abusers. To be Medicaid reimbursable, while services may be delivered in inpatient or outpatient settings (inpatient substance abuse hospital, general hospital with a substance abuse unit, mental health clinic, or by an individual psychiatrist or psychologist), they must constitute a medical-model service delivery system.

All Medicaid policies and requirements (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000, are the same for NCU. Chapter 400 specifically covers behavioral health services and for other Medicaid services coverage, limitations and provider responsibilities, the specific Medicaid Services Manual (MSM) needs to be referenced.

Nevada Medicaid's philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers and informal supports when considered appropriate per the recipient or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the recipient's needs. In the case of child recipients, providers shall deliver youth guided effective/comprehensive, evidence-based treatments and interventions, monitor child/family outcomes through utilization of Child & Family Team meetings, and continuously work to improve

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services in order to ensure overall fidelity of recipient care. (Reference Addendum – Medicaid Services Manual (MSM) Definitions).

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401 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation (FFP) for states that elected to offer medical programs. States must offer the 11 basic required medical services. Two of these are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20). All other mental health and substance abuse services provided in a setting other than an inpatient or outpatient hospital are covered by Medicaid as optional services. Additionally, state Medicaid programs are required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as the result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening for children 21 years or younger, whether or not such services are covered under the state plan (section 1905(a)).

Other authorities include:

- Section 1902(a)(20) of the Social Security Act (State Provisions for Mental Institution Patients 65 and Older)
- Section 1905(a)(13) of the Social Security Act (Other Diagnostic Screening, Preventative and Rehabilitative Services)
- Section 1905(h) of the Social Security Act (Inpatient Psychiatric Services to Individuals Under Age 21)
- Section 1905(i) of the Social Security Act (Definition of an Institution for Mental Diseases)
- Section 1905(r)(5) of the Social Security Act (Mental Health Services for Children as it relates to EPSDT)
- 42 CFR 435.1009 (2) Definition of Institution for Mental Diseases (IMD)
- 42 CFR 435.1010 Definitions Relating to Institutional Status
- 42 CFR 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21)
- 42 CFR 441.150 to 441.156 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)
- 42 CFR, Part 482 (Conditions of Participation for Hospitals)
- 42 CFR, Part 483 (Requirements for States and Long Term Care Facilities)

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- 42 CFR, PART 435 (Eligibility In the States, District of Columbia, the Northern Mariana Islands and American Samoa), 440.130 (Definitions relating to institutional status)
- 42 CFR, PART 440 (Services: General Provisions), 440.130 (Diagnostic, screening, preventive and rehabilitative services)
- CMS 2261-P, Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services)
- CMS State Medicaid Manual, Chapter 4, Section 4390 (Requirements and Limits applicable to Specific Services (IMD))
- Nevada Revised Statute (NRS), Chapter 629 (Healing Arts Generally)
- NRS 432.B (Protection of Children from Abuse and Neglect)
- NRS, Chapter 630 (Physicians, Physician Assistants and Practitioners of Respiratory Care)
- NRS Chapter 632 (Nursing)
- NRS 433.B.010 to 433.B.350 (Mental Health of Children)
- NRS 433.A.010 to 433.A.750 (Mental Health of Adults)
- NRS 449 (Medical and other Related Facilities)
- NRS 641 (Psychologists)
- NRS 641.A (Marriage and Family Therapists and Clinical Professional Counselors)
- NRS 641B (Social Workers)
- Nevada State Plan, Section 4-19.A, page 4
- Nevada Medicaid Inpatient Psychiatric and Substance Abuse Policy, Procedures and Requirements. The Joint Commission Restraint and seclusion Standards for Behavioral Health.

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402 RESERVED

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403 POLICY

403.1 OUTPATIENT SERVICE DELIVERY MODELS

Nevada Medicaid reimburses for outpatient mental health and/or mental health rehabilitative services under the following service delivery models:

A. Behavioral Health Community Networks (BHCN)

Public or private entities that provides or contracts with an entity that provides:

1. Outpatient services, such as assessments, therapy, testing and medication management, including specialized services for Nevada Medicaid recipients who are experiencing symptoms relating to a covered, current International Classification of Diseases (ICD) diagnosis or who are individuals with a mental illness and residents of its mental health service area who have been discharged from inpatient treatment;
2. 24-hour per day emergency response for recipients; and
3. Screening for recipients under consideration for admission to inpatient facilities.

BHCNs are a service delivery model and are not dependent on the physical structure of a clinic. BHCNs can be reimbursed for all services covered in this chapter and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with mental health rehabilitation providers.

B. Independent Professionals - State of Nevada licensed: psychiatrists, psychologists, clinical social workers, marriage and family therapists and clinical professional counselors. These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements and expertise.

C. Individual Rehabilitative Mental Health (RMH) providers must meet the provider qualifications for the specific service. If they cannot independently provide Clinical and Direct Supervision, they must arrange for Clinical and Direct Supervision through a contractual agreement with a BHCN or qualified independent professional. These providers may directly bill Nevada Medicaid or may contract with a BHCN.

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403.2 PROVIDER STANDARDS

A. All providers must:

1. Provide medically necessary services;
2. Adhere to the regulations prescribed in this chapter and all applicable Division chapters;
3. Provide only those services within the scope of their practice and expertise;
4. Ensure care coordination to recipients with higher intensity of needs;
5. Comply with recipient confidentiality laws and Health Insurance Portability and Accountability Act (HIPAA);
6. Maintain required records and documentation;
7. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor;
8. Ensure client's rights; and
9. Cooperate with the Division of Health Care Financing and Policy's (DHCFP's) review process.

B. BHCN providers must also:

1. Have written policies and procedures to ensure the medical appropriateness of the services provided;
2. Operate under medical supervision and ensure medical supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process;
3. Ensure access to psychiatric services, when medically appropriate, through a current written agreement, job description or similar type of binding document;
4. Utilize clinical supervision as prescribed in this chapter and have written policies and procedures to document the process to ensure clinical supervision is performed on a regular, routine basis at least monthly and the effectiveness of the mental health treatment program is evaluated at least annually;

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5. Work on behalf of recipient's in their care to ensure effective care coordination within the state system of care among other community mental health providers and other agencies servicing a joint recipient;
6. **Implement and maintain a Quality Assurance (QA) program which continually assesses quality measures and seeks to improve services on an ongoing basis. A QA program description must be submitted upon enrollment and updated annually on the anniversary of the BHCN enrollment month. The BHCN's QA program description and report must include the following:**
 - a. A list of behavioral health services and evidence based practices that the BHCN provides to recipients.
 - i. Identify the goals and objectives of the services and methods which will be used to restore recipient's highest level of functioning.
 - b. An organization chart that outlines the BHCN's supervisory structure and the employees and positions within the agency. The organizational chart must identify the medical supervisor, clinical supervisor(s), direct supervisor(s), affiliated qualified mental health professional(s) and qualified mental health associate(s) including names and National Provider Identifier (NPI) numbers for each.
 - c. Document how clinical and supervisory trainings are conducted and how they support standards to ensure compliance with regulations prescribed within MSM Chapter 400. Provide a brief description of material covered, date, frequency and duration of training, location, names of employees that attended, and the name of the instructor.
 - d. Demonstration of Effectiveness of Care, Access/Availability of Care, and Satisfaction of Care. The BHCN must adhere to the QIO-like vendor's Billing Manual for further instructions concerning the required Quality Measures below. The following quality measures are required:
 - i. Effectiveness of care:
 1. Identify the percentage of recipients demonstrating stable or improved functioning.
 2. Develop assessment tool to review Treatment and/or Rehabilitation Plans and report results of assessment.

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ii. Access and Availability to Care:

1. Measure timeliness of appointment scheduling between initial contact and rendered face to face services.

iii. Satisfaction of Care:

1. Conduct a recipient and/or family satisfaction survey(s) and provide results.
2. Submit a detail grievance policy and procedure.

- e. The DHCFP may require the BHCN to submit a DHCFP approved Corrective Action Plan (CAP) if the BHCN's QA report has adverse findings. The BHCN's CAP shall contain the following and must be provided within 30 days from the date of notice:

- i. The type(s) of corrective action to be taken for improvement;
- ii. The goals of the corrective action;
- iii. The time-table for action;
- iv. The identified changes in processes, structure, internal/external education;
- v. The type of follow-up monitoring, evaluation and improvement.

- f. QA Programs must be individualized to the BHCN delivery model and services provided. Duplication of QA documentation between BHCNs may be cause for rejection without review.

Failure to submit QA Program documentation or failure to meet standards of the QA Program and/or Corrective Action Plan (CAP) as required in MSM 403.B.6 within designated timeframes will result in the imposition of sanctions including, but not limited to, partial suspension and/or termination of the BHCN provider contract. Further clarification of the QA Program requirements may be found in the Billing Manual.

A BHCN that is **accredited through** the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or Council of Accreditation (COA) may substitute a copy of the documented QA **program and report** required for the certification in lieu of the requirements of 403.2B.6. **Accreditation must be specific to a BHCN delivery model.**

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C. Recipient and Family Participation and Responsibilities

1. Recipients or their legal guardians and their families (when applicable) must:
 - a. Participate in the development and implementation of their individualized Treatment Plan and/or Rehabilitation Plan;
 - b. Keep all scheduled appointments; and
 - c. Inform their Medicaid providers of any changes to their Medicaid eligibility.

403.2A SUPERVISION STANDARDS

1. Medical Supervision – The documented oversight which determines the medical appropriateness of the mental health program and services covered in this chapter. Medical supervision must be documented at least annually and at all times when determined medically appropriate based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication. Medical supervision may be secured through a current written agreement, job description, or similar type of binding document. Behavioral Health Community Networks and all inpatient mental health services are required to have medical supervision.
2. Clinical Supervision – Qualified Mental Health Professional (QMHP), operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials, and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors must assure that the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided. Clinical Supervisors can supervise QMHPs, Qualified Mental Health Associate (QMHA), and Qualified Behavioral Aides (QBA). Clinical Supervisors may also function as Direct Supervisors.

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

- a. An up to date (within 30 days) case record is maintained on the recipient;

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- b. 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);
 - c. A comprehensive and progressive Treatment Plan and/or Rehabilitation Plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP;
 - d. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive, and age and developmentally appropriate;
 - e. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, that the recipient and their family/legal guardian (in the case of legal minors) sign the Treatment and/or Rehabilitation Plan(s), and that the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the Treatment and/or Rehabilitation Plan(s);
 - f. 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;
 - g. Only qualified providers provide prescribed services within scope of their practice under state law; and
 - h. Recipients receive mental and/or behavioral health services in a safe and efficient manner.
3. Direct Supervision – QMHP or QMHA may function as Direct Supervisors. Direct Supervisors must have the practice specific education, experience, training, credentials, and/or licensure to coordinate an array of mental and/or behavioral health services. Direct Supervisors assure servicing providers provide services in compliance with the established treatment/rehabilitation plan(s). Direct Supervision is limited to the delivery of services and does not include Treatment and/or Rehabilitation Plan(s) modification and/or approval. If qualified, Direct Supervisors may also function as Clinical Supervisors. Direct Supervisors must document the following activities:
- a. Their face-to-face and/or telephonic meetings with Clinical Supervisors.
 - 1. These meetings must occur before treatment begins and periodically thereafter;
 - 2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

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

403.2B DOCUMENTATION

1. Treatment Plan-A written individualized plan that is developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and a QMHP within the scope of their practice under state law. When RMH services are prescribed, the provider must develop a Rehabilitation Plan (see definition). The Treatment Plan is based on a comprehensive assessment and includes:
 - a. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);
 - b. Intensity of Needs Determination;
 - c. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;
 - d. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;
 - e. Discharge criteria specific to each goal; and for
 - f. 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

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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.

2. Rehabilitation Plan

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

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must identify the rehabilitation goals and objectives that would be achieved under that plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities.

- d. 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:
1. Be based on a comprehensive assessment of an individual's rehabilitation needs including a covered, current ICD diagnoses and presence of a functional impairment in daily living;
 2. 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;
 3. Be approved by a QMHP, working within the scope of their practice under state law;
 4. Be signed by the individual responsible for developing the plan;
 5. Specify the individual's rehabilitation goals and objectives to be achieved, including recovery goals for persons with mental health related disorders;
 6. Identify the RMH services intended to reduce the identified physical impairment, mental and/or behavioral health related disorder
 7. Identify the methods that would be used to deliver services;

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8. Indicate the frequency, amount and duration of the services;
 9. Indicate the anticipated provider(s) of the services(s) and the extent to which the services may be available from alternate provider(s) of the same service;
 10. 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;
 11. 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
 12. Document that the services have been determined to be rehabilitative services consistent with the regulatory definition.
- e. 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).
- f. At a minimum, Rehabilitation Plans must include all of the following headings:
1. Recipient's Full Name;
 2. Recipient's Medicaid Billing Number;
 3. Intensity of Needs Determination: See Intensity of Needs Determination definition;
 4. Severe Emotional Disturbance (SED) Serious Mental Illness (SMI) Determination: See SED/SMI definitions;
 5. Measurable Goals and Objectives: See Goals and Objectives definitions;
 6. Prescribed Services:
 - a. Identify the specific mental health service or services (i.e., family therapy, individual therapy, basic skills training, day treatment, etc.) to be provided;

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- b. Identify the daily amount, service duration, and therapeutic scope for each service to be provided; and
 - c. Identify the provider or providers that are anticipated to provide each service.
 - 7. Rehabilitation Plan Evaluation and Recipient Progress: A QMHP must evaluate the Rehabilitation Plan at a minimum, every 90 days or more often when rehabilitation needs change. Rehabilitation Plan reviews must demonstrate the recipient's progress towards functional improvements towards established goals and objectives;
 - 8. Discharge Criteria and Plan: Rehabilitation Plans must include discharge criteria and plans. See Discharge Criteria and Discharge Plan definitions; and
 - 9. Required Signatures:
 - a. Clinical Supervisor;
 - b. Recipient and their family/legal guardian (in the case of legal minors); and
 - c. The individual responsible for developing the plan.
- 3. Progress Note – The written documentation of the treatment, services or services coordination provided which reflects the progress, or lack of progress towards the goals and objectives of the Treatment and/or Rehabilitation Plan(s). All progress notes reflecting a billable Medicaid mental health service must be sufficient to support the services provided and must document the amount, scope, duration and provider of the service.
- 4. 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:
 - a. the anticipated duration of the overall services;
 - b. discharge criteria;
 - c. required aftercare services;

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

403.3 PROVIDER QUALIFICATIONS – OUTPATIENT MENTAL HEALTH SERVICES

- A. QMHA - A person who meets the following documented minimum qualifications:
- 1. Licensure as a RN in the State of Nevada or holds a Bachelor’s Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or
 - 2. Holds an Associate’s Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders; or
 - 3. An equivalent combination of education and experience as listed in Section 403.3.A.1-2 above; and
 - 4. Whose education and experience demonstrate the competency under clinical supervision to:
 - a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
 - b. Identify presenting problem(s);

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- c. Participate in Treatment Plan development and implementation;
 - d. Coordinate treatment;
 - e. Provide parenting skills training;
 - f. Facilitate Discharge Plans; and
 - g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.
5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A.
- B. Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a person who meets the definition of a QMHA and also meets the following documented minimum qualifications:
- 1. Holds any of the following educational degrees and licensure:
 - a. Doctorate degree in psychology and license;
 - b. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
 - c. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
 - d. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; or
 - 2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and
 - 3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of services needs, establish measurable goals, objectives and discharge criteria, write and supervise a Treatment Plan and provide direct therapeutic treatment within the scope and limits of their expertise.

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4. Interns/Psychological Assistants

The following are also considered QMHPs:

- a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
- b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
- c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

Reimbursement for Interns/Psychological Assistants is based upon the rate of a QMHP, which includes the clinical and direct supervision of services by a licensed supervisor.

403.4 OUTPATIENT MENTAL HEALTH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. **For case management services, refer to Medicaid Services Manual, Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and documentation requirements.**

- a. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental Health Screen.
 1. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.
 2. Comprehensive Assessment – A comprehensive, evaluation of a recipient’s history and functioning which, combined with clinical judgment, is to include a covered, current ICD diagnosis and a summary of identified rehabilitative

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treatment needs. Health and Behavior Assessment – Used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health needs. The focus of the assessment is not on the mental health needs, but on the biopsychosocial factors important to physical health needs and treatments. The focus of the intervention is to improve the recipient’s health and well-being utilizing cognitive, behavioral, social and/or psycho-physiological procedures designed to ameliorate specific disease related needs. This type of assessment is covered on an individual basis, family with the recipient present or family without the recipient present.

3. Psychiatric Diagnostic Interview – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychiatric diagnostic interview may consist of a clinical interview, a medical and mental history, a mental status examination, behavioral observations, medication evaluation and/or prescription by a licensed psychiatrist. The psychiatric diagnostic interview is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.
4. Psychological Assessment – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.
5. Functional Assessment - Used to comprehensively evaluate the recipient’s skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient’s individualized Treatment Plan. A functional assessment is used to assess the presence of functional strengths and needs in the following domains: vocational, education, self-maintenance, managing illness and wellness, relationships and social.

A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the individualized Treatment Plan. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers shall provide advocacy for the recipient’s goals and independence, supporting the recipient’s participation in the meeting and affirming the recipient’s dignity and rights in the service planning process.

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6. Intensity of Needs Determination - A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the QMHP and/or trained QMHA. This assessment was previously known as a level of care assessment. Currently, the DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by the DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.
 7. Severe Emotional Disturbance (SED) Assessment - Covered annually or if there is a significant change in functioning. The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.
 8. Serious Mental Illness (SMI) Assessment - Covered annually or if there is a significant change in functioning. The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.
- b. Neuro-Cognitive, Psychological and Mental Status Testing
1. Neuropsychological Testing with interpretation and report involves assessment and evaluation of brain behavioral relationships by a neuropsychologist. The evaluation consists of qualitative and quantitative measurement that consider factors such as the interaction of psychosocial, personality/emotional, intellectual, environmental, neurocognitive, biogenetic, and neurochemical aspects of behaviors in an effort to understand more fully the relationship between physiological and psychological systems. This service requires prior authorization from the QIO-like vendor.
 2. Neurobehavioral Testing with interpretation and report involves the clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, memory, visual spatial abilities, language functions and planning. This service requires prior authorization.
 3. Psychological Testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes.

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c. Mental Health Therapies

Mental health therapy is covered for individual, group and/or family therapy with the recipient present and for family therapy without the recipient present and described as follows:

1. Family Therapy

Mental health treatment service provided to a specific recipient by a QMHP using the natural or substitute family as the means to facilitate positive family interactions among individuals. The recipient does not need to be present for family therapy services; however, the services must deal with issues relating to the constructive integration/reintegration of the recipient into the family.

2. Group Therapy

Mental Health treatment service facilitated by a QMHP within their scope of licensure or practice, which utilizes the interactions of more than one individual and the focus of the group to address behavioral health needs and interpersonal relationships. The therapy must be prescribed on the Treatment Plan and must have measurable goals and objectives. Group therapy may focus on skill development for learning new coping skills, such as stress reduction, or changing maladaptive behavior, such as anger management. Participation in group therapy must be documented on the clinical record. Minimum group size is three and maximum therapist to participant ratio is one to ten. Group therapy can be less than three but more than one based on unforeseen circumstances such as a no-show or cancellation, but cannot be billed as individual therapy. Group therapy may also include a family without the recipient present and/or multi-family groups.

3. Individual Therapy Services

Mental health treatment service provided to a specific recipient for a presenting need by an individual therapist for a specified period of time. The amount, scope and duration of individual therapy services may vary depending on the stage of the presenting mental health need, treatment program and recipient's response to the treatment approach. Individual is one recipient. Each direct one-on-one episode must be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's treatment/rehabilitative plan.

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4. Neurotherapy

- a. Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy as a treatment for mental health disorders. Medicaid will reimburse for medically necessary neurotherapy when administered by a licensed QMHP within the scope of their practice and expertise. A certified Biofeedback Technician may assist in the provision of biofeedback treatment; however, a QMHP must provide the associated psychotherapy. Reimbursement for biofeedback treatment provided by a Biofeedback Technician is imbedded in the QMHP rate.
- b. Prior authorization requirements and QIO-like vendor responsibilities are the same for all out-patient therapies, except for the following allowable service limitations for neurotherapy used for treatment of the following covered ICD Codes:
 1. Attention Deficit Disorders – 40 sessions
Current ICD Codes: F90.0, F90.8 and F90.9
 2. Anxiety Disorders – 30 sessions
Current ICD Codes: F41.0 and F34.1
 3. Depressive Disorders – 25 sessions
Current ICD Codes: F32.9, F33.40, F33.9, F32.3, and F33.3
 4. Bipolar Disorders - 50 sessions
Current ICD Codes: F30.10, F30.9, F31.0, F31.10, F31.89, F31.30, F31.60, F31.70, F31.71, F31.72, F31.9, and F39
 5. Obsessive Compulsive Disorders – 40 sessions
Current ICD Codes: F42
 6. Opposition Defiant Disorders and/or Reactive Attachment Disorders – 50 sessions
Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9, and F98.8
 7. Post Traumatic Stress Disorders – 35 sessions
Current ICD Codes: F43.21, F43.10, F43.11, and F43.12
 8. Schizophrenia Disorders – 50 sessions
Current ICD Codes: F20.89, F20.1, F20.2, F20.0, F20.81, F20.89, F20.5, F25.0, F25.1, F25.8, F25.9, F20.3 and F20.9

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Prior authorization may be requested for additional services based upon medical necessity.

d. Mental Health Therapeutic Interventions

1. Partial Hospitalization Program (PHP) - Traditional - Services furnished under a medical model by a hospital, in an outpatient setting, which encompass a variety of psychiatric treatment modalities designed for recipients with mental or substance abuse disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment not generally provided in an outpatient setting. These services are expected to reasonably improve or maintain the individual's condition and functional level to prevent relapse of hospitalization. The services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an exacerbation of a severe and persistent mental illness. PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

2. Intensive Outpatient Program (IOP) – A comprehensive interdisciplinary program of an array of direct mental health and rehabilitative services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization. The services are provided to individuals who are diagnosed as severely emotionally disturbed or seriously mentally ill.

3. Medication Management - A medical treatment service using psychotropic medications for the purpose of rapid symptom reduction, to maintain improvement in a chronic recurrent disorder, or to prevent or reduce the chances of relapse or reoccurrence. Medication management must be provided by a psychiatrist or physician licensed to practice in the State of Nevada and may include, through consultation, the use of a physician's assistant or a certified nurse practitioner licensed to practice in the State of Nevada within their scope of practice. Medication management may be used by a physician who is prescribing pharmacologic therapy for a recipient with an organic brain syndrome or whose diagnosis is in the current ICD section of Mental, Behavioral and Neurodevelopmental Disorders, and is being managed primarily by psychotropic drugs. It may also be used for the recipient whose psychotherapy is being managed by another mental health professional and the billing physician is managing the psychotropic medication. The service includes prescribing, monitoring the effect of the medication and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive only. If the recipient received psychotherapy and drug management at the same visit, the drug management is included as part of that service by definition and medication management should not be billed in addition.

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4. Medication Training and Support – Provided by a professional other than a physician, is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s).

403.5 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

A. INTENSITY OF NEEDS DETERMINATION

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

These components include:

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

B. INTENSITY OF NEEDS GRID

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

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2. Intensity of Need for Children:

Child and Adolescent Service Intensity Instrument (CASII)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Significant Life Stressors and/or current ICD codes, Z55-Z65, R45.850, and R45.821 that does not meet SED criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Outpatient Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders that does not meet SED criteria (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level III Intensive Outpatient Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SED Determination.
Levels IV Intensive Integrated Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and SED Determination.
Level V Non-secure, 24 hour Services with Psychiatric Monitoring	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires specialized treatment (e.g., sex offender treatment, etc).
Level VI Secure, 24 hour, Services with Psychiatric Management	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires inpatient/secured LOC.

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3. Intensity of Needs for Adults:

Level of Care Utilization System for Adults (LOCUS)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders, including Z55-Z65, R45.850, and R45.821 codes, that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Low Intensity Community Based Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders, including Z55-Z65, R45.850, and R45.821 codes that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level III High Intensity Community Based Services (HCBS)	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Levels IV Medically Monitored Non-Residential Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Level V Medically Monitored Residential Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc).
Level VI Medically Managed Residential Services	<ul style="list-style-type: none"> • Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850, and R45.821 codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.

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- C. Utilization Management for outpatient mental health services is provided by the DHCFP QIO-like vendor as follows:
1. For BHCN, all service limitations are based upon the Intensity of Needs Grid in the definitions. The recipient must have an Intensity of Needs determination to supplement clinical judgment and to determine the appropriate service utilization. The provider must document in the case notes the level that is determined from the Intensity of Needs grid;
 2. Independent psychologists are not subject to the service limitations in the Intensity of Needs Grid. The following service limitations are for psychologists:
 - a. Assessments – two per calendar year, additional services require prior authorization from the QIO-like vendor; and
 - b. Therapy (group, individual, family) – a combination of up to twenty-six visits per calendar year is allowed without prior authorization. Additional services require prior authorization from the QIO-like vendor.
 3. Independent psychiatrists are not subject to the service limitations in the Intensity of Needs grid. No prior authorization is required for this particular provider.
 4. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents.

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Child and Adolescent Service Intensity Instrument (CASII)	Intensity of Services (Per Calendar Year ¹)
Levels I Basic Services: Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Assessment 2 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy 10 total sessions; • Medication Management 6 total sessions
Level II Outpatient Services	<ul style="list-style-type: none"> • Assessments: 4 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions
Level III Intensive Outpatient Services	All Level Two Services Plus: <ul style="list-style-type: none"> • IOP
Levels IV Intensive Integrated Services	All Level Three Services <ul style="list-style-type: none"> • PHP
Level V Non-secure, 24 Hour Services with Psychiatric Monitoring	All Level Four Services
Level VI Secure, 24 Hour, Services with Psychiatric Management	All level Five services

Prior Authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Levels III and above only.

- a. Service provision is based on the calendar year beginning on January 1.
- b. Sessions indicates billable codes for this service may include occurrence based codes, time-based, or a combination of both. Session = each time this service occurs regardless of the duration of the service.

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5. Medicaid Behavioral Health Intensity of Needs for Adults

Level of Care Utilization System for Adults (LOCUS)	Intensity of Service (Per Calendar Year ¹)
Levels I Basic Services - Recovery Maintenance and Health Management	<ul style="list-style-type: none"> • Assessment: 2 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 6 total sessions • Medication Management: 6 total sessions
Level II Low Intensity Community Based Services	<ul style="list-style-type: none"> • Assessment: (2 assessments; does not include Mental Health Screen) • Individual, Group or Family Therapy: 12 total sessions • Medication Management: 8 total sessions
Level III High Intensity Community Based Services	<ul style="list-style-type: none"> • Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 12 total sessions • Medication Management: 12 total sessions
Level IV Medically Monitored Non- Residential Services	<ul style="list-style-type: none"> • Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family Therapy: 16 total sessions • Medication Management (12 sessions) • Partial Hospitalization
Level V Medically Monitored Residential Services	<ul style="list-style-type: none"> • Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 18 total sessions • Medication Management (12 sessions) • Partial Hospitalization
Level VI Medically Managed Residential Services	All Level Five Services

Prior Authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Level III and above only.

- a. Service provision is based on the calendar year beginning on January 1.
- b. Sessions indicates billable codes for this service may include occurrence based codes, time-based, or a combination of both. Session = each time this service occurs regardless of the duration of the service.

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D. Non-Covered OMH Services

The following services are not covered under the OMH program for Nevada Medicaid and Nevada Check Up (NCU):

1. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;
2. Therapy for marital problems without a covered, current ICD diagnosis;
3. Therapy for parenting skills without a covered, current ICD diagnosis;
4. Therapy for gambling disorders without a covered, current ICD diagnosis;
5. Custodial services, including room and board;
6. Support group services other than Peer Support Services;
7. More than one provider seeing the recipient in the same therapy session;
8. Services not authorized by the QIO-like vendor if an authorization is required according to policy; and
9. Respite.

403.6 PROVIDER QUALIFICATIONS

403.6A REHABILITATION MENTAL HEALTH (RMH) SERVICES

RMH services may be provided by specific providers who meet the following qualifications for an authorized service:

1. QBA - Is a person who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by the overseeing Clinical Supervisor, to provide RMH services. These services must be provided under direct contract with a BHCN or Independent RMH provider. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services under the Clinical Supervision of a QMHP and the Direct Supervision of a QMHP or QMHA.
 - a. QBAs must also have experience and/or training in service provision to people diagnosed with mental and/or behavioral health disorders and the ability to:

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1. read, write and follow written and oral instructions;
2. perform RMH services as prescribed on the Rehabilitation Plan;
3. identify emergency situations and respond accordingly;
4. communicate effectively;
5. document services provided; and
6. maintain recipient confidentiality.

b. Competency and In-services Training

1. Before QBAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour training program. This training must be interactive, not solely based on self-study guides or videotapes, and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. At a minimum, this training must include the following core competencies:
 - a. Case file documentation;
 - b. Recipient's rights;
 - c. Client confidentiality pursuant to state and federal regulations;
 - d. Communication skills;
 - e. Problem solving and conflict resolution skills;
 - f. Communication techniques for individuals with communication or sensory impairments;
 - g. Cardio Pulmonary Resuscitation (CPR) certification (certification may be obtained outside the agency); and
 - h. Understanding the components of a Rehabilitation Plan.
2. QBAs must also receive, at a minimum, two hours of quarterly in-service training. At a minimum, this training must include any combination (or single competency) of the following competencies:

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- a. Basic living and self-care skills: The ability to help recipients learn how to manage their daily lives, recipients learn safe and appropriate behaviors;
 - b. Social skills: The ability to help recipients learn how to identify and comprehend the physical, emotional and interpersonal needs of others - recipients learn how to interact with others;
 - c. Communication skills: The ability to help recipients learn how to communicate their physical, emotional and interpersonal needs to others – recipients learn how to listen and identify the needs of others;
 - d. Parental training: The ability to facilitate parents’ abilities to continue the recipient’s (child’s) RMH care in home and community-based settings.
 - e. Organization and time management skills: The ability to help recipients learn how to manage and prioritize their daily activities; and/or
 - f. Transitional living skills: The ability to help recipients learn necessary skills to begin partial-independent and/or fully independent lives.
3. For QBAs whom will also function as Peer-to-Peer Supporters, their quarterly in-service training must also include, at a minimum, any combination (or single competency) of the following competencies:
- a. The ability to help stabilize the recipient;
 - b. The ability to help the recipient access community based mental and/or behavioral health services;
 - c. The ability to assist during crisis situations and interventions;
 - d. The ability to provide preventative care assistance; and/or
 - e. The ability to provide personal encouragement, self-advocacy, self-direction training and peer mentoring.
- c. Applicants must have a FBI criminal background check before they can enroll with Nevada Medicaid as QBAs. Applicants must submit the results of their criminal

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background checks to the overseeing BHCN and/or the Individual RMH provider (who must also be a Clinical Supervisor). The BHCN and/or the Individual RMH provider must maintain both the requests and the results with the applicant's personnel records. Upon request, the BHCN and/or the Individual RMH provider must make the criminal background request and results available to the Nevada Medicaid (DHCFP) for review.

- d. Refer to Medicaid Services Manual (MSM) Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:
1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency;
 2. Any other offense determined by the DHCFP to be inconsistent with the best interest of all recipients.

The BHCN or Independent RMH provider upon receiving information resulting from the FBI criminal background check, or from any other source, may not continue to employ a person who has been convicted of an offense as listed above, and as cited within MSM Chapter 100. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, he or she must immediately inform the BHCN or Independent RMH provider, or the DHCFP (respectively) in writing. The BHCN or Independent RMH provider or the DHCFP, that is so informed within five days, may give the employee or independent contractor a reasonable amount of time, but not more than 60 days, to provide corrected information before denying an application, or terminating the employment or contract of the person pursuant to this section.

- e. Have had tuberculosis (TB) tests with negative results documented or medical clearance as outlined in NAC 441.A375 prior to the initiation of service delivery. Documentation of TB testing and results must be maintained in the BHCN or Independent RMH provider personnel record. TB testing must be completed initially and annually thereafter. Testing and surveillance shall be followed as outlined in NAC 441A.375.3.
- f. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and /or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the BHCN or Independent RMH provider. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The

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BHCN or Independent RMH provider must document the comparability of the written verification to the QBA training requirements.

2. QMHA, refer to Section 403.3A.
3. QMHP, refer to Section 403.3B.

403.6B REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

1. **Scope of Service:** RMH services must be recommended by a QMHP within the scope of their practice under state law. RMH services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipient's to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. All RMH services must be directly and medically necessary. RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services, refer to Medicaid Services Manual (MSM) Chapter 1500.

Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a covered, current ICD diagnosis. The assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must assure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

- a. the recipient's name;
- b. progress notes must reflect the date and time of day that RMS services were provided; the recipient's progress toward functional improvement and the attainment of established rehabilitation goals and objectives; the nature, content and number of RMH service units provided; the name, credential(s) and signature of the person who provided the RMH service(s). Progress notes must be completed after each session and/or daily; progress notes are not required on days when RMH services are not provided; a single progress note may include any/all the RMH services provided during that day;

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- c. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;
 - d. indications that the recipients and their families/legal guardians (in the case of legal minors) were involved in all aspects care planning;
 - e. indications that the recipients and their families/legal guardians (in the case of legal minors) are aware of the scope, goals and objectives of the RMH services made available; and
 - f. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement that RMH services are designed to reduce the duration and intensity of care to the least intrusive level of care possible while sustaining the recipient's overall health.
2. Inclusive Services: RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR) and Crisis Intervention (CI).
3. Provider Qualifications:
- a. QMHP: QMHPs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR and CI services.
 - b. QMHA: QMHAs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR services under the Clinical Supervision of a QMHP.
 - c. QBA: QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP/QMHA. QBAs may provide Peer-to-Peer Support services under the Clinical/Direct Supervision of a QMHP.
3. Therapeutic Design: RMH services are adjunct (enhancing) interventions designed to compliment more intensive mental health therapies and interventions. While some rehabilitative models predominately utilize RMH services, these programs must demonstrate the comprehensiveness and clinical appropriateness of their programs prior to receiving prior authorization to provide RMH services. RMH services are time-limited services, designed to be provided over the briefest and most effective period possible. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. Also taken into consideration are other social, educational and intensive mental health obligations and activities. RMH services are planned and coordinated services.

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5. Non-Covered Services: RMH services do not include (from CMS 2261-P):
- a. RMH services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;
 - b. custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training and/or other intrinsic parenting and/or care giver responsibilities;
 - c. maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of RMH goals and objectives, impromptu non-crisis interventions and routine daily therapeutic milieus;
 - d. case management: Conducting and/or providing assessments, care planning/coordination, referral and linkage and monitoring and follow-up;
 - e. habilitative services;
 - f. services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (Unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;
 - g. cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;
 - h. transportation: Transporting recipients to and from medical and other appointments/services;
 - i. educational, vocational or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);
 - j. inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent;
 - k. room and board: Includes housing, food, non-medical transportation and other miscellaneous expenses, as defined below:

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1. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs and insurance), utilities (gas, electricity, fuel, telephone, and water) and housing furnishings and equipment (furniture, floor coverings, major appliances and small appliances);
 2. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;
 3. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs and insurance;
 4. Miscellaneous expenses include clothing, personal care items, entertainment and reading materials;
 5. Administrative costs associated with room and board;
- l. non-medical programs: Intrinsic benefits and/or administrative elements of non-medical programs, such as foster care, therapeutic foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation and juvenile justice;
 - m. services under this chapter for a recipient who does not have a covered, current ICD diagnosis;
 - n. therapy for marital problems without a covered, current ICD diagnosis;
 - o. therapy for parenting skills without a covered, current ICD diagnosis;
 - p. therapy for gambling disorders without a covered, current ICD diagnosis;
 - q. support group services other than Peer Support services;
 - r. more than one provider seeing the recipient in the same RMH intervention with the exception of CI services;
 - s. respite care;
 - t. recreational activities: Recreational activities not focused on rehabilitative outcomes;
 - u. personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives; and/or

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- v. services not authorized by the QIO-like vendor if an authorization is required according to policy.
6. Service Limitations: All RMH services require prior authorization by Medicaid's QIO-Like vendor. RMH services may be prior authorized up to 90-days.
- a. Intensity of Need Levels I & II: Recipients may receive BST and/or Peer-to-Peer services provided:
 - 1. A covered, current ICD and CASII/LOCUS Levels I or II; and
 - 2. clinical judgment; and
 - 3. the overall combination does not exceed a maximum of two hours per day; and
 - 4. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
 - b. Intensity of Need Level III: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:
 - 1. A covered, current ICD, and CASII/LOCUS Level III; and
 - 2. SED or SMI determination; and
 - 3. clinical judgment; and
 - 4. the overall combination does not exceed a maximum of four hours per day; and
 - 5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
 - c. Intensity of Need Level IV: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:
 - 1. A covered, current ICD and CASII/LOCUS Level IV; and
 - 2. SED or SMI determination; and
 - 3. clinical judgment; and

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4. the overall combination does not exceed a maximum of six hours per day; and
 5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
- d. Intensity of Need Levels V & VI: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:
1. A covered, current ICD and CASII/LOCUS Levels V or VI; and
 2. SED or SMI determination; and
 3. clinical judgment; and
 4. the overall combination does not exceed a maximum of eight hours per day; and
 5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.
- e. Additional RMH Service Authorizations: Recipients may receive any combination of additional medically necessary RMH services beyond established daily maximums. Additional RMH services must be prescribed on the recipient's Rehabilitation Plan and must be prior authorized by Medicaid's QIO-Like vendor. Additional RMH services authorizations may only be authorized for 30-day periods. These requests must include:
1. a lifetime history of the recipient's inpatient psychiatric admissions; and
 2. a 90-day history of the recipient's most recent outpatient psychiatric services; and
 3. progress notes for RMH services provided over the most current two-week period.
7. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period, so an interruption in services may be avoided for the recipient. In

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order to receive authorization for RMH services all of the following must be demonstrated in the Rehabilitation Plan and progress notes (if applicable).

- a. The recipient will reasonably benefit from the RMH service or services requested;
 - b. The recipient meets the specific RMH service admission criteria;
 - c. The recipient possesses the ability to achieve established treatment goals and objectives;
 - d. The recipient and/or their family/legal guardian (in the case of legal minors) desire to continue the service;
 - e. The recipient's condition and/or level of impairment does not require a more or less intensive level of service;
 - f. The recipient does not require a level of structure, intensity, and/or supervision beyond the scope of the RMH service or services requested; and
 - g. The retention of the RMH service or services will reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall well being.
8. Exclusion and Discharge Criteria: Prior authorization will not be given for RMH services if any of the following apply:
- a. The recipient will not reasonably benefit from the RMH service or services requested;
 - b. The recipient does not continue to meet the specific RMH service admission criteria;
 - c. The recipient does not possess the ability to achieve established rehabilitation goals and objectives;
 - d. The recipient demonstrates changes in condition, which warrants a more or less intensive level of services;
 - e. The recipient and/or their family/legal guardian (in the case of legal minors) do not desire to continue the service;

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- f. The recipient presents a clear and imminent threat of serious harm to self and/or others (recipient presents the intent, capability and opportunity to harm themselves and others);
- g. The recipient's condition and/or level of impairment requires a more intensive level of service; and
- h. The retention of the RMH service or services will not reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall wellbeing.

403.6C BASIC SKILLS TRAINING (BST) SERVICES

- 1. Scope of Service: BST services are RMH interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients acquire (learn) constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning and other training techniques. BST services teach recipients a variety of life skills. BST services may include the following interventions:
 - a. Basic living and self-care skills: Recipients learn how to manage their daily lives, recipients learn safe and appropriate behaviors;
 - b. Social skills: Recipients learn how to identify and comprehend the physical, emotional and interpersonal needs of others-recipients learn how to interact with others;
 - c. Communication skills: Recipients learn how to communicate their physical, emotional and interpersonal needs to others. Recipients learn how to listen and identify the needs of others;
 - d. Parental training: Parental training teaches the recipient's parent(s) and/or legal guardian(s) BST techniques. The objective is to help parents continue the recipient's RMH care in home and community based settings. Parental training must target the restoration of recipient's cognitive and behavioral mental health impairment needs. Parental training must be recipient centered;
 - e. Organization and time management skills: Recipients learn how to manage and prioritize their daily activities; and/or
 - f. Transitional living skills: Recipients learn necessary skills to begin partial-independent and/or fully independent lives.

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2. Provider Qualifications:
 - a. QMHP: QMHPs may provide BST services.
 - b. QMHA: QMHAs may provide BST services under the Clinical Supervision of a QMHP.
 - c. QBA: QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP or QMHA.
3. Service Limitations: Up to two hours of BST services per day may be performed for all levels. BST services must be prior authorized. Prior authorizations may not exceed 90-day intervals.

If a recipient has been receiving BST services for six consecutive months, the provider must validate that continued services are reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:

- a. Expectation that the patient's condition will improve significantly in a reasonable and predictable period of time, or the services must be necessary for the establishment of a safe and effective rehabilitative therapeutic design required in connection with a specific disease state.
- b. The amount, frequency and duration of BST must be reasonable under accepted standards of practice.
- c. If the rehabilitation plan goals have not been met, the re-evaluation of the rehabilitation/treatment plan must reflect a change in the goal, objectives, services and methods and reflect the incorporation of other medically appropriate services such as outpatient mental health services.
- d. Documentation demonstrates a therapeutic benefit to the recipient by reflecting the downward titration in units of service. The reduction in services should demonstrate the reduction in symptoms/behavioral impairment.

BST services are based on the below daily maximums:

Service Limitations	Children: CASII	Adults: LOCUS
Levels I, II, III, IV, V & VI	Maximum of 2 hours per day	Maximum of 2 hours per day

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4. Admission Criteria: The recipient and at least one parent and/or legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community based services; and assessment documentation must indicate that the recipient has substantial impairments in any combination of the following areas:
 - a. Basic living and self-care skills: Recipients are experiencing age inappropriate deficits in managing their daily lives and are engaging in unsafe and inappropriate behaviors;
 - b. Social skills: Recipients are experiencing inappropriate deficits in identifying and comprehending the physical, emotional and interpersonal needs of others;
 - c. Communication skills: Recipients are experiencing inappropriate deficits in communicating their physical, emotional and interpersonal needs to others;
 - d. Organization and time management skills: Recipients are experiencing inappropriate deficits managing and prioritizing their daily activities; and/or
 - e. Transitional living skills: Recipients lack the skills to begin partial-independent and/or fully independent lives.

403.6D PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT)

1. A multi-disciplinary team-based approach of the direct delivering of comprehensive and flexible treatment, support and services within the community. The team must be composed of at least one QMHP and one other QMHP, QMHA or Peer Supporter.
2. PACT is for individuals who have the most serious and intractable symptoms of a severe mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs or maintaining a safe and affordable place to live and require interventions that have not been effectively addressed by traditional, less intensive services.
3. Services are available 24 hours a day, seven days per week. Team members may interact with a person with acute needs multiple times a day. As the individual stabilizes, contacts decrease. This team approach is facilitated by daily team meetings in which the team is briefly updated on each individual. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs. PACT is reimbursed as unbundled services.

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403.6E RESERVED

403.6F PEER-TO-PEER SERVICES

1. Scope of Service: Peer-to-Peer Support services are RMH interventions designed to reduce social and behavioral impairments and restore recipients to their highest level of functioning. Peer-to-Peer supporters (e.g. peer supporters) help the recipient live, work, learn and participate fully in their communities. Peer-to-Peer services must be delivered directly to recipients and must directly contribute to the restoration of recipient's diagnosis mental and/or behavioral health condition. Peer-to-Peer services may include any combination of the following:
 - a. Helping stabilize the recipient;
 - b. Helping the recipient access community based mental and/or behavioral health services;
 - c. Assisting during crisis situations and interventions;
 - d. Providing preventative care assistance; and/or
2. Providing personal encouragement, self-advocacy, self-direction training and peer mentoring.

Provider Qualifications: A peer supporter is a qualified individual who is currently or was previously diagnosed with a mental and/or behavioral health disorder and who possess the skills and abilities to work collaboratively with and under the Clinical and Direct Supervision of a QMHP. The selection of the supporter is based on the best rehabilitation interest of the recipient. A peer supporter cannot be the legal guardian or spouse of the recipient. At a minimum, a peer supporter must meet the qualifications for a QBA. Peer supporters are contractually affiliated with a BHCN, Independent Professional (Psychologists and Psychiatrists), or Individual RMH providers may provide services to any eligible Medicaid-recipient, if determined appropriate in the treatment planning process.

3. Service Limitation: All Peer-to-Peer services require prior authorization by Medicaid's QIO-Like vendor. Prior authorizations may not exceed 90-day intervals. Peer-to-Peer service limits are based on the below 30-day maximums.

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Service Limitations	Children: CASII	Adults: LOCUS
Levels I to II	Maximum of 6 hour per 90 day period	Maximum of 6 hour per 90 day period
Level III	Maximum of 9 hour per 90 day period	Maximum of 9 hours per 90 day period
Levels IV to VI	Maximum of 12 hours per 90 day period	Maximum of 12 hours per 90 day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets all of the following:
 - a. The recipient would benefit from the peer supporter's understanding of the skills needed to manage their mental and/or behavioral health symptoms and for utilization of community resources;
 - b. The recipient requires assistance to develop self-advocacy skills;
 - c. The recipient requires peer modeling in order to take increased responsibilities for his/her own recovery; and
 - d. Peer-to-Peer support services would be in the best interest of the recipient and would most likely improve recipient's mental, behavioral and overall health.

403.6G PSYCHOSOCIAL REHABILITATION (PSR) SERVICES

1. Scope of Service: PSR services are RMH interventions designed to reduce psychosocial dysfunction (i.e., interpersonal cognitive, behavioral development, etc.) and restore recipients to their highest level of functioning. PSR services target psychological functioning within a variety of social settings.

PSR services may include any combination of the following interventions:

- a. Behavior management: Recipients learn how to manage their interpersonal, emotional, cognitive and behavioral responses to various situations. They learn how to positively reflect anger, manage conflicts and express their frustrations verbally. They learn the dynamic relationship between actions and consequences;
- b. Social competency: Recipients learn interpersonal-social boundaries and gain confidence in their interpersonal-social skills;

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- c. Problem identification and resolution: Recipients learn problem resolution techniques and gain confidence in their problems solving skills;
 - d. Effective communication: Recipients learn how to genuinely listen to others and make their personal, interpersonal, emotional, and physical needs known;
 - e. Moral reasoning: Recipients learn culturally relevant moral guidelines and judgment;
 - f. Identity and emotional intimacy: Recipients learn personal and interpersonal acceptance. They learn healthy (appropriate) strategies to become emotionally and interpersonally intimate with others;
 - g. Self-sufficiency: Recipients learn to build self-trust, self-confidence, and/or self-reliance;
 - h. Life goals: Recipients learn how to set and achieve observable specific, measurable, achievable, realistic and time-limited life goals; and/or
 - i. Sense of humor: Recipients develop humorous perspectives regarding life's challenges.
2. Provider Qualifications:
- a. QMHP: QMHPs may provide PSR services.
 - b. QMHA: QMHAs may provide PSR services under the Clinical Supervision of a QMHP.
 - c. QBA: QBAs may not provide PSR services.
3. Service Limitations: All PSR services require prior authorization by Medicaid's QIO-Like vendor. Prior authorizations may not exceed 90-day intervals. PSR services are based on the below daily maximums.

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Service Limitations	Children: CASII	Adults: LOCUS
Levels I & II	No services authorized	No services authorized
Level III	Maximum of 2 hours per day	Maximum of 2 hours per day
Levels IV & V	Maximum of 3 hours per day	Maximum of 3 hours per day
Level VI	Maximum of 4 hours per day	Maximum of 4 hours per day

4. Admission Criteria: At least one parent or a legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community based services; and the recipient must have substantial deficiencies in any combination of the following criteria:
- a. Behavior management: Recipients are experiencing severe deficits managing their responses (viz., interpersonal, emotional, cognitive and behavioral) to various situations. Recipients cannot age appropriately manage conflicts, positively channel anger, or express frustration verbally. They do not understand the relationship between actions and consequences;
 - b. Social competency: Recipients are experiencing severe deficits navigating interpersonal-social boundaries. They lack confidence in their social skills;
 - c. Problem identification and resolution: Recipients are experiencing severe deficits resolving personal and interpersonal problems;
 - d. Effective communication: Recipients need to learn how to listen to others and make their needs known to others. They cannot effectively communicate their personal, interpersonal, emotional and physical needs;
 - e. Moral reasoning: Recipients are experiencing severe deficits in culturally relevant moral judgment;
 - f. Identity and emotional intimacy: Recipients are experiencing severe deficits with personal and interpersonal acceptance. They avoid and/or lack the ability to become emotionally and interpersonally intimate with other people;
 - g. Self-sufficiency: Recipients are experiencing severe deficits with self-confidence, self-esteem and self-reliance; recipients express feelings of hopelessness and helplessness;

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- h. Dealing with anxiety: Recipients are experiencing severe deficits managing and accepting anxiety, they are fearful of taking culturally normal and healthy rehabilitative risks;
- i. Establishing realistic life goals: Recipients are experiencing severe deficits setting and achieving realistic life goals; and/or
- j. Sense of humor: Recipients are experiencing severe deficits seeing or understanding the various humorous perspectives regarding life's challenges.

403.6H CRISIS INTERVENTION (CI) SERVICES

1. Scope of Services: CI services are RMH interventions that target urgent situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions) and provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore recipients to their highest level of functioning and help prevent acute hospital admissions. CI interventions may be provided in a variety of settings, including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools, homeless shelters, while in transit and telephonically. CI services do not include care coordination, case management, or targeted case management services (see MSM Chapter 2500, Targeted Case Management).

CI services must include the following:

- a. Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization;
 - b. Conduct situational risk-of-harm assessment;
 - c. Follow-up and de-briefing sessions to ensure stabilization, continuity of care and identification of referral resources for ongoing community mental and/or behavioral health services.
2. Provider Qualifications: (QMHPs may provide Crisis Intervention (CI) services. If a multidisciplinary team is used, the team must be lead by a QMHP. The team leader assumes professional liability over the CI services rendered.
 3. Service Limitations: Recipients may receive a maximum of four hours per day over a five-day period (one occurrence). A single occurrence may not exceed five days. Recipients may receive a maximum of three occurrences over a 90-day period.

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Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	<ul style="list-style-type: none"> • Maximum of 4 hours per day over a 5-day period (one occurrence) • Maximum of 3 occurrences over a 90-day period 	<ul style="list-style-type: none"> • Maximum of 4 hours per day over a 5-day period (one occurrence) • Maximum of 3 occurrences over a 90-day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets any combination of the following:
 - a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;
 - b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);
 - c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or
 - d. Recipient will benefit from the stabilization, continuity of care and the referrals for ongoing community mental and/or behavioral health services.

403.7 OUTPATIENT ALCOHOL AND SUBSTANCE ABUSE SERVICES POLICY

Outpatient substance abuse services may be provided by a QHMP within the scope of their practice under state law and expertise.

403.7A COVERAGE AND LIMITATIONS

1. Nevada Medicaid reimburses the following:
 - a. Outpatient alcohol/substance abuse treatment services within the context of services discussed in Section 403.4 of this Chapter (individual and family therapy is limited to one hour per session. Group therapy is limited to two hours per session).
 - b. Psychiatrist (MD) - Office and clinic visits provided by a psychiatrist are a Medicaid benefit. There are no limitations to services and prior authorization is not required.

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- c. Psychologist - Initial office and clinic visits for psychological evaluation and testing require a signed referral from a physician, licensed QMHP, or a signed referral through a Healthy Kids (EPSDT) screening. All services (psychological evaluation, testing and subsequent individual, group, and family therapies) provided by psychologists must be prior authorized using the PAR form. For children under age 21 services beyond 26 sessions per calendar year may only be provided if:
1. prior authorized by the QIO-like vendor; or
 2. resulted from an EPSDT referral.

Testing services may also include an initial psychological evaluation.

- d. APN - Office and clinic visits provided by an APN are a Medicaid benefit. There are no limitations to services and prior authorization is not required.
- e. Psychiatric/Psychological Evaluations - This service is covered once, at the onsite of an illness or suspected illness. It may be utilized for the same recipient but only if a new episode or illness occurs after a hiatus, or admission or readmission to inpatient status due to complications of an underlying condition. Individual therapy services require prior authorization. The individual sessions are limited to a maximum of one hour per session and 26 sessions per calendar year, unless it is the result of a Healthy Kids (EPSDT) screening. When requesting the therapy the provider needs to submit a psychological evaluation or summary with a treatment plan and requested frequency. Approval is usually given for three months at a time.

When requesting additional therapy the provider needs to submit a progress report and include the number of attended sessions. It is the responsibility of the provider to keep track of the sessions.

- f. Group Therapy Services - Group therapy services require prior authorization. These sessions are limited to a maximum of two hours. Each session counts against the 26 hours per calendar year unless there is a Healthy Kids (EPSDT) screening. Group therapy sessions may be requested on an alternate schedule with individual therapy. The provider needs to document what the recipient did, how the focus of the group applies to the diagnosis in their progress report and how the plan of therapy is being met. The provider will need to include the number of attended sessions.
- g. Family Therapy Services - Family therapy services require prior authorization and are a benefit only when the recipient is present during the therapy. These sessions

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are limited to a maximum of one hour and count against the 26 sessions per calendar year unless there is a Healthy Kids (EPSDT) screening. Family therapy may be requested with individual therapy but frequency must be included for each therapy. If additional therapy is requested after the initial request and approval, the provider needs to submit a progress report, number of attended sessions and plan of treatment.

- h. Individual Therapy Services - Individual therapy services require prior authorization. The sessions are limited to a maximum of one hour and to 26 sessions in a calendar year, unless it is the result of a Healthy Kids (EPSDT) screening. When requesting the therapy the provider needs to submit a psychological evaluation or summary with a treatment plan and requested frequency. Approval is usually given for three months at a time. When requesting additional therapy the provider needs to submit a progress report and include the number of attended sessions. It is the responsibility of the provider to keep track of the sessions.

2. Other Covered Services

Please consult Section 403.10 of this Chapter for other covered services.

3. Non-Covered Services

Please consult Section 403.5B of this Chapter for all non-covered services.

4. Billing

For enrollment, prior authorization and billing instructions, please refer to the Billing Manual for Provider Type 11 and 13, located on the QIO-like vendor website.

403.7B PROVIDER RESPONSIBILITIES

Providers are responsible for:

- 1. Verifying Medicaid eligibility.
- 2. Submitting PARs to Medicaid's QIO-like vendor for purposes of obtaining prior authorization.
- 3. Appropriate billing procedures and code usage.

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403.7C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide their Medicaid card to their service providers.
2. Medicaid recipients are expected to comply with the service provider's treatment, care and service plans, including making and keeping medical appointment.

403.7D AUTHORIZATION PROCESS

Prior authorization for psychological services is secured through Medicaid's QIO-like vendor by submitting a PA with substantiating documentation which must include the diagnosis, an evaluation or problem summary denoting the severity of presenting problems or functional disability. Specific, realistically attainable and measurable goals, and anticipated frequency and duration of treatment must be documented. Authorizations may be granted for a period of 90 days (i.e., once per week times 12 weeks). To continue the payment process necessitates a new payment authorization request and approval, progress notes and number of sessions seen.

Psychiatrist/Psychologist led group therapy counts as an office visit and meets the same limitation criteria. Reimbursement for individuals age 21 years and older are limited to 26 individual, group and/or family sessions in a calendar year for psychiatrists and psychologists.

All other specific authorization requirements are addressed earlier in this Chapter in Section 403.5A, Coverage and Limitations.

403.8 RESIDENTIAL TREATMENT CENTER (RTC) SERVICES

- A. RTC services are delivered in psychiatric, medical-model facilities, in- or out-of-state, that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation of Services for Families and Children (COA) and licensed as a Residential Treatment Facility within their state. RTC services are for recipients under age 21 and must be provided before the individual reaches age 21. If the individual was receiving services in an RTC immediately before reaching age 21, these must be provided before:
 1. the date the individual no longer requires the services; or
 2. the date the individual reaches 22; and
 3. is certified in writing to be necessary in the setting in which it will be provided.
- B. The objective of a RTC services is to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders, or conditions, who are no longer at or appropriate for an acute level of care, or who cannot effectively receive services in a less

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restrictive setting and who meet medical necessity and admission criteria for RTC services.

RTCs are part of the mental health continuum of care and are an integral part of Nevada Medicaid's behavioral health system of care. Recipients who respond well to treatment in an RTC are anticipated to be discharged to a lower level of care, such as intensive home and community-based services, or to the care of a psychiatrist, psychologist, or other QMHP.

All Medicaid policies and requirements for RTC's (such as prior authorization, etc.) are the same for NCU, except where noted in the NCU Manual, Chapter 1000.

C. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Accredited Residential Treatment Center (RTC)	Not Authorized

403.8A COVERAGE AND LIMITATIONS

1. Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications, quarterly RTC-sponsored family visits, psycho-educational services and supervised work projects.
2. The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, dental, optometry, durable medical equipment, radiology, lab and therapies (physical, speech and occupational) or formal educational services. Services that are Medicaid benefits must be billed separately by the particular service provider and may require prior authorization.
3. The QIO-like vendor may authorize all RTC stays, both fee for service and Health Maintenance Organization (HMO) (see MSM Chapter 3600) Medicaid in three-month (or less) increments. For Medicaid recipients to remain in RTCs longer than three months, the RTC must, prior to the expiration of each authorization, submit a Continuing Stay Request to the QIO-like vendor for authorization.

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4. For recipients under the age of 21 in the custody of a public child welfare agency, Nevada Medicaid will reimburse for prior authorized RTC services only when the public child welfare agency has also approved the admission.

5. Criteria for Exclusion from RTC Admission

One or more of the following criteria must be met which prohibit the recipient from benefiting rehabilitatively from RTC treatment or involve the RTC's inability to provide a necessary specialized service or program, clinical decisions will be made individually on a case-by-case basis:

- a. Psychiatric symptoms requiring acute hospitalization;
- b. The following conditions which limits the recipient's ability to fully participate in RTC services and cannot be reasonably accommodated by the RTC;
 1. Physical Disability;
 2. Learning Capacity;
 3. Traumatic Brain Injury (TBI);
 4. Organic brain syndrome;
- c. Pregnancy, unless the RTC can appropriately meet the needs of the adolescent, including obtaining prenatal care while in the facility. In the case of the birth of the infant while the recipient is in the RTC, planning for the infant's care is included in the Discharge Plan. (In such an instance the infant would be covered individually by Medicaid for medically necessary costs associated with medical care);
- d. Chronic unmanageable violent behavior incompatible with RTC services which poses unacceptable and unsafe risks to other clients or staff for any reason (i.e., a danger to self, others or property);
- e. Medical illness which limits the recipient's ability to fully participate in RTC services and is beyond the RTC's capacity for medical care;
- f. Drug and/or alcohol detoxification is required as a primary treatment modality before a recipient can benefit rehabilitatively from RTC services; or
- g. A diagnosis of Oppositional Defiant Disorder (ODD) and/or Conduct Disorder, alone and apart from any other covered, current ICD diagnosis.

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6. RTC Therapeutic Home Passes

RTC Therapeutic Home Passes are to be utilized to facilitate a recipient's discharge back to their home or less restrictive setting. RTC recipients are allowed to utilize Therapeutic Home Passes based on individualized treatment planning needs and upon the recommendations of the RTC clinical treatment team. A total of three Therapeutic Home Passes are allowed per calendar year and Therapeutic Home Passes cannot be accumulated beyond a calendar year period. Duration per pass is no greater than 72 hours unless there is a documented medically necessary reason for a longer-term pass. The QIO-like vendor must be notified by the RTC of all therapeutic home passes at least 14 days prior to the pass being issued to the recipient. The notification form can be located on the QIO-like vendor website. All passes which exceed 72 hours must be prior authorized by the QIO-like vendor.

- a. The following guidelines must be adhered to for reimbursement. Failure to follow these guidelines will result in non-payment to RTCs during the time the recipient was away on a Therapeutic Home Pass:
 1. A physician's order is required for all Therapeutic Home Passes. If it is clinically appropriate for the recipient to travel alone, this must be specified in the physician's order.
 2. A Therapeutic Home Pass will only occur within 90 days of the recipient's planned discharge and in coordination with their discharge plan. The recipient must have demonstrated a series of successful incremental day passes before the Therapeutic Home Pass occurs. The recipient must also be in the final phase of treatment in the RTC program.
 3. Therapeutic Home Pass information which verifies days used must be documented in the recipient's case file and must include: dates for each pass, location of the pass, treatment objectives to be met by use of each pass and the total number of days used per calendar year. A copy of the physician order for each pass must also be maintained in the recipient's clinical case file.
 4. The RTC must track the number of Therapeutic Home Passes used as the QIO-like vendor will not reimburse RTCs for pass days for any recipient exceeding a total of three passes per calendar year.
 5. If the recipient leaves without issuance of a Therapeutic Home Pass the recipient will be considered discharged and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.

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6. In the event a recipient unexpectedly does not return to the RTC from a Therapeutic Home Pass or family emergency, and such an absence has been properly documented by the RTC, the RTC may utilize the day the recipient was expected to return from leave as the discharge date as long as the period does not exceed 72 hours. In the case of a family emergency or an extended pass which has been approved by the QIO-like vendor this period cannot exceed 120 hours.
7. Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility. Prior authorization and a Certificate of Need (CON) signed by a physician, is required for payment.
8. The three passes per calendar year Therapeutic Home Pass policy applies to all RTC recipients, regardless of the recipient's custody status.
9. Therapeutic Home Passes include the day the pass begins, and ends the day before the recipient returns (prior to midnight).

7. Transportation

Nevada Medicaid may reimburse the following RTC travel related services for an eligible recipient and attendant when determined to be medically necessary for:

- a. initial travel to the RTC upon admission;
- b. travel for an RTC Therapeutic Home Pass;
- c. travel upon discharge from the RTC; and
- d. travel for transfer from one RTC to another RTC or Acute Inpatient Services.

Transportation must be coordinated in accordance with Chapter 1900 of the MSM.

403.8B PROVIDER RESPONSIBILITIES

1. All RTCs must comply with the regulations in this MSM Chapter and all other applicable MSM Chapters.
2. Critical Events Reporting Requirements

RTCs are required to notify within 48 hours:

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- a. The QIO-like vendor of any critical event or interaction involving any Nevada Medicaid RTC recipient. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff's investigations and physical, sexual or emotional abuse allegations.
- b. The State Medicaid agency, State-designated client protection and advocacy agency and the Nevada State Bureau of Health Care Quality and Compliance (HCQC) of a resident's death, serious injury or suicide attempt for an in-state facility. If the facility is out-of-state, their own state licensing entity or appropriate departments as well as the QIO-like vendor and Nevada State Medicaid;
- c. Their local Centers for Medicare and Medicaid Services (CMS) office of the death of any recipient, no later than the close of business the next business day after the resident's death per 42 Code of Federal Regulations (CFR) 483.374(c).
 1. Upon notification of a critical event, Nevada Medicaid may make an adverse decision against the RTC. In the event of a death, suicide attempt, or very serious injury (injury requiring hospitalization) of a recipient, Nevada Medicaid may make an administrative decision to impose a ban on future Medicaid-eligible admissions and/or remove recipients currently at the RTC, if they are believed to be in danger.
 2. If a ban is imposed, Medicaid must receive and review HIPAA compliant documents requested from the RTC, including but not limited to, police, autopsy, state licensing, social services, and internal death or serious injury reports before a decision is made to remove or continue the imposed ban or terminate the contractual relationship with the RTC.

3. RTC Regulatory and Compliance Requirements

The RTC must ensure on-going Joint Commission, COA or CARF accreditation and comply with all accreditation requirements.

4. Letter of Attestation

The RTC must comply with 42 CFR Subpart G 483.374(a) and submit a Letter of Attestation to Nevada State, by the individual having legal authority to do so (i.e., facility director, CEO, or administrator), which confirms the facility is in compliance with CMS standards governing the use of restraint and seclusion. The Letter of Attestation must be submitted at the time of enrollment as a Medicaid provider and at anytime there is a change in the legal authority of the RTC. A copy of an example Letter of Attestation is available upon request from Nevada Medicaid.

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5. QA/Quality Improvement

The RTC must have a QA/Quality Improvement program in place at the time of enrollment and a process to submit an annual QA report to the DHCFP upon request.

6. Quarterly Family Visits

Quarterly Family Visits are based on clinical appropriateness and are utilized to support person- and family- centered treatment planning. It is the responsibility of out-of-state and in-state RTCs, as part of the all-inclusive daily rate, to bring up to two family members to the facility on a quarterly basis when the family resides 200 miles or more from the RTC. This includes the RTC providing travel, lodging and meals, to the family.

For Medicaid-eligible recipients in the custody of a public child welfare agency, prior to arranging the visit, the RTC must consult with and obtain approval from the agency's clinical representative pertaining to the appropriateness of such a visit.

7. Discharge Accompaniments

RTCs must ensure the following is provided to the legal representative upon discharge of a Medicaid-eligible recipient:

- a. Supply or access to current prescribed medications;
- b. The recipient's Medicaid-eligibility status;
- c. All pertinent medical records and post discharge plans to ensure coordination of and continuity of care.

8. Clinical Requirements

- a. The RTC must have a Medical Director who has overall medical responsibility for the RTC program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry.
- b. Psychiatric/Medical Services
 1. Medicaid-eligible children and adolescents must receive, at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist and a psychiatrist must be available 24 hours a day.
 2. The RTC must provide routine medical oversight to effectively coordinate all treatment, manage medication trials and/or adjustments to minimize

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serious side effects and provide medical management of all psychiatric and medical issues.

- c. Clinical psychotherapy (Individual, Group, or Family Therapy) must be provided by a licensed QMHP. All Rehabilitative Mental Health (RMH) services may also be provided by a QMHP, a QMHA or a QBA within the scope of their practice under state law and expertise. Consultation by a licensed clinical psychologist must be available when determined medically necessary.
- d. RTC Interns/Psychological Assistant
 - 1. RTC providers may be reimbursed for services provided by Interns/ Psychological Assistants within the all-inclusive daily rate if they meet the requirements as prescribed in the Provider Qualifications – Outpatient Mental Health Services section of this Chapter.
 - 2. Approved out-of-state RTC providers must comply with the Interns/Psychological Assistants requirements in their own state.

9. Patient Rights

RTC's must protect and promote Patient's Rights in accordance with all applicable Federal and State regulations.

10. Federal Requirements

RTC's must comply with all Federal and State Admission Requirements. Federal Regulations 42 CFR 441.151 to 441.156 address certification of need, individual plan of care, active treatment and composition of the team developing the individual plan of care.

403.8C AUTHORIZATION PROCESS

1. Admission Criteria

All RTC admissions must be prior authorized by the QIO-like vendor. RTCs must submit the following documentation to the QIO-like vendor:

- a. RTC Prior Authorization Request Form which includes a comprehensive psychiatric assessment current within six months of the request for RTC admission; and
- b. A Certificate of Need (CON) signed by a physician which includes:

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1. The current functioning of the recipient;
 2. The strengths of the recipient and their family;
 3. Covered, current ICD diagnosis;
 4. Psychiatric hospitalization history;
 5. Medical history; and
 6. Current medications.
- c. An initial individualized Treatment Plan; and
- d. A proposed Discharge Plan.
2. The QIO-like vendor must verify the medical necessity for all RTC services and verify:
 - a. The Level of Intensity of Needs for RTC services;
 - b. The ability for the recipient to benefit rehabilitatively from RTC services;
 - c. The Treatment Plan includes active participation by the recipient and their family (when applicable); and
 - d. The Discharge Plan is viable and includes coordinated case management services.
 3. All RTCs must notify the QIO-like vendor of the transfer of a recipient to an acute psychiatric hospital or unit. If the transfer is not emergent, the hospital must receive prior authorization for the transfer. For transfers to an acute psychiatric hospital or unit, the QIO-like vendor must verify the medical necessity for acute inpatient psychiatric services and verify:
 - a. The Level of Intensity of Needs for acute inpatient psychiatric services;
 - b. The ability for the recipient to benefit rehabilitatively from acute inpatient psychiatric services;
 - c. Effective care coordination is in place for pre- and post-transfer service; and
 - d. One of the following admission criteria has been met by the recipient:
 1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt within the past 30 days; or

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2. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g., note) or means to carry out the suicide threat (e.g., gun, knife, or other deadly weapon); or
3. Documented aggression within the 72-hour period before admission which:
 - a. Resulted in harm to self, others or property;
 - b. Demonstrates that control cannot be maintained outside of inpatient hospitalization; and
 - c. Is expected to continue if no treatment is provided.
4. The RTC must request prior authorization from the QIO-like vendor to return a recipient to the RTC from acute psychiatric services. The prior authorization request must include a Discharge Summary of the acute psychiatric inpatient services.
5. Prior authorization is required prior to transferring a recipient from one RTC to another for unanticipated specialized treatment services not available at the initial RTC placement.
6. RTCs may request a retro-eligibility authorization review from the QIO-like vendor for reimbursement for an RTC patient who was not Medicaid-eligible at the time of admission and later becomes eligible for Medicaid for the period RTC services were provided.
 - a. If a client becomes Medicaid eligible after admission to a RTC, the facility must submit an initial Prior Authorization request and all required information to the QIO-like vendor in accordance with MSM Chapter 100.
 - b. The QIO-like vendor will process initial Prior Authorization requests for retro-eligible recipients in accordance with MSM Chapter 100.
7. Continuing Stay Criteria
 - a. The RTC must submit a Continuing Stay Request to the QIO-like vendor prior to the expiration of the current authorization period.
 - b. The QIO-like vendor will process Continuing Stay Requests for RTC services within 14 days of receipt of all required information.

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- c. The RTC must notify the QIO-like vendor of all Medicaid recipient discharges within 24 hours of the discharge and provide a Discharge Summary within 30 days for a planned discharge and within 45 days of 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.
- d. Continued Stays Requests not authorized by the QIO-like vendor will not be reimbursed by Medicaid. The RTC must submit a request for reconsideration to the QIO-like vendor within the timelines as outlined in the QIO-like vendor's Billing Manual for RTC's if the continuing stay request has been denied.

8. Discharge Criteria

The QIO-like vendor will issue a denial or partial denial for RTC services based on review of medical necessity and admission or continuing stay criteria.

Denials may be issued for, but are not limited to:

- a. RTC services are not shown to be medically necessary;
- b. The service exceeds Medicaid program limitations;
- c. Level 6 of Intensity of Needs is not met and services may be provided in a less restrictive setting;
- d. Specialized RTC services are not required;
- e. The legal guardian for the Medicaid recipient has requested the services be withdrawn or terminated;
- f. The services are not a Medicaid benefit; and/or
- g. A change in federal or state law has occurred (the Medicaid recipient is not entitled to a hearing in this case; see MSM Chapter 3100).

9. Reimbursement

RTC's all-inclusive daily rates are negotiated by the provider through the DHCFFP's Rates and Cost Containment Unit. Please see MSM Chapter 700 and the Nevada Medicaid State Plan, Attachment 4.19-A, describing the methods and standards for reimbursement of Residential Treatment Centers.

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403.9 INPATIENT MENTAL HEALTH SERVICES POLICY

- A. Inpatient mental health services are those services delivered in freestanding psychiatric hospitals or general hospitals with a specialized psychiatric unit which include a secure, structured environment, 24-hour observation and supervision by mental health professionals and provide a multidisciplinary clinical approach to treatment.

Inpatient mental health services includes treatments or interventions provided to an individual who has an acute, clinically identifiable covered, current ICD psychiatric diagnosis to ameliorate or reduce symptoms for improved functioning and return to a less restrictive setting.

- B. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Inpatient Hospitalization Authorized	Inpatient Hospitalization Authorized

403.9A COVERAGE AND LIMITATIONS

1. Admissions

- a. Certification Requirement:

1. A physician must issue a written order for admission or provide a verbal order for admission, which is later countersigned by the same physician.

The order must be issued:

- a. During the hospital stay;
- b. At the time acute care services are rendered; or
- c. The recipient has been transferred, or is awaiting transfer to an acute care bed from an emergency department, operating room, admitting department, or other hospital service.

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2. The physician's order must be based on:

a. The recipient meeting Level 6 criteria on the Intensity of Needs grid and must include:

1. The date and time of the order and the status of the recipient's admission (i.e., inpatient, observation, same day surgery, transfer from observation, etc.)

b. Admission Date and Time:

The admission date and time must be reflected on the certification as the date and time the admission order was written prior to or during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies the documentation most relevant to the admission determination contingent upon provision of acute care services.

c. Transfers and Planned Admissions:

For those instances in which a physician's admission order was issued for a planned admission and before the recipient arrives at the hospital the order must be signed by the physician and indicate the anticipated date of admission. A physician's order must also be issued for transfers from another acute care hospital.

Responsibilities:

1. The admission must be certified by the QIO-like vendor based on:

- a. Medical necessity;
- b. Clear evidence of a physician's admission order; and the
- c. Recipient meeting Level 6 on the Intensity of Needs grid.

2. The hospital must submit all required documentation including:

- a. The physician's order which is signed by a physician and reflects the admission date and time; and
- b. All other pertinent information requested by the QIO-like vendor.

d. Observation:

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1. Observation status cannot exceed a maximum of 48 hours.
2. Observation begins when the physician issues an observation status order and ends when the recipient is discharged from the hospital.
3. A new admissions order must be issued and signed by a physician when a recipient is admitted to inpatient status post discharge from an observation stay. Nevada Medicaid reimburses for admissions certified by the QIO-like vendor to a:
 - a. Psychiatric unit of a general hospital, regardless of age; or
 - b. Psychiatric hospital (Institution for Mental Diseases) for recipients under age 21 or 65 or older.

For recipients under age 21 in the custody of the public child welfare agency, Nevada Medicaid reimburses for inpatient mental health services only when:

- a. The child welfare agency also approves the admission/placement (this does not apply to placements at State-owned and operated facilities); and
 - b. The admission is certified by the QIO-like vendor.
4. Reimbursement
 - a. Nevada Medicaid reimburses for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:
 1. The admission is an emergency and is certified by the QIO-like vendor. The hospital must submit clinical documentation to the QIO-like vendor within 24 hours of the first working day of the admission and make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit in as expeditiously as possible; or
 2. The recipient has been dually diagnosed as having both medical and mental diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.
 - b. Nevada Medicaid does not reimburse for services not authorized by the QIO-like vendor.

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- c. If a recipient is initially admitted to a hospital for acute care and is then authorized by the QIO-like vendor to receive mental health services, the acute care is paid at the medical/surgical rate.
- d. Authorized substance abuse services are paid at the substance abuse service rate.

5. Absences

- a. In special circumstances, Nevada Medicaid may allow up to an eight-hour pass from the acute hospital without denial of payment. Absences may include, but are not limited to, a trial home visit, a respite visit with parents (in the case of a child), a death in the immediate family, etc. The hospital must request prior authorization from the QIO-like vendor for an absence if the absence is expected to last longer than eight hours.
- b. There must be a physician's order that a recipient is medically appropriate to leave on pass and the therapeutic reason for the pass must be clearly documented in the chart prior to the issuance of the pass. Upon the recipient's return, the pass must be evaluated for therapeutic effect and the results clearly documented in the recipient's chart.

6. Non-Covered Services

Reference Section 403.9A.

403.9B PROVIDER RESPONSIBILITIES

- 1. Authorization by the QIO-like vendor must be obtained prior to admission. A tentative treatment plan will be required for the QIO-like vendor's authorization. The only exception is in the event of an emergency admission, in which the child may be admitted and the QIO-like vendor must be notified of the admission within 24 hours or the first working day.

In the event authorization is not obtained, the admission will not be authorized and/or certified by the QIO-like vendor for payment.

2. Medical Records

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

- a. An initial assessment of the recipient's clinically identifiable psychiatric disorder, which should include a chief complaint or equivalent, a history of the disorder, a

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statement of the circumstances which led to the request for services, a mental status examination and observations, a diagnosis or differential diagnosis and a statement of treatment goals and objectives and method of treatment.

- b. A written, individualized treatment plan (ITP) to address the problems documented during the intake evaluation. The plan shall include the frequency, modality and the goals of treatment interventions planned. It also shall include the type of personnel that will furnish the service.
- c. Dated progress notes are required for each treatment encounter to include the amount of time services were rendered, the type of service rendered, the progress of the recipient with respect to resolution of the presenting symptoms or problems, any side effects or necessary changes in treatment and the interval to the next treatment encounter.

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

For inpatient and outpatient services, the provider is responsible to meet Healthy Kids (EPSDT) and QIO-like vendor authorization guidelines, as discussed previously in this chapter.

- 3. Patient Self-Determination Act (Advance Directives) Compliance Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding from Medicare and/or Medicaid must comply with The Patient Self-Determination Act (PSDA) of 1990, including Advance Directives. Specifically, the PSDA requires all Medicare and Medicaid hospital providers to do the following:
 - a. Provide written information to all adult (age 18 and older) patients upon admission concerning:
 - 1. The individual's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives (declarations and durable powers of attorney for health care decisions).
 - 2. The written policies of the provider or organization respecting implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.

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At a minimum, a provider's or organization's statement of limitation must:

- a. clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
 - b. identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and
 - c. describe the range of medical conditions or procedures affected by the conscience objection.
- b. Document in the individual's medical record whether the individual has an advance directive.
 - c. Not to condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.
 - d. Ensure compliance with the requirements of state law respecting advance directives. The hospital must inform individuals any complaints concerning the advance directives requirements may be filed with the state survey and certification agency (which in Nevada is the Nevada State Health Division, Bureau of Health Care Quality and Compliance (HCQC)).
 - e. Provide education of staff concerning its policies and procedures on advance directives (at least annually).
 - f. Provide for community education regarding issues concerning advance directives (at least annually). At a minimum, education presented should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives. A provider must be able to document and verify its community education efforts.

Nevada Medicaid is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state Advance Directive requirements.

4. QA Medical Care Evaluation Studies

The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of care (42 CFR 456.141 to 456.145). As part of the conditions of participation in the Medicaid Title XIX program, a minimum of one Medical Care Evaluation Study must be in progress at anytime. Additionally, one study

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must be completed each year. The completed study must be submitted to the QIO-like vendor at the end of each calendar year along with the study in progress topic. (A report summarizing the study topics will be submitted to Nevada Medicaid, by the QIO-like vendor). Hospitals may design and choose their own study topic, or at the request of Medicaid perform a topic designated by Medicaid, and forward a copy of the completed study to the QIO-like vendor office within the specified time frames.

5. Medicaid Form NMO-3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form NMO-3058 to their local Welfare District Office whenever a hospital admission, discharge, or death occurs. Failure to submit this form could result in payment delay or denial. To obtain copies of Form NMO-3058, please contact Medicaid's fiscal agent.

6. Patient Rights

Pertaining to the acute psychiatric hospital's responsibilities of protecting and promoting each patient's rights, please consult the following authorities:

- a. 42 CFR 482.13.
- b. NRS 449.730.
- c. Joint Commission "Restraint and Seclusion Standards for Behavioral Health." (Available at the following website: www.jointcommission.org).

7. Non-Emergency Admissions

Non-emergency admissions for Medicaid eligible recipients must be prior authorized by the QIO-like vendor within one business day of the admission. Physicians may call them during normal business hours. (Non-emergency admissions not prior authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.)

8. Claims for Denied Admissions

Hospitals are not permitted, after having an inpatient service denied by the QIO-like vendor, to submit the claim to Medicaid's fiscal agent as an outpatient service. The only exception to this is if an outpatient or non-inpatient related service was truly rendered prior to the inpatient admission order by the physician but the inpatient stay was denied by the QIO-like vendor (i.e., admit from ER or rollover from observation days).

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9. Hospital Responsibilities for Outside Services

Any hospital receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for that recipient service and treatment needs. If a hospital does not have the proper or functional medical equipment or services, and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing/evaluation/treatment, etc., it is the transferring hospital's responsibility, not Medicaid's, to fund the particular services and, if necessary, transportation.

10. Acute Psychiatric Admission Requirements

- a. 42 CFR 441.152 addresses Certification of Need requirements.
- b. 42 CFR 441.155 addresses Individual Plan of Care requirements.
- c. 42 CFR 441.156 addresses the requirements of the composition of the team developing the individual plan of care.

11. Patient Liability

IMD's/freestanding psychiatric hospitals are exempt from Patient Liability (PL) requirements.

403.9C AUTHORIZATION PROCESS

The QIO-like vendor contracts with Medicaid to provide utilization and quality control review (UR) of Medicaid inpatient psychiatric hospital admissions. Within the range of the QIO-like vendors UR responsibilities are admission and length of stay criteria development, prior authorization, concurrent and retrospective review, certification and reconsideration decisions. The QIO-like vendor must approve both emergency and non-emergency inpatient psychiatric inpatient admissions. Any hospital which alters, modifies or changes any QIO-like vendor certification in any way, will be denied payment.

1. For purposes of Medicaid mental health services, an emergency inpatient psychiatric admission to either a general hospital with a psychiatric unit or freestanding psychiatric hospital, is defined as meeting at least one of the following three criteria:
 - a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 30 days; or
 - b. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g., gun, knife, or

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other deadly weapon); or

- c. Documented aggression within the 72-hour period before admission:
 1. Which resulted in harm to self, others, or property;
 2. Which manifests that control cannot be maintained outside an inpatient hospitalization; and
 3. Which is expected to continue without treatment.

2. Concurrent Reviews

For non-emergency admissions, the prior authorization request form and CON must be submitted at least one business day prior to admission. For emergency admissions, the prior authorization request form and CON must be submitted no later than one business day following admission. Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days. If additional inpatient days are required a provider must submit, a concurrent (continuing stay) authorization request prior to or by the last day of the current/existing authorization period. The request and information submitted must identify all pertinent written medical information that supports a continued inpatient stay. The request and information submitted must be in the format and within the timeframes required by the QIO-like vendor. Failure to provide all pertinent medical information as required by the QIO-like vendor will result in authorization denial. Inpatient days not authorized by the QIO-like vendor are not covered. These concurrent review procedures also apply to inpatient substance abuse detoxification and treatment services.

The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement, during the initial authorization period. In addition, when a recipient remains hospitalized longer than seven days the attending physician must document the medical necessity of each additional inpatient day.

3. Nevada Medicaid will reimburse for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:
 - a. The admission is an emergency admission and is certified by the QIO-like vendor (who must be contacted within 24 hours or the first working day after the admission). The hospital must make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible; or

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- b. The recipient has been dually diagnosed as having both medical and mental conditions/diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive mental health services, the acute care is paid at the medical/surgical tiered rate. The substance abuse services are paid at the substance abuse service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

4. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional authorization for physician ordered psychological evaluations and testing. The psychologist must list the "Inpatient Authorization Number" on the claim form when billing for services.

5. Prior Resources

Pursuant to federal law, Medicaid is payer of last resort whenever any other resources may be responsible for payment. Prior resources include but are not limited to: Medicare, labor unions, Worker's Compensation Insurance carriers, private/group insurance and CHAMPUS. Exceptions to this regulation are Bureau of Family Health Services, Indian Health Services (IHS), Ryan White Act and Victims of Crime, when Medicaid is primary.

Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.

6. Reimbursement

Inpatient freestanding psychiatric and/or alcohol/substance abuse hospitals and general acute hospitals with a psychiatric and/or substance abuse unit are reimbursed a per diem, all inclusive prospective daily rate determined and developed by the Nevada DHCFP's Rate Development and Cost Containment Unit. (Days certified as administrative are paid at the all-inclusive prospective administrative day rate.)

For claims involving Medicare crossover, Medicaid payment is the lower of the Medicare deductible amount or the difference between the Medicare payment and the Medicaid per diem prospective payment. (Medicare crossover claims involving recipient's ages 21 to 64 in freestanding psychiatric hospitals are reimbursable only if the recipient is a QMB.) Also, additional Medicaid reimbursement is not made when the Medicare payment exceeds the Medicaid prospective rate. Service claims denied by Medicare are also denied by Medicaid.

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403.10 INPATIENT ALCOHOL/SUBSTANCE ABUSE DETOXIFICATION AND TREATMENT SERVICES POLICY

Inpatient substance abuse services are those services delivered in freestanding substance abuse treatment hospitals or general hospitals with a specialized substance abuse treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance abuse professionals and a structured multidisciplinary clinical approach to treatment. These hospitals provide medical detoxification and treatment services for individuals suffering from acute alcohol and substance abuse conditions.

403.10A COVERAGE AND LIMITATIONS

1. Hospital inpatient days may be considered a Medicaid benefit when detoxification and treatment for acute alcohol and/or other substance abuse necessitates the constant availability of physicians and/or medical services found in the acute hospital setting. Medicaid reimburses for admissions to substance abuse units of general hospitals (regardless of age), or freestanding psychiatric and substance abuse hospitals for recipients age 65 and older, or those under age 21. The QIO-like vendor must prior authorize and certify all hospital admissions for both detoxification and treatment services to verify appropriateness of placement and justify treatment and length of stay.

Prior authorization is required for all Medicaid and pending Medicaid recipients, and Medicaid recipients covered through primary insurance, except Medicare Part A. If this is the case then authorization may need to be sent through Medicare.

Medicaid reimburses only for the following hospital alcohol/substance abuse detoxification and treatment services:

- a. Detoxification
 1. Recipients (under age 21) - Medicaid reimburses for up to five hospital inpatient detoxification days with unlimited lifetime admission services (Medicaid covers stays beyond five days only if additional detoxification services are deemed medically necessary by the QIO-like vendor).
 2. Recipients age 21 years and older - Medicaid reimburses for up to five hospital inpatient detoxification days with unlimited lifetime admission services. (Medicaid covers stays beyond five days only if additional detoxification services are deemed medically necessary by the QIO-like vendor).
 3. For recipients of all ages, results of a urine drug screen or blood alcohol test must be provided at the time of the initial request for authorization.

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b. Treatment

1. Recipients (under age 21) - Medicaid reimburses for up to 21 hospital inpatient treatment days with unlimited lifetime admission services until the recipient reaches age 21 (stays beyond 21 days are covered only if additional treatment services are deemed medically necessary by the QIO-like vendor).
2. Recipients age 21 years and older - Medicaid reimburses for up to 21 hospital treatment days with unlimited lifetime admissions only if the recipient is deemed amenable for treatment, and has the potential to remain sober, and as determined by the physician. (Stays beyond 21 days are covered only if the additional treatment services are deemed medically necessary by the QIO-like vendor).

To measure the recipient's ability to be amenable to treatment and the potential to remain sober, he/she must:

- a. Be currently attending, or willing to attend during treatment and upon discharge, and actively participate in Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA) meetings.
- b. Develop, over the duration of treatment, a support system to assist sobriety efforts and a substance abuse-free lifestyle.
- c. Seek employment, employment training, or return to past employment if still available, or attend or remain in an educational program (i.e., college, vocational training).

It is the hospital's responsibility to assist the recipient during hospitalization to assure the above mentioned post discharge resources will be utilized. Prior to inpatient admission, the referring or admitting physician must document discussing the above three "amenable to treatment" issues with the recipient, including the recipient's response to each. This documentation must be part of the recipient's inpatient hospital record. Prior to authorizing the admission, the QIO-like vendor will:

- d. per discussion with the physician, verify the physician-patient communication did occur and the recipient accepts his/her responsibility toward maintaining sobriety and/or a drug free lifestyle after treatment; and
- e. verify appropriateness of admission, treatment and length of stay.

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A psychiatric screening must also be completed within 72 hours of any inpatient detoxification or treatment admission.

c. Absences

Please consult Section 403.9A.5, of this Chapter regarding absences.

1. All Other Inpatient Services Coverage and Limitations. Please consult Section 403.9A, of this Chapter for all other Coverage and Limitations.
2. Non-Covered Services

Please consult Section 403.9A for non-covered services.

403.10B PROVIDER RESPONSIBILITIES

1. The need for hospital alcohol/substance abuse detoxification and/or treatment services must be prior authorized by the QIO-like vendor. The only exception is in the event of an emergency, where a delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight, or hearing, injury to self or bodily harm to others. In this instance, the recipient may be admitted and the QIO-like vendor must be contacted for authorization purpose within 24 hours or the first working day of the admission.
2. Please consult Section 403.9B.1-11, of this Chapter for additional provider responsibilities.

403.10C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.
2. Medicaid recipients are expected to comply with the service provider's treatment, care and service plans, including making and keeping medical appointments.

403.10D AUTHORIZATION PROCESS

The QIO-like vendor must certify all inpatient substance abuse detoxification and treatment admissions. Transfers to and from substance abuse detoxification/treatment services require prior authorization by the QIO-like vendor.

1. For recipients under age 21 in the custody of the public agency, Nevada Medicaid reimburses for alcohol/substance abuse detoxification and treatment services only when the following criteria are met:

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- a. The Division of Child and Family Services (DCFS) Regional Resource Council (RRC), Utilization Review Team (URT) or Family Programs Office (FPO) (entities responsible for reviewing, recommending and authorizing appropriate placement and treatment services) approves the admission/placement (does not apply to placements at Desert Willow Treatment Center).
- b. The admission is prior authorized and certified by the QIO-like vendor. For recipients under age 21 not in the custody of the public agency, only “b” applies.
2. Nevada Medicaid reimburses for services for recipients admitted with an alcohol/substance abuse condition/diagnosis to a general hospital without a specialized alcohol/substance abuse unit only under one of the following conditions:
 - a. The admission is an emergency and is certified by the QIO-like vendor (who must be contacted, for authorization purposes, within 24 hours or the first working day of the admission) and the hospital, as determined by the QIO-like vendor, makes all efforts to stabilize the recipient's condition and discharge the recipient to a substance abuse/psychiatric hospital or general hospital with a substance abuse/psychiatric unit as expeditiously as possible; or
 - b. The recipient is dually diagnosed as having both medical and substance abuse conditions which warrant inpatient general hospital services, as determined by the QIO-like vendor; or
 - c. The admission is certified by the QIO-like vendor for medical detoxification only. Medicaid recipients between 21 and 64 years of age are covered for inpatient alcohol/substance abuse detoxification and treatment services only in a general hospital with a specialized alcohol/substance abuse unit. Those Medicaid recipients age 20 and under and age 65 and older are covered for inpatient substance abuse detoxification and treatment services in a freestanding psychiatric and/or alcohol/substance abuse hospital, as well as a general hospital with a specialized alcohol/substance abuse unit.

All transfers from detoxification to treatment require prior authorization. This applies to all Medicaid recipients, regardless of age.

Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive alcohol/substance abuse services, the acute care is paid at the appropriate medical/surgical tier rate. The alcohol/substance abuse services are paid at the substance abuse service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

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3. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional PA for physician ordered psychological evaluations and testing. The psychologist must list the QIO-like vendors "Inpatient's authorization number" on the claim form when billing for services.

4. Retrospective Reviews

The QIO-like vendor authorizes only Medicaid eligible clients, not pending eligible. Should a client become Medicaid eligible while in the facility, a retrospective review must be requested by the provider to the QIO-like vendor:

- a. The medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination.
- b. If the information submitted is not complete, a technical denial for service will be issued.
- c. The QIO-like vendor will complete the review and issue a final determination within 30 days of receipt of all requested information.

5. Determination Letters (Notices)

a. Approvals

The RTC provider is sent a "Notice of Medical Necessity Determination."

b. Denials

The RTC provider is sent a "Notice of Medical Necessity Determination" and "Request for Reconsideration" form. The Medicaid client is sent a "Notice of Decision (NOD) for Authorization Form" and "Hearing Information and Hearing Request Form." Denials may be due to technical/administrative (e.g. the provider did not obtain prior authorization) or clinical (e.g. client did not meet medical or clinical necessity) reasons.

6. Reimbursement

Please consult Section 403.9C.6 of this Chapter regarding reimbursement.

7. Patient Liability

Please consult Section 403.9B.11 of this Chapter regarding patient liability.

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403.11 ADMINISTRATIVE DAYS POLICY

The primary purpose and function of administrative days is to assist hospitals, which, through no fault of their own, cannot discharge a recipient who no longer requires acute level services, due to lack of, or a delay in, an alternative appropriate setting, which includes the adequate and comprehensive documentation of discharge planning efforts. Administrative Days are reimbursed on a retrospective, not cost settlement, basis.

403.11A COVERAGE AND LIMITATIONS

Administrative days are those inpatient days which have been certified for payment by the QIO-like vendor, based on physician advisement, at the Skilled Nursing Level (SNL) or Intermediate Care Level (ICL).

1. SNL is a unique payment benefit of the Nevada Medicaid program. These reimbursement levels provide for ongoing hospital services for those recipients who do not require acute care. Discharge to a nursing facility is not required. Issuance of this level is a reflection of the hospital services required by and provided to the recipient.

SNL days may be authorized when one or more of the following apply, or as determined by physician review:

- a. Recipient is awaiting placement, or evaluation for placement, at a nursing facility/extended care facility, group home, or other treatment setting, for continuity of medical services, e.g.:
 1. Transfers to other facilities.
 2. Rehabilitation or independent living.
 3. Hospice etc.
- b. Recipient is to be discharged home and is awaiting home equipment set up/availability, nursing services and/or other caretaker requirements, e.g.:
 1. Home Health Nursing.
 2. Public Health Nursing.
 3. Durable Medical Equipment.
 4. Family preparation.

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5. Respite care.
 - c. Conditions which may prevent a non-acute recipient from leaving the hospital (e.g., recipient's labs must be monitored, cultures taken for staph infection, or any treatment/work up that could not be safely and effectively accomplished in another setting).
 - d. Recipient is awaiting placement at a residential treatment center, group home, or psychiatric treatment center for continuity of psychiatric services., e.g.:
 1. Partial hospitalization.
 2. Therapeutic foster care.
 3. Day treatment.
 4. Rural mental health follow-up services.
 5. Set up for wrap around services.
 - e. Recipient has mental disabilities that prevent nursing facility placement (e.g., failed PASRR screening), and the recipient will eventually go to an institution of mental diseases.
3. ICL is a unique payment benefit of the Nevada Medicaid program, which provides reimbursement for ongoing hospital services, for those recipients who cannot be discharged due to social reasons.

ICL days are authorized when one or more of the following apply, or as determined by physician review:

 - a. Stable child awaiting adoption or discharge home when the mother is discharged.
 - b. Ready for discharge and is awaiting transportation.
 - c. ICL at a nursing home or alternate setting.
 - d. Victim of crime in need of assessment and evaluation.
4. Administrative days are denied when:
 - a. A recipient, recipient's family, or physician refuses a Nursing Facility (NF) placement.

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- b. A recipient, family, or physician refuses a psychiatric RTC placement, group home, or psychiatric treatment center.
- c. There is insufficient documentation (Monday through Friday contacts and results) in the chart reflecting adequate discharge planning.

403.11B PROVIDER RESPONSIBILITIES

Please consult Section 403.10B of this Chapter for provider responsibilities.

403.11C RECIPIENT RESPONSIBILITIES

- 1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.
- 2. Medicaid recipients are expected to comply with the service provider's treatment, care and service plans, including making and keeping medical appointments.

403.11D AUTHORIZATION PROCESS

If appropriate, the QIO-like vendor certifies administrative days at either an SNL or ICL level of care.

403.12 ELECTROCONVULSIVE THERAPY (ECT)

Effective Date 03/01/2004. ECT is a treatment for mental disorders, primarily depression, but also acute psychotic episodes in Schizophrenia and Bipolar Disorder. A low voltage alternating current is used to induce a generalized seizure that is monitored electrographically while under general anesthesia and muscle relaxation.

Medicaid will reimburse medically necessary ECT treatments when administered by a Board Certified Psychiatrist in a qualified acute care general hospital, contracted acute care psychiatric hospital, or in a hospital outpatient surgery center/ambulatory surgery center. Recipients receiving outpatient ECT do not require a global treatment program provided in the inpatient setting prior to outpatient services.

Prior Authorization is required.

403.12A COVERAGE AND LIMITATIONS

ECT is generally used for treatment of affective disorders unresponsive to other forms of treatment. It has also been used in schizophrenia, primarily for acute schizophrenic episodes.

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1. Prior authorization requires documentation of the following medically necessary indicators:
 - a. Severe psychotic forms of affective disorders.
 - b. Failure to respond to other therapies.
 - c. Medical preclusion to use of drugs.
 - d. Need for rapid response.
 - e. Uncontrolled agitation or violence to self or others.
 - f. Medically deemed for probable preferential response to ECT.
2. Recipients (under 16) years of age must have all of the above indicators and:
 - a. Two prior medication trials predetermined by a physician.
 - b. Two concurring opinions by a Board Certified Psychiatrist.
 - c. Informed written consent by custodial parent(s)/legal guardian.
3. Covered, current ICD Codes:

F20-F29 Schizophrenic disorders

F30-F33.9 Affective psychoses and depressive type psychosis and other nonorganic psychoses
4. Covered CPT Codes:

90870 – Electroconvulsive therapy (includes necessary monitoring); single seizure.
5. Reasons for Denial
 - a. Continuing use of ECT without evidence of recipient improvement.
 - b. Diagnostic codes not encompassed in the foregoing list.
6. Coding Guidelines

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- a. Anesthesia administration for ECT is a payable service only if provided by a physician other than the one administering ECT.
- b. If billing is received for ECT and a visit on the same day, the latter will be denied if rendered by the physician administering ECT.

7. Documentation Requirements

Medical records should include recipient symptoms, physical findings and diagnosis to document the medical necessity of performing ECT.

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404 HEARINGS

Please reference Medicaid Services Manual (MSM), Chapter 3100 Hearings, for hearings procedures.

POLICY #4-01	DAY TREATMENT AGES 3-6	
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A. DESCRIPTION

Day Treatment services are interventions performed in a therapeutic milieu designed to provide evidence based strategies to reduce emotional, cognitive, and behavioral problems. Day Treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day Treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community based settings.

B. POLICY

Day Treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day Treatment services must:

1. Have goals and objectives that are:
 - a. time specific;
 - b. measurable (observable);
 - c. achievable;
 - d. realistic;
 - e. time limited;
 - f. outcome driven;
 - g. individualized;
 - h. progressive; and
 - i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day Treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and Rehabilitative Mental Health (RMH) services; and
3. Provided under a Behavioral Health Community Network (BHCN) medical model.

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C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

- a. Early Childhood Service Intensity Instrument (ECSII) level II or Child and Adolescent Service Intensity Instrument (CASII) score of III or higher;
- b. A primary covered, current ICD diagnosis;
- c. Determined Severe Emotional Disturbance (SED);
- d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community based environments;
- e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;
- f. Adequate social support system available to provide the stability necessary for maintenance in the program; and
- g. Emotional, cognitive and behavioral health issues which:
 1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;
 2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and
 3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, head start, school and/ or home placements.

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Service Limitations	Ages 3-6: CASII
Levels I & II	No Services Authorized
Level III	Maximum of 3 hours per day
Level IV	Maximum of 3 hours per day
Levels V & VI	Maximum of 3 hours per day

2. NON COVERED SERVICES

- a. Transportation or services delivered in transit.
- b. Facilities licensed as a daycare.
- c. Club house, recreational, vocational, afterschool, or mentorship programs.
- d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.
- e. Routine supervision, monitoring or respite.
- f. Non-evidenced based models.
- g. Non milieu models.
- h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement Day Treatment programs must be separately enrolled with the Division of Health Care Financing and Policy (DHCFP).

Program Criteria:

- 1. Services not to exceed three hours per day, five days per week;
- 2. Parental/caregiver involvement and participation in the Day Treatment program;
- 3. Ongoing participation in family counseling/therapy;
- 4. Minimum staff to recipient ratio is 1:3;
- 5. Maximum group size is six;

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Therapeutic milieu design;

6. Services must be provided by a Qualified Mental Health Professional (QMHP) or Qualified Mental Health Associates (QMHA) under the direct supervision of an onsite QMHP;
7. Evidence based programmatic model with established curriculum and schedule;
8. Program admission, service continuation and discharge criteria; and
9. Policies and procedures specific to the Day Treatment program which at a minimum address the following:
 - a. Medical, Clinical, and Direct Supervision;
 - b. Health Insurance Portability and Accountability Act (HIPAA) and client's rights;
 - c. Service provision and documentation; and
 - d. Admission and discharge criteria and process.

For individual provider requirements see Medicaid Service Manual (MSM) Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the Quality Improvement Organization (QIO)-like vendor website.

POLICY #4-02	DAY TREATMENT AGES 7-18	
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A. DESCRIPTION

Day Treatment services are interventions performed in a therapeutic milieu designed to provide evidence based strategies to reduce emotional, cognitive, and behavioral problems. Day Treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day Treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community based settings.

B. POLICY

Day Treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day Treatment services must:

1. Have goals and objectives that are:
 - a. time specific;
 - b. measurable (observable);
 - c. achievable;
 - d. realistic;
 - e. time limited;
 - f. outcome driven;
 - g. individualized;
 - h. progressive; and
 - i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day Treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and RMH services; and
3. Provided under a BHCN medical model.

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C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

- a. CASII score of III or higher;
- b. A primary covered, current ICD diagnosis;
- c. Determined SED;
- d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community based environments;
- e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;
- f. Adequate social support system available to provide the stability necessary for maintenance in the program; and
- g. Emotional, cognitive and behavioral health issues which:
 1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;
 2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and
 3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, school and/ or home placements.

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Service Limitations	Ages 7-18: CASII
Levels I & II	No Services Authorized
Level III	Maximum of 4 hours per day
Level IV	Maximum of 5 hours per day
Levels V & VI	Maximum of 6 hours per day

2. NON COVERED SERVICES

- a. Transportation or services delivered in transit.
- b. Facilities licensed as a daycare.
- c. Club house, recreational, vocational, afterschool, or mentorship programs.
- d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.
- e. Routine supervision, monitoring or respite.
- f. Non-evidenced based models.
- g. Non milieu models.
- h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement Day Treatment programs must be separately enrolled with the DHCFP.

1. Program Criteria:

- a. Services not to exceed six hours per day, five days per week;
- b. Parental/caregiver involvement and participation in the Day Treatment program;
- c. Ongoing participation in individual therapy (not reimbursed under Day Treatment model);
- d. Minimum staff to recipient ratio is 1:5;

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- e. Maximum group size is ten;
- f. Therapeutic milieu design;
- g. Services must be provided by a QMHP or QMHA under the direct and clinical supervision of an onsite QMHP;
- h. Evidence based programmatic model with established curriculum and schedule;
- i. Program admission, service continuation and discharge criteria; and
- j. Policies and procedures specific to the Day Treatment program which at a minimum address the following:
 - 1. Medical, Clinical, and Direct Supervision;
 - 2. HIPAA and client's rights;
 - 3. Service provision and documentation; and
 - 4. Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

POLICY #4-03	DAY TREATMENT AGES 19 AND OLDER	
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A. DESCRIPTION

Day Treatment services are RMH interventions performed in a therapeutic milieu to provide evidence based strategies to restore and/or retain psychiatric stability, social integration skills, and/or independent living competencies to function as independently as possible. Services provide recipients the opportunity to implement and expand upon what was previously learned from other mental or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to prepare recipients for reintegration back into home and community based settings, prevent hospitalizations and ensure stability.

B. POLICY

Day Treatment coverage and reimbursement is limited to medically necessary services and are covered at an hourly rate. Day Treatment services must:

1. Have goals and objective that are:
 - a. time specific;
 - b. measurable (observable);
 - c. achievable;
 - d. realistic;
 - e. time limited;
 - f. outcome driven;
 - g. individualized;
 - h. progressive; and
 - i. age/developmentally appropriate.
2. Must involve the recipient and family or other individuals, as appropriate, and
3. Not be contingent on the living arrangements of the recipient.

Day Treatment services are:

1. Facility based, out of home services.
2. A fluid combination of all the RMH services.
3. Provided under a BHCN medical model.

POLICY #4-03	DAY TREATMENT AGES 19 AND OLDER	
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C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate that the recipient meets all of the following criteria:

- a. Must have Level of Care Utilization System for Adults (LOCUS) score of IV, V or VI;
- b. A primary covered, current ICD diagnosis;
- c. Determined as Serious Mental Illness (SMI);
- d. Requires and benefits from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community based environments;
- e. The recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;
- f. An adequate social support system is available to provide the stability necessary for maintenance in the program; and
- g. Recipient's emotional, cognitive and behavioral issues which:
 1. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and
 2. are incapacitating, interfere with daily activities or place others in danger to the point that it causes anguish or suffering.

Service Limitations	Ages 19 and older: LOCUS
Levels I & II	No Services Authorized
Level III	No Services Authorized
Level IV	Maximum of 5 hours per day
Levels V & VI	Maximum of 6 hours per day

2. NON COVERED SERVICES

- a. Transportation or services in transit.

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- b. Facilities licensed as adult daycare may not provide Day Treatment services.
- c. Recreational, mentorship or club house programs.
- d. Services in a home based or home like settings, including campus/institutions that furnish in single or multiple areas, food, shelter, and some treatment/services to four or more persons unrelated to the proprietor.
- e. Non-evidenced based models.
- f. Non milieu models.
- g. Programs restricted to only those recipients residing at the same location.

E. PROVIDER REQUIREMENTS

1. Program Criteria:

- a. Day Treatment services must be provided by a QMHP or QMHA under the direct supervision of an onsite QMHP;
- b. Services not to exceed a maximum of six hours a day, five days a week;
- c. Must involve the recipient and family or other individuals, as appropriate in the day treatment program and family counseling/therapy;
- d. Minimum staff to recipient ratio is 1:5;
- e. Maximum group size is ten;
- f. Therapeutic milieu design;
- g. Evidence based programmatic model with established curriculum and schedule;
- h. Program admission, service continuation and discharge criteria in place; and
- i. Policies and procedures specific to the Day Treatment program which as a minimum address the following:
 - 1. Medical, Clinical and Direct Supervision;
 - 2. HIPAA and clients rights;
 - 3. Service provision and documentation; and
 - 4. Admission and discharge criteria and process

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Day Treatment services will only be reimbursable to those programs which have been approved and enrolled to serve as Day Treatment Program service providers

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor's Billing Manual and Guidelines.

POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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A. DESCRIPTION/POLICY

B. SUBSTANCE ABUSE AGENCIES MODEL (SAAM)

The Division of Health Care Financing and Policy (DHCFP) covers services for prevention and treatment for recipients who have been diagnosed or at risk of substance abuse disorders. The Substance Abuse policy is under the rehabilitative authority of the State Plan for behavioral health services. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

The below coverage policies are developed based upon the Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (DHHS) and are best-practice guidelines for the treatment of substance abuse disorders.

In addition, the DHCFP utilizes American Society of Addiction Medicine (ASAM) patient placement criteria to establish guidelines for level of care placements within the substance abuse continuum. For mental health continuum the DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients as described under 403.4(7).

The DHCFP encourages providers to utilize SAMHSA's working definition, dimensions and guiding principles of recovery from Substance Use Disorders in their clinical decisions. The definition is continually changing due to updates in the clinical field reference <http://www.samhsa.gov/> for the latest best practices.

There are four major dimensions that support a life in recovery:

1. Health-Overcoming or managing one's disease(s) or symptoms;
2. Home-A stable and safe place to live;
3. Purpose-Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
4. Community-Relationships and social networks that provide support, friendships, love and hope.

The guiding principles of recovery are:

1. Recovery emerges from hope;
2. Recovery is person-driven;
3. Recovery occurs via many pathways;
4. Recovery is holistic;

POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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5. Recovery is supported by peers and allies;
6. Recovery is supported through relationship and social networks;
7. Recovery is culturally-based and influenced;
8. Recovery is supported by addressing trauma;
9. Recovery involves individual, family, and community strengths and responsibility; and
10. Recovery is based on respect.

C. DEFINITIONS

1. Co-Occurring Capable (COC) programs - are those that “address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning” (The ASAM Criteria 2013, p. 416.)
2. Co-Occurring Enhanced (COE) programs - have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse treatment to clients and “are designed to routinely (as opposed to occasionally) deal with patients who have mental health or cognitive conditions that are more acute or associated with more serious disabilities.”

(The ASAM Criteria, 2013, p. 29) Enhanced-level service “place their primary focus on the integration of service for mental and substance use disorders in their staffing, services and program content.” (The ASAM Criteria, 2013, p. 417).

3. Recovery - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
4. Substance abuse - as defined in DSM-V (5th edition, Text Revision; APA 2013) is a “ cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA 2013, p. 483)
5. Substance dependence - is more serious than abuse. This maladaptive pattern of substance abuse includes such features as increased tolerance for the substance, resulting in the need for ever greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems.
6. Integrated interventions - are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or integration, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques. Some examples include:
 - a. Integrated screening and assessment process;

POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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- b. Dual recovery mutual self-help meetings;
- c. Dual recovery groups (in which recovery skills for both disorders are discussed);
- d. Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance use disorder problems;
- e. Group interventions for persons with the triple diagnosis of mental disorder, substance abuse disorder, and trauma, or which are designed to meet the needs of persons with co-occurring disorder and another shared problem such as homelessness or criminality; and
- f. Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder.

Integrated interventions can be part of a single program or can be used in multiple program settings.

- 7. Quadrant of Care Model as developed by the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD):
 - a. Category I: Less Severe mental disorder/less severe substance disorder.
 - b. Category II: More severe mental disorder/less severe substance disorder.
 - c. Category III: Less severe mental disorder/more severe substance disorder.
 - d. Category IV: More severe mental disorder/more severe substance disorder.

This assessment assists the provider in integrating care, defining and guiding treatment options for recipients with co-occurring disorders.

D. PROVIDER REQUIREMENTS

- 1. In order to be recognized and reimbursed as a Prevention and Early Intervention Level 0.5 by the DHCFP, the providers must be:
 - a. Recognized health care clinicians and systems by the U.S. Preventive Services Task Force (USPSTF) within their scope of practice; and
 - b. Certified providers under the Nevada Administrative Code (NAC) 458.103 scope of practice.
- 2. In order to be recognized and reimbursed as a Substance Abuse Treatment Clinic for Levels I-III by the DHCFP, the provider must:

POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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- a. Be certified and receiving funding from the Division of Public and Behavioral Health as an alcohol and drug abuse program under NAC 458.103; and
 - b. Provide Integrated Interventions; and
 - c. Be a Co-Occurring Capable Program; or
 - d. A Co-Occurring Enhanced Program.
3. In order to be recognized and reimbursed as a Substance Abuse Level 4-WM Medically Managed Intensive Inpatient Withdrawal Management Program by the DHCFP the provider must be Licensed by the Nevada Division of Public and Behavioral Health as:
- a. An acute care general hospital with a psychiatric unit; or
 - b. A free standing psychiatric hospital (patients ages 22-64 in an IMD are not covered).
 - c. A licensed chemical dependency specialty hospital with acute care medical and nursing staff (patients ages 22 – 64 in an IMD are not covered).
 - d. Have Medicare certification.

E. QUALITY IMPROVEMENT

The DHCFP requires providers who are receiving funds from the DHCFP to be deemed compliant by the Division of Public and Behavioral Health, Nevada Revised Statutes (NRS) and NAC. Qualification is based upon the Division of Public and Behavioral Health's Substance Abuse Prevention and Treatment Agency (SAPTA) Certification tool. The certification tool reviews the program for areas such as, but not limited to, compliance with federal and state regulations, quality improvement, applications of policies and procedures, health and safety of the recipients, clinical documentation requirements, and staff/training documentation. Non-compliance will result in the DHCFP provider **termination and/or suspension without cause** depending on severity of infraction.

This does not apply to level 4 providers or physicians providing level 0.5 services. They are governed by separate licensing boards.

F. DOCUMENTATION REQUIREMENTS

All program levels require individualized progress notes in the recipient's medical records that clearly reflect implementation of the treatment plan and the recipient's response to the therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Treatment plan reviews are conducted at specified times as documented on the treatment plan.

1. 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 licensed professional within the scope of their practice under state law. The treatment plan is based on a comprehensive assessment and includes:

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POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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- a. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);
 - b. Documentation supporting ASAM Criteria assessment dimensions and levels of care;
 - c. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;
 - d. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;
 - e. Discharge criteria specific to each goal; and for
 - f. High-risk recipients accessing multiple government-affiliated and/or private agencies/ evidence of care by those involved with the recipient’s care.
2. 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 representative’s participation in treatment planning must be documented on the treatment plan.
 3. 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.
 4. Progress Note - Reference section 403.2B(3).
 5. Discharge Plan - Reference section 403.2B(4).
 6. Discharge Summary - Reference Section 403.2B(5).
 7. Required Signatures for Treatment Plan:
 - a. Clinical Supervisor;
 - b. Recipient and their family/legal guardian (in the case of legal minors); and
 - c. The individual responsible for developing the plan.

G. SUPERVISION REQUIREMENTS

Clinical Supervisor – A licensed professional operating within the scope of their practice under state law may function as Clinical Supervisor. Clinical Supervisor must have the specific education, experience, training, credentials, and licensure to coordinate and oversee an array of services for behavioral health. The Clinical Supervisor will have administrative and clinical oversight of the program and must ensure that services provided are medically necessary, clinically appropriate, and follow an evidence based model recognized by the Health Division. The designated supervisor must be approved by the program operator of a SAPTA certified and funded network per NAC 458.103.

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POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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If the Clinical Supervisor will supervise interns, they are required to have the appropriate additional licensure needed per the Board of Examiners in addition to their professional licensure. Supervision must be within the scope of their practice and field.

H. COVERAGE AND LIMITATIONS

The DHCFP reimburses for integrated interventions in a substance abuse medical treatment delivery model provided by qualified Medicaid providers. Patients are assessed as meeting diagnostic criteria for substance-related disorders (including substance use disorder or substance-induced disorders) and/or mental health disorders as defined in the current International Classification of Diseases (ICD).

1. Screening - A brief systematic process to determine the possibility of a co-occurring disorder.
 - a. The following screens are covered within the DHCFP program. Screens must be a nationally accepted screening instrument through SAMHSA/CSAT Treatment Improvement Protocols or other Peer Supported Literature. Below is a list of recognized tools:
 1. Clinical Institute Withdrawal Assessment (CIWA)
 2. Michigan Alcohol Drug Inventory Screen (MADIS)
 3. Michigan Alcoholism Screening Test (MAST)
 4. Modified Mini
 5. Problem Behavior Inventory (PBI)
 6. Substance Abuse Subtle Screening Inventory (SASSI)
 7. Substance Use Disorder (SUDDS)
 8. Recovery Attitude and treatment Evaluator (RAATE)
 9. Treatment Intervention Inventory (TII)
 10. Western Personality Interview (WPI)
2. Assessment - A Comprehensive Co-occurring Assessment is an individualized examination which establishes the presence or absence of mental health and substance abuse disorders, determines the recipient's readiness for change, and identifies the strengths or problem areas that may affect the recipient's treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	
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3. Level of Care Determination and Authorization Requirements
 - a. The DHCFP utilizes the ASAM Criteria, for individuals presenting with substance use disorder(s) to determine appropriate placement in a level of care. In addition, the DHCFP utilizes medical necessity as defined in Medicaid Services Manual (MSM) Chapter 100, Section 103.1. The process considers assessment and documentation of the following six dimensions:
 1. Dimension 1: Acute Intoxication and/or Withdrawal Potential
 2. Dimension 2: Biomedical Conditions and Complications
 3. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
 4. Dimension 4: Readiness to Change
 5. Dimension 5: Relapse, Continued Use, or Continued Problem Potential
 6. Dimension 6: Recovery/Living Environment
 - b. The DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients.
 - c. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request.
 - d. Reference Attachment C for authorization requirements for Substance Abuse Agency Model.
4. Treatment Services – The DHCFP covers the below levels based upon the ASAM patient placement criteria. Reference Attachment C for the coverage and utilization management requirements.
 - a. Level 0.5 Early Intervention/Prevention
 - b. Level 1 Outpatient Services
 - c. Level 2.1 Intensive Outpatient Program
 - d. Level 2.5 Partial Hospitalization
 - e. Level 3 Outpatient Services provided in a Licensed Level 3 environment
 - f. Level 4 Medically Managed Intensive Inpatient Treatment

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5. Pharmaceutical coverage - For coverage and limitations of Narcotic Withdrawal Therapy Agents (Opioid Dependent Drugs) refer to Chapter 1200 of the MSM.
6. Opioid Use Treatment
 - a. Provided in a Nevada licensed entity through SAPTA as an Opioid Use Disorder Treatment Program.
 - b. Coverage of the service:
 1. Requires diagnosis of Opioid Use Disorder; and
 2. Requires documentation as meeting the assessment criteria of all six dimensions of opioid treatment program in The ASAM Criteria.
 - c. The following service is covered for Opioid Treatment Program:
 1. Medication assessment, prescribing, administering, reassessing and regulating dose levels appropriate to the individual, supervising withdrawal management from opioids, opioid use disorder treatment, overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders;
 - d. Opioid use disorder treatment program is required to perform:
 1. Linkage with or access to psychological, medical and psychiatric consultation;
 2. Linkage with or access to emergency medical and psychiatric care through affiliations with more intensive levels of care;
 3. Linkage with or access to evaluation and ongoing primary medical care;
 4. Ability to conduct or arrange for appropriate laboratory and toxicology tests;
 - a. Availability of physicians to evaluate, prescribe and monitor use of methadone and levo-alpha-acetylmethadol (LAAM), and of nurses and pharmacists to dispense and administer methadone or LAAM; and
 - b. Ability to assist in arrangements for transportation services for patients who are unable to drive safely or who lack transportation.
7. Non-Covered Services - the following services are not covered under the substance abuse services program for the DHCFP:
 - a. Services for recipients without an assessment documenting diagnostic criteria for substance-related disorder (including substance use disorder or substance-induced disorders) or mental health disorder as defined in the current ICD;

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- b. Services for marital problems without a covered, current ICD diagnosis;
- c. Services for parenting skills without a covered, current ICD diagnosis;
- d. Services for gambling disorders without a covered, current ICD diagnosis;
- e. Custodial services, including room and board;
- f. More than one provider seeing the recipient in the same therapy session;
- g. Services not authorized by the QIO-like vendor if an authorization is required according to policy;
- h. Respite;
- i. Services for education;
- j. Services for vocation training;
- k. Habilitative services;
- l. Phone consultation services;
- m. Services for individual ages 22-64 in an Institution for Mental Disease (IMD);
- n. Services provided by agencies not receiving funding by Nevada Division of Public and Behavioral Health (DPBH) for Levels I-III under NAC458.103;
- o. Services provided under Nevada State Certification Level 2WM – 3.7 Withdrawal Management programs;
- p. Counseling services for Opioid Treatment Programs; and
- q. Care Coordination and treatment planning.

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention	1. Screening services recommended by the U.S. Preventive Services Task Force: <ul style="list-style-type: none"> a. Depression screening in adults and adolescents. b. Alcohol screening in adults, including pregnant women. c. Tobacco use counseling and interventions for pregnant women. 2. Must be direct visualization. Self-screens and over the phone are non-covered.	A. DEPRESSION SCREENING <u>Adults:</u> Many formal screening tools are available, including instruments designed specifically for older adults. (See Policy, page 4) Asking two simple questions about mood and anhedonia ("Over the past two weeks, have you felt down, depressed, or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?") may be as effective as using more formal instruments (2). There is little evidence to recommend one screening method over another; therefore, clinicians may choose the method most consistent with their personal preference, the patient population being served, and the practice setting. All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (that is, those from the updated <i>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</i>) to determine the presence or absence of specific depressive disorders, such as MDD or dysthymia. The severity of depression and comorbid psychological problems (for example, anxiety, panic attacks, or substance abuse) should be addressed.	No prior authorization required. Limited to one screen per 90 days per disorder.

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention (Continued)		<p><u>Adolescents:</u> Instruments developed for primary care (Patient Health Questionnaire for Adolescents [PHQ-A] and the Beck Depression Inventory-Primary Care Version [BDI-PC]) have been used successfully in adolescents. There are limited data describing the accuracy of using MDD screening instruments in younger children (7-11 years of age).</p> <p>B. ALCOHOL SCREENING</p> <p><u>Adults/Pregnant Women:</u> The USPSTF considers three tools as the instruments of choice for screening for alcohol misuse in the primary care setting: the Alcohol Use Disorders Identification Test (AUDIT), the abbreviated AUDIT-consumption (AUDIT-C), and single question screening (for example, the NIAAA recommends asking, “How many times in the past year have you had five [for men] or four [for women and all adults older than 65 years] or more drinks in a day?”). Of available screening tools, AUDIT is the most widely studied for detecting alcohol misuse in primary care settings; both AUDIT and the abbreviated AUDIT-C have good sensitivity and specificity for detecting the full spectrum of alcohol misuse across multiple populations.</p>	

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention (Continued)		<p>AUDIT comprises ten questions and requires approximately two to five minutes to administer. AUDIT-C comprises three questions and takes one to two minutes to complete. Single-question screening also has adequate sensitivity and specificity across the alcohol-misuse spectrum and requires less than one minute to administer.</p> <p>C. TOBACCO</p> <p><u>Pregnant Women</u> Various primary care clinicians may deliver effective interventions. There is a dose-response relationship between quit rates and the intensity of counseling (that is, more or longer sessions improve quit rates). Quit rates seem to plateau after 90 minutes of total counseling contact time. Helpful components of counseling include problem-solving guidance for smokers (to help them develop a plan to quit and overcome common barriers to quitting) and the provision of social support as part of treatment. Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone "quit lines."</p>	

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Outpatient Services			
Level 1 Outpatient Services	<ol style="list-style-type: none"> 1. Medication management 2. 24 hour crisis intervention services face to face or telephonically available seven days per week 3. Behavioral Health/Substance Abuse Covered Screens 4. Comprehensive biopsychosocial Assessment 5. Individual and group counseling 6. Individual, group, family psychotherapy 7. Peer Support Services 	<p>A clinic model that meets the certification requirement NAC 458.103 for alcohol and drug abuse programs.</p> <p>The entity will provide medical, psychiatric, psychological, services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p>

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Outpatient Services			
Level 2 2.1 Intensive Outpatient Treatment	<p>An evidenced-based/best practice model providing a minimum amount of skilled structured programming hours per week. During the day, before or after work setting, evening, and/or weekend. Provides a milieu “real world” environment. The milieu is a combination of skilled treatment services.</p> <ol style="list-style-type: none"> 1. Medical and psychiatric consultation 2. Psychopharmacological consultation 3. Medication management 4. 24 hour crisis intervention services face to face or telephonically available seven days per week 5. Comprehensive biopsychosocial assessments 6. Behavioral Health/Substance Abuse Covered Screens 7. Individual and group counseling 8. Individual, group, family psychotherapy 9. Self-help/recovery groups 	<p>Frequencies and intensity are appropriate to the objectives of the treatment plan.</p> <p>Requires a comprehensive interdisciplinary program team approach of appropriately credentialed addiction treatment professionals, including addiction – credentialed physicians who assess and treat substance-related disorders. Some staff are cross trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and interactions with substance-related disorders.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p>
2.5 Partial Hospitalization	<ol style="list-style-type: none"> 1. Outpatient hospital setting. 2. All level 2.1 services in addition need the direct access to psychiatric, medical and/or laboratory services. 	<p>Same as above, in addition psychiatric and medical management.</p> <p>Intensity of service required is higher than can be provided in Intensive Outpatient Treatment.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p>

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Outpatient Services			
Level 3 Residential 3.3-.5 Managed Residential	<p>Medical, psychiatric, psychological, services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation.</p> <ol style="list-style-type: none"> 1. 24 hour crisis intervention services face to face or telephonically available seven days per week 2. Medication management 3. Behavioral Health/Substance Abuse Covered Screens 4. Comprehensive biopsychosocial Assessment 5. Individual and group counseling 6. Individual, group, family psychotherapy 7. Peer Support Services 	<p>A clinic model that meets the certification requirement NAC 458.103 for alcohol and drug abuse programs. Room and board is not a reimbursable service through the Division of Health Care Financing and Policy (DHCFP) outpatient program.</p> <p>The entity will provide medical, psychiatric, psychological, services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed.</p>	<p>Prior authorization is required on services, except for: Behavioral Health/Substance Abuse Screens and 24 hour crisis intervention.</p> <p>Post authorization is not required for 24 hour crisis intervention.</p> <p>Intensity of service is dependent upon individual and presenting symptoms.</p>

SUBSTANCE ABUSE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Detoxification Services			
Inpatient Services			
Level 4 Medically Managed Intensive Inpatient and Withdrawal Management Services	<p>Inpatient substance abuse services are those services delivered in freestanding substance abuse treatment hospitals or general hospitals with a specialized substance abuse treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance abuse professionals and a structured multi-disciplinary clinical approach to treatment. These hospitals provide medical detoxification and treatment services for individuals suffering from acute alcohol and substance abuse conditions.</p> <p>Services provided in:</p> <ol style="list-style-type: none"> 1. An acute care general hospital with a psychiatric unit, 2. A free standing psychiatric (patients ages 22-64 are non-covered), and 3. A licensed chemical dependency specialty hospital with acute care medical and nursing staff. 	Reference 403.10.	Prior Authorization required. Reference Inpatient section 403.10.

ATTACHMENT D

POLICY #04-05	INSTITUTION FOR MENTAL DISEASE (IMD)	
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A. DESCRIPTION

Nevada Medicaid Fee-for-Service (FFS) shall not reimburse for any services for individuals who are ages 22-64 years that are in an Institution for Mental Disease (IMD). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.

B. COVERAGE AND LIMITATIONS

1. Institution for Mental Disease (IMD) Exclusion - In accordance with 42 Code of Federal Regulations (CFR) 435.1009 (2), Federal Financial Participation (FFP) is not available for Institutionalized individuals who are individuals under the age of 65 who are patients in an institution for mental diseases (IMD) unless they are under age 22, and are receiving inpatient psychiatric services under 42 CFR 440.160, which is a psychiatric hospital or a residential treatment center for recipients under the age of 21 years. See (2e) for additional clarification.
 - a. All services are excluded from Medicaid payment while a recipient is admitted to an IMD, whether the services are provided in or outside the facility.

2. In accordance with 42 CFR 435.1010: Definition of Institution of Mental Disease means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, and also provides for medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character being 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.
 - a. Facilities licensed as acute care hospitals and/or nursing facilities with designated psychiatric beds-are reviewed based upon their aggregate bed counts.
 - b. The Centers for Medicare and Medicaid Services (CMS) Manual for IMD states, alcohol and other chemical dependency syndromes are classified as mental disorders, which subject them to the IMD regulations. The manual gives further guidance that services delivered by laypersons that do not constitute a medical or remedial model such as Alcoholics Anonymous do not qualify for federal matching funds. The “major factor differentiating these facilities from other chemical dependency treatment facilities are the primary reliance on lay staff.” Chemically dependent patients admitted for CD treatment are counted as mentally ill under the 50 percent guideline.
 - c. An institution for individuals with Intellectual and Developmental Disabilities is not considered an institution for mental diseases.
 - d. Periods of Absence: Regulation allows for an individual to have a conditional release or convalescent leave from the IMD. During this time period the patient is not considered to be in the IMD. Services may be covered by Medicaid during this time period for emergency or other medical treatment. The periods of absence relate to the course of treatment of the recipients mental disorder. If the patient needs emergency or other medical treatment during

ATTACHMENT D

POLICY #04-05	INSTITUTION FOR MENTAL DISEASE (IMD)	
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this time period, these services may be covered because the patient is not considered to be in an IMD. If a patient is transferred while in the IMD for the purpose of obtaining medical treatment, it is not considered a conditional release and is not a covered service.

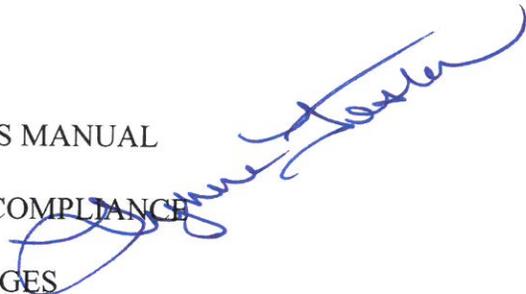
- i. Convalescent- when a patient is sent home for a trial visit.
 - ii. Conditional release - when a patient is released from the institution on the condition that the patient receives outpatient treatment or other comparable services.
- e. Coverage of services for ages 21 up to 22 years - If a patient is receiving services immediately prior to turning age 21 years the services continue until the earlier of the date the individual no longer requires the services or the date the individual reaches 22. In this extenuating circumstance IMD service may continue until age 22. The regulation requires that the patient must be receiving services immediately prior to age 21 and continuously up to age 22. Services cannot begin during the 21st year.
3. Guidelines for Determining if a facility is an IMD: The Centers for Medicare and Medicaid Services has deferred the completion of the determination if a facility is an IMD to the Division of Health Care Financing and Policy (DHCFP). The DHCFP utilizes the criteria as listed in the CMS Medicaid Manual for this determination. The criteria include factors such as, but not limited to:
- a. Facility ownership is one single owner or governing body;
 - b. The Chief Medical Officer is responsible for medical staff activities in all components;
 - c. The Chief Executive Officer is responsible for administrative activities in all components;
 - d. The licensure of each component;
 - e. The geographic location of each facility;
 - f. The Condition of Participation of each component;
 - g. The relationship to the State Mental Health Authority;
 - h. The patient records; that provide evidence of psychiatric/psychological care and treatment; and
 - i. The current need for institutionalization for more than 50 percent of all the patients in the facility is resulting from mental disease, including but not limited to the bed count.
4. Medicaid may reimburse co pays and/or deductibles for Qualified Medicare Beneficiaries (QMB) while in an IMD.

(State Medicaid Manual, Chapter 4, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>)

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 11, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 500 – Nursing Facilities



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 500 – Nursing facilities are being proposed to comply with Federal regulation at 42 CFR section 483.20. Nursing facilities must conduct Resident Assessment Instrument (referring to RAI) Minimum Data Set (referring to MDS) assessment.

The Nevada Supportive Documentation Guidelines form (referred to as NMO-6180) is being incorporated into the Medicaid Services Manual. This form includes federal MDS descriptions and categories. It also presents Nevada-specific requirements in addition to federal requirements. These more stringent standards and documentation requirements are described in the column named “Nevada Specific Requirements.”

Within the Chapter references to MDS assessments will be augmented with a reference to the Nevada Supportive Documentation Guidelines, Attachment A.

These changes are effective October 1, 2016.

MATERIAL TRANSMITTED

MTL 19/16
MSM 500 – NURSING FACILITES

MATERIAL SUPERSEDED

MTL N/A
MSM 500 – NURSING FACILITES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Attachment A	Nevada Supportive Documentation Guidelines	Added Nevada Supportive Documentation Guidelines – Minimum Data Set (MDS) 3.0, Form NMO-6180 to detail Nevada-specific requirements.

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NURSING FACILITIES

500 INTRODUCTION

Nursing Facility (NF) services for individuals age 21 and older is a mandatory Medicaid benefit. NFs are institutions that provide a full range of nursing services from intermediate care at the lower level up to and including skilled nursing services. NFs provide health related care and services on a 24-hour basis to individuals who, due to medical disorders, injuries, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. NF services include services for people who cannot live on their own because they need assistance with certain activities of daily living such as bathing, dressing, eating, toileting and transferring. NFs also provide skilled nursing care and related services for individuals who require medical or nursing care and/or rehabilitation services.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU Manual Chapter 1000.

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501 AUTHORITY

In 1965, Congress authorized the Medicaid Program by adding Title XIX to the Social Security Act. Title XIX of the Social Security Act requires that in order to receive Federal matching funds, certain basic services including Nursing Facility (NF) services for individuals age 21 and older must be offered to the categorically needy population in any State program. As an optional service, Nevada Medicaid also provides NF services for individuals under the age of 21.

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502 RESERVED

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503 POLICY

503.1 PROVIDER REQUIREMENTS

A Nursing Facility (NF) must comply with the following requirements in order to be eligible to participate in the Nevada Medicaid program. All in-state NFs must:

- a. Be licensed by the Division of Public and Behavioral Health (DPBH), Bureau of Health Care Quality and Compliance (BHCQC) in accordance with the Nevada Revised Statute (NRS) and the Nevada Administrative Code (NAC).
- b. Be certified by the Centers for Medicare and Medicaid Services (CMS) which assures that the NF meets the federal requirements for participation in Medicaid and Medicare per 42 Code of Federal Regulations (CFR) 483.
- c. Be enrolled as an NF provider in the Nevada Medicaid program as described in Chapter 100 of the Medicaid Services Manual (MSM).
- d. Accept payment in full for covered services, the amounts paid in accordance with Medicaid policy and not charge a Medicaid recipient for any services covered by Medicaid reimbursement.
- e. Assure that all claims submitted to Nevada Medicaid's fiscal agent for NF services are accurate and timely.
- f. Comply with all federal and state mandated staffing requirements in order to maintain Medicare/Medicaid certification.

Continued participation as a Nevada Medicaid provider will be subject to recertification and compliance with all Federal and State laws, rules and regulations.

Nevada Medicaid will terminate an NF provider contract upon notice that the NF is no longer licensed and/or certified to provide NF services.

Nevada Medicaid will honor, abide by and impose any and all State and Federal sanctions as directed by BHCQC and/or CMS.

Nevada Medicaid staff will refer any possible non-compliance with state and/or federal regulations to the BHCQC for investigation and follow-up.

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503.2 PROGRAM PARTICIPATION

- A. All Medicaid participating NFs must provide or arrange for services including nursing services, social services, rehabilitative services, pharmacy services, dietary services, activity programs, and emergency and routine dental services to the extent covered under the State Plan. In accordance with the federal statutory and regulatory requirements under 42 CFR 483 and the state regulations under NRS 449 and NAC 449, NFs must also provide treatment and services required by individuals with intellectual disabilities not otherwise provided or arranged for by the State, and all other ancillary and supportive services necessary to improve and/or maintain the overall health status of its residents.
- B. The NF must ensure that each Medicaid recipient is admitted to the facility by a physician and has the benefit of continuing health care under the supervision of a physician. The NF is responsible to ensure that upon admission, the physician provides to the facility sufficient information to validate the admission and develop a medical Plan of Care (POC). The POC must include diet, medications, treatments, special procedures, activities and specialized rehabilitative services, if applicable, the potential for discharge. Physician's visits must be conducted in accordance with federal requirements. Physician's visits made outside the requirements must be based upon medical necessity criteria.
- C. The NF must maintain records on each recipient in accordance with accepted professional standards and practices. Recipient records must be complete, accurately documented, organized and readily available. At a minimum, the record must contain sufficient information to identify the recipient, a record of the recipient's assessments, the POC and services ordered and provided the results of the Pre-Admission Screening and Resident Review (PASRR) screenings, the results of the Level of Care (LOC) Assessment screening, and progress notes. The record must also contain relevant documentation to support the Minimum Data Set (MDS) coding. All entries must be signed and dated with the professional title of the author.
- D. Documentation of specialized services provided or arranged for, and the resident's response to such services must remain in the active medical record as long as the resident is recommended to receive specialized services. This documentation must be available for state and federal reviewers.
- E. The facility must report their census information by midnight on the fifth day of each month. This will include the number of vacant beds in the facility which are available for resident occupancy.
- F. The facility is responsible for ensuring the census information is accurate, complete and submitted timely.

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- G. The facility must submit this report to Nevada Medicaid Central Office by the fifth day of the month reported. For example, the January 1st census information must be reported to the Nevada Medicaid Central Office by January 5th.
- H. If the number of certified beds has changed, the facility must submit a copy of the certification to Nevada Medicaid.
- I. The provider must provide for the safekeeping of personal effects, funds, and other property of the recipient. The provider must develop policies and procedures to minimize the risk of theft or loss of the personal property of residents. Recipients and their legal representatives must be notified of these policies and procedures. The NF must be adequately covered against liabilities and purchase a surety bond or otherwise provide assurance of the security of all personal funds deposited with the facility.

503.3 RECIPIENT RESPONSIBILITY

The recipient, upon request, must present:

- a. a valid Medicaid card; and
- b. any form of identification necessary to utilize other health insurance coverage for any and all services.

503.4 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

AUTHORITY

Authority to maintain a PASRR program comes from Public Law 100-203 (OBRA 87) in Subtitle C - Nursing Home Reform Part 2 - Section 1919(b3)(F); Title 42, CFR section 483.100 – 483.138; an Interagency Agreement between the Division of Health Care Financing and Policy (DHCFP) - Nevada Medicaid, the Department of Public and Behavioral Health (DPBH) and the Aging and Disability Services Division (ADSD); the Nevada State Plan, Attachment 1.2-B, page 10; NAC 449.74425 and NRS 449.037.

The DHCFP, Nevada Medicaid, is responsible for development of policies and procedures and the oversight of all operations related to the PASRR program. The DHCFP contracts with the Quality Improvement Organization (QIO)-like vendor to conduct Level I Identification screenings and PASRR Level II determinations. The DHCFP acts as the mental health/intellectual disabilities authority for PASRR's through a Memorandum of Understanding (MOU) with DPBH, and ADSD. The DPBH is designated to provide and/or follow up on all specialized services. The BHCQC monitors and investigates compliance with PASRR through the survey process.

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Compliance with all state and federal PASRR regulations is required. Non-compliance with the PASRR screening requirements may be referred to CMS and/or the BHCQC for investigation.

The provider must assure that every resident is screened in accordance with state and federal PASRR regulations.

The provider must ensure that facility staff is knowledgeable regarding the PASRR process and the implications of a facility's failure to comply with state and federal regulations. The provider must ensure staff participates in state and federal sponsored PASRR-related training.

The provider must present to state and federal reviewers the active medical record containing the applicable proof of Level I, and when indicated, Level II screenings completed prior to admission and the most recent screenings if the individual experienced a significant change in his/her physical/mental condition.

The provider must provide to state and federal reviewers, documentation supporting the provision of any specialized services for any individual identified as needing specialized services. This may include the DPBH or ADSD case manager documentation in the record.

a. DEFINITIONS

LEVEL I IDENTIFICATION SCREENING

A Level I Identification screening must be completed by a licensed health care professional on all applicants to an NF, without exception and regardless of payment source, prior to placement in a Medicaid-certified NF. The licensed health care professional completing the Level I Identification Screening form attests that the individual (or appropriate family and/or guardian) has been informed that he/she is being considered for NF placement. This screening is also required for residents of an NF any time a Level II screening is requested; such as, when a current NF resident experiences a significant change in his/her physical or mental status or a prior PASRR Level II needs to be updated. The purpose of this screening is to identify any indicators of mental illness, intellectual disabilities, or a related condition and to make referrals for PASRR Level II screenings.

The Level I determination identifies that the individual either has or does not have indicators of mental illness, intellectual disabilities, or a related condition. If there are no indicators of mental illness, intellectual disabilities, or a related condition, the individual is cleared through PASRR screening for admission to an NF. The QIO-like vendor will issue a determination letter to the requestor.

If there are indicators of mental illness, intellectual disabilities, or a related condition a determination letter is given to the requestor and the individual screened and/or their legal representative that they are being referred for a PASRR Level II screening. A PASRR

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Level II screening must be completed to determine the appropriateness of placement in an NF prior to admission to an NF.

It is the responsibility of the discharging facility to request and obtain a Level I screening, and when indicated, a PASRR Level II screening prior to discharging the individual to any NF placement.

b. LEVEL II SCREENING

When an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASRR Level II screening must be completed to evaluate the individual and determine if NF services and/or specialized services are needed and can be provided in the NF.

There are two types of PASRR Level II screenings. The Pre-Admission Screening (PAS) refers to a PASRR Level II screening completed on an applicant for NF placement. The Resident Review (RR) refers to a PASRR Level II screening completed on a current resident of an NF who experiences a significant change in his/her physical or mental condition, or had previously been exempted from or was time-limited under a prior PASRR Level II screening. Within the Level II screening, there are two processes, a categorical determination or an individual evaluation and determination.

c. PASRR LEVEL II INDIVIDUAL EVALUATION AND DETERMINATION

If a PASRR Level II Individual Evaluation and Determination screening is indicated through the Level I Identification screening process, the QIO-like vendor's clinical reviewers will make the necessary arrangements for the screening and will notify the requestor.

When the PASRR Level II screening is completed, a Summary of Findings will be provided by the QIO-like vendor to the requestor in the same manner it was requested. (i.e. If the request was faxed in, it will be faxed back, if the request was submitted online, the requester will be able to print the results when completed).

When the facility identifies a significant change in status, as defined in the Resident Assessment Instrument (RAI) User's Manual for either the mental or physical status of a resident, a Resident Review (RR) must be requested, through the submission of a Level I screening request. The QIO-like vendor will review the information and determine whether an RR is necessary. If needed, the QIO-like vendor will proceed with the arrangements for the PASRR Level II evaluation.

The provider must not admit the potential resident until the facility receives confirmation from the QIO-like vendor of the completion of Level II screening.

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If the facility admitted a resident under the Exempted Hospital Discharge, for a less than 30 day stay, and the resident is later found to require more than 30 days of NF care, the facility must request the PASRR Level II (RR) by submitting a completed Level I identification screening to the QIO-like vendor by the 25th day of the admit date.

The provider must track limitation dates on Exempted Hospital Discharges and Categorical Determinations. Before any PASRR limitation date, request the PASRR Level II (RR) by submitting a completed Level I Identification to the QIO-like vendor in a time frame that allows completion of the PASRR II prior to the limitation date.

The provider must assess all residents on an ongoing basis to identify if a resident (1) develops mental illness, or (2) a resident who was not previously identified through the Level I Identification screening as having indicators of MI, IID or RC and is now displaying indicators, or (3) the facility has identified the need for a “Significant Change in Status Assessment” (SCSA) MDS. Any of these may indicate the need for a PASRR Level II screening (RR).

Within 14 days of the identification of a significant change in status, the facility must complete and submit a Level I identification screening to the QIO-like vendor clinical reviewers. The QIO-like vendor clinical reviewers will review the information to determine if a PASRR Level II screening (RR) is indicated. The provider may accept verbal determinations from the QIO-like vendor.

The provider must not admit an individual who has been determined to not need NF services.

The provider must report all discharges directly related to a PASRR determination that an individual is not appropriate for NF services to the Medicaid office on the Nursing Facility Tracking Form.

503.5 EXEMPTED HOSPITAL DISCHARGE

The only exemption from a PASRR Level II screening is when the Level I Identification screening showing indicators of mental illness, intellectual disabilities, or related condition identifies the individual meets *all* the following criteria for an exempted hospital discharge:

- a. Is to be admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital (this does not include admissions from emergency rooms, observation beds, or rehabilitation units);
- b. Requires NF services for the condition for which he or she received care in the hospital; and

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- c. The attending physician has certified before admission to the NF that the individual is likely to require less than 30 days of NF services.

This determination will be made only by the QIO-like vendor's clinical reviewers. If a facility is requesting to admit under the Exempted Hospital Discharge, supporting proof of the above three requirements must be submitted with the Level I Identification screening form to the QIO-like vendor clinical reviewers.

1. ADVANCED GROUP CATEGORICAL DETERMINATIONS

Before proceeding with a PASRR Level II Individual Evaluation, the QIO-like vendor's clinical reviewers will determine that an individual requires NF services, and meets any one of the following criteria for an Advanced Group Categorical Determination:

- a. Convalescent Care from an acute physical illness which required hospitalization and does not meet all the criteria for an exempted hospital discharge.
- b. Terminal Illness in which a physician has certified that life expectancy is six months or less.
- c. Severity of Illness limited to: comatose, ventilator dependent, functioning at brain stem level, Chronic Obstructive Pulmonary Disease (COPD), Severe Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis (ALS), or Congestive Heart Failure (CHF). In addition to having one or more of these diagnoses, due to the severity of the illness, it is anticipated the individual is not expected to benefit from specialized services.
- d. Provisional Admission for cases of:
 - 1. delirium where an accurate diagnosis cannot be made until the delirium clears; or
 - 2. emergency situations requiring protective services with placement in the NF not to exceed seven days; or
 - 3. respite to in-home caregivers to whom individuals with MI or IID is expected to return following a brief NF stay.

If it is determined the individual meets one of the above criteria, the QIO-like vendor's clinical reviewer will make a categorical determination. If the determination is for an advanced group categorical determination, the determination effective dates may be limited and will require an updated PASRR

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Level II (RR) if the individual's stay is expected to exceed the limitation date (see below).

2. COORDINATION AND/OR PROVISION OF SPECIALIZED SERVICES

The provider must provide or arrange for the provision of specialized services when an individual has been recommended for such services through the Level II screening process.

The provider must ensure an interdisciplinary team (which includes a physician, qualified mental health professionals (which may include DPBH and ADSD staff) and other professionals) develops and supervises an individualized POC which addresses the ongoing mental health needs of the resident and results in appropriate treatment.

The provider must notify the DPBH/ADSD upon receiving any Level II screening determination that indicates an individual needs specialized services, to arrange for those services.

The provider must cooperate with DPBH/ADSD PASRR coordination staff who are providing or monitoring the provision of specialized services. DPBH/ADSD staff may contact the facility to arrange for periodic on-site visits with the resident, participate in interdisciplinary care conferences, document each on-site visit and care conference in the active medical record (indicating progress or lack of progress with the specialized services prescribed), and make recommendations for changes to the specialized services needed based on progress or lack of progress.

503.6 ADMISSIONS FROM OTHER STATES

It is the responsibility of the transferring state/facility to ensure the individual has had a Level I screening and when indicated, a PASRR Level II screening completed in the state they are transferring from, prior to sending the individual to a Nevada facility.

It is the receiving Nevada facility's responsibility to obtain a copy and verify the completion of the out-of-state screening. The receiving Nevada facility must also complete and submit a Level I Identification Screening form to the QIO-like vendor to obtain a Nevada screening within one business day of the admission.

503.7 DISCHARGES OR TRANSFERS

The provider must forward copies of the most recent Level I and, when applicable, Level II screening to the receiving facility upon discharge or transfer of a resident.

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The provider must notify the DPBH PASRR coordination staff of a discharge of any resident who has been receiving specialized services and provide them with information about where the individual is being discharged to.

503.7A REIMBURSEMENT

Federal regulation prohibits Medicaid reimbursement to NFs under certain circumstances, such as but not limited to:

1. An individual is admitted to an NF without a Level I screening. Medicaid reimbursement is not available until the date a Level I screening is completed, if there are no indications of MI, MR, or RC.
2. An individual with indicators of MI, MR or RC is admitted to an NF before the completion of the PASRR Level II evaluation; unless an Exempted Hospital Discharge has been approved through Level I process (see below). Medicaid reimbursement is not available until the date the Level II screening is completed indicating NF placement is appropriate.
3. A provider who fails to obtain a completed PASRR Level II screening by day 30 of an admission under the Exempted Hospital Discharge. Medicaid reimbursement is not available until the date of the PASRR II evaluation is completed indicating NF placement is appropriate.
4. A provider fails to obtain an RR Level II individual evaluation prior to the limitation date of a previously limited categorical determination. Medicaid reimbursement is not available until the PASRR II evaluation is completed indicating NF placement is appropriate.
5. A provider fails to request a Nevada screening with one business day of admission when a resident is admitted to a Nevada NF from out-of-state. No Medicaid reimbursement is available until the date the Nevada Level I and, when indicated, the Level II is completed.
6. For individuals who have been determined, through the PASRR process, to not need the services of an NF.

503.7B PASRR HEARINGS

In accordance with 42 CFR 483.204 Subpart E, an individual who has been adversely affected by any PASRR determination made by the State in the context of either an PAS or an RR, has the right to appeal that determination.

Please reference Nevada MSM Chapter 3100, for Medicaid recipient hearing policy.

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503.8 LEVEL OF CARE (LOC)

If the individual is Medicaid eligible, an LOC screening must be completed prior to NF admission. This includes individuals utilizing other insurance as a primary pay source at the time of admission.

If the recipient becomes Medicaid eligible after NF admission, the LOC screening must be completed prior to obtaining a billing authorization for Medicaid reimbursement.

If an individual becomes Medicaid eligible after death or discharge from an NF, the LOC screening may be requested and determined retroactively.

The requestor must submit an LOC screening form with the required documentation to the QIO-like vendor. An LOC determination must be completed by the QIO-like vendor. The NF must receive a copy of the screening indicating the Medicaid eligible individual has a nursing facility level of care prior to admission.

LOC determinations may be time-limited. Reasons for time limitations may include, but are not limited to: total hip or knee replacement, compound fracture, pneumonia, or recent wound care. These determinations may be limited to 90 days. The provider must monitor LOC determinations that are time-limited and request an updated LOC determination prior to the expiration date.

It is the NF's responsibility to verify an LOC determination has been made and the recipient meets an NF LOC. The NF may contact the QIO-like vendor to obtain verification of the determination and a copy of the determination letter.

The provider must request an updated LOC determination if a recipient's condition changes significantly. For example, if a recipient who was previously determined to meet an NF Standard or Pediatric Specialty Care I later becomes ventilator dependent, the NF must request a new LOC determination to establish Ventilator Dependent or Pediatric Specialty Care II. Conversely, if a recipient's condition improves and the recipient was previously determined to meet a Pediatric Specialty Care II, the NF must request a new determination to establish the appropriate LOC.

If it is later discovered that the recipient's condition warranted an updated screening and the facility failed to obtain the determination, the fiscal agent may recoup funds paid to the facility inappropriately.

In the event a recipient is discharged to a community based setting and is later readmitted to the NF, the NF must contact the QIO-like vendor screening office to determine whether the LOC determination is still valid (based on the recipient's current condition), or if a new LOC determination is needed.

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When a recipient does not meet a nursing facility LOC and an NF chooses to admit the recipient, Medicaid reimbursement will not be authorized for that NF.

On initial and subsequent screenings, the QIO-like vendor determines whether the LOC provided or to be provided should be approved based on medical necessity. There are four possible LOC categories based on the care needs and nursing requirements for each individual as determined by the LOC assessment. These include:

- a. NF Standard;
- b. NF Ventilator Dependent;
- c. Pediatric Specialty Care I; and
- d. Pediatric Specialty Care II.

Each of these categories is associated with a provider specific rate for each free-standing NF.

After an LOC has been established, the NF may also request approval the Behaviorally Complex Care Program; which also has associated rates.

NF Ventilator Dependent is limited to recipients who are dependent on mechanical ventilation for a minimum of six out of the 24 hours per day and is an all-inclusive rate. NF and respiratory therapists are not allowed to bill separately for ventilator management services, small volume nebulizer treatments, tracheostomy changes, etc.

NF Ventilator Dependent Rate: a physician's order specifying the ventilator support must accompany the screening request. Current medical records must verify that the ventilator support is required for a minimum of six hours within a 24 hour period. The medical records must also include the date the recipient was placed on the ventilator.

503.9 PEDIATRIC SPECIALTY CARE

Pediatric Specialty Care I and II are limited to recipients who are children from birth to 21 years of age who require specialized, intensive, licensed skilled nursing care beyond the scope of services provided to the majority of NF recipients.

The QIO-like vendor must determine the recipient meets both an NF LOC as well as a Pediatric Specialty Care LOC prior to authorization. Pediatric Specialty Care rates are approved for a maximum of six months but may be extended with an updated LOC screening and supporting documentation. If a new authorization is not obtained prior to expiration of the previous specialty care authorization, the NF will be reimbursed at the NF standard rate until such time a new pediatric specialty care LOC is determined.

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Documentation must be submitted with request to support all treatment and services listed above. Time limited treatments may be authorized up to 90 days. Requests for extension may be granted with supporting documentation.

503.9A PEDIATRIC SPECIALTY CARE I:

The patient's condition requires 24 hour access to nursing care by a Registered Nurse (RN) and the recipient has one or more of the following items (a-c): (a) A tracheostomy that requires suctioning, mist or oxygen and at least one treatment listed in the treatment procedures section below; (b) dependence on Total Parenteral Nutrition (TPN) or other Intravenous (IV) nutritional support and at least one treatment listed in the treatment procedure section below; (c) administration of at least two treatment procedures below. See Treatment Procedures below.

503.9B PEDIATRIC SPECIALTY CARE II

The patient's condition requires 24 hour access to nursing care by an RN and the recipient has one or more of the following items (a-c): (a) A tracheostomy that requires mechanical ventilation a minimum of six hours out of 24 hours per day; (b) patient is on a ventilator weaning program (approval will be time limited); (c) administration of at least three treatment procedures below.

503.9C TREATMENT PROCEDURES

1. Intermittent suctioning at least every eight hours and mist or oxygen as needed;
2. Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy);
3. IV therapy involving:
 - a. Administration of continuous therapeutic agents; or
 - b. Hydration; or
 - c. Intermittent IV drug administration of more than one agent.
4. Peritoneal dialysis treatments requiring at least four exchanges every 24 hours.
5. Tube utilization (nasogastric or gastrostomy; Foley, intermittent catheterization; PEG, rectal tube).
6. Complex wound care (including stage III or IV decubitous wound or recent surgical or other recent wound) requiring extensive dressing or packing approval will be time limited).

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7. Seizure precautions.
8. Moderate behavior issues (including self-abuse) – describe the problem.
9. Central or Peripherally Inserted Central Catheter (PICC) line management.
10. Maximum assist required (quadriplegia or Hoyer lift).
11. Other special treatment(s) not listed above. The provider must describe in detail.

Provider Qualifications for Pediatric Specialty Care Rates:

In addition to Medicaid contractual obligations and all other provider rules contained in MSM Chapters 100 and 500, a free-standing NF must meet specified criteria to qualify for Pediatric Specialty Care rates. An on-site visit by the DHCFP staff is made to verify the NF meets the following criteria:

12. Physical facility requirements:
 - a. Pediatric Specialty Care must be provided in a distinct, identifiable unit or area of the NF.
 - b. The accommodating beds include contiguous rooms, wing, floor, or building of the NF.
13. Staffing Requirements:
 - a. The NF must employ an RN as the Pediatric Specialty Care Unit’s head nurse. The head nurse must have specialized pediatric training and at least one year’s experience in pediatric nursing.
 - b. The NF must ensure that an RN with pediatric training and experience is on duty 24 hours per day on the Pediatric Specialty Care Unit.

503.10 BEHAVIORALLY COMPLEX CARE PROGRAM

The Behaviorally Complex Care Program (BCCP) is for those Nevada Medicaid recipients with a severe, medically-based behavior disorder. Medically-based disorders may include (not all inclusive) traumatic/acquired brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgment, or a resident, who meets the Medicaid criteria for nursing facility level of care and who has a medically-based mental health disorder or diagnosis and exhibits significant behaviors. Those facilities that request and are approved to administer the

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BCCP are reimbursed with a tiered rate established with the intention of providing in-state care that addresses the recipient's needs.

Nursing Facilities must demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff as documented by one or more of the following behaviors:

- a. The resident engages in verbally abusive behavior where he threatens, screams or curses at others;
- b. The resident presents a threat of hitting, shoving, scratching, or sexually abusing other residents.
- c. The resident engages in socially inappropriate and disruptive behavior by doing of one of the following:
 - (i) Makes disruptive sounds, noises and screams;
 - (ii) Engages in self-abuse acts;
 - (iii) Inappropriate sexual behavior;
 - (iv) Disrobes in public;
 - (v) Smears or throws food or feces;
 - (vi) Hoards; and
 - (vii) Rummages through others belongings.
- d. The resident refuses assistance with medication administration or activities of daily living.

Presence of elopement or wandering behaviors alone, not in conjunction with aggressive or assaultive behaviors exhibiting a danger to self or others, does not qualify a recipient for the BCCP. The BCCP is not appropriate for those caring for suicidal individuals. Individuals who are suicidal should be transferred to an acute facility to ensure their safety and appropriate LOC. The BCCP may be requested while the recipient is in an acute placement if there is sufficient documentation to the support a medically based behavior disorder.

503.10A PROVIDER RESPONSIBILITY

Facilities must demonstrate competency to adequately address the individual's behavior. All behavior intervention programs must:

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1. Be part of an individualized behavior modification plan;
2. Apply a precisely planned systematic application of the methods and findings of behavioral science with the intent to reduce observable negative behaviors;
3. Incorporate processes and methodologies that are the least restrictive alternatives available for producing the desired outcomes;
4. Be conducted following only identification and, if feasible, remediation of environmental and social factors that likely precipitate or reinforce the inappropriate behavior;
5. Incorporate a process for identifying and reinforcing a desirable replacement behavior.

Behavior modification programs include, but are not limited to:

1. Staff Training
2. Sensory Stimulation
3. Behavior Management
4. Cognitive Emotion Oriented Therapy
5. Environmental Modification
6. Clinically-Oriented Therapy

Documentation supporting the service need must be provided to the Facilities Unit in DHCFP Long Term Support Services (LTSS) by a person professionally qualified in the field of psychiatric mental health as defined in NRS 433.209 and clearly document the severe medically based behavior disorder or other medical condition prompting the approval of the BCCP.

Tiered rates have been established to cover the broad milieu of accommodations to meet patient needs. Behaviors and their frequency of occurrence will assist in establishing/requesting the appropriate Tier Level. The following is a guide for requesting:

- Tier 1: Behaviors requiring a minimal amount of intervention or assistance.
- Tier 2: Serious behaviors requiring moderate intervention.
- Tier 3: Extreme behaviors exhibiting danger to themselves or others requiring frequent intervention.

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The BCCP care level requires prior authorization. If approved, reauthorization will be required. Reauthorization timeframes are based on the approved tier. Refer to the Billing Guidelines for frequency of reauthorization. In addition, facilities are also required to report to the DHCFP, any change in recipient condition or Tier.

The requested tier will be evaluated based on the frequency and degree of the behaviors exhibited utilizing the Behaviorally Complex Care Program Evaluation Tool. The behaviors must be categorized as follows:

- Always** the recipient always (daily) requires intervention for behaviors.
- Usually** the recipient requires interventions four or more days per week.
- Usually Not** the recipient requires interventions, but fewer than four days a week.
- Never** the recipient does not have behaviors that require interventions.

Each response has a weighted value that must be supported by the medical evidence submitted. Always = 3; Usually = 2; Usually Not = 1; Never = 0 Maximum weighted value =18

- Tier I 3 to 7 points
- Tier II 8 to 13 points
- Tier III 14 to 18 points

Facilities may request the BCCP by submitting NMO-7079 and supporting documentation to the DHCFP. Supporting documentation may include: the face sheet, medication administration records (MAR), primary care provider progress notes, psychiatric notes and/or group therapy note, nurses notes, behavioral plan, care plan, behavior monitor logs, interdisciplinary team notes, behavior management team review, and sleep logs. Absence of the listed documentation does not disqualify approval of the BCCP; the DHCFP staff in the LTSS Facilities Unit or the DHCFP QIO-like vendor will review all materials submitted to determine whether there is sufficient medical documentation and justification for the BCCP. After review, the facility and recipient will receive a Notice of Decision (NOD). The NOD may indicate that:

1. The request is approved at the tier requested;
2. The request is approved for a higher tier than requested;
3. The request is approved for a lower tier than requested; or
4. The request is denied.

Should the BCCP not be approved, the NF will receive the base rate for the applicable quarter. The BCCP care level is determined independently of any NF LOC.

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503.10B HEARINGS FOR BCCP

Upon receipt of the BCCP NOD, facilities or recipients may ask the DHCFP to perform a re-review of the original request. The re-review must be based on information and/or documentation not submitted with the original request. Should the facility not agree with the re-review, a fair hearing may be requested per MSM Chapter 3100.

503.11 NURSING FACILITY TRACKING FORM

Before an NF can receive reimbursement for services rendered for a Nevada Medicaid recipient, the facility must submit a Nursing Facility Tracking Form in order to receive authorization to bill. The purpose of this form is to notify the Medicaid Central Office of any admission, service level change, discharge or death for all Medicaid eligible recipients and to initiate and/or update the system with necessary information prior to billing.

A Nursing Facility Billing Authorization Letter that indicates specific billing days will be sent to the Nursing Facility. Upon receipt of this letter, the facility may submit a billing claim form to the fiscal agent for payment. If it is later discovered that the billing authorization was made in error, the provider will be subject to recoupment for claims submitted and paid in error. Receipt of a Billing Authorization Letter does not guarantee payment.

The facility must review all information on the Nursing Facility Billing Authorization Letter to verify it contains the correct information. If discrepancies are noted, contact the Medicaid office immediately to avoid delayed payment. If more than 30 days have elapsed since the tracking form submission and the facility has not received a Nursing Facility Billing Authorization Letter or been contacted by Medicaid staff, contact the Nevada Medicaid office.

The facility must submit the Nursing Facility Tracking Form to the Nevada Medicaid Central Office upon each occurrence for Medicaid eligible individuals:

- a. Any admission;
- b. Service level update and/or change;
- c. New or retro-eligibility determinations;
- d. Medicaid Managed Care disenrollment;
- e. Hospice enrollment or disenrollment; or
- f. Discharge or death.

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If the resident becomes eligible after admission, the tracking form must be submitted upon notification of the eligibility determination.

Failure of the facility to submit the tracking form may result in payment delays or denials. This form may be accessed on the DHCFP website at <http://www.dhcfp.nv.gov>, which includes completion and submission instructions. The facility should retain a copy for their records.

Billing authorizations become invalid immediately upon discharge from the facility, death, service level change, enrollment to Hospice coverage, or if the recipient becomes ineligible for Medicaid. Nevada Medicaid does not reimburse NFs for the date of discharge or date of death.

503.11A PROVIDER RESPONSIBILITY

The facility must determine if the recipient has other resources including other insurance coverage for any and all services and supplies.

It is the facility's responsibility to verify the recipient's eligibility status monthly by accessing the Eligibility Verification System (EVS). Refer to MSM Chapter 100 regarding eligibility information.

If eligibility is determined for prior months (for service dates prior to the existing billing authorization), the facility must submit another tracking form indicating the eligibility has been determined retroactively. This will initiate another billing authorization for those service dates.

503.12 THERAPEUTIC LEAVE OF ABSENCES

503.12A COVERAGE AND LIMITATIONS

NFs will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of the unused leave days may be carried over into the next calendar year. The facility must maintain accurate leave day records on the recipient's chart, for review by Medicaid staff.

A therapeutic leave must include therapeutic or rehabilitative home and community visits with relatives and friends. Therapeutic leave also includes leave used in preparation for discharge to community living. Therapeutic leave days are considered overnight stays. Therapeutic leave does not apply when a recipient 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.

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The absence of a Medicaid recipient from the facility for the purpose of therapeutic leave must be authorized in writing by the recipient’s attending physician and included in the recipient’s plan of care.

In those instances where a Medicaid recipient resides in more than one NF within a calendar year, the receiving facility must determine the number of therapeutic leave days that have been exhausted by the sending facility within the same calendar year. A record of any leave days must be a part of the information provided to the receiving facility as part of the transfer documents.

Therapeutic leave days must be authorized by the physician for specific dates. If a recipient fails to return to the facility within the specified timeframe, Medicaid reimbursement is not available for dates beyond the physician’s order.

Each therapeutic leave of absence must be authorized by the attending physician’s order to ensure the recipient is medically stable and capable of safely tolerating the absence.

The physicians order should specify:

1. The dates the recipient will be out of the facility;
2. Authorize the facility to send necessary medications; and
3. Provide instructions for the family member/friend on how and when to administer the medications.

A physician’s order such as “may go out on pass” is not acceptable for this purpose. The NF must provide care instructions for the responsible person who will be accompanying the recipient during their therapeutic leave of absence.

The NF must reserve and hold the same room and bed for the Medicaid recipient on a therapeutic leave. The bed may not be occupied by another individual during the period of time in which the Medicaid recipient is on such leave.

When billing for therapeutic leave of absence days, revenue code 183 is used on the billing claim form. See Provider Billing Manual for specific instructions.

The recipient is responsible to abide by the physician’s order and to return to the facility by the date authorized by the physician’s order. The recipient must contact the facility to advise them of any change in the plan regarding therapeutic leave.

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503.13 PATIENT INCOME CHANGES AND PATIENT LIABILITY (PL)

503.13A COVERAGE AND LIMITATIONS

Patient Liability (PL) is determined by the Division of Welfare and Supportive Services (DWSS). The regulations at 42 CFR 435.725 require that the State (Nevada Medicaid) reduce its payment to the NF by the amount of the PL. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made. PL will also be applied to subsequent claims submitted by providers entitled to PL until monthly obligations are fulfilled.

503.13B PROVIDER RESPONSIBILITY

An NF must notify DWSS immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the NF.

DWSS is responsible for determining the amount of PL the resident is responsible for.

When PL is established or changes, the recipient, facility and the fiscal agent are notified of the amount and effective date. Collection of PL is the facility's responsibility and should be done on a monthly basis. If an NF receives a notice adjusting the amount of the PL and the facility has billed and received reimbursement for services, the facility must send a corrected claim to the fiscal agent to receive the appropriate adjustment within 60 days of the notice.

No PL is to be taken during the first 20 days of a Medicare covered stay. Medicaid reimbursement will be reduced by the PL amount for all claims including Medicare co-insurance days 21-100 if applicable. PL is also applied to all other Third Party Liability (TPL) co-insurance claims.

When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by DWSS and a notice is sent regarding the PL adjustment. The NF must refund any remaining balance to the recipient or their legal representative as required.

If a Medicaid recipient is transferred during a month from any provider entitled to collect PL, the discharging provider collects the total PL amount up to billed charges. The balance of the established PL must be transferred with the recipient at the time of transfer. The transferring and receiving providers are responsible for negotiating the collection of PL.

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503.14 PERSONAL TRUST FUND MANAGEMENT

503.14A COVERAGE AND LIMITATIONS

An NF resident has the right to manage his or her financial affairs. An NF may manage resident's funds upon written authorization from the resident.

503.14B MANAGING RESIDENT FUNDS

NFs must have a system for managing residents' funds that, at a minimum, fully complies with the requirements established by Federal law and State regulations.

An NF may not require residents to deposit their personal funds with the NF. The facility must obtain prior written authorization from the recipient prior to the facility assuming management from the resident.

A recipient's personal funds may not be commingled with the NF funds or with the funds of another person. A recipient's personal funds that do not exceed \$50 may be maintained in a non-interest bearing account, interest bearing account or petty cash fund. If a recipient has funds in excess of \$50, these monies must be maintained in an interest bearing account in a local bank insured by the Federal Deposit Insurance Corporation (FDIC). Interest earned must be credited to the recipient's account. The NF must notify each recipient when the amount in the recipient's personal fund account reaches \$200 less than the Supplemental Security Income (SSI) resource limit for one person.

A recipient's personal needs money is for the exclusive use of the recipient, as desired. The recipient's personal funds must not be used to purchase items covered by Medicaid either directly or indirectly as part of the facility's daily rate including nursing services, dietary services, room/bed maintenance, routine personal hygiene items (hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry) or medically related services. However, should a resident request a certain brand or product type, not otherwise supplied, the recipient's personal needs money may be used to purchase those items.

Upon a recipient's request, specialty items not covered by Medicaid may be purchased for the recipient. Allowable expenditures are outlined in 42 CFR§ 483.10 but may include a personal telephone, television, personal comfort items, personal clothing, reading material, gifts purchased on behalf of the recipient, flowers and plants, and decorative items. The facility must not require a recipient (or his or her representative) to request any item or service as a condition of admission or continued stay. In addition, the facility must obtain written authorization from the recipient that

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states what the charge will be. In the event the recipient is unable to sign, the NF must obtain two signatures from NF staff and accurate accounting records must be kept accounting for each purchase.

Statements regarding a recipient's financial record must be available upon request to the recipient or to the recipient's legal representative.

Within 30 days of the death of a recipient, the NF must convey the recipient's funds and a final accounting of those funds to the individual or probate jurisdiction administering the recipient's estate.

503.14C PERSONAL FUND AUDITS

The Division or its representative will periodically audit recipients' personal trust funds to assure federal and state laws, regulations and Medicaid policies are met.

If, as a result of an audit, discrepancies are identified and reported, the facility must submit a plan of corrective action within 30 days of the report of findings to the auditing agency.

If discrepancies are found at audit, the NF must make restitution to the recipient's funds improperly handled, accounted for or dispersed.

A report of the audit findings may be sent to BHCQC and the Medicaid Fraud Control Unit (MFCU), for follow-up regarding potential deficiencies related to state or federal regulations.

Misuse of residents' monies is subject to prosecution under the NRS.

503.14D RECIPIENT RESPONSIBILITY

The recipient has the choice to either manage their own personal funds, or to request that the facility manage their personal funds. If the recipient desires the facility to manage their personal funds, the recipient must provide the facility with written authorization to do so.

Medicaid recipients may choose to spend their personal funds on items of personal care such as professional beauty or barber services or specialty items not covered by Medicaid. In this instance, the recipient must authorize payment for the specialty items in writing.

503.15 TRANSPORTATION

503.15A COVERAGE AND LIMITATIONS

NFs are responsible for ensuring that all recipients receive appropriate medical care and related services.

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It is the responsibility of the NF to provide non-emergency transportation (NET) for Medicaid recipients for all off-site medical and dental appointments and other medically necessary services after admission and prior to discharge. Medically necessary non-emergency transportation costs are included in the NF's rate structure. The NF does not have to provide NET back to the facility after a hospital admission/discharge.

When a recipient is being admitted to an out-of-state NF, the discharging facility must contact the DHCFP Out-of-State Coordinator for authorization prior to the admission.

Refer to MSM Chapter 1900, for transportation policies.

503.16 ROUTINE SERVICES AND SUPPLIES

503.16A COVERAGE AND LIMITATIONS

Routine services and supplies are included in per diem rates. Routine NF services include regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen, the use of equipment and facilities, and other routine services. Examples of routine services and supplies include, but are not limited to:

1. All general nursing services including: the administration of oxygen and related medications; the collection of all laboratory specimens as ordered by a physician such as blood and urine; injections; hand feeding; incontinency care; normal personal hygiene which includes bathing, skin care, hair care or nail care (excluding professional barber and beauty services), shaving, oral hygiene, enemas, etc.
2. Social work services and activity programs: NF staff will provide these services as necessary in order to carry out the plan of care for the Medicaid recipients.
3. Maintenance therapy programs: facility staff will assist the Medicaid recipients as necessary under the guidelines of the recipient's restorative therapy program. Programs are intended to maintain and/or restore specific function(s).
4. Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins, bedpans, etc.
5. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually such as alcohol, applicators, cotton balls, band aids, disposable gloves, incontinency care products including disposable diapers, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, IV equipment, T.E.D. (antiembolism) stockings, hydrogen peroxide, over the counter enemas, tests (Clinitest, Testape, Ketostix, Accu-chek), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or

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specialized cleansing agents, razor, shaving cream, denture adhesive, dental floss, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, sanitary napkins and related supplies, etc).

6. Items which are used by individual residents but which are reusable and expected to be available, such as canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, Intermittent Positive Pressure Breathing (IPPB) machine, electric nebulizers, other durable medical equipment, oxygen concentrators, ventilators, etc.
7. Laundry services, including personal clothing.

503.16B ITEMS INCLUDED IN THE PEDIATRIC SPECIALTY CARE RATE

All services, durable medical equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria including, but not limited to respiratory services, tracheostomy and related services; developmental services, nutritional services, ambulatory aids, support surfaces, and bathing/toiletry services.

Oxygen, and all related equipment and supplies necessary for administration including positive and negative pressure apparatus.

This includes all oxygen therapy equipment, i.e., oxygen-conserving devices (oxymizer and nebulizer (pulmoaide); respiratory equipment, supplies, and services; respiratory therapy; tracheostomy and related services; ventilators, including humidifiers, in-line condensers, in-line temperature measuring devices, and calibration and maintenance services.

1. Feeding pumps and equipment and services necessary for tube feedings.
2. Tracheostomy speaking valves.
3. Equipment and supplies for continuous IV therapy.
4. Ambulatory assistance equipment, supplies and services, including but not limited to canes and wheelchairs.
5. Support surfaces, equipment, supplies and services, i.e., alternating pressure pads, wheelchair cushions, and gel pressure and air fluidized mattresses.
6. Bathing/toileting assistance equipment, supplies, and services, commodes, lifts.
7. Developmental services.

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8. Physical, occupational and speech therapies provided within a supportive or maintenance program.

503.16C PROVIDER RESPONSIBILITY

The NF must provide routine services and supplies and not charge the Medicaid recipient or Nevada Medicaid for these services.

The NF must not charge the Medicaid recipient for any item or service not requested by the recipient.

The facility must inform the Medicaid recipient (or his/her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and the amount of the charge.

503.17 SERVICES AND SUPPLIES NOT INCLUDED IN PER DIEM RATES

503.17A COVERAGE AND LIMITATIONS

Certain services and supplies are not considered part of the NF's Medicaid per diem rate. Payment for these services and supplies may be made to non-NF providers when the criteria for coverage as outlined in the appropriate MSM is met. The provider of the service or supply may be required to obtain prior authorization. Reference MSM Chapter 1200 for Pharmacy Services and MSM Chapter 1300 for DME and Supplies.

Items not included in the Medicaid per diem rate include:

1. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.
2. Nutritional supplements in conjunction with tube feedings.
3. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.
4. Non-standard wheelchairs including power-operated vehicles, wheelchair seating systems, including certain pressure reducing wheelchair cushions needed for the Medicaid recipient's permanent and full time use, etc.
5. Air fluidized bed units and low air loss bed units.
6. Emergency transportation.

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7. Physical, Occupational and Speech therapy services.
8. Physician services.
9. Laboratory, portable x-ray and other diagnostic services.
10. Repair of medical equipment and appliances which belong to the recipient.

503.17B PROVIDER RESPONSIBILITY

1. Non-NF providers must reference the appropriate MSM for specific coverage and limitation policies related to the services and supplies not included in the NF per diem. Providers must abide by the associated rules and prior authorization guidelines before providing an item or service to a recipient.
2. Provider must check for a valid Medicaid card and question the recipient/legal representative about other insurance coverage.

503.17C RECIPIENT RESPONSIBILITY

1. Furnish providers with any forms of identification necessary to utilize other health insurance coverage for any and all services and supplies.
2. Provide written authorization to the provider and NF if purchasing services and supplies not covered in the per diem.

503.17D AUTHORIZATION PROCESS

Refer to the appropriate chapter of the MSM for the authorization processes related to specific services and supplies.

503.18 DISCHARGE REQUIREMENTS

The NF must notify the Nevada Medicaid Central Office of a Medicaid recipient's discharge or death by sending the Nursing Facility Tracking form.

The NF must provide copies of the recipient's medical record to those responsible for post-discharge care including a copy of his or her Advance Directive (AD) (declaration/living will and/or durable power of health care decision).

Facility to facility transfer: To transfer any Medicaid recipient from one facility to another, the transferring facility must:

- a. Obtain the physician's written order for transfer;

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- b. Obtain written consent from the recipient, his/her family and/or guardian;
- c. Notify the Medicaid Central Office of the transfer by sending the Nevada Medicaid Nursing Facility Tracking form;
- d. Transfer necessary medical/social/LOC/PASRR information to the receiving facility;
- e. The discharging facility collects the total PL amount up to billed charges. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made and the balance of the collected PL must be transferred to the receiving NF with the recipient at the time of transfer;
- f. Document the transfer in the recipient’s medical record.

The admitting facility must submit the NF Tracking form to the Nevada Medicaid Central Office upon admission.

If it is determined that a Medicaid recipient no longer meets a nursing facility LOC, the facility will be notified and must facilitate discharge planning and promote appropriate placement. Should the discharge planner need further assistance, a referral can be made to the FOCIS program. Program staff can be reached through the DHCFP District Offices. If an NF intends to discharge a resident, they must provide to the resident/legal representative with a 30 day written notice and include the name and address of the person to whom the resident/legal representative may appeal the discharge.

503.19 FREE-STANDING NURSING FACILITY – RUG CASE MIX

The MDS/Resource Utilization Groups (RUG), system is used to classify residents and objectively determine a free-standing NF’s Case Mix Index (CMI). The RUG classification system was developed by the CMS and is the basis for resident classification for the Medicare prospective payment system and numerous other states’ Medicaid systems. Nevada uses the 34-group version that collapses the special rehabilitation category into four groups. CMS recommends this version for use with Medicaid NF resident populations. CMS has also developed standard CMI indices which will be the basis for calculating the average CMI, or score, for each NF under Nevada’s case-mix system.

Free-standing NFs are reimbursed according to a price-based system. Individual facility rates are developed from prices established from three separate cost centers: operating, direct health care and capital. The direct health care component utilizes each facility’s CMI which is calculated four times per year for residents in the facility on the first day of each calendar quarter (called the “picture date”).

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Refer to MSM Chapter 700, Rates, for detailed information regarding free-standing NF reimbursement.

503.19A PROVIDER RESPONSIBILITY

The provider must assure that each resident's assessment data is complete and accurate in accordance with federal regulations and the *CMS Resident Assessment Instrument (RAI) Users' Manual*.

Comprehensive assessments, quarterly assessments, significant change assessments and annual assessments using the MDS current version must be conducted in accordance with the requirements and frequency schedule found at 42 CFR Section 483.20.

The provider must assure that the Occupancy Report is accurate and submitted within the specified time limit every month.

503.20 FREE-STANDING NURSING FACILITY CASE MIX AND MDS VERIFICATION REVIEW DESCRIPTION

Nevada Medicaid reimburses free-standing NFs based on the facility's overall CMI identified from the MDS. RUG items are identified on the MDS and used to establish each facility's CMI. In order to validate that Medicaid reimbursement to NFs is accurate and appropriate, a periodic review of MDS coding and corresponding medical record documentation is conducted to verify the information submitted on the MDS to the national repository accurately reflects the care required by, and provided to residents.

503.20A COVERAGE AND LIMITATIONS

RNs from Medicaid District Offices conduct Case Mix and MDS Verification reviews at every free-standing Medicaid certified NF at least annually. The review consists of a comparison of medical record documentation and the coding reported on the MDS, specifically the RUG items coded with a positive response. On-site resident reviews may also be conducted to verify documentation and/or information coded on the MDS.

Facilities may be reviewed more frequently when the facility's error rate is greater than 40%, or when any significant increase in errors is identified.

Prior to the review, a sampling of residents is determined using the most recently submitted MDS data and resident listing information. The sampling is selected based on the RUG category of each resident.

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NFs are contacted by the lead nurse approximately one week prior to a scheduled review. Upon notification of an upcoming review, facilities are required to provide a current, accurate census of all residents regardless of their payment source.

A brief entrance meeting is conducted upon the review team's arrival at the facility. The administrator or their designated representative, director of nurses and MDS staff are expected participants in the entrance meeting. Other staff may participate as deemed appropriate by the facility administrator and the lead nurse.

During the review, as questions arise, reviewers will work with facility staff (primarily the MDS Coordinator) to obtain clarification and assistance in locating documentation which supports the reported codes on the MDSs. At this time, review staff may also provide one-to-one training to facility staff.

Upon completion of the record reviews, review staff will conduct a brief exit meeting to discuss the findings of the team. A copy of the findings showing the percentage and types of errors identified will be given to the administrator or their designated representative.

If it is identified that a facility coded an MDS inaccurately, which resulted in the provider being paid more monies than a correctly-coded MDS would have allowed, Medicaid may require the facility to submit a corrected MDS to the national repository. Additionally, Medicaid may recoup monies paid inappropriately.

503.20B PROVIDER RESPONSIBILITY

1. The provider must possess thorough knowledge of the RAI process including the MDS, Resident Assessment Protocols (RAPs) and Care Plans.
2. The provider must maintain current knowledge of the federal MDS Utilization Guidelines.
3. The provider must maintain current knowledge of the Nevada Medicaid Documentation Guidelines which may be obtained by accessing the DHCFP website at: <http://www.dhcfp.nv.gov>.
4. The provider must promptly provide information requested by the review team.
5. The provider must make certain the appropriate staff attends the entrance and exit meetings.
6. The provider must prepare in advance and provide to review staff at the beginning of the entrance meeting:

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- a. copies of the selected MDS' (containing the attestation statement and completion signatures of staff) which review staff will use during the review and keep as a permanent part of the facility's review packet;
 - b. the active medical records selected for review; and
 - c. thinned/purged files and records maintained by the facility in various workbooks which contain information that supports the coding of the MDS.
7. Facility staff responsible for the MDS must be available to Medicaid review staff during the review process.
 8. The provider must analyze the error reports with the appropriate facility staff responsible for coding the MDS.
 9. The provider must identify and make corrections to processes that contribute to inaccurate MDS coding and maintain documentation supporting the current MDS in the active medical record.
 10. The provider must anticipate and prepare for more frequent reviews when the facility's error rate is 40% or higher, or when any significant increase in errors occurs.

503.21 HOSPITAL-BASED NURSING FACILITY

503.21A COVERAGE AND LIMITATIONS

All policies described in this chapter apply to hospital-based NFs with the exception of those specifically identified for free-standing NFs.

Hospital-based NFs are paid under Medicare reasonable cost-based reimbursement principles including the routine cost limitation, and the lesser of cost or charges. Payment will follow any and all applicable Medicare upper payment limitation requirements such that payments will not exceed the upper payment limitation. The routine cost limit is applied at the time of cost settlement. Each facility will receive interim payments of the lower of 1) billed charges; or 2) an interim payment percentage that is the ratio of costs to charges from the facilities most recently audited cost report.

Refer to the MSM Chapter 700, Rates, for specific details related to hospital-based NF reimbursement.

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503.21B PROVIDER RESPONSIBILITY

The hospital-based NF charges for services provided to Medicaid recipients should not exceed the provider's customary charges to the general public for these services. Hospital-based NFs may bill for ancillary services in addition to room and board.

The provider must assure that each claim submitted to the Nevada Medicaid's fiscal agent for NF services is accurate and timely.

Refer to the Provider Billing Manual for specific billing instructions.

503.22 OUT-OF-STATE NURSING FACILITY PLACEMENT

To request approval for out-of-state placement, the in-state provider, such as a hospital or nursing facility, completes the questionnaire identified as Out-of-State Questionnaire and submits the following documentation to Nevada Medicaid, Out-of-State Coordinator:

- a. Documentation supporting that all the appropriate NFs in Nevada were contacted for in-state placement and placement was denied. The documentation should include the reasons Nevada NFs denied admission.
- b. If the recipient was denied admission to in-state NFs due to severe behavior symptoms, a current psychosocial narrative is required.
- c. A PASRR screening indicating NF placement is appropriate.
- d. LOC screening indicating the recipient meets NF placement criteria.
- e. Written statement from the recipient (recipient's family/guardian) concurring with out-of-state placement, indication of who will be responsible for making health care decisions on the recipient's behalf, and that the recipient's (recipient's family/guardian) acknowledge that Medicaid benefits end with death.
- f. The written statement must also include the understanding that burial and funeral arrangements must be made outside of Medicaid intervention. Documentation to show that every effort was made to purchase/obtain a burial policy if the individual does not have funeral or burial coverage.

1. OUT-OF-STATE NURSING FACILITY

The out-of-state NF must be enrolled as a Nevada Medicaid provider.

- a. Admission/Discharge:

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The out-of-state provider must adhere to Nevada Medicaid’s in-state pre-admission, admission and discharge policies as described in this chapter.

b. Eligibility:

Verification of Medicaid eligibility is the provider’s responsibility. Eligibility should initially be verified by validating the recipient’s Medicaid card. Thereafter, eligibility should be verified monthly by utilizing EVS.

The facility is not required to submit the Nursing Facility Tracking Form until the eligibility determination is issued; however, the out-of-state provider should contact the Nevada Medicaid Central Office, Out-of-State Coordinator, when an individual is admitted with a pay source other than Nevada Medicaid, but an application for Nevada Medicaid has been submitted.

To prevent disruption of Nevada Medicaid eligibility due to a change of address by Social Security (Nevada Medicaid recipients must remain residents of Nevada), when contacting Social Security for any reason, facility staff must reiterate that the recipient is a Nevada resident who has been placed out-of-state by Nevada Medicaid.

c. Reimbursement:

Out-of-state NFs are generally reimbursed at their own state’s Medicaid rate.

If a recipient has a severe medically based behavior disorder or another medical condition for which care in Nevada was not available, an out-of-state provider may request a differential “add-on rate” by contacting the Out-of-State Coordinator at the Medicaid Central Office.

Requests for a differential rate require additional documentation which justifies the need for additional reimbursement. The documentation must include a detailed explanation of how the additional reimbursement will be used for the recipient’s specific care needs including items such as but not limited to additional staffing, specific behavioral programs, specialized treatments, etc.

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d. Billing/Payment Process:

Out-of-state NFs must adhere to Medicaid's billing policies. Refer to the Provider Billing Manual and MSM Chapter 100 for complete billing instructions.

If a differential rate is approved, a prior authorization (PA) number will be issued. The PA number must be entered on the billing claim form.

503.22A RECIPIENT RESPONSIBILITY

The recipient (recipient's family/guardian) must concur with the out-of-state placement.

The recipient (recipient's family/guardian) must provide any necessary documentation requested by DWSS to maintain Medicaid eligibility and or utilize other health insurance coverage for any and all services.

503.22B AUTHORIZATION PROCESS

1. IN-STATE PROVIDER

Out-of-state NF admission requires approval from Nevada Medicaid.

To request approval for out-of-state NF placement, the in-state provider must complete the Out-of-State Questionnaire and submit it with the necessary information to Nevada Medicaid's Central Office, Out-of-State Coordinator.

When the out-of-state placement is approved, verbal authorization will be given to the requestor and written authorization will follow. After receiving the verbal approval, the provider may contact the transportation vendor to arrange transportation.

2. OUT-OF-STATE PROVIDER

After a recipient is approved for an out-of-state placement, Medicaid staff will notify the out-of-state provider by telephone. In addition, written approval will be sent to the provider.

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504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100 Hearings, for hearings procedures.

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Available online at: <http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing> (Resources/MDS Guidelines)

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard “no information” code (a dash, “-”) to indicate that the information is not available because it could not be assessed.	
C1000 Cognitive Skills for Daily Decision Making (7-day look back)	-Impaired Cognition (Contributes to ES count)	Observations should be made by staff across all shifts and departments and others with close contact with the resident. Focus on the resident’s actual performance. Includes choosing clothing, knowing when to go to meals; using environmental clues to organize and plan (e.g. clocks, calendars, posted event notices). In the absence of environmental cues seeks information appropriately (not repetitively) from others in order to plan their day; using awareness of one’s own strengths and limitations to regulate the day’s events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker. Does NOT include: Resident’s decision to exercise his/her right to decline treatment or recommendations by staff.	Document the resident’s actual performance in making everyday decisions about tasks or activities of daily living (ADL’S). Does not include financial decision making or statements relating to diagnosis (i.e. dementia). Decisions should relate to the residents life in the facility. Documentation needs to include the observing staff member’s title and As Evidenced By (AEB) examples of the decisions made by the resident within the observation period. If all residents’ needs are anticipated, then an AEB is required. The example needs to be specific not just a reference to the residents safety awareness etc.
D0300 Total Severity Score (PHQ-9) (7-day look back)	-Clinically Complex	Total Security Score defined: <ul style="list-style-type: none">• Sum of all frequency items (D0200 Column 2).• Total Severity Score range is 00-27.• Score >=10 resident is depressed.• Score <=10 resident is not depressed. Total Severity Score interpreted: <ul style="list-style-type: none">• 20-27; severe depression.• 15-19; moderately severe depression.• 10-14; moderate depression.• 5-9; mild depression.• 1-4; minimal depression.	Document date and signature of the professional clinical staff (i.e. licensed nurse or licensed social worker) conducting the interview within the observation period in the medical records. The interview completion date (the date the interview was actually conducted) must be date specific if written in a quarterly, annual, or summary note. The interview completion date in the medical records must match the signature date for the interview section entered at Z0400. The PHQ-9 score coded on the MDS should match the score reported by professional clinical staff.
D0500A, Column 2 Staff assessment Little interest or pleasure in doing things (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none">• Example that demonstrates resident’s lack of interest or pleasure in doing things.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
D0500B, Column 2 Staff assessment Feeling or appearing down, depressed, or hopeless (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J) <ul style="list-style-type: none"> Example that demonstrates resident’s feeling or appearing down, depressed or hopeless. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500C, Column 2 Staff assessment Trouble falling or staying asleep, or sleeping too much (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident’s trouble falling or staying asleep, or sleeping too much. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500D, Column 2 Staff assessment Feeling tired or having little energy (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident’s feeling tired or having little energy. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500E, Column 2 Staff assessment Poor appetite or overeating (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident’s poor appetite or overeating. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500F, Column 2 Staff assessment Indicating that he/she feels bad about self, or is a failure, or has let self or family down (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident’s indication that she/he feels bad about self, or is a failure, or has let self or family down. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500G, Column 2 Staff assessment Trouble concentrating on things, such as reading the newspaper or watching TV (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident’s trouble concentrating on things, such as reading the newspaper or watching TV. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500H, Column 2 Staff assessment	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J).	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that she/he has been moving around a lot more than usual (14-day look back)		<ul style="list-style-type: none"> Example that demonstrates resident's moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless the she/he has been moving around a lot more than usual. 	
D0500I, Column 2 Staff assessment States that life isn't worth living, wishes for death, or attempts to harm self (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident's statements that life isn't worth living, wishes for death, or attempts to harm self. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500J, Column 2 Staff assessment Being short tempered, easily annoyed (14-day look back)	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). <ul style="list-style-type: none"> Example that demonstrates resident's being short tempered, easily annoyed. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0600 Total Severity Score (PHQ-9-OV) (14-day look back)	-Clinically Complex	Total Severity Score defined: <ul style="list-style-type: none"> Sum of all frequency items (D0500 Column 2). Total Severity Score range is 00-30. Score >=9.5 resident is depressed. Score <=9.5 resident is not depressed. Total Severity Score interpreted: <ul style="list-style-type: none"> 20-30; severe depression. 15-19; moderately severe depression. 10-14; moderate depression. 5-9; mild depression. 1-4; minimal depression. 	Documentation needs to include staff interviewed (e.g. day shift nurse, activities personnel). Staff interviewed should be from a variety of shifts and staff who know the resident well. Document date and signature of the professional clinical staff (i.e. licensed nurse or licensed social worker) performing assessment within the observation period . The PHQ-9-OV score coded on the MDS should match the score reported by professional clinical staff .
E0100A Hallucinations (7-day look back)	-Behavior Problems	Hallucinations defined: <ul style="list-style-type: none"> Example of a resident's perception of the presence of something that is not actually there. Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli. 	Document As Evidenced By (AEB) example within the observation period .

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
E0100B Delusions (7-day look back)	-Behavior Problems	Delusions defined: <ul style="list-style-type: none"> Example of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. Does NOT include: <ul style="list-style-type: none"> A resident's expression of a false belief when easily accepts a reasonable alternative explanation. 	Document As Evidenced By (AEB) example within the observation period .
E0200A Physical behavioral symptoms <i>directed toward others</i> (7-day look back)	-Behavior Problems	<ul style="list-style-type: none"> Example and frequency of physical behavior symptoms direct toward others. Hitting, kicking, pushing, scratching, abusing others sexually. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200B Verbal behavioral symptoms <i>directed toward others</i> (7-day look back)	-Behavior Problems	<ul style="list-style-type: none"> Example and frequency of verbal behavior symptoms directed toward others. Threatening others, screaming at others, cursing at others. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200C Other behavioral symptoms <i>not directed toward others</i> (7-day look back)	-Behavior Problems	<ul style="list-style-type: none"> Example and frequency of other behavior symptoms NOT directed toward others. Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds. 	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0800 Rejection of Care Presence and frequency (7-day look back)	-Behavior Problems	Example of the resident's rejection of care (e.g. blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goal for health and well-being. When rejection/decline of care is first identified, it is investigated to determine if the rejection/decline of care is a matter of the resident's choice. Education is provided (risks and benefits) and the resident's choice becomes part of the plan of care. On future assessments, this behavior would not be coded again in this item.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0900 Wandering - Presence and Frequency (7-day look back)	-Behavior Problems	Example and frequency of wandering from place to place without a specified course or known direction. Does NOT include: <ul style="list-style-type: none"> Pacing, walking for exercise or out of boredom. Traveling via a planned course to another specific place (dining room or activity). 	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
<p>ADL Self-Performance</p> <p>G0110A, Bed Mobility</p> <p>G0110B, Transfers</p> <p>G0110H, Eating</p> <p>G0110I, Toilet Use</p> <p>Column 1 ONLY</p> <p>(7-day look back)</p>	<p>-Extensive Services -Rehabilitation -Special Care -Clinically Complex -Impaired Cognition -Behavior Problems -Reduced Physical Functions</p>	<ul style="list-style-type: none"> Documentation 24 hour/7 days within the observation period while in the facility. Initials and dates to authenticate the services provided. Signatures to authenticate initials of staff providing services. <p>ADL Keys: For either ADL grids, or electronic data collection tools, the key for self-performance and support provided must be equivalent to the intent and definition of the MDS key.</p> <p>ADLs NOT supported:</p> <ul style="list-style-type: none"> If there is no ADL key associated with the values, the ADL values will be considered unsupported. ADL keys with words for self-performance such as limited, extensive, etc., without the full definitions will be considered unsupported. ADL tools that lack codes for all possible MDS coding options will be considered unsupported. 	<p>The facility must provide one source document (i.e. ADL flow sheet, nurses, or staff notes) containing data reported over all shifts/departments for the 7-day observation period to support MDS coding.</p>
<p>ADL Support</p> <p>G0110A, Bed Mobility</p> <p>G0110B, Transfers</p> <p>G0110I, Toilet Use</p> <p>Column 2 ONLY (7 day-look back)</p>	<p>-Extensive Services -Rehabilitation -Special Care -Clinically Complex -Impaired Cognition -Behavior Problems -Reduced Physical Functions</p>	<p>ADL support measures the highest level of support provided by the staff over the last seven days, even if that level of support only occurred once. This is a different scale and is entirely separate from the ADL self-performance assessment.</p>	<p>The facility must provide one source document (i.e. ADL flow sheet, nurses, or staff notes) containing data reported over all shifts/departments for the 7-day observation period to support MDS coding.</p>
<p>H0200C Current toileting program or trial</p>	<p>-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions</p>	<p>Documentation must show that the following requirements have been met:</p> <ul style="list-style-type: none"> Implementation of an individualized toileting program that was based on an assessment of the resident’s unique voiding pattern. Evidence that the program was communicated verbally and through a care plan, flow records, and a written report. Resident’s response to the program and evaluation by a licensed nurse provided during the observation period. 	<p>“Program” is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident’s needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding.</p> <p>The program or trial must be recorded in the individual resident record. “All residents are encouraged to use the bathroom before and after meals” is not sufficient to take credit for a Program or trial.</p>

Nevada Supportive Documentation Guidelines

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		<ul style="list-style-type: none"> Toileting plan that is being managed during days of the 7-day look back period with some type of systematic toileting program. A specific approach that is organized, planned, documented, monitored, and evaluated. <p>Does NOT include:</p> <ul style="list-style-type: none"> Less than 4 days of a systematic toileting program. Simply tracing continence status. Changing pads or wet garments. Random assistance with toileting or hygiene. 	<p>The individual resident's toileting schedule must be daily (7-days a week), available and easily accessible to all staff. No time documentation is required for this item.</p>
<p>H0500 Bowel toileting program</p> <p>(7-day look back)</p>	<p>-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions</p>	<p>Documentation must show that the following requirements have been met:</p> <ul style="list-style-type: none"> Implementation of an individualized, resident- specific bowel toileting program that was based on an assessment of the resident's unique bowel pattern. Evidence that the program was communicated verbally and through a care plan, flow records, and a written report. Resident's response to the program and evaluation by a licensed nurse provided during the observation period. <p>Does NOT include:</p> <ul style="list-style-type: none"> Simply tracking of bowel continence status. Changing pads or soiled garments. Random assistance with toileting or hygiene. 	<p>"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding.</p> <p>The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a program or trial.</p> <p>The individual resident's toileting schedule must be daily (7-days a week), available and easily accessible to all staff. No time documentation is required for this item.</p>

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Section I: Active Diagnosis in the Last 7 Days Criteria		
<u>Active Diagnosis look back period</u> Diagnosis that has a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look back period	<u>Documented Diagnosis look back period</u> A healthcare practitioner documented diagnosis in the last 60 days that has a relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.	The monthly recap may be used for diagnosis IF it is signed and dated by the physician, nurse practitioner, physician assistant or clinical nurse specialist within the look back period. ADL documentation cannot be used to document active treatment, as all residents receive ADL assistance.
<u>Step 1</u> Identify diagnosis in the 60-day look back period.		
<u>Step 2</u> Determine diagnosis status: active or inactive in the 7-day look back period.		

MDS 3.0 Location Field Description Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
I2000 Pneumonia (60-7-day look back)	-Special Care -Clinically Complex (Contributes to ES count)	Inflammation of the lungs; most commonly of bacterial or viral origin. An active physician diagnosis must be present in the medical record. Does NOT include: <ul style="list-style-type: none"> • A hospital discharge note referencing pneumonia during hospitalization. 	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of pneumonia within the observation period is required. Documentation of current (within 7-day look back period) treatment of diagnosis must be present in the medical record. X-ray report signed by radiologist may be used to confirm diagnosis.
I2100 Septicemia (60-7-day look back)	-Clinically Complex (Contributes to ES count)	Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted provided the physician has documented the septicemia diagnosis in the resident's clinical record. Urosepsis is not considered for MDS review verification. Does NOT include: <ul style="list-style-type: none"> • A hospital discharge note referencing septicemia during hospitalization. 	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of septicemia within the observation period is required. Documentation of current (within 7-day look back period) treatment of diagnosis must be present in the medical record.
I2900 Diabetes Mellitus (60-7 day look back)	-Clinically Complex (Contributes to ES count)	An active physician documented diagnosis must be present in the medical record.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. May include diet controlled diabetes.

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I4300 Aphasia (60-7 day look back)	-Special Care (Contributes to ES count)	A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e. speaking, writing) or understanding spoken or written language. Includes aphasia due to CVA.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the documentation of active treatment involved which would indicate the resident does have aphasia.
I4400 Cerebral Palsy (60-7 day look back)	-Special Care (Contributes to ES count)	Paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I4900 Hemiplegia/ Hemiparesis (60-7-day look back)	-Clinically Complex (Contributes to ES count)	Hemiplegia/ hemiparesis: Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. Right or left sided weakness or CVA will not be accepted for this item.
I5100 Quadriplegia (60-7-day look back)	-Special Care (Contributes to ES count)	Paralysis (temporary or permanent impairment of sensation, function, motion) of all 4 limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.)	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I5200 Multiple Sclerosis(MS) (60-7-day look back)	-Special Care (Contributes to ES count)	Chronic disease affecting the central nervous system with remissions and relapses of weakness, paresthesia, speech and visual disturbances.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
J1550A Fever (7-day look back)	-Special Care (Contributes to ES count)	The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. <ul style="list-style-type: none"> • Fever of 2.4 degrees above the baseline. • A baseline temperature established prior to the observation period. • A temperature of 100.4 on admission is a fever. 	Documentation of specific occurrences of fever in the observation period. A baseline temperature must be established and documented prior to the observation period for comparison.
J1550B Vomiting (7-day look back)	-Special Care (Contributes to ES count)	Documentation of regurgitation of stomach contents; may be caused by many factors (e.g. drug toxicity, infection, psychogenic.)	Documentation of vomiting in the observation period including description of vomitus (type and amount).
J1550C Dehydrated	-Special Care -Clinically Complex (Contributes to ES count)	Documentation does require two or more of the three dehydration indicators Does include: <ul style="list-style-type: none"> • Usually takes in less than 1500cc of fluid daily. • One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc. • Fluid loss that exceeds intake daily. 	Documentation of signs of dehydration in the observation period.

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(7-day look back)		<p>Does NOT include:</p> <ul style="list-style-type: none"> A hospital discharge note referencing dehydration during hospitalization unless two of the three dehydration indicators are present and documented. A diagnosis of dehydration. 	
<p>J1550D Internal Bleeding (7-day look back)</p>	<p>-Clinically Complex (Contributes to ES count)</p>	<p>Documentation of frank or occult blood.</p> <ul style="list-style-type: none"> Black, tarry stools. Vomiting “coffee grounds”. Hematuria. Hemoptysis. Severe epistaxis (nosebleed) requires packing. <p>Does NOT include:</p> <ul style="list-style-type: none"> Nosebleeds that are easily controlled, menses, or UA with a small amount of red blood cells. 	<p>Documentation of specific occurrences on internal bleeding in the observation period including description.</p>
<p>K0300 Weight Loss (30 and 180 day look back)</p>	<p>-Special Care (Contributes to ES count)</p>	<p>Documentation that compares the resident’s weight in the current observation period with his/her weight at two snapshots in time:</p> <ul style="list-style-type: none"> Weight loss of 5% a point closest to 30 days preceding current observation period. Weight loss of 10% at a point closest to 180 days preceding current observation period. <p>Mathematically round weights prior to completing the weight loss calculation.</p> <p>Physician prescribed weight loss regimen is a weight reduction plan ordered by the resident’s physician with the care plan goal of weight reduction. May employ a calorie restricted diet or other weight loss diets and exercise. Also includes planned diuresis for weight loss. It is important that weight loss is intentional.</p>	<p>Must have a documented weight within the current observation period (within 30 days of ARD) for comparison.</p> <p>Documentation, including dates with weights and prescribed diet if applicable are required.</p>
<p>K0510A either as not a resident (1) or as a resident (2) Parenteral/IV Feeding</p>	<p>-Extensive Services -ADL Score</p>	<p>Documentation of IV administration (while a resident or while not a resident) for <u>nutrition or hydration</u>.</p> <p>Does include:</p> <ul style="list-style-type: none"> IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently. IV at KVO (keep vein open). IV fluids contained in IV Piggybacks. Hypodermoclysis and sub-Q ports in hydration Therapy. IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. 	<p>Documentation of parenteral/IV administration during the observation period which may include medicine administration records (MAR’s) and treatment records.</p> <p>For fluids given while not a resident, facility records are required with amounts administered.</p>

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(7-day look back)		<p>The following items are NOT to be coded in K0510A:</p> <ul style="list-style-type: none"> • IV medications – Code these when appropriate in O0100H, IV Medications. • IV fluids used to reconstitute and/or dilute medications for IV administration. • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • IV fluids administered during chemotherapy or dialysis. 	
K0510B either 1 or 2 Feeding Tube (7-day look back)	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	<p>Documentation of any type of feeding tube for <u>nutrition and hydration while a resident or while not a resident.</u></p> <ul style="list-style-type: none"> • Documentation of any type of tube that can deliver food/nutritional substance directly into the GI system. <p>Does include:</p> <ul style="list-style-type: none"> • NG tubes, gastrostomy tubes, J-tubes, PEG Tubes. 	Presence of the feeding tube is sufficient to code this item.
K0710A Calorie Intake through parenteral or tube feeding (7-day look back)	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	<p>Documentation must support the proportion of all calories <u>actually received</u> for nutrition or hydration through parenteral or tube feeding.</p> <p>For residents receiving PO nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include:</p> <ul style="list-style-type: none"> • Total calories from parenteral route. • Total calories from tube feeding route. • Calculation used to find percentage of calories consumed by artificial routes. 	Dietary notes can be used to support MDS coding.
K0710B Average Fluid Intake Intake by IV or tube feeding. (7-day look back)	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	<p>Documentation must support average fluid intake per day by IV and/or tube feeding.</p> <p>This is calculated by reviewing the intake records, adding the total amount of fluid received each day by IV and/or tube feedings only. Divide the week's total fluid intake by the number of days in the observation period. This will provide the average fluid intake per day.</p>	<p>Dietary notes may be used to support MDS coding.</p> <p>Documentation to include evidence of the average fluid intake per day by IV or tube feeding during the entire seven days' observation period. Refers to the actual amount of fluid the resident received by these modes (not the amount ordered).</p>
M0300A No. of Stage 1 M0300B1 No. of Stage 2 M0300C1 No. of Stage 3	-Special Care (Contributes to ES count)	<p>Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed.</p> <ul style="list-style-type: none"> • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured. • Description of the ulcer including the stage. <p>Does NOT include:</p> <ul style="list-style-type: none"> • Reverse staging. 	<p>Documentation must indicate the number of pressure ulcers on any part of the body observed during the observation period.</p> <p>Pressure ulcer staging must be clearly defined by description and/or measurement in order to support MDS coding during the observation period.</p>

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M0300D1 No. of Stage 4 M0300F1 No. of unstageable (7-day look back)		<ul style="list-style-type: none"> • Pressure ulcers that are healed before the look-back period (these are coded at M0900). • Coding un-stageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured. 	Documentation must include date, clinician signature, and credentials.
M1030 No. of Venous/Arterial Ulcers (7-day look back)	-Clinically Complex (Contributes to ES count)	Venous Ulcers: Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg. Arterial Ulcers: Ulcers caused by peripheral artery disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.	Documentation must indicate the number of venous or arterial ulcers observed during the observation period. Documentation must include date, clinician signature, and credentials.
M1040A Infection of the foot (7-day look back)	-Clinically Complex (Contributes to ES count)	Documentation of signs and symptoms of infection of the foot. Does include: <ul style="list-style-type: none"> • Cellulitis. • Purulent drainage. Does NOT include: <ul style="list-style-type: none"> • Ankle problems. • Pressure ulcers coded in M0300-M0900. 	Documentation of signs and symptoms of infection of the foot must be present in the medical record to support the MDS coding. Documentation to include description and location of the infection. Documentation must include date, clinician signature, and credentials.
M1040B Diabetic foot ulcer M1040C Other open lesion on the foot (7-day look back)	-Clinically Complex (Contributes to ES count)	Documentation of signs and symptoms of foot ulcer or lesions. <ul style="list-style-type: none"> • Description of foot ulcer and/or open lesions such as location and appearance. Does NOT include: <ul style="list-style-type: none"> • Pressure ulcers coded in M0300-M0900. • Pressure ulcers that occur on residents with diabetes mellitus. 	Documentation of sign and symptoms of foot ulcer or other lesion on the foot must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials.
M1040D Open lesions other than ulcers, rashes, cuts (7-day look back)	-Special Care (Contributes to ES count)	Does include: <ul style="list-style-type: none"> • Skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. • Description of the open lesion such as location and appearance. • Documentation in the care plan. Does NOT include: <ul style="list-style-type: none"> • Pressure ulcers coded in M0300-M0900. • Skin tears, cuts, abrasions. 	Documentation of signs and symptoms of open lesion other than ulcers, rashes or cuts must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature, and credentials. RAI manual examples are not all inclusive, other lesions will be considered for inclusion in this item. (i.e. shingles lesions or weeping wounds).
M1040E Surgical Wounds	-Special Care (Contributes to ES count)	Does include: <ul style="list-style-type: none"> • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage site on any part of the body. 	Documentation of a surgical wound must be present in the medical record to support the MDS coding during the observation period.

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(7-day look back)		<ul style="list-style-type: none"> • Pressure ulcers that are surgically repaired with grafts and flap procedures. • Description of the surgical wound such as location and appearance. <p>Does NOT include:</p> <ul style="list-style-type: none"> • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure. • PICC sites, central line sites, IV sites. • Pressure ulcers that have been surgically debrided. 	Cannot be coded after the site is healed even though cleansing and a dressing may still be applied (example healed stoma or G-tube site). Documentation must include date, clinician signature, and credentials.
M1040F Burns (7-day look back)	-Clinically Complex (Contributes to ES count)	<p>Documentation to include a description of the appearance of the second or third degree burns.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Second or third degree burns only; may be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. <p>Does NOT include:</p> <ul style="list-style-type: none"> • First-degree burns (changes in skin color only). 	<p>Documentation of signs and symptoms of second and third degree burns must be present in the medical record to support MDS coding during the observation period.</p> <p>Documentation must include date, clinician signature, and credentials.</p>
M1200A Pressure Relieving Device/chair M1200B Pressure Relieving Device/bed (7-day look back)	-Special Care (Contributes to ES count)	<p>Equipment aimed at relieving pressure away from areas of high risk.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Foam, air, water, gel, or other cushioning. • Pressure relieving, reducing, redistributing devices. <p>Does NOT include</p> <ul style="list-style-type: none"> • Egg crate cushions of any type. • Doughnut or ring devices. 	<p>Documentation and/or description of pressure relieving, reducing, or redistributing devices in the medical record to support MDS coding during the observation period.</p> <p>Each device must be documented separately. (e.g. “Pressure relieving for chair/bed” will not be accepted).</p> <p>Use of the device must be noted in the medical record at least one time during the observation period. Additionally, the term “pressure relieving,” “pressure reducing” or “pressure redistributing” needs to be verifiable through Manufacture documentation and available upon request by the review team.</p>
M1200C Turning/repositioning program	-Special Care (Contributes to ES count)	<p>The turning/repositioning program is specific as to the approaches for changing the resident’s position and realigning the body. The program should specify the intervention (e.g. reposition on side, pillows between knees), and frequency (e.g. every 2 hours).</p> <p>Progress notes, assessments, and other documentation (as directed by facility policy), should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.</p>	<p>“Program” is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident’s needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding.</p> <p>The goals of the program must be measurable and must occur a minimum of 7-days per week.</p>

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(7-day look back)			<p>Evaluation by a licensed nurse during the observation period is required: Co-signing by the nurse will not be accepted.</p> <p>Documentation must be specific if the program is for maintenance or improvement and must include a description of the resident's response to the program within the observation period. Does not include: "Standard of Care Statement," (i.e. q 2 hour turning).</p>
<p>M1200D Nutrition/hydration intervention to manage skin problems</p> <p>(7-day look back)</p>	<p>-Special Care (Contributes to ES count)</p>	<p>Documentation of dietary intervention(s) to prevent or treat specific skin conditions.</p> <ul style="list-style-type: none"> • Description of specific skin condition. <p>Does include:</p> <ul style="list-style-type: none"> • Vitamins and/or supplements. 	<p>Nutrition and/or hydration interventions for the purpose of preventing or treating specific skin conditions (i.e. wound healing) ONLY.</p> <p>The MAR's must note that the medication, vitamin, or supplement is for treatment of a skin condition to support MDS coding of this item.</p>
<p>M1200E Pressure Ulcer Care</p> <p>(7-day look back)</p>	<p>-Special Care (Contributes to ES count)</p>	<p>Documentation to include any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at each Stage (M0300 A-G).</p> <p>Does include:</p> <ul style="list-style-type: none"> • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy. 	<p>Documentation of pressure ulcer treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.</p>
<p>M1200F Surgical Wound Care</p> <p>(7-day look back)</p>	<p>-Special Care (Contributes to ES count)</p>	<p>Documentation to include any intervention for treating or protecting any type of surgical wound.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Topical cleaning. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. <p>Does NOT include:</p> <ul style="list-style-type: none"> • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer. • The observation of the surgical wound. 	<p>Documentation of surgical wound treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.</p>

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M1200G Application of non-surgical dressings; other than to the feet (7-day look back)	-Special Care (Contributes to ES count)	Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. Does include: <ul style="list-style-type: none"> • Dressing application even once. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydro active particles. Does NOT include: <ul style="list-style-type: none"> • Dressing application to the ankle. • Dressing for pressure ulcer on the foot. 	Documentation of application of non-surgical dressing to body part other than the feet must include dressing type, date and clinician signature with credentials in the medical record to support MDS coding.
M1200H Application of ointments/medications other than to the feet (7-day look back)	-Special Care (Contributes to ES count)	Documentation of application of ointment/medications (used to treat or prevent a skin condition) other than to the feet. Does include: <ul style="list-style-type: none"> • Topical creams. • Powders. • Liquid sealants. 	Documentation of application of ointment/medication used to treat or prevent a skin condition other than to the feet must include product, date and clinician signature with credentials in the medical record to support MDS coding
M1200I Application of Dressings (feet) (7-day look back)	Clinically Complex (Contributes to ES count)	Documentation of dressing changes to the feet (with or without topical medication). <ul style="list-style-type: none"> • Interventions to treat any foot wound or ulcer other than a pressure ulcer. 	Documentation of intervention to treat any foot wound or ulcer other than a pressure ulcer must include treatment, date and clinician signature with credentials in the medical record to support MDS coding.
N0300 Injections (7-day look back)	-Clinically Complex (Contributes to ES count)	Documentation includes the number of days that the resident received any medication, antigen, vaccine, etc., by subcutaneous, intramuscular or intradermal injection <u>while resident is in facility.</u> Does include: <ul style="list-style-type: none"> • Subcutaneous pumps, only the number of days that the resident actually required a subcutaneous injection to restart the pump. • Insulin injections. 	Documentation of number of day's injections given must include clinician signature and credentials in the medical record to support MDS coding. Source document for this item may include MAR and/or Diabetic administration flow sheet.
O100A, either as not a resident (1) or as a resident (2) Chemotherapy (14-day look back)	-Clinically Complex (Contributes to ES count)	Documentation to include the administration of any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment.	Documentation of chemotherapy administration, including MAR, while a resident or while not a resident must include date, clinician signature, and credentials. Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
O0100B, either as not a resident (1) or as a resident (2) Radiation (14-day look back)	-Special Care (Contributes to ES count)	Does include: <ul style="list-style-type: none"> • Intermittent radiation therapy. • Radiation administered via radiation implant. • A nurse's note that resident went out for radiation treatment will be sufficient if there is a corresponding physician order. 	Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.
O0100C, either as not a resident (1) or as a resident (2) Oxygen Therapy (14-day look back)	-Clinically Complex (Contributes to ES count)	Documentation must include the administration of oxygen. <ul style="list-style-type: none"> • The administration of oxygen continuously or intermittently via mask, cannula, etc. • Code when used in BiPAP/CPAP. Does NOT include: <ul style="list-style-type: none"> • Hyperbaric oxygen for wound therapy. 	Documentation of oxygen therapy while a resident or while not a resident with liter flow with date, signature/credentials of clinician/staff in the medical record to support MDS coding.
O0100D, either as not a resident (1) or as a resident (2) Suctioning (14-day look back)	-Extensive Services	Documentation of ONLY nasopharyngeal or tracheal suctioning. <ul style="list-style-type: none"> • Nasopharyngeal suctioning. • Tracheal suctioning Does NOT require: <ul style="list-style-type: none"> • Oral suctioning. 	Documentation of suctioning while a resident or while not a resident with signature/credentials of clinician in the medical record to support MDS coding.
O0100E, either as not a resident (1) or as a resident (2) Tracheostomy Care (14-day look back)	-Extensive Services	Documentation of tracheostomy and/or cannula cleansing. Does include: <ul style="list-style-type: none"> • Changing a disposable cannula. 	Documentation of treatment while a resident or while not a resident with signature/credentials of clinician in the medical record to support MDS coding.
O0100F, either as not a resident (1) or as a resident (2) Ventilator or Respirator (14-day look back)	-Extensive Services	Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support devices. Does include: <ul style="list-style-type: none"> • Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days. Does NOT include: <ul style="list-style-type: none"> • CPAP or BiPAP in this field. 	Documentation of ventilator use while a resident or while not a resident with date, signature/credentials of clinician in the medical record to support MDS coding.
O0100H, either as not a resident (1) or as a resident (2) IV Medication	-Extensive Services	Documentation of IV medication by push, epidural pump, or drip administration through a central or peripheral port. Does include: <ul style="list-style-type: none"> • Any drug or biological (contrast material). • Epidural, intrathecal, and Baclofen pumps. • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids. Does NOT include <ul style="list-style-type: none"> • Saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. • Subcutaneous pumps. 	Documentation of IV medication administration must include signature/credentials of clinician in the medical record to support MDS coding.

Nevada Supportive Documentation Guidelines

Available online at: <http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing> (Resources/MDS Guidelines)

Resource Utilization Group, Version III, Revised

For MDS 3.0 Assessments with an ARD on or after 10/01/2016 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(14-day look back)		<ul style="list-style-type: none"> IV medications administered only during chemotherapy or dialysis. 	
O0100I, either as not a resident (1) or as a resident (2) Transfusions (14-day look back)	-Clinically Complex (Contributes to ES count)	Documentation must include transfusions of blood or any blood products administered directly into the blood stream. Does NOT include: <ul style="list-style-type: none"> Transfusions administered during dialysis or Chemotherapy. 	Documentation must include product infused, signature/credentials of clinician in the medical record to support the MDS coding.
O0100J, either as not a resident (1) or as a resident (2) Dialysis (14-day look back)	-Clinically Complex (Contributes to ES count)	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. Does include: <ul style="list-style-type: none"> Hemofiltration. Slow Continuous Ultrafiltration (SCUF). Continuous Arteriovenous Hemofiltration (CAVH). Continuous Ambulatory Peritoneal Dialysis (CAPD). Does NOT include: <ul style="list-style-type: none"> IV, IV medication and blood transfusion during dialysis 	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.
O0400A, 1, 2 & 3 O0400B, 1, 2 & 3 O0400C, 1, 2 & 3 Therapy minutes	-Rehabilitation <u>Individual therapy</u> -Treatment of one resident at a time <u>Concurrent therapy</u> -Treatment of 2 residents at the same time in line-of-sight for Part A only. Residents may not be treated concurrently for Part B— instead report under Group therapy. <u>Group therapy</u> -Treatment of 2 or 4 residents at the same time - Part A only. -Treatment of 2 or more residents at the same time -Part B only.	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. <ul style="list-style-type: none"> Only therapy provided while a resident in the facility. Skilled therapy ONLY. Physician order, treatment plan and assessment. Actual therapy minutes ONLY. Time provided for each therapy must be documented separately. Does include: <ul style="list-style-type: none"> Subsequent reevaluations. Set-up time. Co-treatment when minutes are split between disciplines and do not exceed the total time. Therapy treatment inside or outside the facility. Does NOT include: <u>Therapy services not medically reasonable and necessary.</u> <ul style="list-style-type: none"> Therapy provided prior to admission. Initial evaluation. Conversion of units to minutes. Rounding to the nearest 5th minute. Therapy services that are not medically reasonable and necessary. Therapy provided as restorative nursing. 	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. Includes: <ul style="list-style-type: none"> Only therapy provided while a resident in the facility. Skilled therapy ONLY. Therapy that is physician ordered, treatment planned and assessed. Actual therapy minutes ONLY. Time provided for each therapy must be documented separately. <u>Accepted documentation for therapy minutes can only be the computer generated therapy log/grid that is submitted for billing to CMS.</u>

Nevada Supportive Documentation Guidelines

Available online at: <http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing> (Resources/MDS Guidelines)

Resource Utilization Group, Version III, Revised

For MDS 3.0 Assessments with an ARD on or after 10/01/2016 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		<p>**When residents are part of a group, provide documentation to identify the group, program, minutes and initials of person providing program.</p> <p>Does NOT require: Physician orders</p>	<p>Includes:</p> <ul style="list-style-type: none"> Days for which 15 or more minutes of restorative nursing was provided within a 24-hour period for a minimum of 6-days. Time provided for each restorative program must be documented separately. <p>MDS review staff may ask to review the training records of the facilities restorative program staff.</p> <p>When residents are part of a group, provide documentation to identify the number of residents in the group and how many staff members are assisting. At least one staff member must be a Restorative Nursing Assistant (RNA) or licensed staff person.</p>
<p>O0600 Physician examination</p> <p>(14-day look back)</p>	<p>-Clinically Complex (Contributes to ES count)</p>	<p>Documentation must include evidence of an exam by the physician or other authorized practitioners. Record the number of days that a physician progress note reflects that a physician examined the resident (or since admission if less than 14 days ago).</p> <p>Does include:</p> <ul style="list-style-type: none"> Partial or full exam in facility or in physician’s office. <p>Does NOT include:</p> <ul style="list-style-type: none"> Exams conducted prior to admission or readmission. Exams conducted during an ER visit or hospital observation stay. Exam by a Medicine Man. 	<p>Document the number of days a physician or other authorized practitioner examined the resident. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.</p>
<p>O0700 Physician orders</p> <p>(14-day look back)</p>	<p>-Clinically Complex (Contributes to ES count)</p>	<p>Does include:</p> <ul style="list-style-type: none"> Written, telephone, fax, or consultation orders for new or altered treatment. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. <p>Does NOT include:</p> <ul style="list-style-type: none"> Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes. Activation of a PRN order already on file. Monthly Medicare certification. Orders written by a pharmacist. Orders for transfer of care to another physician. 	<p>Document the number of days a physician or other authorized practitioner changed the resident’s orders. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.</p> <p>Does not include sliding scale dose change based on guidelines already ordered.</p>

Review Procedures

Nevada Supportive Documentation Guidelines

Available online at: <http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing> (Resources/MDS Guidelines)

Resource Utilization Group, Version III, Revised

For MDS 3.0 Assessments with an ARD on or after 10/01/2016 based on MDS 3.0 RAI Manual

Supporting Documentation Related to the MDS/Case Mix Documentation Review:

- a) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction within the observation period.
- b) A quarterly, annual, or summary note will not substitute for documentation which is date specific to the observation period.
- c) Improper or illegible corrections will not be accepted for the MDS case mix documentation review.
- d) All documentation, including corrections, must be part of the original legal medical record.
- e) Any and all MDS coding and interpretation questions shall be referred to the local State RAI Coordinator.
- f) Late entry documentation more than 72 hours from the ARD will not be accepted.

Signature Date at Z0400:

- a) Interview items (BIMS and PHQ-9) must be conducted during the observation periods stated in the RAI Manual and the signature date entered at Z0400 must be prior to or on the ARD.
- b) The signature date for these interview items entered at Z0400 must match the date the interview was actually conducted in the medical records. If these dates do not match, facility will not receive credits for these interview items due to conflicting documentation.
- c) In the rare situation that interview items were collected (completed) by two people or by the same person but on different dates, (e.g. half of the interview questions were conducted on the next day), each person must enter the signature date at Z0400 and indicate specific interview questions conducted (e.g. D0200 2.A through D; D0200 2.E through I and D0300) in “Sections.”
- d) The definition of “date collected” and “date completed”: date information was collected and coding decision were made. They are one, the same date. This is not the same as the data entry date.

Electronic Health Records (EHR)

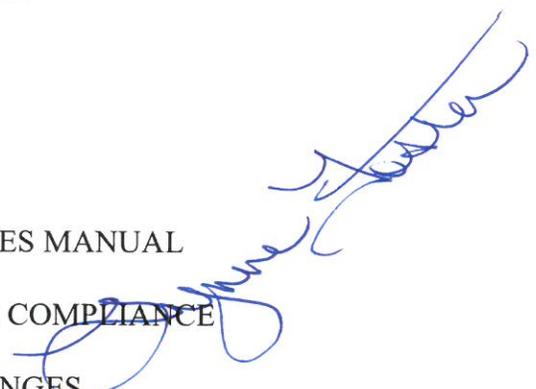
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- a) The facility must grant access to requested medical records in a read-only or other secure format.
- b) The facility is responsible for ensuring data backup and security measures are in place.
- c) Access to EHR must not impede the review process.
- d) Medicaid recipients must have their PASRR and LOC in the active EHR.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – PHYSICIAN SERVICES



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600, Physician Services, include integration of Attachment A, Policy #6-12, Women's Preventive Health – Pregnant and Non-Pregnant, Attachment A, Policy #6-13, Men's Preventive Health, Attachment A, Policy #6-14, Children's Preventive Health, and Attachment A, Policy #06-17 Federally Qualified Health Centers (FQHC) into the body of the chapter. The policy authority for FQHC has been moved to the Section 601.C. The Division of Healthcare Financing and Policy (DHCFP) is removing attachments to better align MSM chapters. Clarifying language has been added to Section 605.2 B regarding dental encounters at an FQHC, referring to MSM Chapter 1000, Dental. Service limitations in Section 605.2 B have also been changed from one to three service encounters, aligning with the Rates State Plan Amendment (SPA). The DHCFP has updated the United States Preventive Services Task Force (USPSTF) screening recommendations for women in abnormal blood glucose and type 2 diabetes mellitus, blood pressure, breast cancer screening, depression, diabetes related to overweight and obesity, HIV screening for pregnant and non-pregnant women, and tobacco screening for pregnant and non-pregnant women; the USPSTF screening recommendations for men in abnormal blood glucose and type 2 diabetes mellitus, blood pressure, depression, diabetes related to overweight and obesity, HIV, and tobacco; and the USPSTF screening recommendations for children in depression and HIV.

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

These changes are effective July 15, 2016

MATERIAL TRANSMITTED

MTL 16/16
PHYSICIAN SERVICES

MATERIAL SUPERSEDED

MTL 25/15
PHYSICIAN SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Attachment A, Policy #06-17	Federally Qualified Health Centers	Integrated Attachment into the body of the chapter creating Section 605, Federally Qualified Health Centers (FQHCs).
601.C	Authority	Added the authority regulations of FQHCs.
605.1	Health Services	<p>Added clarifying language to dental policy for FQHC referring MSM Chapter 1000, Dental, that an FQHC is to bill as an encounter and maximum allowances and services must align with MSM Chapter 1000, Dental.</p> <p>Changed daily encounter reimbursements to up to three service specific visits per patient, per day, allowing a medical, dental, and mental health visit on a single day for the same patient.</p>
Attachment A, Policy #6-12	Women’s Preventive Health – Pregnant and Non-pregnant	Integrated Attachment into the body of the chapter creating Section 606, Preventive Health Services, is now located under 606.2 A.
Attachment A, Policy #6-13	Men’s Preventive Health	Integrated Attachment into the body of the chapter creating Section 606, Preventive Health Services, is now located under 606.2 B.
Attachment A, Policy #6-14	Children’s Preventive Health	Integrated attachment into the body of the chapter creating Section 606, Preventive Health Services, is now located under 606.2 C.
606.2 A	Coverage and Limitations	<p>Added language for abnormal blood glucose and type 2 diabetes mellitus screening for women 40 to 70 years who are overweight or obese.</p> <p>Removed language for blood pressure screening in adults, and added screening for high blood pressure screening in adults and language for obtaining confirmation outside of the clinical setting before treatment.</p> <p>Added clarifying language to breast cancer screening changing the age and frequency of screening mammography.</p> <p>Added clarifying language to depression screening: adults to include the general adult population, including</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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pregnant and postpartum women with adequate screening systems.

Added clarifying language to diabetes screening changing the age of adults who are overweight or obese and removed asymptomatic for type 2 diabetes.

Added clarifying language to HIV screening of pregnant women to include screening for those who present in labor and are unsure of their HIV status.

Added language for HIV screening in non-pregnant women age 15 to 65 years. And screening outside of those ages for only those who are at risk.

Added clarifying language to tobacco use counseling for adults using behavioral interventions and FDA approved pharmacotherapy for cessation.

Added clarifying language to tobacco use counseling for pregnant women.

606.2 B

Coverage and Limitations

Added language for abnormal blood glucose and type 2 diabetes mellitus screening for men 40 to 70 years who are overweight or obese.

Removed language for blood pressure screening in adults, and added screening for high blood pressure screening in adults and language for obtaining confirmation outside of the clinical setting before treatment.

Added clarifying language to depression screening: adults to include the general adult population, including pregnant and postpartum women with adequate screening systems.

Added clarifying language to diabetes screening changing the age of adults who are overweight or obese and removed asymptomatic for type 2 diabetes.

Added language for HIV screening in men age 15 to 65 years. And screening outside of those ages for only those who are at risk.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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606.2 C

Coverage and Limitations

Added clarifying language to tobacco use counseling for adults using behavioral interventions and FDA approved pharmacotherapy for cessation.

Added clarifying language for screening adolescents for major depressive disorder and having adequate systems in place for effective therapy.

Added clarifying language to HIV screening to screen between the ages of 15 and 65 and outside that age range only when presenting at risk.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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600 INTRODUCTION

The Nevada Medicaid Program is dependent upon the participation and cooperation of Nevada physicians and other licensed professionals who provide health care to Medicaid recipients. Licensed professionals providing services within the scope of their license are recognized by Nevada as independently contracted Medicaid providers. The policy in this chapter is specific to the following identified health care professionals:

- A. Advanced Practice Registered Nurse APRN;
- B. Certified Registered Nurse Anesthetists (CRNA);
- C. Chiropractors (DC);
- D. Certified-Nurse Midwives (CNM);
- E. Physicians (M.D. and D.O. including those in a teaching hospital);
- F. Physician Assistants (PA/PA-C); and
- G. Podiatrists (DPM).

To enroll as a physician or health care professional for the Division of Health Care Financing and Policy (DHCFP) in the Nevada Medicaid Program, the above listed licensed professionals working within their scope of practice must be authorized by the licensing authority of their profession to practice in the state where the service is performed at the time the state services are provided. Specific service exclusions will be noted in policy.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Services Manual, Chapter 1000.

The DHCFP encourages integrated interventions as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). Please reference Medicaid Services Manual (MSM) Chapter 400 for specific policy.

Disclaimer: The term “Physician” used throughout this chapter is an all-inclusive description relative to the above identified providers working within their respective scope of practice and does not equate one professional to another. It serves only to make the document more reader-friendly. A Primary Care Physician (PCP) is considered to be an M.D/D.O. with a specialty in general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology.

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601 AUTHORITY

- A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (CFR) Part 440, Subpart A – Definitions, Subpart B and sections 1929 (a), 1902 (e), 1905 (a), 1905 (p), 1915, 1920, and 1925 of the Act. Physician’s services are mandated as a condition of participation in the Medicaid Program Nevada Revised Statute (NRS) 630A.220.
- B. Regulations for services furnished by supervising physicians in teaching settings are found in 42 CFR Part 415; Subpart D. Key portion is defined in [Reg. 415.172(a)].
- C. The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:
 - 1. Section 330 of the Public Health Service (PHS) Act;
 - 2. NRS Chapter 634 - Chiropractic;
 - 3. NRS Chapter 629 - Healing Arts Generally;
 - 4. NRS Chapter 632 - Nursing;
 - 5. NRS Chapter 630 - Physicians and Physician Assistants and Practitioners of Respiratory Care General Provisions;
 - 6. NRS Chapter 633 - Osteopathic Medicine;
 - 7. NRS Chapter 635 - Podiatry;
 - 8. NRS Chapter 450B Emergency Medical Services;
 - 9. Section 1861 of the Social Security Act;
 - 10. Section 1905 of the Social Security Act;
 - 11. Section 1461 of the Omnibus Budget Reconciliation Act of 1990.

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602 RESERVED

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603 PHYSICIANS AND LICENSED PROFESSIONAL POLICY

603.1 PHYSICIAN'S ROLE IN RENDERING SERVICES

603.1A COVERAGE AND LIMITATIONS

1. The Division of Health Care Financing and Policy (DHCFP) reimburses for covered medical services that are reasonable and medically necessary, ordered or performed by a physician or under the supervision of a physician, and that are within the scope of practice of their prognosis as defined by state law. The physician must:
 - a. Examine the recipient;
 - b. Make a diagnosis;
 - c. Establish a plan of care; and
 - d. Document these tasks in the appropriate medical records for the recipient before submitting claims for services rendered. Documentation is subject to review by a state authority or contracted entity.

2. Services must be performed by the physician or by a licensed professional working under the personal supervision of the physician.
 - a. The following are examples of services that are considered part of the billable visit when it is provided under the direct and professional supervision of the physician:
 1. An injection of medication;
 2. Diagnostic test like an electrocardiogram (ECG);
 3. Blood pressure taken and recorded between M.D./D.O. visits;
 4. Dressing changes; and
 5. Topical application of fluoride.
 - b. Physicians or their designee may not bill Medicaid for services provided by, but not limited to, the following:
 1. Another Provider;
 2. Psychologist;

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3. Medical Resident (unless teaching physician);
4. Therapist: Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (SP), Respiratory Therapist (RT);
5. Counselor/Social Worker;
6. Advanced Practice Registered Nurse (APRN) (other than diagnostic tests done in the office which must be reviewed by the physician);
7. Physician Assistants (PA/PA-C); and
8. Certified Registered Nurse Anesthetist (CRNA).

3. Teaching Physicians

Medicaid covers teaching physician services when they participate in the recipient's care. The teaching physician directs no more than four residents at any given time and is in such proximity as to constitute immediate availability. The teaching physician's documentation must show that he or she either performed the service or was physically present while the resident performed the key and critical portions of the service. Documentation must also show participation of the teaching physician in the management of the recipient and medical necessity for the service. When choosing the appropriate procedure code to bill, consideration is based on the time and level of complexity of the teaching physician, not the resident's involvement or time.

The DHCFP follows Medicare coverage guidelines for Teaching Physicians, Interns, and Residents including the exceptions as outlined by Medicare's policy.

4. Out-of-State Physicians

- a. If a prior authorization is required for a specific outpatient or inpatient service in-state, then a prior authorization is also required for an out-of-state outpatient or inpatient service by the Nevada Medicaid Quality Improvement Organization (QIO)-like vendor. Conversely, if a prior authorization is not required for a service in state (i.e. office visit, consultation), then a prior authorization is not required for the same service out of state. (Please refer to Medicaid Services Manual (MSM) Chapter 1900, Transportation Services, for out-of-state transportation policy.) The QIO-like vendor's determination will consider the availability of the services within the State. If the recipient is being referred out-of-state by a Nevada physician, the Nevada physician is required to obtain the prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.

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- b. When medical care is unavailable for Nevada recipients residing near state borders (catchments areas) the contiguous out-of-state physician/clinic is considered the Primary Care Physician (PCP). All in-state benefits and/or limitations apply.
- c. All service physicians must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. (See MSM Chapter 100.)

5. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The EPSDT program provides preventative health care to recipients (from birth through age 20 years) eligible for medical assistance. The purpose of the EPSDT program is the prevention of health problems through early detection, diagnosis, and treatment. The required screening components for an EPSDT examination are to be completed according to the time frames on a periodicity schedule that was adopted by the American Academy of Pediatrics and the DHCFP. See MSM Chapter 1500, Healthy Kids.

603.2 PHYSICIAN OFFICE SERVICES

Covered services are those medically necessary services when the physician either examines the patient in person or is able to visualize some aspect of the recipient’s condition without the interposition of a third person’s judgment. Direct visualization would be possible by means of X-rays, electrocardiogram (ECG) and electroencephalogram (EEG) tapes, tissue samples, etc.

Telehealth services are also covered services under the DHCFP. See MSM Chapter 3400 for the complete coverage and limitations for Telehealth.

A. Consultation Services

A consultation is a type of evaluation and management service provided by a physician and requested by another physician or appropriate source, to either recommend care for a specific condition or problem or determine whether to accept responsibility for ongoing management of the patient’s entire care. A consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient’s medical record by either the consulting or requesting physician or appropriate source. The consultant’s opinion and any services that are ordered or performed must also be documented in the patient’s medical record and communicated by written report to the requesting physician or appropriate source. When a consultant follows up on a patient on a regular basis, or assumes an aspect of care on an ongoing basis, the consultant becomes a manager or co-manager of care and submits claims using the appropriate hospital or office codes.

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1. When the same consultant sees the same patient during subsequent admissions, the physician is expected to bill the lower level codes based on the medical records.
2. A confirmatory consultation initiated by a patient and/or their family without a physician request is a covered benefit. Usually, requested second opinions concerning the need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) third opinion will be covered if the first two opinions disagree.

B. New and Established Patients

1. The following visits are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility:
 1. Minimal to low level visits - Most patients should not require more than nine office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a three month period. No prior authorization is required.
 2. Moderate visits - Generally, most patients should not require more than 12 office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a 12 month calendar year. No prior authorization is required.
 3. High severity visits - Generally, most patients should not require more than two office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a 12 month period. Any exception to the limit requires prior authorization.
2. Documentation in the patient's medical record must support the level of service and/or the medical acuity which requires more frequent visits and the resultant coding. Documentation must be submitted to Medicaid upon request. A review of requested reports may result in payment denial and a further review by Medicaid's Surveillance and Utilization Review (SUR) subsystem.
3. Medicaid does not reimburse physicians for telephone calls between physicians and patients (including those in which the physician gives advice or instructions to or on behalf of a patient) except documented psychiatric treatment in crisis intervention (e.g. threatened suicide).

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4. New patient procedure codes are not payable for services previously provided by the same physician or another physician of the same group practice, within the past three years.
5. Some of the procedures or services listed in the Current Procedural Terminology (CPT) code book are commonly carried out as an integral component of a total service or procedure and have been identified by the inclusion of the term “separate procedure”. Do not report a designated “separate procedure” in addition to the code for the total procedure or service of which it is considered an integral component. A designated “separate procedure” can be reported if it is carried out independently or is considered to be unrelated or distinct from other procedures/services provided at the same time.
6. Physical therapy administered by a Physical Therapist (PT) on staff or under contract in the physician’s office requires a prior authorization before rendering service.

If the physician bills for physical therapy, the physician, not the PT, must have provided the service.

A physician may bill an office visit in addition to physical therapy, on the same day in the following circumstances:

- a. A new patient examination which results in physical therapy on the same day;
- b. An established patient with a new problem or diagnosis; and/or
- c. An established patient with an unrelated problem or diagnosis.

Reference MSM Chapter 1700 for physical therapy coverage and limitations.

7. Physician administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200 for coverage and limitations.
8. Non-Covered Physician services
 - a. Investigational or experimental procedures not approved by the Food and Drug Administration (FDA).
 - b. Reimbursement for clinical trials and investigational studies.

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- c. Temporomandibular Joint (TMJ) related services (see MSM Chapter 1000 - Dental).

A. Referrals

When a prior authorization is required for either in-state or out-of-state services, the referring physicians are responsible for obtaining a prior authorization from the QIO-like vendor. If out-of-state services are medically necessary, the recipient must go to the nearest out-of-state provider for services not provided in-state. It is also the responsibility of the referring physician to obtain the authorization for a recipient to be transferred from one facility to another, either in-state or out-of-state.

B. Hospice

Physicians are responsible for obtaining prior authorization for all services not related to the morbidity that qualifies the recipient for Hospice. Physicians should contact Hospice to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200 for coverage and limitations.

C. Home Health Agency (HHA)

HHA services provide periodic nursing care along with skilled and non-skilled services under the direction of a qualified physician. The physician is responsible for writing the orders and participating in the development of the plan of care. Reference MSM Chapter 1400 for coverage and limitations.

D. Laboratory

Reference MSM Chapter 800 for coverage and limitations for laboratory services.

E. Diagnostic Testing

Reference MSM Chapter 300 for coverage and limitations for diagnostic services.

603.2A AUTHORIZATION PROCESS

Certain physician services require prior authorization. There is no prior authorization requirement for allergy testing, allergy injections or for medically necessary minor office procedures unless specifically noted in this chapter. Contact the QIO-like vendor for prior authorization information.

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603.3 FAMILY PLANNING SERVICES

State and federal regulations grant the right for eligible Medicaid recipients of either sex of child-bearing age to receive family planning services provided by any participating clinics, physician, PA, APRN, CNM, or pharmacy.

Females, who are enrolled for pregnancy-related services only, are covered for all forms of family planning, including tubal ligation and birth control implantation up to 60 days post-partum including the month in which the 60th day falls.

Abortions (surgical or medical) and/or hysterectomies are not included in Family Planning Services. These procedures are a Medicaid benefit for certain therapeutic medical diagnoses.

Family Planning Services and supplies are for the primary purpose to prevent and/or space pregnancies.

A. Prior authorization is not required for:

1. Physician services.
2. Physical examination.
3. Annual pap smear for family planning.
4. Birth control devices which include but are not limited to the following:
 - a. Intrauterine contraceptive device (IUD);
 - b. Birth control pills;
 - c. Diaphragm;
 - d. Foam and/or jelly;
 - e. Condoms;
 - f. Implanted contraception capsules/devices;

Note: When a woman has an implanted device inserted, she may no longer be eligible for Medicaid when it is time to remove the implant. There is no process for Medicaid reimbursement when the recipient is not Medicaid-eligible.

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- g. Depo-Provera injections; (if drug obtained by Rx, physician bills for IM admin only). If in the case of birth control injections, the only service rendered is the injection, an appropriate minimal office visit may be listed in addition to the injection.
1. Vaginal suppositories;
 2. Contraceptive dermal patch; and/or
 3. Contraceptive injection, other.
5. Vasectomy or tubal ligation (age 21 and over). In accordance with federal regulations, the recipient must fill out a consent form at least 30 days prior to the procedure. The physician is required to send the consent form to the fiscal agent with the initial claim. (See the DHCFP website at <http://dhcfnv.gov/> under Forms and the Hewlett Packard Enterprise Services (HPES) provider portal at: <https://www.medicaid.nv.gov/providers/forms/forms.aspx> for consent forms).
- B.** Medicaid has removed all barriers to family planning counseling/education provided by qualified physicians. (e.g. Physicians, Rural Health Clinics/Federally Qualified Clinics, Indian Health Services/Tribal Clinics, and Home Health Agencies, etc.) The physician must provide adequate counseling and information to each recipient when they are choosing a birth control method. If appropriate, the counseling should include the information that the recipient must pay for the removal of any implants when the removal is performed after Medicaid eligibility ends.
- C.** Family planning education is considered a form of counseling intended to encourage children and youth to become comfortable discussing issues such as sexuality, birth control and prevention of sexually transmitted disease. It is directed at early intervention and prevention of teen pregnancy. Family planning services may be provided to any eligible recipient of childbearing age (including minors who may be considered sexually active).
- D.** Insertion of Long Acting Reversible Contraceptives (LARC) immediately following delivery is a covered benefit for eligible recipients. LARC insertion is a covered benefit post discharge as medically necessary.
- E.** Family Planning Services are not covered for those recipients, regardless of eligibility, whose age or physical condition precludes reproduction.

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603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, delivery, and postpartum care provided by a physician and/or a nurse midwife. For women who are eligible for pregnancy-related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the month in which the 60th day falls. She is eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21, and eligible for pregnancy only, are not entitled to EPSDT services.

It is the responsibility of the treating physician to employ a care coordination mechanism to facilitate the identification and treatment of high risk pregnancies. “High Risk” is defined as a probability of an adverse outcome to the woman and/or her baby greater than the average occurrence in the general population.

For those females enrolled in a managed care program, the Managed Care Organization (MCO) physicians are responsible for making referrals for early intervention and case management activities on behalf of those women. Communication and coordination between the physicians, service physicians, and MCO staff is critical to promoting optimal birth outcomes.

A. Stages of Maternity Care

1. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery totaling approximately 13 routine visits. Any other visits or services within this time period for non-routine maternity care should be coded separately. Antepartum care is not a covered benefit for illegal non-U.S. citizens.
2. Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without an episiotomy/forceps), or cesarean delivery. Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the CPT Medicine and Evaluation and Management Services section in addition to codes for maternity care.
 - a. In accordance with standard regulations, vaginal deliveries with a hospital stay of three days or less and cesarean-section deliveries with a hospital stay of four days or less do not require prior authorization. Reference MSM Chapter 200 for inpatient coverage and limitations.
 - b. Non-Medically Elective Deliveries

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1. Reimbursement for Avoidable Cesarean Section

To make certain that cesarean sections are being performed only in cases of medical necessity, the DHCFP will reimburse physicians for performing cesarean sections only in instances that are medically necessary and not for the convenience of the provider or patient. Elective cesarean sections must be prior authorized and will be reimbursed at the vaginal delivery rate.

2. Early Induction of Labor (EIOL)

The American Congress of Obstetricians and Gynecologists (ACOG) issued a Revision of Labor Induction Guidelines in July 2009, citing, “The rate of labor induction in the US has more than doubled since 1990. In 2006, more than 22% (roughly one out of every five) of all pregnant women had their labor induced.” The revision further states, “... the ACOG recommendations say the gestational age of the fetus should be determined to be at least 39 weeks or that fetal lung maturity must be established before induction.”

Research shows that early elective induction (<39 weeks gestation) has no medical benefit and may be associated with risks to both the mother and infant. Based upon these recommendations, the DHCFP will require prior authorization for hospital admissions for EIOL prior to 39 weeks to determine medical necessity.

The DHCFP encourages providers to review the toolkit compiled by The March of Dimes, The California Maternity Quality Care Collaborative, and The California Department of Public Health, Maternal, Child and Adolescent Health Division. The aim of the toolkit is to offer guidance and support to Obstetrician/Gynecologist (OB/GYN) providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

c. Physician responsibilities for the initial newborn examination and subsequent care until discharge includes the following:

1. The initial physical examination done in the delivery room is a rapid screening for life threatening anomalies that may require immediate billable attention.

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2. Complete physical examination is done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized. This examination is billable.
 3. Brief examinations should be performed daily until discharge. On day of discharge, physician may bill either the brief examination or discharge day code, not both.
 4. Routine circumcision of a newborn male is a Medicaid benefit for males up to one year of age. For males older than one year of age, a prior authorization is required to support medical necessity.
 5. If a newborn is discharged less than 24 hours after delivery, Medicaid will reimburse newborn follow-up visits in the physician's office up to four days post delivery.
 6. In accordance with Nevada Revised Statute (NRS) 442.540, all newborns must receive hearing screenings. This testing and interpretation is included in the facility's per diem rate.
3. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery. Women, who are eligible for Medicaid on the last day of their pregnancy, remain eligible for all pregnancy related and postpartum medical assistance including family planning education and services for 60 days immediately following the last day of pregnancy. Pregnancy related only eligible women are not covered for any Medicaid benefits not directly related to their pregnancy.
 4. Reimbursement: If a physician provides all or part of the antepartum and/or postpartum care, but does not perform delivery due to termination of the pregnancy or referral to another physician, reimbursement is based upon the antepartum and postpartum care CPT codes. A global payment will be paid to the delivering obstetrician, when the pregnant woman has been seen seven or more times by the delivering obstetrician. If the obstetrician has seen the pregnant woman less than seven times with or without delivery, the obstetrician will be paid according to the Fee-for-Service (FFS) visit schedule using the appropriate CPT codes. For MCO exceptions to the global payment please refer to MSM Chapter 3600. Please refer to MSM Chapter 700 – Rates and Cost Containment for more information.

B. Maternal Diagnostic Testing

1. Fetal Non-Stress testing (NST) is the primary means of fetal surveillance for most conditions that place the fetus at high risk for placental insufficiency. The test is

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classified as reactive if, during a 20- minute period, at least two accelerations of the fetal heart rate are present, each at least 15 beats above the baseline rate and lasting at least 15 seconds. The test is non-reactive if fewer than two such accelerations are present in a 45-minute period.

2. There is a difference in placing a patient on a monitor to see if she is contracting, versus performing a complete NST. Therefore, when billing for an NST, the following must be included in the final interpretation:
 - a. patient name;
 - b. date of service;
 - c. gestational age;
 - d. diagnosis;
 - e. indication for test;
 - f. interpretation;
 - g. fetal heart rate baseline;
 - h. periodic changes;
 - i. recommended follow up; and
 - j. provider signature

3. Medicaid recognizes the following NST schedule (presuming fetal viability has been reached):

Diagnosis	Testing interval
Prior stillbirth	Weekly (starting at 32-35 weeks)
Maternal medical conditions: Insulin-dependent diabetes Hypertension Renal disease Collagen vascular disease	Weekly at 32-35 weeks (earlier if indicated), then twice weekly Weekly (starting at 32-35 weeks or when indicated) Weekly (starting at 32-35 weeks or when indicated) Weekly (starting at 32-35 weeks or when indicated)
Obstetric complications: Premature rupture of membranes Preeclampsia Discordant twins Intrauterine growth retardation	At admission to hospital Twice weekly if stable Twice weekly Twice weekly

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Postdates pregnancy	Twice weekly from 41.5 weeks
Fetal abnormalities: Diminished movement Decreased amniotic fluid volume	As needed Twice weekly
Labor	As needed

4. Home uterine activity monitoring service may be ordered for a recipient who has a current diagnosis of pre-term labor and a history of pre-term labor/delivery with previous pregnancies. Reference Nevada Medicaid’s Durable Medical Equipment (DME) Coverage and Limitation Guidelines (MSM Chapter 1300).

C. Maternal/Fetal Diagnostic Studies

Obstetrical ultrasound of a pregnant uterus is a covered benefit of Nevada Medicaid when it is determined to be medically necessary. Ultrasound for the purpose of sex determination is not a covered benefit. Per CPT guidelines, an obstetrical ultrasound includes determination of the number of gestational sacs and fetuses, gestational sac/fetal structure, qualitative assessment of amniotic fluid volume/gestational sac shape, and examination of the maternal uterus and adnexa. The patient’s record must clearly identify all high risk factors and ultrasound findings.

A first trimester ultrasound may be covered to confirm viability of the pregnancy, to rule out multiple births and better define the Estimated Date of Confinement (EDC).

One second trimester ultrasound with detailed anatomic examination is considered medically necessary per pregnancy to evaluate the fetus for known or suspected fetal anatomic abnormalities.

It is policy to perform ultrasound with detailed fetal anatomic study only on those pregnancies identified as being at risk for structural defects (e.g. advanced maternal age, prior anomalous fetus, medication exposure, diabetes, etc.).

The use of a second ultrasound in the third trimester for screening purposes is not covered. Subsequent ultrasounds, including biophysical profiles should clearly identify the findings from the previous abnormal scan and explain the high-risk situation which makes repeated scans medically necessary. The patient’s record must clearly identify all high risk factors and ultrasound findings.

For a list of maternal/fetal diagnostic codes, please refer to the billing manual.

NOTE: The use of the diagnosis of “Supervision of High Risk Pregnancy” or “Unspecified Complications of Pregnancy” without identifying the specific high risk or complication will result in non-payment.

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603.4A COVERAGE AND LIMITATIONS

A. Ultrasound coverage includes, but is not limited to:

1. Suspected abnormality in pregnancy, such as:

- a.** Suspected ectopic pregnancy;
- b.** Suspected hydatiform mole;
- c.** Threatened or missed abortion;
- d.** Congenital malformation, fetal or maternal;
- e.** Polyhydramnios;
- f.** Oligohydramnios;
- g.** Placenta previa;
- h.** Abruptio placenta; or
- i.** Vaginal bleeding.

2. Medical conditions threatening the fetus and/or delivery, such as:

- a.** Suspected abnormal presentation;
- b.** Suspected multiple gestation;
- c.** Significant difference between the size of the uterus and the expected size based on EDC (> 3 cm);
- d.** Elevated maternal serum alpha-fetoprotein;
- e.** Suspected fetal death;
- f.** Suspected anatomical abnormality of uterus;
- g.** Maternal risk factors, such as family history of congenital anomalies or chronic systemic disease (hypertension, diabetes, sickle cell disease, anti-phospholipid syndrome, poorly controlled hyperthyroidism, Hemoglobino-

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pathies, cyanotic heart disease, systemic lupus erythematosus) or substance abuse;

h. Suspected macrosomia; or

i. Intrauterine Growth Retardation-IUGR ($\leq 15^{\text{th}}$ percentile of the combined biometrical parameters-biparietal diameter, head circumference, abdominal circumference, head/abdominal circumference ration, length of femur and length of humerus, and estimated fetal weight).

3. Confirmation of the EDC when clinical history and exam are uncertain. In general, a single ultrasound performed between 14 and 24 weeks is sufficient for this purpose.

4. Diagnosis of “decreased fetal movement” (accompanied by other clinical data, i.e. abnormal kick counts).

5. Follow up ultrasounds which may be considered medically necessary if the study will be used to alter or confirm a treatment plan.

B. Noncoverage - Ultrasound is not covered when it fails to meet the medical necessity criteria listed above or for the reasons listed below:

1. When the initial screening ultrasound (regardless of trimester) is within normal limits or without a significant second diagnosis.

2. When used solely to determine the sex of the neonate, or to provide the mother with a picture of the baby.

603.4B PROVIDER RESPONSIBILITY

A. For repeat evaluations, documentation should include, at a minimum:

1. Documentation of the indication for the study (abnormality or high risk factors);

2. Crown-rump length (CRL);

3. Biparietal diameter (BPD);

4. Femur length (FL);

5. Abdominal circumference (AC);

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6. Re-evaluation of organ system;
7. Placental location;
8. Number of fetuses (embryos);
9. Amniotic fluid volume assessment (qualitative or quantitative)
 - a. Oligohydramnios; or
 - b. Polyhydramnios.
10. Intrauterine growth restriction (IUGR).

The following table offers a guideline for biophysical profile.

BPP SCORE	ASSESSMENT	MANAGEMENT
10/10 or 8/10 with normal AFV*	Low risk	<ul style="list-style-type: none"> • for high risk pregnancies • may repeat in 1 week
8/10 with abnormal AFV*	High Risk	re-eval for AVF* within 24 hours**
6/10 with normal AFV*	Equivocal Result	may repeat in 24 hours**
6/10 with abnormal AFV*	High Risk	may repeat in 24 hours**
0/10, 2/10, 4/10	High Risk	intervention or delivery

* AFV – Amniotic Fluid Volume

** The repeat biophysical profile must clearly indicate the previous abnormal result and reason for repeating this exam.

B. Abortion/Termination of pregnancy

1. Reimbursement is available for an induced abortion to save the life of the mother, only when a physician has attached a signed certification to the claim that on the basis of his/her professional judgment, and supported by adequate documentation, the life of the mother would be endangered if the fetus were carried to term. (See the DHCFP website at <http://dhcfp.nv.gov/> under Forms and the HPES provider portal at: <http://www.medicaid.nv.gov/providers/forms/forms.aspx> or substitute any form that includes the required information.)
2. Reimbursement is available for induced abortion services resulting from a sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to the claim (See the DHCFP website at <http://dhcfp.nv.gov/> under Forms and the HPES portal at <https://www.medicaid.nv.gov/providers/forms/forms.aspx> or substitute any form that includes the required information). The Nevada mandatory reporting laws related to child abuse and neglect must be followed for

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all recipients under the age of 18 and physicians are still required to report the incident to Child Protective Services (CPS) through the Division of Child and Family Services (DCFS) or, in some localities, through County Child Welfare Services.

3. Reimbursement is available for the treatment of incomplete, missed, or septic abortions under the criteria of medical necessity. The claim should support the procedure with sufficient medical information and by diagnosis. No certification or prior authorization is required.

NOTE: Any abortion that involves inpatient hospitalization requires a prior authorization from the QIO-like vendor. See MSM Chapter 200 for further information.

C. Hysterectomy

According to federal regulations, a hysterectomy is not a family planning (sterilization) procedure. Hysterectomies performed solely for the purpose of rendering a female incapable of reproducing are not covered by Medicaid. All hysterectomy certifications must have an original signature of the physician certifying the forms. A stamp or initial by billing staff is not acceptable. Payment is available for hysterectomies as follows:

1. Medically Necessary – A medically necessary hysterectomy may be covered only when the physician securing the authorization to perform the hysterectomy has informed the recipient or her representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the recipient permanently incapable of reproducing, and the recipient or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form (See the DHCFP website at <http://dhcfp.nv.gov/> under Forms and the HPES provider portal at <http://www.medicaid.nv.gov/providers/forms/forms.aspx> for a sample of the form).
2. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form is also required. Therefore, it is advisable to inform the recipient or her authorized representative prior to the exploratory surgery or biopsy.
3. Emergency – The physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The completed Physician Statement must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, and anesthesiologist). The physician must include a description of the nature of the emergency and this certification must be

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dated after the emergency. The recipient does not have to sign this form. An example of this situation would be when the recipient is admitted to the hospital through the emergency room for immediate medical care and the recipient is unable to understand and respond to information pertaining to the acknowledgment of receipt of hysterectomy information due to the emergency nature of the admission.

4. Sterility – The physician who performs the hysterectomy certifies in writing that the recipient was already sterile at the time of the hysterectomy and needs to include a statement regarding the cause of the sterility. The completed Physician Statement must be attached to each claim form related to the hysterectomy. The recipient does not have to sign the form. (For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.)
5. Hysterectomies Performed During a Period of Retroactive Eligibility – Reimbursement is available for hysterectomies performed during periods of retroactive eligibility. In order for payment to be made in these cases, the physician must submit a written statement certifying one of the following conditions was met:
 - a. He or she informed the woman before the operation the procedure would make her sterile. In this case, the recipient and the physician must sign the written statement; or,
 - b. The woman met one of the exceptions provided in the physician’s statement. In this case, no recipient signature is required. Claims submitted for hysterectomies require the authorization number for the inpatient admission. The authorization process will ensure the above requirements were met. Payment is not available for any hysterectomy performed for the purpose of sterilization or which is not medically necessary.

603.5 ANNUAL GYNECOLOGIC EXAM

Nevada Medicaid reimburses providers for annual preventative gynecological examinations, along with the collection of a Pap smear, for women who are or have been sexually active or are age 18 or older. The examinations include breast exam, pelvic exam and tissue collection (also known as Pap smear).

603.6 CHIROPRACTIC SERVICES POLICY

Medicaid will pay for a chiropractic manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuro-musculoskeletal condition for which manipulation is the appropriate treatment.

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Services are limited to Medicaid eligible children under 21 years of age and Qualified Medicare Beneficiaries (QMB's).

A. Prior authorization is not required for:

1. Four or less chiropractic office visits (emergent or non-emergent) for children under 21 years of age in a rolling 365 days. The visits must be as a direct result of an EPSDT screening examination, diagnosing acute spinal subluxation.
2. Chiropractic services provided to a QMB recipient.

B. Prior authorization is required for:

Chiropractic visits for children under 21 years of age whose treatment exceeds the four visits. The physician must contact the Nevada Medicaid QIO-like vendor for prior authorization.

603.7 **PODIATRY**

Podiatry services are those services provided by health professionals trained to diagnose and treat diseases and other disorders of the feet. A podiatrist performs surgical procedures and prescribes corrective devices, medications and physical therapy. For Nevada Medicaid recipient's podiatric services are limited to QMB recipients and Medicaid eligible children referred as the result of a Healthy Kids (EPSDT) screening examination.

A. Prior Authorization

1. Prior authorization is not required for podiatric office visits provided for children as a direct result of a Healthy Kids (EPSDT) screening examination).
2. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination or a surgical procedure must be billed using the appropriate Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS) code. Medicaid will pay for the orthotic in addition to the office visit.
3. Prior authorization is not required for Podiatry services provided to a QMB or QMB/MED recipient. Medicaid automatically pays the co-insurance and deductible up to Medicaid's maximum reimbursement after Medicare pays. If Medicare denies the claim, Medicaid will also deny payment.

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B. Non Covered Services

Preventive care including the cleaning and soaking of feet, the application of creams to insure skin tone, and routine foot care are not covered benefits. Routine foot care includes the trimming of nails, cutting or removal of corns and calluses in the absence of infection or inflammation.

603.8 PHYSICIAN SERVICES PROVIDED IN RURAL HEALTH CLINICS

A. Rural Health Clinic (RHC)

1. Medicaid covered outpatient services provided in RHCs are reimbursed at an all-inclusive per recipient per encounter rate. Regardless of the number or types of providers seen, only one encounter is reimbursable per day.

This all-inclusive rate includes any one or more of the following services and medical professionals:

- a. Physician (MD/DO);
- b. Dentist;
- c. Advance Practice Registered Nurse (APRN);
- d. Physician Assistant (PA/PA-C);
- e. Certified Registered Nurse Anesthetist (CRNA);
- f. Certified Nurse Midwife (CNM);
- g. Psychologist;
- h. Licensed Clinical Social Worker (LCSW);
- i. Registered Dental Hygienist;
- j. Podiatrist (DPM);
- k. Radiology;
- l. Optometrist (OD);
- m. Optician (including dispensing of eyeglasses); and

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n. Clinical Laboratory.

2. Encounter codes are used for primary care services provided by the RHCs in the following areas:

a. Core visits include the following:

1. Medical and dental office visits, patient hospital visits, injections and oral contraceptives;
2. Women's annual preventive gynecological examinations; and
3. Colorectal screenings.

b. Home visits; or

c. Family planning education.

1. Up to two times a calendar year the RHC may bill for additional reimbursement along with the encounter rate.

3. For billing instructions for RHC, please refer to Billing Manual for Provider Type 17.

B. Indian Health Programs (IHP)

Please refer to MSM Chapter 3000.

603.9 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and CRNAs are based on the Centers for Medicare and Medicaid Services (CMS) base units.

A. Each service is assigned a base unit which reflects the complexity of the service and includes work provided before and after reportable anesthesia time. The base units also cover usual preoperative and post-operative visits, administering fluids and blood that are part of the anesthesia care, and monitoring procedures.

B. Time for anesthesia procedures begins when the anesthesiologist begins to prepare the recipient for the induction of anesthesia and ends when the anesthesiologist/CRNA is no longer in personal attendance, and the recipient is placed under postoperative supervision.

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- C.** All anesthesia services are reported by use of the anesthesia five-digit procedure codes. Nevada Medicaid does not reimburse separately for physical status modifiers or qualifying circumstances.
- D.** Using the CPT/ASA codes, providers must indicate on the claim the following:
1. Type of surgery;
 2. Length of time;
 3. Diagnosis;
 4. Report general anesthesia and continuous epidural analgesia for obstetrical deliveries using the appropriate CPT codes; and
 5. Unusual forms of monitoring and/or special circumstances rendered by the anesthesiologist/CRNA are billed separately using the appropriate CPT code. Special circumstances include but are not limited to nasotracheal/bronchial catheter aspiration, intra-arterial, central venous and Swan-Ganz lines, transesophageal echocardiography, and ventilation assistance.

603.10 PHYSICIAN SERVICES IN OUTPATIENT SETTING

- A.** Outpatient hospital based clinic services include non-emergency care provided in the emergency room, outpatient therapy department/burn center, observation area, and any established outpatient clinic sites. Visits should be coded using the appropriate Evaluation/Management (E/M) CPT code (e.g. office visit/observation/etc.) on a CMS-1500 billing form. Do not use emergency visit codes.

Services requiring prior authorization include the following:

1. Hyperbaric Oxygen Therapy for chronic conditions (reference Appendix for Coverage and Criteria);
2. Bariatric surgery for Morbid Obesity;
3. Cochlear implants (See MSM Chapter 2000 – Audiology Services);
4. Diabetes training exceeding 10 hours;
5. Vagus nerve stimulation; and
6. Services requiring authorization per Ambulatory Surgical Center (ASC) list.

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B. Emergency Room Policy

The DHCFP uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services are defined as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the recipient (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 function of any bodily organ or part.” The threat to life or health of the recipient necessitates the use of the most accessible hospital or facility available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

1. Prior authorization will not be required for admission to a hospital as a result of a direct, same day admission from a physician’s office and/or the emergency department. The requirement to meet acute care criteria is dependent upon the QIO-like vendor’s determination. The QIO-like vendor will continue to review and perform the retrospective authorization for these admissions based upon approved criteria. Prior authorization is still required for all other inpatient admissions.
2. Direct physical attendance by a physician is required in emergency situations. The visit will not be considered an emergency unless the physician’s entries into the record include his or her signature, the diagnosis, and documentation that he or she examined the recipient. Attendance of a physician’s assistant does not substitute for the attendance of a physician in an emergency situation.
3. Physician’s telephone or standing orders, or both, without direct physical attendance does not support emergency treatment.
4. Reimbursement for physician directed emergency care and/or advanced life support rendered by a physician located in a hospital emergency or critical care department, engaged in two-way voice communication with the ambulance or rescue personnel outside the hospital is not covered by Medicaid.
5. Services deemed non-emergency and not reimbursable at the emergency room level of payment are:
 - a. Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition;
 - b. Refusal to comply with currently ordered procedures or treatments;

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- c. The recipient had previously been treated for the same condition without worsening signs or symptoms of the condition;
- d. Scheduled visit to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion;
- e. Visits made to receive a “tetanus” injection in the absence of other emergency conditions;
- f. The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition;
- g. Medical clearance/screenings for psychological or temporary detention ordered admissions; and
- h. Diagnostic x-ray, diagnostic laboratory, and other diagnostic tests provided as a hospital outpatient service are limited to physician ordered tests considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body member. For coverage and limitations, reference MSM Chapter 300 for Radiology and Diagnostic Services and MSM Chapter 800 for Laboratory Services.

C. Therapy Services (OT, PT, RT, ST)

Occupational, Physical, Respiratory and Speech Therapy services provided in the hospital outpatient setting are subject to the same prior authorization and therapy limitations found in the MSM, Chapter 1700 – Therapy.

D. Observation Services Provided by The Physician

- 1. Observation services are provided by the hospital and supervising physician to recipients held but not admitted into an acute hospital bed for observation. Consistent with federal Medicare regulations, the DHCFP reimburses hospital “observation status” for a period up to, but no more than 48 hours.
- 2. Observation services are conducted by the hospital to evaluate a recipient’s condition or to assess the need for inpatient admission. It is not necessary that the recipient be located in a designated observation area such as a separate unit in the

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3. hospital, or in the emergency room in order for the physician to bill using the observation care CPT codes, but the recipient’s observation status must be clear.
4. If observation status reaches 48 hours, the physician must make a decision to:
 - a. Send the recipient home;
 - b. Obtain authorization from the QIO-like vendor to admit into the acute hospital; or
 - c. Keep the recipient on observation status with the understanding neither the physician nor the hospital will be reimbursed for any services beyond the 48 hours.
5. The physician must write an order for observation status, and/or an observation stay that will rollover to an inpatient admission status.

See MSM Chapter 200 for policy specific to the facility’s responsibility for a recipient in “observation status.”

E. End Stage Renal Disease (ESRD) Outpatient Hospital/Free-Standing Facilities. The term “end-stage renal disease” means the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

1. Treatment of ESRD in a physician-based (i.e. hospital outpatient) or independently operated ESRD facility certified by Medicare is a Medicaid covered benefit. Medicaid is secondary coverage to Medicare for ESRD treatment except in rare cases when the recipient is not eligible for Medicare benefits. In those cases, private insurance and/or Medicaid is the primary coverage
2. ESRD Services, including hemodialysis, peritoneal dialysis, and other miscellaneous dialysis procedures are Medicaid covered benefits without prior authorization.
3. If an established recipient in Nevada needs to travel out of state, the physician or the facility must initiate contact and make financial arrangements with the out of state facility before submitting a prior authorization request to the QIO-like vendor. The request must include dates of service and the negotiated rate. (This rate cannot exceed Medicare’s reimbursement for that facility).

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4. Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are covered services for hemodialysis and Continuous Ambulatory Peritoneal Dialysis (CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.
5. Reference Attachment A, Policy #6-09 for ESRD Coverage.

F. Ambulatory Centers (ASC) Facility and Non-Facility Based

Surgical procedures provided in an ambulatory surgical facility refers to freestanding or hospital-based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients who do not generally require extended lengths of stay or extensive recovery or convalescent time.

Outpatient surgical procedures designated as acceptable to be performed in a physician's office/outpatient clinic, ambulatory surgery center or outpatient hospital facility are listed on the QIO-like vendors website. For questions regarding authorization, the physician should contact the QIO-like vendor.

1. Prior authorization is not required when:
 - a. Procedures listed are to be done in the suggested setting or a setting which is a lower level than suggested;
 - b. Procedures are part of the emergency/clinic visit; and
 - c. If the recipient is a QMB the procedure is covered first by Medicare, and Medicaid reimburses the co-insurance and deductible, up to the Medicaid allowable.
2. Prior authorization is required from the QIO-like vendor when:
 - a. Procedures are performed in a higher level facility than it is listed in the ASC surgical list (e.g., done in an ASC but listed for the office);
 - b. Procedures on the list are designated for prior authorization;
 - c. Designated podiatry procedures; and

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- d. The service is an out-of-state service, and requires a prior authorization if that same service was performed in-state.
3. Surgical procedures deemed experimental, not well established or not approved by Medicare or Medicaid are not covered and will not be reimbursed for payment. Below is a list of definitive non-covered services.
 - a. **Cosmetic Surgery:** The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the recipient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or the improvement of a malformed body member, to restore or improve function, which coincidentally services some cosmetic purpose. Examples of procedures which do not meet the exception to the exclusion are facelift/wrinkle removal (rhytidectomy), nose hump correction, moon-face, routine circumcision, etc;
 - b. Fabric wrapping of abdominal aneurysm;
 - c. Intestinal bypass surgery for treatment of obesity;
 - d. Transvenous (catheter) pulmonary embolectomy;
 - e. Extracranial-Intracranial (EC-IC) Arterial bypass when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries;
 - f. Breast reconstruction for cosmetic reasons, however breast reconstruction following removal of a breast for any medical reason may be covered;
 - g. Stereotactic cingulotomy as a means of psychosurgery to modify or alter disturbances of behavior, thought content, or mood that are not responsive to other conventional modes of therapy, or for which no organic pathological cause can be demonstrated by established methods;
 - h. Radial keratotomy and keratoplasty to treat refractive defects. Keratoplasty that treats specific lesions of the cornea is not considered cosmetic and may be covered;
 - i. Implants not approved by the FDA; Partial ventriculectomy, also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery;

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- j. Gastric balloon for the treatment of obesity;
 - k. Transsexual surgery, also known as sex reassignment surgery or intersex surgery and all ancillary services including the use of pharmaceuticals;
 - l. Cochleostomy with neurovascular transplant for Meniere's Disease;
 - m. Surgical procedures to control obesity other than bariatric for morbid obesity with significant comorbidities. See Appendix A for policy limitations; and
 - n. Organ transplantation and associated fees are a limited benefit for Nevada Medicaid recipients.
4. The following organ transplants, when deemed the principal form of treatment are covered:
- a. Bone Marrow/Stem Cell – allogeneic and autologous;
 - b. Noncovered conditions for bone marrow/stem cell:
 - 1. Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma;
 - 2. Autologous stem cell transplantation is not covered as treatment for acute leukemia not in remission, chronic granulocytic leukemia, solid tumors (other than neuroblastoma) and tandem transplantation for recipients with multiple myeloma;
 - c. Corneal – allograft/homograft;
 - d. Kidney – allotransplantation/autotransplantation; and
 - e. Liver – transplantation for children (under age 21) with extrahepatic biliary atresia or for children or adults with any other form of end-stage liver disease. Coverage is not provided with a malignancy extending beyond the margins of the liver or those with persistent viremia.
5. Prior authorization is required for bone marrow, kidney, and liver transplants from Medicaid's contracted QIO-like vendor.
6. A transplant procedure shall only be approved upon a determination that it is a medically necessary treatment by showing that:

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- a. The procedure is not experimental and/or investigational based on Title 42, Code of Federal Regulations (CFR), Chapter IV (Health Care Financing Administration) and Title 21, CFR, Chapter I FDA;
- b. The procedure meets appropriate Medicare criteria;
- c. The procedure is generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is proposed, or there is authoritative evidence that attests to the proposed procedures safety and effectiveness; and
- d. If the authorization request is for chemotherapy to be used as a preparatory therapy for transplants, an approval does not guarantee authorization for any harvesting or transplant that may be part of the treatment regimen. A separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out of state.

603.11 SERVICES IN THE ACUTE HOSPITAL SETTING

- A. Admissions to acute care hospitals both in and out of state are limited to those authorized by Medicaid's QIO-like vendor as medically necessary and meeting Medicaid benefit criteria.
- B. Physicians may admit without prior approval only in the following situations:
 1. An emergency (defined in MSM Chapter 100);
 2. Obstetrical labor and delivery; or
 3. Direct Admission from doctor's office.
- C. All other hospital admissions both in-state and out-of-state must be prior authorized by the QIO-like vendor. Payment will not be made to the facility or to the admitting physician, attending physician, consulting physician, anesthesiologist, or assisting surgeons denied by the QIO-like vendor admissions.
- D. Attending physicians are responsible for ordering and obtaining prior authorization for all transfers from the acute hospital to all other facilities.
- E. Physicians may admit recipients to psychiatric and/or substance abuse units of general hospitals (regardless of age), or freestanding psychiatric and substance abuse hospitals for recipients 65 and older or those under the age of 21. All admissions must be prior

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authorized by the QIO-like vendor with the exception of a psychiatric emergency. Refer to MSM Chapter 400 for coverage and limitations.

F. Inpatient Hospital Care

1. Routine Inpatient Hospital Care is limited to reimbursement for one visit per day (same physician or physicians in the same group practice) except when extra care is documented as necessary for an emergency situation (e.g., a sudden serious deterioration of the recipient's condition).
2. The global surgical package includes the following when provided by the physician who performs the surgery, whether in the office setting, out-patient or in-patient:
 - a. Preoperative visits up to two days before the surgery;
 - b. Intraoperative services that are normally a usual and necessary part of a surgical procedure;
 - c. Services provided by the surgeon within the Medicare recommended global period of the surgery that do not require a return trip to the operating room; and follow-up visits related to the recovery from the surgery which are provided during this time by the surgeon; and
 - d. Post surgical pain management.
3. The surgeon's initial evaluation or consultation is considered a separate service from the surgery and is paid as a separate service, even if the decision, based on the evaluation, is not to perform the surgery. If the decision to perform a major surgery (surgical procedures with a 90-day global period) is made on the day of or the day prior to the surgery, separate payment is allowed for the visit on which the decision is made, however supporting documentation may be requested. If post payment audits indicate documentation is insufficient to support the claim, payment will be adjusted accordingly.
4. If a recipient develops complications following surgery that requires the recipient to be returned to the operating room for any reason for care determined to be medically necessary, these services are paid separately from the global surgery amount. Complications that require additional medical or surgical services but do not require a return trip to the operating room are included in the global surgery amount.
5. Payment may be made for services by the surgeons that are unrelated to the diagnosis for which the surgery was performed during the post-operative period.

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Supportive documentation may be requested. Services provided by the surgeon for treating the underlying condition and for a subsequent course of treatment that is not part of the normal recovery from the surgery are also paid separately. Full payment for the procedure is allowed for situations when distinctly separate but related procedures are performed during the global period of another surgery in which the recipient is admitted to the hospital for treatment, discharged, and then readmitted for further treatment.

6. Payment for physician services related to patient-controlled analgesia is included in the surgeon's global payment. The global surgical payment will be reduced if post-payment audits indicate that a surgeon's recipients routinely receive pain management services from an anesthesiologist. (For a list of covered codes, please refer to the billing manual).
7. For information on payment for assistant surgeons, please refer to the billing manual.
8. There is no post-operative period for endoscopies performed through an existing body orifice. Endoscopic surgical procedures that require an incision for insertion of a scope will be covered under the appropriate major or minor surgical policy which will include a post-operative period according to the Medicare recommended global period.
9. For some dermatology services, the CPT descriptors contain language, such as "additional lesion", to indicate that multiple surgical procedures have been performed. The multiple procedure rules do not apply because the RVU's for these codes have been adjusted to reflect the multiple nature of the procedure. These services are paid according to the unit. If dermatologic procedures are billed with other procedures, the multiple surgery rules apply. For further information, please refer to the billing manual.
10. Critical Care

Critical Care, the direct delivery of medical care by a physician or physicians for a critically ill or critically injured recipient to treat a single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the recipient's conditions, is reimbursed by Medicaid. Reimbursement without documentation is limited to a critical illness or injury which acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the recipient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system functions. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic,

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and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology, critical care may be provided in life threatening situations when these elements are not present.

- a. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the recipient, provided that the recipient's condition continues to require the level of physician attention described above. Providing medical care to a critically ill, injured, or post-operative recipient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.
- b. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.
- c. Services for a recipient who is not critically ill but happen to be in a critical care unit, are reported using other appropriate evaluation/management (E/M) codes.
- d. According to CPT, the following services are included in reporting critical care when performed during the critical period by the physicians providing critical care: the interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) gastric intubation, temporary transcutaneous pacing, ventilatory management and vascular access procedures. Any services performed which are not listed above should be reported separately.
- e. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient.

11. Neonatal and Pediatric Critical Care

- a. Neonatal and Pediatric Critical Care CPT codes are used to report services provided by a single physician directing the care of a critically ill neonate/infant. The same definitions for critical care services apply for the adult, child and neonate. The neonatal and pediatric critical care codes are global 24-hour codes (billed once per day) and are not reported as hourly services consistent with CPT coding instructions.

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- b. Neonatal critical care codes are used for neonates (28 days of age or less) and pediatric critical care codes are used for the critically ill infant or young child age 29 days through 71 months of age, admitted to an intensive or critical care unit. These codes will be applicable as long as the child qualifies for critical care services during the hospital stay.
- c. If the physician is present for the delivery and newborn resuscitation is required, the appropriate E&M code can be used in addition to the critical care codes.
- d. Care rendered under the pediatric critical care codes includes management, monitoring, and treatment of the recipient including respiratory, enteral and parenteral nutritional maintenance, metabolic and hematologic maintenance, pharmacologic control of the circulatory system, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.
- e. In addition to critical services for adults, the pediatric and neonatal critical care codes also include the following procedures:
 - 1. peripheral vessel catheterization;
 - 2. other arterial catheters;
 - 3. umbilical venous catheters;
 - 4. central vessel catheters;
 - 5. vascular access procedures;
 - 6. vascular punctures;
 - 7. umbilical arterial catheters;
 - 8. endotracheal intubation;
 - 9. ventilator management;
 - 10. bedside pulmonary function testing;
 - 11. surfactant administration;

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12. continuous positive airway pressure (CPAP);
13. monitoring or interpretation of blood gases or oxygen saturation;
14. transfusion of blood components;
15. oral or nasogastric tube placement;
16. suprapubic bladder aspiration;
17. bladder catheterization; and
18. lumbar puncture.

Any services performed which are not listed above, may be reported separately.

- f. Initial and Continuing Intensive Care Services are reported for the child who is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, or for services provided by a physician directing the continuing intensive care of the Low Birth Weight (LBW) (1500-2500 grams) present body weight infant, or normal (2501-5000 grams) present body weight newborn who does not meet the definition of critically ill, but continues to require intensive observation, frequent interventions, and other intensive care services.

603.12 PHYSICIAN'S SERVICES IN NURSING FACILITIES

- A. Physician services provided in a Nursing Facility (NF) are a covered benefit when the service is medically necessary. Physician visits must be conducted in accordance with federal requirements for licensed facilities. Reference MSM Chapter 500 for coverage and limitations.
- B. When the recipient is admitted to the NF in the course of an encounter in another site of service (e.g., hospital ER, physician's office), all E/M services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. Admission documentation and the admitting orders/plan of care should include the services related to the admission he/she provided in the other service sites.
- C. Hospital discharge or observation discharge services performed on the same date of NF admission or readmission may be reported separately. For a recipient discharged from inpatient status on the same date of nursing facility admission or readmission, the hospital

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discharge services should be reported as appropriate. For a recipient discharged from observation status on the same date of NF admission or readmission, the observation care discharge services should be reported with the appropriate CPT code.

603.13 PHYSICIAN'S SERVICES IN OTHER MEDICAL FACILITIES

A. Intermediate Care Facility/Mentally Retarded (ICF/MR)

A physician must certify the need for ICF/MR care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/MR, before the Nevada Medicaid Office authorizes payment.) The certification must refer to the need for the ICF/MR level of care, be signed and dated by the physician and be incorporated into the resident's record as the first order in the physician's orders.

Recertification by a physician or an APRN for the continuing need for ICF/MR care is required within 365 days of the last certification. In no instance is recertification acceptable after the expiration of the previous certification. For further information regarding ICF/MR refer to MSM Chapter 1600.

B. Residential Treatment Center (RTC)

Physician services, except psychiatrist are not included in the all-inclusive facility rate for RTCs. Please reference MSM Chapter 400.

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604 COMMUNITY PARAMEDICINE SERVICES

The Division of Health Care Financing and Policy (DHCFP) reimburses for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services fill patient care gaps in a local health care system and prevent duplication of services while improving the healthcare experience for the recipient. Prevention of unnecessary ambulance responses, emergency room visits, and hospital admissions and readmissions can result in cost reductions for the DHCFP.

604.1 COMMUNITY PARAMEDICINE PROVIDER QUALIFICATIONS

- A. The following Nevada-licensed providers may provide community paramedicine services for Nevada Medicaid recipients:
 - 1. Emergency Medical Technician (EMT);
 - 2. Advanced Emergency Technician (AEMT);
 - 3. Paramedic; or
 - 4. Community Paramedic.
- B. Required endorsement:
 - 1. Community paramedicine endorsement from the Nevada Division of Public and Behavioral Health, Office of Emergency Medical Services; or
 - 2. Community paramedicine endorsement from the Southern Nevada Health District's Board of Health.
- C. Must be enrolled as a Nevada Medicaid provider and employed by a permitted Emergency Medical System (EMS) agency.
- D. Must possess a scope of service agreement, based upon the provider's skills, with the Medical Director of the EMS agency under which they are employed.
 - 1. The Medical Director of the EMS agency providing community paramedicine services must be enrolled as a Nevada Medicaid Provider.

604.2 COVERAGE AND LIMITATIONS

Community paramedicine services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed primary care provider (PCP), including a physician (MD/DO),

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an advanced practice registered nurse (APRN) or physician’s assistant (PA) following an appropriate assessment. The PCP must consult with the EMS agency service’s medical director to coordinate the care plan with all local community health providers and the local public health agencies, including home health and waiver services, to avoid duplication of services to the recipient. If a fee-for-service recipient requires more than five visits in the home during a three-month period, they will be referred to the Care Management Organization (CMO) by the EMS agency.

A. The following services can be provided within a community paramedicine provider’s scope of practice as part of a community paramedicine visit when requested in a primary care provider’s care plan:

1. Evaluation/health assessment;
2. Chronic disease prevention, monitoring and education;
3. Medication compliance;
4. Immunizations and vaccinations;
5. Laboratory specimen collection and point of care lab tests;
6. Hospital discharge follow-up care;
7. Minor medical procedures and treatments within their scope of practice as approved by the EMS agency’s medical director;
8. A home safety assessment; and
9. Telehealth originating site.

B. Non-covered services:

1. Travel time;
2. Mileage;
3. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital;
4. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code;

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- 5. Duplicated services; and
 - 6. Personal Care Services.
- C. For a list of covered procedure and diagnosis codes, please refer to the billing manual.
- D. Prior authorization is not required for community paramedicine services.

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605 **FEDERALLY QUALIFIED HEALTH CENTERS**

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. Nevada Medicaid reimburses for medically-necessary services provided at FQHCs and follows State and Federal laws pertaining to them.

605.1 **HEALTH SERVICES**

A. The DHCFP reimburses FQHCs an outpatient encounter rate.

1. Encounter: Any one or more of the following medical professionals are included in the all-inclusive, daily outpatient encounter:

- a. Physician or Osteopath;
- b. Dentist;
- c. Advanced Practice Registered Nurse (APRN);
- d. Physician Assistant;
- e. Certified Registered Nurse Anesthetist (CRNA);
- f. Certified Registered Nurse Midwife;
- g. Psychologist;
- h. Licensed Clinical Social Worker;
- i. Registered Dental Hygienist;
- j. Podiatrist;
- k. Radiology;
- l. Optometrist;
- m. Optician; and
- n. Clinical Laboratory

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B. Encounters are used by FQHCs for Medicaid-covered, HRSA-approved services which include:

1. Primary care services: medical history, physical examination, assessment of health status, treatment of a variety of conditions amenable to medical management on an ambulatory basis by an approved provider and related supplies;
2. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;
3. Early periodic screenings (Refer to Medicaid Services Manual (MSM) Chapter 1500, Healthy Kids), for EPSDT screening policy and periodicity recommendations;
4. Preventive health services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and education (Refer to MSM Chapter 600, Physicians Services, Attachments #6-12 through #6-14 for preventive services policy);
5. Home visits;
6. Diagnostic laboratory and radiology services, including but not limited to cholesterol screening, stool testing for occult blood, tuberculosis testing for high risk patients, dipstick urinalysis;
7. Family Planning services including contraceptives;

Up to two times a calendar year, the FQHC may bill for additional reimbursement for family planning education on the same date of service as the encounter.
8. For women: annual preventive gynecological examinations, prenatal and post-partum care, prenatal services, clinical breast examination, thyroid function test;
9. Vision and hearing screenings;
10. Dental office visits;

Dental encounters are to be billed as applicable with the FQHC encounter reimbursement methodology. An FQHC may bill a dental encounter for each face-to-face encounter. Dentures provided by an FQHC are included in the daily encounter rate unlike the denture policy established in MSM Chapter 1000, Dental, for fee-for-service recipients who obtain dentures at non-FQHC facilities. Medicaid will pay for a maximum of one emergency denture reline and/or a maximum of six adjustments (dental encounters) done not more often than every six months, beginning six months after the date of partial/denture purchase. A prior authorization is not required for relines.

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The FQHCs in-office records must substantially document the medical emergency need. Denture/partial relines and adjustments required within the first six months are considered prepaid with the Medicaid's Dental encounter payment for the prosthetic. All other coverage policies (covered and non-covered for dental, MSM Chapter 1000) are still applicable.

11. Service Limits: An FQHC may reimburse for up to three service specific visits per patient per day to allow for a medical, mental health, and dental visit to occur on a single day for the same patient.

C. Non-covered services under an FQHC encounter:

1. Group therapy;
2. Eyeglasses;
3. Hearing aids;
4. Durable medical equipment, prosthetics, orthotics and supplies; and
5. Ambulance services.

605.2 ANCILLARY SERVICES

All services not recognized by HRSA as approved FQHC encounter services which are an approved Nevada Medicaid State plan service.

- A. Ancillary services may be reimbursed on the same date of service as an encounter by a qualified Medicaid provider.
- B. The FQHC must enroll within the appropriate provider type and meet all MSM coverage guidelines for the specific ancillary service.

605.3 MEDICAL NECESSITY

In order to receive reimbursement, all services provided must be medically necessary as defined in the Medicaid Services Manual (MSM) Chapter 100 (Medical Program).

605.4 PRIOR AUTHORIZATION

- A. FQHC encounters do not require prior authorization.

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- B. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific service provided.

For billing instructions for FQHCs, please refer to the Billing Manual for Provider Type 17.

For Indian Health Programs (IHP) policy, please refer to MSM Chapter 3000, Indian Health.

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606 PREVENTITIVE HEALTH SERVICES

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a patient’s current or possible future health care risks through assessments, lab work and other diagnostic studies.

Nevada Medicaid reimburses for preventive medicine services for men as recommended by the U.S. Preventive Services Task Force (USPSTF) A and B Recommendations.

USPSTF A and B Recommendations

606.1 PRIOR AUTHORIZATION

A. No prior authorization is required.

606.2 COVERAGE AND LIMITATIONS

A. The following preventive health services are covered by Nevada Medicaid for women:

Topic	Description
Abnormal blood glucose and Type 2 diabetes mellitus: screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Alcohol misuse counseling*	The USPSTF recommends clinicians screen adults age 18 years or older, including pregnant women, for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
Aspirin to prevent CVD: women	The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

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Topic	Description
BRCA risk assessment and genetic counseling/testing*	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer preventive medication	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Breast cancer screening	The USPSTF recommends biennial screening mammography for women aged 50-74 .
Breastfeeding counseling*	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

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Topic	Description
Depression screening: adults*	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to assure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	The USPSTF recommends screening abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant woman after 24 weeks gestation.
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
Healthy diet counseling*	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis B screening: non-pregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

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Topic	Description
High blood pressure in adults: screening*	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: pregnant women	The USPSTF strongly recommends that clinicians screen all pregnant women for HIV including those who present in labor who are untested and whose HIV status is unknown.
HIV screening: non-pregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
Intimate partner violence screening: women of childbearing age*	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Obesity screening and counseling: adults*	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Osteoporosis screening: women	The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.
Preeclampsia prevention: aspirin*	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24-28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Skin cancer behavioral counseling*	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer

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Topic	Description
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults*	The USPSTF recommends that clinicians ask all adults about tobacco use, and advise them to stop using tobacco, and provide behavioral interventions U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, and advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

B. The following preventive health services are covered by Nevada Medicaid for men:

Topic	Description
Abnormal blood glucose and type 2 diabetes mellitus: screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol misuse: screening and counseling*	The USPSTF recommends clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

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Topic	Description
Aspirin to prevent CVD: men	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Depression screening: adults*	The USPSTF recommends screening for depression in the general adult population. Screening should be implemented with adequate systems in place to assure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Healthy diet counseling*	The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hepatitis B screening: adolescents and adults*	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

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Topic	Description
High blood pressure in adults: screening*	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: adolescents and adults	The USPSTF strongly recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Young adolescents and older adults who are at increased risk should also be screened.
Obesity screening and counseling: adults*	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Skin cancer behavioral counseling*	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults*	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.

C. The following preventive health services are for children as is age appropriate:

Topic	Description
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF also recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.

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Topic	Description
Depression screening: adolescents	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD). Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective therapy and appropriate follow-up.
Gonorrhea prophylactic medication: newborns*	The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
Hearing loss screening: newborns*	The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns*	The USPSTF recommends screening for sickle cell disease in newborns.
HIV screening: adolescents	The USPSTF strongly recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
Hypothyroidism screening: newborns*	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Obesity screening and counseling: children*	The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
PKU / metabolic screening: newborns*	The USPSTF recommends screening for phenylketonuria (PKU) in newborns.
Skin cancer behavioral counseling*	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.

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Topic	Description
Tobacco use interventions: children and adolescents*	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Visual acuity screening in children*	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

* These screening tests may be performed as part of an office visit, hospital visit or global fee and may not be billed separately.

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607 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM) - 3100 for hearings procedures.

ATTACHMENT A

POLICY #6-01	RESERVED FOR FUTURE USE	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06
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RESERVED FOR FUTURE USE

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POLICY #6-02	WOUND MANAGEMENT	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-01
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A. DESCRIPTION

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

B. POLICY

Wound care is a Nevada Medicaid covered benefit for recipients who have a viable healing process.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. The patient's medical record must include a comprehensive wound history that includes date of onset, location, depth and dimension, exudate characteristics, circulatory, neuropathy, and nutritional assessments, current management and previous treatment regime. The provider must culture all infected wounds prior to initiating systemic antibiotics, per Center for Disease Control guidelines. Photographs are necessary to establish a baseline and to document the progress of the wound, as are weekly measurements. Physicians are expected to educate recipients about the disease process, how to manage their own wound care, and the importance of complying with the treatment plan. This education should be documented in the recipient's medical record.
2. The use of supplies during wound care treatment is considered part of the treatment. Do not bill separately.
3. Burn Care
 - a. Burn care provided in the outpatient hospital setting will follow wound care guidelines with the exception of requiring a prior authorization.
 - b. All diagnosis codes must be coded to the highest level of specificity.

E. COVERED CPT CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-03	OUTPATIENT HOSPITAL BASED HYPERBARIC OXYGEN THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-03
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A. DESCRIPTION

Hyperbaric Oxygen Therapy (HBOT) is therapy in which a recipient breathes 100% oxygen intermittently while the pressure of the treatment chamber is increased to a point higher than sea level pressure (i.e., >1 atm abs.). Breathing 100% oxygen at 1 atm of pressure or exposing isolated parts of the body does not constitute HBOT; the recipient must receive the oxygen by inhalation within a pressurized chamber.

B. POLICY

1. This Nevada Medicaid benefit is covered in an outpatient hospital, with limitations, for chronic conditions. Payment will be made where HBOT is clinically practical. HBOT is not to be a replacement for other standard successful therapeutic measures. Treatment of acute conditions, e.g., acute carbon monoxide intoxication, decompression illnesses, cyanide poisoning, and air or gas embolism may be provided in an outpatient hospital.
2. PRIOR AUTHORIZATION IS REQUIRED for chronic conditions (see billing manual)
3. PRIOR AUTHORIZATION IS NOT REQUIRED for acute conditions (see billing manual)
4. Documentation supporting the reasonableness and necessity of the procedure must be in the recipient's medical record including recipient's risk factors and submitted with the PA when required.

C. COVERAGE AND LIMITATIONS

1. Wound Therapy

Approval will be restricted to requests documenting that the wound has not responded to conventional treatments as outlined in the WOUND MANAGEMENT POLICY (6-02), and initiated by a physician. Attach a copy of the physician's order to the request for treatment. Maximum numbers of treatments authorized on consecutive days are 45. Therapy is conducted once or twice daily for a maximum of 2 hours each treatment.

2. HBOT must be provided and attended by an HBOT physician. Reimbursement will be limited to therapy provided in a chamber (including the one-person unit). No payment will be made for topical HBOT, or for other than the covered diagnosis.
3. Diabetic wounds of the lower extremities in patients who meet the following three criteria:
 - a. Patient has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;
 - b. Patient has wound classified as Wagner grade III or higher; and
 - c. Patient has failed an adequate course of standard wound therapy.

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POLICY #6-03	OUTPATIENT HOSPITAL BASED HYPERBARIC OXYGEN THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-03
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D. COVERED DIAGNOSIS CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-04	INTRATHECAL BACLOFEN (ITB) THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-04
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A. DESCRIPTION/POLICY

FDA approved Intrathecal Baclofen (ITB) Therapy is a Nevada Medicaid covered benefit for recipients with severe spasticity of spinal cord origin, [(e.g. Multiple Sclerosis (MS), Spinal Cord Injury (SCI)], or spasticity of cerebral origin, [e.g., Cerebral Palsy (CP), and Brain Injury (BI)], who are unresponsive to oral Baclofen therapy or who have Intolerable Central Nervous System (CNS) side effects.

B. PRIOR AUTHORIZATION IS REQUIRED

C. COVERAGE AND LIMITATIONS

1. Coverage of treatment will be restricted to recipients with the following indicators:
 - a. Spasticity due to spinal cord origin or spasticity of cerebral origin. If spasticity is result of BI, the injury must have occurred over one year prior to be considered for ITB therapy;
 - b. Severe spasticity (as defined by a score of 3 or more on the Ashworth Scale) in the extremities for a duration of six months or longer;
 - c. Recipients with increased tone that significantly interferes with movement and/or care;
 - d. Spasm score of 2 or more; documentation to include pre and post testing of strength, degree of muscle tone, and frequency of spasm (Spasm Scale not applicable to CP recipients as spasms are not a frequent symptom in these recipients);
 - e. Recipient is four years or older and has sufficient body mass to support the infusion pump;
 - f. Documented six-weeks or more of failed oral antispasmodic drug therapy at the maximum dose. Recipient is refractory to oral Baclofen, or has intolerable side effects;
 - g. Recipient has adequate cerebrospinal fluid flow as determined by myelogram or other studies;
 - h. Recipient has no known allergy to Baclofen;
 - i. Documentation of a favorable response to a trial dose of ITB prior to pump implantation. If recipient requires a second and/or third trial dose of ITB, documentation needs to include videotape of the recipient's arm and leg range of motion to assess spasticity and muscle tone before and after increased test doses of ITB. Recipients who do not respond to a 100-mcg intrathecal bolus of medication are not candidates for an implanted pump for chronic infusion therapy. Recipient must be free of infection at the time of the trial dose;
 - j. Recipient, family, and physicians should agree on treatment goals. Recipient, family and caregivers should be motivated to achieve the treatment goals and be committed to meet the follow-up care requirements;

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POLICY #6-06	INTRATHECAL BACLOFEN (ITB) THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06
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- k. Recipient must be free of systemic infection and/or infection at the implantation site at the time of surgery;
- l. Benefit coverage includes up to three trial doses of ITB, surgical implantation of the device, and follow-up physician office visits for dose adjustments and pump refills.
- 2. Documentation in the recipient’s medical record should include what the expected functional outcomes and improvements in quality of life are for the recipient post procedure, e.g., increased independence, ease of caretaking activities, decreased pain, increased ADL’s, and improved communication. Also, document why the recipient is not a candidate for Botox injections.
- 3. Reimbursement for recipients with low muscle tone (often described as floppy muscles), chorea (uncontrollable, small jerky types of movements of toes and fingers), or athetosis (involuntary movements of face, arms or trunk) are not a Nevada Medicaid benefit.

D. COVERED CODES

For a list of covered procedure and diagnostic codes, please see the billing manual.

POLICY #6-06	RESERVED FOR FUTURE USE	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06
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RESERVED FOR FUTURE USE

POLICY #6-06	VAGUS NERVE STIMULATOR (VNS)	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06
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A. DESCRIPTION

Vagus Nerve Stimulation (VNS) is a method for treating recipients with refractory epilepsy who are not candidates for intracranial surgery and/or continue to be refractory following epilepsy surgery. The programmable NeuroCybernetic Prosthesis (NCP) is surgically implanted in the upper left chest with the leads tunneled to the vagus nerve in the left neck. An external magnet is provided to activate the generator and deliver additional impulses when needed. The external magnet may also be used to inhibit the NCP generator in the event of a malfunction.

B. POLICY

The Vagus Nerve Stimulator (VNS) is a covered Nevada Medicaid benefit. The benefit includes diagnostic EEG, surgical procedure, device and medically necessary follow-up office visits for analysis and reprogramming.

C. PRIOR AUTHORIZATION IS REQUIRED

Documentation supporting the medical necessity of the procedure must be in the recipient's medical record and submitted with the PA when required.

D. COVERAGE AND LIMITATIONS

1. Implantation of VNS is used as an adjunctive therapy in reducing the frequency of seizures in adults and children over age six who have seizures which are refractory to Antiepileptic Drugs (AED). It is also indicated in recipients for whom surgery is not an option, or in whom prior surgery has failed.
2. Coverage is restricted to those recipients with the following indicators:
 - a. Diagnosis of intractable epilepsy;
 - b. Failed antiepileptic drug (AED) therapy tried for two to four months. The medical record should indicate changes/alterations in medications prescribed for the treatment of the recipient's condition. Documentation to include maintaining a constant therapeutic dose of AED as evidenced by laboratory results per manufacturer's recommendations;
 - c. Have six or more medically intractable seizures per month;
 - d. Have no other independent diagnosis that could explain why seizures are failing to respond to treatment;
 - e. A recipient whose epileptologist/neurologist has recommended VNS implantation;
 - f. A surgeon experienced with implantation of the VNS;
 - g. The VNS will be managed by a physician familiar with the settings and protocols for use of the device;

POLICY #6-07	VAGUS NERVE STIMULATOR (VNS)	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-08
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- h. Recipients from three to six years of age must have all of the above indicators;
- i. Be the result of a Healthy Kids Screening (EPSDT) referral for treatment; and
- j. Be supported by peer review literature, and a written recommendation for VNS implantation and use from two Board Certified Pediatric Neurologists (other than the treating neurologist(s)).

- 3. Reasons for non-coverage include, but are not limited to the following diagnoses/conditions: status epilepticus, progressive or unstable neurologic or systemic disorders, severe mental retardation, drug abuse, gastritis, gastric/duodenal ulcers, status post bilateral or left cervical vagotomy, unstable medical condition, pregnancy, use of investigational AED's, bradycardia, hypersecretion of gastric acid and/or a seizure disorder etiology more appropriately treated by other means (i.e., operation).

E. COVERED CODES

For a list of covered procedure and diagnosis codes, please see the billing manual.

POLICY #6-07	BARIATRIC SURGERY FOR MORBID OBESITY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-08
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A. DESCRIPTION/POLICY

1. Bariatric Surgery is a covered Nevada Medicaid benefit reserved for recipients with severe and resistant morbid obesity in whom efforts at medically supervised weight reduction therapy have failed and who are disabled from the complications of obesity. Morbid obesity is defined by Nevada Medicaid as those recipients whose Body Mass Index (BMI) is 35 or greater, and who have significant disabling comorbidity conditions which are the result of the obesity or are aggravated by the obesity. Assessment of obesity includes BMI, waist circumference, and recipient risk factors, including family history.
2. This benefit includes the initial work-up, the surgical procedure and routine post-surgical follow-up care. The surgical procedure is indicated for recipients between the ages of 21 and 55 years with morbid obesity. (Potential candidates older than age 55 will be reviewed on a case by case basis.)

B. PRIOR AUTHORIZATION IS REQUIRED

Documentation supporting the reasonableness and necessity of bariatric surgery must be in the recipient's record and submitted with the PA.

C. COVERAGE AND LIMITATIONS

1. Coverage is restricted to recipients with the following indicators:
 - a. BMI of 35 or greater;
 - b. Waist circumference of more than 40 inches in men, and more than 35 inches in women;
 - c. Obesity related comorbidities that are disabling;
 - d. Strong desire for substantial weight loss;
 - e. Well-informed and motivated;
 - f. Committed to a lifestyle change; and
 - g. Negative history of significant psychopathology that contraindicates this surgical procedure.
2. Documentation supporting the reasonableness and necessity of the surgery must be in the medical record, and should include evidence of participation in a medically supervised weight loss program for a minimum of three months prior to the surgery. There must also be documentation of weight loss therapy participation including recipient efforts at dietary therapy, physical activity, behavior therapy, pharmacotherapy, combined therapy or any other medically supervised therapy.
3. No coverage will be provided for pregnant women, women less than six months postpartum, or women who plan to conceive in a time frame less than 18 to 24 months post gastric bypass surgery.

ATTACHMENT A

POLICY #6-07	BARIATRIC SURGERY FOR MORBID OBESITY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-08
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D. COVERED CODES

For a list of covered procedure codes, please see the billing manual.

E. REFERENCES:

1. <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/mm5013.pdf>
2. http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf

POLICY #6-08	HYALGAN AND SYNVISIC INJECTIONS	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-09
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A. DESCRIPTION

Hyalgan and Synvisc are injectable drugs that are used to treat osteoarthritis of the knee. These solutions act like an “oil” to cushion and lubricate the knee joint. Hyalgan is injected directly into the osteoarthritic knee for a single course of treatment. Injections are administered one week apart for a total of five injections. Synvisc is administered as a total of three intra-articular injections into the knee joint during a three-week period. Each course of treatment must be performed by a qualified physician.

B. POLICY

1. Hyalgan and Synvisc injectables are a covered Nevada Medicaid benefit for the treatment of pain due to osteoarthritis of the knee. Diagnosis must be supported by radiological evidence.
2. Repeat treatment is not reimbursable, as it is not medically indicated, if the first course of treatment is not beneficial to the recipient.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. Hyalgan and Synvisc are indicated for recipients who do not obtain adequate relief from simple pain medication and/or from exercise and physical therapy.
2. An Evaluation & Management (E&M) service will not be covered during subsequent visits for injections unless there is a separately identifiable problem.

POLICY #6-09	END STAGE RENAL DISEASE SERVICES	EFFECTIVE DOS 9/1/03 Superseded Policy News N199-10 and New ESRD Policy
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A. DESCRIPTION

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are a covered service for hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.

B. PRIOR AUTHORIZATION IS NOT REQUIRED

C. COVERAGE AND LIMITATIONS

1. A physician's service furnished to dialysis recipients who are treated as outpatients, are divided into two major categories: direct recipient care and administrative.
2. Physician's evaluation and management-type services, "unrelated" to the dialysis procedure (not provided during a dialysis treatment) may be billed in addition to the dialysis procedure.
3. Physicians providing evaluation and management-type services "related" to the dialysis procedure same day dialysis is performed, or during a dialysis treatment) are billed as included in the dialysis procedure. Service units equal number of treatments. (Fee schedule paid to physician.)
4. Criteria for instituting IDPN/IPN:
 - a. Three month average predialysis serum albumin level of <3.4 mg/dl.
 - b. Three month average predialysis serum creatine of <8.0 mg/dl.
 - c. Three month average predialysis serum pre-albumin level of <25 mg/dl.
 - d. Weight loss of 7.5% of usual body weight over 3 months.
 - e. A clinical exam consistent with moderate to severe malnutrition.
 - f. A dietary history of reduced food intake (protein <0.8 g/kg/day; calories <25 cal/kg/day).
 - g. Failed attempts at dietary and oral supplementation.
 - h. Eternal tube feeding contraindicated.
 - i. Gastrointestinal diagnosis, supported by GI consult, GI medications (Prilosec, Reglan, Imodium, etc.).

POLICY #6-09	END STAGE RENAL DISEASE SERVICES	EFFECTIVE DOS 9/1/03 Superseded Policy News N199-10 and New ESRD Policy
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5. Criteria for discontinuing IDPN/IPN:
 - a. Three month average predialysis serum albumin level of >3.8 mg/dl.
 - b. Three month average predialysis serum creatine of >10 mg/dl.
 - c. Three month average predialysis serum pre-albumin level of >28 mg/dl.
 - d. A clinical exam consistent with improved nutritional status.
 - e. A dietary history of increased food intake (protein 1.0 g/kg/day; calories 30 cal/kg/day).
 - f. Absence of active inflammation or other serious condition characterized by high albumin turnover.
 - g. No improvement with IDPN/IPN treatment after six months.
 - h. Complications or intolerance associated with IDPN/IPN treatment.

6. No coverage will be provided for situations involving temporary impairments (less than 90 days).
No coverage will be provided if recipients are noncompliant with the plan of treatment.

POLICY #6-10	DIABETIC OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES	EFFECTIVE DOS 9/1/03 Supersedes Policy News N299-08
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A. DESCRIPTION

1. Nevada Medicaid defines Diabetic Outpatient Self-Management Training Services as the development of a specific treatment plan for Type I and Type II diabetics to include blood glucose self-monitoring, diet and exercise planning, and motivates recipients to use the skills for self-management.
2. Reimbursement will follow Medicare guidelines for initial recipient and group training sessions. For information regarding blood glucose monitors and diabetic supplies see Chapter 1300.
3. Services must be furnished by certified programs which meet the National Diabetes Advisory Board (NDAB) standards, and hold an Education Recognition Program (ERP) certificate from the American Diabetes Association and/or the American Association of Diabetic Educators. Program instructors should include at least a nurse educator and dietician with recent didactic and training in diabetes clinical and educational issues. Certification as a diabetes educator by the National Board of Diabetes Educators is required.

B. PRIOR AUTHORIZATION IS REQUIRED

When recipients require additional or repeat training sessions that exceed ten hours of training.

C. COVERAGE AND LIMITATIONS

1. The physician managing the recipient's diabetic condition certifies the comprehensive plan of care to provide the recipient with the necessary skills and knowledge in the management of their condition, and to ensure therapy compliance. The program must be capable of offering, based on target population need, instruction in the following content areas:
 - a. Diabetes review;
 - b. Stress and psychological adjustment;
 - c. Family involvement and social support;
 - d. Medications;
 - e. Monitoring blood glucose and interpretation of results;
 - f. Relationships between nutrition, exercise and activity, medication, and glucose levels;
 - g. Prevention, detection, and treatment of both acute and chronic diabetic complications, including instruction related to care of feet, skin, and teeth;
 - h. Behavioral change strategies, goal setting, risk factor reduction, and problem solving;
 - i. Benefits, risks, and management options for improvement of glucose control;

POLICY #6-10	DIABETIC OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES	EFFECTIVE DOS 9/1/03 Supersedes Policy News N299-08
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- j. Preconception care, pregnancy, and gestational diabetes; and
 - k. Utilization of health care systems and community resources.
2. Indications for repeat training Prior Authorization (PA) is required for recipients whose diabetes is poorly controlled include:
- a. Hemoglobin A 1 c blood levels of 8.5 or greater;
 - b. Four or more serious symptomatic hypoglycemic episodes in a two month period;
 - c. Two or more hospitalizations for uncontrolled diabetes in a six month period;
 - d. Any ketoacidosis or hyperosmolar state;
 - e. Pregnancy in a previously diagnosed diabetic; or
 - f. Diabetics beginning initial insulin therapy.
3. No coverage will be provided for initial training which exceeds ten hours, or for repeat training, without a prior authorization.

D. COVERED CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-11	BOTULINUM TOXIN	EFFECTIVE DATE 12/18/04 RE-ISSUE/UPDATE 07/10/14
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A. DESCRIPTION

1. Botulinum toxin is a neuromodulator derived from neurotoxins produced by the bacteria *Clostridium botulinum*, a gram positive bacillus. Botulinum toxin inhibits the release of acetylcholine at presynaptic cholinergic nerve terminals of the peripheral nervous system and autonomic nerve terminals of the autonomic nervous system, thereby preventing neurotransmission and inducing flaccid paralysis. Three botulinum toxin type A products are approved by the Food and Drug Administration (FDA), including abobotulinumtoxinA (Dysport®), incobotulinumtoxinA (Xeomin®) and onabotulinumtoxinA (Botox®). RimabotulinumtoxinB (Myobloc®) is the only botulinum toxin B product approved by the FDA. FDA-approved indications differ among the individual botulinum toxin products.
2. The botulinum toxin products are not interchangeable with one another. The potency (in units) of one botulinum toxin product is specific to the preparation and assay method utilized by the manufacturer and units of biological activity of one product cannot be compared to or converted into units of any other botulinum toxin products assessed with any other specific assay method. All botulinum toxin products include a boxed warning in their labeling regarding the risk of botulinum toxin spreading beyond the site of injection, resulting in adverse events and death in some cases. Follow CPT guidelines for chemodenervation. Bill using the National Drug Code (NDC) for agents administered. See billing guide for billing instructions.

Current Medications Available in Therapeutic Class

Non-Proprietary Name (Trade Name)	FDA-Approved Indication(s)
OnabotulinumtoxinA (BOTOX®)	<ul style="list-style-type: none"> • Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., SCI, MS) in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting four hours a day or longer); • Treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis); • Treatment of adults with cervical dystonia, to reduce the severity of abnormal head position and neck pain associated with cervical dystonia; • Treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents; and • Treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above.

POLICY #6-11	BOTULINUM TOXIN	EFFECTIVE DATE 12/18/04 RE-ISSUE/UPDATE 07/10/14
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AbobotulinumtoxinA (DYSPORT®)	<ul style="list-style-type: none"> • Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients.
IncobotulinumtoxinA (XEOMIN®)	<ul style="list-style-type: none"> • Treatment of adults with cervical dystonia to decrease the severity of abnormal head position and neck pain in both botulinum toxin-naïve and previously treated patients; and • Treatment of adults with blepharospasm who were previously treated with onabotulinumtoxinA (Botox).
RimabotulinumtoxinB (MYOBLOC®)	<ul style="list-style-type: none"> • Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

B. POLICY

Botulinum Toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries, and multiple sclerosis. The injections may also reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow better range of motion, to permit better physical therapy, and provide adequate perineal hygiene.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. For a complete list of covered indications, please refer to the “Provider Type 20, 24 and 77 Billing Guide,” applicable to botulinum toxins. It is expected that physicians will be familiar with and experienced in the use of the botulinum toxin product(s), and utilize FDA-approved product labeling, compendia, and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each patient condition.
2. Before consideration of coverage can be made, it must be established that the patient has been unresponsive to conventional methods of treatment such as medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions.
3. Coverage is limited to certain conditions listed in the covered diagnosis code section of the billing manual.
4. In order to determine the proper injection(s) site, electromyography (EMG) guidance may be required.
5. The patient who has a spastic or excessive muscular contraction condition is usually started with a low dose of Botulinum Toxin with increases as required. Some spastic or muscular contraction conditions, e.g., eye muscle disorders, (e.g., blepharospasm) may require lesser amounts. For larger muscle groups, it is generally agreed that once a maximum dose per site has been reached, and there is no response, the treatment is discontinued. Treatments may be resumed at a later date if indicated. If a response is positive, the effect of the injections generally continues for three

POLICY #6-11	BOTULINUM TOXIN	EFFECTIVE DATE 12/18/04 RE-ISSUE/UPDATE 07/10/14
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months, at which time the patient may need to repeat the injections for continued control. It is seldom medically necessary to repeat injections more frequently than every 90 days, unless acceptable justification is documented for more frequent use in the initial therapy.

6. Medicaid will allow payment for one injection per site, regardless of the number of injections made into the site. A site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, neck, etc.
7. Coverage will not be provided for injections given for cosmetic or for investigational purposes.
8. Anesthesia for Botulinum injections is usually provided as a local anesthetic (e.g., for blepharospasm), or conscious sedation, although some patients, such as pediatric, may require more than conscious sedation. (See appropriate anesthesia CPT codes listed below).

POLICY #6-15	FAMILY PLANNING PREVENTIVE HEALTH	EFFECTIVE DATE 04/11/2012
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A. DESCRIPTION

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a patient's current or possible future health care risks through assessments, lab work and other diagnostic studies.

B. POLICY

Nevada Medicaid reimburses for preventive medicine services for family planning as recommended by the U. S. Preventive Services Task Force (USPSTF) A and B Recommendations.

[USPSTF A and B Recommendations](#)

C. PRIOR AUTHORIZATION: YES NO

D. COVERAGE AND LIMITATIONS:

The following preventive health services are covered by Nevada Medicaid for Family Planning purposes:

Topic	Description
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

ATTACHMENT A

POLICY #6-15	FAMILY PLANNING PREVENTIVE HEALTH	EFFECTIVE DATE 04/11/2012
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* These screening tests may be performed as part of an office visit, hospital visit or global fee and may not be billed separately.

POLICY #6-16	SCHOOL BASED HEALTH CENTER	EFFECTIVE DATE 01/01/15
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A. DESCRIPTION

School Based Health Centers (SBHCs) provide primary and preventive medical services to Medicaid and Nevada Check Up recipients. SBHCs are health centers located on or near a school facility of a school district, independent school, or board of an Indian tribe or tribal organization. An SBHC operates as a separate delivery model from School Based Child Health Services (SBCHS) provided through an Individual Education Plan (IEP).

B. POLICY

1. The center(s) will, through providers of healthcare operating within the scope of their practice under state law, be used exclusively to provide primary and preventive health services to children and adolescents in accordance with recommended guidelines. Each center will be organized through the school, community, and health care provider agreements, and will be administered by a sponsoring agency.
2. Staffing and providers include but are not limited to: Support Staff, Site Director, Immunization Coordinator, Medical Doctor, Osteopathic Doctor, APRN, Ph.D. of Nursing, PA/PA-C, and Qualified Mental Health Professionals. The DHCFP reimburses for services that are medically necessary and performed by a qualified provider within the scope of practice as defined by state law.

C. PRIOR AUTHORIZATION

Medical services provided by SBHCs must follow prior authorization policy for each service provided under corresponding prior authorization rules throughout the Medicaid Services Manuals (MSMs).

D. COVERAGE AND LIMITATIONS

1. All services that are provided must be medically necessary (see MSM Chapter 100) to be considered covered SBHC services. Medically necessary services provided by a qualified provider practicing within their scope of work may include but are not be limited to:
 - a. Primary and preventive health care and medical screenings;
 - b. Treatment for common illnesses and minor injuries;
 - c. Referral and follow-up for serious illnesses and emergencies;
 - d. Care and consultation, as well as referral and follow-up for pregnancy, chronic diseases and disorders, and emotional and behavioral problems;
 - e. Referral, preventive services, and care for high risk behaviors and conditions such as drug and alcohol abuse, violence, injuries, and sexually transmitted diseases;
 - f. Sports physicals as part of a comprehensive well child checkup;
 - g. Immunizations;

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POLICY #6-16	SCHOOL BASED HEALTH CENTER	EFFECTIVE DATE 01/01/15
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- h. Diagnostic and preventive dental, and referral services; and
 - i. Laboratory testing.
2. NON-COVERED SERVICES

Non-covered services include, but are not limited to:

- a. Services that are not medically necessary;
- b. Services that require prior authorization and one has not been obtained or approved; and
- c. Medical services listed on the recipient's IEP.

Note: An IEP is identified with SBCHS and are not covered under the SBHC.

E. PARENTAL CONSENT

1. A parent or guardian must sign a written consent form for a student to receive SBHC services. Once the parent signs the written consent form and the center-specific forms, the Health Center will provide or refer the student for any of the services that the child needs. Parents may indicate if they do not want the child to receive a specific service by writing the name of the service in the appropriate space on the center-specific form.
2. Although the Health Center will attempt to keep parents informed of the services their child receives, signing the Uniform Consent gives the Health Center permission to provide medical and behavioral health services to the child without contacting the parent each time the child visits the Center. Except in an emergency situation, no child is treated, counseled or referred without a consent form signed by a parent.
3. In emergencies, the Health Center will call the parent, but the Health Center is required by law to treat the child even when the parent cannot be reached.

F. MINOR CONSENT LAWS

Physicians practicing in SBHCs are governed by and must abide by the Nevada Revised Statutes (NRS) Minor's Consent for examination and treatment.

G. THIRD PARTY LIABILITY (TPL)

SBHCs must follow TPL and other health care coverage guidelines as set forth in the MSM Chapter 100 (Medicaid Program). There are no regulatory exceptions regarding TPL for SBHCs. SBHCs must bill the appropriate TPL and other health care coverage prior to submitting reimbursement claims to the Quality Improvement Organization (QIO)-like vender contracted with the DHCFFP.

POLICY #06-17	SCHOOL BASED HEALTH CENTER	EFFECTIVE DATE 3/01/15
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H. PROVIDER RESPONSIBILITIES

1. The provider must be certified by the Division of Public and Behavioral Health as an SBHC.
2. Enroll with the QIO-like vendor for Nevada Medicaid, meeting all provider qualifications as an SBHC.
3. Ensure the billing number and servicing number are the same.
4. Follow all billing guidelines for SBHCs.
5. Provider must work within the scope of services for each professional providing services.

POLICY #06-17	FEDERALLY QUALIFIED HEALTH CENTERS	EFFECTIVE DATE 3/01/15
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A. DESCRIPTION

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations.

B. POLICY

Nevada Medicaid reimburses for medically-necessary services provided at FQHCs and follows State and Federal laws pertaining to them.

C. AUTHORITY

1. Section 4161 of the Omnibus Budget Reconciliation Act of 1990
2. Section 330 of the Public Health Service (PHS) Act
3. Section 1861 of the Social Security Act
4. Section 1905 of the Social Security Act

D. HEALTH SERVICES

1. The DHCFP reimburses FQHCs an outpatient encounter rate.
 - a. Encounter: Any one or more of the following medical professionals are included in the all-inclusive, daily outpatient encounter:
 1. Physician or Osteopath;
 2. Dentist;
 3. APRN;
 4. Physician Assistant;
 5. CRNA;
 6. Certified Registered Nurse Midwife;
 7. Psychologist;
 8. Licensed Clinical Social Worker;
 9. Registered Dental Hygienist;
 10. Podiatrist;

POLICY #06-17	FEDERALLY QUALIFIED HEALTH CENTERS	EFFECTIVE DATE 3/01/15
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11. Radiology;
 12. Optometrist;
 13. Optician; and
 14. Clinical Laboratory.
2. Encounters are used by FQHCs for Medicaid-covered, HRSA-approved services which include:
- a. Primary care services: medical history, physical examination, assessment of health status, treatment of a variety of conditions amendable to medical management on an ambulatory basis by an approved provider and related supplies;
 - b. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;
 - c. Early periodic screenings (Refer to Medicaid Services Manual (MSM) Chapter 1500, Healthy Kids), for EPSDT screening policy and periodicity recommendations;
 - d. Preventive health services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and education (Refer to MSM Chapter 600, Physicians Services, Attachments #6-12 through #6-14 for preventive services policy);
 - e. Home visits;
 - f. Diagnostic laboratory and radiology services, including but not limited to cholesterol screening, stool testing for occult blood, tuberculosis testing for high risk patients, dipstick urinalysis;
 - g. Family Planning services including contraceptives;

Up to two times a calendar year, the FQHC may bill for additional reimbursement for family planning education on the same date of service as the encounter.
 - h. For women: annual preventive gynecological examinations, prenatal and post-partum care, prenatal services, clinical breast examination, thyroid function test;
 - i. Vision and hearing screenings;
 - j. Dental office visits;

For dental encounters, the quantity limitations and prior authorizations listed in MSM Chapter 1000, Dental, do not apply, as an FQHC is under an encounter reimbursement methodology. An FQHC may bill a dental encounter for each face-to-face encounter. Dentures provided by an FQHC are included in the daily encounter rate unlike the denture policy established in MSM Chapter 1000, Dental, for fee-for-service recipients who obtain dentures at non-FQHC facilities. All other coverage policies (covered and non-covered for dental) are still applicable.

POLICY #06-17	FEDERALLY QUALIFIED HEALTH CENTERS	EFFECTIVE DATE 03/01/15
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Service Limits: Regardless of the number or types of providers seen, only one encounter is reimbursable per recipient, per day.

3. Non-covered services under an FQHC encounter:
 - a. Group therapy;
 - b. Eyeglasses;
 - c. Hearing aids;
 - d. Durable medical equipment, prosthetics, orthotics and supplies; and
 - e. Ambulance services.

E. ANCILLARY SERVICES

All services not recognized by HRSA as approved FQHC encounter services which are an approved Nevada Medicaid State plan service.

1. Ancillary services may be reimbursed on the same date of service as an encounter by a qualified Medicaid provider.
2. The FQHC must enroll within the appropriate provider type and meet all MSM coverage guidelines for the specific ancillary service.

F. MEDICAL NECESSITY

In order to receive reimbursement, all services provided must be medically necessary as defined in the Medicaid Services Manual (MSM) Chapter 100 (Medicaid Program).

G. PRIOR AUTHORIZATIONS

1. FQHC encounters do not require prior authorization.
2. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific service provided.

For billing instructions for FQHCs, please refer to the Billing Manual for Provider Type 17.

For Indian Health Programs (IHP) policy, please refer to MSM Chapter 3000, Indian Health.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 12, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
MSM CHAPTER 700 – RATES AND COST CONTAINMENT



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 700 were made to add Section 702, which outlines the rules and certifications for provider participation in Nevada Private Hospital Upper Payment Limit (UPL) supplemental payment program.

These changes are effective December 13, 2013.

MATERIAL TRANSMITTED

MTL 21/13
CHAPTER 700 – RATES AND COST
CONTAINMENT

MATERIAL SUPERSEDED

MTL 16/12
CHAPTER 700 – RATES AND COST
CONTAINMENT

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
702	Eligibility	Section added to outline the rules and certifications for provider participation in Nevada Private Hospital Upper Payment Limit (UPL) supplemental payment program.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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RATES AND COST CONTAINMENT

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	MTL 19/09
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 700
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

700 INTRODUCTION

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

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

- a. Attachment 4.19-A describes methods and standards for reimbursing inpatient hospitals, residential treatment centers, Indian Health Service and Tribal 638 Health Facilities.
- b. Attachment 4.19-B describes the methods and standards for reimbursing medical services provided by licensed professionals in various settings and those items ancillary to licensed medical services, such as laboratory and x-ray, pharmaceuticals, dentures, prosthetic devices, eyeglasses, medical supplies, appliances and equipment, and transportation.
- c. Attachment 4.19-C describes the methods and standards for reimbursing reserved beds in various institutions excluding acute care facilities.
- d. Attachment 4.19-D describes the methods and standards for long-term care facilities including hospital-based and freestanding nursing facilities, intermediate care facilities for the mentally retarded and swing beds in hospitals.

	MTL 26/07
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 701
MEDICAID SERVICES MANUAL	Subject: AUTHORIZATION

701 AUTHORITY

701.1 FEE TO INCREASE QUALITY OF NURSING CARE

NRS 442.3755 to NRS 422.379

701.2 COST REPORTS

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

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

701.3 MEDICAID RATE(S) APPEAL

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

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702 ELIGIBILITY RULES FOR SUPPLEMENTAL PAYMENT PROGRAMS

702.1 RULES OF PARTICIPATION FOR INPATIENT UPPER PAYMENT LIMIT (UPL) FOR PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM

Attachment 4.19-A, Section XV, Part B of the Nevada State Plan for Medicaid authorizes Medicaid supplemental payments to certain private hospitals affiliated with Nevada units of government through a Low Income and Needy Care Collaboration Agreement. Participation in the program must be consistent with federal approval of the State Plan.

In order to be eligible to provide the non-federal share of these Medicaid supplemental payments, *a unit of government* must execute a certification that it will comply with the program limitations adopted by the Division of Health Care Financing and Policy (DHCFP) in its Nevada Medicaid Supplemental Payment Program Conditions of Participation (CoP). Each unit of government must execute this certification on a form promulgated by the DHCFP. Each unit of government's participation must be consistent with federal approval of the State Plan.

In order to be eligible to receive Medicaid supplemental payments under this section of the Nevada State Plan for Medicaid, *a hospital* must execute a certification that it will comply with the program limitations adopted by the DHCFP in its Nevada Medicaid Supplemental Payment Program Conditions of Participation. Each hospital must execute this certification on a form promulgated by the DHCFP. Each private hospital's participation must be consistent with federal approval of the State Plan.

The State Plan, Conditions of Participation, certification forms and other participation requirements are available to the public at the DHCFP's office and on the website at: <https://dhcfp.nv.gov/hcfpdata.htm>.

In order to be consistent with the Code of Federal Regulation, Title 42, Chapter IV, part 447, Subpart C, Section 447.272, the DHCFP:

- Prohibits any cash or in-kind transfers from the private hospitals to the governmental entity that have a direct or indirect relationship to Medicaid payments;
- Does not allow a governmental entity to condition the amount it funds the Medicaid program on a specified or required minimum amount of low income and needy care;
- Does not allow a governmental entity to assign any of its contractual or statutory obligations to a private hospital receiving payments under State Plan Amendment (SPA) 10-002C;

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- Does not allow the governmental entity to recoup funds from a hospital that has not adequately performed under the Low Income and Needy Care Collaboration Agreement;
- Prohibits each private hospital from returning any of the supplemental payments it receives under SPA 10-002C to the governmental entity that provides the non-federal share of the payments; and
- Prohibits each governmental entity from receiving any portion of the supplemental Medicaid payments made to the private hospitals under SPA 10-002.

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MEDICAID SERVICES MANUAL	Subject: POLICY

703 POLICY

703.1 INPATIENT HOSPITAL SERVICES

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

703.2 FEE TO INCREASE QUALITY OF NURSING CARE

The DHCFP established the following policy to assess and collect fees to increase the quality of nursing care. Nevada Revised Statute (NRS) 422.3775 states: *“Each nursing facility that is licensed in this State shall pay a fee assessed by the Division to increase the quality of nursing care in this State.”*

a. Reporting Requirements:

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

b. Payment of Fee:

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

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

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

703.3 COST REPORTS

The DHCFP established the following policy to collect Medicare/Medicaid Cost Reports. (A Medicare/Medicaid Cost Report is the standard Medicare Cost Report with the required Medicaid sections completed.)

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

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

a. Hospital Cost Reporting Requirements:

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

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b. Free Standing Cost Reporting Requirements:

1. Free-standing nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must complete and file an annual Medicare/Medicaid cost report with the DHCFP.
2. Cost reports are to be received by the DHCFP by the last day of the third month following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame a request for a 30 day extension can be requested from the DHCFP prior to the original cost report due date. Reasonable extension requests will be granted.
3. Minimum Direct Care Staffing Requirement: In the event that a nursing facility does not incur direct care cost, at least equal to 94% of the direct care median, the Department will have the option to recoup, from future payments to that provider, an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing. Any penalties collected shall accrue to the State General fund and shall be used to offset Medicaid expenses.

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

1. Facilities failing to file a Medicare/Medicaid cost report in accordance with these provisions may have their Medicaid payments suspended, or be required to pay back to the Medicaid program all payments received during the fiscal year period for which they were to provide a cost report. Facilities may also be subject to an administrative fine of up to \$500 per day for each day the required cost reports are delinquent.
2. The DHCFP may withhold any amounts due under 3.a. (above) from a facility's Medicaid claims payments until such amounts are paid in full.

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704 MEDICAID RATE(S) APPEAL

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

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

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

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

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

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Actual costs from the most recent prior year(s), or costs from part of the current year, may be used in developing the methodology for the relief request, so long as it is not a cost reimbursement methodology;

5. Any other information the provider believes to be relevant to the review.
- c. The Administrator, or his designee, may consider the following factors in deciding whether to grant rate relief:
1. Whether there are circumstances related to the appellant when compared to other providers that cause the appellant to have higher Medicaid costs in the rate category reviewed;
 2. Whether the circumstances relating to the provider are adequately considered in the rate-setting methodology set forth in the State Plan;
 3. The extent to which comparable health care services are available and accessible for all people in the geographic area served by the appellant/provider;
 4. Whether Medicaid payments are sufficient to meet Medicaid costs in the appealed rate(s);
 5. The total Medicaid payments to the provider and all Medicaid payments for the appealed rate(s): In the case of hospitals, this includes total Medicaid costs to the hospital for inpatient care and the hospital's Medicaid costs for the appealed rate(s);
 6. Audit review information, if any;
 7. Information and data used to set the existing or appealed rate;
 8. Such other information or documentation as the Administrator, or his designee, deems relevant; and
 9. That the basis for relief results in uncompensated Medicaid costs to the provider, both in the appealed rate(s) and in aggregate Medicaid payments under the State Plan.
- d. The Administrator, or his designee, shall review the appeal and supporting documentation and issue a written decision within 90 calendar days of receipt of a properly submitted appeal. The Administrator, or his designee, may request any additional information from the provider, including independent verification by an unrelated third party of the provider's claims. If the Administrator, or their designee,

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requests additional information or verification, the period in which the Administrator or his designee must issue a decision is extended to 90 calendar days from the receipt of the requested information.

- e. The decision on the appeal shall set forth Findings of Fact and Conclusions of Law.
- f. The decision will be sent in writing by certified mail, return receipt requested, to the person designated in 704.2.a.
- g. The Administrator's decision may be appealed to the District Court in and for Carson City of the State of Nevada pursuant to NRS 422.306(3). Such appeal shall be filed within 30 calendar days from the date the decision of the Administrator is received.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 9, 2014

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LAURIE SQUARTSOFF, ADMINISTRATOR



SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 800 – LABORATORY SERVICES

BACKGROUND AND EXPLANATION

The proposed revision to Medicaid Services Manual (MSM) Chapter 800 would refer newborn metabolic screenings to the Nevada State Public Health Laboratory, as they are now the preferred provider for the State of Nevada. There are no coverage criteria changes based upon this policy change.

This change is effective November 1, 2014.

MATERIAL TRANSMITTED

MTL 15/14
CHAPTER 800 – LABORATORY
SERVICES

MATERIAL SUPERSEDED

MTL 09/11, 04/13
CHAPTER 800 – LABORATORY
SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
803.1A.1.i	Coverage and Limitations	Updated the preferred provider for laboratory services for newborn metabolic screenings from the Oregon State Laboratory to Nevada State Public Health Laboratory.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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800 LABORATORY SERVICES

INTRODUCTION

The Nevada Medicaid Laboratory Services program is designed to provide laboratory services under a Clinical Laboratory Improvement Amendment of 1988 (CLIA) certified provider. These services include microbiology, serology, immunohematology, cytology, histology, chemical, hematology, biophysical, toxicology or other methods of “in-vitro” examination of tissues, secretions, excretions, or other human body parts. Clinical laboratory services are furnished primarily in three distinct settings: independent clinical laboratories, physician office laboratories and hospital-based laboratories. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions specified within this chapter.

All providers participating in the Medicaid Program must deliver services in accordance with the rules and regulations of the Medicaid Program.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU Manual, Chapter 1000.

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801 AUTHORITY

The Centers for Medicare and Medicaid Services (CMS) mandate that necessary and essential laboratory services be available for all Nevada Medicaid recipients. Laboratory services for children are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program per the Social Security Act of 1905 (a)(3)(1)(B)(iv)(r)(5). The Nevada EPSDT program provides children with services additional to those available to adult recipients.

Laboratory services are available through the Medicaid Program according to the:

Code of Federal Regulations (CFR):

- 42 CFR 493 Laboratory Requirements
- 42 CFR 410.32 Diagnostic X-Ray and Laboratory Tests
- 42 CFR 440.30 Other Laboratory and X-Ray Services
- 42 CFR 441.17 Laboratory Services

Nevada Revised Statute (NRS) Chapter 652 (Medical Laboratories)

Medicaid State Plan Attachment 1.2-B, 101.9.C and Attachment 4.19-B.3.

Other authorities regarding laboratory services available through the Medicaid Program include:

Social Security Act:

- Section 1902(a)(9)(C) (State Plans for Medical Assistance)
- Section 1905(a)(3), Section 1905(r)(1)(B)(iv), and Section 1905(r)(5) (EPSDT, Provision of Laboratory Services)

42 CFR 482.27 (Conditions of Participation for Hospitals, Laboratory Services)

NRS:

- NRS 442.600- 442.660 (Serologic or rapid test HIV)
- NRS 442.010 (Serologic testing for syphilis in the first and third trimester of pregnancy)

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802 RESERVED

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803 POLICY

803.1 Nevada Medicaid and Nevada Check Up (NCU) reimburse for medically necessary, diagnosis related, covered laboratory services provided to all eligible recipients.

Nevada Medicaid and NCU provide outpatient clinical laboratory services through one or more independent clinical laboratories, physician office laboratories, clinics and hospital-based laboratories.

803.1A COVERAGE AND LIMITATIONS

1. Covered Services:

- a. Except for specific laboratory tests identified under non-covered services, **the** Division of Health Care Financing and Policy (DHCFP) reimburses organ or disease oriented panels, therapeutic drug assays, evocative/suppression testing, clinical pathology consultations, urinalysis, chemistry, hematology and coagulation, immunology, tissue typing, transfusion medicine, microbiology, cytopathology, cytogenic, surgical pathology, total transcutaneous bilirubin, and tests specified under, “Other Procedures” in the most recent version of Current Procedural Terminology (CPT). Reference the Nevada Medicaid and NCU billing guidelines for Provider Type 43, Laboratory, Pathology/Clinical, for covered CPT codes.
- b. Follow-up testing performed by either the discharging hospital laboratory and/or the newborn’s physician for newborns discharged with a hyperbilirubinemia diagnosis.
- c. Ova and parasite testing for medically appropriate diagnosis.
- d. An arterial blood drawing fee for Arterial Blood Gases (ABG) performed by physicians and/or respiratory therapists.
- e. Specialized or unique testing which cannot be performed within the State and catchment area laboratories referred to a reference laboratory. Reference **Section 803.1C.2** regarding prior authorization requirements.
- f. Genotype and Phenotype assay testing for recipients:
 1. With an acute (new or recent) Human Immunodeficiency Virus (HIV) diagnosis upon entry into HIV care and/or prior to the initiation of antiretroviral therapy;

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2. Presenting with documented virologic failure after initiation of antiretroviral therapy; or
 3. Demonstrating documented suboptimal suppression of viral load after initiation of antiretroviral therapy.
- g. One venipuncture specimen collection fee per patient, per date of service, specifically when the specimen is sent directly from a physician's office laboratory or clinic to an independent clinical laboratory for testing.
 - h. Laboratory tests associated with the Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Healthy Kids Program) screening examination referenced in Medicaid Services Manual (MSM) Chapter 1500. The associated costs of the hematocrit and urine "dip stick" with the exception of metabolic screening (e.g. **Phenylketonuria (PKU)**) and sickle cell screening fees, are included as part of the fee for EPSDT.
 - i. Metabolic screening (e.g. PKU) tests are referred to the **Nevada State Public Health** Laboratory.
 - j. Sickle cell screens are referred to an independent clinical laboratory.
 - k. Serological or rapid-test HIV testing during the first and/or third trimester of pregnancy or during childbirth performed in accordance with Nevada Revised Statute (NRS) 442.600 – 442.660.
 - l. A HIV rapid test for newborns (including infants in foster care) when the mother has not been tested for HIV prior to or during the delivery or if the mother's HIV status is unknown post partum.
 - m. Serologic testing for syphilis in the first and third trimester of pregnancy in accordance with NRS 442.010.
 - n. Semen analysis, motility and count following a vasectomy procedure, not including Huhner test, is limited to the CPT code is specified in the DHCFP's/Quality Improvement Organization (QIO)-like vendor billing manual.
 - o. HIV tropism testing, not meeting criteria specified in 803.1A.2.m.
2. Non-Covered Services

Laboratory tests listed in the most recent, annually updated CPT publication which are not benefits include:

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- a. post mortem examination codes.
- b. reproductive medicine procedures, except as indicated in 803.1.A.1.m.
- c. handling/conveyance fees (e.g. urine, stool cultures, pap smears).
- d. Medicaid and NCU Managed Care recipients (laboratory tests are the sole responsibility of the managed care provider).
- e. those services deemed inappropriate to a probable diagnosis are not covered. Services deemed inappropriate will be reviewed for possible recoupments.
- f. all unlisted laboratory codes except for the unlisted microbiology code used to bill phenotype assay tropism testing only.
- g. routine venipuncture by a provider testing the laboratory specimen or referring the laboratory specimen to an affiliate laboratory.
- h. collection of a capillary blood specimen (e.g. finger, heel, or ear stick) when it is part of or integral to the test procedure (e.g. a bleeding or clotting time).
- i. physician services related to deviation from standard blood banking procedures (e.g. use of outdated blood or Rh incompatible units).
- j. microdissection by laser capture.
- k. caffeine halothane contracture test.
- l. routine use (e.g. serial testing) of genotype and/or phenotype testing in individuals without virologic failure or suboptimal viral response or with viral loads maintained at an undetectable level on a current medication regime.
- m. HIV tropism test:
 - 1. Subsequent to a prior mixed or dual tropism test result; or
 - 2. Testing performed more than twice in a recipient's lifetime.
- n. blood typing for paternity testing.

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803.1B PROVIDER RESPONSIBILITY

Providers must:

1. verify recipients Medicaid eligibility and program benefit. Medicaid Fee-For-Service (FFS) will not reimburse for laboratory procedures performed for Medicaid or NCU recipients in managed care. Managed care plans may have their own authorization requirements. See Chapter 3600.
2. have appropriate state licensure or registration from the state where the laboratory is located, as applicable.
3. have current and appropriate Clinical Laboratory Improvement Amendments (CLIA) certification for the level of laboratory tests performed.
4. except in the case of provision of emergency laboratory services, have a valid Provider Contract with the Nevada DHCFP and Nevada Medicaid enrollment number or be an affiliate of an in-state laboratory that has a valid Medicaid enrollment number.

An out-of-state laboratory providing covered, emergency medical laboratory services to a Medicaid or NCU recipient is exempt from the enrollment process for these services as long as the provider is enrolled as a Medicaid provider and is licensed to provide the laboratory service in the provider's home state.

5. be in compliance with all applicable federal, state, and local laboratory requirements.
6. be in compliance with all Nevada Medicaid State Manual policies.
7. be in compliance with claim and billing requirements specified in MSM Chapter 100, the QIO-like vendor/ Medicaid and NCU billing manual, and the most recent version of the Current Procedural Terminology and the Healthcare Common Procedure Coding System manuals.
8. include on all claims the highest level of code specificity in accordance with the most current International Classification of Diseases, Clinical Modification manual related to the laboratory test performed. If a diagnosis or narrative diagnosis is not submitted by the prescribing practitioner, a laboratory must request this information from the physician/practitioner who ordered the service.
9. specify the current CLIA number of the laboratory performing the test on all claims, except when billing for CLIA exempt tests.

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10. only bill for laboratory services that the laboratory is currently licensed/registered and certified to perform.
11. ensure each recipient's laboratory record contains the following information:
 - a. Identification number of the specimen;
 - b. Name or any other means of confidentially identifying the person from whom the specimen was taken;
 - c. Name of the prescriber and, if applicable, the referring laboratory that submitted the specimen;
 - d. Date the specimen was collected by the prescriber or laboratory;
 - e. Date the specimen was received in the laboratory;
 - f. Condition of unsatisfactory specimens when received (e.g. broken, leaked, hemolyzed, or turbid);
 - g. Test performed;
 - h. Date the test was performed;
 - i. Results of the test and the date of reporting; and
 - j. Name and address of the laboratory where any specimen is referred, if applicable.
12. ensure that there is a written report on file for laboratory and pathology services that have a professional component requiring physician interpretation, whether or not "with interpretation and report" is stated in the code description of the service provided.
13. maintain a quality-control program and make results of proficiency testing programs available to Nevada Medicaid or the QIO-like vendor upon request.

803.1C PRIOR AUTHORIZATION

The ordering physician must obtain prior authorization for the following services, except for Medicare/Medicaid dual eligible recipients who are still eligible for Medicare benefits:

1. Genotype and phenotype assay testing for recipients with chronic HIV infection prior to initiation of highly active antiretroviral therapy.

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2. Laboratory tests referred by a physician office laboratory directly to an out of state laboratory.

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804 HEARINGS

Reference Nevada **Medicaid Services Manual (MSM)** Chapters 100 and 3100 for the Medicaid Hearings and Grievance process.

POLICY # 08-01	BRCA1 / BRCA2 GENE ANALYSIS	EFFECTIVE DATE August 1, 2014
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DESCRIPTION

Breast Cancer gene 1, (BRCA1) and Breast Cancer gene 2 (BRCA2) are human genes that belong to a class of genes known as tumor suppressors. Mutation of these genes has been linked to hereditary breast and ovarian cancer. A woman's risk of developing breast and/or ovarian cancer is greatly increased if she inherits a deleterious BRCA1 or BRCA2 mutation. Men with these mutations also have an increased risk of breast cancer.

POLICY

BRCA1/BRCA2 testing services for individuals without a personal history of breast and/or ovarian cancer should be provided to high risk individuals as defined below, or as otherwise defined by the US Preventive Services Task Force (USPSTF).

BRCA1/BRCA2 testing services for women with a personal history of breast and/or ovarian cancer and for men with a personal history of breast cancer should be provided as defined below, or as otherwise defined by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines.

Genetic counseling must precede genetic testing for hereditary cancer.

If the mutation in the family is known, only the test for that mutation is covered. For example, if a mutation for BRCA1 has been identified in a family, a single site mutation analysis for that mutation is covered, while a full sequence BRCA1 and BRCA2 analyses is not. An exception to this can be considered if a Certified Genetic Counselor presents sufficient justifiable need.

If the individual is of Ashkenazi Jewish descent, test the three common mutations first. Then if negative, consider comprehensive ("Reflex") testing based on assessment of individual and family history as if the individual is of non-Ashkenazi Jewish descent.

PRIOR AUTHORIZATION: YES NO

COVERAGE AND LIMITATIONS:

Frequency is limited to once in a lifetime.

BRCA1/BRCA2 gene analysis is covered for individuals meeting the following criteria:

1. For individuals without diagnosis of breast or ovarian cancer:
 - a. Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 years or younger;
 - b. A combination of three or more first- or second-degree relatives with breast cancer regardless of age at diagnosis;
 - c. A combination of both breast and ovarian cancer among first- or second-degree relatives;
 - d. A first-degree with bilateral breast cancer;

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- e. A combination of two or more first- or second-degree relatives with ovarian cancer, regardless of age at diagnosis;
 - f. A first or second-degree relative with both breast and ovarian cancer at any age;
 - g. History of breast cancer in a male relative; or
 - h. For women of Ashkenazi Jewish descent, any first-degree relative (or two second-degree relatives on the same side of the family) with breast or ovarian cancer.
2. A family history of breast or ovarian cancer that includes a relative with a known deleterious BRCA mutation; or
 3. A personal history of breast cancer plus one or more of the following:
 - a. Diagnosed at age ≤ 45 years;
 - b. Diagnosed at age ≤ 50 years with ≥ 1 close blood relative with breast cancer diagnosed at any age or with a limited family history;
 - c. Two breast primaries when first breast cancer occurred at age ≤ 50 years;
 - d. Diagnosed at age ≤ 60 years with a triple negative breast cancer;
 - e. Diagnosed at age ≤ 50 years with a limited family history;
 - f. Diagnosed at any age, with ≥ 1 close blood relative with breast cancer diagnosed ≤ 50 years;
 - g. Diagnosed at any age with ≥ 2 close blood relatives with breast cancer at any age;
 - h. Diagnosed at any age with ≥ 1 close blood relative with epithelial ovarian cancer;
 - i. Diagnosed at any age with ≥ 2 close blood relatives with pancreatic cancer or aggressive prostate cancer (Gleason Score ≥ 7) at any age;
 - j. Close male blood relative with breast cancer; or
 - k. For an individual of ethnicity associated with higher mutation frequency (e.g. Ashkenazi Jewish) no additional family history may be required.
 4. Personal history of epithelial ovarian cancer; or
 5. Personal history of male breast cancer; or
 6. Personal history of pancreatic cancer or aggressive prostate cancer (Gleason Score ≥ 7) at any age with ≥ 2 close blood relatives with breast and/or ovarian and/or pancreatic cancer or aggressive prostate cancer (Gleason Score ≥ 7) at any age.

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REFERENCES:

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MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 26, 2008

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM:  JOHN A. LIVERATTI, CHIEF OF COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 900 – PRIVATE DUTY NURSING

BACKGROUND AND EXPLANATIONS

Current language in Chapter 900 indicates that all Medicaid recipients that need private duty nursing are to have services authorized by DHCFP or their QIO-like vendor. When, in fact, recipients enrolled in a Managed Care Organization (MCO) are to receive prior authorization from the MCO.

This change adds language that identifies the responsibility of the Managed Care Organization as it relates to the private duty nursing prior authorization process. Additional verbiage revisions provide clarification and match the language used in other MSM chapters without changing the meaning of the policy.

MATERIAL TRANSMITTED

MTL 22/08

CHAPTER 900 – PRIVATE DUTY
NURSING

MATERIAL SUPERSEDED

MTL 10/03

CHAPTER 900 – PRIVATE DUTY
NURSING

Section 903.1D.1

Added “PDN” after Private Duty Nursing

Added “Quality Improvement Organization
(QIO-like vendor)”

Added “vendor” five times through section

Added “Private Duty Nursing services
requested for a recipient enrolled in a
Managed Care Organization (MCO) must be
prior authorized by the MCO. The MCO has
sole responsibility for all decisions related to
the PDN service for MCO recipients.”

Section 903.1D.1.a

Added “vendor”

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900 PRIVATE DUTY NURSING

INTRODUCTION

Private duty nursing (PDN) is an optional benefit offered under Nevada Medicaid State Plan. Private duty nursing provides more individual and continuous care than is available from a visiting nurse. The intent of private duty nursing is to assist the non-institutionalized recipient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. This benefit is not intended to replace care giving responsibilities of parents, guardians or other responsible parties, but to promote family-centered, community based care that enables the recipient to remain safely at home rather than in an acute or long-term care facility. Private duty nursing services may be provided, within program limitations, to a recipient in his/her home or in settings outside the home wherever normal life activities may take them. Service may be approved based on medical necessity, program criteria, utilization control measures and the availability of the state resources to meet recipient needs.

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

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901 AUTHORITY

Federal Law Section 1905 (a) (8) of the Social Security Act
Private duty nursing is an optional benefit under Section 1905 (a) (8) of the Act.

42 CFR 440. 80 Private duty nursing services

Private duty nursing services mean 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 skilled nursing facility. These services are provided:

- a. By a registered nurse or a licensed practical nurse ;
- b. Under the directions of the recipient's physician: and
- c. At the State's option, to a recipient in one or more of the following locations:
 1. His or her own home;
 2. A hospital; or
 3. A nursing facility

Nevada has opted to provide private duty nursing in the recipient's home.

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902 DEFINITIONS

902.1 AUTHORIZATION NUMBERS

The assigned numbers issued by Nevada Medicaid's Quality Improvement Organization (QIO-like) or Nevada Medicaid home care staff for approved home health agency services. Authorization numbers are used for submitting claims to the Nevada Medicaid fiscal agent for reimbursement.

902.2 CAREGIVER

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

902.3 COMPANION CARE

A service for individuals who spend time with another individual for friendly or social reasons.

902.4 CONCURRENT CARE

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

902.5 EXPLANATION OF BENEFITS (EOB)

Statement from a third party payor/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.

902.6 FULL TIME (F/T)

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

902.7 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,

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4. father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law,
5. grandparents or grandchild, 6) spouse of grandparent or grandchild. No reimbursement is made for services provided by an immediate relative.

902.8 INCAPABLE CAREGIVER

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

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

902.9 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.

902.10 INTERMITTENT SERVICES

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

902.11 PLAN OF CARE (POC)

The Plan of Care (POC) refers to the medical treatment plan established by the treating physician with the assistance of the home health care nurse.

The POC must contain all pertinent diagnoses, including the patient's mental status, the type of service, supplies, and equipment required, prognosis, rehabilitation potential, functional limitations, nutritional requirements all medications and treatments, instructions for timely discharge or referral and any additional pertinent to service provision.

902.12 PRIMARY DIAGNOSIS

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

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902.13 RESPITE

Respite is the short-term, temporary care provided to people with disabilities in order to allow responsible adults/primary care giver a break from the daily routine of providing care for the recipient. Respite is not covered under State Plan Services.

902.14 SITTERS

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

902.15 UNAVAILABLE

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

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903 POLICY

903.1 POLICY STATEMENT

The private duty nursing benefit reimburses medically necessary and appropriate hourly nursing services by a registered nurse or licensed practical nurse. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to maintain the recipient at home. Service hours are determined based on skilled nursing need and are not related to diagnoses of mental illness (MI) or mental retardation (MR). Service hours take into consideration the availability and capability of legally responsible caregivers or other willing primary caregivers.

903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

- a. The recipient has ongoing Medicaid eligibility for services;
- b. The recipient's legally responsible adult or primary caregiver is unavailable or incapable of providing all necessary care;
- c. The services have been determined to meet the medical criteria for private duty nursing; and
- f. The service can be safely provided in the home setting.

2. COVERED SERVICES

- a. PDN service may be approved for recipients who need more individual and continuous skilled nursing than can be provided in a skilled nurse visit through a home health agency, and whose care exceeds the scope of service that can be provided by home health aide or personal care aide (PCA).
- b. PDN services may be approved for up to 16 hours per day for new ventilator dependent recipients for an eight week interval in the period immediately following discharge from the hospital.
- c. PDN services may be approved for up to 12 hours per day for new tracheotomy recipients for an eight week interval in the period immediately following discharge from the hospital.
- d. PDN services may be approved for recipients who are chronically ill who require extensive skilled nursing care to remain at home.

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3. MEDICAL CRITERIA

PDN is considered medically necessary when a recipient requires the services of a licensed registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN to perform skilled nursing (SN) interventions to maintain or improve the recipient's health status. Skilled nursing refers to assessments, judgments, intervention and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the recipient's care and the frequency of SN interventions. Services must be provided under the direction of a physician and according to a signed plan of care.

a. The following criteria are used to establish the appropriate intensity of skilled nursing need (SNN) category.

1. SKILLED NURSING NEED CATEGORY 1

Limited to recipients who, in addition to skilled nursing observation, have at least one continuous skilled nursing need (as opposed to an intermittent need, such as wound care). An example of this category type recipient is the recipient who has a gastroscopy tube (g-tube) that receives nutritional feedings and medication administration through the tube, but who is unable to participate or direct his/her own care.

2. SKILLED NURSING NEED CATEGORY 2

Limited to the recipients that in addition to skilled nursing observation require 2 or more different skilled nursing interventions.

3. SKILLED NURSING NEED CATEGORY 3

Limited to recipients that are ventilator dependent at least 6 hours per day, or to recipients that, in addition to skilled nursing observation, have 4 or more different skilled nursing interventions daily*.

* Different skilled nursing intervention refers to distinct tasks that affect different body systems and require separate skilled nursing knowledge. For example, care for a tracheotomy and care for total parenteral nutrition (TPN) would be considered two (2) different SNN tasks.

Related skilled nursing interventions are tasks that are an intrinsic component of the SN task. For example, suctioning is an integral part of tracheotomy care and would be considered one (1) SNN task.

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Examples of what are typically determined to be “skilled nursing interventions” are identified below:

1. Ventilator care.
2. Tracheotomy with related suctioning and dressing changes;
3. Total parenteral nutrition (TPN);
4. Peritoneal dialysis;
5. Gastroscopy tube or nasogastric tube feedings, with related suctioning and administration of medication, are considered a SNN when associated with complex medical problems or with medical fragility of the recipient.
6. Complex medication administration – six or more medications on different frequency schedules or four or more medications requiring close monitoring of dosage and side effects.
7. Oxygen-unstable – continuous oxygen administration, in combination with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.
8. Multiple sterile complex dressing change required at least BID. The dressing change must be separate from other SNN interventions such as changing a tracheotomy site dressing when associated with tracheotomy care.

Additional major procedures not listed here may be considered in determining the intensity of skilled nursing needed. The Nevada Medicaid Central Office or their designee should be contacted with information on what the procedure is and the amount of nursing skill time needed to perform this task.

b. **DECISION GUIDE**

The decision guide identifies the benefit limitations for individual recipients based upon the skilled nursing need intensity of care (SNN 1, SNN 2, and SNN 3) and the family/caregivers situation. Family situation includes the availability of caregivers in the home, the health status of caregivers and the recipient’s attendance at school. The decision guide is Nevada Medicaid’s tool used to determine the appropriate range of nursing hours that can be authorized under the Medicaid PDN benefit.

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4. NON COVERED SERVICES

The following services are not covered benefits under PDN program and are therefore not reimbursable:

- a. Services provided to recipients that are ineligible for Medicaid;
- b. Services normally provided by a legally responsible adult or other willing and capable caregiver;
- c. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a nursing facility for the mentally ill (NF/MI) or intermediate care facility for the mentally retarded (ICF/MR) or at institution for the treatment of mental health or chemical addiction.
- d. Services rendered to recipients in pediatric and adult day centers.
- e. Services rendered at school sites responsible for providing "school based health service" pursuant to IDEA §300.24.
- f. Services provided to someone other than the intended recipient;
- g. Services that Nevada Medicaid determines could reasonably be performed by the recipient;
- h. Services provided without authorization;
- i. Services that are not on the approved plan of care;
- j. Service requests that exceed program limits;
- k. Respite care that is intended to relieve a legally responsible adult or primary caregiver from the daily routine of providing care for the recipient;
- l. Companion Care that is intended to provide friendly or social time with a recipient;
- m. Sitters or services that are intended for individuals to watch or supervise a recipient in the absence of a legally responsible adult or primary caregiver and that provide no skilled care;
- n. Homemaker services;
- o. Medical Social Services (MSS);

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- p. Duplicative services, such as personal care services that are provided during private duty nursing hours;
- q. Travel time to and from the recipient's residence;
- r. Transportation of the recipient by the private duty nurse to Medicaid reimbursable settings. PDN recipients may require immediate skilled nursing intervention. Such intervention would be precluded by the SN driving the vehicle.

903.1B PROVIDER RESPONSIBILITIES

The provider shall furnish qualified registered nurses and licensed practical nurses, under the supervision of a registered nurse to assist eligible Medicaid recipients with complex skilled nursing tasks as identified in the physician's written plan of care (POC). Services are to be provided as specified in this Chapter.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare certified Home Health Agency, licensed and authorized by State and Federal Laws to provide health care in the home.

2. MEDICAID ELIGIBILITY

The provider must verify each month continued Medicaid eligibility for each recipient. This can be accomplished by viewing the recipient's Medicaid Identification card, contacting the eligibility staff at the welfare office hot line, or utilizing the electronic verification of eligibility (EVE) system. Verification of Medicaid eligibility is the sole responsibility of the provider agency.

3. PHYSICIAN ORDER AND PLAN OF CARE

The provider must provide PDN services initiated by a physician's order and designated in the plan of care (POC) which is documented on a CMS 485. The POC is a written set of medical orders signed by the physician which certify the specific HHA services that will be provided, the frequency of the services, and the projected time frame necessary to provide such services. The plan of care is reviewed by the physician every 60 days. A new POC is required when there is a change in the recipient's condition, change in orders following hospitalization, and/or change in the physician.

4. PRIOR AUTHORIZATION

The provider must obtain prior authorization for all private duty nursing services prior to the start of care. Refer to the authorization process 3903.1D.

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5. THIRD PARTY LIABILITY (TPL)

The provider must determine on admission the primary payor source. If Medicaid is not the primary payor, the provider must bill the third party payor before billing Medicaid. The provider must also inform the recipient orally and in writing of the following:

- a. The extent to which payment may be expected from third party payors; and
- b. The charges for services that will not be covered by third party payors; and
- c. The charges that the patient may have to pay.

6. PLACE OF SERVICE

The provider must provide PDN service in the recipient's place of residence or in settings where normal life activities take the recipient other than the recipient's residence. School sites are excluded as a matter of special education law (IDEA §300.24).

7. CASE INITIATION

A referral from any source, physicians, discharge planners or recipient triggers the process for private duty hours (PDN).

The provider should make an initial visit to the recipient's home or to the hospital to complete an evaluation to determine if the recipient is appropriate for PDN hours and if they can accept the case. During this visit the provider must:

- a. Complete a nursing assessment, using an OASIS or age appropriate evaluation;
- b. Complete a Nevada Medicaid PDN assessment form; and
- c. Establish the safety of the recipient in the home setting.

If the provider determines the recipient is not appropriate for private duty nursing services or they cannot accept the case, the provider must contact the Nevada Medicaid District Office Care Coordinator and inform them of the reason the service cannot be delivered. If the provider is able to initiate service, a request for PDN service should be faxed to the QIO-like, along with the OASIS or age appropriate nurse evaluation and the PDN assessment.

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8. CONFIDENTIALITY

The provider must ensure the confidentiality of recipient records and other information, such as the health, social, domestic and financial circumstances learned in providing services to recipients.

The provider shall not release information related to recipients without written consent from the recipient or the recipient's legal representative, except as required by law.

Providers meeting the definition of a "covered entity" as defined in the HIPAA Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

9. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers will be in compliance with all laws relating to incident of abuse, neglect, or exploitation.

a. CHILD ABUSE

State law requires that certain person employed in certain capacities must make a report to a child protective services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect a child has been abused or neglected.

For minors under the age of 18, the Division of Child and Family Services or the appropriate county agency accepts reports of suspected abuse.

Refer to NRS 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adults aged 60 and over, the Division for Aging Services accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

For all other individuals, contact social services and/or law enforcement agencies.

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10. RECIPIENT RIGHTS

The governing body of the provider agency has an obligation to protect and promote the exercise of the recipient rights. A patient has the right to exercise his rights as a patient of the provider. A patient's family or guardian may exercise a patient's rights when a patient has been judged incompetent. The recipient has the right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. Refer to recipient rights later in this Chapter.

11. ADVANCE DIRECTIVES

The provider must provide the recipient or parent/legal guardian with information regarding their rights to make decisions about their health care, including the right to execute a living will or grant a power of attorney to another individual, per 42 CFR 489.102, Patient Self Determination Act (Advance Directives).

HHA's must also:

- a. Provide written information to recipients at the onset of service concerning an individual's right under Nevada state law, NRS 449.540 to 449.690, to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate Advance Directives.
- b. Inform recipients about the agency's policy on implementing Advance Directives.
- c. Document in the individual's medical record whether or not the individual has executed an Advance Directive.
- d. Ensure compliance with the requirements of NRS 449.540 to 449.690 regarding Advance Directives at agencies of the provider or organization.
- e. Provide (individually or with others) education to staff and the community on issues concerning Advance Directives.
- f. Not discriminate against a recipient based on whether he or she has executed an Advance Directive.

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12. NON DISCRIMINATION

The provider must act in accordance with federal rules and regulations, and may not discriminate unlawfully against recipients on the basis of race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions).

13. COMPLAINT RESOLUTION

The provider must respond to all complaints in a reasonable and prompt manner. The provider must perform recipient/provider problem solving and complaint resolution.

- a. The provider must maintain records that identify the complaint, the date received and the outcome.
- b. The provider must submit documentation regarding the complaint to NMCO immediately upon request.

14. TERMINATION OF SERVICES

- a. The provider may terminate services for any of the following reasons:
 1. The recipient or other persons in the household subjects the skilled nurse to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;
 2. The recipient is ineligible for Medicaid;
 3. The recipient requests termination of services;
 4. The place of service is considered unsafe for the provision of PDN services;
 5. The recipient is admitted to an acute hospital setting or other institutional setting;
 6. The recipient or caregiver refuses to comply with the physician's POC;
 7. The recipient or caregiver is non co-operative in the establishment or delivery of services.
 8. The recipient no longer meets the criteria for PDN services;

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9. The recipient refuses service of a skilled nurse based solely or partly on the race, religion, sex, marital status, color, age, disability or national origin;
10. The provider is no longer able to provide services as authorized (i.e. no qualified staff).

Note: A provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's PDN program. The recipient may choose another provider.

b. IMMEDIATE TERMINATION

The provider may terminate PDN services immediately for reasons one through five listed above.

Note: The nurse provider must comply with 632.895.6 of the Nurse Practice Act.

c. ADVANCE NOTICE TERMINATION

The provider must provide at least 5 calendar days advance written notice to recipients when PDN services are terminated for reasons six through ten listed above.

d. NOTIFICATION REQUIREMENTS

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The Nevada Medicaid Central Office (NMCO) Home Care Coordinator should be notified by telephone within two working days. The provider should submit written documentation within five working days.

The provider will send a written notice which advises the NMCO of an effective date of the action of the termination of service, the basis for the action, and intervention/resolution attempted prior to terminating services.

15. RECORDS

The provider must maintain medical records which fully disclose the extent and nature of the service provided to the recipient and which supports fees or payments made. Medical and financial records and all other records provided must be maintained for an interval of not less than six (6) years. Following HIPAA Privacy Regulations contained in 45 CFR 160 and 164, the provider must make records available upon request to the Division.

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903.1C RECIPIENT'S RESPONSIBILITIES

The recipient or personal representative shall:

1. Provide the HHA with a valid Medicaid card at the start of service and each month thereafter;
2. Provide the HHA with accurate and current medical information, including diagnosis, attending physician, medication regime, etc.;
3. Notify the HHA of all third party insurance information, including the name of other third party insurance, such as Medicare, Champus, Workman's Compensation, or any changes in insurance coverage;
4. Inform the HHA of any other home care benefit that he/she is receiving through state plan services, such as personal care aide (PCA) services, intermittent HHA skilled nursing or therapy services. Services provided through another agency or program such as respite, case management or participation in a Waiver program should also be identified;
5. Have a primary caregiver, residing in the recipient's place of residence, who accepts responsibility for the individual's health, safety and welfare. The primary care giver must be responsible for the majority of daily care in a 24-hour interval;
6. Have an identified alternate caregiver, or a backup plan to be utilized if the primary care giver and/or the provider are unable to provide services. If a single parent/caregiver is the sole person with responsibility for the recipient and becomes unable to care for the recipient there would be no one legally capable of making decisions about a minor's care. The PDN nurse provider is not an alternate caregiver with legal authority;
7. Have written emergency plans in place. The caregiver/parent should inform the provider of an alternate caregiver and or with a plan that indicates his/her wishes if the responsible caregiver became ill or disabled and is unavailable to provide care for any other;
8. Cooperate in establishing the need for and the delivery of services;
9. Have necessary backup utilities, communication systems available for technology dependent recipients;
10. Comply with the delivery of services as outlined in the Plan of Care;
11. Sign the PDN visit forms to document the hours and the services that were provided;

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12. Notify the provider when scheduled visits cannot be kept or services are no longer required;
13. Notify the provider of unusual occurrences of complaints regarding the delivery of services and of dissatisfaction with specific staff;
14. Give the provider agency a copy of an Advance Directive, if applicable;
15. Not request the provider agency staff to work more hours than authorized or to change the days/hours approved;
16. Not request the provider agency staff to provide care to non recipients or to provide service not on the POC (babysitting, housekeeping tasks, etc.);
17. Not subject the provider or Division staff to physical and/or verbal abuse, sexual harassment, exposure to the use of illegal substances, illegal situations or threats of physical harm;
18. Not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability, and/or national origin.

RECIPIENT RIGHTS

Every Medicaid recipient, their LRA or legal guardian is entitled to receive a statement of "Recipient Rights" from their provider. The recipient should review and sign this document. The recipient's rights should include the following:

1. A recipient has the right to courteous and respectful treatment, privacy and freedom from abuse and neglect.
2. A recipient has the right to be free from discrimination because of race, creed, color, national origin, sexual orientation and diagnosis.
3. A recipient has the right to have his property treated with respect.
4. A recipient has the right to confidentiality with regard to information about his health, social and financial circumstances and about what takes place in his home.
5. A recipient has the right to access information in his own record upon written request.
6. A recipient has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing

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services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.

7. The recipient has the right to be informed of the provider's right to refuse admission to, or discharge any recipient whose environment, refusal of treatment, or other factors prevent the HHA from providing safe care.
8. The recipient has the right to be informed of all services offered by the agency prior to, or upon admission to the agency.
9. The recipient has the right to be informed of his condition in order to make decisions regarding his home health care.
10. The recipient has the right to be advised, in advance, of the disciplines that will be furnished, care, and frequency of visits proposed to be furnished.
11. The recipient has the right to be advised, in advance, of any change in the plan of care before the change is made.
12. The recipient has the right to participate in the development of the plan of care, treatment, and discharge planning.
13. The recipient has the right to refuse services or treatment.
14. The recipient has the right to request a Fair Hearing when disagreeing with Nevada Medicaid's action to deny, terminate, reduce or suspend service.

903.1D AUTHORIZATION PROCESS AND REIMBURSEMENTS

1. PRIOR AUTHORIZATION

Private Duty Nursing (PDN) services must be prior authorized by Nevada Medicaid staff (or their designee). The provider must fax a completed payment authorization request to the Quality Improvement Organization (QIO-like vendor). The provider agency must submit the OASIS or age appropriate form, and the PDN assessment to the QIO-like vendor.

The QIO-like vendor will review the request and supporting documentation utilizing the decision guide before authorizing PDN hours. The QIO-like vendor will issue an authorization number for the approved PDN service hours. Service hours cannot be initiated until the QIO-like vendor has issued an authorization number. If the request is for more hours than can be authorized according to program criteria, the recipient will be issued a Notice of Decision (NOD) by the QIO-like vendor.

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Private Duty Nursing services requested for a recipient enrolled in a Managed Care Organization (MCO) must be prior authorized by the MCO. The MCO has sole responsibility for all decisions related to the PDN service for MCO recipients.

a. INITIAL EVALUATION VISIT

The initial evaluation visit does not require prior authorization from Nevada Medicaid or their QIO-like vendor. During the visit the skilled nurse evaluator must complete a nursing assessment using an OASIS or age appropriate tool. The nurse must complete a Nevada Medicaid PDN form.

Reimbursement: The initial registered nurse visit will be reimbursed as an RN extended visit. Refer to reimbursement code table for specific billing code.

b. HOLIDAY RATES

For recipients who require 7-day-per-week home care service, an increased rate will be paid for visits made on State recognized holidays. The holiday rate must be requested on the Nevada Medicaid Home Health Authorization Payment Request form, which covers the certification period in which the State recognized holiday(s) occur.

Nevada Medicaid currently recognizes the following holidays: New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Nevada Admission Day (last Friday in October), Veteran's Day, Thanksgiving Day, Family Day (the day after Thanksgiving), and Christmas Day. The recognized holiday is the same day as State offices are closed.

Reimbursement: Time and one-half will be reimbursed for State recognized holidays. Refer to reimbursement code table for specific billing code.

c. THIRD PARTY LIABILITY

The provider must bill all other payment resources available from both private and public insurance.

d. DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies require a prior authorization request at the time of request for Home Health Authorization (HHA) services and are to be listed on the Home Health Prior Authorization Form. Wound care supplies will be authorized for the HHA for an initial ten-day period only. Supplies will be authorized only for the specific procedure or treatment requested. Each item must be listed separately.

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Routine supplies must be obtained from a Durable Medical Equipment (DME) or Pharmacy Provider.

Reimbursement: Unit price per fee schedule. Refer to reimbursement code table for specific billing code.

e. HOME HEALTH AGENCY RATE

Home Health Agency rates are based on the recipient's place of residence at the time the service is rendered.

Reimbursement: Reimbursement is made according to regions, urban, rural and out of state, defined in the following manner:

1. Urban: In Southern Nevada, urban is Boulder City and the portion of Clark County within Las Vegas Valley including the cities of Las Vegas, North Las Vegas, Henderson and the urbanized townships. In Northern Nevada, urban includes the cities of Reno, Sparks, and Carson City, and unincorporated areas of Washoe County that are within 30 miles of Reno, as approved by the District Office.
2. All other areas within Nevada are classified as rural. Use rural billing code modifier TN.
3. All outside Nevada services use rural billing code modifier TN.

f. MILEAGE

Actual mileage is reimbursed one way from the HHA/Private Duty Nurse (PDN) office to the recipient's residence. Actual mileage should be listed on the prior authorization request form to establish a base line for reimbursement.

Reimbursement: Mileage is paid per actual miles. Refer to reimbursement code table for specific billing code.

2. ONGOING AUTHORIZATIONS

Requests for continuing PDN services must be submitted to the QIO-like at a minimum of 15 working days but no more than 30 days prior to the expiration date of the existing authorization. The completed request must be submitted to the QIO-like along with a current nurse assessment and PDN assessment form. The QIO-like will review for appropriate number of hours using the Decision Guide and based on program criteria. PDN services may be authorized for a maximum of six months.

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3. ADDITIONAL AUTHORIZATIONS

a. School Break

During “planned breaks” of at least five (5) consecutive school days (e.g. track break, summer vacation), additional hours may be authorized within program limitations. A separate authorization request should be submitted for the specific number of hours requested beyond those already authorized. Parental availability during these breaks must also be documented.

b. Change in Condition/Situation

A new authorization must be requested when the recipient has a change of condition or situation that requires either a reduction in PDN hours or an increase in PDN hours. A completed PAR must be faxed to the QIO-like along with documentation supporting medical necessity and program criteria (parental availability/capability).

4. RETRO AUTHORIZATIONS

- a. A request for authorization of services provided to pending recipients may be made retroactively, once Medicaid eligibility has been established. Medicaid may authorize services retroactively for covered services within limitations of program criteria. The PAR must include the date of determination (DOD) of eligibility. Any service provided during pending status is at the provider’s own risk.

903.2 24 HOUR CARE

In the event a primary caregiver is absent due to a medical need of the caregiver or a family member, a Medicaid recipient under 21 years of age may be eligible to receive 24-hour care at home through an EPSDT referral. 24-hour care must be prior authorized.

903.2A COVERAGE AND LIMITATIONS

1. 24-hour care is limited to 5 days per calendar year;
2. No other legally responsible adult or caregiver is available to provide care;
3. 24-hour day care is medically necessary and placement in a facility would be detrimental to the recipient’s health;

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903.2B PROVIDER RESPONSIBILITIES

1. The provider is responsible for requesting documentation that the primary caregiver or family member is absent due to a medical need.
2. The provider must submit an EPSDT screening by a physician provider (31) that the 24-hour care is medically necessary and placement in a facility is detrimental to the recipient's health.
3. The provider needs to secure an authorization for disclosure from the Legally Responsible Adult (LRA) or primary caregiver to provide documentation of absence due to a medical need. Such information will be released to Nevada Medicaid or their designee for determination of eligibility for this benefit.

All other policies found in Section 3903.1B, Provider Responsibilities, of this Chapter shall apply.

903.2C RECIPIENT RESPONSIBILITIES

1. The primary caregiver must provide supporting documentation of the absence of the primary caregiver due to medical need.
2. The primary caregiver must pursue the availability of alternate caregivers to provide care during the interval before requesting 24-hour care.
3. All other policies found in Section 3903.1C, Recipient Responsibilities, of this Chapter shall apply.

903.2 D AUTHORIZATION PROCESS

1. The provider may request a verbal authorization of the QIO-like if the need for such service was unanticipated. A written request, along with supporting information should be submitted as soon as possible thereafter, but no later than 3 working days after the verbal request
2. The provider agency must submit a PAR along with the EPSDT screening referral and supporting documentation of the absence of a primary caregiver to the QIO-like prior to the provision of 24-hour coverage, if the need for such service was anticipated.

903.3 CONCURRENT CARE

Concurrent care allows for the provision of PDN service by a single nurse to more than one recipient simultaneously. A single nurse may provide care for multiple recipients (up to 3) if care can be provided safely. Concurrent care allows for authorized nursing hours to be collectively

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used for the multiple recipients. Concurrent care allows for optimum utilization of limited skilled nurse resources while providing safe skilled nursing care to Nevada Medicaid recipient. Concurrent care must be prior authorized.

903.3B PROVIDER RESPONSIBILITIES

1. The provider shall evaluate and determine the safety of settings for the provision of concurrent care.
2. The provider shall adjust requests for PDN hours when concurrent care is provided.

All policies found in Section 3903.1 of this Chapter shall apply.

903.4 OUT-OF-STATE SERVICES

PDN services are allowed out-of-state for Medicaid recipients absent from the state per (42CFR 431.52). Payment for services furnished in another state are reimbursed to the same extent that Nevada would pay for service provided within Nevada's boundaries. Out-of-state PDN services are reimbursed at the rural rate.

903.4A COVERAGE AND LIMITATIONS

In addition to the policies described in Section 3903.1A, of this Chapter, the following apply for Out-of-State.

Out-of-state services may be authorized when:

1. There is a medical emergency and the recipient's health would be endangered if he were required to return to the State of Nevada to obtain medical services;
2. The recipient travels to another state because the Division finds the required medical services are not available in Nevada;
3. The Division determines that it is general practice for recipients in a particular locality to use medical services in another state (e.g., Nevada counties that border other State lines);
4. The recipient is on personal business. Nevada Medicaid may reimburse for these services, however, they will be limited to service hours currently authorized.

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903.4B PROVIDER RESPONSIBILITIES

1. The out-of-state provider must contact provider enrollment at Nevada Medicaid Central Office (NMCO) to become enrolled as a Nevada Medicaid Home Health Agency Provider.
2. The out-of-state provider must comply with all provisions identified in 3903.1B.

903.4C RECIPIENT RESPONSIBILITIES

1. The recipient or their personal representative should contact Home Health Agency providers in the geographic out-of-state region on which they wish service to be provided, to determine the availability of Nevada Medicaid PDN service providers.
2. The recipient should notify the out-of-state provider who is not a Nevada Medicaid provider who is interested in becoming a provider to contact provider enrollment at Nevada Medicaid Central Office (NMCO).

The recipient must comply with all the provision identified in 3903.1C and 3903.D of this Chapter.

903.5 CRISIS OVERRIDE

The private duty nursing benefit allows, in rare circumstances, a short term increase of nursing hours beyond standard limits in a crisis situation. A crisis situation is one that is generally unpredictable and puts the patient at risk of institutionalization without the provision of additional hours.

903.5A COVERAGE AND LIMITATIONS

1. Additional services may be covered up to twenty percent (20%) above program limits
2. Additional services are limited to one (1), sixty (60) day interval in a three year period (calendar years).

903.5B PROVIDER RESPONSIBILITIES

Must contact the Division of Health Care Financing and Policy, Central office Home Care Coordinator or designee with information regarding the crisis situation and need for additional hours.

All other policies as discussed in Section 3903.1.

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904 HEARINGS

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

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905 REFERENCES AND CROSS-REFERENCES

905.1 PROVIDER SPECIFIC INFORMATION

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

Medicaid Services Manuals:

Chapter 100	Eligibility, Coverage and Limitations
Chapter 1300	DME, Prostheses and Disposable Supplies
Chapter 1400	Home Health Agencies
Chapter 1500	Healthy Kids Program
Chapter 1900	Medical Transportation
Chapter 2800	School Based Child Health Services
Chapter 3100	Hearings
Chapter 3200	Hospice Services
Chapter 3300	Surveillance and Utilization Review
Chapter 3500	Personal Care Aide Services
Chapter 3600	Managed Care Organizations

Nevada Check Up Manual:

Chapter 1000	Nevada Check Up Program
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905.2 FIRST HEALTH SERVICES CORPORATION

PROVIDER RELATIONS UNITS

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

PRIOR AUTHORIZATION DEPARTMENTS

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

PHARMACY POINT-OF-SALE DEPARTMENT

First Health Services Corporation
 Nevada Medicaid Paper Claims Processing Unit

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PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238

905.3 WELFARE ELIGIBILITY OFFICES

Welfare District Offices:

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

905.4 STATE OFFICES

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

- a. Division of Health Care Financing and Policy
Nevada Medicaid Office
1100 E. William Street Suite 101
Carson City, Nevada 89701
Telephone: (775) 684-3600

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

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c. NEVADA MEDICAID DISTRICT OFFICES (NMDO):

Carson City	(775) 684-3651
Reno	(775) 687-1900
Las Vegas	(702) 668-4200
Elko	(775) 753-1191

PRIVATE DUTY NURSING SERVICES – DECISION TOOL

FACTOR I. Availability of Caregivers Living in Home

Household Situation and Resource Consideration	INTENSITY OF CARE		
	Skilled Nursing Level 1	Skilled Nursing Level 2	Skilled Nursing Level 3
*Unavailable – Works or attends school either full-time (FT) or part-time (PT).			
a.) 2 or more caregivers; - Both unavailable * FT or PT. <i>No available /capable caregiver</i>	Not to exceed 20 hours per week.	Not to exceed 40 hours per week.	Not to exceed 56 hours per week.
b.) 2 or more caregivers; - 1 unavailable* FT or PT. <i>1 available /capable caregiver</i>	Not to exceed 10 hours per week.	Not to exceed 20 hours per week.	Not to exceed 28 hours per week. **
c.) 2 or more caregivers; - Neither unavailable* FT or PT <i>2 available / capable caregivers</i>	0 hours per week.	Not to exceed 12 hours per week.	Not to exceed 20 hours per week.
d.) 1 caregiver; - Unavailable* FT or PT. <i>No available / capable caregiver</i>	Not to exceed 24 hours per week.	Not to exceed 48 hours per week.	Not to exceed 67 hours per week.
e.) 1 caregiver; - Not unavailable* FT or PT. <i>1 available / capable caregiver</i>	Not to exceed 12 hours per week.	Not to exceed 24 ** hours per week.	Not to exceed 34 hours per week.

**** Up to 40 hours per week may be allowed when overnight care is needed.**

FACTOR II: Capability of Caregiver

Household Situation and Resource Consideration	INTENSITY OF CARE		
	Skilled Nursing Level 1	Skilled Nursing Level 2	Skilled Nursing Level 3
Primary caregiver as identified in Factor I above. †Verification required.			
a.) Available caregiver has health issues † which inhibits their ability to provide any of the need ed care.	May allow an additional 2 hours per day. <i>NTE 25 total hours per week.</i>	May allow an additional 3 hours per day. <i>NTE 48 total hours per week.</i>	May allow an additional 4 hours per day. <i>NTE 67 total hours per week.</i>
b.) Available caregiver has moderate health issues † which impacts their ability to provide all of the needed care.	May allow an additional 1 hour per day. <i>NTE 20 total hours per week.</i>	May allow an additional 2 hours per day. <i>NTE 40 total hours per week.</i>	May allow an additional 3 hours per day. <i>NTE 56 total hours per week.</i>

FACTOR III: Recipient’s Participation in School

Household Situation and Resource Consideration	INTENSITY OF CARE		
	Skilled Nursing Level 1	Skilled Nursing Level 2	Skilled Nursing Level 3
Limitations imposed on the hours identified in Factor I above. † Limitations imposed on all school aged recipients regardless of homebound status. ††			
a.) Recipient attends school 20 or more hours per week †	Reduce allowable hours by 2 hours per day. <i>NTE 14 hours per week</i>	Reduce allowable hours by 2 hours per day. <i>NTE 38 hours per week</i>	Reduce allowable hours by 2 hours per day. <i>NTE 57 hours per week</i>

† Includes hours attending school plus transportation time.

†† During planned breaks (i.e. summer vacation) of at least five consecutive school days, hours may be authorized pursuant to Factor I and II.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 11, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

A revision to Medicaid Services Manual (MSM) Chapter 1000 is being proposed to clarify coverage and limitations regarding initial diagnostic services when required for prior authorization of Orthodontia treatment. The codes include D0470-diagnostic cast, D0330-panoramic x-rays, and D0350-diagnostic photographs. These diagnostic services are considered to be Orthodontia services only for reimbursement to Provider Type 22 Dental with specialty 079-Orthodontist.

These changes are effective February 12, 2016.

MATERIAL TRANSMITTED

MTL 03/16
CHAPTER 1000 - DENTAL

MATERIAL SUPERSEDED

MTL 14/15
CHAPTER 1000 - DENTAL

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8	Orthodontics (D8000-D8999)	Added clarification of coverage of Current Dental Terminology (CDT) codes outside D8000 series that are considered part of Orthodontia treatment only when required for Prior Authorization (PA) and provided by an Orthodontist.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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1000 DENTAL

INTRODUCTION

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. Dental services provided shall maintain a high standard of quality and shall be provided within the coverage and limitation guidelines outlined in this Chapter. All Medicaid policies and requirements, (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Manual Chapter 1000 are the same for NCU.

All providers participating in the Medicaid program must provide services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available through Medicaid's Quality Improvement Organization (QIO) like vendor.

Nevada Medicaid provides dental services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. For Medicaid-eligible adults age 21 years and older, dental services are an optional service as identified in this chapter and the Billing Guide documents located at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist.

Individuals under Age 21

Through the EPSDT benefits, individuals under the age of 21, receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services, including orthodontia when medically necessary and pre-approved by the Nevada Medicaid QIO-like vendor. The EPSDT screening provider may refer children for dental services. However, such a referral is not necessary if the parent otherwise elects to contact a Medicaid dental provider. The local Medicaid District Office can direct the parent/guardian to local dental providers.

Individuals age 21 and older

Dental services for Medicaid-eligible adults who qualify for full benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations.

Pregnancy Related Services

Nevada Medicaid offers expanded dental services in addition to the adult dental services for Medicaid-eligible pregnant women. These expanded pregnancy related services require prior authorization.

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Nevada Revised Statute (NRS) 631- Dentistry and Dental Hygiene.

The State Plan of Nevada describes the amount, duration and scope of dental care and services provided to the categorically needy in Attachments 3.1-A 10 and 3.1-A 12b.

The Centers for Medicare and Medicaid Services (CMS) state that necessary and essential dental services are mandatory for all eligible Medicaid children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under the Social Security Act 1905(r)(5). The Nevada EPSDT program provides children with services that are in addition to those available to adult recipients as cited in the Code of Federal Regulations (CFR) Section 441.56.

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1002 RESERVED

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1003 NEVADA MEDICAID POLICY

Reference the Coverage, Limitations, and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist Billing Guide for a list of CDT codes detailing prior authorization requirements and service limitations.

1003.1 DIAGNOSTIC AND PREVENTIVE SERVICES (D0100-D1999)

The branch of dentistry used to identify and prevent dental disorders and disease.

The United States Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Nevada Medicaid lists these recommendations in the Medicaid Services Manual (MSM) Chapter 600, Attachment A.

The USPSTF recommends application of fluoride varnish to primary teeth of all infants, children, starting at the age of primary tooth eruption, and at the age of six for children whose water supply is fluoride deficient in primary care practices.

Nevada Medicaid authorizes payment of diagnostic and preventive dental services for qualified recipients.

a. COVERAGE AND LIMITATIONS

Coverage is limited to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for persons less than 21 years of age. Coverage for persons over 21 years of age is limited to diagnostic services needed for emergency extractions or palliative care.

b. AUTHORIZATION REQUIREMENTS

No Prior Authorization (PA) is necessary for these services covered under EPSDT.

1003.2 RESTORATIVE DENTISTRY SERVICES (D2000-D2999)

The branch of dentistry used to restore the integrity of the teeth through the use of fillings or crowns.

Nevada Medicaid authorizes payment of restorative dentistry for qualified recipients.

a. COVERAGE AND LIMITATIONS

Restorative services are limited to EPSDT, for persons less than 21 years of age.

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For recipients age 21 years and older, with a prior authorization, Nevada Medicaid reimburses for certain fillings and crowns on teeth that are adjacent to a partial denture and are the abutment (anchor) tooth for that partial denture. Nevada Medicaid also reimburses for palliative treatment for persons 21 years of age and older. Pregnancy related services as defined in the MSM Addendum for persons 21 years of age and older are listed in the QIO-like vendor's web portal at www.medicaid.nv.gov in the Provider Type 22 Dentist Billing Guide.

Fillings are limited to the use of amalgam or plastic.

Crowns are limited to stainless steel and composite resin repairs.

b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT.

1003.3 ENDODONTIC SERVICES (D3000-D3999)

The branch of dentistry specializing in disease or injury that affects the root tips or nerves in the teeth through the use of root canals.

Nevada Medicaid authorizes payment of endodontics for qualified recipients.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT for persons less than 21 years of age.

b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT.

1003.4 PERIODONTIC SERVICES (D4000-D4999)

The branch of dentistry used to treat and prevent disease affecting supporting bones, ligaments and gums of the teeth.

Nevada Medicaid authorizes payment of periodontics for qualified recipients.

a. COVERAGE AND LIMITATION

1. Coverage is limited to EPSDT, for persons less than 21 years of age, or as palliative treatment (codes D4355 and D4999) for persons 21 years of age and older.

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2. Periodontal scaling and root planing for pregnant recipients is a covered service. Due to the risk of pregnancy gingivitis, Medicaid will cover a second cleaning during pregnancy as well as 100% coverage of the treatment of inflamed gums around wisdom teeth during pregnancy.

Medicaid carefully monitors for the appropriate use of codes D4341 and D4342. These codes are generally limited to recipients who are at least 14 years old. Providers' in-office records must verify x-rays, periodontal charting, and diagnoses documenting the need for these procedures.

b. AUTHORIZATION REQUIREMENTS

1. No PA is necessary under EPSDT.
2. Some codes require a PA for Pregnancy related services for persons age 21 and older.

Reference the Coverage, Limitations, and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

1003.5 PROSTHODONTICS SERVICES (D5000-D6999)

The branch of dentistry used to replace missing teeth or restore oral structure through the use of partials, dentures, etc.

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Emergency prosthetic repair refers to dental prosthetics that are rendered completely unserviceable. Loose dentures or dentures with broken/missing teeth do not meet the intent of the definition unless irritation is present and sufficiently documented. The dentist's in-office records must substantiate the emergency for the purposes of Medicaid post-payment utilization review and control.

a. COVERAGE AND LIMITATIONS

1. Partial dentures and full dentures may be provided when medically necessary to prevent the progression of weight loss and promote adequate mastication. Medicaid limits reimbursement of services to one new full or partial denture per five years. Given reasonable care and maintenance, prostheses should last five years. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service.

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2. Medicaid will pay for necessary emergency x-rays required to diagnose Medicaid covered removable prostheses. No PA is necessary for the initial emergency examination and x-rays. The dentist's office records must substantiate the recipient's medical necessity (e.g., x-ray evidence, reported significant loss of weight, sore and bleeding gums, painful mastication, etc.). Payment for the examination and x-rays may be withdrawn if post-payment reviews of in-office records do not substantiate the medical necessity. Payment for dentures or partials includes any adjustments or relines necessary for six months after the date of delivery.
3. A person qualifies for a partial denture with four or more missing teeth, if anterior to the second molar in the same arch, or the four or more missing teeth are unilaterally (on one side only) in sequence as in, "2, 3, 4 & 5." Medicaid does not allow unilateral partials except in the immediately preceding and following examples. In the following examples the person would be eligible for a partial because four teeth would be missing and the person would be expected to have difficulty with mastication: missing 18, 19, 20 and 28 or 29; or 18, 19, 20 and 21 (four teeth in a row). However, a person would not be eligible for a partial if missing 19, 20, and 31 or 32 because there are not enough teeth missing for significant difficulty with mastication.
4. Third molars are not replaceable as missing teeth nor are they considered in the qualification for payment of partial dentures. Second molars are replaceable as missing teeth with missing posteriors in the same quadrant as explained in the above examples. A flipper may be used as a temporary replacement for employment purposes when an anterior tooth is extracted. For healing purposes, a flipper may be used temporarily when the partial for an anterior tooth will not be available for greater than 3 months.
5. Employment required partials may be authorized for payment. A person may also qualify for a partial when missing any one of the six upper or lower anterior teeth (6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 or 27) when necessary for employment. A supportive written Division of Welfare and Supportive Services, New Employees of Nevada (NEON) report meets the employment verification requirement. The recipient must receive the report from the NEON program for the dentist's submission with his request. Without the NEON report, the fiscal agent returns requests for work-required partials. The fiscal agent forwards complete requests to the Medicaid Dental Consultant for a determination. The consultant may approve this service when accompanying documentation substantiates employment necessity.

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6. Requests to override the 5-year limitation on full and partial dentures will require a PA and will only be considered for the following exceptional circumstances:
- a. Dentures were stolen (requires a copy of the police report). Also, under consideration is if the theft is a repeatedly occurring event. The recipient must exercise reasonable care in maintaining the denture.
 - b. Dentures were lost in a house fire (requires a copy of the fire report or other notification documenting the fire such as a newspaper article).
 - c. Dentures were lost in a natural disaster (requires a copy of documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or any other documentation indicating that the recipient's residence was in the area affected by the natural disaster).
 - d. Dentures no longer fit due to a significant medical condition. Requires one letter from each of the recipient's physician/surgeon and dentist. Physician/surgeon documenting the supporting medical condition. The dentist stating that the existing denture cannot be made functional by adjusting or relining it and that new dentures will be functional. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.
 - e. Dentures could not be made functional by issuing dentist. Requires a letter from the recipient's new dentist, the recipient's physician/surgeon and the recipient. The physician/surgeon stating the medical necessity for the denture. The dentist stating that the existing denture cannot be made functional by adjusting or relining it and that the new denture will be functional. The recipient stating that they returned to the issuing dentist requesting the denture be made functional and the issuing dentist was unable to comply. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

Process to request an override based on the above exceptional circumstances requires PA, the provider must submit the following:

- f. A properly completed ADA claim form clearly marked "Request for Denture Override".
- g. Copies of current radiographs when requesting an override for a partial denture to a full denture.

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- h. Any supporting documentation listed in this section, as applicable.
- i. A cover letter that clearly describes the circumstances of the case.
- j. These requests must be mailed to Medicaid's QIO-like vendor's dental consultant.

7. Medicaid will pay for a maximum of one emergency denture reline and/or maximum of six adjustments done not more often than every six months, beginning six months after the date of partial/denture purchase. No prior approval is required for relines. The provider's in-office records must substantially document the medical emergency need. Denture/partial relines and adjustments required within the first six months are considered prepaid with Medicaid's payment for the prosthetic. Dentists should call or write to the fiscal agent to insure the reline is not being done within six months of the date of the last reline or new denture purchase. A claim submitted for a reline or adjustment sooner than six months since the last payment for a reline or adjustment will deny for payment. Post payment review will be done to assure that medical necessity of the service has been substantially documented.
8. If the recipient is unable to wear the denture, the recipient must schedule an appointment with the issuing dentist to have the denture/partial made functional. Factors which would cause the denture to not be functional would include improper fit, sore or bleeding gums and painful mastication. If the issuing dentist is unable to make the denture functional, resulting in the recipient requiring services from another dentist, a full or partial recoupment of payment may occur less the cost of the laboratory services. When the issuing dentist receives a recoupment notice the dentist must provide a copy of the invoice detailing the laboratory charges so that it may be deducted from the recoupment amount. The requirements in Section 1003.6 are applicable if a dentist requests a new denture within a five year period.

b. PROVIDER RESPONSIBILITY

1. New dentures or partials (or their replacements every five years) must be evaluated for medical necessity. Medicaid will not pay for routine examinations (code D0150) in connection with new dentures or denture replacements. For new dentures, dentists may bill code D0140 for the initial dental emergency and another code D0140 for the evaluation/provision of the dentures. Dentists may bill one examination charge at the time of the first visit. They may bill the other examination on the same service date used to bill the denture or partial. For replacement of full dentures the provider may not bill code D0140 a second time with the date of service used to bill the denture(s).

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2. Keep diagnosable, panoramic or full mouth x-rays as part of the dentist's record for all removable prosthetics. The x-rays and dentists office notes must substantiate all missing teeth.
3. The recipient must sign and date a delivery receipt to verify that the dentures/partials were received and are accepted and/or acceptable. The date of the signature on the delivery receipt must be the date the dentures/partials were received by the recipient. The delivery receipt must include the recipient's name, quantity, detailed description of the time(s) delivered and the date and time of delivery.

c. AUTHORIZATION REQUIREMENTS

1. PA is required for partials and/or full dentures for all recipients residing in Nursing Facilities or receiving Hospice services.
2. Requests for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services must explain the significance of all of the following qualifications of medical need:
 - a. The recipient's medical need for the service in considering his/her total medical condition. Requires one letter each from the recipient's primary care physician and dentist documenting the supporting medical condition.
 - b. Factors relating to conditions that hinder effective functioning, including but not limited to, impaired mastication, muscular dysfunction, type of diet, current weight compared to the previous year, diagnosis, ability to swallow and reason for poor nutrition. When documenting reason for poor nutrition, specify whether this is related to dental structures, or related to the recipients physical or medical condition and will not be improved with dentures.
 - c. Mental status relating to the recipients ability to understand the use and care of the partials and/or full dentures.
3. No PA is required for partials and/or full dentures for all other recipients. Post payment review will be completed at the discretion of the fiscal agent with recoupment of payment for any partials or full dentures not meeting the above policy for qualification of coverage.

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1003.6 DENTURE IDENTIFICATION IMBEDDING

Nevada Medicaid provides payment of denture identification imbedding for qualified recipients.

a. COVERAGE AND LIMITATIONS

Any removable prosthetic appliance paid for by the Nevada Medicaid program must have permanent identification labeling imbedded in it.

b. PROVIDER RESPONSIBILITY

Medicaid requires imbedding of the recipient's first initial, last name, and the last four digits of the social security number for complete dentures, partial dentures with acrylic saddles, and when relining unmarked appliances. Failure to include imbedding on prosthetic claims will result in nonpayment of dentures, partials, and relines. In cases of insufficient room, you may reduce the person's name and identifiers to the first and second initials, plus the last four digits of the social security number.

Code D5899 and descriptor "ID Imbedding" must be completed by delivery unless the prosthetics already show such markings and the provider so states. The fiscal agent will return all requests/billings for prosthetics, unless this requirement is met. If denture identification is impractical for another reason, the provider's written explanation will be evaluated by the QIO-like vendor's Dental Consultant for approval and exceptional processing.

c. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not require PA for ID imbedding.

1003.7 ORAL SURGERY (D7000-D7999)

The branch of dentistry using surgery to treat disorders/diseases of the mouth.

Nevada Medicaid authorizes payment of oral surgery for qualified recipients.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age, pregnant persons 21 years of age and older, and as palliative treatment for persons 21 years of age and older.

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b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT and for some pregnancy related services, or for persons 21 years of age and older, if the service is considered an emergency extraction or palliative care.

Reference the Coverage, Limitations, and Prior Authorization Requirements document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in Provider Type 22 Dentist Billing Guide.

1003.8 ORTHODONTICS (D8000-D8999)

The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function.

Nevada Medicaid authorizes payment for orthodontics for qualified recipients under 21 years of age.

The diagnostic codes D0330, D0350, and D0470 are considered to be "Orthodontia" services only when required for Orthodontia treatment prior authorization.

a. COVERAGE AND LIMITATIONS

Medicaid excludes orthodontic work, except that which is authorized by the Children with Special Health Care Needs Program and reimbursed by Medicaid, or when specifically authorized by Medicaid's QIO-like vendor dental consultant as medically necessary under EPSDT.

Panoramic films. After an initial panoramic film, additional x-rays of this type require PA, except in an emergency. Examples of emergencies include fractured jaw, unusual swelling, etc.

b. PROVIDER RESPONSIBILITY

1. Medicaid considers orthodontist billings for "Pre-orthodontic treatment visits" under code D8660 and related procedures. Medicaid will not reimburse billings for "pre-orthodontic treatment visits" under code D8660 and related procedures billed by general dentists. Only dentists with a specialty of orthodontia will be allowed to bill D8660 for reimbursement. A copy of the Client History Form must be completed by the recipient's treating general or pediatric dentist and submitted with the billing. Medicaid may deny orthodontist's payment for their billings if the attached referral report does not show the recipient has a good history of keeping appointments and complying with dental care treatment. Orthodontists should

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2. advise recipients to establish good compliance and appointment-keeping histories before requesting initial or subsequent orthodontic treatment.
3. Coordination with Ancillary Dentists: The orthodontist and any ancillary dentists must coordinate with each other to assure Medicaid will pay for the ancillary dental services. For example, the orthodontist's proposed treatment plan should show he/she will be referring the child for extractions or other services. The ancillary dentist need not obtain separate approval for his/her services.

c. AUTHORIZATION REQUIREMENTS

1. Medicaid dental consultants use the assistance of board-certified and/or board eligible orthodontists and other dentists for authorization decisions. Consultants may require documentation to substantiate their decisions.
2. Requests for orthodontia must explain the significance of one or more of the following considerations of "medical need":
 - a. Functional factors relating to conditions that hinder effective functioning, including, but not limited to, impaired mastication and muscular dysfunction.
 - b. Factors related to the degree of deformity and malformation which produce a psychological need for the procedure. The psychological need must be based on objective evidence and reviewed by the dental consultant.
 - c. The recipient's overall medical need for the service in light of his/her total medical condition. For example, an orthodontia need which might be slight in an otherwise healthy child may become quite severe for a child suffering from complicating ailments such as cerebral palsy or epilepsy.
 - d. The medical appropriateness of an orthodontic treatment plan as opposed to other available dental treatment. Appropriate consideration may be given, for example, to a child's inability to understand and follow a treatment plan where failure to follow the plan would result in medical complications of the child's condition.
 - e. A score of 26 or higher on the Handicapping Labiolingual Deviation Index (HLD). (form found at: www.medicaid.nv.gov)

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3. When the orthodontist has assured the above requirements are met, use a separate form to bill the following initial services: examination, diagnosis, diagnostic cast, panoramic x-rays and diagnostic films. These can be provided by a dentist or orthodontist according to services limitations.
The following documents are required to be attached with the prior authorization request to the QIO-like vendor's Dental Consultant:
- a. HLD Index Report Form.
 - b. Client Treatment History Form.
 - c. Statement addressing the diagnosis/treatment plan and prognosis.
 - d. Any other documentation that may be required to substantiate prior authorization decision.

All forms are located on the QIO-like vendor's web portal at www.medicaid.nv.gov.

4. The Dental Consultant may require the orthodontist to shorten their treatment plan, periodically reviewing/determining the child's continuing need for active treatment and retention care.
5. All orthodontic treatment authorizations by Medicaid will be to specialists in orthodontia only. Medicaid approves interceptive orthodontia for general dentists and pediatric dentists only.
- a. Orthodontists must use one of the codes for "limited" or "comprehensive" orthodontic treatment for bills and payment PA requests. Coverage, Limitations, and Prior Authorization requirements document can be found on the QIO-like vendor's web portal at www.medicaid.nv.gov.
 - b. Use one of the "limited" codes whenever possible. The treating orthodontist should try to achieve tolerances below Medicaid's treatment-need criteria.
 - c. Failure to achieve sufficient results in the approved amount of time is sufficient for Medicaid to deny a treatment extension. Medicaid will definitely deny an extension if results are poor and the recipient has failed to keep appointments and comply with treatment.
 - d. PA submittals must show all procedures. List the following at a minimum; initial banding, months of treatment including retention treatments, and

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any retainers. Medicaid expects the provider to render unlisted but necessary treatment components at no additional charge. The provider's usual and customary charge must show for each service. Stating a total fee for all services is not acceptable.

6. For orthodontia approvals, a dental consultant will sign the returned request form and indicate the "Total amount" shown on the form. Medicaid's QIO-like vendor will keep a record of the approved payment amount and treatment plan. The fiscal agent will return denied orthodontia request forms to the provider.
7. When the provider begins the authorized work, he/she enters the service date and amount on the form, and returns it to the fiscal agent. The fiscal agent will make payment for the total specified on the approved treatment plan.
8. An orthodontist's acceptance of full payment is considered his/her agreement to prorate and forward payment to any orthodontist the recipient may select to complete the orthodontic treatment. The recipient may select a new orthodontist if the recipient becomes dissatisfied with the original orthodontist or must geographically move before finishing treatment. The orthodontist must refund any unused payment when the recipient fails to contact the orthodontist's office within a four month period. Also, the orthodontist must refund Medicaid if the recipient has not kept at least one appointment within a nine-month period.
9. Medicaid will adjust the sending provider's future payments if the Medicaid dental consultants determine the provider allotted an insufficient amount of money to the receiving provider or Medicaid.
10. Orthodontists may not assess the recipient for additional charges on broken bands and other necessary services, even if the recipient's poor compliance or carelessness caused the need for additional services. However, orthodontic providers may discontinue treatment due to poor recipient compliance, returning any unused prorated expenditures to Medicaid with a written explanation for the Medicaid fiscal agent's records.
11. Under no circumstances should the provider release Medicaid money to anyone other than another orthodontist provider who promises to use the money to complete the purchased treatment. Without such a promise, return the money to the QIO-like vendor at the address listed in the cross-reference of this chapter at Section 1005.1. Write refund checks payable to Nevada Medicaid.
12. Once the remaining portion of the payment is returned, no further payment can be made to complete care for recipients who have become ineligible. Most children who lose Medicaid coverage are seldom able to finance the completion of

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orthodontic care. Therefore, Medicaid understands and holds the refunding orthodontist responsible for removing any banding and providing retainers at no additional cost to the recipient. Orthodontists accept this responsibility as part of doing business with Medicaid.

1003.9 ADJUNCTIVE GENERAL SERVICES (D9000-D9999)

The branch of dentistry for unclassified treatment including palliative care and anesthesia.

Nevada Medicaid authorizes payment of adjunctive general services for qualified recipients under 21 years of age and for palliative care and anesthesia for persons 21 years of age and older.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age, and for palliative care for persons 21 years of age and older.

b. AUTHORIZATION REQUIREMENTS

No PA is necessary under EPSDT. Persons 21 years of age and older require PA unless the service is for emergency extractions, palliative care, partials or dentures.

1003.10 PERSONS 21 YEARS OF AGE AND OLDER

Nevada Medicaid authorizes payment for qualified persons 21 years of age and older for partials, dentures, emergency extractions, and palliative care only.

a. COVERAGE AND LIMITATIONS

Reference Nevada Medicaid Fee Schedule, Coverage and Limitations and Prior Authorization document for Provider Type 22, can be found on the QIO-like vendor's web portal at www.medicaid.nv.gov.

b. PROVIDER RESPONSIBILITY

1. Providers must keep all substantiating x-rays on file for a minimum of six years following the date of service. Providers must keep the x-rays, related charting, and other case documentation easily available to Medicaid reviewers during this period.
2. The Medicaid program considers emergency extractions a program benefit without prior or post approval. This includes the use of in-office sedation or anesthesia. The program never covers extractions for cosmetic purposes. Dentists

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need not routinely submit substantiating x-rays to the Medicaid fiscal agent. However, Medicaid will periodically request copies of x-rays substantiating third molar extractions (teeth 1, 16, 17 and 32 for adults and children) related to tissue impaction, partial and full bony and surgical vs. simple extractions. The dentists on-file x-rays must reveal sufficient bone and root complications for difficult surgical removal procedures.

3. For treatment necessary to avoid life-threatening health complications, providers perform services necessary to prevent life-threatening deterioration of a person's physical health without PA even though the services do not immediately qualify as Medicaid covered emergency services. The dentist must certify the services were medically necessary due to health complicating conditions such as HIV, AIDS, cancer, bone marrow transplantation, or post kidney transplant. The dentist's certification must be part of a note explaining why the treatment was necessary to avoid life-threatening problems. For example, the dentist may explain successful cancer treatment or organ transplantation depended on extractions or treatment of caries to protect the recipient's compromised immune system from the stress of oral infection.

c. AUTHORIZATION REQUIREMENTS

No authorization is needed if the service is for emergency extraction or palliative care.

1003.11 SERVICES NOT COVERED BY MEDICAID

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not cover the following services:

1. Cosmetic services, unless prior approved by the QIO-like vendor's Dental Consultant to return the recipient to work.
2. Routine and preventive dental care, such as periodic prophylaxis, restoration of incipient or minor decay, treatment of sensitivity to hot and cold or other minor pain is not covered for persons 21 years of age and older. (Prophylaxes and restorative dental services under pregnancy related services require PA and reviewed on an individual basis based on medical necessity.)
3. Crowns are not allowed for persons 21 years of age and older, except where required on an anchor or abutment tooth for a partial denture. Gold crowns are not a covered benefit for any age.
4. TMJ services are not covered by Nevada Medicaid.

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5. No show appointments or charges for missed appointments are not allowed.

1003.12 PHARMACY SERVICES

Nevada Medicaid authorizes payment of pharmacy services for qualified recipients.

a. COVERAGE AND LIMITATIONS

Fluoride supplements are covered only for recipients less than 21 years old.

b. PROVIDER RESPONSIBILITY

Supplements need no PA when ordered by a dentist. The dentist should write, “Result of Healthy Kids” or “Result of EPSDT” on the prescription. The recipient must present the prescription with a Nevada Medicaid card to a Medicaid participating pharmacy provider. Providers must verify eligibility prior to service.

c. AUTHORIZATION PROCESS

These guidelines do not change any Medicaid policy regarding non-covered medications or medications which always require PA.

1003.13 RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Nevada Medicaid authorizes payment for services provided in an ICF/IID to full Medicaid-eligible recipients.

All dental services provided to recipients in an ICF/IID are administered under the same policy coverage and limitations provided throughout this dental chapter.

a. COVERAGE AND LIMITATIONS

Under Federal regulations, the ICF/IID is required to include comprehensive dental services to their resident. Specifically, the ICF/IID’s are responsible for:

1. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within 12 months before admission.
2. Periodic examination and diagnosis done at least annually for each recipient.

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3. Comprehensive dental treatment including dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.
4. Necessary access to the services, excluding sealants, orthodontia, pharmacy services, fluoride treatments, and fluoride treatments with prophylaxis.
5. Emergency dental treatment on a 24-hour-a-day basis by a qualified dentist.
6. If appropriate, the dentist's/hygienist's participation in development, review, and updating of the individual program plan as part of the Interdisciplinary Team (IDT) process, either in person or through written reports to the IDT.

For dental services beyond the Medicaid coverage benefit the facility must provide or make arrangements for each client from qualified personnel, including licensed dentists and dental hygienists to establish a relationship with the ICF/IID.

b. PROVIDER RESPONSIBILITY

For dental services beyond the Medicaid coverage benefit the dentist must establish a relationship with the ICF/IID facility staff to assure verification of the recipient's ICF/IID residency, and payment source for dental services prior to service.

1003.14 PROVIDERS OUTSIDE NEVADA

Nevada Medicaid authorizes payment for out-of-state providers under Medicaid guidelines.

a. COVERAGE AND LIMITATIONS

Out-of-state providers are subject to the coverage and limitations of dental services under Nevada Medicaid.

b. PROVIDER RESPONSIBILITY

Out-of-state providers are subject to all Medicaid rules and guidelines.

c. AUTHORIZATION REQUIREMENTS

Out-of-state providers must use the same PA process as in-state dental providers.

1003.15 PAYMENT OF NON-COVERED SERVICES

A. COVERAGE AND LIMITATIONS

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Nevada Medicaid does not authorize payment for non-covered services.

B. PROVIDER RESPONSIBILITY

Dental providers must inform the recipient of his/her financial responsibility before rendering any uncovered service. Consider this done when the recipient or a responsible designee signs a written document acknowledging acceptance of financial responsibility for each specific itemized service. The signed document must state, "I understand Medicaid will not cover the above itemized service cost(s). I agree to pay for the services."

If Medicaid covers a procedure, the provider cannot charge the recipient for the balance after Medicaid's payment. Also, providers cannot charge Medicaid for one covered service and provide a different service. For example, since Medicaid does not cover restorations or prosthetics made of gold, Medicaid's payment on a covered restoration or prosthesis cannot be used to offset one made of gold. The recipient would need to pay the complete charge for the gold restoration or prosthesis, or the recipient must accept the Medicaid benefit service only.

C. RECIPIENT RESPONSIBILITY

Services exceeding program limitations are not considered Medicaid benefits. These services are the financial responsibility of the recipient.

D. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not authorize payment for non-covered services.

1003.16 SERVICES PROVIDED IN NURSING FACILITIES

Nevada Medicaid authorizes payment for services provided in nursing facilities to qualified recipients eligible with full Medicaid benefits.

a. COVERAGE AND LIMITATIONS

All dental services provided to recipients in a nursing facility are administered under the same policy coverage and limitations provided throughout this dental chapter.

b. PROVIDER RESPONSIBILITY

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Medicaid advises dentists to confirm the recipient's eligibility through the Eligibility Verification System (EVS) for the month the service will be provided and retain a copy prior to service. Medicaid advises dentists to develop procedures with nursing facility staff to screen for ineligible recipients. Medicaid recommends dentists become users of EVS by making arrangements with Medicaid's QIO-like vendor.

c. NURSING FACILITY RESPONSIBILITY

Nursing facility staff must screen for Medicaid eligibility.

d. AUTHORIZATION REQUIREMENTS

NOTE: If the recipient is covered under Managed Care and has been an in-patient over 45 days, the recipient is then covered by fee-for-service from the 46th day forward.

PA is required for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services.

1003.17 HOSPITAL/SURGICAL CENTERS

A. COVERAGE AND LIMITATIONS

Nevada Medicaid authorizes payment for certain dental services in hospital or surgical centers for qualified recipients with PA unless it is an emergency.

B. AUTHORIZATION REQUIREMENTS

1. Two authorizations for inpatient hospitalization for a dental procedure are necessary for Medicaid reimbursement.

a. The dental consultant must prior authorize the dental procedure.

b. The Medicaid's QIO-like vendor or the Managed Care Organization (MCO) must certify the necessity for the recipient to be hospitalized for the performance of the inpatient dental procedure. The certification must be done before or on the date of the admission.

The provider must write, "Hospital Admission" at the top of the Examination and Treatment Plan box of the claim form.

2. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must write, "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

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- a. Specific authorization is not required for the anesthesiologist and/or outpatient facility for recipients less than 21 years of age.
- b. All dentists providing surgical center services to Medicaid recipients must retain in-office copies of x-rays, intra-oral preoperative photographs (when necessary), and documentation necessary to substantiate service need. The substantiating evidence must be retained and remain readily available for no less than six years. Medicaid holds the provider responsible for assuring the evidence is sufficient for the Medicaid agency's post utilization review/control purposes.
- c. In situations where the dentist believes his treatment plan to have weak support from x-rays, intra-oral photographs, etc., the dentist should submit the evidence with a request for PA. Without PA, Medicaid will reclaim payment for the services if post service review findings do not support the dentist's treatment plan and medical necessity.
- d. All outpatient facility services for Medicaid recipients 21 years of age and older must be prior authorized.
- e. Medicaid does not reimburse providers for travel and hospital call related costs for services done in an outpatient surgical center.

1003.18 MAXILLOFACIAL SURGERY AND OTHER PHYSICIAN SERVICES

Nevada Medicaid authorizes payment for maxillofacial surgery and other physician services for qualified recipients.

Temporomandibular Joint (TMJ) related disease encompasses a variety of conditions. For recipients, age 20 years and younger, TMJ services may be provided by a dentist or medical doctor. Adult dental services continue to be restricted to palliative treatment, emergency extractions and dentures/partial with PA.

a. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT, for persons less than 21 years of age.

Coverage for the medical management of TMJ related disease for recipients, age 20 years and younger will be limited to appropriate current TMJ related diagnosis codes.

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The following CPT codes are covered for TMJ services for recipient's age 20 years and younger:

99241-99245 Office and Other Outpatient Consultations
21089 Prepare face/oral prosthesis
70328 X-ray exam of jaw joint
70330 X-ray exam of jaw joints
70336 Magnetic image, jaw joint
70355 Panoramic x-ray of jaws
76100 X-ray exam of body section

b. PROVIDER RESPONSIBILITY

Program utilization control requires that each type of provider (dentist, physician, pharmacist, etc.) be delineated with the use of a specific Provider Type number. For example, dentists are a Provider Type 22 while physicians are a Provider Type 20. All dental related services must be billed/requested with the most appropriate dental code found on the QIO-like vendor's web portal at www.medicaid.nv.gov. When the list of accepted dental codes provides only a "By Report" code, the provider must use the most appropriate "By Report" code. When an appropriate dental code is not available, a Current Procedural Terminology (CPT) code from range 10000 through 69999 and 99241 through 99245 may be used. A dentist, Provider Type 22, who is a dually boarded Maxillofacial Surgeon, may bill the following CPT codes in addition to those previously listed: 00190, 21085, 70250, 70300, 70328, 70330, 70350, 70355, 70380, and 99281 through 99285.

Fluoride varnish application which can be administered by Provider Types 17, 20, 24 and 77 should be billed on a CMS 1500 form using the most appropriate and available ICD diagnosis code.

c. AUTHORIZATION REQUIREMENTS

See B. Provider Responsibility.

1003.19 CONDITIONS FOR PARTICIPATION

All dental providers must have a current license to practice dentistry, dental surgery, or dental hygiene which has been issued by the Nevada State Board of Dental Examiners. Out of state dentists must meet the licensing requirements of the state in which they practice and be enrolled as a Nevada Medicaid provider.

Dental services may also be performed in a clinic setting as long as the care is furnished by or under the direction of a dentist. The clinic must have a dental administrator and all professional

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staff, dentists, hygienists, etc. must have a current Nevada license and/or certification from the appropriate state licensing board.

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MEDICAID SERVICES MANUAL	Subject: HEARINGS

1004 HEARINGS

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

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1005 REFERENCES AND CROSS REFERENCES/FORMS

Other sources which may impact the provision of Dental services include, but are not limited to the following:

- Chapter 100: Eligibility Coverage and Limitations
- Chapter 200: Hospital Services Program
- Chapter 300: Diagnostic Testing and Radiology Services
- Chapter 500: Nursing Facility
- Chapter 600: Physician Services
- Chapter 1200: Prescription Services (Rx)
- Chapter 1500: Healthy Kids (EPSDT)
- Chapter 1600: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- Chapter 2100: Home and Community-Based Services Waiver (MR)
- Chapter 3100: Fair Hearing Process

1005.1 CONTACTS

A. Nevada Medicaid Provider Support
Division of Health Care Financing and Policy
1100 East Williams Street
Carson City, NV 89701
(775) 684-3705
<https://dhcfp.nv.gov>

B. Hewlett Packard Enterprise Services
Customer Services Center
(For claim inquiries and general information)
(877) 638-3472
www.medicaid.nv.gov

Prior Authorization for Dental and Personal Care Aide
Attn: Dental PA
PO Box 30042
Reno, NV 89520-3042
(800) 525-2395 (Phone)
(855) 709-6848 (Fax)

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- D. Mail all paper claims (CMS 1500, UB-92, ADA, and Medicare Crossover) to the following address:

Quality Improvement Organization (QIO) – Claims
(Include claims type e.g. CMS 1500, UB-92)
P. O. Box 30042
Reno, NV 89520-3042

1005.2 FORMS

- A. The ADA 2012 version is required for all prior authorization requests, claims, adjustments and voids.

1005.3 DENTAL PERIODICITY SCHEDULE

The recommended periodicity schedule can be found at <https://www.aap.org>.

REFERENCES:

- AAPD Recommendations for Pediatric Oral Health Care
- UNLV School of Dentistry Patient Oral Disease Preventative Studies/Protocol
- Counseling to Prevent Dental and Periodontal Disease, Guide to clinical preventive services, 2nd edition, Baltimore MD, Williams &Wilkins; 1996, 711-722, National Guideline Clearinghouse
- CMAJ March 1995, Prevention of Dental Caries, National Guideline Clearinghouse
- Larry Pierce, DDS
- Small Smiles Dentistry of Reno
- Bruce Dow, DDS

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
 FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
 SUBJECT: MEDICAID SERVICES MANUAL CHANGES
 CHAPTER 1100 - OCULAR SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1100 are being proposed to clarify and eliminate duplicative language, and remove reference to the International Classification of Diseases and Related Health Problems (ICD)-9 codes.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED

MTL 24/15
CHAPTER 1100 - OCULAR SERVICES

MATERIAL SUPERSEDED

MTL 32/03, 24/08, 20/09, 33/11
CHAPTER 1100 - OCULAR SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1103.1A.1.b	Coverage and Limitations	Deleted "EPSDT) from title, HEALTHY KIDS.
1103.1A.2.b		Spelled out acronym EPSDT - "Early and Periodic Screening, Diagnosis and Treatment". Removed "(e.g., conjunctivitis, glaucoma examination)". Added language "within the scope of their license". Removed language "to receive services. Medical diagnosis ICD-9 codes must substantiate the service".
1103.1A.2.d		Removed language "Ocular examinations for the following medical conditions are covered based

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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upon medical necessity and do not require prior authorization and are not limited to the 12 month restriction for examination and lenses”.

Added “Following cataract surgery, if the recipient is Medicare eligible and requires eyeglasses, the provider must bill Medicare first and attach the Medicare Explanation of Benefits (EOB) to the claim for co-insurance and deductible”.

Deleted language "1. Glaucoma 2. Diabetes. 3. Healthy Kids/EPSTD referral services. 4. Or, following cataract surgery. If the recipient is Medicare eligible, and requires eyeglasses, the provider must bill Medicare first and attach the Medicare EOB to the claim for co-insurance and deductible".

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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OCULAR SERVICES

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1100
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

1100 INTRODUCTION

The Nevada Medicaid Ocular program reimburses for medically necessary ocular services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Support Services at Nevada Medicaid.

Ocular services are an optional benefit within the Nevada Medicaid Program.

All Medicaid policies and requirements, (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of areas where Medicaid and NCU policies differ. For further clarification, please refer to the NCU Manual, Chapter 1000.

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MEDICAID SERVICES MANUAL	Subject: AUTHORITY

1101 AUTHORITY

The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulation, (CFR) Part 440.200, and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Social Security Act. CFR 440.225 and 441.30. New State Plan, Section 3.1 page 19, 216 and 27

The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- Physicians: NRS Chapter 630.375
- Optometry: NRS Chapter 636
- Dispensing Opticians: NRS Chapter 637

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1102 RESERVED

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1103
MEDICAID SERVICES MANUAL	Subject: POLICY

1103 POLICY

1103.1 OCULAR SERVICES

1103.1A COVERAGE AND LIMITATIONS

Medicaid will reimburse for routine comprehensive ophthalmological examinations and/or refractive examinations of the eyes and glasses with a prescription for and provision of corrective eyeglasses to eligible Medicaid recipients of all ages once every twelve months. Any exceptions require prior authorizations.

1. HEALTHY KIDS (EPSDT)

- a. Nevada Medicaid provides for vision screenings as referred by any appropriate health, developmental, or educational professional after a Healthy Kids Screening Exam. Optometrists and ophthalmologists may perform such exams without prior authorization upon request or identification of medical need. "Medical Need" may be identified as any ophthalmological examination performed to diagnose, treat, or follow any ophthalmological condition that has been identified during the Healthy Kids examination.
- b. Glasses may be provided at any interval without prior authorization for **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** recipients, as long as there is a change in refractive status from the most recent exam, or for broken or lost glasses. Physician records must reflect this change and the records must be available for review for the time mandated by the federal government. Recipients enrolled in a Managed Care plan are mandated to access Healthy Kids EPSDT ocular services through their Managed Care provider.

2. EXAMINATIONS

- a. Refractive examinations performed by an optometrist or ophthalmologist are covered for Medicaid recipients of all ages once every twelve months. Any exceptions require prior authorization.
- b. Ocular examinations performed by an optometrist for medical conditions **within the scope of their license** do not require a prior authorization.
- c. Ocular examinations performed by an ophthalmologist for medical conditions do not require prior authorization and are considered a regular physician visit. Current limitations are based on medical necessity.

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- d. Following cataract surgery, if the recipient is Medicare eligible and requires eyeglasses, the provider must bill Medicare first and attach the Medicare Explanation of Benefits (EOB) to the claim for co-insurance and deductible.

3. LENSES

Lenses are covered for recipients of all ages. No prior authorization is needed for recipients under 21. For recipients over 21, a prior authorization is required if the 12 month limitation is exceeded.

a. COVERED

The following are covered for Nevada Medicaid recipients of all ages as noted:

1. A change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within the 12 month limitation;
2. Lens material may be tempered glass tillyer grade or equivalent, or standard plastic, at recipient's option;
3. Ultra lightweight plastics, e.g., Lite Style and polycarbonate-style, are covered when they are medically necessary to avoid very heavy glasses which would hurt the bridge of the nose. The acceptable means for avoiding severe imbalance of the weight of the glasses are up to ± 7 diopters in children;
4. Polycarbonate lenses are covered under EPSDT when medically necessary.
5. Safety lenses when the recipient has vision in only one eye;
6. A single plano or balance lens is handled as if it were a corrective lens, and so called "half glasses" are handled as if they were standard size corrective lenses;
7. Slab-off lenses, Prisms, Aspheric, Lenticular lenses;
8. "Executive" bifocals may be covered for children with: esotropia, and esophoria, accommodation, oculomotor dysfunction such as tracking and saccadic problems. Prior authorization is not required when using one of the above medical diagnoses;

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9. Filters: PLS 40 filters when prescribed for patients with the following diagnoses: macular degeneration, retinitis pigmentosa, rod/cone dystrophy, or achromastopia. In all these cases, the best uncorrected vision must test better than 20/200;
10. UV filters when prescribed following cataract surgery;
11. Bifocals and trifocals are reimbursable for a combination of any of the conditions at near or far point, including but not limited to: estropia, esophoria, cataracts, glaucoma, accommodative dysfunctions, nystogmus, stigmatism, myopia, presbyopia;
12. Double segment lenses required for employment which must be prior authorized;
13. Therapeutic contact lenses when prescribed for treatment of a medical condition;
14. Tints are covered when medically necessary;
15. Low vision aides such as telescopic lenses, magnifying glasses, bioptic systems and special inserts in regular lenses which must be prior authorized;
16. Scratch-proof coatings for plastic lenses are covered for EPSDT recipients.

b. NON-COVERED

The following are not covered:

1. Sunglasses and cosmetic lenses.
2. Contact lenses are disallowed UNLESS their use is:
 - a. The only means to bring vision to the minimum criteria required to avoid legal blindness; or
 - b. Medically indicated following cataract surgery; or
 - c. The necessary means for avoiding very heavy glasses which would hurt the bridge of the nose (e.g., where the correction is 9+ diopters in each eye). The necessary means for avoiding severe imbalance of the weight of glasses is where one eye is corrected to 9+ diopters and the other eye is 3+; or

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- d. Required when the recipient has a diagnosis of Keratoconus.
 - 3. Replacement of lenses, unless the patient has a significant change in refractive status.
 - 4. Blended and progressive multi-focal lenses, “transitional lenses”.
 - 5. Faceted lenses.
 - 6. “Additional” Cost of an Extended Repair, Replacement warranty (ERR).
4. **FRAMES**
- a. **COVERED**
 - 1. Existing frames must be used whenever possible. If new frames are necessary, they may be metal or plastic, at the patient's option, up to Medicaid’s allowable cost.
 - 2. Providers must stock a variety of frames to enable the recipient to choose a frame at no cost to them, if they so choose.
 - b. **NON-COVERED**

The following are not covered:

 - 1. Frames with ornamentation.
 - 2. Eyeglass frames which attach to or act as a holder for hearing aid(s).
5. **OCULAR PROSTHESIS**
- Ocular prostheses are a covered Medicaid benefit and must be prior authorized.
6. **VISION THERAPY**
- Vision therapy is a covered Medicaid benefit and must be prior authorized by the QIO-like vendor.

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1103.1B PROVIDER RESPONSIBILITY

1. Providers must confirm the recipient's eligibility by reviewing the current Medicaid card before providing services, or access eligibility via the Electronic Verification of Eligibility (EVE) system.
2. It is the provider's responsibility to ask the recipient if there is additional visual coverage through third party payers.

1103.1C RECIPIENT RESPONSIBILITY

Services requested by the recipient but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid, such as eyeglass extras. Prior to service, the recipient must be informed in writing and agree in writing he/she will be responsible for payment.

1. The recipient is responsible for presenting a valid Medicaid card to the examiner and/or optician.
2. The recipient is responsible for presenting any form or identification necessary to utilize other health insurance coverage.
3. If the recipient selects a frame with a wholesale cost greater than the Medicaid allowable, they will be responsible for the additional amount. The recipient's agreement to make payment must be in writing. A copy of the agreement must be retained in the recipient's chart. The Nevada Medicaid Surveillance and Utilization Review Unit (SURS) conducts a regular review of claims history to monitor this.
4. If the recipient selects a lens options not covered by Medicaid, he/she is then responsible for payment only of the non-covered options. Medicaid pays the lens cost minus the cost of options. Non-covered options must be listed separately on the invoice. Claims will be returned to providers for correction.
5. If the recipient chooses an Extended Repair Replacement warranty (ERR) which is not covered by Medicaid's payment, he/she is responsible for warranty payment.
6. The recipient is responsible for making and keeping appointments with the doctor.
7. The recipient is responsible for contacting the provider of the eyeglasses (if different from the examiner) for fitting and delivery.

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8. The recipient is responsible for picking up the eyeglasses and returning for any necessary adjustments within the time allotted for such adjustments. (Medicaid will not pay for office visits for adjustments. The provider is expected to make reasonable adjustments and repair, without charge).

9. UNCLAIMED EYEGLASSES

The recipient has 15 days to claim eyeglasses reimbursed by Nevada Medicaid. If after 15 days the item is still held by the provider:

- a. The provider shall notify the appropriate district office.
- b. The caseworker attempts to contact the recipient and make arrangements to claim the eyeglasses.

If the caseworker is unable to contact the recipient or the recipient refuses to claim the eyeglasses, the worker advises the Nevada Medicaid Office (NMO) and notifies the provider the item will not be picked up NMO then notifies Utilization Control for a possible restriction of the recipient's medical services.

- c. Following notification the item will remain unclaimed; provider may submit a bill in the normal fashion to the Nevada Medicaid fiscal agent.

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MEDICAID SERVICES MANUAL	Subject: HEARINGS

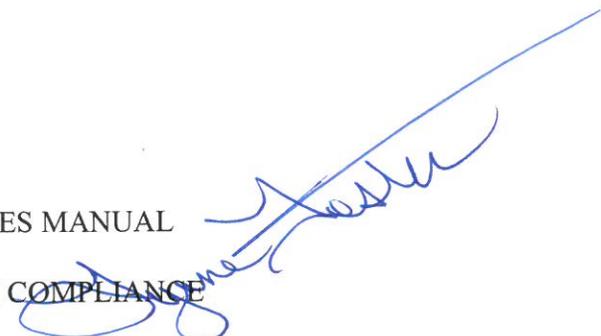
1104 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM) Chapter 3100, for Medicaid Recipient Hearings process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS



BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 1200, Prescribed Drugs, Section 1203 will revise the Preferred Drug List Exception Criteria. The Continuity of Care clause will be revised to include all psychotropic medications not just antidepressants.

Revisions to Appendix A of MSM Chapter 1200, Prescribed Drugs, were made to reflect approved actions by the Drug Use Review (DUR) Board at the September 3, 2015 and the November 5, 2015 meetings.

The DUR Board is a requirement of the Social Security Act to identify and reduce fraud, abuse, overuse, and medically unnecessary care. The DUR Board also works to minimize drug interactions, drug-induced illness, and undesirable drug reactions in recipients.

Revised and new prior authorization criteria were approved by the DUR Board on September 3, 2015. Prior authorization criteria were revised for Psychotropic Medications for Children and Adolescents; Kalydeco® (ivacaftor); Anti-fungal Onychomycosis agents; and Sedative Hypnotics. New prior authorization criteria were approved for Corlanor® (ivabradine).

Revised and new prior authorization criteria were approved by the DUR Board on November 5, 2015. Prior authorization criteria were revised for Immunomodulator Drugs, adding Arcalyst® (rilonacept), Cosentyx® (secukinumab) and Ilaris® (canakinumab) to the current criteria. New prior authorization criteria were approved for Orkambi® (lumacaftor/ivacaftor); Invega Trinza® (paliperidone palmitate); Praluent® (alirocumab); Entresto® (sacubitril/valsartan); Technivie® (ombitasvir/paritaprevir/ritonavir); and Daklinza® (daclatasvir).

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

These changes are effective May 16, 2016.

MATERIAL TRANSMITTED

MTL 09/16
CHAPTER 1200 – PRESCRIBED DRUGS

MATERIAL SUPERSEDED

MTL 26/15
CHAPTER 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1A.2.a.7	COVERAGE AND LIMITATIONS	The Continuity of Care clause is being revised to include all psychotropic medications (not just antidepressants).
Appendix A Section H	ANTI-FUNGAL ONCYCHOMYCOSIS (LAMISIL®, SPORANOX®, PENLAC®)	Deleted “Oncychoycosis (Lamisil®, Sporanox®, Penlac®) from the Section Title. Revised the Last Reviewed date to September 3, 2015. Added the standard notification regarding agents are subject to prior authorizations and/or quantity limitations based on Section 1927 of the Social Security Act. Deleted redundant language regarding subject to prior authorization. Changed Section H – Anti-Fungal to section I.
Appendix A Section I.1.a		Added language regarding approval requires US FDA approval.
Appendix A Section I.1.c1-5		Moved listed criteria: pain which limits activity, disease is iatrogenically-induced, associated with immuosuppression, diabetes or significant peripheral vascular compromise to Section I.1.b.1-5.
Appendix A Section I.1.c.		Added language that requires the length of therapy to be appropriate based on the agent and location of infection.
Appendix A Section I.1.c		Deleted language regarding positive KOH stain.
Appendix A Section I.1.d.1-2		Listed the drug and agent specific criteria. Removed Lamisil and Penlac. Added Terbinafine: no pre-existing liver disease; Itraconazole: no heart failure and no ventricular

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		dysfunction.
		Added oral granules and Onmel: documentation why terbinafine or itraconazole can't be used. Deleted Length of Authorization.
Appendix A Section I.1.		Added Section I.1.e. Topical dosage forms: documentation why ciclopirox 8% solution, terbinafine, or itraconazole can't be used.
Appendix A Section I.1		Added Section I.1.f.
Appendix A Section I.2		Added language regarding Onmel tablets.
Appendix A Section I.2		Added language regarding Prior Authorizations will be based on the appropriate use.
Appendix A Section L	IMMUNOMODULATOR DRUGS	Revised the Last Reviewed date to November 5, 2015.
		Added Arcalyst®, Cosentyx® and Ilaris® to the list of drugs.
Appendix A Section L.1.a		Added a list of the requirements for all recipients.
		Added language regarding no approvals to be given for the use of more than one biologic at a time.
		Added language that each request must meet diagnosis-specific criteria.
Appendix A Section L.1.a	Rheumatoid Arthritis (RA)	Renumbered Rheumatoid Arthritis as Section L.1.b.
		Added the age requirement, 18 years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.b	Psoriatic Arthritis	Renumbered Psoriatic Arthritis as Section L.1.c.
		Added the age requirement, 18 years of age or older.
		Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.c	Ankylosing Spondylitis	Renumbered Ankylosing Spondylitis as Section L.1.d.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
<p>Appendix A Section L.1.d.</p>	<p>Juvenile Rheumatoid Arthritis/Idiopathic Arthritis</p>	<p>Added the age requirement, 18 years of age or older.</p>
		<p>Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.</p>
		<p>Renumbered Juvenile Rheumatoid Arthritis/Idiopathic Arthritis as Section L.1.e.</p>
		<p>Added language that the age of the recipient and the drug used is appropriate.</p>
		<p>Added age requirement for abatacept as six years of age or older.</p>
<p>Appendix A Section L.1.e</p>	<p>Plaque Psoriasis</p>	<p>Added age requirement for adalimumab, canakinumab, etancercept, and tocilizumab as two years of age or older.</p>
		<p>Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.</p>
		<p>Renumbered Plaque Psoriasis as Section L.1.f.</p>
		<p>Added the age requirement, 18 years of age or older.</p>
		<p>Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.</p>
<p>Appendix A Section L.1.f</p>	<p>Crohn's Disease</p>	<p>Renumbered Crohn's Disease as Section L.1.g.</p>
		<p>Added language that the age of the recipient and the drug used is appropriate.</p>
		<p>Added age requirement for adalimumab, ainfliximab as six years of age or older.</p>
		<p>Added language that for all others (drugs) the age requirement is 18 years of age or older.</p>
		<p>Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.</p>
<p>Appendix A Section L.1.g</p>	<p>Ulcerative Colitis</p>	<p>Renumbered Ulcerative Colitis as Section L.1.h.</p> <p>Added language that the age of the recipient and the</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		<p>drug used is appropriate.</p> <p>Added language adding an age requirement for infliximab as six years of age or older and all others 18 years of age or older.</p> <p>Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.</p>
Appendix A Section L.1.i	Cryopyrin-Associated Periodic Syndromes (CAPS)	<p>Added new criteria for Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflammatory Syndromes (FCAS) and Muckle-Wells Syndrome (MWS).</p>
Appendix A Section L.1.j	Neonatal-Onset Multisystem Inflammatory Disease	<p>Added new diagnosis requirement for Cryopyrin-Associated Periodic Syndromes (CAPS); Neonatal-Onset Multisystem Inflammatory Disease (NOMID).</p> <p>Deleted language regarding one biologic at a time as it is now in Section 1.a.</p>
Appendix A Section N	Psychotropic Medications for Children and Adolescents	<p>Revised the Last Reviewed date to September 3, 2015.</p> <p>Added the standard notification regarding agents are subject to prior authorizations and/or quantity limitations based on Section 1927 of the Social Security Act.</p>
Appendix A Section N.1		<p>Replaced language on the drugs that are subject to prior authorization and criteria must be met and documented.</p>
Appendix A Section N.1		<p>Revised the first paragraph, adding therapeutic classes, medication combinations and poly-pharmacy.</p> <p>Changed the psychotropic class Lithium Preparations to Mood Stabilizers.</p> <p>Added a new section for children less than 18 years of age.</p> <p>Added clarifying language for physician monitoring to include and/or prescriber. Added “any psychotropic” medications.</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section N.1.c		Regarding language for initial treatment, added “have not received any doses previously.”
		Regarding continuing therapy though unstable added “has had a dose change in the last three months.”
		Added and/or prescriber throughout this paragraph.
Appendix A Section N.1.c.1- 6		Revised definition for poly-pharmacy.
		Deleted language regarding three or more psychotropic medication is to be avoided.
		Added that each psychotropic medication must independently treat a specific diagnosis.
		Deleted paragraph regarding multiple-drug therapy.
Appendix A Section N.1.d		Added language regarding requirements for recipients under six years of age such as a medically accepted indication as established by the FDA or peer-reviewed literature.
Appendix A Section N.1.e.1- 2		Revised Continuity of Care to allow mental health inpatient recipients under 18 years of age, who have been discharged, six months to establish outpatient mental health services before requiring a prior authorization for applicable medications.
		A six month allowance will also be granted for recipients under 18 years of age stable on psychotropic medications before Medicaid coverage.
Appendix A Section N.2	Psychotropic Medications for Children and Adolescents	Revised exceptions to criteria to include anticonvulsants, ADD/ADHD and Abilify.
		Added clarifying language regarding a certain diagnosis codes on the prescription will bypass the prior authorization requirement in the POS system.
		Deleted Abilify bypass prior authorization requirement.
Appendix A Section N.3		Deleted previous Prior Authorization criteria.
		Added Prior Authorization Guidelines.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section V	Anti-Insomnia Agents (Sedative Hypnotics)	<p>Revised the Therapeutic Class and Last Reviewed Date to September 3, 2015.</p> <p>Added language that Section N also has sedative/hypnotic criteria when prescribed for a psychotropic indication.</p> <p>Added Coverage and Limitations, to include criteria must be met and documented, and FDA approved diagnosis.</p> <p>For the drug Hetlioz® (tasimelteon) it requires a diagnosis of non-24 hour sleep-wake disorder.</p> <p>All other agents require a diagnosis of insomnia.</p> <p>Added Prior Authorization Guidelines.</p>
Appendix A Section LL	Kalydeco® (ivacaftor)	Revised the Last Reviewed date to September 3, 2015.
Appendix A Section LL.1.c		<p>Changed recipient age from six to two years of age or older.</p> <p>Added additional gene mutations to the list of covered gene mutations.</p>
Appendix A Section DDD	Corlanor® (ivabradine)	<p>Added new drug, new criteria.</p> <p>Added Therapeutic Class, Date Reviewed by the DUR Board as September 3, 2015.</p> <p>Added standard disclaimer that Corlanor® is subject to prior authorization and quantity limitations.</p> <p>Added Coverage and Limitations which must be met and documented.</p> <p>New Criteria includes, a diagnosis of chronic heart failure, left ventricular ejection fraction \leq 35%, resting heart rate \geq 70 bpm, the recipient is 18 years of age or older, the prescriber is a cardiologist, the recipient has a normal sinus rhythm, and the recipient is on a tolerated dose of a beta-blocker or has a contraindication to a beta-blocker.</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		<p>Added Prior Authorization Guidelines including language that approvals will be based on appropriate use of agents.</p>
<p>Appendix A Section EEE</p>	<p>Praluent® (alirocumab)</p>	<p>Added new drug, new criteria.</p> <p>Added Therapeutic Class, Date Reviewed by the DUR Board as September 3, 2015.</p> <p>Added standard disclaimer that Praluent® is subject to prior authorization and quantity limitations.</p> <p>Added Coverage and Limitations which must be met and documented.</p> <p>Initial request criteria includes a list of required qualifying cardiac diagnoses, prescribed by a cardiologist, recipient must be on a low-fat diet.</p> <p>Recipient must meet one of the following conditions, an inadequate response to a high intensity or moderate intensity statin, has received add-on therapy with exetimibe, has had the LDL-C after therapy, and statin therapy will be continued with PCSK-9 therapy.</p> <p>Added recertification criteria, the recipient is adherent to PCSK-9 inhibitor therapy, adherent to statin therapy, has a contraindication to statin therapy, continuing on a low-fat diet, and has achieved a reduction in the LDL-C level.</p> <p>Added Prior Authorization Guidelines, initial request will be for six months and recertification will be for one year.</p>
<p>Appendix A Section FFF</p>	<p>Invega Trinza® (paliperidone palmitate)</p>	<p>Added new drug, new criteria.</p> <p>Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015.</p> <p>Added standard disclaimer that Invega Trinza® is subject to prior authorization and quantity limitations.</p> <p>Added Coverage and Limitation which must be met and documents.</p>

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**Appendix A
Section GGG**

**Technivie®
(ombitasvir/paritaprevir/
ritonavir)**

Added the recipient must have a diagnosis of schizophrenia, stabilized on a once-monthly paliperidone palmitate injection for at least four months, be 18 years of age or older, and the requested dose is for one injection every three months.

Added Prior Authorization Guidelines. Approvals will be for one year.

Added new drug, new criteria.

Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015.

Added standard disclaimer that Technivie® (ombitasvir/paritaprevir/ritonavir) is subject to prior authorization and quantity limitations.

Added Coverage and Limitations which must be met and documented.

Added the recipient must have a diagnosis of chronic Hepatitis C, Genotype F4, is eight years of age or older, does not have cirrhosis, does not have moderate or severe hepatic impairment, the requested dose is two Technivie® tablets daily, the duration of treatment must not exceed 12 weeks, treatment naïve and treatment experienced recipients must also use ribavirin in combination unless they cannot take or tolerate ribavirin.

Added Prior Authorization Guidelines. Approvals will be for 12 weeks.

**Appendix A
Section HHH**

**Orkambi®
(lumacaftor/ivacaftor)**

Added new drug, new criteria.

Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015.

Added standard disclaimer that Orkambi® (lumacaftor/ivacaftor) is subject to prior authorization and quantity limitations.

Added Coverage and Limitations which must be met

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and documented.

Added the recipient has a diagnosis of cystic fibrosis, is 12 years of age or older, is homozygous for the F508del mutation in the CFTR gene, the requested dose is two tablets every 12 hours, or one tablet every 12 hours with severe hepatic impairment.

Added Prior Authorization Guidelines. Approvals will be for one year.

**Appendix A
Section III**

**Daklinza®
(daclatasvir)**

Added new drug, new criteria.

Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015.

Added standard disclaimer that Dalinza® (daclatasvir) is subject to prior authorization and quantity limitations.

Added Coverage and Limitations which must be met and documented.

Added the recipient has a diagnosis of Hepatitis C, genotype 3, is 18 years of age or older, has not had a liver transplant, the requested agent will be used in combination with Sovaldi®, the recipient is not on a CYP3A inducer, the recipient does not have cirrhosis, the requested dose of Daklinza® is 60 mg daily, or 30 mg daily with a concomitant strong CYP3A inhibitor, or 90 mg daily with a concomitant moderate CYP3A, usage is based on peer-reviewed literature, the requested duration of treatment is 12 weeks.

Added Prior Authorization Guidelines. Approvals will be for 12 weeks.

**Appendix A
Section JJJ**

**Enteresto®
(sacubitril/valsartan)**

Added new drug, new criteria.

Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015.

Added standard disclaimer that Enteresto® (sacubitril/valsartan) is subject to prior authorization and quantity limitations.

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Added Coverage and Limitations which must be met and documented.

Added the recipient has a diagnosis of chronic heart failure, has a reduced left ventricular ejection fraction, is 18 years of age or older, the prescriber is a cardiologist, the recipient has had a trial of ACE or ARB, the recipient will not concurrently receive and ACE inhibitor, is on an individualized dose of a beta-blocker, Entresto® will be given twice daily with a maximum dose of 97/103 mg.

Added Prior Authorization Guidelines. Approvals will be for one year.

**Appendix A
Section 4**

**BLOOD GLUCOSE
TESTING**

Paragraph two: Deleted language requiring a diagnosis and that diagnosis to be kept on the premises for 37 months.

Paragraph five: Added language regarding a diagnosis on the prescription is only required for newly diagnosed or transitioning recipients.

Paragraph six: Deleted as this will be move to the billing manual.

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MEDICAID SERVICES MANUAL
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1200 INTRODUCTION

The Nevada Medicaid Pharmacy Services program pays for medically necessary prescription services for eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions hereinafter specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Services.

This Chapter describes covered services, service limitations, and general reimbursement methodology.

This manual obsoletes all previous policy and procedure manuals, bulletins and policy news.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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1201 AUTHORITY

- A. The Code of Federal Regulations (CFR), Title 42, Public Health, Chapter IV Center for Medicare and Medicaid Services (CMS), Subchapter C Medical Assistance Programs, Parts 430 through 456, states prescription drug coverage is an optional service under Title XIX.
- B. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates additional preventive health care services for infants, children and young adults (newborn through age 20) eligible for Medicaid. These mandates provide that children and adolescents under age 21 receive follow-up services for a medically necessary condition discovered in a screening examination Early Preventative Screening and Diagnostic Testing (EPSDT) see Medicaid Services Manual (MSM) Chapter 1500; this includes prescription services.
- C. CFR Title 42 and Section 1927 of the Social Security Act, require states to provide for a Drug Utilization Review (DUR) program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results (Social Security Administration (SSA), Title 19, (g)(1)(A)).
- D. Section 1927 of the Social Security Act allows a state to require a prior authorization on any covered outpatient drug, providing the prior authorization program complies with the requirements outlined in the act.

The Social Security Act requires the establishment of a DUR board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of program beneficiaries.
- E. Chapter 422 of Nevada Revised Statute (NRS) amended by AB 384 to require the Department of Health and Human Services (DHHS) to:
 - 1. develop a list of preferred prescription drugs;
 - 2. manage prescription drug use through the use of prior authorization and step therapy; and
 - 3. create the Pharmacy and Therapeutics Committee.
- F. U.S. Troop Readiness, Veteran’s Health Care, Katrina Recovery and Iraq Accountability Appropriations Act 2007, Section 7002(b) of the act requires Medicaid outpatient drugs (defined in Section 1927(k)(2) of the Social Security Act) will be reimbursable only if non-electronic written prescriptions are executed on a tamper-resistant prescription pad.

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- G. The Deficit Reduction Act of 2005 requires Fee-for-Service (FFS) State Medicaid programs to capture and report National Drug Codes (NDC) for outpatient drugs in order for the state to receive federal financial participation.

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1202 RESERVED

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1203 POLICY

Nevada Medicaid reimburses pharmacies for prescriptions dispensed to each Medicaid recipient, with a maximum of a 34 day supply. Maintenance medications have a maximum of 100 day supply.

1203.1 PHARMACEUTICALS

All legend and non-legend pharmaceuticals must be prescribed by a licensed physician, podiatrist, osteopath, dentist, Advanced Practitioner of Nursing (APN), or physician's assistant within the scope of their practice.

1203.1A COVERAGE AND LIMITATIONS

1. Covered

The Nevada Medicaid Drug program will pay for the following prescribed pharmaceuticals with a written prescription, dispensed per the manufacturer's guidelines, and may be subject to restrictions (such as prior authorization, quantity limitations etc):

- a. Medicaid is mandated by Federal statute to require all written (non-electronic) prescriptions for all outpatient drugs for Medicaid recipients to be on tamper-resistant prescription pads. This requirement does not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. Refer to Medicaid Services Manual (MSM) Addendum for more information on tamper-resistant prescription pads.
- b. Legend and non-legend pharmaceuticals manufactured by companies participating in the federal Medicaid Drug Rebate Program, not on the excluded list (see below).
- c. Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Pharmacy and Therapeutics (P&T) Committee. Reference Medicaid Operations Manual (MOM) Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug classes reviewed by the P&T Committee require prior authorization, unless exempt under Nevada Revised Statute (NRS) or federal law, or excluded through recommendations of the P&T Committee or excluded by the Division of Health Care Financing and Policy (DHCFP).
 1. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan are available under prior authorization

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guidelines until the P&T Committee reviews the product or evidence.

2. Existing pharmaceutical products for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan, are available under prior authorization guidelines until the P&T Committee can review the new evidence.
3. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.
4. If the P&T Committee determines that there are no significant differences between drugs within specific classes based on clinical efficacy and safety, the DHCFP or its Quality Improvement Organization (QIO)-like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.
5. The Drug Utilization Review (DUR) Board shall not be required to develop, review or approve prior authorization policies necessary for the operations of the PDL.
6. Due to the 76th Special Session and in accordance with Senate Bill (SB) 4, every therapeutic prescription drug that is classified as an anticonvulsant medication or antidiabetic medication that was covered by the Medicaid program on June 30, 2010 must be included on the PDL as a preferred drug. If a therapeutic prescription drug that is included on the list of preferred prescription drugs is prescribed for a clinical indication other than the indication for which it was approved as of June 30, 2010, the Committee shall review the new clinical indication for that drug in accordance with Section 1203 of this chapter.
7. Due to the 76th Special Session and in accordance with SB 4, the P&T Committee must prefer atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness, anticonvulsant medications and antidiabetic medications for a patient who is receiving services pursuant to Medicaid if the patient:
 - a. was prescribed the prescription drug on or before June 30, 2010, and takes the prescription drug continuously, as prescribed, on and after that date; and
 - b. maintains continuous eligibility for Medicaid.
- d. Pharmaceuticals prescribed for a medically accepted indication.

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e. Family planning items such as diaphragms, condoms, foams and jellies.

Reference Appendix A for coverage and limitations of medications with special criteria.

2. Standard Preferred Drug List Exception Criteria

Drugs that have a “non-preferred” status are a covered benefit for recipients if they meet the coverage criteria.

a. Coverage and Limitations

1. Allergy to all preferred medications within the same class;
2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;
3. History of unacceptable/toxic side effects to all preferred medications within the same class;
4. Therapeutic failure of two preferred medications within the same class.
5. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication;
6. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a Food and Drug Administration (FDA)-approved indication;
7. **Psychotropic** Medication – Continuity of Care.

Recipients discharged from an institution on non-preferred psychotropic medication(s), their drugs will continue to be covered by Medicaid for up to six months to allow the recipient time to establish outpatient mental health services.

8. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications the recipient demonstrated therapeutic failure on one preferred agent.

b. Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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3. Excluded

The Nevada Medicaid Drug Rebate program will not reimburse for the following pharmaceuticals:

- a. Agents used for weight loss.
- b. Agents used to promote fertility.
- c. Agents used for cosmetic purposes or hair growth.
- d. Yohimbine.
- e. Drug Efficacy Study and Implementation (DESI) list “Less than Effective Drugs”: In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is Identical, Related or Similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

This includes pharmaceuticals designated “ineffective” or “less than effective” (including identical, related or similar drugs) by the FDA as to substance or diagnosis for which prescribed.

- f. Pharmaceuticals considered “experimental” as to substance or diagnosis for which prescribed. Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated “1-A” by the FDA.
- g. Agents used for impotence/erectile dysfunction.

4. Refills

A refill is a prescription subject to the limitations below:

- a. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) Chapter 639.

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- b. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. If a prescription is for a 34-day supply, a consistent refill would be filled in 30 days; an inconsistent refill date would be filled in 20 days from the original fill.
- c. Lost Medications. Nevada Medicaid does not pay for replacement of lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the medication. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications only. See Quantity of Medication in this chapter for more information on maintenance medications.

5. Early Refills

Nevada Medicaid only pays for up to a 34 day supply of medications (100 day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the non-controlled substance prescription, and 90% of the controlled substance prescription, is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill. This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

6. Quantity of medication

The maximum quantity of medication per prescription payable by the Medicaid program is a 34 day supply. Exceptions are allowed for maintenance medications.

- a. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)
- b. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

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- c. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day supply.

The following drug categories are considered maintenance medications:

1. Antianginals;
2. Antiarrhythmics;
3. Anticonvulsants;
4. Antidiabetics;
5. Antihypertensives;
6. Cardiac Glycosides;
7. Diuretics;
8. Thyroid preparations;
9. Estrogens;
10. Progesterone; and
11. Oral/Topical Contraceptives.

7. Emergency supply of medication

- a. In an emergency situation, after QIO-like vendor working hours and weekends, dispensing of up to a 96 hour supply those covered outpatient drugs that require prior authorization will be allowed.
- b. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization.
- c. The physician must indicate the diagnosis on the prescription (preferably with an International Classification of Disease (ICD) code) to support the use of the emergency policy.
- d. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor, to obtain a verbal verification number.

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8. Nevada Check Up (NCU)

All coverage and limitation policies and rules, including any prior authorization requirements, outlined in this chapter apply to NCU recipients as well as Nevada Medicaid Fee-for-Service (FFS) recipients. There are NO exceptions.

9. Immunizations

Nevada Medicaid recognizes the importance of preventative health care through vaccines and immunizations. Unless otherwise stated in this chapter, immunizations are covered without prior authorization. Reference Appendix A of this chapter.

- a. Childhood Immunizations: All childhood immunizations are covered without prior authorization under the Healthy Kids Program. Refer to MSM Chapter 1500, Healthy Kids Program, for more information on childhood immunizations.
- b. Adult Immunizations: Adult immunizations such as tetanus, flu vaccine, and pneumococcal vaccine are covered without prior authorization. For a list of covered adult immunizations, please reference the Physician's Fee Schedule under "Professional Rates" at: <http://www.dhcfp.nv.gov/RatesUnit.htm>
- c. Human Papillomavirus (HPV) Vaccine: The quadrivalent HPV vaccine (for both males and females) is available to Medicaid eligibles age 19 years through 26 years, based on the US FDA approved indications. The bivalent HPV vaccine for ages 19-26 years is also available to Medicaid eligible females only. These may be accessed by following the link: <http://www.fda.gov/cber/products/gardasil.htm> The HPV vaccines are available through the state Health Division as part of the Vaccines for Children (VFC) program for eligible females and males age nine through 18 years. Please refer to MSM Chapter 1500, for more information on the VFC program.
- d. Pharmacies may administer childhood and adult vaccines/immunizations.
 1. Pharmacies must adhere to all Nevada State Board of Pharmacy (BOP) regulations regarding vaccine/immunization administration including certification to administer as documented in NAC Chapter 639.
 2. Pharmacies must receive childhood immunizations through the VFC Program. The DHCFP or Nevada Medicaid and NCU do not reimburse for vaccines included in the VFC Program.
 3. Covered immunizations not included in the VFC Program will be reimbursable per the Nevada Medicaid and NCU Pharmacy Manual.

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4. If the pharmacist administers the immunization, the dispensing fee will not be reimbursed. An administration fee is paid instead.

1203.1B PROVIDER RESPONSIBILITY

1. For information on In-State and Out-Of-State Provider Participation refer to MSM Chapter 100.
 - a. The pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required.
 1. The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.
 2. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.
2. Utilization Control
 - a. Prospective (Concurrent) Drug Utilization Review (Pro-DUR)

Pro-DUR functions will be carried out via the Point of Sale (POS) Systems.

 1. Pro-DUR edits apply to POS claims and paper Uniform Claim Form (UCF) claims.
 2. Long Term Care (LTC) claims are subject to all Pro-DUR edits that apply to retail.
 3. Providers may submit override codes using the National Council for Prescription Drug Programs (NCPDP) standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.
 4. No long term prior authorizations are issued, codes must be entered each time errors occur. Reference the Nevada Medicaid and NCU Pharmacy Manual (Pharmacy Manual) for more information on the current Pro-DUR edits and override procedures.
 5. All drugs may be subject to quantity limitations. Refer to the Nevada Medicaid and NCU Pharmacy Manual for established quantity limits.

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b. Retro Drug Utilization Review (DUR)

Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.

c. Drug Utilization Review (DUR)

Nevada Medicaid policy and federal law allows the state appointed DUR Board to conduct review of the information compiled about individual clients and providers and allows the DUR Board to educate Medicaid providers about the changes in drug therapeutics. Educational programs may include information such as drug interactions between medications that physicians have prescribed for the clients and medications they are prescribing that are unnecessarily expensive. In this case, educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid clients.

d. Eligibility

Please refer to MSM Chapter 100 for information on Medicaid eligibility, eligibility verification and the Eligibility Verification System (EVS).

e. Lock-in Program: When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, or the DHCFP has determined that the recipient requires close medical management, the recipient may be “locked-in” to a specific pharmacy and/or provider. This means that Medicaid will only pay for controlled substance prescriptions/medical services at a single pharmacy/provider.

1. Criteria that is evaluated by the DHCFP when determining if a recipient should be locked in to a specific pharmacy begins with the number of controlled substance prescriptions filled in 60 days.

If the recipient has filled ten or more controlled substance prescriptions in the past 60 day period (includes controlled substance pharmaceuticals given in the emergency room) then the clinical review continues with the following criteria:

- a. The recipient has utilized more than one pharmacy in the past 60 day period;
- b. The recipient has utilized more than three physicians in the past 60 day period;

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- c. The recipient has utilized the emergency room(s) for receiving controlled substances;
 - d. The recipient has been diagnosed with a drug dependency related condition;
 - e. The dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or
 - f. The recipient has other noted drug seeking behaviors(s).
2. The POS system will not allow another pharmacy to bill for controlled substance prescriptions, and a message will be given at the time of service to notify the pharmacy that the recipient is locked-in. Any non-controlled substance prescriptions can be filled at any pharmacy.
 3. Recipients who are locked-in to one pharmacy can change their locked-in pharmacy at any time by contacting their Medicaid District Office.
 4. Pharmacies may call the Technical Call Center for an override to the locked-in pharmacy if:
 - a. The locked-in pharmacy is out of stock.
 - b. The locked-in pharmacy is closed.
 - c. The recipient is out of town and cannot access the locked-in pharmacy.

3. Generic Substitution

Per NRS Chapter 639, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

- a. is less expensive than the drug prescribed by brand name;
- b. is biologically equivalent to the drug prescribed by brand name;
- c. has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and

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- d. is of the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

4. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient’s medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

- a. The certification must be in the physician's own handwriting.
- b. Certification must be written directly on the prescription blank.
- c. The phrase “Dispense as written” is required on the face of the prescription. For electronically transmitted prescriptions “Dispense as written” must be noted. Not acceptable: A printed box on the prescription blank checked by the prescriber to indicate “brand necessary” or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.
- d. A prior authorization is required to override generic substitution.
- e. Certification is not required if a generic is not manufactured.
- f. A fax copy/verbal order may be taken by the pharmacist from the physician but the pharmacy must obtain an original printed copy and keep on file.

1203.1C SERVICE DELIVERY MODEL

For the rate and reimbursement methodology see MSM Chapter 700, Rates. For POS claims refer to the Pharmacy Manual, and for Medicaid Management Information System (MMIS) claims refer to the Nevada Medicaid and NCU Billing Manual (Billing Manual).

1. Institutional settings

- a. Medical/Surgical, Specialty and Psychiatric Hospitals – All pharmacy services are included in the daily per diem rate for inpatient services, which are billed through MMIS.

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b. Long Term Care (LTC)

1. Nursing Facilities (NF) – Legend pharmaceutical services are excluded from the daily per diem facility rate. This includes compound prescriptions and Total Parental Nutrition (TPN) solution and additives. Legend pharmaceuticals are billed directly by a licensed pharmacy through POS.

Non-legend pharmaceuticals are not separately reimbursable.

2. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) – Legend and non-legend pharmaceuticals are excluded from the facility rate. Pharmaceuticals are billed directly by a licensed pharmacy through POS.

2. Outpatient Pharmaceuticals

- a. Covered outpatient drugs that are billed separately from medical services, in accordance with Section 1927 of the Social Security Administration (SSA).

1. Retail pharmacies, (billed through POS).
2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics, (billed through POS). Refer to the Intravenous (IV) Therapy Provider Type 37 Section of this chapter.
3. Physician administered drugs, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate National Drug Code (NDC) and NDC quantity. The administration of the drug is billed using the appropriate Current Procedural Terminology (CPT) code(billed through MMIS).
4. Hospital based outpatient clinics, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).
5. End Stage Renal Disease (ESRD) Facilities, any administered drugs not included in the Prospective Payment System (PPS) Rate are to be billed using the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS). Drugs included in the PPS Rate as documented in the CMS Manual

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6. System, Publication # 100-04, Medicare Claims Processing, Transmittal 2134 will deny if billed separately.

b. Covered outpatient drugs that are not reimbursed separately in accordance with 1927(k)(2) of the SSA.

1. Ambulatory Surgical Centers (ASC)/Hospital-Based Ambulatory Infusion Centers, all pharmacy services are included in the facility rate. Pharmacy charges may not be billed separately, (billed through MMIS).

2. Emergency Rooms, all pharmacy services are included in the Emergency Room charges. "Take home" medications are also included in the facility rate and may not be billed separately, (billed through MMIS).

3. Disposable Medical Supplies

Please refer to MSM Chapter 1300, Durable Medical Equipment (DME) for instructions on billing and any applicable limitations for these items.

4. Unit Dose (Repackage and Re-Stock) Repackage

Nevada Medicaid provides reimbursement incentives for LTC providers who repackage non-unit dose pharmaceuticals; An additional \$0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit dose products are not covered for this policy.

This incentive is available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the QIO-like Vendor Pharmacy Department to enroll in this incentive program.

In accordance with the CMS, State Medicaid Director Letter (SMDL) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State Board of Pharmacy. In addition, NFs must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of the medication.

5. Coordination of Benefits (COB)

On-line COB (cost avoidance) is part of the Nevada Medicaid POS system.

a. If Nevada Medicaid is the recipient's secondary carrier, claims for COB will be accepted.

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- b. Nevada Medicaid is always the payer of last resort.
 - c. Other coverage will be identified by the presence of other carrier information on the recipient eligibility file.
 - d. If the recipient shows other coverage, the claim will be denied. The POS system will return a unique client-identified carrier code identifying the other carrier, the recipient's policy number and the carrier name in the additional message filed. It is possible that a recipient may have more than one active other carrier; in that case, the returned code will be from the first carrier, subsequent codes will be returned until fully exhausted. Providers will be required to submit this code OTHER PAYER ID (#340-7C) field as part of the override process.
 - e. Even if "no other insurance" is indicated on the eligibility file, the claim will be processed as a TPL claim if the pharmacy submits.
 - f. If other insurance is indicated on the eligibility file, the claim will be processed as a TPL regardless of what TPL codes the pharmacy submits.
 - g. In all cases, the Nevada Medicaid "allowed amount" will be used when calculating payment. In some cases, this may result in a "0" payment, when the insurance carrier pays more than the Medicaid "allowable amount".
 - h. In order to facilitate the TPL/COB process, Nevada Medicaid will allow providers to override "days supply limits" and/or "Drug Requires PA" conditions by entering a value of "5" (exemption from prescription limits) in the PA/MC CODE field (NCPCP #416DG) if there are no prior authorization requirements on these drugs from the primary insurer.
6. Non-participating Health Maintenance Organization (HMO) Providers
- a. Recipients, who have Medicaid and HMO coverage, including Medicare HMOs, must seek treatment and services through their preferred provider network or HMO. Nevada Medicaid is not liable to pay for HMO covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. Unless the provider is an authorized provider of a recipient's health plan, the recipient should be referred to the plan for covered treatment, or the provider should contact the HMO for treatment authorization. Refer to MSM Chapter 3600, Managed Care Organizations (MCO), or MSM Chapter 100, Medicaid Program, for more information.

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b. Exceptions to Medicaid liability policy are:

1. The service(s) is/are a non-covered benefit of the HMO plan;
2. The service is an emergency and a participating provider is more than 25 miles away;
3. The service is for family planning;
4. The recipient resides outside the service area of the HMO; or
5. The recipient's HMO coverage has been exhausted.

7. Pharmacy Billing Process

a. NCPDP Standard Billing Units

Nevada Medicaid reimburses for outpatient pharmaceuticals according to NCPDP "Billing Unit Standard Format" guidelines. The standard provides for the billing of pharmaceuticals in one of three billing units for all drug products. These units are "each", "milliliter (ml)", and "gram (g)". The following guidelines are to be used when billing Nevada Medicaid for pharmaceuticals:

Tablets, Capsules, Suppositories, Pre-filled Syringes: must be billed by "each" or by "mls". For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.

Liquids, Liquid Orals, Suspensions, Solutions, Ophthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guaifenesin is dispensed, the quantity entered will be 560.

PLEASE NOTE:

Ounces must be converted to ml (1 ounce = 30ml).

Liters must be converted to ml (1L = 1000ml).

Ointments, Bulk Powders: must be billed by grams. For example, if a two ounce tube of oxiconazole nitrate is dispensed, the quantity entered will be 60.

PLEASE NOTE:

Ounces must be converted to grams (1 ounce = 30g, ½ ounce = 15g).

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Oral Contraceptives/Therapy packs: must be billed per “each” tablet dispensed, not the number of packages. For example, Ortho Tri-Cyclen is a 28-day dial pack, the quantity entered will be 28.

Transdermal Patches/Powder Packets: must be billed per “each” patch/packet dispensed, regardless of whether they are pre-packaged in a box or come in individual pouches/packets. For example, Catapres-TTS comes in a box of four patches. If two of these boxes are dispensed, the quantity entered will be eight.

Inhalers and Aerosols: must be billed as either grams or ml, as specified by the manufacturer on the labeling. For example a 90mcg(microgram)/inh Albuterol Inhaler has a total of 17gm in the canister. If one of these is dispensed, 17 will be quantity entered.

Topical Products: must be billed as either grams or ml, as specified by the manufacturer on the labeling.

PLEASE NOTE: Ounces must be converted to grams or ml.

1 ounce = 30ml

1 ounce = 30g

Reconstitutables (oral, otic, ophthalmic): must be billed per ml that are/will be in the bottle after reconstitution according to the manufacturer’s instructions.

Liquid Injectables (vials, ampoules): must be billed by milliliters (ml). For example, if a 10ml vial of Novolin 70/30 is dispensed, the quantity entered will be 10.

Powdered Injectables (vials): must be billed by “each” vial given per dose. For example if the recipient receives Ampicillin 1g every six hours for one week, the quantity entered will be 1, as only one vial is used per dose (assuming a 1gm vial is used), and the # of doses entered will be 28 (4 per day x 7 days).

PLEASE NOTE: If the product is supplied with a diluent, the quantity entered is only the number of powdered vials dispensed, the diluent is not factored in.

Intravenous Solutions: must be billed in ml administered per dose. For example, if a recipient receives 250ml of Normal Saline four times per day, the quantity entered will be 250, as that is the quantity per dose.

Blood Derived Products: products may vary in potency from batch to batch. Anithemophilic products must be billed as the number of antihemophilic units

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dispensed (each). Prolastin must similarly be billed as the number of milligrams dispensed (each).

Kits: defined as products with a least two different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single NDC. Kits are intended to be dispensed as a unit and should be billed as a unit of each kit dispensed (each).

For further information, refer to the NCPDP Billing Unit Standard Format Official Release.

b. Provider Numbers

The state National Association of Boards of Pharmacy (NABP) provider number is to be used and entered when billing online using the POS system or when using the UCF.

8. State Maximum Allowable Cost (SMAC)

a. SMAC is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the DHCFP, or Fiscal Agent.

1. The DHCFP Fiscal Agent will perform ongoing market analysis to monitor pricing patterns and product availability.
2. The DHCFP Fiscal Agent will perform monthly updates of the drugs subject to the SMAC.
3. All drugs subject to the SMAC and updates will be posted on the following website:
<http://www.medicaid.nv.gov/providers/rx/MACinfo.aspx>

b. Providers may appeal the current SMAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.

1. The pharmacy must contact the Fiscal Agent technical call center to initiate the appeal.
2. Information needed to make a decision will include NDC number, manufacturer, drug name, strength, and price paid. A faxed copy of the actual invoice for the drug may be requested.

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3. Inquiries not resolved by the technical call center are forwarded to the Fiscal Agent’s SMAC Coordinator for investigation and resolution.
4. If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to:
 - a. adjust SMAC pricing for the particular claim being appealed; and
 - b. make changes to the SMAC pricing file.
5. Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

1203.1D AUTHORIZATION PROCEDURES

Prior Authorization Requests: Physician’s may request payment for exceptions to program limitations and medications requiring prior authorization by forwarding a prior authorization request to the QIO-like vendor. Prior authorization requests may be done via phone, fax or internet. Refer to the Pharmacy Manual for more information.

1. When requesting a prior authorization, providers must:
 - a. Provide all relevant diagnoses.
 - b. List all routine essential drugs being prescribed.
 - c. The requesting physician will be advised of the decision within 24 hours of receipt. A facsimile signature stamp is acceptable on faxed prior authorization requests.
 - d. Unless otherwise indicated by the QIO-like vendor, the prior authorization is for no more than one 34-day supply of prescription for each authorized drug per month.
2. Prior Authorization Protocols
 - a. Alternate media (e.g. paper/UCF claims) are subject to all prior authorization types.

LTC claims, regardless of the media type, are subject to all prior authorization types. Note that the POS system does not require a “Prior Authorization Number” to be entered on a paper or electronic claim; the only requirement is that the prior authorization record is activated in the system prior to the claim submission. The

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approved prior authorization will be in the POS system and will be active for all pharmacies using the POS system, unless the recipient is “locked-in” to a particular pharmacy for abuse/misuse reasons.

- b. A prior authorization will typically be required to be requested and entered prior to the dispensing of the medication, however there may be situations in which an authorization request is considered after the fact (e.g. retroactive eligibility).
- c. For clinical prior authorizations in which a Clinical Call Center Prior Authorization Unit pharmacist or pharmacy technician requests information from the prescribing physician, the prior authorization will deny if the doctor does not respond to a request for information within three working days.
- d. The Nevada Medicaid QIO-like vendor will send all denial of service letters.
- e. For any prior authorization requests that are denied due to criteria not being met, the recipient (only) may appeal the decision. Reference MSM Chapter 3100 for the hearings process.
- f. Standard protocols for “Emergency” or “72-96 Hour Fill” type of overrides will be used.

1203.2 INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37

The purpose of IV therapy is to sustain life, reduce or eliminate infections, replace or provide necessary chemicals to maintain electrolyte balance or provide blood product or hemotherapeutics. IV therapy and treatment should only be used when the Medicaid recipient cannot use oral medications.

a. Billing Guidelines

IV therapy is billed through the pharmacy POS system using the multi-ingredient functionality. A 37 provider number is required (Home Infusion Therapy Provider). The paper Multi-ingredient UCF may also be used if an exception is granted by the Division. Drug coverage edits and prior-authorization edits will be performed at the individual ingredient level.

The billing units used should be the NCPDP standards of “each”, milliliters (ml) or grams(g). Please refer to section 1203.1(D)(8) of this Chapter for complete explanation of these standards.

For specific instructions related to billing via the POS system, refer to the Nevada Medicaid QIO-like pharmacy vendor.

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b. Dispensing Fees

A daily dispensing fee of \$22.40 will be applied to IV therapy claims for outpatient antibiotic therapy. For recipients in LTC, a daily dispensing fee of \$16.80 will be applied to the claim. This will be multiplied by the number of days the therapy was provided.

c. Supplies

Supplies for IV therapy, Enteral Nutrition and TPN are billed through the DME program (under Provider Type 33). Please refer to MSM Chapter 1300, DME, Disposable Supplies and Supplements, for instructions on billing and any applicable limitations on these items.

d. Long Term Care (LTC)

1. Non-Billable Items

IV hydration therapy of standard fluids without additives (e.g., antibiotics, potassium, and heparin) as well as supplies only associated with IV therapy, Enteral Nutrition, and TPN administration are included in Nevada Medicaid's LTC/NF rate and may not be billed as a separate charge.

2. Billable Items

IV Drugs/TPN for recipients in LTC facilities may be billed as a separate charge. Please refer to MSM Chapter 500 (Nursing Facilities) for further information on items which may be billed separately to Nevada Medicaid.

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1204 HEARINGS

1204.1 Please reference Nevada Medicaid Services Manual (MSM), Chapter 3100 for the Medicaid Hearings process.

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All drugs in Appendix A may be subject to Quantity Limitations.

Check the Nevada Medicaid and Nevada Check Up Pharmacy Manual for a listing of the exact Quantity Limitation.

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1. DRUGS REQUIRING A PRIOR AUTHORIZATION AND/OR QUANTITY LIMITATION

A. Proton Pump Inhibitors (PPIs)

Therapeutic Class: Proton Pump Inhibitor

Last Reviewed by the DUR Board: April 24, 2014

Proton Pump Inhibitors (PPIs) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. Prior Authorization is not required for once per day treatment if the following criteria is met:
 1. The recipient is not on concomitant therapy of an H2 antagonist or sucralfate.
- b. Requests for PPIs exceeding once per day must meet one of the following:
 1. The recipient has failed an appropriate duration of once daily dosing; or
 2. The recipient has a diagnosis of a hypersecretory condition (e.g., Zollinger-Ellison Syndrome), esophagitis, Barrett's esophagitis, reflux esophagitis, or treatment of an ulcer caused by H.Pylori.

2. Prior Authorization Guidelines

Prior authorization approval will be for up to one year.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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B. Cox-2 Inhibitors

Therapeutic Class: NSAIDs (nonsteroidal anti-inflammatory drugs)

Last Reviewed by the DUR Board: April 28, 2011

Cox-2 Inhibitors are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer for the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Indications:

A diagnosis of osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, primary dysmenorrhea, or acute pain in adults.

Upon documentation of a listed indication, authorization will be given if the patient meets one of the following criteria:

- a. Patient is at high risk of NSAID induced adverse GI events as evidenced by any of the following:
 1. Patient has a documented history or presence of peptic ulcer disease.
 2. Patient has a history or presence of NSAID-related ulcer.
 3. Patient has a history or presence of clinically significant GI bleeding.
- b. Patient is greater than 65 years of age.
- c. Patient is at risk for GI complications due to the presence of any of the following concomitant drug therapies:
 1. Anticoagulants (e.g. warfarin, heparin or Low Molecular Weight (LMW) heparin).
 2. Chronic use of oral corticosteroids.
- d. Patient has a documented history of inability to tolerate therapy with at least two non-selective (traditional) NSAIDs.
- e. The patient is not being treated daily with aspirin for cardioprophylaxis unless concurrent use of a proton pump inhibitor is documented.

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- f. The patient does not have a documented history of a cardiac event (e.g. stroke, myocardial infarction or has undergone coronary artery bypass graft procedure) in the past six months.
- g. The patient does not have a history of allergies to sulfonamides, aspirin or other NSAIDs.

2. Prior Authorization Guidelines

Prior authorization approval may be authorized for up to one year.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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C. Agents used for the treatment of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Therapeutic Class: ADHD/ADD Agents

Last Reviewed by the DUR Board: January 24, 2008

Agents, both stimulants and non-stimulants used for the treatment of ADD/ADHD are subject to prior authorization for pediatric, adolescent, and adult clients that meet the criteria for coverage.

1. Coverage and Limitations

Approval for medications will be given at the therapeutics class level if the following criteria is met and documented:

a. General Criteria (Children and Adults)

1. Only one long-acting agent at a time may be used for the treatment of ADD/ADHD (applies to the entire ADD/ADHD/Stimulant Class); a 30-day transitional overlap in therapy will be allowed.
2. The following two criteria's must be met and documented in the recipient's medical record for adult and pediatric recipients.
 - a. The decision to medicate for ADD or ADHD must be based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: school, home, work or with peers; and
 - b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out.

b. Children (up to age 18 years)

In addition to the general criteria above, the following conditions apply and must be documented in the recipient's medical record.

1. Prescriptions for ADD/ADHD medications do not require prior authorizations for children five years of age, up to eighteen years of age, if the following conditions apply:
 - a. The medication is prescribed by a psychiatrist; and
 - b. An ICD code for Attention Deficit Disorder with or without Hyperactivity is documented on the prescription.

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2. In all other cases, prior authorization is required. The following is required for prior authorization.
 - a. An initial evaluation or examination has been done within the past 12 months by the treating physician, pediatrician, psychiatrist or neurologist documenting the developmental history, physical evaluation, medical history or a primary neurological diagnosis and all of the following:
 1. School information, Standardized Teachers Rating Scales testing reports such as Test of Variables of Attention (TOVA), achievement test, neuropsychological testing if indicated, Conner’s scale, speech and language evaluation;
 2. Diagnosis and symptoms of ADD or ADHD, presence or absence-child behavior checklist, development and context of symptoms and resulting impairment, including school, family and peers, diagnostic symptoms of possible alternate or comorbid psychiatric diagnosis, history of psychiatric, psychological pediatric or neurological treatment for ADD or ADHD; and
 3. Family history including diagnosis of ADD and ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder and other anxiety disorders, past or present family stressors, crises, any abuse or neglect, interview with parent(s) or guardian(s).
 - c. Adults (18 years and above) In addition to the general criteria above, the following must be present and documented in the recipient’s medical record:
 1. An initial evaluation-complete psychiatric assessment, present and past, diagnostic symptoms of ADD or ADHD, history of development and context of symptoms and resulting past and present impairment, including academic achievement, learning disorder evaluation, and
 2. One of the following:
 - a. Medical history, medical or primary neurological diagnosis, identify medication(s) that could be causing symptoms (e.g. Phenobarbital, steroids), or;
 - b. History of other psychiatric disorder(s) and treatment, or;
 - c. Diagnostic symptoms of ADD and ADHD presence or absence, possible alternate comorbid psychiatric diagnosis (especially:

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personality disorder, mood disorder, depression or mania, anxiety disorder, dissociative disorder, tic disorder including Tourette’s disorder and substance abuse disorder); or

- d. Family history including diagnosis of ADD or ADHD, tic disorder, substance abuse disorder, conduct disorder, personality disorder, mood disorder and anxiety disorder, possible family stressors, any history of abuse or neglect.

- 3. Prior Authorization will be given for a one year time period.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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D. Growth Hormone

Therapeutic Class: Growth Hormone

Last Reviewed by the DUR Board: July 25, 2013

Growth Hormones are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

Approval will be given if the following criteria are met and documented.

- a. Genotropin® (somatropin); Humatrope® (somatropin); Norditropin® (somatropin); Nutropin® (somatropin); Omnitrope® (somatropin); Saizen® (somatropin); Tev-Tropin® (somatropin):

1. Children, (up to age 21, with open epiphyses and with remaining growth potential) must meet all of the following:

- a. The recipient has had an evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for growth hormone therapy; and
- b. The recipient has had an evaluation ruling out all other causes for short stature; and
- c. The recipient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonadotropic hormones.

The recipient must then meet one of the following:

1. The recipient has a diagnosis of Noonan Syndrome, Prader-Willi Syndrome or Turner Syndrome and their height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender; or
2. The recipient has a diagnosis of chronic renal insufficiency (<75 mL/minute), and their height is at least two standard deviations below the mean or below the third percentile for the recipient's age and gender; or
3. The recipient has a diagnosis of being small for gestational age, the recipient is two years of age or older, and their

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height is at least two standard deviations below the mean or below the third percentile for the recipient's age and gender; or

4. The recipient is a newborn infant with evidence of hypoglycemia, and has low growth hormone level (<20 ng/mL), low for age insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3 (no stimulation test required for infants); or
5. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma or cranial irradiation), and their height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender.

And recipient must meet one of the following:

- a. The recipient has failed two growth hormone stimulation tests (<10 ng/mL); or
 - b. The recipient has failed one growth hormone stimulation test (<10 ng/mL) and one IGF-1 or IGFBP-3 test; or
 - c. The recipient has failed one growth hormone stimulation test (<10 ng/mL) or IGF-1 or IGFBP-3 test and they have deficiencies in three or more pituitary axes (e.g., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotrophic hormone (ACTH) or antidiuretic hormone (ADH).
2. Adults, (age 21 years and older, with closed epiphyses, and no remaining growth potential) must meet all of the following:
 - a. The recipient is being evaluated by an endocrinologist; and
 - b. The recipient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids or gonadotropic hormones; and
 - c. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to

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structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation); and

The recipient must then meet one of the following:

1. The recipient has failed two growth hormone stimulation tests (<5 ng/mL); or
 2. The recipient has failed one growth hormone stimulation test (<5 ng/mL) and one IGF-1 or IGFBP-3 test; or
 3. The recipient has failed one growth hormone stimulation test (<5 ng/mL) or IGFBP-3 test and has deficiencies in three or more pituitary axes (i.e., TSH, LH, FSH, ACTH, ADH), and has severe clinical manifestations of growth hormone deficiency as evident by alterations in body composition (e.g., decreased lean body mass, increased body fat), cardiovascular function (e.g., reduced cardiac output, lipid abnormalities) or bone mineral density.
3. Continued authorization will be given for recipients (up to age 21, with remaining growth potential) who meet all of the following:
- a. The recipient has a diagnosis of chronic renal insufficiency, growth hormone deficiency, hypothalamic pituitary disease, newborn infant with evidence of hypoglycemia, Noonan Syndrome, Prader-Willi Syndrome, small for gestational age or Turner Syndrome; and
 - b. The recipient's epiphyses are open; and
 - c. The recipient's growth rate on treatment is at least 2.5 cm/year; and
 - d. The recipient does not have evidence of an expanding lesion or tumor formation; and
 - e. The recipient has not undergone a renal transplant.
4. Continued authorization will be given for recipients (age 21 years and older, with closed epiphyses and no remaining growth potential) who meet all of the following:
- a. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease; and

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- b. There is documentation of improvement in clinical manifestations associated with growth hormone deficiency.

b. Serostim® (somatropin)

Recipients must meet all of the following:

1. The recipient has a diagnosis of Human Immune Deficiency Virus (HIV) with wasting or cachexia; and
2. The medication is indicated to increase lean body mass, body weight and physical endurance; and
3. The recipient is receiving and is compliant with antiretroviral therapy; and
4. The recipient has experienced an involuntary weight loss of >10% pre-illness baseline or they have a body mass index of <20 kg/m²; and
5. The recipient has experienced an adverse event, allergy or inadequate response to megestrol acetate, or the recipient has a contraindication to treatment with this agent; and
6. The recipient has experienced an adverse event, allergy or inadequate response to an anabolic steroid (e.g., testosterone, oxandrolone, nandrolone), or the recipient has a contraindication to treatment with these agents.

c. Zorbitive® (somatropin)

Recipients must meet all of the following:

1. The recipient has a diagnosis of short bowel syndrome; and
2. The recipient is age 18 years or older; and
3. The medication is being prescribed by or following a consultation with a gastroenterologist; and
4. The recipient is receiving specialized nutritional support (e.g., high carbohydrate, low-fat diets via enteral or parenteral nutrition).

2. Prior Authorization Guidelines:

- a. Prior Authorization approval will be 12 weeks for Serostim® (somatropin).

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- b. Prior Authorization approval will be six months for initial authorization (for all somatropin products except for Serostim®).
- c. Prior Authorization approval will be one year for continuing treatment (for all somatropin products except Serostim®).
- d. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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E. Over-the-Counter Medications

Last Reviewed by the DUR Board: N/A

Over-the-Counter (OTC) medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Any more than two prescription requests for medications within the same therapeutic class will require prior authorization.

A Prior Authorization form must be submitted to the Nevada QIO-like vendor. The QIO-like vendor will request further information needed on a case by case basis to determine the necessity of the medication for the recipient.

Note: Insulin will be exempt from any prior authorization requirements.

Approval will be for a one month time limit.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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F. Transdermal Fentanyl

Therapeutic Class: Analgesics, Narcotic

Last Reviewed by the DUR Board: January 22, 2015

Transdermal fentanyl, a narcotic agonist analgesic, is indicated in the management of chronic pain in patients requiring continuous opioid analgesia for pain that cannot be managed by lesser means such as acetaminophen-opioid combinations, non-steroidal analgesics or PRN dosing with short-acting opioids. Transdermal fentanyl is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal is contraindicated in management of acute or postoperative pain, mild or intermittent pain responsive to PRN or non-opioid therapy, or in doses exceeding 25 mcg/hr at the initiation of opioid therapy. Therefore, patients must meet the following criteria in order to gain prior authorization approval:

- a. Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteroidal analgesics, or PRN dosing with short-acting opioid.
- b. Patient requires continuous opioid administration.
- c. Prescribers are encouraged to check the Nevada State Board of Pharmacy's Prescription Monitoring Program (PMP) prior to prescribing narcotic analgesics. Refer to the PMP website at <http://bop.nv.gov/links/PMP/>.
- d. If transitioning from another opioid, daily morphine equivalent doses are used to calculate the appropriate fentanyl patch dose.
 1. Morphine 60-134 mg/day PO; Initial Transdermal Fentanyl dose 25 mcg/hr.
 2. Morphine 135-224 mg/day PO; initial Transdermal Fentanyl dose 50 mcg/hr.
 3. Morphine 225-314 mg/day PO; initial Transdermal Fentanyl dose 75 mcg/hr.
 4. Morphine 315-404 mg/day PO; initial Transdermal Fentanyl dose 100 mcg/hr.

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5. Morphine 405-494 mg/day PO; initial Transdermal Fentanyl dose 125 mcg/hr.
6. Morphine 495-584 mg/day PO; initial Transdermal Fentanyl dose 150 mcg/hr.
7. Morphine 585-674 mg/day PO; initial Transdermal Fentanyl dose 175 mcg/hr.
8. Morphine 675-764 mg/day PO; initial Transdermal Fentanyl dose 200 mcg/hr.
9. Morphine 765-854 mg/day PO; initial Transdermal Fentanyl dose 225 mcg/hr.
10. Morphine 855-944 mg/day PO; initial Transdermal Fentanyl dose 250 mcg/hr.
11. Morphine 945-1034 mg/day PO; initial Transdermal Fentanyl dose 275 mcg/hr.
12. Morphine 1035-1124 mg/day PO; initial Transdermal Fentanyl dose 300 mcg/hr.

2. Prior Authorizations

Prior approval will be given for a 12 month time period.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

G. Immediate-Release Fentanyl Products

Therapeutic Class: Analgesics, Narcotic

Last Reviewed by the DUR Board: July 25, 2013

Immediate-Release Fentanyl Products are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. Subsys® (fentanyl sublingual spray), Onsolis® (fentanyl citrate buccal film), Fentora® (fentanyl citrate buccal tablet), Lazanda® (fentanyl citrate nasal spray), Abstral® (fentanyl citrate sublingual tablet) and Actiq® (fentanyl citrate transmucosal lozenge):

The recipient must meet all of the following:

1. The recipient is ≥ 18 years of age or ≥ 16 years of age if requesting fentanyl citrate transmucosal lozenge (Actiq®); and
2. The recipient has pain resulting from a malignancy; and
3. The recipient is already receiving and is tolerant to opioid therapy; and
4. The recipient is intolerant of at least two of the following immediate-release opioids: hydrocodone, hydromorphone, morphine or oxycodone.

2. Prior Authorization Guidelines

- a. Prior Authorization approval will be for six months.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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H. Hematopoietic/Hematinic Agents

Therapeutic Class: Erythropoiesis Stimulating Agents (ESAs)

Last Reviewed by the DUR Board: January 24, 2008

This policy applies in all settings with the exception of inpatient facilities. Hematopoietics and Hematinics are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Recipients must meet one of the following criteria for coverage:

- a. Achieve and maintain hemoglobin levels within the range of 10 to 12 gm/dl in one of the following conditions:
 1. Treatment of anemia secondary to myelosuppressive anticancer chemotherapy.
 2. Treatment of anemia related to zidovudine therapy in HIV-infected patients.
 3. Treatment of anemia secondary to End Stage Renal Disease (ESRD).
- b. Epoetin alfa (Epogen®) is indicated to reduce the need for allogenic transfusions in surgery patients when a significant blood loss is anticipated. It may be used to achieve and maintain hemoglobin levels within the range of 10 to 13 gm/dl. Darbepoetin Alfa (Aranesp®) does not have this indication.

2. Non-Covered Indications

- a. Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis.
- b. Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML), or erythroid cancers.
- c. Anemia of cancer not related to cancer treatment.
- d. Any anemia associated only with radiotherapy.
- e. Prophylactic use to prevent chemotherapy-induced anemia.
- f. Prophylactic use to reduce tumor hypoxia.

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- g. Patients with erythropoietin-type resistance due to neutralizing antibodies.
- h. Anemia due to cancer treatment if patients have uncontrolled hypertension.

3. Prior Authorizations

Prior approval will be given for a one month period. Recent laboratory results are required for prior authorization, i.e. serum hemoglobin within seven days of prior authorization request.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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I. Anti-Fungal Onychomycosis

Therapeutic Class: Antifungal Agents

Last Reviewed by the DUR: **September 3, 2015**

Anti-Fungal Onychomycosis **Agents** are subject to prior authorization **and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.**

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

- a. **The agent is U.S. Food and Drug Administration (FDA) approved for the treatment of onychomycosis (tinea unguium).**
- b. **And one of the following:**
 1. **The recipient is experiencing pain which limits normal activity; or**
 2. **The recipient's disease is iatrogenically-induced; or**
 3. **The recipient's disease is associated with immunosuppression; or**
 4. **The recipient has diabetes; or**
 5. **The recipient has significant peripheral vascular compromise.**
- c. **And the requested length of therapy is appropriate, based on the agent and infection location.**
- d. **And the drug and/or formulation-specific criteria is met:**
 1. **Terbinafine: no pre-existing liver disease.**
 2. **Itraconazole: The recipient does not have a diagnosis of heart failure and there is no evidence of ventricular dysfunction.**
 3. **Oral granules dosage form: clinical rationale documenting why the recipient cannot or should not use terbinafine tablets or itraconazole capsules.**

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e. Topical dosage forms:

1. Inadequate response after an appropriate length of therapy with ciclopirox 8% solution or an adverse reaction or contraindication to ciclopirox 8% solution, and
2. Inadequate response after an appropriate length of therapy to either terbinafine tablets or itraconazole capsules or an adverse reaction or a contraindication to terbinafine tablets or itraconazole capsules or a clinical rationale why the recipient cannot use terbinafine tablets or itraconazole capsules.

f. Onmel (itraconazole) tablets: Clinical rationale documenting why the recipient cannot or should not use terbinafine tablets or itraconazole capsules.

2. Prior Authorization Guidelines

- a. The extent of Prior Authorization approvals will be based on the appropriate use for the individual agents.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

J. Pramlintide Injection (Symlin®)

Therapeutic Class: Antihyperglycemic, Amylin Analog-Type
Last Reviewed by the DUR Board: September 21, 2006

Pramlintide injection is subject to prior authorization and age restriction:

1. Coverage and Limitations (For recipients 15 years or older)

Authorization will be given if the following criteria are met and documented:

- a. Diagnosis of Type 1 or Type 2 Diabetes Mellitus;
- b. Documentation that recipient has not achieved desired HbA1c despite optimal insulin therapy;
- c. Documented HbA1c < 9%;
- d. Patient is competent and has received diabetic education, able to self-administer drug, and willing to perform blood glucose monitoring;

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- e. Approval period of six months; and
- f. Exclusion criteria:
 - 1. HbA1c>9%;
 - 2. Confirmed diagnosis of gastroparesis;
 - 3. Use of drugs that alter GI motility;
 - 4. Presence of hypoglycemia unawareness; and
 - 5. Use of alpha-glucosidase inhibitors (e.g. acarbose, miglitol).
- 2. Prior Authorization Guidelines

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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K. Regranex®

Therapeutic Class: Diabetic Ulcer Preparations, Topical
Last Reviewed by the DUR Board: July 17, 2008

Regranex® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

- a. Diagnosis of lower extremity diabetic ulcer(s); and
- b. Recipient must be age 16 years or older.

2. Prior Authorization Guidelines

Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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L. Immunomodulator Drugs

Therapeutic Class: Immunomodulators

Last Reviewed by the DUR Board: **November 5, 2015**

Actemra® (tocilizumab)	Ilaris® (canakinumab)
Amevive® (alefacept)	Kineret® (anakinra)
Arcalyst® (rilonacept)	Orencia® (abatacept)
Cimzia® (certolizumab pegol)	Remicade® (infliximab)
Consentyx® (secukinumab)	Simponi® (golimumab)
Enbrel® (etanercept)	Simponi® ARIA™ (golimumab)
Entyvio® (vedolizumab)	Stelara® (ustekinumab)
Humira® (adalimumab)	Xeljanz® (tofacitinib)

Immunomodulator Drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. **For all recipients:**

1. **The recipient has had a negative tuberculin test, and**
2. **The recipient does not have an active infection or a history of recurring infections, and**
3. **The approval will not be given for the use of more than one biologic at a time (combination therapy), and**
4. **Each request meets the appropriate diagnosis-specific criteria (b-j).**

b. Rheumatoid Arthritis (RA):

1. The recipient has a diagnosis of moderately to severely active RA; and
2. **The recipient is 18 years of age or older; and**
3. The recipient has had a rheumatology consultation, including the date of the visit; and **one of the following:**
 - a. The recipient has had RA for \leq six months (early RA) and has high disease activity; and an inadequate or adverse reaction to a disease

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modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline and sulfasalazine); or

- b. The recipient has had RA for \geq six months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine); or
- c. The recipient has had RA for \geq six months (intermediate or long-term disease duration) and has high disease activity.

c. Psoriatic Arthritis:

- 1. The recipient has a diagnosis of moderate or severe psoriatic arthritis; and
- 2. **The recipient is 18 years of age or older; and**
- 3. The recipient has had a rheumatology consultation including the date of the visit or a dermatology consultation including the date of the visit; and
- 4. The recipient had an inadequate response to any one nonsteroidal anti-inflammatory drug (NSAID) or a contraindication to treatment with an NSAID or to any one of the following DMARDs (methotrexate, leflunomide, cyclosporine or sulfasalazine).

d. Ankylosing Spondylitis:

- 1. The recipient has a diagnosis of ankylosing spondylitis; and
- 2. **The recipient is 18 years or older; and**
- 3. The recipient has had an inadequate response to NSAIDs; and
- 4. The recipient has had an inadequate response to any one of the DMARDs (methotrexate, hydroxychloroquine, sulfasalazine, leflunomide, minocycline).

e. Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis:

- 1. The recipient has a diagnosis of moderately or severely active juvenile RA; and
- 2. The recipient is at **an appropriate age, based on the requested agent, and:**

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- a. Abatacept: Six years of age or older.
 - b. Adalimumab, canakinumab, etanercept, tocilizumab: Two years of age or older.
3. And the recipient has at least five swollen joints; and
 4. The recipient has three or more joints with limitation of motion and pain, tenderness or both; and
 5. The recipient has had an inadequate response to one DMARD.
- f. Plaque Psoriasis:
1. The recipient has a diagnosis of chronic, moderate to severe plaque psoriasis; and
 2. The recipient is 18 years of age or older; and
 3. The agent is prescribed by a dermatologist; and
 4. The recipient has failed to adequately respond to a topical agent; and
 5. The recipient has failed to adequately respond to at least one oral treatment.
- g. Crohn's Disease:
1. The recipient has a diagnosis of moderate to severe Crohn's Disease; and
 2. The recipient is at an appropriate age, based on the requested agent:
 - a. Adalimumab, infliximab: Six years of age or older.
 - b. All others: 18 years of age or older.
 3. And the recipient has failed to adequately respond to conventional therapy (e.g. sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide); or
 4. The recipient has fistulizing Crohn's Disease.
- h. Ulcerative Colitis:
1. The recipient has a diagnosis of moderate to severe ulcerative colitis; and

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2. The recipient is at an appropriate age, based on the requested agent:
 - a. Infiximab: Six years of age or older.
 - b. All others: 18 years of age or older.
3. And the recipient has failed to adequately respond to one or more of the following standard therapies:
 - a. Corticosteroids;
 - b. 5-aminosalicylic acid agents;
 - c. Immunosuppressants; and/or
 - d. Thiopurines.
- i. Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflammatory Syndromes (FCAS) or Muckle-Wells Syndrome (MWS):
 1. The recipient has a diagnosis of FCAS or MWS; and
 2. The recipient is at an appropriate age, based on the requested agent:
 - a. Canakinumab: Four years of age or older.
 - b. Riloncept: 12 years of age or older.
- j. Cryopyrin-Associated Periodic Syndromes (CAPS): Neonatal-Onset Multisystem Inflammatory Disease (NOMID):
 1. The recipient has a diagnosis of NOMID.
2. Prior Authorization Guidelines

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

Prior authorization approval will be for one year.

M. Topical Immunomodulators

Therapeutic Class: Immumomdulators, Topical
 Last Reviewed by the DUR Board: April 26, 2007

Elidel®
 Protopic®

Topical Immunomodulators drugs are a subject to prior authorization and quantity limitations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

- a. Patient must have a therapeutic failure with the use of a topical steroid.
- b. Patient has a documented diagnosis of Atopic Dermatitis:
 1. Elidel®: for mild to moderate, for ages \geq two years.
 2. Protopic® 0.03%; moderate to severe, for ages \geq two years.
 3. Protopic® 0.1%; moderate to severe, for ages \geq 18 years.
- c. Not for chronic use.
- d. Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.
- e. Not recommended for use in immunocompromised patients.

2. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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N. Psychotropic Medications for Children and Adolescents

Therapeutic Class: Psychotropic Agents

Last Reviewed by the DUR Board: **September 3, 2015**

Psychotropic medications for children and adolescents are subject to prior authorization **based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for billing information.**

Authorization will be given if the following criteria are met and documented.

1. Coverage and Limitations

The Division of Health Care Financing and Policy (DHCFP) requires prior authorization approval for children and adolescents for the psychotropic therapeutic classes below and medication combinations considered to be poly-pharmacy. The DHCFP has adopted the following practice standards to strengthen treatment outcomes for our children and adolescents.

a. The psychotropic therapeutic classes subject to this policy are:

1. Antipsychotics
2. Antidepressants
3. Mood Stabilizers (including lithium and anticonvulsants used for behavioral health indications.)
4. Sedative hypnotics
5. Antianxiety agents

b. For all children under 18 years of age, the following must be documented in the medical record for authorization.

1. For psychotropic medications in this age group, when possible, be prescribed by or in consultation with a child psychiatrist.
2. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy.
3. Physician **and/or prescriber** monitoring is required while the recipient is utilizing **any psychotropic** medication.

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- a. For recipients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), medical documentation must support a monthly or more frequent visit with the physician and/or prescriber. If the recipient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber.
 - b. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.
- c. **Poly-pharmacy:** Each psychotropic medication prescribed must be independently treating a specific symptom and/or diagnosis.
1. Poly-pharmacy (intra-class) is defined as more than one drug within the same therapeutic class within a 60 day time period.
 - a. Prior authorization approval is required for two or more drugs in the same therapeutic class within a 60 day period.
 2. Poly-pharmacy (inter-class) is defined as more than one drug across different therapeutic classes within a 60 day time period.
 - a. Prior authorization approval is required for four or more drugs across all psychotropic therapeutic classes listed in this policy within a 60 day time period.
 3. Approval for poly-pharmacy may be given in situations where the requested medication(s) will be used for cross tapering and situations where the recipient will be discontinuing the previously prescribed agent. A 30 day cross-taper will be allowed.
 4. Approval for poly-pharmacy may be given for a medication to augment the effect of another psychotropic medication as long as the purpose of the poly-pharmacy is clearly documented in the recipient's medical record and each agent is supported by individual authorizations.
 5. The recipient must have a trial of each individual medication alone. The reasons for an inadequate response must be documented in the medical record.
 - 4-6. For intra-class and inter-class poly-pharmacy, all psychotropic medications must be utilized for a medically accepted indication as

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7. established by the Food and Drug Administration (FDA), and/or peer reviewed literature.
- d. For children under six years of age, in addition to the Coverage and Limitation requirements, all psychotropic medications require a prior authorization approval and must be utilized for a medically accepted indication as established by the FDA and/or peer-reviewed literature.
- e. Continuity of Care. In an effort to improve recipient safety and quality of care:
 1. For recipients under 18 years of age, who have been discharged from an institutional facility, they will be allowed to remain on their discharge medication regimen for up to six months to allow the recipient time to establish outpatient mental health services. The initial prior authorization after discharge must document the name of the discharge institution and the date of discharge.
 2. For all other recipients under the age of 18, a six month prior authorization will be granted to cover current medication(s) when it is documented that the recipient has been started and stabilized. This will allow the recipient time to establish services if necessary and to transition to medication(s) per Nevada Medicaid policy.
2. Exceptions to this criteria for Anticonvulsants and ADD/ADHD medications:
 - a. Treatment for seizure disorders with anticonvulsants are not subject to this policy. The ICD Codes for Epilepsy and/or Convulsions will bypass the prior authorization requirement at the pharmacy POS if the correct ICD Code is written on the prescription and transmitted on the claim. Or the prior authorization requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system.
 - b. The current policy for treatment of ADD/ADHD is to be followed. Refer to this Chapter's Appendix A.
3. Prior Authorization Guidelines:

Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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O. Lidoderm 5% Patches®

Therapeutic Class: Topical, Local Anesthetics
Last Reviewed by the DUR Board: April 30, 2009

1. Coverage and Limitations

Topical Lidoderm Patches® are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

Authorization will be given if one of the following criteria are met and documented:

- a. If an ICD code for herpes zoster is documented on the prescription; or
- b. Completion of a prior authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy.

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P. Xolair® (Omalizumab)

Therapeutic Class: Respiratory Monoclonal Antibody Agents

Last Reviewed by the DUR Board: April 23, 2015

Xolair® (Omalizumab) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented: Recipients must meet at least one condition (a. or b.) listed below:

- a. The recipient must have a diagnosis of moderate to severe persistent asthma; and

The recipient must meet all of the following criteria:

1. The recipient must be age 12 years or older; and
2. The recipient must have tried and failed, or have a contraindication to inhaled oral corticosteroids; and
3. The recipient must have tried and failed, or have a contraindication to an oral second generation antihistamine; and
4. The recipient must have tried and failed, or have a contraindication to a leukotriene receptor antagonist; and
5. The prescriber must be either a pulmonologist or allergist/immunologist; and
6. The recipient must have a history of a positive skin test or Radioallergosorbent (RAST) test to a perennial aeroallergen; and
7. The recipient must have had a pretreatment serum total Immunoglobulin E (IgE) level; and
8. The recipient's current weight must be recorded; and
9. The requested dose is appropriate for the recipient's pre-treatment serum IgE and body weight.

- b. The recipient has a diagnosis of chronic idiopathic urticaria (CIL), and

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The recipient must meet all of the following criteria:

1. The recipient is age 12 years or older; and
2. The recipient must have tried and failed, or have a contraindication to two oral second generation antihistamines; and
3. The recipient must have tried and failed, or have a contraindication to an oral second generation antihistamine in combination with a leukotriene receptor antagonist; and
4. The prescriber must be either an allergist/immunologist, dermatologist or a rheumatologist.

2. Prior Authorization Guidelines

- a. Prior Authorization approval will be for 12 months.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

Table 1: Dosing for Xolair® (omalizumab)*

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	>60-70	>70-90	>90-150
≥30-100	150 mg	150 mg	150 mg	300 mg
>100-200	300 mg	300 mg	300 mg	225 mg
>200-300	300 mg	225 mg	225 mg	300 mg
>300-400	225 mg	225 mg	300 mg	
>400-500	300 mg	300 mg	375 mg	
>500-600	300 mg	375 mg		
>600-700	375 mg		DO NOT DOSE	
Every 2 Weeks Dosing				
Every 4 Weeks Dosing				

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Q. Long-Acting Narcotics

Therapeutic Class: Analgesics, Narcotic

Last Reviewed by DUR Board: July 30, 2009

Long-Acting Narcotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Indications: Management of moderate-to-severe pain when continuous around-the-clock analgesic is needed for an extended period of time. Medications:

a. Oxycontin (including generic); MS Contin (including generic); Avinza; Kadian; Oramorph.

1. No prior authorization is required for diagnosis of terminal cancer.

b. Please Note: The use of Long – Acting Narcotics for acute/short term treatment of pain not within the quantity limits will not be approved.

Approval will be for a three month time limit.

2. Prior Authorization Guidelines:

The prior authorization must be initiated by the prescriber. The approved Payment Authorization Request (PAR) must be available if requested.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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R. Toradol® (ketorolac tromethamine) tablets

Therapeutic Class: Nonsteroidal Antinflammatory Drugs, NSAIDS
Last Reviewed by the DUR Board: Not Available

The pharmaceutical Toradol® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Ketorolac is indicated for the short-term (up to five days) management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. The following criteria must be met:

- a. Oral treatment is indicated only as continuation therapy to IV/IM therapy.
- b. Oral treatment is not to exceed five days.

2. Prior Authorization Guidelines

The prior authorization must be initiated by the prescriber. The approved prior authorization must be available if requested.

Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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S. Anti-Migraine Medications

Therapeutic Class: Triptans

Last Reviewed by the DUR Board: September 21, 2006

Serotonin 5-HT₁ receptor agonists commonly referred to as “triptans” or anti-migraine medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

An approved prior authorization is required for any prescription exceeding the quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

- a. The recipient’s current medication history documents the use of prophylactic medications for migraine headache or the medical provider agrees to initiate such therapy which includes beta-blockers, tricyclic antidepressants, anticonvulsants, Selective Serotonin Reuptake Inhibitors (SSRIs) and/or calcium channel blockers; or
- b. The medical provider is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required monthly.
 1. Recipient’s current medication history must NOT have Monoamine Oxidase (MAO) Inhibitors present for approval of Imitrex® (sumatriptan), Maxalt® (rizatriptan) or Zomig® (zolmitriptan).
 2. Recipients whose current medication history indicates the use of propranolol will NOT be granted prior authorization of Maxalt® (rizatriptan) 10mg tablet or 10mg orally disintegrating tablet.
 3. Prior authorization will NOT be given to patients with ischemic heart disease.

Approval for exceeding the quantity limits on triptans will be given for a two month time period.

2. Prior Authorization Guidelines

The prior authorization must be initiated by the prescriber. The approved prior authorization must be available if requested.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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T. Tobacco Cessation Products

Therapeutic Class: Tobacco Cessation Agents

Last Reviewed by the DUR Board: Not Available

Smoking cessation products, including patches, gums, lozenges and inhalers (based on the recipients' route of choice), are subject to quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

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U. Xopenex® (Levalbuterol)

Therapeutic Class: Beta Adrenergic Agents
Last Reviewed by the DUR Board: July 26, 2012

Xopenex® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

- a. Authorization only for recipients experiencing side effects on one other beta-adrenergic agent of any formulation.
- b. Authorization for patients whose cardiovascular status is considered to be in severe deteriorating condition.

2. Prior Authorization Guidelines

Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

V. Anti-Insomnia Agents (Sedative Hypnotics)Therapeutic Class: **Anxiolytics, Sedatives and Hypnotics**Last Reviewed by the DUR Board: **September 3, 2015**

See Section N of this Appendix for criteria for Sedatives and Hypnotics when prescribed for a psychotropic indication.

Sedatives Hypnotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented.

a. A Food and Drug Administration (FDA) approved diagnosis:

1. **Hetlioz® (tasimelteon): A diagnosis of non-24-hour sleep-wake disorder, or**
2. **All other agents: A diagnosis of insomnia.**

2. Prior Authorization Guidelines

- a. **Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>**

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W. Inhaled Anticholinergic Agents

Therapeutic Class:

Last Reviewed by the DUR Board:

Inhaled anticholinergic agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. General Criteria

- a. Only one inhaled anticholinergic agent may be used in a 30 day period.

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X. Antiemetics – Serotonin Receptor Antagonists (also known as 5-HT3 Antiemetics)

Therapeutic Class: Antiemetics, Antivertigo Agents

Last Reviewed by the DUR Board: October 28, 2010

1. Coverage and Limitations

5-HT3 Antiemetics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

An approved prior authorization is required for any prescription exceeding the quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

- a. The recipient has failed on chemotherapy-related antiemetic therapy at lower doses; or
- b. The recipient is receiving chemotherapy treatments more often than once a week; or
- c. The recipient has a diagnosis of AIDS associated nausea and vomiting; or
- d. The recipient has a diagnosis of hyperemesis gravidarum and has failed at least one other antiemetic therapy or all other available therapies are medically contraindicated.

2. Prior Authorization Guidelines

A prior authorization to override the quantity limits to allow for a 30 day fill for these drugs may be effective for up to six months.

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Y. Synagis® Palivizumab

Therapeutic Class: Antiviral Monoclonal Antibodies

Last Reviewed by the DUR Board: January 22, 2015

Synagis® (palivizumab) injections are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

For consideration outside these guidelines, a prior authorization may also be submitted with supporting medical necessity documentation.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. Recipients younger than 12 months of age at the start of Respiratory Syncytial Virus (RSV) season, must meet one of the following criteria:
 1. The recipient was born at 28 weeks, six days of gestation or earlier; or
 2. The recipient has a diagnosis of chronic lung disease (CLD) of prematurity; or
 3. The recipient has hemodynamically significant congenital heart disease; or
 4. The recipient has congenital abnormalities of the airways or neuromuscular disease; or
 5. The recipient has a diagnosis of cystic fibrosis; and
 - a. The recipient has clinical evidence of CLD and/or nutritional compromise.
- b. Recipients younger than two years of age at the start of RSV season must meet one of the following criteria:
 1. The recipient has a diagnosis of CLD of prematurity; and
 - a. The recipient has required medical therapy (e.g., bronchodilator, diuretics, oxygen, corticosteroids) within six months to the start of RSV season; or
 2. The recipient has had a cardiac transplant; or

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3. The recipient is severely immunocompromised (solid organ or hematopoietic stem cell transplant, chemotherapy, or other conditions) during the RSV season; or
 4. The recipient has had a cardiopulmonary bypass and continues to require prophylaxis after surgery or at the conclusion of extracorporeal membrane oxygenation; or
 5. The recipient has a diagnosis of cystic fibrosis; and
 - a. The recipient has had manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persists when stable) or weight for length less than the tenth percentile.
2. Prior Authorization Guidelines
- a. Prior Authorization approval will be up to five doses per RSV season for recipients meeting criteria.
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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Z. Cymbalta® (duloxetine)

Therapeutic Class: Serotonin-Norepinephrine Reuptake Inhibitor (SNRI)

Last Reviewed by the DUR Board: July 25, 2013

Cymbalta® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented. Recipients must meet at least one diagnosis listed below:

a. Diabetic Peripheral Neuropathy (DPN):

1. If an ICD code for Diabetes with Neurological Manifestations is documented on the prescription and transmitted on the claim; or
2. Completion of a prior authorization documenting a diagnosis of Diabetes with Neurological Manifestations.

b. Fibromyalgia:

1. If an ICD code for Fibromyalgia, Myalgia and Myositis unspecified is documented on the prescription and transmitted on the claim; or
2. Completion of a prior authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

c. Chronic Musculoskeletal Pain:

The recipient must meet one of the following:

1. The recipient has experienced an inadequate response or adverse event to at least two oral or topical non-steroidal anti-inflammatory drug (NSAIDS); or
2. The recipient has an allergy or contraindication to two NSAIDS.

d. Generalized Anxiety Disorder:

The recipient must meet the following:

1. The recipient has experienced an inadequate response or adverse event to at least two antidepressants from any of the following classes: selective

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serotonin reuptake inhibitors, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors or buspirone.

e. Major Depressive Disorder:

The recipient must meet the following:

1. The recipient has experienced an inadequate response, and/or adverse event and/or an allergy and/or contraindication to at least two antidepressants.
2. Prior Authorization Guidelines
 - a. Prior Authorization approval will be for one year.
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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AA. Savella® (milnacipran)

Therapeutic Class: Fibromyalgia Agents: Serotonin-Norepinephrine Reuptake Inhibitor
Last Reviewed by DUR Board: June 3, 2010

Savella® (milnacipran) is subject to prior authorization.

Coverage and Limitations

1. Diagnosis of Fibromyalgia:
 - a. If an ICD code for Myalgia and Myositis unspecified is documented on the prescription; or
 - b. Completion of a prior authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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BB. Buprenorphine/Naloxone (Suboxone®)

Therapeutic Class: Narcotic Withdrawal Therapy Agents

Last Reviewed by the DUR Board: July 25, 2013

Buprenorphine/Naloxone (Brand Suboxone®) and Buprenorphine (Brand Subutex®) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Nevada Medicaid encourages recipients to participate in formal substance abuse counseling and treatment.

Approval will be given if all of the following criteria are met and documented:

a. Buprenorphine/Naloxone (Suboxone®)

The recipient must meet all of the following:

1. The recipient has a diagnosis of opioid dependence; and
2. The recipient is 16 years of age or older; and
3. There is documentation that the recipient has honored all of their office visits; and
4. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique “X” DEA number.

b. Buprenorphine (Subutex®) (for female recipients):

The recipient must meet all of the following:

1. There is documentation that the recipient is pregnant or there is documentation the recipient is breastfeeding an infant who is dependent on methadone or morphine; and
2. The recipient has a diagnosis of opioid dependence; and
3. The recipient is 16 years of age or older; and
4. There is documentation that the recipient has honored all of their office visits; and

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5. The medication is being prescribed by a physician with a Drug Addiction Treatment Act (DATA) of 2000 waiver who has a unique “X” DEA number.
2. Prior Authorization Guidelines
 - a. Prior Authorization approval will be for one year.
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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CC. Ampyra® (dalfampridine)

Therapeutic Class: Agents for the treatment of Neuromuscular Transmission Disorder
 Last Reviewed by the DUR Board: July 25, 2013

Ampyra® (dalfampridine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval for Ampyra® (dalfampridine) will be given if all of the following criteria are met and documented:

a. Ampyra® (dalfampridine)

The recipient must meet all of the following:

1. The recipient must have a diagnosis of Multiple Sclerosis ; and
2. The medication is being used to improve the recipient’s walking speed; and
3. The medication is being prescribed by or in consultation with a neurologist; and
4. The recipient is ambulatory and has an EDSS score between 2.5 and 6.5; and
5. The recipient does not have moderate to severe renal dysfunction (CrCL >50 ml/min); and
6. The recipient does not have a history of seizures; and
7. The recipient is not currently pregnant or attempting to conceive.

2. Prior Authorization Guidelines

- a. Initial Prior Authorization approval will be for three months.
- b. Requests for continuation of therapy will be approved for one year.
- c. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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DD. Androgel®, Androderm®, Testim® (Testosterone gel and transdermal system)

Therapeutic Class: Androgenic Agents

Last Reviewed by the DUR Board: July 22, 2010

Topical Androgens are subject to prior authorization.

1. Coverage and Limitations

Recipients must meet all of the criteria for coverage:

2. Criteria for approval

a. Recipient is a male;

b. Use is for the FDA Approved Indication:

Primary (congenital or acquired) or secondary (congenital or acquired) hypogonadism with an ICD code for hypogonadism;

c. The patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used;

d. The patient does not have breast or prostate cancer, a palpable prostate nodule or induration, prostate-specific antigen greater than 4 ng/ml or severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) > 19;

e. The patient does not have a hematocrit > 50%;

f. The patient does not have untreated severe obstructive sleep apnea; and

g. The patient does not have uncontrolled or poorly controlled heart failure.

3. Prior Authorization Guidelines

Prior authorization approval will be for up to one year.

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

Length of authorization: one year.

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EE. Colchicine (Colcrys®)

Therapeutic Class: Antigout Agents

Last Reviewed by the DUR Board: October 28, 2010.

Colchicine (Colcrys®) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

- a. Recipient has a diagnosis of Familial Mediterranean Fever (FMF); or
- b. Recipient has a diagnosis of acute gout and recipient has failed therapy with NSAIDs (indomethacin, naproxen, ibuprofen, sulindac or ketoprofen) or corticosteroids (oral or intra-articular) in the last 90 days; or
- c. Recipient has a diagnosis of chronic gout requiring prophylaxis and recipient has failed therapy with both xanthine oxidase inhibitors within the last 180 days or recipient has a contraindication to two xanthine oxidase inhibitors.

2. Prior Authorization Guidelines:

- a. A prior authorization for additional medication beyond this limit will be approved for recipients with:
 1. FMF.
 2. Chronic gout requiring prophylaxis and recipient has failed therapy with two xanthine oxidase inhibitors or has a contraindication to both xanthine oxidase inhibitors. The quantity limit for prophylaxis of chronic gout is 60 tablets/30 days.

3. Length of Approval (up to): one year

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FF. Thrombin Inhibitors

Therapeutic Class: Thrombin Inhibitors

Last Reviewed by the DUR Board: January 22, 2015

Thrombin Inhibitors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. A diagnosis code associated with the FDA approved indication(s) is documented on the prescription and transmitted on the claim; and
- b. There are no contraindications to prescribing this medication; or
- c. An approved Prior Authorization documenting the recipient meeting all of the criteria above (1.) (a. and b.).

2. Prior Authorization Guidelines

- a. Prior Authorization approval will be for up to one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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GG. Makena™ (Criteria for Physician Administered Drug)

Therapeutic Class: Progestational Agents

Last Reviewed by the DUR Board: April 28, 2011

Makena™ is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if all of the following criteria are met and documented:

- a. Treatment with Makena™ is ordered by or recommended by a physician specializing in Obstetrics/Gynecology, Perinatology or Maternal/Fetal Medicine; and
- b. The recipient is female, 16 years of age or older, and pregnant with a singleton pregnancy; and
- c. The recipient's pregnancy is between 16 weeks, 0 days and 20 weeks, six days of gestation when therapy begins; and
- d. The recipient has a history of singleton spontaneous preterm birth (prior to 37 weeks gestation); and
- e. The recipient does not have other risk factors for preterm birth; and
- f. There is no known major fetal anomaly or fetal demise; and
- g. The recipient has not been treated with heparin therapy during the current pregnancy; and
- h. The recipient has no history of thromboembolic disease; and
- i. The recipient has no maternal/obstetrical complication (e.g. current or planned cerclage, hypertension requiring medication or seizure disorder).

2. Length of approval:

Makena™ will be approved for use until the recipient's pregnancy is 36 weeks, six days of gestation or delivery, whichever occurs first.

3. Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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HH. Anti-Hepatitis Agents – Protease Inhibitor Agents

Therapeutic Class: Anti-Hepatitis Agents-Protease Inhibitors

Last Reviewed by the DUR Board: January 22, 2015

Victrelis® (boceprevir), Incivek® (telaprevir), and Olysio® (simeprevir) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Victrelis® (boceprevir)

1. For treatment initiation (treatment weeks 5 through 28), the recipient must have all of the following:
 - a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and
 - b. The recipient will be treated with peginterferon alfa and ribavirin for four weeks prior to starting Victrelis® (boceprevir) and will continue peginterferon alfa and ribavirin for the entire duration of treatment with Victrelis® (boceprevir); and
 - c. The recipient has not received a previous course of therapy with Incivek® (telaprevir), Olysio® (simeprevir) or Victrelis® (boceprevir) unless the drug is being switched due to an adverse event with the alternative drug.
2. For treatment continuation for treatment weeks 28 through 36, the recipient must have one of the following:
 - a. The recipient is treatment-naïve and their HCV-RNA level was detectable at treatment week eight and undetectable at treatment week 24; or
 - b. The recipient is a previous partial responder or a relapser to peginterferon alfa and ribavirin and their HCV-RNA was undetectable at treatment week eight and treatment week 24.
3. For treatment continuation for treatment weeks 28 through 48, the recipient must have one of the following:

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- a. The recipient has a diagnosis of chronic hepatitis C genotype 1 with compensated cirrhosis and their HCV-RNA was detectable at treatment week 24; or
 - b. The recipient had a $<2\text{-log}_{10}$ HCV-RNA drop by treatment week 12 on prior treatment with peginterferon alfa and ribavirin and HCV-RNA on triple therapy is undetectable at treatment week 24; or
 - c. The recipient is treatment-naïve and poorly interferon responsive based on $<1\text{-log}_{10}$ decline in HCV-RNA at treatment week four following lead-in therapy with peginterferon alfa.
- b. Incivek® (telaprevir)
1. For treatment initiation (weeks one through eight) the recipient must have all of the following:
 - a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and
 - b. The recipient will be treated with concomitant peginterferon alfa plus ribavirin; and
 - c. The recipient has not received a previous course of therapy with Incivek® (teaprevir), Olysio® (simeprevir) or Victrelis® (boceprevir) unless the drug is being switched due to an adverse event with the alternative drug.
 2. For treatment continuation for treatment weeks nine through 12:
 - a. The recipient is treatment-naïve and their HCV-RNA level was <1000 IU/mL at treatment week four.
- c. Olysio® (simeprevir)
1. For treatment initiation (treatment weeks one through eight), the recipient must meet all of the following:
 - a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and
 - b. The recipient will be treated with concomitant peginterferon alfa plus ribavirin; and

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- c. The recipient has not received a previous course of therapy with Incivek® (telaprevir), Olysio® (simeprevir), or Victrelis® (boceprevir) unless the drug is being switched due to an adverse event with the alternative drug; and
 - d. The recipient has been pre-screened and does not test positive for the 1A NS3 Q80K polymorphism.
2. For treatment continuation for treatment weeks nine through 12, the recipient must have one of the following:
 - a. The recipient is treatment-naïve, and their HCV-RNA level was <25 IU/mL at treatment week four; or
 - b. The recipient is a previous prior relapser and their HCV-RNA level was <25 IU/mL at treatment week four; or
 - c. The recipient is a partial or a null-responder to previous therapy of interferon and ribavirin alone (no other HCV protease inhibitors) and their HCV-RNA was <25 IU/mL at treatment week four.
 3. The initial prescription for Olysio, with peginterferon alfa and ribavirin must be for a two week supply. Subsequent refills can be up to 34 days.
2. Prior Authorization Guidelines:
 - a. Victrelis® (boceprevir)
 1. Initial prior authorization will be for 24 weeks (through treatment week 28).
 2. For recipients meeting criteria for continuation treatment for treatment weeks 28 through 36, a prior authorization may be renewed once for an additional eight weeks.
 3. For recipients meeting criteria for continuation treatment for treatment weeks 28 through 44, a prior authorization may be renewed once for an additional 24 weeks.
 - b. Incivek® (teleprevir) and Olysio® (simeprevir)
 1. Initial prior authorization approval will be for eight weeks.
 2. For recipients meeting criteria for continuation treatment for treatment weeks nine through 12, a prior authorization approval may be renewed once for an additional four weeks.

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- c. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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II. Daliresp® (roflumilast)

Therapeutic Class: Phosphodiesterase-4 Inhibitors.

Last Reviewed by the DUR Board: July 26, 2012

Daliresp® (roflumilast) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

- a. The recipient has experienced an inadequate response, adverse event or has a contraindication to a long-acting anticholinergic agent;
- b. The recipient has experienced an inadequate response, adverse event or has a contraindication to a long-acting β agonist;
- c. The recipient has experienced an inadequate response, adverse event or has a contraindication to an inhaled corticosteroid;
- d. The recipient has a diagnosis of severe Chronic Obstructive Pulmonary Disease (COPD) associated with chronic bronchitis; and
- e. The recipient has a history of COPD exacerbations.

2. Prior Authorization Guidelines:

- a. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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JJ. Hereditary Angioedema Agents

Therapeutic Class: Hereditary Angioedema Agents

Last Reviewed By DUR Board: July 25, 2013

Hereditary angioedema agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Cinryze® (C1 esterase inhibitor)

The recipient must meet all of the following:

1. The recipient has a diagnosis of hereditary angioedema; and
2. The medication is being prescribed by or in consultation with an allergist or immunologist; and
3. The medication is being used as prophylaxis for hereditary angioedema attacks; and
4. The recipient has experienced an inadequate response or adverse event with an attenuated androgen (e.g. danazol, stanozolol) or antifibrinolytic (e.g. tranexamic acid, aminocaproic acid) agent or has a contraindication to all agents in these classes; and
5. The recipient routinely experiences more than one hereditary angioedema attack per month, or the recipient has a history of laryngeal attacks.

b. Berinert® (C1 esterase inhibitor), Kalbitor® (ecallantide) and Firazyr® (icatibant)

The recipient must meet all of the following:

1. The recipient has a diagnosis of hereditary angioedema; and
2. The medication is being prescribed by or in consultation with an allergist or immunologist; and
3. The medication is being used to treat acute hereditary angioedema attacks.

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2. Prior Authorization Guidelines:

- a. Initial Prior Authorization approval will be for six months.
- b. Prior Authorization requests for continuation therapy will be approved for one year.
- c. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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KK. Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide)

Therapeutic Class: Incretin Mimetics

Last Reviewed by the DUR Board: July 26, 2012

Byetta® (exenatide), Bydureon® (exenatide extended-release) and Victoza® (liraglutide) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

- a. The recipient is 18 years of age or older;
- b. The recipient has a diagnosis of type 2 diabetes mellitus; and
- c. The recipient has failed to achieve glycemic control despite an appropriate trial with metformin and/or a sulfonylurea.

2. Prior Authorization Guidelines:

- a. Prior authorization approval will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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LL. Kalydeco® (ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent

Last Reviewed by the DUR Board: **September 3, 2015**

Kalydeco® (ivacaftor) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient is **two** years of age or older; and
- b. The recipient has a diagnosis of cystic fibrosis; and
- c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the following **gene mutations**: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N or S549R.

2. Prior Authorization Guidelines

- a. Prior authorization approval will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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MM. Natroba® (spinosad)

Therapeutic Class: Topical Antiparasitics

Last Reviewed by the DUR Board: July 26, 2012

Natroba® (spinosad) is subject to prior authorization.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

- a. The recipient has experienced an allergy or adverse event with a permethrin or pyrethrin-containing pediculicide product; or
- b. The recipient has experienced a treatment failure with a permethrin or pyrethrin-containing pediculicide product despite a full course of treatment (two applications); or
- c. The recipient has a contraindication to treatment with permethrin or pyrethrin-containing pediculicide product.

2. Prior Authorization Guidelines

- a. Prior authorization approval will be for the date of service only.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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NN. Platelet Inhibitors

Therapeutic Class: Platelet Inhibitors

Last Reviewed by the DUR Board: January 23, 2014

Brilinta® (ticagrelor) and Effient® (prasugrel) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. Brilinta® (ticagrelor)

1. The recipient has a diagnosis of Acute Coronary Syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction); and
2. The recipient does not have an active pathological bleed or history of intracranial hemorrhage; and
3. The recipient will be receiving concomitant treatment with aspirin in a dose of <100 mg/daily; and
4. The recipient has been started and stabilized on the requested medication; or
5. The recipient has experienced an adverse event with or has an allergy or contraindication to clopidogrel; or
6. Another clinically appropriate rationale is provided for why clopidogrel cannot be used.

b. Effient® (prasugrel)

1. The recipient has a diagnosis of ACS (unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction); and
2. The recipient does not have an active pathological bleed or history of transient ischemic attack or cerebral vascular accident (CVA); and
3. The recipient will be receiving concomitant treatment with aspirin in a dose of <100 mg/daily; and

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4. The recipient has a history of percutaneous coronary intervention; and
 5. The recipient has been started and stabilized on the requested medication;
or
 6. The recipient has experienced an adverse event with or has an allergy or
contraindication to clopidogrel; or
 7. Another clinically appropriate rationale is provided for why clopidogrel
cannot be used.
2. Prior Authorization Guidelines
- a. Prior authorization approval will be for one year.
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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OO. Prolia® (Denosumab)

Therapeutic Class: Bone Resorption Inhibitors (Osteoporosis Agents)

Last Reviewed by DUR Board: October 25, 2012

Prolia® (Denosumab) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Postmenopausal Osteoporosis

1. The recipient has a T score \leq -2.5, and
2. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture, and
3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently, and
4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.

b. Male Osteoporosis

1. The recipient has a T score \leq -2.5, and
2. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture, and
3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently, and
4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.

c. Non-metastatic Prostate Cancer

1. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture;

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2. The recipient is receiving treatment with androgen-deprivation therapy (e.g., anti-androgen or luteinizing hormone-releasing hormone agents;
 3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently; and
 4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.
- d. Breast Cancer
1. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture;
 2. The recipient is receiving adjuvant aromatase inhibitor therapy (e.g., anastrozole, exemestane and letrozole);
 3. The recipient is not receiving any second line or third line osteoporosis therapy concurrently; and
 4. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate; or the recipient has had esophagitis; or the recipient is unable to remain upright.
2. Prior Authorization Guidelines
- a. Prior authorization approval will be for one year.
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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PP. Forteo® (Teriparatide)

Therapeutic Class: Parathyroid/Bone Formation Stimulating Agent (Osteoporosis Agents)
Last Reviewed by DUR Board: October 25, 2012

Forteo® (Teriparatide) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has been diagnosed with Postmenopausal Osteoporosis; or Glucocorticoid-Induced Osteoporosis, or the recipient is male and diagnosed with Primary or Hypogonadal Osteoporosis;
- b. The recipient has a T score of ≤ 2.5 ;
- c. The recipient has a history of osteoporotic fracture, or has multiple risk factors for fracture;
- d. The recipient has experienced an inadequate response, adverse event or has a contraindication to one bisphosphonate;
- e. The recipient is not receiving any second line or third line osteoporosis therapy concurrently; and
- f. The total duration of treatment with this agent has not exceeded two years.

2. Prior Authorization Guidelines

- a. Prior authorization approval will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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QQ. Cesamet® (Nabilone) and Marinol® (Dronabinol)

Therapeutic Class: Antiemetic

Last Reviewed by DUR Board: October 25, 2012

Cesamet® (Nabilone) and Marinol® (Dronabinol) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Cesamet® (Nabilone)

1. The recipient has a diagnosis of chemotherapy-induced nausea and/or vomiting; and
2. The recipient has experienced an inadequate response, adverse event, or has a contraindication to at least one serotonin receptor antagonist; and
3. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent; and
4. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient.

b. Marinol® (Dronabinol)

1. The recipient has a diagnosis of chemotherapy-induced nausea and/or vomiting; and
 - a. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one serotonin receptor antagonist; and
 - b. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent; and
 - c. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient; or

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2. The recipient has been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) and has anorexia associated with weight loss; and
 - a. The recipient has experienced an inadequate response, adverse event or has a contraindication to megestrol (Megace®); and
 - b. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient.

2. Prior Authorization Guidelines
 - a. Prior Authorization approval will be for one year.
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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RR. Omontys® (Peginesatide)

Therapeutic Class: Erythropoiesis Stimulating Agent (ESA)

Last Reviewed by DUR Board: October 25, 2012

Omontys® (Peginesatide) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of anemia secondary to chronic kidney disease, and
- b. The recipient must be over 18 years of age;
- c. The recipient is receiving dialysis;
- d. Other causes for anemia have been evaluated and ruled out (e.g., iron, vitamin B12 or folate deficiencies);
- e. The recipient's hemoglobin level is <10 g/dL, (laboratory values from the previous 14 days must accompany the request); and
- f. The target hemoglobin level will not exceed 11 g/dL.

2. Prior Authorization Guidelines

- a. Prior Authorization approval will be for one month.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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SS. Colony Stimulating Factors (Point of Sale Claims Only)

Therapeutic Class: Colony Stimulating Factors

Last Reviewed by the DUR Board: July 25, 2013

Colony Stimulating Factors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Leukine® (sargramostim)

The recipient must meet one of the following:

1. The requested medication is being used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; or
2. The recipient has a diagnosis of acute myeloid leukemia, and has received induction chemotherapy; or
3. The recipient has a diagnosis of non-Hodgkin's lymphoma, acute lymphoblastic leukemia or Hodgkin's disease and is undergoing autologous bone marrow transplantation; or
4. The recipient is undergoing allogeneic bone marrow transplantation from human leukocyte antigen-matched related donors; or
5. The recipient has undergone allogeneic or autologous bone marrow transplantation and is experiencing engraftment failure or delay.

b. Neulasta® (pegfilgrastim)

The recipient must meet the following criteria:

1. The recipient has a diagnosis of nonmyeloid malignancy and
 - a. The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of $\geq 20\%$; or
 - b. The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65 , absolute

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neutrophil count (ANC) <100 cells/ μ L, or the expected duration of neutropenia is > 10 days); or

- c. The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as secondary prophylaxis.

- c. Neupogen® (filgrastim)

The recipient must meet one of the following (1 to 5):

1. The recipient has a diagnosis of nonmyeloid malignancy; and
 - a. The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of \geq 20%; or
 - b. The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age >65, ANC <100 cells/ μ L or the expected duration of neutropenia is >10 days); or
 - c. The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as a secondary prophylaxis; or
2. The recipient has a diagnosis of acute myeloid leukemia and has received induction or consolidation chemotherapy; or
3. The recipient has a diagnosis of nonmyeloid malignancy and is undergoing myeloablative chemotherapy followed by marrow transplantation; or
4. The recipient has a diagnosis of symptomatic congenital neutropenia, cyclic neutropenia or idiopathic neutropenia; or
5. The requested medication is being used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis.

2. Prior Authorization Guidelines

- a. Prior Authorization approval will be for one month.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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TT. Auvi-Q (epinephrine injection device)

Therapeutic Class: Anaphylaxis-Self Injectable Epinephrine

Last Reviewed by the DUR Board: January 23, 2014

Auvi-Q (Epinephrine Injection Device) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient or recipient's caregiver is unable to read or comprehend written directions.

2. Prior Authorization Guidelines:

- a. Initial Prior Authorization approval will be for one year.
- b. Recertification approval will be for one year.
- c. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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UU. Sovaldi® (sofosbuvir)

Therapeutic Class: Anti-Hepatitis Agents-Polymerase Inhibitor Agents

Last Review by the DUR Board: January 22, 2015

Sovaldi® (sofosbuvir) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

Approval for Sovaldi® (sofosbuvir) for mono-infected or HCV/HIV-1 co-infected recipients will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of chronic hepatitis C Genotype 1 infection; and the recipient will be treated in combination with peginterferon alfa and ribavirin or, if the recipient is ineligible to receive peginterferon alfa, in combination with ribavirin; or
- b. The recipient has a diagnosis of Chronic Hepatitis C Genotype 2 or 3 Infection; and the recipient will be treated in combination with ribavirin; or
- c. The recipient has a diagnosis of Chronic Hepatitis C Genotype 4 Infection; and the recipient will be treated in combination with peginterferon alfa and ribavirin; or
- d. The recipient has a diagnosis of Chronic Hepatitis C Genotype 1, 2, 3, or 4 infection; and the recipient has a diagnosis of hepatocellular carcinoma and is awaiting a liver transplant; and the recipient will be treated in combination with ribavirin.

2. The initial prescription for Sovaldi must be for a two week supply. Subsequent refills can be up to 34 days.

3. Prior Authorization Guidelines

- a. Prior Authorization approval will be for 12 weeks for ALL of the following:
 1. Recipients with a diagnosis of Chronic Hepatitis C Genotype 1 infection and combination therapy with peginterferon alfa and ribavirin.
 2. Recipients with a diagnosis of Chronic Hepatitis C Genotype 2 infection and combination therapy with ribavirin.

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- b. Prior Authorization approval will be for 24 weeks for all of the following:
 - 1. Recipients with a diagnosis of Chronic Hepatitis C Genotype 1 infection and combination therapy with ribavirin.
 - 2. Recipient with a diagnosis of Chronic Hepatitis C Genotype 3 infection and combination therapy with ribavirin.
- c. Prior Authorization approval will be for up to 48 weeks or until liver transplantation for recipients with a diagnosis of hepatocellular carcinoma and is awaiting a liver transplant combination therapy with ribavirin.
- d. Prior Authorizations will be renewed in 12 week intervals based on genotype.
- e. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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VV. Medications for the Treatment of Acne

Therapeutic Class: Acne Agents

Last Reviewed by the DUR Board: July 24, 2014

Acne agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

No prior authorization necessary for recipients up to 21 years of age.

Approval will be given if the following criteria are met and documented:

- a. The recipient is age 21 years of age or older; and
- b. The recipient has a diagnosis of moderate to severe acne (Grade III or higher).

2. Prior Authorization Guidelines

- a. Prior Authorization approval will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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WW. Harvoni® (ledipasvir/sofosbuvir)

Therapeutic Class: Anti-Hepatitis Agents-Polymerase Inhibitor Agents
 Last Reviewed by the DUR Board: January 22, 2015

Harvoni® (ledipasvir/sofosbuvir) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval for Harvoni® (ledipasvir/sofosbuvir) will be given if the following criteria is met and documented:

- a. The recipient has a diagnosis of chronic hepatitis C genotype 1 infection; and
- b. The recipient is 18 years of age or older; and
- c. The requested dose is 90 mg/400 mg, once daily; and

2. The initial prescription for Harvoni® must be for a two week supply. Subsequent refills can be up to 34 days.

3. PA Guidelines

- a. PA approval will be given for eight weeks of therapy if the recipient is treatment-naïve, does not have cirrhosis and as a pretreatment (within the last 12 weeks) HCV RNA viral load less than 6 million IU/mL; or
- b. PA approval will be given for 12 weeks of therapy, if one of the following are met and documented:
 1. The recipient is treatment-naïve, does not have cirrhosis and has a pre-treatment (within the last 12 weeks) HCV RNA viral load greater than or equal to 6 million IU/mL; or
 2. The recipient is treatment-naïve and has cirrhosis; or
 3. The recipient is treatment-experienced (failed treatment with peginterferon alfa + ribavirin ± an HCV protease inhibitor) and does not have cirrhosis. (NOTE: recipients who have failed a previous course of therapy with Sovaldi® is also acceptable to meet this criterion); or
- c. Approval will be given for 24 weeks of therapy if the recipient is treatment-experienced (failed treatment with peginterferon alfa + ribavirin ± an HCV

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protease inhibitor) and has cirrhosis. (NOTE: recipients who have failed a previous course of therapy with Sovaldi® is also acceptable to meet this criterion).

Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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XX. Xartemis® XR (oxycodone and acetaminophen)

Therapeutic Class: Opioid Analgesic

Last Reviewed by the DUR Board: January 22, 2015

Xartemis® XR (oxycodone and acetaminophen) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient is 18 years or older; and
- b. A diagnosis code of Acute Pain is documented on the prescription and transmitted on the claim; or
- c. An approved Prior Authorization documenting the recipient meeting the following criteria:
 1. The recipient is 18 years or older; and
 2. A diagnosis code of Acute Pain is documented on the Prior Authorization form.

2. PA Guidelines

- a. More than two fills of a quantity of 60 each, within six months requires an approved Prior Authorization documenting the reason to exceed the prescribing limit.
- b. Prior Authorization approval will be for six months.
- c. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

DIVISION OF HEALTH CARE FINANCING AND POLICY

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YY. Viekira Pak® (dasabuvir-ombitasvir-paritaprevir-ritonavir)

Therapeutic Class: Anti-Hepatitis Agents-Polymerase Inhibitor Agents
 Last Reviewed by DUR Board: April 23, 2015

Viekira Pak® (dasabuvir-ombitasvir-paritaprevir-ritonavir) is subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of hepatitis C virus (HCV) genotype 1; and
- b. The recipient is 18 years of age or older; and
- c. The recipient does not have severe hepatic impairment (Child-Pugh class C); and
- d. The recipient has not failed previous therapy that included an HCV protease inhibitor (i.e. boceprevir (Victrelis®), simeprevir (Olysio®) teleprevir (Incivek®); and
- e. The recipient has not failed previous therapy that included sofosbuvir (Sovaldi®); and
- f. The requested dose is 25/150/100 mg of dasabuvir-paritaprevir-ritonavir (two tablets) once daily in combination with dasabuvir 250 mg (one tablet) twice daily; and
- g. The recipient will be using combination therapy with ribavirin for any of the following:
 1. genotype 1a infection (all);
 2. genotype 1b infection (cirrhosis is present);
 3. recipient has had a liver transplant; and
- h. The requested duration of therapy is appropriate; and
- i. If the recipient has had a liver transplant, they have no or mild hepatic fibrosis (Metavir fibrosis score 2 or less).

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2. Prior Authorization Guidelines

- a. Prior Authorization approvals will be given for a period of 12 weeks at a time.
- b. Total length of therapy authorized will be based on the following:
 - 1. Genotype 1a (no cirrhosis): 12 weeks
 - 2. Genotype 1a (cirrhosis): 24 weeks
 - 3. Genotype 1b: 12 weeks
 - 4. Genotype 1a or 1b (recipient has had a liver transplant): 24 weeks
- c. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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ZZ. Vivitrol® (naltrexone)

Therapeutic Class: Opioid Dependence Agents

Last Reviewed by DUR Board: April 23, 2015

Vivitrol® (naltrexone®) is subject to prior authorizations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The drug is being used for an FDA approved indication; and
- b. Recipients must be given the Naloxone Challenge Test prior to administration to assure recipient is opiate free before initiation of therapy; and
- c. The drug must be delivered directly to the prescriber's office; and
- d. The drug is only to be administered once per month.

2. Prior Authorization Guidelines

- a. Prior Authorization approvals will be for six months.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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AAA. Xyrem® (sodium oxybate), Provigil® (modafinil), Nuvigil® (armodafinil)

Therapeutic Class: Narcolepsy Agents (non-stimulants)

Last Reviewed by DUR Board: April 23, 2015

Xyrem® (sodium oxybate), Provigil® (modafinil), Nuvigil® (armodafinil) are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Provigil® (modafinil), and Nuvigil® (armodafinil):

1. The recipient has a diagnosis of narcolepsy.

b. Xyrem® (sodium oxybate):

1. The recipient has tried and failed on Provigil® (modafinil), or Nuvigil® (armodafinil); and/or

2. The recipient has a diagnosis of narcolepsy with cataplexy; and

3. The drug was prescribed by or in consultation with a neurologist or sleep specialist.

2. Prior Authorization Guidelines

a. Prior Authorization approvals will be for one year.

b. Prior Authorization forms are available at:

<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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BBB. Vimovo® (naproxen/esomeprazole magnesium), Duexis® (ibuprofen/famotidine)

Therapeutic Class: Nonsteroidal Anti-inflammatory Drug/Anti-ulcer Agent Combinations
Last Reviewed by DUR Board: April 23, 2015

Vimovo® (naproxen/esomeprazole magnesium), Duexis® (ibuprofen/famotidine) are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The drug is being used for an FDA approved indication; and
- b. The recipient's medical records documents one of the following risk factors for developing a NSAID-related ulcer:
 1. Previous history of a major gastrointestinal bleed, perforation or obstruction; or
 2. Previous history of a peptic ulcer, hemorrhagic gastritis, hemorrhagic gastropathy, or erosive esophagitis; or
 3. Concomitant therapy for an anticoagulant or antiplatelet agent (including aspirin) or chronic oral corticosteroids; or
 4. The recipient has had gastric bypass surgery (Roux-en-Y gastric bypass); and
- c. The recipient is intolerant to a COX-2 inhibitor or has had a gastric or duodenal ulcer while taking a COX-2 inhibitor; and
- d. The recipient has experienced an NSAID-associated ulcer in the past while taking a single-entity proton pump inhibitor (PPI) or prostaglandin agent concomitantly with an NSAID or the recipient is intolerant to both PPIs and prostaglandin agents; and
- e. The recipient's medical records document an inadequate response or adverse reaction with concurrent therapy of an equivalent dose of the individual components.

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2. Prior Authorization Guidelines

- a. Prior Authorization approvals will be for one year.
- b. Prior Authorization forms available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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CCC. Rayos® (prednisone delayed-release)

Therapeutic Class: Corticosteroid, Systemic
Last Reviewed by DUR Board: April 23, 2015

Rayos® (prednisone delayed-release) is subject to prior authorizations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board.

1. Coverage and Limitations

Approval will be given if all of the following criteria are met and documented:

- a. The requested drug is being used for a FDA approved indication; and
- b. The recipient's medical records document an inadequate response or adverse reaction to generic prednisone immediate-release tablets.

2. Prior Authorization Guidelines

- a. Prior Authorization approvals will be:
 1. Initial therapy: three months.
 2. Recertification: one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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DDD. Corlanor® (ivabradine)

Therapeutic Class: Cardiovascular Agent

Last Reviewed by the DUR Board: September 3, 2015

Corlanor® (ivabradine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

Approval will be given if the following criteria are met and documented:

- a. A diagnosis of chronic heart failure, and
- b. A left ventricular ejection fraction (LVEF) \leq 35%, and
- c. A resting heart rate \geq 70 bpm, and
- d. The recipient is \geq 18 years of age, and
- e. The prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted regarding the diagnosis and treatment recommendations, and
- f. The recipient is in a normal sinus rhythm, and
- g. The recipient is on a maximally tolerated dose of a beta-blocker or the recipient has a contraindication to beta-blocker use.

2. Prior Authorization Guidelines:

- a. The extent of prior authorization approvals will be based on the appropriate use for the individual agents.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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EEE. Praluent® (alirocumab)

Therapeutic Class: Antilepemic Agent, PCSK9 Inhibitor Agent
 Last Reviewed by the DUR Board: November 5, 2015

Praluent® (alirocumab) is subject to prior authorization and quantity limitation based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented.

a. Initial Request (the recipient must meet all criteria (1-4))

1. The recipient has a diagnosis of heterozygous familial hypercholesterolemia (HeFH); or

The recipient has clinical atherosclerotic cardiovascular disease and requires additional lowering of LDL-C (defined as acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin); and

2. The agent will be used as an adjunct to a low-fat diet and exercise; and
3. The agent is prescribed by or in consultation with a cardiologist or lipid specialist; and
4. The recipient must meet the criteria for one of the following responses (a-d):

- a. The recipient has had an inadequate response to high intensity statin therapy defined by all of the following:

1. The recipient has received therapy with atorvastatin \geq 40 mg or rosuvastatin \geq 20 mg for at least the past three months; and
2. The recipient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past three months or the recipient has a contraindication to ezetimibe therapy; and

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3. The LDL-C after therapy for at least the past three months was ≥ 100 mg/dL (HeFH) for ≥ 70 mg/dL (clinical atherosclerotic cardiovascular disease); and
 4. The statin therapy will be continued with PCSK-9 therapy.
- b. Or, the recipient has had an inadequate response to moderate intensity statin therapy defined as all of the following:
1. The recipient has had an intolerance or contraindication to high intensity statin therapy; and
 2. The recipient has received therapy with:
 - a. atorvastatin 10 to 20 mg, or
 - b. rosuvastatin 5 to 10 mg, or
 - c. simvastatin > 20 mg, or
 - d. pravastatin >40 mg, or
 - e. lovastatin 40 mg, or
 - f. fluvastatin XL 80 mg, or
 - g. fluvastatin 40 mg twice daily, or
 - h. pitavastatin > 2 mg

for at least the past three months; and
 3. The recipient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past three months or the recipient has a contraindication to ezetimibe therapy; and
 4. The LDL-C after therapy for at least the past three months was ≥ 100 mg/dL (HeFH) or ≥ 70 mg/dL (clinical atherosclerotic cardiovascular disease); and
 5. Statin therapy will be continued with PCSK-9 therapy.
- c. Or, the recipient experienced an adverse reaction to at least two statins, the statins and adverse reactions must be documented in the recipient's medical record.

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- d. Or the recipient has a labeled contraindication to all statins, the contraindication is documented in the recipient's medical record.
2. Recertification Request (The recipient must meet all criteria (a-d)).
- a. The recipient has been adherent with PCSK-9 inhibitor therapy; and
 - b. The recipient has been adherent with statin therapy or the recipient has a labeled contraindication to statin therapy; and
 - c. The recipient is continuing a low-fat diet and exercise regimen; and
 - d. The recipient has achieved a reduction in LDL-C level.
3. Prior Authorization Guidelines:
- a. Prior Authorizaiton approvals will be for:
 - 1. Initial request: six months
 - 2. Recertification request: one year
 - b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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FFF. Invega Trinza® (paliperidone palmitate)

Therapeutic Class: Second Generation (Atypical) Antipsychotic

Last Reviewed by the DUR Board: November 5, 2015

Invega Trinza® (paliperidone palmitate) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented.

- a. The recipient has a diagnosis of schizophrenia; and
- b. The recipient has been stabilized on once-monthly paliperidone palmitate injection (Invega Sustenna®) for at least four months with the two most recent doses of the once-monthly injection being the same strength; and
- c. The recipient is 18 years of age or older; and
- d. The requested dose is one injection every three months.

2. Prior Authorization Guidelines:

- a. Prior Authorization approvals will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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GGG. Technivie® (ombitasvir/paritaprevir/ritonavir)

Therapeutic Class: Polymerase Inhibitors/Combination Products

Last Reviewed by the DUR Board: November 5, 2015

Technivie® (ombitasvir/paritaprevir/ritonavir) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of chronic hepatitis C, genotype 4, and
- b. The recipient is 18 years of age or older, and
- c. The recipient does not have cirrhosis (Metavir score F4), and
- d. The recipient does not have moderate or severe hepatic impairment (Child-Pugh grade B or C), and
- e. The requested dose is two Technivie® tablets daily, and
- f. The total duration of therapy does not exceed 12 weeks, and
- g. For treatment-naïve recipients:
 1. Technivie® will be used in combination with ribavirin, or
 2. Technivie® will be used without ribavirin. There is documentation that the recipient cannot take or cannot tolerate ribavirin.
- h. Or for treatment-experienced recipients:
 1. Technivie® will be used in combination with ribavirin.

2. Prior Authorization Guidelines:

- a. Prior Authorization approvals will be for 12 weeks.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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HHH. Orkambi® (lumacaftor/ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent

Last Reviewed by the DUR Board: November 5, 2015

Orkambi® (lumacaftor/ivacaftor) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of cystic fibrosis, and
- b. The recipient is 12 years of age or older, and
- c. The recipient is homozygous for the F508del mutation in the CFTR gene, and
- d. The requested dose is two tablets every 12 hours, or
- e. The requested dose is one tablet every 12 hours in the presence of severe hepatic impairment.

2. Prior Authorization Guidelines:

- a. Prior Authorization approvals will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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III. Daklinza® (daclatasvir)

Therapeutic Class: Anti-hepatitis Agents

Last Reviewed by the DUR Board: November 5, 2015

Daklinza® (daclatasvir) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of hepatitis C genotype 3, and
- b. The recipient is 18 years of age or older, and
- c. The recipient has not had a liver transplant, and
- d. The requested agent will be used in combination with Sovaldi, and
- e. The recipient is not on a strong CYP3A inducer, and
- f. The recipient does not have cirrhosis (Metavir score F4), and one of the following:
 1. The requested dose of Daklinza® is 60 mg (one tablet) daily, or
 2. The requested dose of Daklinza® is 30 mg (one tablet) daily and the recipient is receiving a concomitant strong CYP3A inhibitor; or
 3. The requested dose of Daklinza® is 90 mg (one 30 mg tablet and one 60 mg tablet) daily and the recipient is receiving a concomitant moderate CYP3A inducer. Medical necessity of continued use of the moderate CYP3A inducer during Daklinza® therapy must be provided; and
- g. Usage is based on current clinical peer-reviewed literature, and
- h. The requested length of therapy is 12 weeks.

2. Prior Authorization Guidelines:

- a. Prior Authorization approval will be for 12 weeks.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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JJ. Entresto® (sacubitril/valsartan)

Therapeutic Class: Angiotension II Receptor Blocker
Last Reviewed by the DUR Board: November 5, 2015

Entresto® (sacubitril/valsartan) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

- a. The recipient has a diagnosis of chronic heart failure NYHA Class II to IV; and
- b. The recipient has reduced left ventricular ejection fraction (LVEF); and
- c. The recipient is 18 years of age or older; and
- d. The prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted; and
- e. The recipient has had a trial of an ACE or an ARB for at least four weeks prior to the initiation of therapy; and
- f. The recipient will not concurrently receive an ACE inhibitor; and
- g. The recipient is on an individualized dose of a beta blocker or the recipient has a contraindication to beta blocker use; and
- h. Entresto® will be given twice daily with a maximum dose of 97/103 mg.

2. Prior Authorization Guidelines:

- a. Prior Authorization approval will be for one year.
- b. Prior Authorization forms are available at:
<http://www.medicaid.nv.gov/providers/rx/rxforms.aspx>

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2. MEDICATIONS WITH GENDER/AGE EDITS

A. Prenatal Vitamins

1. Payable only for female recipients.

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B. Oral/Topical Contraceptives

1. Payable only for female recipients.

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C. Hormones

1. Estrogen – payable only for female recipients.
2. Progestins – payable only for female recipients.
3. Estrogen and Androgen Combinations – payable only for female recipients.
4. Estrogen and Progestin Combinations – payable only for female recipients.
5. Contraceptive Hormones – payable only for female recipients.
6. Transdermal Testosterone – payable only for male recipients.
7. Androgen Hormone Inhibitor – payable only for male recipients.

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D. Vitamins with Fluoride

1. Payable only for recipients up to age 21 years.

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3. ANTIRETROVIRALS

Antiretrovirals for the treatment of HIV/AIDS are a covered benefit for Nevada Medicaid recipients. FDA approved antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not Drug Efficacy Study and Implementation (DESI) drugs, are covered.

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4. BLOOD GLUCOSE TESTING

Nevada Medicaid and NCU participate in a Diabetic Supply Procurement Program. This program allows for the State to receive additional rebates for diabetic monitors and test strips. Effective March 1, 2009, diabetic monitors and test strips are covered for Nevada Medicaid and NCU from preferred manufacturers. Preferred manufacturers are listed in the pharmacy billing manual. This policy does not negatively impact freedom of choice for recipients. The providers billing for the service will continue to be all willing enrolled pharmacies.

Blood glucose monitors and testing supplies for home use **require a prescription and** are subject to quantity limitations. A recipient or their caregiver must specifically request refills of glucose supplies before they are dispensed. The provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if a recipient has “authorized” in advance.

For all items in excess of the limitations, a prior authorization must be obtained from the Nevada Medicaid QIO-like vendor.

Blood Glucose monitors with special features (e.g. voice synthesizers) require a prior authorization. For special blood glucose monitors, **a diagnosis and** a statement from the physician **documenting the** impairment, and manufacturers’ invoice **of cost is** required with **a** prior authorization.

ICD codes for Diabetes Mellitus, Diabetes, gestational (in pregnancy) **are only required for newly diagnosed diabetics who are receiving diabetic prescription medication, a glucometer or test strips for the first time, or for recipients who are new to Medicaid or transitioning from an MCO. For recipients with an ongoing diagnosis of diabetes and a history of Nevada Medicaid paid claims for diabetic prescriptions no ICD code is required.**

Blood glucose monitors and related supplies are billed on the National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) or on-line through the Point of Sale (POS) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is Wholesale Acquisition Cost (WAC) plus 8% and handling and dispensing fee of \$1.54 per prescription.

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CATAMARAN AD HOC REPORTING SYSTEM
STANDARD THERAPEUTIC CLASSES

Standard Therapeutic	
Class	Description
00	MEDICAL SUPPLIES
01	ANTI-ULCER PREPS/GASTROINTESTI
02	EMETICS
03	ANTIDIARRHEALS
04	ANTISPASMODIC-ANTICHOLINERGICS
05	BILE THERAPY
06	LAXATIVES
07	ATARACTICS-TRANQUILIZERS
08	MUSCLE RELAXANTS
09	ANTIPARKINSON
10	CNS STIMULANTS
11	PSYCHOSTIMULANTS-ANTIDEPRESSAN
12	AMPHETAMINE PREPARATIONS
13	ALL OTHER ANTI OBESITY PREPS
14	ANTIHISTAMINES
15	BRONCHIAL DILATORS
16	COUGH PREPARATIONS/EXPECTORANT
17	COLD AND COUGH PREPARATIONS
18	ADRENERGICS
19	TOPICAL NASAL AND OTIC PREPARA
20	OPHTHALMIC PREPARATIONS
21	TETRACYCLINES
22	PENICILLINS
23	STREPTOMYCINS
24	SULFONAMIDES
25	ERYTHROMYCINS
26	CEPHALOSPORINS
27	OTHER ANTIBIOTICS
28	URINARY ANTIBACTERIALS
29	CHLORAMPHENICOL
30	ANTINEOPLASTICS
31	ANTIPARASITICS
32	ANTIMALARIALS
33	ANTIVIRALS
34	TB PREPARATIONS
35	TRIMETHOPRIM
36	CONTRACEPTIVES, NON-SYSTEMIC
37	VAGINAL CLEANSERS
38	GENERAL ANTIBACTERIALS AND ANT
39	DIAGNOSTICS
40	NARCOTIC ANALGESICS

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42	ANTIARTHRITICS
43	ANESTHETICS GEN INHALANT
44	ANESTHETICS GEN INJECT
45	ANESTHETIC LOCAL TOPICAL
46	SEDATIVE BARBITURATE
47	SEDATIVE NON-BARBITURATE
48	ANTICONVULSANTS
49	ANTINAUSEANTS
50	CORTICOTROPINS
51	GLUCOCORTICOIDS
52	MINERALOCORTICOIDS
53	ALDOSTERONE ANTAGONISTS
54	ANTIDOTES
55	THYROID PREPS
56	ANTITHYROID PREPS
57	IODINE THERAPY
58	DIABETIC THERAPY
59	ANABOLICS
60	ANDROGENS
61	ESTROGENS
62	PROGESTERONE
63	SYSTEMIC CONTRACEPTIVES
64	OTHER HORMONES
65	LIPOTROPICS
66	CHOLESTEROL REDUCERS
67	DIGESTANTS
68	PROTEIN LYSATES
69	ENZYMES
70	RAUWOLFIA
71	OTHER HYPOTENSIVES
72	VASODILATORS CORONARY
73	VASODILATORS PERIPHERAL
74	DIGITALIS PREPARATIONS
75	XANTHINE DERIVATIVES
76	OTHER CARDIOVASCULAR PREPS
77	ANTICOAGULANTS
78	HEMOSTATICS
79	DIURETICS
80	FAT SOLUBLE VITAMINS
81	WATER SOLUBLE VITAMINS
82	MULTIVITAMINS
83	FOLIC ACID PREPARATIONS
84	B COMPLEX WITH VITAMIN C
85	VITAMIN K

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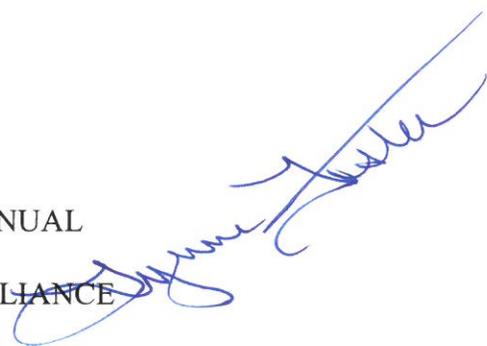
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MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 11, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1300 – DURABLE MEDICAL EQUIPMENT,
PROSTHETICS, ORTHOTICS, AND SUPPLIES



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1300 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies are being proposed as follows:

- Clarifying Provider responsibilities to address mobility equipment proper use and modifications were made to the Mobility Assessment Form.
- Clarifying the requirements and allowable documentation on orders/scripts, revised language to indicate “rental only” modifying used equipment option policy as NV Medicaid hasn’t ever reimbursed for equipment used by other recipients.
- Addition of non-covered items electric implantable osteogenesis stimulators, travel, activity, or corner chairs, feeder seats and floor sitters.
- Policies for hospital beds were revised and oximeter policy changed to allow purchase rather than just rental.
- Added definition of “current” as being within the last 60 days for specific equipment to spell out timeframes for the provider.

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

These changes are effective May 1, 2016.

MATERIAL TRANSMITTED

MTL 08/16
CHAPTER 1300 – DURABLE MEDICAL
EQUIPMENT, PROSTHETICS,
ORTHOTICS, AND SUPPLIES

MATERIAL SUPERSEDED

MTL 27/15
CHAPTER 1300 – DURABLE MEDICAL
EQUIPMENT, PROSTHETICS,
ORTHOTICS, AND SUPPLIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.1.A.9	General Information	Updated web link for rates location.
1303.1.A.10	General Information	Added “access to” a same item for non reimbursement.
1303.1.B.8	Provider Responsibility	Added the provider is responsible to teach how to care for, use, maintain, and how not to use the equipment.
03.2.A.1.a	Orders/ Prescriptions	Clarified orders/scripts need to be relevant to the face-to face and it is required to be with the treating physician and clearly documented.
1303.2.A.1.b.1	Verbal Orders	Corrected the web link to DME MAC Noridian
1303.2.A.2	Detailed Product Description	Clarified usual and customary (UCC) to manufacturer’s invoice of cost and that warranty information can be documented by the physician.
1303.3	Rental and Purchase Option	Added a manufacturer’s invoice is required when NV Medicaid has not assigned a rate.
1303.3.a.4.a, b, c, d	Rent-to-Purchase Option	Removed UCC and whichever is less verbiage and reworded to clarify rental only option and removed UCC adding if no rate assigned a manufacturer’s invoice is needed. Added modifier verbiage for RR and NU to locate when an item is rental only.
1303.3.a.5.a	Rental Only option	Reworded for clarification.
1303.3.b.2, a, c	Purchase Used Equipment Option	Changed Used to Rental for clarity of equipment options and reworded a and c.
1303.4.A.2	Review Consideration	Updated web link to Noridian.
1303.4.A.5.d, C	DMEPOS Specific Prior Authorization Forms	Added the clinical assessment section of the Mobility Assessment Form must be completed by the treating physician. Corrected web links.
1303.4.A.6.a	Denied Prior Authorization Requests	Reworded language and added sections clarifying process of when a prior authorization is denied what the recipient can do.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.4.B.2	Coverage and Limitations	Updated web link.
1303.5.A.2.e	Delivery Method 2. Suppliers utilizing a delivery/shipping service to deliver items	Clarified NV Medicaid does not reimburse for shipping/delivery to an out of state provider and will only reimburse for Medicare covered supplies for a Medicare covered recipient.
1303.9.A	DME at Institutional Facility (IF)	Added reference to nursing facility MSM Chapter 500 Nursing Facilities.
Appendix A.1	Non-Covered	Added travel, activity, or corner chairs, feeder seats and floor sitters.
Appendix A.2	Non-Covered	Updated web link to DHCFP rates for DMEPOS.
Appendix B, page 1	Forms and Documentation, Misc policy statements	Added to determine pricing, a MSRP will not be accepted. Reworded for rental only items and added reimbursement will not be made if item is provided before PA is approved.
Appendix B, page 4	Beds and Accessories	Separated types of beds clarifying policy requirements and requiring manufacturer's cost invoice for beds without a rate. Added note for type of beds not covered and why.
Appendix B	Forms and Documentation	Added throughout Manufacturer's cost invoice required for items without a rate.
Appendix B, Diabetic Services, page 18, and 20	Forms and Documentation and Qualifications	Clarified current is defined as within last 60 days.
Appendix B, Mobility Assistive Equipment	Forms and Documentation Requirements	Added Nevada Medicaid assigned rate and removed Usual and Customary Charge for clarification of pricing.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix B, Orthotic and prosthetic Devices, TLSO/LSO	Misc Policy Statements	Note added regarding low back pain and brace therapy not being of a benefit and not recommended.
Appendix B, Osteogenesis Devices	Misc Policy Statements	Clarified rental calculations and added Electric Implantable devices are not covered.
Appendix B, Pneumatic Compression devices and Pregnancy Related	Misc Policy Statements	Added notes as rental items only.
Appendix B, Respiratory, Apnea	Misc Policy Statements	Removed references to time limits, prior authorizations, and specific HCPCs. Note added regarding rental calculation towards purchase price.
Appendix, Respiratory, BiPAP and CPAP	Misc Policy Statements	Added replacement requires proof of compliance or medical necessity.
Appendix B, Respiratory, High Frequency	Misc Policy Statements	Note added stating non reimbursement for item when provided prior to PA approval.
Appendix B, Respiratory Services, Oximeter	Misc Policy Statements	Condensed Qualification for all recipients, removed verbiage regarding short and long term, added manufacturer's invoice if no rate and rental calculation for purchase, clarified recertification eligibility, opened policy for purchase, clarified requirement for additional features and plan for training.

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1300 INTRODUCTION

Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS) are a covered benefit for Nevada Medicaid recipients. All items are subject to program criteria and reimbursement restrictions as outlined throughout this chapter. Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Items classified as educational or rehabilitative by nature are not covered by Provider Type 33. Administrative authorization for additional services may be made by the Division of Health Care Financing and Policy (DHCFP) in collaboration with the Quality Improvement Organization (QIO)-like vendor for exceptional cases where medical need is adequately documented.

Products must have received approval from the federal Food and Drug Administration (FDA) and be consistent with the approved use. Products or usage considered experimental or investigational are not covered services. Consideration may be made on a case-by-case basis for items approved by FDA as a Humanitarian Device Exemption (HDE) under the Safe Medical Device Act of 1990 and as defined by FDA. That is, a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), except as indicated in the NCU Manual Chapter 1000. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program, Addendums Chapter, and MSM Definitions for further information.

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1301 AUTHORITY

The Division of Health Care Financing and Policy (DHCFP) covers Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) as a mandatory program under Title XIX of the Social Security Act (SSA).

The citations denoting the amount, duration and scope of services can be found in 42 Code of Federal Regulations (CFR), Part 440, Sections 70 and 230, Section 1902 (a)(10)(d) of Title XIX of the Social Security Act, 42 United States Code (USC) Chapter 7, Section 1396a and 1397jj.

Reference Title XIX State Plan §Attachment 3.1-A Page 2h and 3c, Attachment 4.19-B page 1b and page 2.

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1302 DEFINITIONS

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.

CUSTOM FABRICATED ORTHOSIS

A 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.

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.

DURABLE MEDICAL EQUIPMENT (DME)

DME is defined as equipment 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 illness or injury and is appropriate for use in the home.

DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR (DME MAC)

The Centers for Medicare and Medicaid Services (CMS) utilize four insurance companies to process durable medical equipment, 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 durable medical equipment, prosthetics, orthotics, and disposable medical supplies. The acronym is pronounced “demipose.”

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MEDICAL DOCUMENTATION

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

MISUSE

To use in a manner in which an item is not intended, excessive use, or to use incorrectly.

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.

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.

PREFABRICATED ORTHOSIS

A 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.

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:

- a. Artificially replace a missing portion of the body;
- b. Prevent or correct physical deformity or malfunction; or

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c. 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.

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 activities of daily living. SGDs are covered as DME. Requests for SGDs must provide the information required in Appendix B to this Chapter of the Medicaid Services Manual (MSM).

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1303 POLICY

1303.1 DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTIC DEVICES, DISPOSABLE MEDICAL SUPPLIES (DMEPOS) PROGRAM

A. GENERAL INFORMATION

1. DMEPOS Program coverage areas include parenteral and enteral nutrition (PEN), medical foods, and oxygen and oxygen equipment; all of which must meet the definition of durable medical equipment, a prosthetic device, an orthotic device, or disposable medical supply.
2. Durable Medical Equipment (DME) of a medical nature, needed as a result of a medical condition, and which lasts a considerable time without significant deterioration and appropriate for use within the home, is covered by the Division of Health Care Financing and Policy (DHCFP) and Nevada Check Up (NCU) for eligible recipients. **New** equipment, repairs, or replacement requires medical documentation and **are** subject to limitations of model, cost and frequency, which are deemed reasonable by the program.
3. Disposable medical supplies are covered by the DHCFP and NCU for eligible recipients only if they are necessary for the treatment of a medical condition and would not generally be useful to a person in the absence of an illness, disability or injury.
4. All DMEPOS products and services must be medically necessary, safe and appropriate for the course and severity of the condition, using the least costly and equally effective alternative to meet the recipient's medical needs.
5. Deluxe equipment will not be authorized when it is determined **that** a standard model will meet the basic medical needs of the recipient. The recipient must have a medical need for each component of the item(s) requested. This includes accessory items and features not included in the standard models of the product.
6. Equipment which the program determines is principally for education or rehabilitation will not be approved.
7. Refer to Appendix A of this Chapter for non-covered services, and for special coverage considerations that are based on medical necessity outside of the DMEPOS Program or that is considered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids Program.

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8. Refer to Appendix B of this Chapter, for Coverage and Limitation Policies regarding specific coverage information, qualifications, documentation requirements, and miscellaneous information.
9. Refer to the Provider Type 33 DMEPOS Fee Schedule for specific item coverage under the DMEPOS program.
Access <http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain>.
10. The DHCFP does not reimburse for items that are the same or similar to items that the recipient has already acquired **or has access to** such as, but not limited to, back-up equipment, unless allowed in the specific policy for that item. Duplicate items intended to be used within the same span of time are not considered medically necessary.
11. Individuals deemed eligible for Nevada Medicaid or NCU and who have ownership of existing equipment from any prior resource must continue using that equipment. Existing equipment, regardless of who purchased it, must be identified, including the estimated date of purchase or age of equipment, and medical documentation showing evidence of need for replacement. All documentation must be submitted with a prior authorization request.
12. Some items not covered under the DMEPOS Program may be covered under other Medicaid programs such as Pharmacy, Audiology, or Ocular programs. Additional resources may be available through other agencies or through waiver programs for items not covered under the DMEPOS Program or by the Medicaid State Plan.

B. PROVIDER RESPONSIBILITY

1. All DMEPOS providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DMEPOS. Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program for further information on enrollment and provider responsibilities. Also refer to the Enrollment Checklist posted on the following website at: <https://www.medicaid.nv.gov>.
2. Suppliers of products covered under the Medicare Part B program are required to be enrolled in the Medicare Part B program in order to provide those services to Medicare and Medicaid dually eligible recipients. This includes obtaining and maintaining the Centers of Medicare and Medicaid Services (CMS) required accreditation and surety bond.

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3. Potential providers who are not enrolled with the Medicare Part B program and who will not be supplying products covered under the Medicare Part B program to individuals eligible for Medicare are required to provide a statement on/with their application that requests a waiver of the requirements for Medicare Part B enrollment. This statement must indicate that they do not service Medicare-eligible individuals and include a listing of the products they plan to supply.
4. A Medicaid-contracted DMEPOS provider may be reimbursed for services rendered to Medicaid eligible recipients when provided in accordance with established policies, guidelines and timeframes.
5. The provider is responsible for ensuring the equipment is appropriate for the recipient and the recipient's residence prior to billing the DHCFP.
6. The provider is responsible for providing a manufacturer's invoice of cost for certain items, where no rate has been established.
7. The DMEPOS provider must comply with additional requirements as specified throughout this Chapter and its Appendices, Medicaid Services Manual (MSM) Chapter 100, the Provider Type (PT) 33 DMEPOS Fee Schedule, the Provider Billing Manual, and DMEPOS Billing Guidelines.
8. The provider is responsible to teach the recipient, caregivers, or authorized representative(s) about the operation, proper use, maintenance requirements, and any unacceptable use of the medical equipment.

C. RECIPIENT RESPONSIBILITY

The eligible Nevada Medicaid or NCU recipient and/or their authorized representative will:

1. Make and keep appointments necessary for securing medical services/equipment;
2. Present current verification of Nevada Medicaid or NCU eligibility;
3. Present any forms or identification necessary to utilize other health insurance coverage;
4. Contact and return to the provider of services/equipment for any necessary adjustment within the time allotted for such adjustments;

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5. Maintain the equipment provided by routinely cleaning and caring for the devices according to user information and supplier's guidance. Provide safe, secure storage for item(s) when not in use to protect item(s) from loss or theft;
6. Not misuse, abuse or neglect purchased or rented item(s) in a way that renders the item(s) unsafe or non-usable;
7. Return all rented equipment to the DMEPOS provider when no longer being used, or upon the DME provider's request. Failure to return rented equipment could result in a recipient's financial responsibility for the retail price of the rented equipment, even if the equipment is lost/stolen, the recipient has moved, or they are no longer eligible for Nevada Medicaid/NCU.
8. Comply with additional requirements as specified throughout this Chapter and its Appendices and MSM Chapter 100.

1303.2 DOCUMENTATION REQUIREMENTS

- A. Supplier/provider records must substantiate the medical necessity for all DMEPOS items dispensed to recipients. The following describes the requirements for specific types of documentation associated with DMEPOS.

1. ORDERS / PRESCRIPTIONS

- a. All DME items, Prosthetics, Orthotics, or Disposable Supplies (POS) dispensed must have an order/prescription from the treating physician or practitioner, (To determine included practitioners, refer to MSM, Chapter 600 – Physician's Services), such as a Physician's Assistant (PA), or Advanced Practitioner of Nursing (APN), when within their scope of practice and in accordance with federal and state laws governing that entity, prior to dispensing the item.

In accordance with the Patient Protection and Affordable Care Act (PPACA) (The Affordable Care Act) of 2010 (Public Law 111-148), all orders for DMEPOS items, whether verbal or written, must be incidental/relevant to the treating physician-documented face-to-face encounter between the recipient and the prescribing physician/practitioner (as allowed by The Act) within 30 days prior to the start date of the order/script. The encounter must be clearly documented and relevant to the need for the prescribed DMEPOS.

Refer to Appendix B of this Chapter for additional order requirements on specific products.

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General standards of care/practice mandate that if an order is not clear, a clarification of the order must be obtained from the ordering practitioner prior to acting on it.

b. Verbal Orders:

1. Verbal orders from the prescribing physician/practitioner may be accepted for DMEPOS items that do not require prior authorization by the DHCFP (except when Medicare is primary and Medicaid co-payment will be requested, and Medicare requires a written order for that item prior to delivery). Refer online to the DME MAC Jurisdiction D Supplier Manual, Chapter 3 – Documentation Requirements, for a current listing of those items at: <https://med/noridianmedicare.com/web/jddme/education/supplier-manual>
2. The verbal dispensing order must include:
 - a. A description of the item;
 - b. The recipient's name;
 - c. The physician's name;
 - d. The start date and length of need of the order; and
 - e. Additional information sufficient to allow appropriate dispensing of the item.
3. Suppliers must maintain written documentation of the verbal order and, if the verbal order is used for dispensing the item, the supplier must obtain a detailed written order prior to billing the DHCFP.

c. Written Orders:

1. Written orders are acceptable for all transactions involving DMEPOS and must be obtained prior to submitting a prior authorization for any DMEPOS items. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original “pen-and-ink” document.
2. All written orders must, at a minimum:

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- a. Clearly specify the start date of the order;
 - b. Include the length of need;
 - c. Be sufficiently detailed, including all options or additional features that are needed to meet the recipient's needs. The description must be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number; and
 - d. Be signed and dated by the treating physician/practitioner. Signature includes computer signature and pen and ink, no signature stamps allowed.
3. Certain items require additional elements in the written orders, as follows:
- a. If the written order is for supplies that will be provided on a periodic basis, the written order must include appropriate information on the quantity used, frequency of change, and duration of need. (For example, an order for surgical dressings might specify one 4x4-hydrocolloid dressing that is changed one to two times per week for one month or until the ulcer heals).
 - b. If the written order is for an item such as, but not limited to, enteral formula, oxygen, etc., the order must specify the name of the product, concentration (if applicable), dosage, frequency and route of administration, and duration of infusion (if applicable).
 - c. Custom-fabricated items must be clearly indicated on the written order that has been signed and dated by the prescribing physician/practitioner.
4. There are additional specifications for orders for certain items, such as, but not limited to, Power Mobility Devices (PMDs). Refer to Appendix B for details.
5. The detailed description of the item(s) may be completed by an employee of the ordering physician/practitioner; however, the

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prescriber must review the detailed description and personally indicate agreement by signing and dating the order.

6. Medical necessity information (such as the most current appropriate diagnosis code(s) (ICD) diagnosis code, narrative description of the recipient's condition, abilities, and limitations) is not in itself considered to be part of the order although it may be put on the same document as the order.

d. New Orders Are Required When:

1. There is a change in the order of a specific DMEPOS item;
2. There is a change in the resident's condition that warrants a change in the order, a change in the treating physician/practitioner, or DMEPOS supplier;
3. An item is replaced for any reason; or
4. An ongoing unchanged order continues to be medically necessary one year after the original order (orders are only valid for up to one year, unless documented with a shorter length of time).

2. DETAILED PRODUCT DESCRIPTION

The detailed product description must contain the Healthcare Common Procedure Coding System (HCPCS) code, manufacturer, make and model, and the provider's/supplier's **invoice of cost** for each item supplied. The warranty information must also be included. This may be completed by the provider/supplier but **can** also be **documented** by the physician.

3. PROOF OF DELIVERY (POD)

A POD is a supplier's delivery receipt, which is dated and timed.

NOTE: Item(s) ordered must be delivered within 120 days of the date of the order.

4. ADDITIONAL MISCELLANEOUS MEDICAL RECORDS

The recipient's medical records must contain sufficient documentation of the recipient's medical condition to substantiate the necessity for the type and

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quantity of items ordered and the frequency of the use or replacement. The information must include the recipient's diagnosis and other pertinent information, including but not limited to: duration of recipient's condition, clinical course (deteriorating or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The records must include physician's office records, hospital, nursing home or home health records, records from other professionals including but not limited to: nursing, physical and occupational therapists, prosthetists and orthotists, although medical necessity for item(s) requested must be stated by the prescribing physician/practitioner.

5. ADVANCED DETERMINATION OF MEDICARE COVERAGE (ADMC)

When Medicare is the primary payer, for all items requiring an ADMC (refer online to the DME MAC Jurisdiction D, Supplier Manual, Chapter 9). The ADMC determination must be submitted to the Quality Improvement Organization (QIO)-like vendor at the same time the prior authorization is submitted.

B. PROVIDER RESPONSIBILITY

1. The provider must obtain the required documentation in a timely manner as described under each section listed previously.
2. The provider must maintain records at the physical location of their business for each item billed to, and paid by, the DHCFP for at least six years from the Remittance Advice (RA) date. At a minimum, this includes the original signed order/prescription, all supporting medical documentation, and proof of delivery.
3. The provider must maintain records in a readily accessible location and, for audit and investigation purposes, to make available upon request by Medicaid staff or its contractors, all supporting information related to prior authorizations, dispensed items, and/or paid claims for DMEPOS items.

1303.3 RENTAL AND PURCHASE OPTIONS

Items identified in the DMEPOS Fee Schedule with an **RR modifier** for rental and an **NU modifier** for purchase option **may** require prior authorization to determine if the recipient's needs justify rental or purchase based on the item prescribed, the individual's anticipated length of need and prognosis (as determined by the prescriber) and cost effectiveness to the DHCFP and NCU. **If a Nevada Medicaid rate has not been assigned, a manufacturer's invoice of cost is required to be submitted with the prior authorization (PA) request or claim, if a PA is not already required for that item.**

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A. RENTAL

1. In addition to all other requirements and qualifications for specific products, if the DMEPOS Fee Schedule allows a rental option, a device may be rented when:
 - a. the anticipated length of need (per physician's/practitioner's order) is short term (six months or less) and rental would be more cost effective than purchase;
 - b. a temporary trial period is required for the item according to Medicaid's policy;
 - c. the item is only available as a rental per the DMEPOS Fee Schedule; or
 - d. a temporary rental is needed while a recipient-owned like item is being repaired.
2. During a rental period, rental rates include all supplies and accessories necessary to render the equipment useable and safe, delivery and set up services, education and training for recipient and family, routine maintenance and servicing (such as testing, cleaning, regulating and checking equipment), repairs, non-routine maintenance and servicing (such as breaking down sealed components and performing tests which require specialized equipment and skills of a technician), and replacement of items. These services are the responsibility of the owner, the DMEPOS supplier.
3. Throughout any rental period, there must be an active physician's/practitioner's order for ongoing use, the prior authorization effective dates are still applicable, and there is a continued medical need for the item. The DMEPOS supplier must contact the recipient or their representative within five business days prior to each billing cycle to verify the rented item is still medically necessary, in working condition, and being used by the recipient (contact does not include system generated correspondence). Verification must be documented and maintained in the DMEPOS supplier's records and be accessible for audits.
4. Rent-to-Purchase Option:
 - a. The DHCFP allows rental of certain DMEPOS items up to the maximum Medicaid allowable purchase price of the item.
 - b. **Only certain equipment, as specifically defined by Medicaid, will be rental only.**

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Once the total cumulative payments have reached the maximum Medicaid allowable purchase rate, then the item is considered purchased in full and recipient-owned.

- c. The provider shall automatically transfer the title for the equipment to the recipient. Providers are not to submit prior authorization^s to transfer titles. Providers are also not to submit prior authorizations coded as a purchase after the Medicaid allowable purchase rate is reached. No rental or purchase payments will be made for the remaining reasonable useful lifetime of the device (usually not less than five years (60 months)). The provider's records must include the date the title was transferred to the recipient.
 - d. When an item was new at the time of issuance, and it is later determined the recipient will need the item long term, rental payments will be applied toward the total purchase rate (the Medicaid allowable **or if no Medicaid rate exists, the manufacturer's invoice of cost**). Refer to "Purchase Used Equipment Option" in Section 1303.
 - e. Equipment that was not new at the time of issuance, such as items from the provider/supplier rental fleet, supplied as a temporary short term rental item must be replaced with new equipment as soon as it is identified the recipient will need the device long term (no later than in the sixth month of rental). Payments made on rental fleet-type items will not be applied to the purchase price of a new item. Purchase or transfer of titles to recipients when the used equipment is from a rental fleet is not allowed.
 - f. For this option, non-routine maintenance and servicing or repairs may be covered for service dates after the item is owned by the recipient; no sooner than the month following the last rental month.
5. Rental Only Option:
- a. **Only specific equipment will be** identified by Nevada Medicaid as a rental only. For these items, a monthly rental will be allowed as long as the recipient continues to meet all qualifications and requirements, and the recipient continues to use the device.
 - b. For this option, the DMEPOS supplier retains ownership of the equipment, regardless of the length of rental. As the owner, the DMEPOS supplier is responsible to ensure the equipment remains in safe working condition for the reasonable useful lifetime of the device. The rental rates include all

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supplies and accessories, repairs including routine and non-routine maintenance and servicing, and replacement of items when needed.

B. PURCHASE

1. Purchase New Equipment Option:

- a. Certain products are identified by Nevada Medicaid in the DMEPOS Fee Schedule with a purchase option for new equipment, or can only be purchased, such as disposable supplies and custom-made items which can only be used by that recipient. These will be considered for purchase when, in addition to all other requirements and qualifications for a specific item/device:
 1. the anticipated length of need (per physician's order) is long term (more than six months); and
 2. the provider will be supplying a new device/item to the recipient; or
 3. the item is only available for purchase.

2. Purchase **Rental** Equipment Option:

- a. **Nevada Medicaid identifies specific** products for purchase when an item was new at the time it was dispensed to a recipient for rental purposes, and prior to billing the third month of rental, **if** it is determined the item will be needed indefinitely, the DHCFP may purchase the item for the recipient for ongoing use. The DHCFP does not purchase used equipment from the provider's inventory of rental items used for re-issuance to same or multiple persons over time (rental fleets, etc.).
- b. The DHCFP will only purchase equipment when, in addition to all other requirements and qualifications for the item:
 1. the recipient meets the criteria for purchase of new equipment;
 2. the item was new when placed in the recipient's use and has been used for less than three months; and
 3. the item is currently being used by the same recipient during a trial period and it has been determined the length of need will now be indefinite.

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- c. A prior authorization must be submitted to request purchase of a **rented piece of equipment** with all supportive medical documentation to show the date the item was initially issued to the recipient and that the recipient continues to have an ongoing need for the item.

1303.4 PRIOR AUTHORIZATION

A. Prior authorization is a review conducted by the Quality Improvement Organization (QIO)-like vendor’s medical professionals who review the prior authorization form and any additional information submitted to evaluate medical necessity, appropriateness, location of service, and compliance with the DHCFP’s policy, prior to delivery of service. Reference the MSM, Chapter 100 and the general Billing Manual for detailed information on prior authorizations and Medicaid eligibility for all providers at: <http://www.medicaid.nv.gov/providers/BillingInfo.aspx>.

1. Submission:

- a. Prior authorizations must be completed and submitted by a current Medicaid provider (requestor), and the approval must be received, prior to delivery of services. The exception to this is if the recipient is determined eligible for Medicaid retroactively or if number four of this section applies.
- b. A prior authorization is required for most durable medical equipment, prosthetics, orthotics, and oxygen.
- c. A Medicaid provider may submit the prior authorization electronically using the QIO-like vendor’s on-line prior authorization system or may fax or mail the prior authorization to the QIO-like vendor. For more information, refer to the prior authorization section posted at: <https://www.medicaid.nv.gov>.
- d. Requestors must submit a prior authorization with the most appropriate HCPCS code available and may not unbundle items included in the HCPCS code description. If an item has a designated code available, the miscellaneous code cannot be used. Providers may contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor, or the DME MAC for guidance on correct coding.
- e. Documentation requirements are the same regardless of which mode of submission is used (e.g. the on-line prior authorization system, faxed, or mailed). Documentation submitted for consideration of the request must include the physician’s order and must clearly support coverage

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qualifications and recipient's medical need for the equipment. Failure to provide all of the supporting medical documentation in its entirety, and within the required timeframes, will result in a denial of the prior authorization request, regardless of mode of submission.

- f. Unless otherwise stated in policy, a prior authorization may be submitted to request authorization to exceed established quantity limitations when the medical documentation supports medical necessity for the increased quantity or frequency.
2. Review Consideration:
 - a. In addition to the specifications mentioned previously, for reviewing the prior authorization, products and services must be medically necessary, safe and appropriate for the course and severity of the condition using the least costly equally effective alternative to meet the recipient's needs.
 - b. The recipient must have a medical need for, and the requested item must be suitable for use within the home. Consideration will also be based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: attending school, work, and shopping. This information must be included in the supportive documentation submitted with the prior authorization.
 - c. For durable medical equipment, prosthetics, orthotics, and disposable medical supplies and appliances where coverage and limitation policies have not been established within this Chapter or its Appendices, the DHCFP may defer to DME MAC Jurisdiction D, Local Coverage Determination (LCD) and policy articles for coverage and limitation criteria. These can be accessed at: <https://med.noridianmedicare.com/web/jddme>. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply and must be necessary to meet the medical needs of the recipient, and must be part of the prescribing physician's/practitioner's Plan of Care (POC).
 - d. The DHCFP has the option of requesting an Independent Medical Evaluation (IME) to determine the recipient's limitations and abilities to support medical necessity.
 3. Prior Authorization Requirements for Third Party Liability (TPL) and Medicare Crossovers:

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- a. Refer to MSM, Chapter 100, for more information on TPL, and Medicare Crossovers and the requirements for securing prior authorizations.
4. Prior Authorization Emergency Situations:
 - a. In an emergency situation, when an order is received by the supplier after the QIO-like vendor working hours or over weekends or State holidays, dispensing of a 72-hour supply of those DMEPOS items that require prior authorization will be allowed only when:
 1. A delay of 24 hours of 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; and
 2. The treating physician/practitioner indicates the most current appropriate diagnosis code(s)/ICD code on the prescription that supports the use of the emergency policy.
 - b. The provider/supplier must submit the prior authorization the next business day with all required supportive documentation. The documentation must include proof of the date and time the order was received by the supplier and documentation to support both 1303.4(a)(1) and (2).
 5. DMEPOS Specific Prior Authorization Forms:

All forms must be completed and submitted by a current Medicaid provider. Forms used must be the most current version.

 - a. All Forms and Form Release Memorandums or instructions may be accessed at the DHCFP's website: <http://dhcfnv.gov/>. The instructions provide detailed guidance on form completion requirements.
 - b. Specific DME prior authorization forms are found on the QIO-like vendor's website: <https://www.medicaid.nv.gov/providers/forms/forms.aspx>. All DMEPOS items that require prior authorization must be requested on these forms and submitted electronically, by fax or by mail to the QIO-like vendor for approval.
 - c. Usage Evaluation – For Continuing Use of Bi-Level and Continuous Positive Airway Pressure (BIPAP and CPAP) Devices use the form, found

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on the QIO-like vendor's website. This form may be completed and submitted for continuing usage of BIPAP or CPAP devices.

- d. Mobility Assessment for Mobility Devices, Wheelchair Accessories and Seating Systems, form found on the QIO-like vendor's website. This form must be submitted for all mobility devices, wheelchair accessories and seating systems. **The Clinical Assessment must be completed and signed by the treating physician.**

6. Denied Prior Authorization Requests:

- a. There are various processing levels associated with prior authorization requests which do not support medical necessity. These may include, but are not limited to: a contact to the provider by the QIO-like vendor, a system generated technical denial, a system generated denial or reduction of services, a provider-requested reconsideration, a provider-requested peer-to-peer review with the physician. For **additional** information on **the below** time limits and an explanation of each, refer to the general Billing Manual for all providers at:
<https://www.medicaid.nv.gov/providers/billinginfo.aspx>.

- 1. If a prior authorization request is denied or reduced, the provider and recipient will be sent a Notice of Decision (NOD) with a citation/reason to provide a general explanation of the denial.
 - A. **The provider may request a peer-to-peer review within 10 days of the date of decision via phone contact to the fiscal agent.**
 - B. The provider may request consideration of the denial by submitting additional **medical documentation** and requesting a **reconsideration in writing via fax within 30 days of denial.**
 - C. If a reconsideration is not appropriate or is also denied, the recipient may be entitled to request a hearing **within 90 days from the date of decision.** Refer to MSM Chapter 3100 – Hearings.

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B. COVERAGE AND LIMITATIONS

1. Coverage and limitations are explained throughout this Chapter, including its appendices. Appendix B details coverage qualifications, prior authorization documentation requirements, and limitations for specific items.
2. Refer to the Nevada Medicaid Provider Type 33 – DME Fee Schedule posted at: <http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/> for covered services. The Fee Schedule identifies covered services/items (listed in alpha-numeric order according to HCPCS code), and rates. Codes are updated yearly. Codes not included in the fee schedule after the yearly update are considered non-covered.

C. PROVIDER RESPONSIBILITY

1. The requesting DME provider (supplier) and the prescribing physician/practitioner must work collaboratively to accurately and timely complete and submit prior authorization requests, including all supportive documentation in order to ensure the item(s) being requested is/are the most appropriate to meet the recipient’s medical needs. This must be done prior to dispensing any DMEPOS item requiring a prior authorization. Refer to the prior authorization section of the general Billing Manual for all providers at: <https://www.medicaid.nv.gov/providers/BillingInfo.aspx> for detailed information on form completion and submission/transmission of prior authorization requests.
2. In the event additional information is requested by the QIO-like vendor, the provider should submit the requested information within established time limits, and/or review the notice of decision to determine the reason for denial, make any necessary corrections, continue to work collaboratively with the prescribing physician/practitioner to obtain medical justification, and/or when appropriate, request a reconsideration by providing additional supportive information to justify the medical need for the equipment. Refer to the general Billing Manual for all providers for details on denied requests.

D. RECIPIENT RESPONSIBILITY

1. The recipient and/or their representative must accurately represent their needs in relationship to obtaining medical equipment.
2. The recipient must attend appointments with Physical Therapy (PT), Occupational Therapy (OT), and/or physician/ practitioners for the purpose of evaluation for DMEPOS, and with DME providers for adjustments and servicing of equipment.

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3. The recipient and/or representative must provide the written order/prescription from the physician/practitioner. If assistance is needed to obtain DMEPOS, the recipient or their authorized representative should contact the local Nevada Medicaid District Office Care Coordination unit for assistance. The exception to this is if the ordering physician/practitioner submits the information directly to the DME provider/supplier on behalf of the recipient.
4. The recipient and/or their authorized representative must present proof of identity and provide documentation of Medicaid coverage and any form of identification necessary to utilize other health insurance coverage.

1303.5 DISPENSING AND DELIVERY OF DMEPOS

A. Dispensing/Duration of Orders

Medical supply orders must be dispensed at a monthly interval. DMEPOS is dispensed according to the physician's orders, subject to coverage limitations. The physician's order for medical supplies is valid up to one year. Suppliers may not ship items on a regular, monthly basis without documentation from the recipient, family member, or authorized representative that the supply is needed. Documentation of this need must be kept on file. It is acceptable for the supplier to contact the recipient to verify a re-order.

B. Delivery of DMEPOS

1. Delivery Method 1. Supplier delivering items directly to the recipient or authorized representative:
 - a. The delivery receipt must include the signature and the signature date which must match the date the DMEPOS item was received by the recipient or their authorized representative to verify the DMEPOS item was received.
 - b. The delivery receipt must include the recipient's name, quantity, a detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable), and date and time of delivery.
 - c. The date of service on the claim must be the date the DMEPOS item was received by the recipient or their authorized representative. An exception to this would be when an item must be billed using a date span and the quantity dispensed crosses over into the next month.
2. Delivery Method 2. Suppliers utilizing a delivery/shipping service to deliver items:

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- a. An acceptable delivery/shipping service receipt POD includes the supplier's shipping invoice (Bill of Lading (BOL or BL)).
- b. The supplier's BOL must include the recipient's name, quantity, detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable), date and time of delivery/shipment, and delivery service package identification number associated with recipient's package(s).
- c. The POD must reference the recipient's package(s), delivery address, and the corresponding package identification number given by the delivery service.
- d. Without the POD that identifies each individual package with a unique identification number and delivery address, the item will be denied and any overpayment will be recouped.
- e. Nevada Medicaid only reimburses out-of-state providers for mail order supplies for a recipient who is on Medicare and the supply is Medicare covered. Nevada Medicaid does not reimburse for shipping or delivery service costs.

1303.6 REPAIR, REPLACEMENT AND WARRANTY OF EQUIPMENT

A. REPAIR

1. Repair means to fix or mend a non-functioning part of equipment and to return damaged or worn equipment back to a safe operating condition. Repair of an item may be appropriate when the anticipated lifetime of the base equipment (usually not less than five years) has not been exceeded and repair of the item is more cost effective than replacement.
2. Reimbursement to the provider may be made for repairs of recipient-owned medically necessary equipment. Medical documentation by the prescribing practitioner must be submitted to support the recipient's ongoing medical necessity for the item needing repair. Additionally the prior authorization must substantiate the absence of misuse, negligence, malicious involvement or wrongful disposition on the part of the recipient, their legal representative, or their caregivers. It must indicate the equipment was being used appropriately in a manner prescribed or recommended. The prior authorization and claim must include HCPCS modifier RB for all DMEPOS parts furnished as part of the repair.

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3. If a recipient-owned piece of medically necessary equipment requires repairs that will take more than a day and the recipient needs the device while the repairs are being performed, the provider must submit a prior authorization to request temporary (up to one month) rental of an equivalent item which can meet the recipient's basic medical needs while the recipient-owned item is being repaired.
4. Repairs to equipment owned or rented by a DMEPOS provider or an institutional facility in which the recipient is receiving services will not be covered by Nevada Medicaid or NCU.
5. Repair HCPCS codes are not to be used for: routine servicing, cleaning, installation, delivery, set-up, travel necessary to make a repair, or for services covered by warranty as these costs are included in the cost of the item.
6. A re-manufactured part with a warranty used to make a repair is considered used equipment and must be billed as such, using the HCPCS modifier UE.

B. REPLACEMENT

1. Replacement of recipient-owned equipment refers to the provision of an identical or nearly identical item. Replacement may be considered on a case-by-case basis when prior authorization request substantiates the need for the replacement and is a result of either:
 - a. Irreparable Wear: due to significant deterioration sustained from day-to-day use over time and a specific event (as indicated below) cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the useful lifetime of the equipment which is usually not less than five years. The prior authorization must substantiate the absence of negligence and/or malicious involvement on the part of the recipient, their legal representative, or their caregiver, and that the equipment was being used appropriately. Intentional utilization of DME in a manner not prescribed or recommended, such as an excessive form of transportation may be reason for denial of equipment replacement - see misuse listed in Definitions of this chapter.
 - b. Irreparable Damage: due to a specific accident or natural disaster (e.g., fire, flood) which resulted in irreparable damage or loss. These requests may be considered only when the prior authorization request includes a copy of a police or fire report, documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or a newspaper article that indicates the recipient's residence was affected by the disaster. Police or fire reports will only be considered if filed/dated within ten

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business days of the loss. The prior authorization must substantiate the absence of negligence and/or malicious involvement on the part of the recipient, their legal representative or their caregiver, and that the equipment was being used appropriately. The prior authorization and claim must include HCPCS modifier code RA for all DMEPOS provided as a replacement. Nevada Medicaid and NCU are payers of last resource and would be secondary to any insurance claim/reimbursement. Reference MSM Chapter 100 – Medicaid Program.

2. Replacement of any recipient-owned item, regardless of how it was originally acquired, requires a new physician's/practitioner's order and the recipient must meet current qualifications for the item. Any assessment(s) necessary to support medical necessity must have been completed within six months of the date of request.
3. Lost or stolen DMEPOS resulting from failure to maintain possession or properly secure the item is not covered by Nevada Medicaid or NCU.

C. WARRANTY

1. The purchase of many items includes a product warranty by the manufacturer and/or the DMEPOS provider. Any service (item or labor) covered by warranty cannot be billed to Nevada Medicaid or NCU, the recipient, or their representative.
2. The requesting provider must obtain verification that any repairs or replacement items being requested are not covered under the existing warranty. This documentation must be submitted with the prior authorization.

1303.7 SECTION RESERVED FOR FUTURE USE

1303.8 SECTION RESERVED FOR FUTURE USE

1303.9 DME AT INSTITUTIONAL FACILITY (IF)

- A. The DHCFP's hospital and nursing facility rates for an inpatient stay are all inclusive and cover all items needed by the patient during the length of stay. **Refer to MSM Chapter 500 Nursing Facilities for information on nursing facility policy.** This includes all:
 1. Disposable supplies;
 2. Wound care supplies;

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3. Urological supplies;
4. Respiratory supplies;
5. Metabolic, Nutritional and Temperature supplies;
6. Endocrine supplies;
7. Fluid and Electrolyte supplies;
8. Dental supplies;
9. Emollient supplies; and
10. Supplements.

B. Prosthetics and Orthotics

Prosthetics and Orthotics: Are included in the all inclusive per-diem if provided to a patient during an inpatient hospital prior to discharge and the patient uses item for medically necessary inpatient treatment or rehabilitation. (e.g. after spinal surgery).

C. DME that cannot be utilized by another recipient due to its unique custom features (e.g. seating system), are not part of the institution's inclusive rate.

1. All DME must be prior authorized for exception to inclusive facility rates.
2. Hospital and nursing facility patients may be approved for wheelchairs in preparation for discharge. The DHCFP may approve power chairs one month in advance of discharge. Physician documentation to substantiate discharge date may be required.
3. Specialized or custom-made items, which will be needed by the patient upon discharge may be requested during the inpatient stay. However, approval of the items may be restricted to delivery to the patient at the time of discharge to his home or other place of residence. Providers of requested items will be paid directly only if the required prior authorization has been approved. Facilities will not be paid for items supplied by another provider.

1303.10 SECTION RESERVED FOR FUTURE USE

1303.11 SECTION RESERVED FOR FUTURE USE

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1303.12 SECTION RESERVED FOR FUTURE USE

1303.13 SECTION RESERVED FOR FUTURE USE

1303.14 SECTION RESERVED FOR FUTURE USE

1303.15 UTILIZATION CONTROL

A. Pre-Service

The coverage, limitations and exclusions outlined in this chapter constitute pre-service controls on over-utilization.

B. Pre-Payment

The QIO-like vendor will screen each claim for existence and/or application of prior resources, correct coding of services, and appropriate authorization form. In addition, each claim will be screened for accuracy in computation and compliance with published procedures.

C. Post-Payment

All providers offering services to Medicaid recipients are subject to post-payment review. The Medicaid Program Integrity Section is responsible for review of any improper, abusive, or fraudulent practices. Definition of abuse and the sanctions to be imposed are delineated in the Nevada MSM, Chapter 100.

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1304 HEARINGS

Please reference the Division of Health Care Financing and Policy (DHCFP) Medicaid Services Manual (MSM), Chapter 3100 for the Medicaid Hearings process.

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APPENDIX A

NON-COVERED SERVICES

1. The Division of Health Care Financing and Policy's (DHCFP's) Durable Medical Equipment, Prosthetics, Orthotics, and Disposable Supplies (DMEPOS) program does not cover the following items as they either do not meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supplies; or are not considered primarily medical in nature. This list is not all-inclusive and may be revised periodically:

- **Equipment used for physical fitness or personal recreation, such as but not limited to:**

- Bicycles/tricycles
- Electronic devices primarily designed for entertainment
- Exercise equipment
- Hot tubs or Jacuzzis
- Personal computers
- Playground equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses)
- Printers
- Pulse tachometers
- Swimming equipment (such as earplugs)
- Tape recorders
- Tennis/gym shoes
- Video recorders or DVD players

- **Personal care or hygiene products, such as but not limited to:**

- Car Seats
- Dental care supplies (toothbrushes, toothpaste, dental floss and toothettes)
- Disposable gloves (non-sterile and sterile)
- Disposable wipes (includes baby wipes and Attends-type wash cloths)
- Enuresis or bed-wetting alarms
- Feeder seats**
- Feeding instruments – tableware and/or baby bottles
- First aid products
- Floor sitters**
- Foam cushion pads
- Food - table foods (with exception of medical foods as defined in Appendix B)
- Glasses (magnifying or reading)
- Heat and massage aids
- Ice packs (disposable)
- Massage devices
- Medical alert bracelets/jewelry
- Menses products
- Scales (bathroom, kitchen, food, or diet)

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Strollers (exception: pediatric wheelchair type classified as a medical device by SADMERC, with a HCPCS code)

Thermometers and covers

Travel, activity, or corner chairs

- **Household items, such as but not limited to:**

Air conditioners (includes swamp coolers)

Appliances (microwave, cutting boards or other adaptive equipment for cooking, cleaning, etc.)

Food blenders

Furniture

High chairs

Humidifiers or dehumidifiers (room type or central)

Lift chairs

Orthopedic mattresses

Overbed tables

Safety/Canopy Beds

Telephones (and related items: answering machines, telephone alert systems, or telephone arms)

Vaporizers

Waterbeds

- **Household equipment and supplies/Home or Vehicle modification equipment, such as but not limited to:**

Ceiling fans

Elevators

Home security systems

Intercom monitors

Medical alert systems

Motorized lifts for vehicle

Power door openers

Ramps or wheelchair ramps

Trays

Stair lifts

Switches

- **Environmental products such as but not limited to:**

Air filters

Conditioners

Hypoallergenic bedding and linens

Purifiers

- **Miscellaneous:**

Erectile Dysfunction equipment and supplies

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2. The DHCFP has the authority to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396(a)) based on such criteria as medical necessity or utilization control (42 CFR 440.230 (d)). The DHCFP has an approved list of covered DMEPOS items. The Provider Type 33 – DMEPOS Fee Schedule is available on the DHCFP website at: <http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/>.
 - a. The DHCFP is required to have a process and criteria for seeking modifications or exceptions to established coverage policies. This process is available to recipients on a case-by-case basis for DMEPOS items excluded from the DMEPOS Fee Schedule. Because a provider prescribes, orders, and/or recommends a service or supply does not, of itself, make it an eligible benefit.
 - b. Consideration will be made on a case-by-case basis using the following criteria:
 1. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply as defined in Section 1302 – the Addendum Medicaid Services Manual (MSM) Definitions;
 2. The prescribing physician/practitioner must submit supporting documentation identifying the individual’s specific medical needs that meet the standard definition of medical necessity as defined in MSM Chapter 100 (e.g. physical assessment indicating the limitations to be ameliorated by the use of the item(s), peer review documentation indicating this is an accepted standard of care within Nevada’s medical community); and
 3. The prescribing physician/practitioner must document that other items have been used and were found ineffective. The requested item(s) must be the most cost-effective alternative, medically necessary service, provided at the most appropriate level to meet the medical needs of the recipient, that it is reasonable and accessible to the recipient.

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Policy: INTRODUCTION AND GENERAL INFORMATION		
Introduction		
<p>1. Appendix B is a supplement to the main body of Chapter 1300 and provides: specific coverage qualifications, forms and documentation requirements, and miscellaneous policies related to specific items of durable medical equipment, prosthetic devices, orthotic devices, or disposable medical supplies (DMEPOS).</p> <p>2. For DMEPOS where coverage and limitations have not been addressed in this Chapter, its Appendices, or the DMEPOS Fee Schedule, the Division of Health Care Financing and Policy (DHCFP) may defer to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction D, Local Coverage Determinations (LCD) and Policy Articles for coverage and limitations information. This information is available at https://www.noridianmedicare.com.</p>		
QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
<p>1. Qualifications identified for each specific item listed within this Appendix must all be met for coverage by the DHCFP.</p> <p>2. If all qualifications are not met, refer to Appendix A for other possible coverage options.</p>	<p>1. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional form completion requirements are found in the Form Release Memorandums or Instructions on the QIO-like vendor's website at: http://www.medicaid.nv.gov/providers/forms/forms.aspx</p> <p>2. All documentation, reports, evaluations and testing must support medical necessity as specified under the Qualifications section. Requirements must be met for each specific item listed within this Appendix and as specified for that item.</p> <p>a. Physician's/Practitioner's Order/Prescription.</p> <p>b. Prior authorization form (when indicated) - Durable Medical Equipment Prior Authorization Forms are available on the QIO-like vendor's website at the above link. There are specific forms for certain items of DMEPOS. Refer to policies to determine if a specific form is required. Prior authorization is required to exceed program limitations.</p> <p>c. All services provided in an institutional facility require a prior authorization.</p> <p>d. Detailed Product Description.</p> <p>e. Proof of Delivery.</p> <p>f. Additional Miscellaneous Medical Records.</p> <p>g. Manufacturer's Invoice of cost (to determine pricing) for certain items, where the DHCFP rate has not been established. A Manufacturer's Suggested Retail Price invoice will not be accepted.</p>	<p>Refer to the main body of Chapter 1300 for general DMEPOS policies.</p> <p>1. For all items, documentation must support all criteria in the Qualifications section, as specified in each category.</p> <p>2. Providers must submit an approved prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description.</p> <p>3. Rented devices are to be considered purchased by the DHCFP once the purchase price has been reached. The exception to this is when the item is deemed as a rental only by the DHCFP. Refer to main body of Chapter 1300 and the DMEPOS Fee Schedule.</p> <p>4. Inclusion of a HCPCS code in this Appendix is not an indication of coverage. Refer to the DMEPOS Fee Schedule and Appendix A.</p> <p>5. The DHCFP will not reimburse providers who supply DMEPOS prior to PA approval except in certain situations, such as retro eligibility.</p>

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Policy: BATHING AND TOILETING AIDS			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Commodes-standard Commode pail Toilet Safety Frame- (versaframe) Raised Toilet Seat Bed Pan-plastic Urinal	<ol style="list-style-type: none"> 1. Medical evidence/ documentation recipient is physically incapable of utilizing regular toilet facilities; and 2. Recipient has a supporting diagnosis. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 	
Shower Chairs (with back and without back) Tub Transfer Bench (padded and non- padded)	<ol style="list-style-type: none"> 1. Recipient shows medical evidence/ documentation of incapability to utilize regular bathing facilities; and 2. Recipient has a supporting diagnosis. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 	

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MEDICAID SERVICES MANUAL

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COVERAGE AND LIMITATIONS POLICIES

Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
<p>Fixed Height Hospital Bed</p> <p>Variable Height Hospital Bed (Manual)</p> <p>Semi-Electric Hospital Bed</p> <p>Heavy Duty Extra Wide Hospital Bed</p> <p>Extra Heavy Duty Hospital Bed</p>	<p>Medical evidence/documentation showing:</p> <ol style="list-style-type: none"> 1. Recipient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition lasting at least one month; 2. Alleviation of pain due to positioning of the body in ways not feasible with an ordinary bed; 3. Elevation of the head more than 30 degrees due to a medical condition, i.e.: Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), aspiration problems. <p>Recipient meets the criteria for Fixed Height Bed and requires a bed height different than a fixed height bed to permit transfers to chair, wheelchair or standing position.</p> <p>Recipient meets the criteria for a Fixed Height Bed and requires frequent changes in body position and/or has an immediate need for a change in body position.</p> <p>Recipient meets the criteria for a Fixed Height Hospital Bed and the recipient's weight is more than 350 pounds, but does not exceed 600 pounds.</p> <p>Recipient meets the criteria for a hospital bed and the recipient's weight exceeds 600 pounds.</p>	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An Invoice of Cost if there is no rate established by the DHCFP. 	<p>NOTE:</p> <p>Total Electric Hospital Beds are non-covered; the electric height adjustment feature is a convenience feature.</p> <p>Safety Beds/Enclosure Beds/Canopy are primarily intended for prevention of injury and use is not primarily medical in nature. Per policy, medically necessary services and supplies are medically needed to diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. Although these beds may prevent injury, they are not considered care or treatment of disease or injury, and are therefore not considered medically necessary.</p>

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Trapeze Bars	<ol style="list-style-type: none"> 1. Medical evidence/documentation recipient needs assistance to sit up due to respiratory conditions, change body positions, or to assist in transfers in/out of bed. 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 	
Lifts and Lift Slings	<ol style="list-style-type: none"> 1. Medical evidence/documentation showing the recipient requires more than one person in assisting in transfers from bed/bath, bed/commode, or bed/chair. 2. Must have an environment able to accommodate equipment. 3. Capable caregiver to assist with transfers. 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	
Group 1 Support Surfaces	<p>Recipient must meet the following criteria:</p> <ol style="list-style-type: none"> 1. Completely immobile (recipient cannot make changes in body position without assistance); 2. Limited mobility (recipient cannot independently make changes in body position significant enough to alleviate pressure); or 3. Any stage pressure ulcer on the trunk or pelvis; and <ol style="list-style-type: none"> a) At least one of the following: <ol style="list-style-type: none"> i) Impaired nutritional status; ii) Fecal or urinary incontinence; iii) Altered sensory perception; iv) Compromised circulatory status. 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed PA Form. 2. Medical documentation supporting qualifying factors. 	Product needs to be adequate enough to prevent the recipient from bottoming out.

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Pressure Pad For Mattress: Non-Powered Pressure Reducing Mattress Overlays	(E0185) Gel/gel-like mattress overlay, with gel layer 2 inches or greater (E0197) Air mattress overlay interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump. (E0198) Water mattress overlay with a filled height of 3 inches or greater. (E0199) Foam mattress overlay with base thickness of 2 inches or greater and a peak height of 3 inches or greater if it is a convoluted overlay (egg-crate) or an overall height of at least 3 inches if it is a non-convoluted overlay. Foam with a density and other qualities that provide adequate pressure reduction, and durable waterproof cover. 1. Recipient must meet group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	
Non-Powered Pressure Reducing Mattress	(E0184) Foam height of 5 inches or greater, and foam with a density and other qualities that provide adequate pressure reduction, and can be placed directly on a hospital bed frame. (E0186, E0187, E0196) Air, water or gel mattress, height of 5 inches or greater of the air, water or gel layer (retrospectively), and durable, waterproof cover and can be placed directly on a hospital bed frame. 1. Recipient must meet group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Powered Pressure Reducing Mattress Overlay Systems	(E0181, E0182, A4640) Alternating pressure or low air loss systems; Air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for APP overlays) and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out. Recipient must meet group 1 support surfaces criteria for qualification.	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	
Group 2 Support Surfaces	Recipient must meet the following criteria: <ol style="list-style-type: none"> 1. Multiple stage II pressure ulcers located on the trunk or pelvis; 2. Recipient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface. <ol style="list-style-type: none"> a. Treatment includes patient/caregiver education, regular assessment by a licensed healthcare practitioner, appropriate turning and positioning, appropriate wound care, appropriate management of moisture/incontinence, nutritional assessment and intervention consistent with the overall plan of care; and 3. Ulcers have worsened or remained the same over the past month; <u>OR</u> 4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis; <u>OR</u> 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) Group 2 Support Surfaces	within the past 60 days); and 6. Recipient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).		
Powered Pressure Reducing Mattress	(E0277) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear. Can be placed directly on a hospital bed frame. (E0193) Describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics previously defined. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Non-Powered Pressure Reducing Mattress Overlay	(E0371) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevents bottoming out, and total height of 3 inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 surfaces. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	

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Powered Pressure Reducing Mattress Overlay	(E0372) Low air loss, powered flotation without low air loss, or alternating pressure which is characterized by all of the following: Air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear. 1. Recipient must meet criteria for Group 2 support surfaces.	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	
Advanced Non-Powered Pressure Reducing Mattress	(E0373) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevents bottoming out, and total height of 5 inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and can be placed directly on a hospital bed frame. 1. Recipient must meet criteria for Group 2 support surfaces.	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Group 3 Air-fluidized Bed	<p>(E0194) Device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.</p> <ol style="list-style-type: none"> 1. Recipient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore; 2. Is bedridden or chair bound as a result of severely limited mobility; 3. In the absence of an air fluidized bed, the recipient would require institutionalization; 4. Ordered in writing by recipient's attending physician after comprehensive assessment and evaluation after completion of conservative treatment. Evaluation performed within one month prior to indication of therapy with air fluidized bed; 5. Conservative treatment must have been at least one month in duration without progression toward wound healing. Treatment should include: <ol style="list-style-type: none"> a. Frequent repositioning of recipient (usually every 2 hours); b. Use of group 2 support surface; c. Necessary treatment to resolve any wound infection; d. Optimization of nutrition status to promote wound healing; e. Debridement by any means, including wet-to-dry gauze dressings to remove devitalized tissue from the wound bed; f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering while the wound heals; 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	

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(continued) Group 3 Air-fluidized Bed	<ul style="list-style-type: none"> g. Education of the recipient and caregiver on the prevention and management of pressure ulcers; h. Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly; and i. Appropriate management of moisture /incontinence. <p>6. Trained adult caregiver is available to assist the recipient with ADL's, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage;</p> <p>7. A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; and</p> <p>8. All other equipment has been considered and ruled out.</p>		

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Policy: COMMUNICATION DEVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
<p>Speech Generating Device (SGD) <i>(also known as Augmentative Communication Device (ACD) or Augmentative and Alternative Communication (AAC) Device</i> (E2500 – E2510)</p> <p>Digitized Speech Devices: (E2500, E2502, E2504, E2506)</p> <p>Synthesized Speech Devices: (E2508, E2510)</p>	<ol style="list-style-type: none"> 1. A dedicated speech generating device (SGD) may be covered when it is medically necessary to restore the function of speech to an individual with a functional disability caused by a long term (lasting more than one year) and severe speech impairment; and 2. When all of the following are met: <ol style="list-style-type: none"> a. The recipient has had a formal written evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP) which contains all of the items specified in the Forms/ Documentation column; b. The recipient's medical condition is one resulting in a long term (lasting more than one year) and severe expressive speech impairment; c. The recipient's speaking needs cannot be met using natural communication methods; d. Other forms of treatment have been considered and ruled out; e. The recipient's speech impairment will benefit from the device ordered; and f. A copy of the SLP's written evaluation and recommendation was forwarded to the recipient's treating physician / practitioner and the prescribing physician / practitioner agreed with, and ordered the specific device and accessories as recommended. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 2. Prior Authorization. 3. Detailed Product Description. 4. Additional Miscellaneous Medical Records (if needed); and: 5. Speech and Language Pathologist (SLP)'s formal written evaluation which includes, at a minimum, all of the following: <ol style="list-style-type: none"> a. Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment; b. An assessment of whether the recipient's daily communication needs could be met using other natural modes of communication or with low-technology devices; c. A description of the functional communication goals expected to be achieved and treatment options; d. Rationale for selection of a specific device and any accessories; e. Demonstration that the recipient possesses a treatment plan that includes a training schedule for the selected device; f. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate; and g. An attestation statement from the SLP performing the recipient evaluation and/or recommending the product(s) indicating they are not an employee of, 	<ol style="list-style-type: none"> 1. For all items, documentation must support all criteria in the Qualifications section. 2. Providers must submit prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description. 3. Codes E2500 – E2510 perform the same essential function - speech generation and may not be issued in conjunction with E2511. 4. Code E2511 – SGD software program for Personal Computers (PC) or Personal Digital Assistant (PDA) may not be issued in conjunction with E2500 – E2510. 5. Computer-based and PDA-based AAC devices/speech generating devices are covered when they have been modified to run only AAC software and will not be reimbursed in conjunction with another SGD. Laptop computers, desktop computers, personal digital assistants (PDAs), tablets or other devices that are not dedicated SGDs do not meet the definition of durable medical equipment (DME) and are therefore non-covered. 6. Expected lifespan of SGD E2500-E2510 or E2511 is considered 60 months and are limited accordingly. Replacement equipment may be authorized prior to the 60 months based on medical necessity.

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(continued) Speech Generating Device (SGD)		<p>and have no financial relationship with the supplier/manufacturer of the SGD.</p> <p>h. For a subsequent upgrade to a previously issued SGD, documentation must support the medical necessity regarding the functional benefit to the recipient of the upgrade compared to the initially provided SGD.</p> <p>i. SLP evaluations and recommendations should consider recipient's needs both at present and over the useful lifespan of the device being recommended.</p> <p>6. Prior authorizations for synthesized speech output SGDs and digitized speech output SGDs with dynamic displays must include the software required for operation of the device. Any requests for supplemental software for a synthesized speech output SGD must be established as specifically medically necessary.</p> <p>7. Prior authorizations for digitized speech output SGDs with static displays must identify the symbol set that will be used to operate the device.</p> <p>8. For all products and accessories, the Manufacturer's Invoice of cost which includes: name of product, make, model, HCPCS code, and cost.</p>	<p>The recipient's condition and product performance will be taken into review.</p> <p>7. Refer to Section 1303.4 for exceptions to quantity and frequency limitations. Refer to section 1303.6 for policy regarding lost, stolen, or damaged equipment.</p> <p>8. Reimbursement for codes E2500, E2502, E2504, E2506, E2508 and E2510 is intended to include all applicable software programs (whether they are on the device when shipped by the manufacturer or added by the supplier prior to delivery) necessary to render the device operational, batteries, battery chargers and AC adapters, and a carrying case. These items may not be billed separately at the time of initial issuance.</p> <p>9. Non-integrated keyboards provided with an SGD are not separately reimbursable.</p> <p>10. One symbol set may be billed separately using code E2599.</p> <p><u>Device Descriptions:</u></p> <p>1. Digitized speech devices, sometimes referred to as devices with "whole message" speech output, utilize words or phrases that have been recorded by an individual other than the SGD user for playback upon command of the SGD user.</p> <p>2. Synthesized speech devices translate a user's input into device-generated speech. Users of synthesized speech SGDs are not limited to pre-recorded messages but rather can independently create messages as their communication needs dictate.</p>

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(continued) Speech Generating Device (SGD)			<ol style="list-style-type: none"> 3. Devices that have the capability to generate both digitized and synthesized speech are coded as E2508 or E2510, depending on the method of synthesized speech formulation and device access. 4. E2508 devices require that the user make physical contact with a keyboard, touch screen or other display containing letters. 5. E2510 devices permit the user multiple methods of message formulation and multiple methods of device access. <ol style="list-style-type: none"> a. Multiple methods of message formulation must include the capability for message selection by two or more of the following methods: letters, words, pictures or symbols. b. Multiple methods of access must include the capability to access the device by two or more of the following: direct physical contact with a keyboard or touch screen, indirect selection techniques with a specialized access device such as a joystick, head mouse, optical head pointer, switch, light pointer, infrared pointer, scanning device, or Morse Code.
Speech Generating Device (SGD) Accessories (E2599)	<ol style="list-style-type: none"> 1. Accessories (E2599) for E2500 – E2510 may be covered if the basic coverage qualifications previously described for the base device are met and medical necessity for each accessory is clearly documented in the formal evaluation by the SLP and ordered by the physician/practitioner. 	<ol style="list-style-type: none"> 1. As previously described for SGD. 	

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Speech Generating Software Programs for Personal Computer (PC) or Personal Digital Assistant (PDA) (E2511)	<ol style="list-style-type: none"> All of the previously described qualifications for a Speech Generating Device are met; and The recipient currently owns the PC or PDA to which the software will be applied to enable the device to function as a Speech Generating Device (SGD). 	<ol style="list-style-type: none"> As previously described for SGD. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	<ol style="list-style-type: none"> Installation of the software program or technical support that enables a recipient-owned laptop computer, desktop computer or PDA to function as an SGD is included in the cost of the software program, therefore is not separately reimbursable. Medically necessary upgrades to speech generating devices and/or software programs may be reimbursed 60 months after the month of initial issuance of the device. Repairs to, or replacement of recipient-owned equipment (PC and PDA) is not reimbursable.
Access Device (E2599) <i>(such as, but not limited to: optical head pointers, joysticks, switches and scanning devices)</i>	<ol style="list-style-type: none"> All of the previously described qualifications for a Speech Generating Device (SGD) are met; and The access device has been determined to be medically necessary. 	<ol style="list-style-type: none"> Documentation by a licensed medical professional, such as a physician, speech-language pathologist, or physical therapist, which supports the medical necessity for the requested access device. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	<ol style="list-style-type: none"> An access device enables the selection of letters, words or symbols via direct or indirect selection techniques. Any components such as software programs, interfaces, cables, adapters, interconnects or switches necessary for the access device to interface with the SGD should be included in the charge for the access device itself and is therefore not separately reimbursable.
Electronic Components (E2599)	<ol style="list-style-type: none"> All of the previously described qualifications for a Speech Generating Device (SGD) are met; and The electronic components are necessary to allow the SGD to be operated by the drive control interface of a power wheelchair. 	<ol style="list-style-type: none"> Documentation must include that the recipient requires the use of a power wheelchair, and must address the recipient's ability to operate the SGD from the power wheelchair. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	

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SGD Mounting Systems (E2512)	<ol style="list-style-type: none"> All of the previously described qualifications for a Speech Generating Device are met; and The accessories are needed to place the SGD, switches or other access devices within the reach of the recipient. 	<ol style="list-style-type: none"> Documentation supporting medical necessity for the mounting system and that the recipient has a medical need for, and owns the device to which the SGD is to be mounted. 	
SGD Batteries, Battery Chargers, and AC Adapters	<ol style="list-style-type: none"> All of the previously described qualifications for a Speech Generating Device are met; and The accessories are needed to replace an SGD battery, a battery charger, or AC adapter that was provided with initial issuance of the SGD and is no longer functioning. 		
SGD Carrying Case	<ol style="list-style-type: none"> All of the previously described qualifications for a Speech Generating Device are met; and A carrying case may be paid separately with the initial issuance of an SGD when it would be charged separately to the general public or to the primary insurer; or Replacement is needed to protect a medically necessary device due to wear and tear; no more frequently than one (1) unit per calendar year. 		

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Policy: DIABETIC SERVICES			
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External Ambulatory Infusion Pump, Insulin (E0784)	<p>Covered ICD codes: Diabetes Mellitus Gestational Diabetes</p> <p>All of the following conditions must be met:</p> <ol style="list-style-type: none"> 1. Fasting serum C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method or as an alternative must be beta cell autoantibody positive. 2. Recipient has completed a comprehensive diabetic education program within the last year. 3. Recipient is motivated to achieve and maintain improved glycemic control. 4. Recipient has been on a program of multiple daily injections of insulin (e.g., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to request for the insulin pump. 5. Documented frequency of glucose self-testing is an average of at least 4 times per day during the 2 months prior to starting the insulin pump. 6. Glycosylated hemoglobin level (HbA1C) > 7.0% <p>In addition, one or more of the following indications must be present:</p> <ol style="list-style-type: none"> 1. History of recurring hypoglycemia; 2. Wide fluctuations in blood glucose before mealtime (e.g., preprandial blood glucose level commonly exceeds 140 mg/dl; 3. Dawn phenomenon with fasting blood sugars frequently >200 ml/dl; 	<ol style="list-style-type: none"> 1. A prescription from a physician who manages recipients with insulin pumps and who works closely with a team including nurses, diabetes educators, and dietitians. 2. Prior authorization is required for the insulin pump with all of the following documentation: <ol style="list-style-type: none"> a. Certification of Diabetic Education Class with first time request. b. Signed statement from the physician acknowledging medical necessity and the following: <ol style="list-style-type: none"> 1. Recipient is motivated to achieve and maintain improved glycolic control, indicated by showing documented finger sticks (at least 4 times per day) with multiple injections. 2. Recipient has been on a program of multiple injections of insulin (at least 3 times per day) with frequent self-adjustment of insulin doses at least 6 months prior to initiation of the insulin pump. 3. Cognitive ability to operate pump and calculate insulin dosages. 3. Qualifying lab results per qualifications. 4. Physician current history and physical including one or more of the additional indications listed in the qualification column. 5. Documentation requirements for recipients using the insulin pump prior to Medicaid eligibility requires a PA with the following documentation: <ol style="list-style-type: none"> a. A HbA1C level (within last 60 days). b. Signed narrative from the physician documenting the recipient's compliance 	<ol style="list-style-type: none"> 1. External ambulatory infusion pump recipients with Gestational Diabetes whom do not meet conditions 1 through 6 but do meet qualifications under Gestational Diabetes approval of the insulin pump will be on a rental basis until the end of the pregnancy. 2. Insulin Pump-related Supplies through the DMEPOS program: E0784 - External Ambulatory Infusion pump, Insulin A4230 - Infusion set for external pump, non-needle cannula type A4231 - Infusion set for external pump, needle type A4232 - Syringe with needle for external insulin pump, sterile, 3cc

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(continued) External Ambulatory Infusion Pump, Insulin (E0784)	4. Extreme insulin sensitivity; or 5. Gestational diabetes or when pregnancy occurs or is anticipated within 3 months in a previously diagnosed diabetic with ANY of the following indications: a. Erratic blood sugars in spite of maximal recipient compliance and split dosing; or b. Other evidence that adequate control is not being achieved. Qualifications for recipients on the external ambulatory infusion pump prior to Medicaid eligibility: 1. A Glycosylated hemoglobin level (HbA1C) within the last 60 days. 2. Recipient has been compliant with using the insulin pump and has the ability of self-adjusting the insulin pump according to glucose levels.	and ability to self adjust the insulin pump according to glucose levels. 6. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Diabetic Equipment and Supplies		1. Physician's/Practitioner's Order / Prescription	1. Diabetic shoes, fitting, and Modification A5500 – A5507, A5512 – A5513 2. Diabetic equipment and supplies, such as Glucometers, Test strips, Lancet Device and Lancets, Insulin syringes for self-injection are not covered under the DHCFP's DME program. These supplies are covered under the DHCFP's pharmacy program and must be billed through the Point of Sale (POS). Refer to MSM Chapter 1200, Pharmacy Services.

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Disposable Incontinent Supplies	<ol style="list-style-type: none"> 1. Disposable briefs/diapers, pull-ons/protective underwear, liners/ shields/ guards/ pads/ undergarments, and underpads may be covered for individuals age four years and older with a medical diagnosis (1) of a neurological or neuromuscular disorder or other diagnosis of a medical condition that causes urinary or bowel incontinence, and (2) a diagnosis of urinary and/or bowel incontinence. 2. Diagnoses must be supported by medical documentation which includes other recent (within past 6 months) interventions used to treat or ameliorate the incontinence, such as but not limited to a bowel and bladder training/retraining program, other toileting programs, exercise and strengthening regimens. 3. The individual's weight, waist/girth measurements, and belt-to-belt measurements must be consistent with manufacture's recommendations for the sizing of their products. 4. Recipients with waist size greater than 60 inches may be considered for Bariatric size briefs/diapers. 5. Individuals under four years of age must have a diagnosis of Human Immune Deficiency Virus (HIV) positive or Acquired Immune Deficiency Syndrome (AIDS) with an accompanying gastrointestinal abnormality causing frequent or intractable diarrhea which is documented by the prescribing practitioner. 	<ol style="list-style-type: none"> 1. A physician's order. In addition to other requirements for written orders, the prescriber must indicate on the written order all of the following: <ol style="list-style-type: none"> a. Diagnosis of medical condition causing incontinence with a diagnosis of urinary and/or bowel incontinence; b. The specific item (diaper/brief, pull-on, liner/ shield/ guard/ pad, underpads) and the order must specify the recipient's measurements for the ordered item; c. Frequency of replacement and/or changes needed and monthly quantity of each item to be dispensed; d. The size of the item to be dispensed including the individual's current weight, waist/girth and belt to belt measurements to support the size of product needed. The size of the product supplied must be consistent with the manufacturer's recommendation for their product. 2. Documentation of other interventions tried or currently in progress to treat or ameliorate the incontinence. 3. Documentation must be included in the medical record and must be part of the treatment plan for the individual. The supplier must retain copies of all supporting documentation for audits. 4. Prior authorization is always required for code T4543, Bariatric size brief/diapers, or to exceed established quantity limitations, or for ages less than four years old. 	<ol style="list-style-type: none"> 1. Use of diapers and related products for individuals under the age of four years are considered age appropriate and are non-covered, unless the individual meets the qualifications and the order was a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening. These would require prior authorization. 2. Refer to the DMEPOS Fee Schedule. Prior authorization may be submitted to exceed established limits for these products when medical documentation clearly indicates a greater quantity is medically necessary. 3. Use of multiple types of briefs, diapers, pull-ons, or protective underwear in any size combination cannot exceed the maximum limit (either 100 units or 186 units per month depending on the item) without PA. Liners, shields, guards, pads, and underpads in any combination cannot exceed the maximum limit of 100 units per month without prior authorization and may be in addition to diapers, briefs, pull-ons, or protective underwear. 4. Gloves, sterile or non-sterile and disposable wipes/washcloths are not considered medically necessary for use with incontinence care and are non-covered. 5. Underpads used for tube feedings or other procedures not related to incontinence are non-covered as these

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(continued) Disposable Incontinent Supplies			would be considered convenience items and not medically necessary. 6. Any products used for menses are non-covered. Failure of the provider to maintain required documentation could result in post-payment recoupment of monies paid.

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<p>MAE General Information <i>(pertains to all items in this policy section)</i></p>	<p>The qualifications identified in this “general information” section must all be met for any items included in this policy section. Each specific item may also have additional qualifications listed further in this appendix that must be met. Items may be covered if all of the following qualifications are met:</p> <ol style="list-style-type: none"> The recipient has a mobility limitation that significantly impairs his/her ability to participate in one or more Mobility-Related Activities of Daily Living (MRADL) performed in the home and in each of the environments the recipient is likely to encounter in their daily routines, such as but not limited to: attending school, work, and shopping. The MRADLs to be considered in this and all other statements in this policy are: toileting, grooming, bathing, dressing, eating, and transferring. Note: A mobility limitation is one that: <ol style="list-style-type: none"> Prevents the recipient from accomplishing the MRADL entirely; Places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or Prevents the recipient from completing the mobility-related Activities of Daily Living (ADL) within a reasonable time frame. All required assessments, evaluations, and physician/practitioner’s orders as indicated throughout this section were completed within the required time limits. 	<p>The forms and specifications as described in this “general information” section pertain to all MAE items. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional completion requirements are found in the Form Release Memorandums/ Instructions for the Division’s forms on the following website: https://www.medicaid.nv.gov/providers/forms/form_s.aspx</p> <p>Each specific item may also have additional form requirements and specifications listed further that must be met.</p> <ol style="list-style-type: none"> Physician’s/Practitioner’s Order/Prescription. Prior authorization, forms found on the QIO-like vendor’s website (when indicated) refer to the DMEPOS Fee Schedule to determine need for a prior authorization for each item. Note: For items that require prior authorization and have a Nevada Medicaid assigned rate of less than \$500.00, use the DME Prior Authorization, Form FA-1; for items with a Nevada Medicaid assigned rate of \$500.00 or more, the Mobility Assessment and Prior Authorization Form, FA-1B is required. A Manufacturer’s Invoice of cost if there is no rate established by the DHCFP. Detailed Product Description. Proof of Delivery. Additional Miscellaneous Medical Records. 	<p>Refer to the main body of MSM Chapter 1300 for general DMEPOS policies. The comments/ policy statements identified in this “general information” section pertain to all MAE items.</p> <ol style="list-style-type: none"> For all MAE items, documentation must support all criteria in the Qualifications section, as specified in each category. <ol style="list-style-type: none"> All rented mobility devices are to be considered purchased by the DHCFP once the purchase price is reached. Providers must submit prior authorization and claim with the most appropriate HCPCS code and may not unbundle items included in the HCPCS code description. Inclusion of a HCPCS code in this policy section is not an indication of coverage. Refer to the DMEPOS Fee Schedule. The recipient must have a medical need within the home for the requested item. In addition, consideration will include: <ol style="list-style-type: none"> recipient’s medical needs; use of the item; and the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: <ol style="list-style-type: none"> attending school; work; and shopping.

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(continued) MAE General Information <i>(pertains to all items in this policy section)</i>			This information must be included in the supportive documentation submitted with the prior authorization.
Canes and Crutches Cane Accessories Crutch Accessories	<ol style="list-style-type: none"> 1. The MAE General Qualifications are met and the recipient: <ol style="list-style-type: none"> a. has a medical condition causing impaired ambulation and there is a potential for ambulation; b. is able to safely use the cane or crutches; and c. has functional mobility deficit that can be sufficiently resolved by use of the item. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 	<ol style="list-style-type: none"> 1. Cane and/or crutch accessory items may be provided as replacement items for recipient-owned MAE. When the cane or crutch HCPCS description includes the accessory item, these items cannot be billed separately with the initial purchase.
Crutch Substitute, Lower Leg Platform, With or Without Wheels (E0118)	<ol style="list-style-type: none"> 1. The MAE General Qualifications are met and the recipient: <ol style="list-style-type: none"> a. has a below-the-knee injury and/or surgery causing impaired ambulation and there is a potential for ambulation; b. is medically unable to safely use a cane(s), standard crutches, a walker, or a wheelchair; c. has functional mobility deficit that can be sufficiently resolved by use of the item; and d. (self) or care giver is not requesting the device for convenience. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 2. Prior Authorization. 3. The additional medical documentation by the prescribing physician/practitioner, submitted with the prior authorization, must indicate why the recipient is not able to use an alternative, more cost effective mobility device, such as: cane(s), crutches, walker, or a wheelchair. 	
Walkers Walker Accessories	<ol style="list-style-type: none"> 1. If the MAE General Qualifications are met, a standard walker may be covered if the recipient: <ol style="list-style-type: none"> a. is <i>unable</i> to safely use appropriately fitted canes or crutches to resolve functional mobility deficits; and b. is <i>able</i> to safely use the walker; and c. has functional mobility deficit that can be 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 2. Prior Authorization, when indicated. 3. A heavy duty walker requires a prior authorization to verify weight. 	<p>All from General Information Miscellaneous Policy Statement section; and</p> <ol style="list-style-type: none"> 1. Walker accessory items may be provided as replacement items for recipient-owned MAE. When the walker HCPCS description includes the accessory item, these items cannot

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(continued) Walkers Walker Accessories	sufficiently resolved with use of a walker. 2. In addition to #1 and #2 in the MAE General Information Qualification section and #1 of this section, a heavy duty walker may be covered if the recipient's weight is greater than 300 pounds.		be billed separately with the initial purchase.
Gait Trainers	1. EPSDT only. 2. Mobility Assistive Device for moderate to maximum support for walking. 3. Functional mobility deficit cannot be resolved using a walker.	1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization documenting recipient's inability to utilize a standard or reverse walker and how the gait trainer will meet the recipient's needs. 3. Must demonstrate the capability of independently walking with the use of a gait trainer. 4. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	Note: Rehab equipment and physical/occupational therapy equipment for home use is not covered.
Wheelchairs <i>(pertains to all wheelchair types – manual and power)</i>	1. In addition to the MAE General Qualification section, a wheelchair may be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, or a walker; and 2. The recipient meets the specific qualifications listed further in this section for the type of wheelchair being requested. 3. The recipient must have a medical need for, and the requested item must be suitable for use in the home, in accordance with 42 CFR 440.70(b)(3). Consideration for prior authorization is also based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines.	All from MAE General Qualification section; and 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300. 2. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	1. Medicaid allows only one wheelchair at a time. Backup chairs are denied as not medically necessary. 2. For all Medicare/Medicaid dual eligible recipients, Medicaid is payer of last resort. Therefore, any MAE that qualifies as an Advanced Determination of Medicare Coverage (ADMC) item must be submitted to Medicare prior to requesting approval by Medicaid. After the ADMC decision is received from Medicare, provider/supplier must submit a copy of the ADMC written decision by Medicare with the prior authorization. 3. Reimbursement for all wheelchair

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(continued) Wheelchairs (<i>pertains to all wheelchair types – manual and power</i>)			codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support, such as emergency services, delivery, set-up education, and on-going assistance with use of the wheelchair. 4. For all wheelchairs (manual or power) recipient weight capacity is: Standard Duty = 300 lbs or less; Heavy Duty = 301-450 lbs; Very Heavy Duty = 451 – 600 lbs; Extra Heavy Duty = 601 lbs or more.
Manual – Standard Adult size	<ol style="list-style-type: none"> 1. The recipient’s home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided; 2. Use of an optimally configured manual wheelchair will significantly improve the recipient’s ability to participate in MRADLs. Note: an optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories; 3. The recipient’s weight is within the established weight limitations of the wheelchair that is requested/provided; 4. The recipient will use it on a regular basis in the home; 5. The recipient or their caregiver has not expressed an unwillingness to use the manual wheelchair that is provided in the home; and 6. The recipient has sufficient upper extremity strength, function, and other physical and 		

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(continued) Manual – Standard Adult size	mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day, or the recipient has a caretaker available, willing, and able to assist in the operation of the wheelchair.		
Manual – Standard Pediatric Size	<ol style="list-style-type: none"> 1. The pediatric recipient must meet the qualifications in relationship to his/her age-appropriate developmental stages and mobility limitations for all qualifications for a Manual – Standard Adult Size Wheelchair; 2. Pediatric wheelchairs are covered only for a pediatric recipient (or an adult of very small stature). Recipient’s weight cannot exceed 125 pounds; and 3. Recipient has not mastered age appropriate sensory and motor development requirements (e.g., two years old is unable to ambulate/walk). 4. Stroller-type pediatric wheelchair devices, rigid or folding, will be considered only when: <ol style="list-style-type: none"> a. classified by the DME Pricing, Data Analysis, and Coding (PDAC) contractor as pediatric wheelchairs, when all of the previous criteria are met; b. due to severity of illness, injury, and/or absence of or malfunction of a body part, there is a medical need for the features of the device requested to provide for the recipient’s proper alignment/positioning, transportation of the individual, and any medical devices attached to the individual; and c. a manual wheelchair would not be more beneficial to the individual’s 	<ol style="list-style-type: none"> 1. All requirements from the Forms/Documentation section under “Wheelchairs”, plus: 2. All pediatric device requests must include the growth capabilities of the equipment requested and address how that equipment can accommodate for the recipient’s growth over the 60 month period that follows approval. This information should be included on the Mobility Assessment, form found on the QIO-like vendor’s website. 	<ol style="list-style-type: none"> 1. Stroller-type devices readily available without a prescription in commercial or retail stores, and which have not been coded by the DME Pricing, Data Analysis and Coding (PDAC) contractor as medical devices, will be denied as not primarily medical in nature. 2. Stroller-type devices used for children absent of illness, injury and/or a missing or malfunction of a body part do not meet the definition of Durable Medical Equipment (DME) and, are therefore not considered medically necessary.

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(continued) Manual – Standard Pediatric Size	developmental needs and there is no potential for the recipient to participate in self propelling a manual wheelchair.		
Manual Specialty	1. May be covered if, in addition to the general qualifications for a wheelchair and a manual wheelchair, the qualifications for the following specified devices are met and determined to be medically necessary.		
Standard Hemi-Wheelchair (K0002)	1. May be covered when the recipient requires a lower seat height (17" to 18") because of short stature or to enable the recipient to place his/her feet on the ground for propulsion.		
Lightweight Wheelchair (K0003)	1. May be covered when a recipient: a. cannot self-propel in a standard wheelchair; and b. the recipient can and does self-propel in a lightweight wheelchair.		
High Strength Lightweight Wheelchair (K0004)	1. May be covered when a recipient: a. self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or b. requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair. Note: This type of wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).		
Ultra-light-weight Wheelchair (K0005)	1. May be determined for coverage on an individual consideration basis, as follows: a. Recipient must have a medical condition which is progressively deteriorating, or be at risk for injury due to use of another	1. Additional documentation of the medical necessity must include a description of the recipient's routine activities, types of activities the recipient frequently encounters, and whether the recipient is fully independent in	

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(continued) Ultra-light-weight Wheelchair (K0005)	<ul style="list-style-type: none"> b. Recipient must have a medical need for anticipated future adaptations of the wheelchair that can only be accommodated by the K0005 device. 	the use of the wheelchair. Describe the features of the K0005 base which are needed and not available in the K0001 - K0004 bases. This may be included in the Mobility Assessment form.	
Heavy Duty Wheelchair (K0006)	<ul style="list-style-type: none"> 1. May be covered if the recipient weighs more than 250 pounds or has severe spasticity. 		
Extra Heavy Duty Wheelchair (K0007)	<ul style="list-style-type: none"> 1. May be covered if the recipient weighs more than 300 pounds. 		
Power Mobility Devices (PMDs) <i>(pertains to all POVs and PWCs below)</i>	<ul style="list-style-type: none"> 1. May be covered if the recipient meets all previously described qualifications for a wheelchair (either adult or pediatric, whichever is appropriate); and the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, walker, or an optimally-configured manual wheelchair; 2. The recipient does not have sufficient upper extremity strength or function needed to safely self propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day. Note: Limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity or absence of one or both upper extremities are to be assessed in the Mobility Assessment; and 3. The recipient meets the additional qualifications for the specific device requested, as indicated further in this section. 	<ul style="list-style-type: none"> 1. Additional Documentation Requirements for a Power Mobility Device or Power Wheelchair: <ul style="list-style-type: none"> a. Orders: The physician/ practitioner's order must contain all of the following components: <ul style="list-style-type: none"> 1. Recipient's name. 2. Description of the item ordered. This may be general – e.g., "power wheelchair", "power operated vehicle", or "power mobility device" – or may be more specific. 3. Pertinent diagnosis/conditions that relate to the need for the power device. 4. Length of need. 5. Physician/practitioner's signature. b. Order must be received by the provider within 45 days after the completion of the Mobility Assessment. 2. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300 – Prior 	<ul style="list-style-type: none"> 1. Purchase of any Power Mobility Device is not considered medically necessary when the underlying condition is reversible and the length of need is less than six months. The item may be approved for rental if all qualifications are met. 2. The Mobility Assessment, and written supportive documentation must be performed by an individual who is fiscally, administratively, and contractually independent from the DME provider/supplier, and who receives no form of compensation from the billing DME provider / supplier. Note: The exception to this is information about whether the recipient's home can accommodate the requested equipment, which may be obtained from or documented by the DME provider/supplier. 3. Prescribing physician/practitioners may bill an additional fee using HCPCS code G0372 on the claim for the office visit (CPT 99211) during

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(continued) Power Mobility Devices (PMDs) <i>(pertains to all POVs and PWCs below)</i>		Authorization section. 3. Additional supporting documentation may include the Medicare-required Face-to-Face evaluation/examination.	which the Medicare-required Face-to-Face examination was completed.
Power Operated Vehicle (POV)	<ol style="list-style-type: none"> 1. The recipient is able to: <ol style="list-style-type: none"> a. safely transfer to and from the POV; b. operate the tiller steering system; and c. maintain postural stability and position while operating the POV in the home; 2. The recipient's mental capabilities (e.g., cognition and judgment) and physical capabilities (e.g., vision and hearing) are sufficient for safe mobility using a POV in the home; 3. The recipient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the POV that is requested/provided; 4. Use of a POV will significantly improve the recipient's ability to participate in MRADLs; 5. The recipient will use it on a regular basis in the home; 6. The recipient or their caregiver has not expressed an unwillingness to use the POV that is provided in the home; 7. If unable to operate the POV independently, the recipient has a caretaker available, willing, and able to assist in the operation of the POV; 8. The recipient's weight is within the established weight limitations of the POV that is requested/provided; and 9. Documented outcome of the Mobility Assessment for the recipient determines this to be the most appropriate device for their needs. 		

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MEDICAID SERVICES MANUAL	Subject: COVERAGE AND LIMITATIONS POLICIES

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Power Wheelchairs (PWC) - Adult	<ol style="list-style-type: none"> 1. May be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, walker, an optimally-configured manual wheelchair, or a POV; 2. Recipient <i>does not have</i> sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home; 3. Recipient <i>does have</i> the mental and physical capabilities, or has a willing and capable caregiver to safely operate the power wheelchair that is requested/provided; 4. Recipient's home <i>does not</i> provide adequate access between rooms, maneuvering space, and surfaces for the operation of a POV with a small turning radius; 5. Recipient's home <i>does</i> provide adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is requested/ provided; Use of a power wheelchair will significantly improve the recipient's ability to participate in MRADLs; 6. Recipient will use it on a regular basis in the home; 7. Recipient or their caregiver has not expressed an unwillingness to use the power wheelchair that is requested/provided in the home; 8. If the recipient is not able to operate the power wheelchair independently, the recipient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; 		

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	and 9. The recipient's weight is within the established weight limitations of the power wheelchair requested/provided.		
Power Wheelchair (PWC) – Pediatric	1. The recipient is expected to grow in height with a maximum weight of 125 pounds; and 2. The outcome of the Mobility Assessment has determined this item to be the most appropriate for the individual over the 60-month period following approval.		
Power Wheelchairs (listed by specific groups)	1. Meets above qualifications for a PWC (either adult or pediatric, whichever is appropriate); and as indicated for each specific item below.		

Power Wheelchairs (PWCs) are categorized into Groups based on their performance and the following specifications table:

CHARACTERISTICS	GROUP 1	GROUP 2	GROUP 3	GROUP 4	GROUP 5
Length	<= 40"	<= 48"	<= 48"	<= 48"	<= 48"
Width	<= 24"	<= 34"	<= 34"	<= 34"	<= 28"
Minimum Obstacle Height	20mm	40mm	60mm	75mm	60mm
Minimum Top-end Speed – flat surface	3 MPH	3 MPH	4.5 MPH	6 MPH	4 MPH
Minimum Range	5 miles	7 miles	12 miles	16 miles	12 miles
Dynamic Stability Incline	6 degrees	6 degrees	7.5 degrees	9 degrees	9 degrees
Chair Accommodates	Non-powered options and seating systems (recline-only, manually elevating leg rests – except captain's chair)	Seating and positioning items (seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports - except captain's chair)	Same as Group 2	Same as Group 2	Weight capacity up to 125#; and Same as Group 1 and Group 2; and Adjustability for growth (minimum of 3" for width, depth, and back height adjustments)

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Group 1, 2, or 3 PWC “Standard”	1. As previously stated for Power Wheelchairs. No additional qualifications.		
Group 2 PWC “Single Power Option”	1. Recipient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or 2. Recipient meets qualifications for a power tilt or recline seating system and the system is being used on the wheelchair.		
Group 2 PWC “Multiple Power Option”	1. Same as Group 2 Single Power Option qualifications; and 2. The recipient meets the qualifications for a power tilt and/or recline seating system with three or more actuators; or 3. The recipient uses a ventilator, which is mounted on the wheelchair.		
Group 3 PWC “Single Power Option”	1. Same as Group 2 Single Power Option qualifications; and 2. The recipient’s mobility limitation is due to a neurological condition, myopathy, or skeletal deformity in which the mobility limitation cannot be accommodated by a Group 2 option.		
Group 3 PWC “Multiple Power Option”	1. Same as Group 2 Multiple Power Option qualifications; and 2. The recipient’s mobility limitation is due to a neurological condition, myopathy, or skeletal deformity in which the mobility limitation cannot be accommodated by a Group 2 option.		
Group 4 PWC “Any Power Option”	This group of PWC is rarely considered medically necessary due to the added features, such as increased speed, climbing ability, and travel distance which are not needed to complete MRADLs. 1. The recipient must meet the qualifications for	As listed previously; additional documentation from the prescribing physician/practitioner that specifically addresses why the Group 4 PWC and accompanying accessories are medically necessary and why a Group 1, 2, or 3 PWC with accompanying accessories will not meet the	

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) Group 4 PWC “Any Power Option”	<ul style="list-style-type: none"> a. Group 1, Group 2, or Group 3 PWC with the same power option being requested for the Group 4 PWC. 2. The recipient must have additional medical needs and mobility limitations that cannot be accommodated by an appropriately configured Group 1, 2, or 3 PWC. 	recipient’s medical needs.	
Group 5 Pediatric PWC “Single Power Option”	<ul style="list-style-type: none"> 1. Same as Group 2 Single Power Option qualifications; and 2. The recipient is expected to grow in height. 		
Wheelchair Options, Accessories, and Seating Systems	<ul style="list-style-type: none"> 1. Options and accessories for wheelchairs may be covered if: <ul style="list-style-type: none"> a. The recipient meets the wheelchair qualifications as indicated previously, and has either a manual or power wheelchair; b. The device is an appropriate option/accessory for the type of chair the individual has; c. The option/accessory itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor’s website; d. When the option/accessory is not a required component of the mobility device at the time of initial dispensing; e. The option/accessory is not covered under an existing warranty; and f. As indicated for each specific item listed further in this section. 2. All wheelchair seating system items in this category may be covered if: <ul style="list-style-type: none"> a. The recipient meets the wheelchair qualifications as indicated above, and has either a manual or power wheelchair; 	<p>For all items under this heading: all from General Information section above; and</p> <ul style="list-style-type: none"> 1. Mobility Assessment, form found on the QIO-like vendor’s website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section. 2. A Manufacturer’s Invoice of cost if there is no rate established by the DHCFP. 	<p>See also General Information; Coverage and Limitations; and Non-covered Services:</p> <ul style="list-style-type: none"> 1. An option/accessory that is beneficial primarily in allowing the recipient to perform leisure or recreational activities. 2. Electronic interface used to control lights or other electrical devices is not primarily medical in nature. 3. Power seat elevation feature and power standing feature are not primarily medical in nature. 4. Non-medically necessary power wheelchair features including but not limited to: stair climbing (A9270), electronic balance (A9270), ability to balance on two wheels (A9270), remote operation (A9270), an attendant control (E2331) provided in addition to a patient-operated drive control system.

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(continued) Wheelchair Options, Accessories, and Seating Systems	<ul style="list-style-type: none"> b. The item is appropriate for the type of chair the individual has; c. The item itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website; d. When the item is not a required component of the mobility device at the time of initial dispensing; e. The item is not covered under an existing warranty; and f. As indicated for each specific item further. 		
Anti-rollback Device (E0974)	<ul style="list-style-type: none"> 1. May be covered if the recipient propels himself/herself and needs the device because of ramps which enable the individual to gain access to and from or within the home. 		
Arm of Chair Adjustable Arm Height Option (E0973, K0017, K0018, K0020)	<ul style="list-style-type: none"> 1. May be covered if the recipient requires an arm height that is different than that available using nonadjustable arms and the recipient spends at least two hours per day in the wheelchair. 		
Arm Trough (E2209)	<ul style="list-style-type: none"> 1. May be covered if recipient has quadriplegia, hemiplegia, or uncontrolled arm movements. 		
Batteries / Chargers	<ul style="list-style-type: none"> 1. Up to two batteries (E2361, E2363, E2365, E2371, K0731, and K0733) at any one time are allowed if required for a power wheelchair. 		<ul style="list-style-type: none"> 1. Replacements only when not covered under warranty.
Footrest / Leg rest Elevating Leg rests (E0990, K0046, K0047, K0053, K0195)	<ul style="list-style-type: none"> 1. May be covered if: <ul style="list-style-type: none"> a. The recipient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; b. The recipient has significant edema of the lower extremities that requires having an 		

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(continued) Footrest / Leg rest Elevating Leg rests (E0990, K0046, K0047, K0053, K0195)	elevating leg rest; or 2. The recipient meets the qualifications for and has a reclining back on the wheelchair.		
Hardware Swingaway, Retractable, Removable for Joystick, Other Control Interface, or Positioning Accessory (E1028)	1. May be covered if recipient needs to move the component out of the way to perform a slide transfer to a bed or chair, or to enable performance of MRADLs, unless the hardware is included in the allowance for the item (such as E2325, a sip and puff interface).		
Headrest (E0955)	1. May be covered when the recipient has a manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair, or power tilt and/or recline power seating system.		1. A headrest for a POV or a power wheelchair with a captain's chair seat is non-covered as not medically necessary.
Manual Fully Reclining Back option (E1226)	1. May be covered if the recipient has one or more of the following conditions: a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.		
Non-Standard Seat Frame Dimensions Non-Standard Seat Width and/or Depth for a Manual Wheelchair (E2201-E2204)	1. May be covered only if the recipient's dimensions justify the need.		
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Power Tilt and/or Recline Seating Systems: (E1002-E1010) Power Seating System <i>(tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests)</i>	1. May be covered if the recipient meets the criteria for a power wheelchair and the outcome of the Mobility Assessment, form found on the QIO-like vendor's website has determined the specific feature to be medically necessary; and <ol style="list-style-type: none"> a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 2. The power seating system is needed to manage increased tone or spasticity.		
Power Wheelchair Drive Control Systems An Attendant Control (E2331)	1. May be covered in place of a patient-operated drive control system if recipient meets MAE qualifications for a wheelchair, is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.		
Power Wheelchair Electronic Interface (E2351) <i>(to allow a Speech Generating Device to be operated by the PWC control interface)</i>	1. May be covered if the recipient meets the criteria for, and has a covered speech generating device.		
Push-Rim Activated Power Assistive Device (E0986) for a Manual Wheelchair	1. May be covered if the recipient meets all qualifications for a power mobility device; and the recipient has been self-propelling in a manual wheelchair for at least one year.		

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Safety Belt / Pelvic Strap (E0978)	1. May be covered if the recipient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning.		
Seating Systems (wheelchair):	As listed for Wheelchair Options, Accessories and Seating Systems.	For all items under this heading: all from MAE General Information; and 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section.	All from MAE General Information; and 1. All seating and positioning devices/material and included components must meet the requirements of CMS and as set forth in the DME MAC Local Coverage Determination (LCD) – L15670 (or more current) and related Policy Articles at the time of dispensing. 2. Coverage and Limitations/Non-Covered as not medically necessary: a. Powered seat cushion (E2610) (effectiveness has not been established). b. A seat or back cushion provided for a transport chair. c. A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the DME Pricing, Data Analysis and Coding (PDAC) contractor.
General Use Seat Cushion (E2601, E2602) and Wheelchair Back Cushion (E2611, E2612) (Pre-fabricated)	1. May be covered if the recipient has a manual or power wheelchair with a sling/solid seat/back.		1. General use seat cushion or wheelchair back cushion for a POV or a PWC with a captain's chair seat is not medically necessary.

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Custom Fabricated Seat Cushion (E2609)	<ol style="list-style-type: none"> 1. May be covered if the recipient meets all qualifications for a prefabricated skin protection seat cushion or positioning seat cushion; and 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs. 		
Custom Fabricated Back Cushion (E2617)	<ol style="list-style-type: none"> 1. May be covered if the recipient meets all qualifications for a prefabricated positioning back cushion; and 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs. 		
Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)	<ol style="list-style-type: none"> 1. May be covered for a recipient who has a manual or power wheelchair with a sling/solid seat/back; and either of the following: <ol style="list-style-type: none"> a. Current or past history of a pressure ulcer on the area of contact with the seating surface; or b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post polio paralysis, traumatic brain injury resulting in quadriplegia, spina 		

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(continued) Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)	bifida, childhood cerebral degeneration, Alzheimer's disease, or Parkinson's disease.		
Positioning Seat Cushion (E2605, E2606), Positioning Back Cushion (E2613-E2616, E2620, E2621) and/or Positioning Accessory (E0955-E0957, E0960)	<ol style="list-style-type: none"> 1. May be covered for a recipient who: <ol style="list-style-type: none"> a. Has a manual or power wheelchair with a sling/solid seat/back; and b. Has any significant postural asymmetries that are due to one of the diagnoses listed in Skin Protection Seat Cushion qualification 1.b. above, or to one of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonia, spinocerebellar disease. 		
Combination Skin Protection and Positioning Seat Cushion (E2607, E2608, K0736, K0737)	<ol style="list-style-type: none"> 1. May be covered for a recipient who meets the qualifications for both a Skin Protection Seat Cushion and a Positioning Seat Cushion as indicated previously. 		

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Policy: NUTRITIONAL SERVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Parenteral Nutrition	<ol style="list-style-type: none"> Total Parenteral Nutrition (TPN) is covered for a recipient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition. Permanence does not require a determination that there is no possibility that the recipient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. The recipient must have: <ol style="list-style-type: none"> A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or Disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the gastrointestinal (GI) system. 	<ol style="list-style-type: none"> Physician's/Practitioner's Order / Prescription All TPN services require prior authorization. Medical coverage will be determined by the DHCFP QIO-like vendor. A new authorization would be required when: <ol style="list-style-type: none"> Nutrients billed with a different code are ordered; The number of days per week administered is increased or decreased; or Parenteral nutrition services are resumed when they are not required for two consecutive months. There must be objective evidence supporting the clinical diagnosis. 	<ol style="list-style-type: none"> Parenteral nutrition will be denied as non-covered in situations involving temporary impairments.
Infusion Pumps Equipment and Supplies: (B9004 and B9006)	<ol style="list-style-type: none"> Infusion pumps (B9004 and B9006) are covered for recipients in whom parenteral nutrition is covered. 	<ol style="list-style-type: none"> A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	<ol style="list-style-type: none"> Only one pump (stationary or portable) will be covered at any one time. Additional pumps will be denied as not medically necessary.
Supply Kit, (B4220 or B4222) Administration Kit	<ol style="list-style-type: none"> If the coverage requirements for parenteral nutrition are met, one supply kit (B4220 or B4222) and one administration kit will be covered for each day that parenteral nutrition is administered, if such kits are medically necessary and used. 		

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Enteral Nutrition	<ol style="list-style-type: none"> 1. Enteral equipment and supplies are a Medicaid program benefit that requires a prior authorization. The following diagnoses and conditions are acceptable for medical coverage, based on severity and the QIO-like vendor determination: <ol style="list-style-type: none"> a. AIDS wasting syndrome (as indicated by a weight loss of 20 pounds or 10% of reference weight); b. Carcinoma of gastrointestinal tract; c. Disease of pancreas; d. Dysphagia; e. Failure to thrive; f. Fistulas of the gastrointestinal tract; g. Gastrostomy tube, artificial opening status; h. Gastrostomy tube, attention to artificial opening; i. Inborn errors of metabolism; j. Inflammatory bowel disease; k. Intestinal malabsorption; l. Malabsorption; m. Malnutrition; n. Necrotizing enterocolitis; o. Noninfectious gastroenteritis and colitis; p. Pancreatitis and pancreatic insufficiency; q. Radiation or chemotherapeutic enteropathy; r. Short bowel syndrome; and/or s. Vascular disease of the small bowel. 2. As a non-allergenic source of food in infants when all (e.g., soy base formulas) other food formulas are not tolerated; or 3. Other medical conditions with appropriate medical justification. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization when indicated. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. 	<ol style="list-style-type: none"> 1. Non-covered nutritional supplies and products: <ol style="list-style-type: none"> a. Enteral nutrition will be denied as non-covered in situations involving temporary impairments. b. Enteral nutrition is non-covered for recipients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc. c. Enteral nutrition products that are administered orally and related supplies are non-covered. d. Baby food and other regular grocery products that can be blenderized and used with the enteral system will be denied as non-covered. 2. Nutritional supplements carved out from institutional per diem if clinical coverage criteria are met.

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Medical Foods for Inborn Errors of Metabolism (S9435)	<ol style="list-style-type: none"> 1. Authorization of “medical foods” will be considered for recipients under the age of 21 years as an EPSDT service with a diagnosis of an inherited metabolic disease in which treatments are restricted and a monitored diet consisting of specially formulated low-protein foods are an established standard of care. The following inherited metabolic conditions fit the category, but are not limited to: Phenylketonuria (PKU) Homocystinuria Maple Syrup Urine Disease 2. Definitions and qualifications: <ol style="list-style-type: none"> a. Medical foods refer to products designed for the specific nutrition management of a disease or condition for which distinctive nutrition requirements based on recognized scientific principles are established by medical evaluation. b. “Inherited metabolic disease” means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law. c. Medical foods are products specially formulated or modified to have less than one gram of protein per serving. This does not include a food that is naturally low in protein. d. Medical food is prescribed by and consumed under the direction of a physician for the dietary treatment of a qualifying metabolic disease. e. The recipient is currently receiving comprehensive nutrition services by a physician and dietician for the dietary 	<ol style="list-style-type: none"> 1. A prescription signed by the requesting physician specializing in the treatment of metabolic conditions for requested “medical foods”; 2. A completed prior authorization form that includes: <ol style="list-style-type: none"> a. types of medical food (e.g., LP baking mix); b. product line company names and product code numbers; c. total amount (units or case) of each medical food; d. number of servings for each product unit (number of servings per box, can or case); e. cost per unit or case for each medical food product; f. total cost of all products submitted; and g. Dates and duration of request 3. History and physical examination and current evaluation (within the last six months) which includes all existing diagnoses and medical conditions from the physician specializing in the treatment of metabolic conditions or an appropriate specialist. Documentation must include test results used in establishing the diagnosis and any other pertinent medical data/reports to justify products being requested; 4. A copy of the nutritional assessment and treatment plan by a registered dietitian and/or physician specializing in nutritional assessment and treatment of metabolic conditions; and including: <ol style="list-style-type: none"> a. Daily number of phenylalanine exchange 	<ol style="list-style-type: none"> 1. Medical foods will be approved after review of submitted documentation if found to meet the following conditions: <ol style="list-style-type: none"> a. Documentation supports dietary treatment of the metabolic disease or conditions mentioned in this policy for which nutritional requirements are established by medical evaluation, but does not include a natural food that is naturally low in protein; b. Submitted supporting documentation is found to support inherited metabolic diagnosis; and c. Approved time-frame will be for a maximum of six-months and the servicing provider can only be a Medicaid Pharmacy or DME provider. Grocery stores, health food stores, and/or retail vendors may not be authorized as providers for medical foods.

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(continued) Medical Foods for Inborn Errors of Metabolism (S9435)	<p>treatment of a qualifying metabolic disease.</p> <p>f. Medical foods specifically used to meet the distinctive nutritional requirements of a qualifying metabolic disorder and not generally used by persons in the absence of a qualifying metabolic disorder.</p> <p>g. Medical foods should be requested as part of an EPSDT supplement service.</p> <p>h. Medical foods are not food products readily available in the grocery stores and health food stores. For example, a child with diabetes could find a variety of foods in the grocery store to meet the child's nutritional requirements without specially formulated medical foods.</p> <p>i. Approval will be limited to \$2,500.00 per year unless proof of medical necessity exceeds that amount.</p>	<p>or total protein intake for disorders requiring a protein restriction. Snack foods do not exceed 10% of total cost of foods requested; and</p> <p>b. Documentation that the medical food is specially formulated and necessary for specific dietary management of the metabolic disorder.</p>	

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Policy: ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Orthotics and/or Prosthetics Adjustments, Repairs and Component Replacements	1. Replacement of a prosthesis, prosthetic component or orthosis is covered if the treating physician orders a replacement device or part because of any of the following: <ol style="list-style-type: none"> a. A change in the physiological condition of the recipient; b. Irreparable wear of the device or a part of the device, without evidence of recipient negligence; or c. The condition of the device or part of the device requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device or of the part being replaced. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization, when indicated. 	<ol style="list-style-type: none"> 1. Routine periodic servicing such as testing, cleaning, and checking is non-covered. Adjustments to a prosthesis required by wear or by a change in the recipient's condition are covered under the initial physician's order for the prosthesis for the life of the prosthesis. 2. Maintenance recommended by the manufacturer that must be performed by the prosthetist is a covered repair. 3. Repairs are covered when necessary to make the prosthesis functional. The cost of the repairs must not exceed the cost for a replacement.
Orthopedic Shoe-Related Services (inserts, arch supports, footwear, lifts, wedges, heels, and related services) – HCPCS “L” codes	<ol style="list-style-type: none"> 1. Devices are covered for individuals under age 21 years when determined to be medically necessary through EPSDT screening and recommendations. 2. A surgical boot/shoe or Plastazote sandal may be covered for individuals of any age when ordered and determined to be medically necessary. 	<ol style="list-style-type: none"> 1. Physician's order. 2. Prior authorization is required when “L” code product rate is \$250.00 or more per unit. 	<ol style="list-style-type: none"> 1. Refer to Diabetic Services section and HCPCS “A” codes in Fee Schedule for diabetic shoe insert coverage information.

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Policy: ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Orthotics Ankle-Foot Orthoses (AFO) Knee-Ankle-Foot Orthoses (KAFO)	<ol style="list-style-type: none"> 1. Appliances necessary for the straightening or correction of a deformity are covered by the DHCFP for eligible recipients. 2. <u>AFOs used in non-ambulatory recipients:</u> A static AFO (L4396) is covered if all of the following criteria are met: <ol style="list-style-type: none"> a. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (e.g., a non-fixed contracture); b. Reasonable expectation of the ability to correct the contracture; c. Contracture is interfering or expected to interfere significantly with the recipient's functional abilities; and d. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons. 3. <u>AFO/KAFOs used in ambulatory recipients:</u> A molded-to-patient-model, or custom-fabricated are covered for ambulatory recipients if the following are met: <ol style="list-style-type: none"> a. The recipient could not be fit with a prefabricated AFO; b. The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months); c. There is a need to control the knee, ankle or foot in more than one place; d. The recipient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or e. The recipient has a healing fracture which 	<ol style="list-style-type: none"> 1. Physician order. 2. Prior Authorization. 3. Original orthotics, adjustments, repairs, replacement of parts or an entire orthosis require medical documentation and may be subject to limitations of costs and frequency which are deemed reasonable by the program. 	<ol style="list-style-type: none"> 1. Orthotics include but may not be limited to: braces, orthopedic shoes, elastic stockings, back supports/ corsets, splints, and garments for treating burn patients. 2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association.

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(continued) Orthotics Ankle-Foot Orthoses (AFO) Knee-Ankle-Foot Orthoses (KAFO)	lacks normal anatomical integrity or anthropometric proportions.		
Thoracic-Lumbar-Sacral Orthoses (TLSO) Lumbar-Sacral Orthoses (LSO)	<ol style="list-style-type: none"> 1. TLSO or LSO are covered when it is ordered for one of the following indications: <ol style="list-style-type: none"> a. To reduce pain by restricting mobility of the trunk; b. To facilitate healing following an injury to the spine or related soft tissue; c. To facilitate healing following a surgical procedure on the spine or related soft tissue; or d. To otherwise support weak spinal muscles and/or a deformed spine. 		Note: The use of a LSO or TLSO brace for patients with chronic low back pain is not recommended because there is no pertinent medical evidence of any long-term benefit or evidence that brace therapy is effective in the treatment of patients with chronic (> 6 months) low back pain.

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Policy: ORTHOTIC AND PROSTHETIC DEVICES			
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Prosthetic Devices	<p>Appliances necessary to replace a missing part by an artificial substitute are covered by the DHCFF for eligible recipients.</p> <p>A determination of the medical necessity for certain components/additions to the prosthesis is based on the recipient's potential functional abilities.</p> <p>1. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including but not limited to:</p> <ol style="list-style-type: none"> a. The recipient's past history (including prior prosthetic use if applicable); b. The recipient's current condition including the status of the residual limb and the nature of other medical problems; c. The recipient's desire to ambulate; and d. Clinical assessments of recipient rehabilitation potential must be based on the following classification levels: <p><u>Level 0:</u> Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.</p> <p><u>Level 1:</u> Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory.</p> <p><u>Level 2:</u> Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited</p>	<ol style="list-style-type: none"> 1. Initial prosthetics, adjustments for which payment is to be made, repairs, replacement of parts, or an entire prosthetic device require medical documentation and may be subject to limitations of cost and frequency which are deemed reasonable by the program. 2. Sufficient clinical documentation of functional need for the technology or design feature of a given type of prosthesis is required to be retained in the physician's or prosthetist's files and must be available for Medicaid review. 	<ol style="list-style-type: none"> 1. Myoelectrically controlled prostheses and related equipment are not covered by this program. 2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association. 3. The following items are included in the reimbursement for a prosthesis and are not separately billable: <ol style="list-style-type: none"> a. Evaluation of the residual limb and gait; b. Fitting of the prosthesis; c. Cost of base component parts and labor contained in HCPCS base codes; d. Repairs due to normal wear or tear within 90 days of delivery; e. Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the recipient's functional abilities.

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(continued) Prosthetic Devices	<p>community ambulator.</p> <p><u>Level 3:</u> Has the ability or potential for ambulation with variable cadence. Typical for the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion.</p> <p><u>Level 4:</u> Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete. Services billed for this functional level are non-covered by Medicaid.</p> <p>Foot and Knee Prosthesis: Foot and knee prosthesis coverage will be based on medical necessity by the QIO-like vendor. The recipient's functional level will be taken into consideration.</p> <p>Sockets: 1. Test (diagnostic) sockets for immediate prostheses (L5400-L5460) are not medically necessary. 2. No more than two test (diagnostic) sockets for an individual prosthesis are medically necessary without additional documentation. 3. No more than two of the same socket inserts (L5654-L5665) are allowed per individual prosthesis at the same time.</p>		

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Policy: OSTEOGENESIS STIMULATOR DEVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Osteogenesis Stimulator <i>(Non-spinal Noninvasive Electrical)</i>	Device may be covered if: 1. Non-union of a long bone fracture after six months have elapsed without healing of the fracture; 2. Failed fusion of a joint, other than in the spine, where a minimum of nine months have elapsed since the last surgery; or 3. Congenital pseudarthrosis	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Rental for 20-week intervals, additional authorization will be considered with medical justification. 2. Electric Implantable and Ultrasonic Osteogenic Stimulators are non-covered Medicaid services.
Osteogenesis Stimulator <i>(Spinal Noninvasive Electrical)</i>	Device may be covered if: 1. Failed spinal fusion where a minimum of nine months have elapsed since the last surgery; 2. Following a multilevel spinal fusion surgery involving three or more vertebrae; or 3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Rental for 20-week intervals, additional authorization will be considered with medical justification. 2. Electric Implantable and Ultrasonic Osteogenic Stimulators are non-covered Medicaid services.

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Policy: PHOTOTHERAPY UNITS			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Phototherapy Unit	1. Bilirubin levels must be at or greater than 12.0 with bilirubin therapy on initial day of treatment. 2. Authorization is for a maximum of three days.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	

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Policy: PNEUMATIC COMPRESSION DEVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Pneumatic Compression Devices <i>(used for lymphedema)</i>	<ol style="list-style-type: none"> 1. One or more limbs involved; and 2. Radical surgical procedure with removal of regional groups of lymph nodes (after radical mastectomy); or 3. Post radiation fibrosis; 4. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction; 5. Scarring of lymphatic channels, 6. Onset of puberty (Milroy's disease); or 7. Congenital anomalies; and 8. Must be treatment of last resort with documented evidence that elevation and custom fabricated gradient pressure stockings or sleeves are ineffective; and 9. Continuous oversight by treating physician (including instruction, treatment plan, fracture and duration of use ongoing monitoring and evaluation). 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 	Note: Rental only.

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Policy: PREGNANCY-RELATED EQUIPMENT			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Home-Based (outpatient) Terbutaline Infusion Pump Therapy	<p>Terbutaline infusion pump therapy is a covered benefit when the following conditions are met:</p> <ol style="list-style-type: none"> 1. The recipient is at high risk for preterm labor and delivery based on one or a combination of factors: <ol style="list-style-type: none"> a. Current diagnosis of preterm labor with uterine contractions of four or more per hour and progressive cervical change; b. Cervical dilatation is less than four centimeters; c. History of preterm labor/delivery with previous pregnancies. 2. The recipient is currently or has recently been under treatment to prevent preterm labor with a combination of the following methods: <ol style="list-style-type: none"> a. Bed rest or restricted activity; b. Oral tocolytic therapy (document ineffectiveness); c. Increased office visits or phone contact for counseling; d. Hospitalization. 3. Appropriate alternative treatment has been tried and was not successful or was contraindicated. 4. Physician states recipient is capable of complying with home Terbutaline infusion pump therapy. 5. Recipient is not less than 20 weeks gestation or more than 37 weeks gestation. 6. Fetus is alive and well with an estimated weight of less than 2,500 grams. 7. Costs associated with Terbutaline infusion pump therapy do not exceed \$240/day. 	<ol style="list-style-type: none"> 1. Physician's/Practitioner's Order/Prescription. 2. Requires a prior authorization. 3. Medical records from physician must be submitted to substantiate all qualifications. 4. Prior authorization will not be processed without medical records to substantiate request. 	Note: Rental only.

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Home Uterine Activity Monitor	<ol style="list-style-type: none"> 1. Recipient has a current diagnosis of pre-term labor and a history of previous pre-term labor/delivery with pregnancies. 2. Records from physician showing pre-term labor with uterine contractions of four or more per hour and progressive cervical changes. 3. Cervical dilation is less than four centimeters. 4. Recipient is ordered on bed rest or restricted activities. 5. Tocolytic therapy initiated (oral, subcutaneous, or intravenous route). 6. Documentation will show there is an increase in physician/patient contact due to pre-term labor symptoms. 7. The recipient is, in the opinion of the physician, capable of complying with the home monitoring program. 8. Recipient is not less than 24 weeks gestation or more than 37 weeks gestation. 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Prior Authorization <u>Note</u>: Prior authorization submitted more than ten days after onset of service may be denied. 3. Medical documentation supporting qualifying factors 	<ol style="list-style-type: none"> 1. Reimbursement only for days of documented telephone contact between recipient/physician and monitoring device. <p style="color: red; margin-top: 10px;">Note: Rental only.</p>

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Apnea Monitor	<ol style="list-style-type: none"> 1. One year qualification for at least one of: <ol style="list-style-type: none"> a. Prematurity (gestational age must be listed on CMS 1500); b. Substantially small for gestational age; c. HX of maternal alcohol abuse; d. HX of maternal narcotics abuse; and/or e. HX of maternal hallucinogenic agent abuse. 2. Six month qualification for at least one of: <ol style="list-style-type: none"> a. Gastro-esophageal reflux; b. Abnormal pneumogram indicating desaturating apnea; c. Periodic respirations; d. Significant bradycardia or tachycardia of unknown or specified origin; e. Congenital heart defect; f. Bronchopulmonary dysplasia or newborn respiratory distress; g. Respiratory distress; h. Family history of SIDS (siblings only); i. Respiratory Syncytial Virus (RSV); j. Apparent Life Threatening Episode (ALTE) with subsequent visits to physician or emergency room; k. Laryngeotracheal malacia; l. Tracheal stenosis; and/or m. Swallowing abnormality. 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 	<ol style="list-style-type: none"> 1. Program limit to one year for diagnoses including prematurity and maternal substance abuse. 2. Other diagnoses limited to six months. 3. An Apnea Monitor is a non-reimbursable service in conjunction with a pressure ventilator, with pressure control pressure support, and flow triggering features.

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Policy: RESPIRATORY SERVICES			
EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
<p>Bi-Level Positive Airway Pressure (BiPAP) Device</p> <p>BiPAP ‘S’ (E0470) (without back up)</p> <p>BiPAP ‘ST’ (E0471) (with back up rate)</p> <p>Bi-Level Positive Airway Pressure (BiPAP) Device</p> <p>BiPAP ‘S’ (E0470) (without back up)</p> <p>BiPAP ‘ST’ (E0471) (with back up rate)</p>	<p>1. For an E0470 or E0471 Respiratory Assist Device (RAD) to be covered, the treating physician must fully document in the recipient’s medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc. A RAD (E0470, E0471) used to administer Noninvasive Positive Pressure Respiratory Assistance (NPPRA) therapy is covered for those recipients with clinical disorder groups characterized as (Group I) restrictive thoracic disorders (e.g., progressive neuromuscular diseases or severe thoracic cage abnormalities), (Group II) severe chronic obstructive pulmonary disease (COPD), (Group III) central sleep apnea (CSA), or (Group IV) obstructive sleep apnea (OSA) (E0470 only) and who also meet the following criteria:</p> <p><u>Group I: Restrictive Thoracic Disorders:</u></p> <p>a. There is documentation in the recipient’s medical record of a progressive neuromuscular disease (e.g., amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (e.g., post-thoracoplasty for TB); and</p> <p>b. An arterial blood gas PaCO₂ , done while awake and breathing the recipient’s usual FIO₂ is > 45 mm Hg; or</p> <p>c. Sleep oximetry demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing the recipient’s usual FIO₂; or</p>	<p>1. Prescription and/or MD signed Prior Authorization/CMN Form.</p> <p>2. Sleep Study (Diagnostic and Titrated sleep studies).</p> <p>3. Medical documentation supporting qualifying factors.</p> <p>4. Refer to specific documentation requirements specified in the Qualifications section for each scenario.</p> <p>5. Manufacturer’s Invoice of cost is required when no rate is established by the DHCFP.</p>	<p>1. The initial rental will be for three months.</p> <p>2. Further approval requires:</p> <p>a. A letter of compliance from the recipient; or</p> <p>b. A completed form found on the QIO-like vendor’s website; or</p> <p>c. Follow up notes from physician documenting compliance with the BiPAP; or</p> <p>d. A readout/printout from the BiPAP supplier documenting regular usage of the BiPAP.</p> <p>3. BiPAP replacement requires proof of compliance or medical necessity.</p> <p>Note: The BiPAP will be rented until the purchase price is reached; this includes the initial three month rental period.</p>

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(continued) BiPAP 'ST' (E0471) <i>(with back up rate)</i>	<ul style="list-style-type: none"> d. For a progressive neuromuscular disease (only), maximal inspiratory pressure is < 60 cm H2O or forced vital capacity is < 50% predicted; and e. Chronic Obstuctive Pulmonary Disease (COPD) does not contribute significantly to the recipient's pulmonary limitation. <p>3. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients within this group of conditions for the first three months of NPPRA therapy (see continued coverage after the initial three months). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary.</p> <p><u>Group II: Severe COPD:</u></p> <ul style="list-style-type: none"> a. An arterial blood gas PaCO₂ done while awake and breathing the recipient's usual FIO₂ is ≥ 52 mm Hg; and b. Sleep oximetry demonstrates oxygen saturation ≤ 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual FIO₂ (whichever is higher); c. An arterial blood gas PaCO₂, done while awake and breathing the recipient's usual FIO₂, is ≥ 52 mm Hg; and d. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out. 		

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(continued) Bi-Level Positive Airway Pressure (BiPAP) Device BiPAP 'S' (E0470) <i>(without back up)</i> BiPAP 'ST' (E0471) <i>(with back up rate)</i>	4. If all of the previously described criteria for recipients with COPD are met, an E0470 device will be covered for the first three months of NPPRA therapy (see Continued Coverage). An E0471 device will not be covered for a recipient with COPD during the first two months, because therapy with a E0470 device with proper adjustments of the device's settings and recipient accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. (See further in this section for coverage of an E0471 device for COPD after two month's use of an E0470 device). 5. If all of the previously described criteria are not met, E0470 and related accessories will be denied as not medically necessary. If E0471 is billed, even if the criteria for an E0470 device are met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary. <u>Group III: Central Sleep Apnea (e.g., apnea not due to airway obstruction):</u> Prior to initiating therapy, a complete facility-based, attended polysomnogram must be performed documenting the following: <ol style="list-style-type: none"> The diagnosis of central sleep apnea (CSA); The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventilation; The ruling out of CPAP as effective 		

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	<p>therapy if OSA is a component of the sleep-associated hypoventilation; and</p> <p>d. Oxygen saturation \leq 88% for at least five continuous minutes, done while breathing the recipient's usual FIO₂; and</p> <p>e. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the recipient's usual FIO₂.</p> <p>6. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients with documented CSA conditions for the first three months of NPPRA therapy (see Continued Coverage). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary.</p> <p><u>Group IV: Obstructive Sleep Apnea (OSA):</u> Criteria (a) and (b) are both met:</p> <p>a. A complete facility-based, attended polysomnogram has established the diagnosis of obstructive sleep apnea according to the following criteria:</p> <ol style="list-style-type: none"> 1. The apnea-hypopnea index (AHI) is \geq 15 events per hour; <u>or</u> 2. The AHI is from 5 to 14 events per hour with documented symptoms of: <ol style="list-style-type: none"> a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; <u>or</u> b. Hypertension, ischemic heart 		

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(continued) Bi-Level Positive Airway Pressure (BiPAP) Device BiPAP 'S' (E0470) <i>(without back up)</i> BiPAP 'ST' (E0471) <i>(with back up rate)</i>	<p>disease, or history of stroke; and</p> <p>b. A single level device E0601, Continuous Positive Airway Pressure (CPAP) device has been tried and proven ineffective.</p> <p>7. If the previously described criteria is met, an E0470 device will be covered for the first three months of NPPRA therapy (see Continued Coverage). If E0470 is billed and these criteria are not met but the coverage criteria in the DMEMAC LCD and/or Policy Articles for Continuous Positive Airway Pressure System (CPAP) are met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601.</p> <p>8. An E0471 device is not medically necessary if the primary diagnosis is OSA. If E0471 is billed, since the E0471 is in a different payment category than E0470 and E0601 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.</p> <p>Continued Coverage For E0470 And E0471 Devices Beyond First Three Months Of Therapy:</p> <p>1. Recipients covered for the first three months for an E0470 or E0471 device must be re-evaluated to establish the medical necessity of continued coverage beyond the first three months. While the recipient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which will base a decision to continue coverage beyond this time must occur no</p>		

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(continued) Bi-Level Positive Airway Pressure (BiPAP) Device BiPAP ‘S’ (E0470) <i>(without back up)</i> BiPAP ‘ST’ (E0471) <i>(with back up rate)</i>	<p>sooner than 61 days after initiating therapy by the treating physician. Medicaid will not continue coverage for the fourth and succeeding months of NPPRA therapy until this re-evaluation has been completed.</p> <p>2. There must be documentation in the recipient’s medical record about the progress of relevant symptoms and recipient usage of the device up to that time. Failure of the recipient to be consistently using the E0470 or E0471 device for an average of four hours per 24 hour period by the time of the re-evaluation (on or after the 31st day, but no later than 91 days after initiation of therapy) would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason to deny continued coverage as not medically necessary.</p> <p>3. The following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months: a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the recipient is compliantly using the device (an average of four hours per 24 hour period) and that the recipient is benefiting from its use. A “Usage Evaluation” form FH-1A, found on the QIO-like vendor’s website is available for use at: https://www.medicaid.nv.gov/, select “Provider” then “Forms”. It is not mandatory that this form be used as long as the above information is provided by the treating physician.</p>		

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(continued) Bi-Level Positive Airway Pressure (BiPAP) Device BiPAP 'S' (E0470) <i>(without back up)</i> BiPAP 'ST' (E0471) <i>(with back up rate)</i>	4. If the above criteria are not met, continued coverage of an E0470 or E0471 device and related accessories will be denied as not medically necessary. 5. For Group II (COPD) recipients who qualified for an E0470 device, if at a time no sooner than 61 days after initial issue and compliant use of an E0470 device, the treating physician believes the recipient requires an E0471 device, the E0471 device will be covered if the following criteria are met: <ol style="list-style-type: none"> an arterial blood gas PaCO₂, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the recipient's usual FIO₂, still remains ≥ 52 mm Hg; a sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of an E0470 device, and while breathing with the E0470 device, demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual FIO₂ (whichever is higher); and a signed and dated statement from the treating physician, completed no sooner than 61 days after initiation of the E0470 device, declaring that the recipient has been compliantly using the E0470 device (an average of four hours per 24 hour period) but that the recipient is NOT benefiting from its use. 6. If the above criteria for an E0471 are not met, since the E0471 is in a different payment category than E0470 and a least costly		

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(continued) Bi-Level Positive Airway Pressure (BiPAP) Device BiPAP ‘S’ (E0470) <i>(without back up)</i> BiPAP ‘ST’ (E0471) <i>(with back up rate)</i>	medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.		
Continuous Positive Airway Pressure Device CPAP (E0601)	<ol style="list-style-type: none"> A single level continuous positive airway pressure (CPAP) device (E0601) is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram <u>and</u> meets either of the following criteria (a or b): <ol style="list-style-type: none"> The AHI is ≥ 15 events per hour; <u>or</u> The AHI is from 5 to 14 events per hour with documented symptoms of: <ol style="list-style-type: none"> Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; <u>or</u> Hypertension, ischemic heart disease, or history of stroke. <p><u>Note:</u> The AHI must be calculated based on a minimum of 2 hours of recorded sleep and must be calculated using actual recorded hours of sleep (e.g., the AHI may not be an extrapolated or a projected calculation).</p> Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 31st day but no later than 91 days after initiating therapy, the supplier ascertain from either the recipient or the treating physician that the recipient is 	<ol style="list-style-type: none"> Prescription and/or MD signed Prior Authorization/CMN Form. Sleep Study (Diagnostic and Titrated sleep studies). Medical documentation supporting qualifying factors. Manufacturer’s Invoice of cost is required when no rate is established by the DHCFP. Refer to specific documentation requirements specified in the Qualifications section for each scenario. 	<ol style="list-style-type: none"> The initial rental will be for three months. Further approval requires: <ol style="list-style-type: none"> letter of compliance from the recipient; or a completed form found on the QIO-like vendor’s website; or follow up notes from physician documenting compliance with the CPAP; or a readout/printout from the CPAP supplier documenting regular usage of the CPAP. CPAP replacement requires proof of compliance or medical necessity. <p>Note: The CPAP will be rented until the purchase price is reached; this includes the initial three month rental period.</p>

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(continued) Continuous Positive Airway Pressure Device CPAP (E0601)	<p>continuing to use the CPAP device. Continued use is defined as an average of four hours per 24 hour period.</p> <p>A "Usage Evaluation" form FH-1A, found on the QIO-like vendor's website is available for use at: https://www.medicaid.nv.gov/, select "Provider" then "Forms". It is not mandatory that this form be used as long as the previously listed is provided by the treating physician.</p> <p>The supplier cannot provide answers to any of the information, as it must be obtained from the recipient, caregiver, spouse, or attending physician. Information should include:</p> <ol style="list-style-type: none"> Number of hours a day the machine is used. Number of months using machine. Will the recipient continue to use the machine in the future? <p>Identify who has answered the information (cannot be the supplier).</p>		

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
<p>High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)</p> <p>(Rental and the initial purchase includes hose and vest)</p> <p>Replacement Items:</p> <p>High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)</p> <p>High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)</p>	<p>FDA-approved high frequency chest compression (HFCC) device (vest coupled to a pneumatic compressor) is a covered benefit for recipients who meet all of the following qualifications:</p> <ol style="list-style-type: none"> 1. Documented medical justification for the need and length of time the HFCC system will be utilized; and 2. Recipient must have one of the following diagnoses which causes excessive, tenacious secretions and impairs ability to clear secretions: <ol style="list-style-type: none"> a. Cystic fibrosis; b. Chronic bronchiectasis; or c. Chronic neuromuscular disorder with prior history of pneumonia or other significant worsening of pulmonary functioning; 3. Well-documented failure of other methods, or inability to use other airway clearance therapies including chest physical therapy (CPT), flutter valve, etc. to adequately mobilize retained secretions; 4. Documentation of physician’s treatment plan that includes external manipulation of the thorax at least daily to release retained secretions; 5. Documented evidence that recipient is having difficulty with secretion clearance, or presence of atelectasis caused by mucus plugging confirmed by high resolution, spiral, or standard CT scan; 6. Age greater than 2 years; and 7. Recipient and caregiver cannot adequately perform the needed bronchial drainage treatment (such as having more than one child requiring CPT or a valid medical reason that prohibits the CPT). 	<ol style="list-style-type: none"> 1. Physician’s order/prescription. 2. Completed prior authorization form. 3. Physician’s assessment to include the diagnosis for treatment. Clearly defined medical need for airway clearance as evidenced by retained secretions, prior history of pneumonia or other significant worsening pulmonary function, presence of atelectasis caused by mucus plugging by report. 4. Documented failure of CPT, type used, frequency, duration of use and outcomes. 5. Current medications, route of administration, dosage, and frequency. 6. Diagnostic studies such as high resolution, spiral, or standard CT scan. 7. Number of times per day recipient requires CPT. 8. Age of recipient. 9. Identify primary caregiver and the caregiver availability. 10. The prescribing physician will need to submit periodic follow-up reports. 11. Manufacturer’s Invoice of cost is required when no rate is established by the DHCFP. 	<ol style="list-style-type: none"> 1. Disease conditions such as: cystic fibrosis (CF), bronchiectasis, and immotile cilia syndrome can lead to abnormal airway clearance which is a source of increased sputum production, often purulent and tenacious; chest physiotherapy (CPT) becomes necessary. In conditions such as CF, excessive tenacious secretions necessitate routine CPT to prevent airway obstruction leading to secondary infection, the principal cause of morbidity and mortality. 2. The standard method of CPT is manual percussion and postural drainage. In the home setting, CPT is administered to the recipient by a trained adult one to three times a day for 20 - 30 minutes per session. 3. FDA approved HFCC (oscillating devices) have been utilized as an alternative to conventional manual chest physical therapy to promote the clearance of respiratory secretions in patients with impaired ability to cough or otherwise expel them on their own. 4. For purchase to be considered, a three month trial period on a rental basis is required. After the trial period and receipt of the follow up documentation showing evidence of compliance and effectiveness, the HFCC device may be approved for purchase. 5. The QIO-like vendor will provide authorization to include the 61st through 120 days if medically necessary.

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<p>(continued)</p> <p>High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)</p> <p>(Rental and the initial purchase includes hose and vest)</p> <p>Replacement Items:</p> <p>High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)</p> <p>High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)</p>	<p>Recipients who have a documented diagnosis, other than those listed under item 2, which causes excessive, tenacious secretions and impairs ability to clear secretions may be reviewed on a case-by-case basis to determine Medical Necessity (e.g., not experimental or investigational). For consideration, the recipient must meet the following qualifications:</p> <ol style="list-style-type: none"> 1. Recipient meets qualifications 1 through 7, excluding item 2; and 2. Documented evidence of a recent prior history of pneumonia or other significant worsening pulmonary functioning. <p>Qualifications for Continued Use</p> <p>Continued coverage of the HFCC device beyond the three-month trial of therapy requires documentation dated no sooner than the 61st day, but not later than 120 days after initiating therapy in one of the following formats:</p> <ol style="list-style-type: none"> 1. The treating physician submits documentation to include the effectiveness of treatment, recipient's compliance and tolerance of the therapy; or 2. Report via monthly usage meter checks documenting use at least 67% of prescribed frequency. 		<p>Not Medically Necessary</p> <ol style="list-style-type: none"> 1. When the criteria in this policy are not met. 2. Recipient receiving duplication of services. 3. The DHCFP will not reimburse providers for bronchial drainage performed by a therapist or other health care professional while the recipient has the bronchial drainage vest (e.g., home health services where a physical therapist, nurse, and/or aide is performing CPT and postural drainage). 4. Recipients who have contraindication of external manipulation of the thorax as defined by American Association of Respiratory Care (AARC) contained in their clinical practice guidelines for Postural Drainage Therapy which include, but are not limited to: <ul style="list-style-type: none"> a. unstable head or neck injury; b. active hemorrhage with hemodynamic instability; c. subcutaneous emphysema; d. spinal fusion or spinal anesthesia; e. recent skin grafts or flaps on the thorax; f. burns, open wounds; g. skin infections of the thorax; h. recently placed trans-venous pacemaker or subcutaneous pacemaker; i. suspected pulmonary tuberculosis; j. lung contusion; k. bronchospasm;

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(continued) High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483) (Rental and the initial purchase includes hose and vest) Replacement Items: High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025) High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)			l. osteoporosis; m. osteomyelitis of the ribs; n. coagulopathy; and/or o. complaint of significant chest wall pain. Note: The DHCFP will not reimburse providers when items are provided prior to PA approval.
Humidifiers and Supplies	1. Medical evidence/documentation recipient is a new start or compliant with current positive airway pressure therapy. 2. Sleep study or equipment fitting documentation showing recommended type and sizing. 3. Quantity limited to reimbursable guidelines.	1. Prescription and/or MD signed Prior Authorization Form 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 fee schedule.

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Nebulizers and Compressors	<p>1. A small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570, E0571) are covered when:</p> <ol style="list-style-type: none"> a. It is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease; b. It is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alfa to a recipient with cystic fibrosis; c. It is medically necessary to administer pentamidine to recipients with HIV, and complications of organ transplants; or d. It is medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions. <p><u>Note:</u> For criterion (a) to be met, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs. The reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an MDI must be documented in the recipient's medical record and be available to Medicaid on request.</p> <p>2. A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A7018 or A4216) are covered when it is medically necessary to deliver humidity to a recipient with thick, tenacious secretions, who has cystic fibrosis, a tracheobronchial stent.</p>	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 	<ol style="list-style-type: none"> 1. Reference DMEPOS PT 33 fee schedule. 2. Small volume ultrasonic nebulizer (E0574) and large volume ultrasonic nebulizer (E0575) will be reimbursed at the least costly alternative of a pneumatic compressor (E0570).

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(continued) Nebulizers and Compressors	Combination code E0585 will be covered for the same indications. An E0565 or E0572 compressor and filtered nebulizer (A7006) are also covered when it is medically necessary to administer pentamidine to recipients with HIV. If a large volume nebulizer, related compressor/generator, and water or saline are used predominantly to provide room humidification it will be denied as non-covered.		

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<p>Oximeter: E0445- device for measuring blood oxygen levels, non-invasive</p> <p>Accessories: Oxygen probe (A4606) for use with continuous oximeter device, replacement</p>	<ol style="list-style-type: none"> 1. The DHCFP covers Pulse Oximetry in the home as medically necessary when one of the following criteria is met: <ol style="list-style-type: none"> a. Any age determination: <ol style="list-style-type: none"> 1. Recipient is dependent on both a ventilator and supplemental oxygen; 2. Recipient has a tracheostomy and is oxygen dependent; 3. Recipient is on supplemental oxygen and weaning is in process; or 4. Recipient is discharged from inpatient stay for pulmonary diagnosis. 	<ol style="list-style-type: none"> 1. Prescription by physician; 2. Prior authorization; and 3. Documentation by the physician of recipient's medical condition, which documents the need for in-home use of an oximeter, finger or continuous models, duration of use, and responses for decreased O₂. 4. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP. <p>Recertification of Prior Authorization:</p> <ol style="list-style-type: none"> 1. Recertification is allowed until the recipient no longer meets criteria, the device is removed from the home, or purchase price has been met; and 2. Physician progress notes/narratives to substantiate the continued need to use the oximeter for decreased O₂ saturations. Allowable notations to include family, recipient and/or caregivers responses. 	<ol style="list-style-type: none"> 1. Initial approval may be for 30-90 days. 2. Approval for a Continuous Oximeter model requires medical necessity for all additional features i.e.: pulse, Alarm, O₂ Stats, etc. 3. Oximeter testing is not a reimbursable service for DME providers. 4. Requires plans for training/instructions of family/caregiver.
<p>Oxygen (O₂): Concentrators Portables Regulators O₂ Carts</p> <p>Oxygen Supplies: Tubing Cannulas O₂ Masks Humidifiers</p>	<ol style="list-style-type: none"> 1. Arterial blood gases or an ear oximetry reporting: <ol style="list-style-type: none"> a. PO₂ Level of 60 mmHG or less on room air; or b. 80 mmHG or less on O₂; or c. O₂ saturation (sat) level of 89% or less; and d. Medical Necessity; e. Must list conditions of study (rest, sleeping, exercising, room air, on oxygen). 2. CHILDREN: 92% or less room air saturation, at rest. 3. O₂ sats must be performed within 60 days of requested dates of service. 	<ol style="list-style-type: none"> 1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Oximetry spot check or overnight tape results 3. Medical documentation supporting qualifying factors. 	<ol style="list-style-type: none"> 1. Oximetry test must be performed by a physician or qualified laboratory. O₂ saturations (sats) will not be accepted from an oxygen supplier. 2. Liquid oxygen and related equipment are non-covered Medicaid services unless recipient does not have electrical utilities at residence. Reimbursement will be only for stationary at the same rate as concentrator.

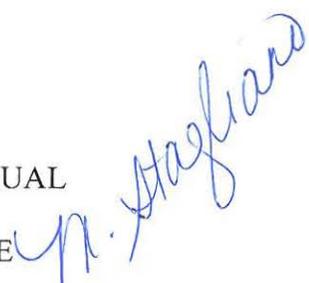
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Respirometers	1. Medical evidence/documentation supporting a related diagnosis for equipment.		
Suction Pumps	1. Recipients who have difficulty raising and clearing secretions due to: a. Cancer or surgery of the throat or mouth; b. Dysfunction of the swallowing muscles; c. Unconsciousness or obtunded state; or d. Tracheostomy (V44.0).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 Fee Schedule for quantity limits.
Ventilators	1. Medical evidence/documentation supporting a related diagnosis for equipment (e.g., tracheostomy).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP.	1. Medical Supplier must keep back up inventory available for rented equipment in emergent situations. Reimbursement for a back up ventilator provided in the recipient's home will only be allowed if it is medically prohibitive for a provider to respond in an emergent situation such as a recipient being on 24 hour ventilation support.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 8, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1400 – HOME HEALTH AGENCY



BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 1400, Home Health Agency, has been revised to remove the Definitions and References/Cross References sections. The Definitions were moved to the MSM Addendum and the References/Cross References to MSM Chapter 100.

These policy changes are effective November 9, 2011.

<u>MATERIAL TRANSMITTED</u>	<u>MATERIAL SUPERSEDED</u>
MTL 26/11 CHAPTER 1400 – HOME HEALTH AGENCY	MTL 35/03, 23/07, 11/09 CHAPTER 1400 – HOME HEALTH AGENCY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1402	Reserved	Removed Definition Section.
1405	References and Cross References	Removed References.

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1400 INTRODUCTION

HOME HEALTH AGENCY (HHA) SERVICES

The Division of Health Care Financing and Policy (DHCFP) Home Health Agency (HHA) Program is a mandated home health care benefit provided to recipients in his/her residence. HHA services are a component in the continuum of care which allows recipients to remain in his/her home. HHA services may be provided to eligible recipients, based on medical necessity, program criteria, utilization control measures and the availability of the state's resources to meet recipient needs. HHA services are provided on an intermittent basis, certified by a physician and provided under a physician approved Plan of Care (POC). The Home Health Agency (HHA) service benefit provides Skilled Nursing (SN) services, and other therapeutic services such as Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Home Health Aides or Certified Nursing Aides (CNAs). Respiratory Therapists (RT) and Registered Dieticians (RD) are also a benefit with limitations. Services are generally provided on a short-term basis as opposed to long-term custodial services.

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

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1401 AUTHORITY

- A. The Home Health Agency (HHA) program is a mandatory benefit under 1905(1)(18) of the Social Security Act.
- B. The citation, which explains and interprets the federal regulations governing Home Health services, is found in the Code of Federal Regulations (CFR) Title 42, Part 440.70 and 441.15.

	MTL 26/11
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 1402
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1402 **RESERVED**

	MTL 23/07
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1403 POLICY

1403.1 POLICY STATEMENT

The home health care benefit reimburses for medically necessary and appropriate home visits by skilled nurses, physical therapists, occupational therapists, speech therapists, respiratory therapists, dieticians and home health aides to Medicaid recipients. A home health agency provides skilled services and non-skilled services to recipients on an intermittent and periodic basis.

Services are intended to provide skilled intervention with emphasis on recipient/caregiver teaching. Legally responsible adults, willing caregivers and recipients are expected to be taught care which can be rendered reasonably and safely by non medical persons.

1403.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

To be determined eligible for HHA services, the following are necessary:

- a. The recipient must be program eligible for Title XIX (Medicaid) or Title XXI (Nevada Check Up) services;
- b. A Legally Responsible Adult (LRA) or other willing caregiver is not available or capable of providing all services;
- c. The recipient must have a need for a qualifying skilled service.
- d. Services must be reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipients' unique medical condition and the standard of practice within the community.
- e. Services must be sufficient in amount, duration and scope to reasonably achieve its purpose;
- f. Services must be provided under a Plan of Care (POC) signed by the physician;
- g. Services must be provided on an intermittent and periodic basis;
- h. Services must have prior authorization;
- i. Services must be provided in the recipient's place of residence;

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- j. Services cannot be provided in a physician's office, clinic or other outpatient setting.
- k. Home care services may be appropriate when one or more of the following situations exist:
 - 1. The recipient's illness, injury or disability precludes going to the physician's office, clinic or outpatient setting;
 - 2. A hardship would occur if service were provided outside the home, i.e., a recipient just out of the hospital following major surgery;
 - 3. The service is contraindicated outside the home based on recipient's medical condition, i.e., a recipient who must be protected from infection;
 - 4. The service outside the home would interfere with the effectiveness of the service, i.e., traveling an extreme distance or a recipient whose frequent service need, such as IV therapy three times per day, cannot reasonably be accommodated outside the home;
 - 5. The recipients documented medical condition is so fragile or unstable that the physician state that leaving the home is undesirable; and
 - 6. The service, such as teaching, can be more effectively accomplished at home.

2. COVERED SERVICES

- a. Skilled nursing services provided by a licensed nurse performing skilled interventions to maintain or improve the recipient's health status.
- b. Physical therapy services provided by a licensed physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.
- c. Occupational therapy services provided by a licensed occupational therapist to improve or restore function.
- d. Speech therapy provided by a licensed speech pathologist for the treatment of speech and language disorders, communicative disabilities or swallowing disorders.
- e. Respiratory therapy provided by a licensed respiratory therapist.

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- f. Dietician services provided by a registered dietician for consultative services for nutritional deficits or recipients at risk of nutritional deficits.
- g. Home Health Aide services provided by a Certified Nursing Aide (CNA) under the supervision of a registered nurse and in accordance with the Nurse Practice Act.

3. NON-COVERED HHA SERVICES

No reimbursement or coverage will be provided for:

- a. Services provided to a recipient that is ineligible or becomes ineligible for Title XIX or Nevada Check Up;
- b. Services normally provided by an immediate relative, legally responsible adult or other willing and capable caregiver;
- c. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a Nursing Facility for the Mentally Ill (NF/MI) or Intermediate Care Facility for the Mentally Retarded (ICF/MR) or an institution for the treatment of chemical addiction;
- d. Services rendered to recipients in pediatric or adult day care centers;
- e. Services rendered at school sites which provide "school based health service" pursuant to IDEA 300.24;
- f. Services provided to someone other than the intended recipient;
- g. Services that the DHCFP determines could reasonably be performed by the recipient;
- h. Services provided without authorization;
- i. Services provided by the HHA that were not noted on the initial physician or subsequent medical orders, or Plan of Care (POC);
- j. Service requests that exceed program limits;
- k. Services provided at a recipients home that could have been obtained in an outpatient setting (e.g. lab work for an ambulatory recipient);
- l. Services determined not medically necessary by DHCFP;

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- m. Homemaker services;
- n. Medical Social Services (MSS);
- o. Companion care that is intended to provide friendly or social time with a recipient;
- p. Sitter or services that are intended for individuals to watch or supervise a recipient in the absence of a legally responsible adult or primary caregiver and that provide no skilled care;
- q. Respite care;
- r. Duplication of services;
- s. Transportation of recipients to Medicaid reimbursable settings, unless the HHA is a Medicaid transportation provider. Refer to Chapter 1900;
- t. Travel time to and from the recipients residence;
- u. Routine services such as physical checkups or assessments that are performed without relationships to a treatment of diagnosis for a specific illness;
- v. Routine newborn teaching and post-partum follow ups and assessments;
- w. Skilled nursing visits to children for the administration of Synagis outside the guidelines of Nevada Medicaid policy;
- x. Routine supplies customarily used during the course of HHA visits. These supplies are included in the staff's supplies and are not designated for a specific recipient. Routine supplies may include but are not limited to non-sterile gloves and thermometer covers. These supplies are included in the cost-per-visit of HHA service;
- y. Routine personal hygiene supplies may include, but are not limited to such items as shampoos, soaps, lotions or powders, toothpaste, combs, etc.;
- z. Routine disposable supplies required on a monthly basis. These supplies must be obtained from a DME or pharmacy provider (refer to Chapters 1200 and 1300);
- aa. Personal comfort items which do not contribute to the treatment of an illness or injury or the functioning of a malformed body part. Personal comfort items may include but are not limited to items such as air conditioner, radios, etc.

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1403.1B PROVIDER RESPONSIBILITY

The provider shall furnish skilled nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, home health aides or certified nursing aides, respiratory therapists and registered dieticians to eligible recipients as identified in the physician's written Plan of Care (POC). Services are to be provided as specified in this Chapter.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare Certified Home Health Agency (HHA) licensed and authorized by state and federal laws to provide health care services in the home.

2. MEDICAID ELIGIBILITY

HHAs must verify the recipient's eligibility for Medicaid. Authorization for home health care is valid only if the recipient is eligible for Medicaid during the month the service is provided. The provider must verify each month the continued Medicaid eligibility for each recipient. Verification of Medicaid eligibility is the responsibility of the HHA.

3. THIRD PARTY LIABILITY (TPL)

HHAs must determine, on admission to HHA services, the primary payer. If Medicaid is not the primary payer, the provider must bill the third party payor before billing Medicaid.

4. PHYSICIANS ORDER AND PLAN OF CARE

HHA services are initiated per a physicians order. HHA program services are provided per the Plan of Care (POC) which is documented on a CMS 485. The POC is a written set of medical orders signed by the physician which certify the specific HHA services that will be provided, the frequency of the services, and the projected time frame necessary to provide such services. The Plan of Care is reviewed by the physician every 60 days. A new POC is required when there is a change in the recipient's condition, change in orders following hospitalization, and/or change in the physician.

5. PRIOR AUTHORIZATION

HHAs must obtain proper authorization for all Home Health Agency services prior to the start of care. Refer to the authorization process 1403.1D.

6. PLACE OF SERVICE

HHA services must be provided in the recipient's place of residence.

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7. HOME HEALTH AGENCY VISITS

a. Evaluation visit

HHA's are required to have written policies concerning the acceptance of the recipient by the agency. This includes consideration of the physical facility available in the recipient's place of residence, homebound status and the attitudes of family members for the purpose of evaluating the feasibility of meeting the recipient's medical needs in the home health setting.

When personnel of the HHA make an initial visit to assess the recipient the cost of the visit is considered an administrative cost and is not reimbursable as a visit at this point since the recipient has not been accepted for care. If during the course of the initial visit, the recipient is determined appropriate for home health care by the agency and the recipient received the first skilled service as ordered under the POC, the visit becomes the first billable visit as an RN extended visit.

b. Supervisory visit

A supervisory visit made by a registered nurse to complete a recertification visit or to evaluate the delivery of specific needs of the recipient by a CNA or LPN can be authorized only once every 60-62 days. This is authorized as a RN extended visit.

c. Visit types

Two types of visits may be provided under skilled nursing. These are: An extended visit, which is defined as any visit exceeding 30 minutes but not more than 90 minutes; and the nurse's brief visit, which is defined as a visit of 30 minutes or less. Visits for certified nursing aides are approved for the first hour and each additional ½ hour thereafter.

8. RECIPIENT RIGHTS

The Home Health Agency (HHA) has an obligation to protect and promote the exercise of the recipient rights. A patient has the right to exercise his rights as a patient of the provider. A patient's family or guardian may exercise a patient's rights when a patient has been judged incompetent. The recipient has the right to be notified in writing of his rights and obligations before treatment is begun. HHA's must provide each patient and family with a written copy of the recipient's bill of rights. A signed and dated statement acknowledging receipt of the patient's Bill of Rights will be included in the patient's medical record. Refer to recipient rights later in this Chapter.

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9. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers will be in compliance with all laws relating to incidents of abuse, neglect, or exploitation.

a. CHILD ABUSE

State law requires that certain persons employed in certain capacities must make a report to a child protective services agency or law enforcement agency immediately, but in no event later than 24 hours, after there is reason to suspect a child has been abused or neglected. For minors under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected abuse.

Refer to NRS 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adult aged 60 and over, the Division for Aging Services (DAS) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

For all other individuals, contact local social services and/or law enforcement agencies.

10. COMPLAINT RESOLUTION

The provider must respond to all complaints in a reasonable and prompt manner. The provider must perform recipient/provider problem solving and complaint resolution.

a. The provider must maintain records that identify the complaint, the date received and the outcome; and

b. The provider must submit documentation regarding the complaint to Nevada Medicaid Central office (NMCO) immediately upon request.

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11. TERMINATION OF SERVICES

a. The provider may terminate services for any of the following reasons:

1. The recipient or other persons in the household subjects home care staff to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;
2. The recipient is ineligible for Medicaid;
3. The recipient requests termination of services;
4. The place of service is considered unsafe for the provision of HHA services;
5. The recipient is admitted to an acute hospital setting or other institutional setting;
6. The recipient or caregiver refuses to comply with the physician's POC;
7. The recipient or caregiver is non cooperative in the establishment or delivery of services;
8. The recipient no longer meets the criteria for HHA services;
9. The recipient refuses service of a skilled nurse based solely or partly on the race, religion, sex, marital status, color, age, disability or national origin;
10. The provider is no longer able to provide services as authorized (i.e. no qualified staff).

Note: A provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's HHA program. The recipient may choose another provider.

b. IMMEDIATE TERMINATION

The provider may terminate HHA services immediately for reasons one through five listed above.

Note: The nurse provider must comply with 632.895.6 of the Nurse Practice Act. Other licensed professionals must comply within their standard practice act.

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c. ADVANCE NOTICE TERMINATION

The provider must provide at least five calendar days advance written notice to recipients when HHA services are terminated for reasons six through ten listed above.

d. NOTIFICATION REQUIREMENTS

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The QIO-like vendor must be informed of the termination of services as the Nevada Medicaid District Office (NMDO) Care Coordinator within two working days. The provider must submit written documentation regarding the termination to the NMDO within five working days.

12. RECORDS

The provider must maintain medical records which fully disclose the extent and nature of the service provided to the recipient and which supports fees or payments made. Medical and financial records and all other records provided must be maintained for an interval of not less than six years. Following HIPAA Privacy Regulations contained in 45 CFR 160 and 164, the provider must make records available upon request to the Division.

1403.1C RECIPIENT RESPONSIBILITY

1. The recipient or personal representative shall:

- a. Provide the HHA with a valid Medicaid card;
- b. Provide the HHA with accurate and current medical information, including diagnosis, attending physician, medication regime, etc.;
- c. Notify the HHA of all insurance information, including the name of other third party insurance coverage, such as Medicare, CHAMPUS and Veterans Administration;
- d. Inform the HHA of any other home care benefit that he or she is receiving through state plan services, such as Personal Care Aide (PCA) services, Private Duty Nursing (PDN) visits or therapy services. Services provided through another agency or program such as respite, case management or participation in a Waiver program must also be identified;
- e. Sign the HHA visit form to verify services were provided;

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- f. Cooperate in establishing the need for and the delivery of services;
- g. Comply with the delivery of service as outlined in the Plan of Care;
- h. Notify the HHA when scheduled visits cannot be kept or services are no longer required;
- i. Notify the HHA of unusual occurrences or complaints regarding delivery of services or dissatisfaction with specific staff;
- j. Provide the HHA with a copy of Advance Directives, if applicable;
- k. Not request the provider agency staff to work more hours than authorized or to change the days/hours approved;
- l. Not request the provider agency staff to provide care to non-recipients or to provide service not on the POC (babysitting, housekeeping tasks, etc.); not subject the provider to physical and/or verbal abuse, sexual harassment, exposure to the use of illegal substances or threats of physical harm; and
- m. Not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability, and/or national origin.

2. Recipient Rights

Every Medicaid recipient, their LRA or legal guardian is entitled to receive a statement of "Patient Rights" from their provider. The recipient should review and sign a statement acknowledging receipt of this document. The patient rights should include, at a minimum, the following:

- a. A patient has the right to courteous and respectful treatment, privacy, and freedom from abuse;
- b. A patient has the right to be free from discrimination because of race, creed, color, sex, national origin, sexual orientation, and diagnosis;
- c. A patient has the right to have his property treated with respect;
- d. A patient has the right to confidentiality with regard to information about his health, social and financial circumstances, and about what takes place in his home;
- e. A patient has the right to access information in his own record upon written request;

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- f. A patient has the right to voice grievances regarding treatment of care that is, or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so;
- g. A patient has the right to be informed of the provider's right to refuse admission to, or discharge any patient whose environment, refusal of treatment, or other factors prevent the HHA from providing care;
- h. A patient has the right to be informed of all services offered by the agency prior to, or upon admission to the agency;
- i. A patient has the right to be informed of his condition in order to make decisions regarding his or her home health care;
- j. The HHA must advise a patient in advance of the disciplines that will be furnished, the care to be furnished, and the frequency of visits;
- k. The patient must be notified in advance of any changes in the plan of care before the change is made;
- l. A patient has the right to participate in the development of the plan of care, treatment, and discharge planning;
- m. A patient has the right to refuse services or treatment; and
- n. A patient has the right to request a Fair Hearing when disagreeing with the DHCFF's action to deny, terminate, reduce or suspend service.

1403.1D AUTHORIZATION PROCESS AND REIMBURSEMENTS

1. PRIOR AUTHORIZATION

Home Health Agency (HHA) services may be authorized after providers fax a completed Home Health Prior Authorization form to Nevada Medicaid's Quality Improvement Organization (QIO-like vendor). The request should be submitted two days prior to the start of care. The QIO-like vendor will review and complete the authorization process for Home Health Agency (HHA) services utilizing criteria identified in a clinical decision support guide. QIO-like vendor staff will use this criterion to review for medical necessity and utilization control procedures.

The authorization number will be issued by the QIO-like vendor using a numbering system. The QIO-like vendor will fax the authorization to the requesting provider with the

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authorization number. The QIO-like vendor will specify the exact number of services approved. The QIO-like vendor will generate the Notice of Decision (NOD) if the services approved are less than requested and/or constitute an adverse action. A copy will be sent to the recipient and the provider.

All requests, except initial assessments, require prior authorization request. The Home Health prior authorization form must be complete, including the primary diagnosis, ICD-9 codes, descriptions of wound(s), social situation, Dates of Service (DOS), Third Party Liability (TPL), Plan of Care (POC), and specific services requested. Processing may be delayed, or a technical denial issued, if information submitted is illegible or incomplete.

In an emergent situation when the QIO-like vendor is closed, such as nights or weekends, the request for authorization must be submitted to the QIO-like vendor within two working days after the start date. An emergent situation exists when skilled nursing services are required to be implemented immediately such as in the case of wound care, IV medication, etc.

2. HOLIDAY RATES

For recipients who require seven day-per-week home care service, an increased rate will be paid for visits made on State recognized holidays. The holiday rate must be requested on the Home Health Prior Authorization form, which covers the certification period in which the State recognized holiday(s) occur.

Nevada Medicaid currently recognizes the following holidays: New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Nevada Admission Day (last Friday in October), Veteran's Day, Thanksgiving Day, Family Day (the day after Thanksgiving), and Christmas Day. The recognized holiday is the same days that State offices are closed.

Reimbursement: Time and one-half will be reimbursed for State recognized holidays. Use modifier TV to designate holiday rate.

a. PRIOR RESOURCES

When the HHA has a recipient that has another insurance (Medicare or Private Insurance) and the agency has identified the services requested are not a covered benefit of the third party payor, HHA must request "bypass Medicare" or "bypass other" when requesting prior authorization.

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b. DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies require a prior authorization request at the time of request for HHA services and are to be listed on the Home Health Prior Authorization Form. Wound care supplies will be authorized for the HHA for a ten day period only. Supplies will be authorized only for the specific procedure or treatment requested. Each item must be listed separately. Supplies must be specifically prescribed by the physician and designated in the POC. A copy of the physician's orders specifying supplies required for home care should be retained in the recipient's HHA file and submitted to Nevada Medicaid upon request. Routine supplies or disposable supplies must be obtained from a Durable Medical Equipment (DME) or pharmacy provider.

Reimbursement: Unit price per fee schedule. Refer to reimbursement code table for specific billing code.

c. MILEAGE

Actual mileage is reimbursed one way from the HHA office to the recipient's residence. Actual mileage should be listed on the Home Health prior authorization request form to establish a base line for reimbursement. Reimbursement: Mileage is paid per actual miles. Refer to the reimbursement code table for specific billing code.

3. AUTHORIZATION INTERVALS

Services will be authorized for three distinct periods. They are:

- a. The initial authorization for all requests. Services may be authorized up to a 60 day interval, beginning with the start date.
- b. The reauthorization covers an additional 60 day interval following the completion of the initial visits. This applies to the recipient who requires an extension of the same services that were requested during the initial authorization period. This period, combined with the initial authorization may be up to 120 days.
- c. The long-term authorization covers the recipient with continued needs following 120 day episode. This additional authorization interval may be up to one year if services are documented as medically necessary and are expected to continue unchanged for a prolonged interval. (i.e. monthly suprapubic catheter change).

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4. ONGOING AUTHORIZATION

Request for continuing HHA services must be submitted to the QIO-like vendor a minimum of ten working days but no more than 30 days prior to the expiration of the current authorization.

The authorization request must include adequate information to support medical necessity, availability of willing and able caregiver or the presence of a qualified LRA. The QIO-like vendor will review for appropriate number of hours using the decision guide and based on program criteria. HHA services may be authorized for a maximum authorization period of one year.

5. ADDITIONAL AUTHORIZATION

An additional authorization request for an additional/PRN one time only visit during a current authorization period may be submitted for authorization approval. Information must be submitted that supports the need for the additional visit. (i.e. foley catheter leaking and a needed replacement). In this situation, the Prior Authorization Request (PAR) must be submitted within 30 days of the service being provided.

6. REVIEW FOR RETROACTIVE AUTHORIZATION

If Medicaid eligibility is established retroactively, Medicaid may authorize retroactive payment to the agency for covered services within limitations of program criteria. The Home Health Prior Authorization form must include the Date of Determination (DOD) of eligibility. Retroactive authorization must be requested within 30 days from the DOD.

7. WOUND MANAGEMENT

a. Authorization for wound care will be based on the clinical decision support guide (Interqual) based on the data submitted following a skilled nursing assessment. The assessment should include the primary diagnosis, pertinent medical, surgical and social history, medication, wound history (e.g. onset, longevity, current management) and pain. Clinical data should include a complete wound assessment (e.g. location, size, depth, partial/full thickness, tissue appearance, sinus tracts, tunneling, stages for pressure ulcers, status of wound edges, condition of skin around the wound, exudates (color, odor, amount) other wound characteristics, and the treatment plan as prescribed by the physician.

b. All initial requests for wound care will be authorized for up to a 60 day interval. All Home Health Prior Authorization forms must be submitted with the required information.

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- c. Ongoing request for additional visits will be approved according to the criteria identified in the clinical decision support guide. Supporting information must be submitted to the QIO-like vendor. For long-term authorizations, diagnostics studies and nutritional assessments or other evaluations may be required. Authorizations for identified services, such as a registered dietician will be approved if identified as medically necessary.
- d. Disposable wound supplies will be authorized for the Home Health Agency (HHA) for an initial ten-day supply only. Thereafter the supplies must be obtained from a Durable Medical Equipment or Pharmacy provider.
- e. Specialty beds or other wound care items must be obtained as required per Nevada Medicaid Services Manual, Chapter 1300.

8. ORAL MEDICATIONS

The recipient is expected to self-administer his or her oral medications. The authorization of daily visits for the administration of oral medications is not a covered benefit. A weekly visit for a medication set up may be authorized. Whether it is a brief or extended visit depends on the number of medications and the number of times per day the medications are taken. One visit may be authorized per week. A request should include a substantiating diagnosis, such as mental illness that would limit the recipient's ability to set up his/her own medications. The names and frequency of the medication taken should be on the request.

9. INJECTIONS

Requests for injections are and routinely covered and must meet medical necessity for HHA service. If determined to be medically necessary Intramuscular (IM) or Subcutaneous (SC) may be approved for brief visits only. The sole exception for this is Synagis injections. Synagis may be approved for an RN/LPN extended visit. No more than two brief visits per day may be approved (usually this is for administration of insulin). The recipient, LRA and other willing caregivers should be taught this skill.

10. LABORATORY DRAWS

Requests for laboratory draws may be authorized for brief RN visits only. An extended visit may be authorized, if there is supporting documentation that it was a difficult blood draw and required multiple attempts.

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11. HOME HEALTH AGENCY CLAIMS/BILLING GUIDELINES

The Division of Health Care Financing and Policy establishes reimbursement rates for covered services. Providers submit claims using an established revenue code, HCPCS code and modifier. Reimbursement codes for HHA services are listed in the QIO-like vendor billing manual or via mail with a hard copy of the form.

a. Third Party Liability

If there is another insurance that covers or partially covers HHA services, a claim must be submitted to that entity first and a copy of the EOB must be attached to the Medicaid reimbursement claim. For services that are not a benefit of Medicare or other private insurance, it is not necessary to bill the other insurance first. Instead, note on each claim the date, phone number and the name of the person from whom the information on the insurance status was obtained. Indicate "Bypass Medicare" or "Bypass Private Insurance" (specify insurance name) on the claim.

b. HOME HEALTH AGENCY RATE

Home Health Agency rates are based on the recipient's place of residence at the time the service is rendered.

Reimbursement: Reimbursement is made according to regions, urban, rural and out of state, defined in the following manner:

1. Urban: In Southern Nevada, urban is Boulder City and the portion of Clark County within Las Vegas Valley including the cities of Las Vegas, North Las Vegas, Henderson and the urbanized townships. In Northern Nevada, urban includes the cities of Reno, Sparks, and Carson City, and unincorporated areas of Washoe County that are within 30 miles of Reno, as approved by the District Office.
2. All other areas within Nevada are classified as rural. Providers should utilize modifiers related to service area when billing to assure appropriate payment. Instructions for claims coding can be found in the Fiscal Agent's Nevada Medicaid and Nevada Check Up UB-92 Provider Billing Manual.
3. All outside Nevada services use Rural modifier TN.

1403.2 SKILLED NURSING SERVICES (SN)

Skilled nursing services are a covered service when provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse in accordance with the POC, to be safe

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and effective. In determining whether a service requires the skill of a nurse, consideration must be given to the inherent complexity of the service, the condition of the patient and the accepted standards of medical and nursing practice.

1403.2A COVERAGE AND LIMITATIONS

1. Observation and Assessment

Nursing visits for observation and assessment will be reimbursed by the home health agency benefit when:

- a. There is a reasonable likelihood that the recipient will experience an acute episode;
- b. There is reasonable likelihood that the recipient will develop a complication (either as a result of his/her disease process or as a result of prescribed medical therapy);
- c. The skills of a nurse are required to assess the recipient's health status and identify significant change;
- d. The change in the recipient's health status (as a result of another acute episode or complication) is likely to respond to a change in the recipient's plan of treatment or prescribed medical therapy.

2. Performance of Skilled Procedures

Nursing visits for the performance of skilled procedures of a nurse in the home setting will be reimbursed as a skilled nursing service when the procedure can only be performed safely by a nurse.

Factors that the DHCFP considers when determining if the performance of a specific procedure requires the skill of a nurse include:

- a. The complexity of the procedure to be performed;
- b. The recipient's physical and functional status;
- c. The presence/absence of a willing, able, and competent caregiver in the home; and
- d. The service is reasonable and necessary to the treatment of the patient.

3. Examples of covered skilled nursing procedures include but are not limited to:

- a. Administration of intravenous, intra-muscular, or subcutaneous medications or

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infusions;

- b. Vitamin B-12 injections, when administered for the treatment of certain conditions, such as pernicious anemia, megaloblastic anemia, fish tapeworm anemia, certain gastrointestinal disorders or certain neuropathics with the supporting lab work;
 - c. Insulin administration when the recipient is unable to self-administer the insulin and there is no other willing and able caregiver available. The recipient's plan of care must continue to document that there is no willing and able caregiver available and the recipient continues to be unable to self administer the insulin with each re-certification period. Nursing visits to perform glucometer testing are not covered as it does not require the skill of a nurse to perform;
 - d. The administration of Synagis for recipients under the age of two years who meet established Medicaid criteria;
 - e. Skilled nursing visits for venipuncture are covered when the collection of the specimen cannot be performed in the cause of regularly scheduled absences from the home and is necessary for the monitoring of therapeutic blood levels of medications, monitoring of blood counts and electrolyte levels when affected by the recipient's medication regimen, and related to the recipient's illness or medical condition;
 - f. Nasogastric tube and gastrostomy tube feeding;
 - g. Ostomy care during the immediate post-operative period;
 - h. Tracheotomy aspiration;
 - i. Catheter care (urethral or suprapubic) insertion and replacement (every 30 days for jelly or 60-90 for silicone catheters) and irrigation;
 - j. Wound care, when the skills of the nurse are required to safely/effectively perform the wound care; and
 - k. Total Parenteral Nutrition (TPN).
4. Teaching Recipient/Family to Manage Care at Home

Teaching the recipient/family/caregiver how to manage the recipient's care at home will be reimbursed on a limited and short term basis as a skilled nursing service when the teaching or training is appropriate to the recipient's functional loss, illness or injury.

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Teaching and/or training activities must include a time frame in the POC when goals will be accomplished. Teaching visits will be authorized according to the following criteria:

- a. The skills of the nurse are required to teach the recipient/family/caregiver how to manage the recipient's care at home. The care itself may be considered to be “unskilled” (not requiring the skills or expertise of the nurse to perform the care), but the amount of skill needed to teach the care must require the skills of a nurse;
- b. The teaching is reasonable and necessary for the treatment/management of the recipient's health problem(s);
- c. The initial authorization for teaching visits will be authorized according to the criteria identified in the clinical decision support guide. The initial authorization may be up to a 60 day interval. Additional teaching visits may be authorized if documentation is submitted that supports the ability of the recipient and/or the caregiver to learn the material. The content or skill covered by the teaching is new to the learner and does not represent reinforcement or review of previously learned, repeated, or taught content. Teaching will not be covered when the recipient or caregiver is not able to learn or be trained.

Examples of teaching and training activities which require the skill of a licensed nurse include, but are not limited to the following:

- d. Self administration of injectable medications;
- e. New complex medications;
- f. Complex wound care;
- g. Self catheterization;
- h. Administration of enteral feedings; and
- i. Care and maintenance of intravenous or central lines and administration of medication through such lines.

5. Skilled Psychiatric Nursing Services

Evaluation of the recipient and the performance of psychotherapy require the skills of a nurse who meets criteria for credentialing as a psychiatric nurse. Services of a non-psychiatric nurse may be ordered by the psychiatrist for visits to administer injections or behavior modifying medications.

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Psychiatric mental health services are covered services and are authorized according to the criteria identified in the clinical decision support guide, when the following conditions are met:

- a. The psychiatric mental health services are reasonable and necessary for the treatment of the recipient's health status; and
- b. The home care services are ordered by a psychiatrist and provided under a written POC. Medical orders must be established and reviewed by the primary physician.

1403.2B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.2C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.2D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.3 SKILLED PHYSICAL THERAPY SERVICES

Periodic home visits may be made by licensed physical therapists, to provide services as ordered by a physician and identified in the POC, when the services are inherently complex and can only be performed safely and effectively by a skilled therapist, and when the recipient cannot access out-patient services.

Reimbursement is based on the diagnosis of a medical condition plus the presence of functional limitations, which can respond or improve as a result of the prescribed POC. There must be an expectation the condition will improve in a reasonable, predictable period of time.

1403.3A COVERAGE AND LIMITATIONS

Skilled physical therapy services may be authorized for home care recipients; HHA visits are included in the total available outpatient limits up to 24 visits per year. These include visits for one or more of the following:

1. Assessment of the recipient's rehabilitation needs and potential;
2. Development and implementation of a physical therapy program when it is medically necessary to the recipient's treatment;

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3. Objective tests and measurements such as range of motion, strength, balance coordination, endurance, and functional ability;
4. Performance of therapeutic exercises which require the skills and expertise of a physical therapist to implement safely/effectively;
5. Gait evaluation and gait training for persons who have an impaired ability to ambulate secondary to a neurological, muscular, or skeletal abnormality;
6. Services are required to maintain a person's function that involves complex and sophisticated procedures and the judgment/skill of a physical therapist;
7. Administration of ultrasound treatments; and
8. Administration of heat treatments only when the recipient's overall condition is such that the skills and judgment of a physical therapist are required to safely administer these treatments.

1403.3B PROVIDER RESPONSIBILITY

In addition to 1403.1B, the provider must monitor that the total number of paid visits, do not exceed the total available therapy visits (24) per year.

1403.3C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C

1403.3D AUTHORIZATION PROCESS

Refer to Section 1403.1D

In addition to 1403.1D the physical therapist must submit the completed evaluation along with the Home Health Prior Authorization form to the QIO-like vendor. The provider should contact the QIO-like vendor to determine the number of authorized visits.

1403.4 SKILLED OCCUPATIONAL THERAPY SERVICES

Periodic home visits may be made by licensed occupational therapists to provide services as ordered by the physician and identified in a signed POC. Reimbursement is based on the diagnosis of a medical condition plus the presence of a limitation, which can respond or improve as a result of the prescribed POC. There must be an expectation that the condition will improve in a reasonable period of time.

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1403.4A COVERAGE AND LIMITATIONS

Skilled occupational therapy services may be authorized for home care recipients. HHA visits are included in the total available outpatient limits of up to 24 visits per year. These visits include one or more of the following:

1. Assessment of the recipient's rehabilitation potential and needs.
2. Plan/implement/supervise a therapeutic program to:
 - a. Restore physical function;
 - b. Restore sensory-integrative function;
 - c. Provide individualized therapeutic activity as part of an overall active treatment program for persons with diagnoses of psychiatric illness;
 - d. Teach compensatory techniques to improve functional independence in the performance of activities of daily living; and
 - e. Provide vocational and prevocational assessment and training that is directed toward the restoration of function in ADL's lost due to illness or injury.

1403.4B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B.

1403.4C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.4D AUTHORIZATION PROCESS

A Home Health Prior Authorization form must be submitted along with the completed evaluation to the QIO-like vendor prior to the initiation of service. The initial evaluation does not require prior authorization. Refer to Section 1403.1D.

1403.5 SKILLED SPEECH LANGUAGE PATHOLOGY SERVICES

Nevada Medicaid may pay for the services of a licensed speech pathologist to provide service as ordered by the physician and identified in a signed POC. Reimbursement is based upon diagnosis and treatment of speech and language disorders that result in communications disabilities and for the diagnosis and treatment of swallowing disorders, regardless of the presence of a

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communication disability. There must be an expectation that the condition will improve in a reasonable period of time.

1403.5A COVERAGE AND LIMITATIONS

Skilled speech language therapy service may be authorized for home care recipients. HHA visits are included in the total outpatient limits up to 24 visits per year. These include visits for the following:

1. Diagnosis and treatment of expressive and receptive communication disorders;
2. Diagnosis and treatment of swallowing disorders;
3. Assessment of a recipient's rehabilitation needs and potential;
4. Services directed toward specific speech or voice production if a deficit exists resulting from an illness or an injury; Establishment of a hierarchy of speech-voice-language communication tasks and cueing that is directed toward the achievement of specific communication goals;
5. Training the recipient/family/caregiver to augment: the speech language communication; treatment; or to establish a maintenance program;
6. Assisting persons who are aphasic in rehabilitation of speech and language skills; and
7. Assisting a person with voice disorders to learn to control vocal or respiratory systems for correct voice production.

1403.5B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.5C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.5D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

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1403.6 RESPIRATORY THERAPY SERVICES

Respiratory therapy is a covered service through a HHA provider, when it is prescribed by a physician and provided under assigned plan of care by a licensed respiratory therapist.

1403.6A COVERAGE AND LIMITATIONS

The services of a respiratory therapist that may be provided to recipients in a home setting include:

1. Ventilator management.
 - a. Weaning the recipient off a ventilator; and
 - b. Changing settings on ventilators, C-PAP, Bi-PAP, Bi-PAP-ST.
2. Drawing arterial blood gases when a nurse is incapable of doing so. The services of a respiratory therapist will not be reimbursed for the setting up of rental equipment.

1403.6B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.6C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.6D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.7 REGISTERED DIETICIAN SERVICES

Registered dietician services are covered by the Medicaid HHA program. A registered dietician may provide consultative services when the recipient has a nutritional deficit or is at risk for a deficit.

1403.7A COVERAGE AND LIMITATIONS

Home health agency dietician services are appropriate for but not limited to recipients with diagnoses of cachexia, failure to thrive, poor wound healing and newly diagnosed diabetics who are unable to go outside the home for dietician services.

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1403.7B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B.

1403.7C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.7D AUTHORIZATION PROCESS

In addition to Section 1401.1D the provider must submit a copy of the completed evaluation must be submitted to the QIO-like vendor along with the Home Health Prior Authorization Form. The QIO-like vendor will review the evaluation to determine if medical necessity has been met. The initial evaluation does not require prior authorization.

1403.8 HOME HEALTH AIDE SERVICES

To receive home health aide services through the HHA program, the recipient must have a qualifying skilled service and must have an impairment or deficit so that he/she requires assistance with routine activities of daily living. Services must be reasonable and necessary to the treatment of the recipient's illness or injury. Home health aides can be appropriately utilized to assist in carrying out the plan of care. Home health aide services must be incorporated into an outcome specific nursing plan. Home health aides must meet the qualifications specified by 42 CFR 484.36. When it is identified that recipient has an ongoing need for assistance with ADLs, the HHA must advise the recipient and/or caregiver about other available services (e.g. personal care aide services) that may be more appropriate to their needs.

1403.8A COVERAGE AND LIMITATIONS

Home Health Aide services may provide assistance with:

1. Personal care services, such as bathing;
2. Simple dressing changes that do not require the skills of a licensed nurse;
3. Assistance with medications that are self administered;
4. Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist, such as, routine maintenance exercise;
5. Routine care of prosthetic and orthotic device;
6. Monitoring vital signs;

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7. Reporting of changes in recipient condition and needs;
8. Any task allowed under Nevada Revised Statutes (NRS), Chapter 632 – Nursing, and directed in the physician’s approved plan of care (POC).

1403.8B PROVIDER RESPONSIBILITY

In addition to Section 1401.1B the HHA RN must make a supervisory visit to the recipient’s residence at least once every 60 days.

1403.8C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.8D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.9 END STAGE RENAL DISEASE (ESRD) SERVICES

ESRD recipients may qualify for HHA services. A recipient diagnosed with ESRD must meet all the general requirements for the HHA program plus the recipient must require skilled services that are not directly related to his/her dialysis treatments.

1403.9A COVERAGE AND LIMITATIONS

Refer to Section 1403.1A of this Chapter.

1403.9B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.9C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.9D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

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1403.10 OUT-OF-STATE SERVICES

HHA services are allowed out-of-state for Medicaid recipients absent from the state pursuant to 42 CFR 431.52. Payment for services furnished in another state are reimbursed to the same extent that Nevada would pay for services provided within Nevada boundaries. Out-of-state HHA services are reimbursed at the rural rate, using rural modifier TN.

1403.10A COVERAGE AND LIMITATIONS

Out-of-state services may be allowed when:

1. There is a medical emergency and the recipient's health would be endangered if he/she were required to return to the State of Nevada to obtain medical services;
2. The recipient travels to another state because DHCFP has determined the required medical services are not available in Nevada, or it is determined that the needed medical services or necessary supplementary resources are more readily available in another state;
3. DHCFP determines that it is general practice for recipients in a particular locality to use medical services in another state (e.g., Nevada counties that border other state lines);
4. The recipient is on personal business. DHCFP may reimburse for these services; however, they will be limited to those currently listed on the recipient's Plan of Care (POC).

1403.10B PROVIDER RESPONSIBILITY

1. The out-of-state provider must contact First Health Services Corporation (FHSC) provider enrollment unit to become enrolled as a DHCFP Home Health Agency provider.
2. The out-of-state provider must also comply with all provisions in Section 1403.1D.

1403.10C RECIPIENT RESPONSIBILITY

1. The recipient or their personal representative must contact Home Health Agency providers in the geographic region of which they wish service to be provided, to determine the availability of HHA service providers.
2. The recipient must notify an out-of-state provider who is not a DHCFP provider, but who is interested in becoming a provider to contact the QIO-like vendor.
3. The out-of-state provider must also comply with all provision in Section 1403.1C.

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1403.10D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.11 EARLY & PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Nevada Medicaid may authorize HHA services for medically necessary therapies on children ages 0-20 with chronic special health care needs who are referred to the program through an EPSDT screening. Physical therapy, speech therapy and occupational therapy may be authorized for six months at a time when the child has an EPSDT screening examination, which identifies the medical diagnosis and the need for such therapy. EPSDT screening examinations for these services must be updated at six-month intervals. EPSDT therapies may be authorized beyond the 24 visits per year, if medically necessary as determined by DHCFP.

Reimbursement is based on the diagnosis of a medical condition plus the presence of functional limitations, which can respond or improve as a result of the prescribed POC. There must be an expectation the condition will improve significantly in a reasonably, predictable period of time.

1403.11A COVERAGE AND LIMITATIONS

Refer to Section 1403.1A.

1403.11B PROVIDER RESPONSIBILITY

The therapist must complete the initial evaluation; identify the treatment need, therapy goals, frequency and expected duration of therapy treatment whether for occupational therapy, physical therapy, and/or speech therapy. The provider must comply with all other requirements in Section 403.1B.

1403.11C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.11D AUTHORIZATION PROCESS

The following documentation needs to be provided:

1. A completed Home Health Prior Authorization Form requesting therapy(s);
2. A copy of the evaluation and/or POC which includes therapy goals, frequency and expected duration;
3. Referral from EPSDT Screening; and

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4. The provider must also comply with all other requirements of Section 1403.1D.

1403.12 SERVICES TO CHILDREN

HHA services are not intended to relieve a parent of their child caring or other legal responsibilities. HHA services for children may be appropriate when the parent is unqualified or otherwise unable to provide care. Home health agency services are intended to provide intermittent skilled intervention with emphasis on caregiver education. Legally responsible adults and other willing primary caregivers are expected to be taught care which can be rendered reasonably and safely by non-medical persons.

1403.12A COVERAGE AND LIMITATIONS

Children are not considered homebound based upon their age. Home health, intermittent skilled nursing and therapy services are available only when the child is considered so medically fragile that leaving the home poses eminent danger to the health of the child. Home health agency services are not to be provided as a convenience to parents, the physician or the physician supplier. In authorizing services to children, consideration will be given to the inherent complexity of the skilled intervention, the capacity of available primary caregivers to be taught, and the availability of these caregivers. It is expected that the legally responsible adult or willing caregiver, after demonstrating competency, will provide the service.

1403.12B PROVIDER RESPONSIBILITY

Verify the availability and capability of the legally responsible adult or primary caregiver and include such information with request.

1403.12C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.12D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.13 FAMILY PLANNING

Home health agencies providing post partum home visiting service to Medicaid eligible women, may bill for family planning education.

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1403.13A COVERAGE AND LIMITATIONS

This service must be provided:

1. In conjunction with the newborn assessment screening;
2. Be provided by a registered nurse; and
3. Consist of counseling and education about:
 - a. Appropriate spacing of pregnancies
 - b. Family planning options.

1403.13B PROVIDER RESPONSIBILITY

Refer to Section 1401.1B of this Chapter.

1403.13C RECIPIENT RESPONSIBILITY

Refer to Section 1401.1C of this Chapter.

1403.13D AUTHORIZATION PROCESS

No prior authorization is required. Submit on UB-92 0581 -- H1011 FP, TD (Old CPT Code = C98970).

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1404 HEARINGS

Please reference Medicaid Services Manual, Chapter 3100 Hearings, for hearing procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 7, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1500 - HEALTHY KIDS PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids Program is being proposed to add language allowing separate billing for objective vision testing for amblyopia.

These changes are effective June 8, 2016.

MATERIAL TRANSMITTED

MTL 16/16
Chapter 1500 - Healthy Kids Program

MATERIAL SUPERSEDED

MTL 29/15
Chapter 1500 - Healthy Kids Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1503.3A(1)(g)	Coverage and Limitations	Added language to allow separate billing for objective vision testing for amblyopia.
1503.3A(2)		Added language to include exception of separate billing for amblyopia.

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1500 INTRODUCTION

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are preventive and diagnostic services available to most recipients under age 21. In Nevada, the EPSDT program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary treatment to correct such conditions. Healthy Kids offers the opportunity for optimum health status for children through regular, preventive health services and the early detection and treatment of disease.

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1501 AUTHORITY

- A. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21.

Services available under the Healthy Kids Program are provided as defined in the following:

1. Omnibus Budget Reconciliation Act of 1989;
2. Social Security Act 1905 (a) and (r);
3. Social Security Act 1902 (a);
4. Social Security Act 1903 (i);
5. 42 Code of Federal Regulations (CFR), Subpart B, 441.50 – 441.62;
6. State Medicaid Manual (Part 5); and
7. Nevada Medicaid’s State Plan.

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1502 RESERVED

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1503 POLICY

1503.1 EARLY PERIODIC SCREENINGS

A child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated. Assessment of a child's health at regularly scheduled intervals assures that a condition, illness or injury is not developing or present. The Healthy Kids program has established a periodicity schedule for screening, vision, hearing and dental services based upon the American Academy of Pediatrics (AAP). The periodicity schedule utilized by the Healthy Kids program can be found at the Bright Futures /AAP website: <http://brightfutures.aap.org>.

1503.1A COVERAGE AND LIMITATIONS

1. The Healthy Kids program encourages providers to follow the recommended schedule for developmental screenings offered by the AAP. Recipients will be sent letters by the division's Quality Improvement Organization (QIO)-like vendor reminding them to schedule a screening visit on a periodic basis.
2. Dental services are outlined in Medicaid Services Manual (MSM) Chapter 1000, Dental. Dental services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, they must include relief of pain and infection, restoration of teeth, and maintenance of dental health. Generally, dental services should be age-appropriate and must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.
3. Vision services are outlined in MSM Chapter 1100, Ocular Services. Vision services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services must include diagnosis and treatment for defects in vision, including eye glasses. Generally, vision services should be age-appropriate and must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.
4. Hearing services are outlined in MSM Chapter 2000, Audiology. Hearing services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services should be age-appropriate and must include diagnosis and treatment for defects in hearing, including hearing aids. Generally, hearing services must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.

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1503.1B PROVIDER RESPONSIBILITY

1. The provider is expected to follow the periodicity guidelines as recommended when conducting Healthy Kids examinations whenever possible. The provider should offer services as deemed medically appropriate.
2. The provider shall determine whether a screening request is medically necessary when it falls outside the periodicity schedule and will conduct the intervention necessary to address suspected medical problems.
3. The provider should assure the elements listed in Section 1503.3A are included in a screening examination. The provider should seek out and incorporate information regarding the child's usual functioning from parents, teachers, and others familiar with the child when conducting an examination. Medical records should document the assessments and significant positive and negative findings. Discussions with the child and family about the findings should be an integral part of every examination and documented as well. A referral to another Medicaid provider should occur if the provider is unable to perform any screening component. Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening forms and EPSDT Participation Reports can be found on the Division of Health Care Financing and Policy (DHCFP) website: <https://dhcfnv.gov/epsdt.htm>.
4. Medical records should contain the following information specific to EPSDT screening services:
 - a. Reason for the visit;
 - b. The date screening services were performed, the specific tests or procedures performed, the results of these tests and the person who provided the service;
 - c. Documentation of medical contraindication or a written statement from a parent or a guardian of a screened child, for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations;
 - d. Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening;
 - e. Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as the medical screening;
 - f. Documentation of declination of screening services by the parent;

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- g. Referrals made for diagnosis, treatment or other medically necessary health services for conditions found in the screenings;
 - h. Date the next screening is due; and
 - i. Documentation of direct referral for age-appropriate dental services.
5. Providers should submit claims using the established billing codes related to the Healthy Kids screening examination. These examination codes can be found in the Hewlett Packard Enterprise Services (HPES) Billing Guide, Physician Billing Guide.
 6. The provider should make referrals for diagnostic testing after discussing the need for such services with the recipient/parent/legal guardian during a post screening interview. The physician's progress notes should indicate the need for such testing.
 7. A dated written referral should be given to the recipient or parents or forwarded to the referral service provider. The referral should include the following information:
 - a. The name of the child;
 - b. The Medicaid ID number of the child;
 - c. The date of the screening;
 - d. The abnormality noted;
 - e. The name, address, telephone and fax numbers of the child's primary physician if different from the screening provider; and
 - f. The physician to whom the referral applies if known.
 8. The provider should advise recipients of possible resources for obtaining testing as appropriate.

1503.2 INTERPERIODIC SCREENINGS

Healthy Kids screenings are provided to all eligible persons under the age of 21, which may include medically necessary intervals that are outside an established periodicity schedule, also known as interperiodic screenings.

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1503.2A COVERAGE AND LIMITATIONS

1. The DHCFP has identified a periodicity schedule that allows for access to screening, vision, hearing and dental services at intervals which meet reasonable standards of medical practice. The periodicity schedule can be found at the Bright Futures /AAP website: <http://brightfutures.aap.org>.
2. A recipient may request a health care screening or any component of the health screening at any time. Screening services which are medically necessary, such as when a new health problem has occurred or when a previously diagnosed condition has become more severe or changed sufficiently to require a new examination, will be offered, regardless of whether the request falls into the periodicity schedule established by the State.

1503.3 COMPREHENSIVE SCREENING EXAMINATION

A comprehensive child health assessment is provided to determine if a child has a condition, illness or injury that should be referred for further evaluation and/or treatment. A Healthy Kids screening examination must comply with 1905(r) of the Social Security Act (SSA). http://www.socialsecurity.gov/OP_Home/ssact/title19/1905.htm.

1503.3A COVERAGE AND LIMITATIONS

1. Screening services are designed to evaluate the general physical and mental health, growth, development and nutritional status of infants, children and adolescents.

The following is a description of each of the required age-appropriate screening components:

a. COMPREHENSIVE HEALTH AND DEVELOPMENTAL/BEHAVIORAL HISTORY

At the initial screening, the provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

1. Family medical history (health of the parents and current family members, identification of family members with chronic, communicable or hereditary diseases);

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2. Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies, current health problems and medications);
3. Nutritional history;
4. Immunization history;
5. Environmental risk;
6. Family background of emotional problems, problems with drinking or drugs, or history of violence or abuse;
7. Patient history of behavioral and/or emotional problems;
8. History of sexual activity, if appropriate; and
9. Menstrual and obstetrical history for females, if appropriate.

b. DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

1. Assessment of developmental and behavioral status should be completed at each visit by observation, interview, history and appropriate physical examination. The developmental assessment should include a range of activities to determine whether or not the child has reached an age-appropriate level of development.
2. Nevada Medicaid will reimburse separately for developmental screenings, provided that a valid, standardized developmental screening tool, (i.e. Parents Evaluation of Developmental Status (PEDS), Ages and Stages, Early Language Milestone Screen) has been utilized and entered into the child's health care record. Although the American Academy of Pediatrics recommends the use of a standardized screening tool at ages nine, 18, and 30 months, and three and four years of age, the exact frequency of standardized testing depends on the clinical setting and provider's judgment as to medical necessity. Asking questions about development as part of the general informal developmental survey or history is not a "standardized screening" and is not separately reportable. Providers may be subject to a random audit of records to assure the use of the screening tool. For billing instructions, see the HPES Billing Manual at: <http://www.medicaid.nv.gov/providers/BillingInfo.aspx>.

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c. **COMPREHENSIVE UNCLOTHED PHYSICAL EXAM**

A completed unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques. The examination must include all body parts and systems listed below:

1. Cranium and face;
2. Hair and scalp;
3. Ears;
4. Eyes;
5. Nose;
6. Throat;
7. Mouth and teeth;
8. Neck;
9. Skin and lymph nodes;
10. Chest and back;
11. Abdomen;
12. Genitalia;
13. Musculoskeletal system;
14. Extremities; and
15. Nervous system.
16. The examination should include screening for congenital abnormalities and responses to voices and other external stimuli.

d. **APPROPRIATE IMMUNIZATIONS**

1. The child's immunization status must be reviewed each screening visit.

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Appropriate immunizations that are due must be administered during the screening visit and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines: <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>.

2. Nevada Medicaid cannot reimburse for immunizations (except administration fees) that are available through the State Health Division as part of the Vaccines for Children (VFC) program. Providers are encouraged to enroll with the VFC program which provides the VFC vaccines at no cost to eligible children. Medicaid cannot be billed for the cost of a vaccine obtained through VFC, (even if the provider is not enrolled with VFC) unless there is a documented statewide shortage. To become a VFC provider, please access the website via <http://health.nv.gov/>.
3. Nevada Check Up (NCU) provides the same vaccines through a different funding source, but providers must use the same billing guidelines.
4. For specific guidelines for the Human Papilloma Virus (HPV) vaccine, please refer to MSM Chapter 1200, Pharmacy Services.

e. LABORATORY PROCEDURES

Age-appropriate laboratory procedures must be performed at intervals in accordance with the Healthy Kids periodicity schedule. These include blood lead level assessment appropriate to age and risk, urinalysis, Tuberculin Skin Test (TST), Sickle-cell, hemoglobin or hematocrit and other tests and procedures that are age-appropriate and medically necessary, such as Pap smears.

f. HEALTH EDUCATION

1. Health education related to the physical assessment should be provided at each screening visit. It is designed to help children and their parents understand the health status of the child as well as provide information which emphasizes health promotion and preventive strategies. Health education explains the benefits of a healthy lifestyle, prevention of disease and accidents, normal growth and development, and age-appropriate family planning services.
2. Anticipatory guidance should be offered which includes discussion of information on what to expect in the child's current and next developmental phase. It is given in anticipation of health problems or decisions which may occur before the next periodicity visit.

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3. Information should also include a summarization of the results of the screening and laboratory tests, review of the child's health status, and discussion regarding any specific problems detected in the screening.

g. VISION SCREENING

The purpose is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malformations, eye diseases, color blindness and refractive errors. The screening should include distance visual acuity, color perception and ocular alignment tests. The vision screening is part of the complete physical examination and should be given by age three. **Screening for amblyopia may be separately reimbursed.**

h. HEARING SCREENING

The purpose is to detect sensorineural and conductive hearing loss, congenital abnormalities, noise-induced hearing loss, central auditory problems, or a history of conditions that may increase the risk for potential hearing loss. The examination must include information about the child's response to voice and other auditory stimuli, speech and language development, and specific factors or health problems that place a child at risk for hearing loss.

i. DENTAL SCREENING

An oral inspection must be performed by the screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries should be noted. The oral inspection is not a substitute for a complete dental screening examination provided by a dentist. An initial dental referral should be provided on any child age three or older unless it is known that the child is already receiving regular dental care. When the screening indicates a need for dental services at an earlier age, referral must be made. The importance of regular dental care should be discussed with the family (and the child as appropriate) on each screening visit for children three years and older.

2. Immunizations and laboratory tests should be billed separately from the screening visit. Objective vision and hearing testing performed during the same visit as the physical examination should not be billed separately, **with the exception of testing for amblyopia.** If hearing and vision testing needs to be performed separately from the exam, these procedures should be billed as outlined in applicable MSM chapters.

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3. Nevada Medicaid does not cover “sick kid” visits under the Healthy Kids program. A majority of the screening elements should be completed during a screening appointment to be billed as a Healthy Kids screening. The screening visit should be rescheduled if the child is too ill to complete the examination and the current visit should be billed using a routine office visit code.

1503.4 DIAGNOSTIC SERVICES

Nevada Medicaid provides diagnostic services as indicated through a Healthy Kids screening.

1503.4A COVERAGE AND LIMITATIONS

1. Any condition discovered during a screening should be followed up for diagnosis. Prior authorization is not necessary for these diagnostic examinations if they are part of or referred through a Healthy Kids screening. Referrals can include but are not limited to:
 - a. Vision Services.
 - b. Dental Services.
 - c. Hearing Services.
 - d. Other Necessary Health Care.
2. Although preferred, a Healthy Kids screening is not a requirement for medically necessary diagnostic services.

1503.5 TREATMENT

Nevada Medicaid provides for medically necessary treatment as indicated through a Healthy Kids screening and diagnosis.

1503.5A COVERAGE AND LIMITATIONS

1. Health care and treatment is available to correct or improve defects and physical and mental illnesses or conditions discovered by Healthy Kids screening and diagnostic services. Covered services include all mandatory and optional services that a state can cover under the benefit plan, whether or not such services are covered for adults. The scope of medical services available are described in the SSA, Section 1905(a).
2. Services that are not medical in nature, including educational interventions, are excluded. Treatment must be medically necessary and prior authorized if not typically included in

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the benefit plan. The QIO-like vendor will review the suggested treatment to ensure it meets with current medical practice standards for the given diagnosis.

3. When treatment is needed to correct or improve identified conditions, the DHCFP's established requirements for prior authorization apply. See the MSM Chapters related to the requested service to determine if prior authorization is needed before treatment is rendered.
4. Although it is preferred, a Healthy Kids screening is not a requirement for medically necessary treatment under EPSDT guidelines [SSA, Section 1905(r)].

1503.6 FAMILY PLANNING

Family planning services are available to recipients.

1503.6A COVERAGE AND LIMITATIONS

Family planning information should be offered during a Healthy Kids examination as appropriate and requested.

1503.7 TRANSPORTATION

Assistance with transportation is available to and from a Healthy Kids examination. (Please reference MSM Chapter 1900, Transportation).

1503.7A COVERAGE AND LIMITATIONS

Nevada Medicaid pays for transportation in order for a recipient to receive medically necessary care and services. Transportation requires prior authorization in all but emergency situations. The guidelines outlined in MSM Chapter 1900 should be followed.

1503.8 PREGNANCY RELATED ONLY

The Healthy Kids benefit package is not available to recipients who are eligible solely because of pregnancy.

1503.8A COVERAGE AND LIMITATIONS

A recipient who is less than 21 years old and whose eligibility status is pregnancy related only (P) is not eligible for Healthy Kids. She is eligible for pregnancy related services only, which includes prenatal care, labor and delivery services, and postpartum care for 60 days after the date of delivery, including the month in which the 60th day falls. The recipient may be eligible for

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services that relate to conditions that might complicate the pregnancy, but those services cannot be billed as a Healthy Kids service.

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1504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100 for Medicaid Recipient Hearing process policy.

ATTACHMENT A

POLICY #15-1	CLINICAL STUDIES	EFFECTIVE DATE: NOVEMBER 1, 2014
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DESCRIPTION

Nevada Medicaid covers the routine costs of qualifying phase III and IV clinical trials for children less than 21 years of age. Reasonable and necessary items and services used to diagnose and treat complications arising from participation in phase III and IV clinical trials are covered. These services must be a Nevada Medicaid covered service.

POLICY

Any clinical trial receiving Medicaid coverage of routine costs must meet the following requirements:

1. The subject or purpose of the trial must be the evaluation of an item or service that is covered by Nevada Medicaid (e.g., physicians' service, Durable Medical Equipment (DME), diagnostic test) and is not excluded from coverage (e.g., cosmetic surgery);
2. The trial must not be designed exclusively to test toxicity or disease pathophysiology, it must have therapeutic intent;
3. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers; and
4. The clinical trial is approved by one of the following:
 - a. National Institute of Health (NIH);
 - b. Department of Defense (DOD);
 - c. Veterans Affairs (VA);
 - d. Centers for Disease Control (CDC);
 - e. Centers for Medicare & Medicaid Services (CMS);
 - f. Agency for Healthcare Research & Quality (AHRQ); or
 - g. National Cancer Institute (NCI).

PRIOR AUTHORIZATION IS REQUIRED

Clinical trials that meet the qualifying coverage criteria will receive Medicaid coverage of routine costs after prior authorization from the Quality Improvement Organization (QIO)-like vendor.

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COVERAGE AND LIMITATIONS

Covered Services

1. Items or services that are typically provided absent a clinical trial (e.g., conventional care);
2. Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service in particular, for the diagnosis or treatment of complications.

Non-Covered Services

1. Phase I or II clinical trials.
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly Computed Tomography (CT) scans for a condition usually requiring only a single scan).
3. Items and services customarily provided by the research sponsors free of charge for the enrollee in the trial.
4. For items and services, including items and services for which Medicaid reimbursement is not available, Medicaid only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated reasonable and necessary care. However, if the item or service is not covered by Medicaid and is the focus of a qualifying clinical trial, the routine costs of the clinical trial (as defined above) will be covered by Medicaid but the non-covered item or service, itself, will not.

NOTE: For policy regarding pharmaceutical clinical studies, please refer to MSM Chapter 1200, Prescribed Drugs.

ATTACHMENT A

POLICY #15-2	EXPERIMENTAL TREATMENT	EFFECTIVE DATE: NOVEMBER 1, 2014
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DESCRIPTION/POLICY

Nevada Medicaid does not cover any item or service that is not medically necessary, that is unsafe or is not generally recognized as an accepted method of medical practice or treatment.

PRIOR AUTHORIZATION IS REQUIRED

If experimental treatment is medically necessary, providers must request prior authorization for services which may fall into the above category prior to rendering service.

COVERAGE AND LIMITATIONS

Nevada Medicaid completes prior authorization on medical services to assure that the care and the services proposed are actually needed, are equally effective, less expensive alternatives have been given consideration, and the proposed service and materials conform to commonly accepted standards.

Nevada Medicaid's QIO-like vendor completes the authorization review.

ATTACHMENT B

POLICY #15-3	APPLIED BEHAVIOR ANALYSIS	EFFECTIVE DATE: JANUARY 1, 2016
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INTRODUCTION

Applied Behavior Analysis (ABA) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. ABA is a behavior intervention model based on reliable evidence based practices focusing on targeted skills in all areas of development. The Division of Health Care Financing and Policy (DHCFP) utilizes the Center for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and Behavior Analyst Certification Board (BACB) “Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.)” as guiding principles for this policy.

All DHCFP policies and requirements (such as prior authorizations, etc.) except for those listed in the Nevada Check up (NCU) Chapter 1000 are the same for NCU.

All DHCFP policies and requirements for Outpatient Physical, Occupational, Speech, and Maintenance Therapy are listed in Chapter 1700 of the Medicaid Services Manual (MSM). Chapter 1500, Attachment #15-3 specifically covers ABA services; for other Medicaid services, coverage, limitations and provider responsibilities the specific MSM needs to be referenced.

AUTHORITY

A comprehensive array of preventive, diagnostic, and treatment services are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21, including children with Autism Spectrum Disorder (ASD).

1. ABA is an evidence based behavior intervention meeting the provision of the law as defined in the following:
 - a. Social Security Act 1905 (a) and (r);
 - b. 42 Code of Federal Regulation (CFR), Subpart B, 441.50-441.62;
 - c. Nevada Revised Statute (NRS) Chapter 641 describes persons deemed to practice ABA services; and
 - d. Nevada Medicaid State Plan describes the amount, duration and scope of ABA services provided to the categorically needy.

DEFINITIONS

1. Applied Behavior Analysis (ABA) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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2. Autism Spectrum Disorder (ASD) is a group of developmental disabilities that can cause significant social, communication and behavioral challenges.

POLICY

Medicaid will reimburse for ABA rendered to Medicaid eligible individuals under age 21 in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage authority. The behavior intervention must be medically necessary (reference MSM 100) to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of ASD or other condition for which ABA is recognized as medically necessary. It must be rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner Registered Nurse (APRN). The treatment regimen must be designed and signed off on by the qualified ABA provider.

The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, or in the recipient's home.

All services must be documented as medically necessary and appropriate and must be prescribed on an individualized treatment plan.

COVERAGE AND LIMITATIONS

Covered Services

1. There are two types of ABA treatment delivery models recognized by the DHCFP, Focused and Comprehensive. Based upon the Behavior Analyst Certification Board (BACB), Inc. (2014) within each of the two delivery models there are key characteristics which must be demonstrated throughout the assessment and treatment. These characteristics include:
 - a. Comprehensive assessment that describes specific levels of baseline behaviors when establishing treatment goals.
 - b. Establishing small units of behavior which builds towards larger changes in functioning in improved health and levels of independence.
 - c. Understanding the current function and behaviors targeted for treatment.
 - d. Use of individualized and detailed behavior analytic treatment.
 - e. Ongoing and frequent direct assessment, analysis and adjustments to the treatment plan by a Behavior Analyst by observations and objective data analysis.
 - f. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across all environments.
 - g. Direct support and training of family members and other involved qualified professionals.

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- h. Supervision and management by a licensed provider with expertise and formal training in ABA for treatment of ASD. “Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2014) (2nded.)”.
http://bacb.com/Downloadfiles/ABA_Guidelines_for_ASD.pdf

2. Focused Delivery Model

- a. Focused ABA is treatment directly provided to the individual for a limited number of specific behavioral targets.
 - 1. The appropriate target behaviors are prioritized. When prioritizing multiple target areas, the following behaviors are considered:
 - a. behaviors that may threaten the health and safety of themselves or others; and
 - b. absence of developmentally appropriate adaptive, social or functional skills.
 - 2. Treatment may be delivered in individual or small group format.

3. Comprehensive Delivery Model

- a. Comprehensive ABA is treatment provided to the individual for a multiple number of targets across domains of functioning including cognitive, communicative, social and emotional.
 - 1. The behavior disorders may include co-occurring disorders such as aggression, self-injury and other dangerous disorders.
 - 2. Treatment hours are increased and decreased as recipient responds to treatment goals.
 - 3. Treatment is intensive and initially provided in a structured therapy setting. As recipient progresses towards treatment goals the setting may be expanded to alternative environments such as group settings.

4. Services covered within the ABA delivery models

- a. Behavioral Screening - A brief systematic process to determine developmental delays and disabilities during regular well-child doctor visits. Screens must be a nationally accepted Developmental Screen. A recommended list of screens may be found at: <http://www.medicalhomeinfo.org/downloads/pdfs/DPIPscreeningtoolgrid.pdf>. Refer to Chapter 600 of the MSM for coverage of developmental screens.
- b. Comprehensive Diagnostic Evaluations - Is the further review and diagnosis of the child’s behavior and development. Coverage of this service is found within Chapter 600 of the MSM.
- c. Behavioral Assessment - A comprehensive assessment is an individualized examination which establishes the presence or absence of developmental delays and/or disabilities and determines the recipient’s readiness for change, and identifies the strengths or problem areas that may affect

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the recipient’s treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

- d. Adaptive Behavioral Treatment Intervention - Is the systematic use of behavioral techniques and intervention procedures to include intensive direction instruction by the interventionist and family training and support.
 - e. Adaptive Behavioral Family Treatment - The training in behavioral techniques to be incorporated into daily routines of the child and ensure consistency in the intervention approach. The training should be extensive and ongoing and include regular consultation with the qualified professional. The training is broken down into two components:
 - 1. Family Treatment with the child present – Is training that includes the parent/guardian or authorized representative in behavioral techniques during the behavior intervention with the child.
 - 2. Family Treatment without the child present – Is training in behavioral techniques provided to the parent/guardian or authorized representative without the child present. The training may be for the review of prior adaptive behavioral treatment sessions to break down the exhibited behavior and training techniques.
5. The coverage of ABA services require the following medical coverage criteria to be met:
- a. The recipient must be zero to under 21 years of age;
 - b. Have an established supporting diagnosis of ASD;
 - c. The individual exhibits excesses and/or deficits of behavior that impedes access to age appropriate home or community activities (examples include, but are not limited to aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);
 - d. ABA services are rendered in accordance with the individual’s treatment plan with realistic and obtainable treatment goals to address the behavioral dysfunction;
 - e. Treatment may vary in intensity and duration based on clinical standards. Approval of fewer hours than recommended/supported in clinical literature requires justification based on objective findings in the medical records;
 - f. A reasonable expectation on the part of the treating healthcare professional that the individual will improve, or maintain to the maximum extent practical functional gains with behavior intervention services;

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- g. The treatment plan must be based on evidence-based assessment criteria and the individual’s test results;
 - h. Behavioral assessments which are previously performed at the Local Education Agency (LEA) must be utilized and not duplicatively billed under the DHCFP if current (within six months) and clinically appropriate; and
 - i. Services must be prior authorized.
6. Services may be delivered in an individual or group (two to eight individuals) treatment session.
 7. Services may be delivered in the natural setting (i.e. home and community-based settings, including clinics).
 8. Individuals with Disabilities Education Act (IDEA) related services:
 - a. Part C, Early Intervention ages zero up to three - Services identified on an Individualized Family Services Plan (IFSP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under “provider qualifications” for ABA service. These providers must directly bill the DHCFP.
 - b. Part B, Special Education and related services ages three up to 21 - Services identified on an Individual Educational Plan (IEP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under “provider qualifications” for ABA services. These providers must directly bill the DHCFP.

PRIOR AUTHORIZATION REQUIREMENTS

1. Behavioral Screens do not require prior authorization.
2. Behavioral Initial assessment and re-assessments do not require prior authorization. Assessments are limited to one in every 180 days or unless prior authorized.
3. Adaptive Behavioral Treatment (individual and group) requires prior authorization from the Quality Improvement Organization (QIO)-like vendor.
4. Adaptive Family Behavioral training (individual and group) requires prior authorization from the QIO-like vendor.
5. ABA services identified through an IEP. When an IEP is issued by the school system, the IEP must accompany a request for ABA services and coordination of services is expected.
6. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both) of the current authorization, the provider is responsible for the submittal of a new prior authorization request.

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NON COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.
2. Services used to reimburse a parent/guardian for participation in the treatment plan.
3. Services rendered by the parent/guardian.
4. Services that are duplicative services under an IFSP or an IEP.
5. Treatment whose purpose is vocationally or recreationally based.
6. Services, supplies, or procedures performed in a non-conventional setting including but not limited to Resorts, Spas, and Camps.
7. Custodial services:
 - a. For the purpose of these provisions, custodial care:
 1. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs) such as bathing, dressing, eating, and maintaining personal hygiene and safety;
 2. is provided primarily for maintaining the recipient's or anyone else's safety; and
 3. could be provided by persons without professional skills or training.
8. Parenting services without a diagnosis of ASD.
9. Services not authorized by the QIO-like vendor if an authorization is required according to policy.
10. Respite services.
11. Child care services.
12. Services for education.
13. Equine therapy.
14. Hippo therapy.
15. Phone consultation services.
16. Care coordination and treatment planning billed independently of direct service.
17. ABA services cannot be reimbursed on the same day as other rehabilitative mental health services as described within Chapter 400 of the MSM.

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PROVIDER QUALIFICATIONS

In order to be recognized and reimbursed as an ABA provider by the DHCFP, the provider must be one of the following:

1. Licensure as a Physician by the Nevada State Board of Medical Examiners acting within their scope of practice (NRS 630.630, 630.165, 630.195, 633 Nevada Administrative Code (NAC) 630.080), and 42 CFR §440.50.
2. A Psychologist licensed under NRS 641.170.3. A qualified Behavior Analyst is an individual who has earned a master's degree level and/or doctorate from an accredited college or university in a field of social science or special education and holds a current certificate as a Board Certified Behavior Analyst (BCBA and BCBA-D) by the BACB, Inc., and licensed by the Nevada State Board of Psychological Examiners under NRS 641.170.
4. A qualified Assistant Behavior Analyst is an individual who has earned a bachelor's degree from an accredited college or university in a field of social science or special education and holds a current certification as a Board Certified Assistant Behavior Analyst (BCaBA) by the BACB, Inc., and licensed by the Nevada State Board of Psychological Examiners under NRS 641.170 and is under the direction of a physician, psychologist, BCBA-D, or BCBA.
5. A Registered Behavior Technicians (RBT) is an individual who has earned a high school diploma or equivalent, completed training and testing as approved and credentialed by the BACB, Inc., and acting within the scope of practice under direction of a physician, psychologist, BCBA-D, BCBA, or BCaBA.

SUPERVISION STANDARDS

Clinical Supervision as established by NRS 641.100, which includes: program development, ongoing assessment and treatment oversight, report writing, demonstration with the individual, observation, interventionist and parent/guardian training/education, and oversight of transition and discharge plans. All supervision must be overseen by a Licensed Psychologist, BCBA-D or BCBA who has experience in the treatment of autism, although the actual supervision may be provided by a BCaBA at their direction. The amount of supervision must be responsive to individual needs and within the general standards of care and may temporarily increase to meet the individual needs at a specific period in treatment.

PROVIDER RESPONSIBILITY

1. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.
2. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.
3. Ensure services are consistent with applicable professional standards and guidelines relating to the practice of ABA as well as state Medicaid laws and regulations and state licensure laws and regulations.
4. Ensure caseload size is within the professional standards and guidelines relating to the practice of ABA.

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PARENT/GUARDIAN RESPONSIBILITY

The parent/guardian when applicable must:

1. Be present during all provider training and supervisory visits that occur during home-based services. A parent/guardian may designate an authorized representative, who is 18 years of age or older, to participate in the parent/guardians absence during home-based services.
2. Participate in discussions during supervisory visits and training.
3. Participate in training by demonstrating taught skills to support generalization of skills to the home and community environment.
4. Sign the treatment plan indicating an understanding and agreement of the plan.
5. Participate in treatment hours.
6. Keep scheduled appointments.
7. Inform provider within 24 hours if the appointment needs to be rescheduled.

TREATMENT PLAN

All ABA services must be provided under a treatment plan developed and approved by a licensed psychologist, BCBA-D or BCBA, supported by a BCaBA where applicable. The licensed psychologist, BCBA-D, or BCBA trains the BCaBA and RBT to implement assessment and intervention protocols with the individual, and provides training and instruction to the parent/guardian and caregiver as necessary to support the implementation of the ABA treatment plan. The licensed psychologist, BCBA-D, or BCBA is responsible for all aspects of clinical direction, supervision, and case management.

ABA services shall be rendered in accordance with the individual's treatment plan that is reviewed no less than every six months by a licensed psychologist, BCBA-D, or BCBA. All treatment plans are based on documentation of medical necessity for specific treatment goals to address specific behavior targets based on the appropriate treatment model. The treatment plan shall include:

1. Goals derived from the functional assessment and/or skill assessment that occur prior to initiation of treatment, and relating to the core deficit derived from the assessment;
2. Specific and measurable objectives to address each skill deficit and behavioral excess goal:
 - a. Delineate the baseline levels of target behaviors;
 - b. Identify short, intermediate, and long-term goals and objectives that are behaviorally defined;
 - c. Criteria that will be used to measure achievement of behavioral objectives; and
 - d. Target dates for when each goal will be mastered.

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3. Interventions consistent with ABA techniques;
4. Specific treatment, intervention including amount, scope, duration and anticipated provider(s) of the services;
5. Training and supervision to enable the BCaBAs and RBTs to implement assessment and treatment protocols;
6. Care coordination involving the parent/guardian, community, school, and behavior health and/or medical providers who are concurrently providing services. Care coordination must include parent/guardian’s documented consent;
7. Parent/guardian training, support and participation;
8. Parent/guardian or designated authorized representative responsibility to be physically present and observant during intervention process occurring in the home;
9. Parent/guardian signature; and
10. Discharge criteria to include requirements of discharge, anticipated discharge date, next level of care, and coordination of other services.

DISCHARGE PLAN

All ABA services must include discharge criteria as a written component of the treatment plan at the initiation of services and updated throughout the treatment process; involving a gradual step down in services. Discharge planning should include the details of monitoring and follow up for the individual.

1. Discharge planning should occur when:
 - a. The individual has achieved treatment goals; or
 - b. The individual no longer meets the diagnostic criteria for ASD; or
 - c. The individual does not demonstrate progress towards goals for successive authorization periods;
or
 - d. The parent/guardian requests to discontinue services; or
 - e. The parent/guardian and provider are unable to reconcile concerns in treatment planning and delivery.
2. Discharge plan must identify:
 - a. The anticipated duration of the overall services;
 - b. Discharge criteria;

ATTACHMENT B

POLICY #15-3	APPLIED BEHAVIOR ANALYSIS	EFFECTIVE DATE: JANUARY 1, 2016
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- c. Required aftercare services;
- d. The identified agency(ies) or Independent Provider(s) to provide the aftercare services; and
- e. A plan for assisting the recipient in accessing these services.

A Discharge summary is 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, towards treatment goals and objectives, as documented in the ABA treatment plan. The discharge summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 21, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE *M. Stagliano*
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1600 – INTERMEDIATE CARE FOR THE MENTALLY
RETARDED

BACKGROUND AND EXPLANATION

The policy has been revised in the area of transportation to provide examples of services not reimbursable to the facility and refer the reader to Medicaid Services Manual (MSM) Chapter 1900, Transportation Services. The changes reduce conflict of information between program chapters and provide additional direction regarding transportation to an Adult Day Health Care (ADHC) setting. The second revision addresses a provider's use of ADHC services. Further changes direct the provider to the Rates and Cost Containment Unit for information regarding the Uniform Cost Report. Lastly, additional direction has been provided for the management of a patient's trust fund account.

To bring the chapter into formatting consistent with other manual chapters the Definitions section and the References and Cross References section have been deleted and are being reserved for future use.

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

These policy changes are effective July 22, 2011.

MATERIAL TRANSMITTED

MTL 12/11
CHAPTER 1600 - INTERMEDIATE CARE
FOR THE MENTALLY RETARDED

MATERIAL SUPERSEDED

MTL 36/03, 38/08, 21/10
CHAPTER 1600 - INTERMEDIATE CARE
FOR THE MENTALLY RETARDED

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1602	Definitions	The section was deleted and is being reserved for

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		future use.
1603.4	Transportation	Added types of transportation a facility must provide that are not reimbursable, the word “ambulance” to specify the type of emergency transportation that is reimbursable, and reference to Chapter 1900 as the authority regarding transportation policy.
1603.6	Professional Services	Added explanation of ADHC as part of an Active Treatment Program but separate reimbursement is not allowed.
1603.7	Reimbursement Rate and Allowable Costs	Revisions made to directions regarding contact and instructions for Uniform Cost Report. Added new sub-section “Patient Trust Fund Management” explaining the handling of patient trust funds and refers reader to MSM Chapter 500, Nursing Facilities
1605	References and Cross References	The section was deleted and is being reserved for future use.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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1600 INTRODUCTION

Nevada Medicaid's Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Program was established in 1971 to provide reimbursement for individuals residing in institutions for people with mental retardation or other related conditions. The Social Security Act specifies that these institutes must provide active treatment in addition to other Conditions of Participation. Many of the residents who are served by the program are also non-ambulatory, may have seizure disorders, behavioral problems, mental illness, can be visually or hearing impaired or have a combination of these conditions.

The Division of Health Care Financing and Policy (DHCFP) has opted to provide services for people residing in an ICF/MR as a benefit under the State Plan for Medical Assistance.

All DHCFP (Nevada – Medicaid) policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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1601 AUTHORITY

Federal Statutes, Regulations, and Policies Governing the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program.

The following are the relevant statutes, regulations, and State Operations Manuals (SOM) that govern the ICF/MR Program.

FEDERAL STATUTES governing ICF/MR – Social Security Act:

- Section 1905(d) – Defines ICF/MR
- Section 1905(a)(15) – Defines ICF/MR
- Section 1902(a)(33) – Directs Centers for Medicare and Medicaid Services (CMS) to make independent and binding determinations
- Section 1902(i)(1) – State plans for medical assistance and the ICF/MR program.
- Section 1922 – Correction and Reduction Plans for ICF/MR
- REGULATIONS governing the ICF/MR program – Title 42 of the Code of Federal Regulations (CFR)
- 42 CFR 435.1009 – Definitions relating to institutional status for the purpose of Federal Financial Participation (FFP)
- 42 CFR 440.150 – ICF/MR services
- 42 CFR 440.220 – Required services for the medically needy
- 42 CFR 442.118-119 – Denial of new admissions
- 42 CFR 483.10 – Resident Rights
- 42 CFR 483.400-480 – Conditions of Participation for ICF/MR
- 42 CFR 498.3-5 – Appeals procedures for determinations that affect participation in the Medicare program and for determinations that affect the participation of ICF/MR and certain Nursing Facilities in the Medicaid program.
- SURVEY procedures governing the ICF/MR program – State Operations Manual (SOM), Chapters 1, 2, 3, 9 – Exhibit 80 and Appendix J.

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1602 **RESERVED**

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1603 POLICY

1603.1 Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must be certified and comply with all Federal Conditions of Participation in eight areas, including management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment and dietetic services.

In Nevada, the Bureau of Health Care Quality and Compliance (HCQC) of the State Health Division licenses ICF/MR facilities, conducts surveys and recommends certification of the facilities as Medicaid providers.

1603.1A COVERAGE AND LIMITATIONS

1. ADMISSION AND CONTINUED STAY CRITERIA

- a. The recipient must be diagnosed as mentally retarded or have a condition related to mental retardation. Some standardized scales which can be used to determine level of mental retardation include, but are not limited to, the Vineland Social Maturity Scale, the Adaptive Behavior Scale, and the Behavior Development Survey.
- b. The recipient must have an Individual Program Plan (IPP).
- c. A physician must certify the need for ICF/MR care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/MR, before the Nevada Medicaid Office (NMO) authorizes payment).
- d. The certification must refer to the need for the ICF/MR level of care, be signed and dated by the physician, and be incorporated into the resident's record in the physician's orders.
- e. Recertification by a physician or a nurse practitioner of the continuing need for ICF/MR care is required within 365 days of the last certification.

In no instance is recertification acceptable after the expiration of the previous certification.
- f. The physical exam must document the resident does not have any active communicable, contagious, or infectious disease.
- g. The Interdisciplinary Team (IDT) evaluation documents that the recipient needs more intensive treatment than can be provided in a day treatment program or a community residential program.

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The IDT evaluation documents that the recipient needs and can probably benefit from the active treatment program. The program is directed toward the acquisition of behaviors necessary to maximize the recipient's possible independence and self determination or to prevent or decelerate regression or loss of the recipient's current level of functioning for a recipient for whom no further positive growth is demonstrable.

- h. The IDT has developed an appropriate IPP based on its evaluation and reevaluated the plan as required.
- i. The recipient had Medicaid Eligibility on the date(s) of service.
- j. Services are provided in a Medicaid certified participating facility.

1603.1B PROVIDER RESPONSIBILITY

1. MEDICAID ELIGIBILITY

The provider is responsible to verify a recipient's Medicaid eligibility. The Electronic Verification System (EVS) may be used.

Refer to Chapter 100 of the Medicaid Services Manual (**MSM**) for detailed information on application and eligibility categories.

2. FACILITY CERTIFICATION

Certification of compliance with federal requirements for participation in the Medicaid program is required; contact the HCQC of the State Health Division for information and procedures.

The facility must also have a valid Provider Agreement with the Nevada Medicaid Office; the Agreement must be co-terminus with Medicaid's period of certification, including any automatic cancellation dates imposed by **Centers for Medicare and Medicaid Services (CMS)**. The maximum duration of a Provider Agreement is 12 months.

3. PRELIMINARY ASSESSMENT

The IDT must complete a preliminary assessment of each recipient prior to admission to the facility.

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The preliminary assessment must include background information and current valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the recipient's needs, if the recipient is likely to benefit from placement in the facility, and what services are needed to meet those needs.

4. PSYCHOLOGICAL EVALUATION

There must be a psychological evaluation documenting the need for care which must be completed within three months before admission and prior to authorization of payment.

For an urgent or emergency initial ICF/MR placement, a psychologist may review the most recent psychological evaluation and document with a progress note or addendum to the psychological evaluation that the recipient is eligible and needs ICF/MR placement. The note or addendum must confirm the recipient's specific level of retardation or identify the condition related to mental retardation and be signed and dated within 90 days prior to admission or on the admission date. This progress note or addendum must be attached to the most recent psychological evaluation.

For readmission and discharge to another ICF/MR, a new psychological evaluation is not required unless the IDT determines the existing evaluation is no longer accurate.

5. PHYSICIAN'S CERTIFICATION AND MEDICAL PLAN OF CARE

The physician must complete a medical plan of care if the resident requires 24-hour licensed nursing care. It must include:

- a. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- b. Any orders for:
 1. medications;
 2. treatments;
 3. restorative and rehabilitative services;
 4. activities;
 5. therapies;

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6. diet;
7. medical equipment utilized to help treat medical conditions, such as helmets or orthopedic splints; and
8. special procedures designed to meet the objectives of the plan of care.

6. THIRTY-DAY EVALUATION RECORD REQUIREMENTS

Within 30 days of admission, the following assessments and evaluation which were completed (as appropriate to the recipient's needs) must be entered in the resident's record.

- a. A physical examination and history which was completed within five days prior to or 30 days after admission. The examination and history may be conducted by an advanced practitioner of nursing or physician's assistant, if within their scope of practice, or a physician. The examination must include screening for vision and hearing.
- b. A complete dental examination which is completed within 12 months prior to or one month after admission.
- c. Evaluation of nutritional status which includes the determination of diet adequacy, total food intake, potential need for additives or supplements, and the skills associated with eating or feeding, food services practices, monitoring, and supervision of the resident's own nutritional status.
- d. Routine laboratory examinations as determined necessary by a physician.
- e. Speech and language screening.
- f. Social assessment which includes, but is not limited to, family history, social relationships and interactions with peers, friends and relatives, and social development.
- g. Active Treatment Schedule.
- h. A nursing assessment which includes medication and immunization history, developmental history, and current health care needs.
- i. Assessment of sensorimotor development which includes the development of perceptual skills which are involved in observing the environment and making sense of it; the development of those behaviors which primarily involve muscular, neuromuscular, or physical skills and varying degrees of physical dexterity;

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identifying the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status.

- j. Assessment of affective development which includes the development of behaviors which relate to the recipient's interests, attitudes, values, and emotional expressions.
- k. Assessment of cognitive development which refers to the development of those processes by which information received by the senses is stored, recovered, and used including the development of the processes and abilities involved in memory and reasoning.
- l. Assessment of adaptive behaviors and independent living skills which includes the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected of their age and cultural group and skills such as meal preparation, laundry, bed making, budgeting.
- m. Assessment of vocational or prevocational development, as applicable, which includes work interests, work skills, work attitudes, work related behaviors and present and future employment options.

All of the assessments must describe what recipients can and cannot do in terms of skills needed within the context of their daily lives.

In addition, the assessments must:

- n. Identify the recipient's present problems and disabilities and where possible, their causes;
- o. Identify the recipient's specific developmental strengths;
- p. Identify the recipient's specific developmental and behavioral management skills;
- q. Identify the recipient's need for services without regard to the actual availability of services needed.

7. INDIVIDUAL PROGRAM PLAN (IPP)

- a. Within 30 days of admission, the IDT develops an IPP for each resident based on the interdisciplinary professional comprehensive evaluations.

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- b. The purpose of the IPP is to help the individual function at the greatest physical, intellectual, social, or vocational level the recipient has presently or can potentially achieve.
- c. The interdisciplinary team must prepare an IPP which includes opportunities for individual choice and self management and identifies the discrete measurable criteria-based objective the recipient is to achieve, and the specific individualized program of specialized and generic strategies, supports and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the recipient to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

8. IMPLEMENTATION OF CONTINUOUS ACTIVE TREATMENT

- a. The ICF/MR must provide active treatment. Once the IDT has developed the recipient's IPP, the recipient must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the plan.
- b. The individual's time in the home or living unit must maximize toward further development and refinement (including self-initiation) of appropriate skills.
- c. For the active treatment process to be effective, the overall pattern of interaction between staff and a recipient must be related to the comprehensive functional assessment and the IPP.
- d. Except for those facets of the IPP which must be implemented by licensed personnel, each recipient's program plan must be implemented by all staff who work with the recipient, including professional, para-professional, and other staff, including direct care staff.
- e. The facility must ensure that during staff time spent with each recipient, the staff members are able to provide needed interventions or reinforce acquired skills in accordance with the program plan. The activities of the ICF/MR must be coordinated with other habilitation and training activities in which the recipient may participate outside of the ICF/MR and vice versa, i.e. school or Community Training Center (CTC).

9. ACTIVE TREATMENT SCHEDULE

Within 30 days of admission to the facility, staff must develop an active treatment schedule which outlines the current active treatment program and is readily available for

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review by relevant staff. The schedule should direct the intensity of the daily work of the staff and the recipient in implementing the individual program plan. To the extent possible, the schedule should allow for flexible participation of the recipient in a broad range of options, rather than on a fixed regimen.

The facility must develop an active treatment schedule for each recipient which:

- a. Does not allow for periods of unscheduled activity of longer than three continuous hours;
- b. Allows free time for individual or group activities using appropriate materials;
- c. Includes planned outdoor period year-round;
- d. Reflects some of the specific programs for the individual rather than a facility or unit-wide generic calendar.

10. QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP) REVIEWS

a. Reviews

A facility must have one or more QMRP's review the IPP and assure it is revised as necessary. The frequency of the QMRP reviews are determined by the facility. The duties of the QMRP are:

1. Monitoring the delivery of each IPP;
2. Integrating and coordinating the various aspects of the active treatment program;
3. Reviewing each recipient's program plan and insuring it is revised as necessary, including but not limited to, situations in which the recipient:
 - a. Has successfully completed an objective or objectives identified in the IPP;
 - b. Is regressing or losing skills already gained;
 - c. Is failing to progress toward identified objectives after reasonable efforts have been made; or
 - d. Is being considered for new training.

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4. Obtaining input and review by other IDT members when the revisions result in significant differences from the team's original intent;
5. Documents information relevant to the IPP, assuring it is recorded as changes occur.

11. ANNUAL INTERDISCIPLINARY TEAM (IDT) REVIEW

Within one year of the resident's admission date and at least once annually thereafter, the IDT must re-evaluate each recipient and revise the IPP. Revisions must be developed and implemented and recommendations acted upon within 30 days of the IDT meeting, unless other time frames are justified.

- a. The annual review must include:
 1. The advisability of continued ICF/MR placement versus an alternative placement;
 2. When the recipient is an adult, the need for guardianship and how the recipient can exercise his/her civil and legal rights;
 3. The continuing appropriateness of the IPP objectives;
 4. The continuing appropriateness of services provided to reach the plan's objectives;
 5. The progress or failure to progress toward the plan's objectives;
 6. Modification of the activities, objectives and/or training programs of the IPP as are necessary; and
 7. A comprehensive functional reassessment to be based upon:
 - a. Physical examination including a vision and hearing screening, which may be completed by a physician or an advanced nurse practitioner;
 - b. Dental examination;
 - c. Social reassessment;
 - d. Physician's recertification of need for ICF/MR;

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- e. Nursing reassessment;
 - f. Routine screening laboratory tests as determined necessary by the physician;
 - g. Nutritional reassessment;
 - h. The IDT must determine whether other assessments are still accurate.
8. Accurate assessments must include:
- a. Current, relevant and valid data;
 - b. Skills, abilities and training needs identified which correspond to the resident's actual status; and
 - c. The cultural background and experiences of the resident are reflected in the choice, administration and interpretation of the assessments.

Assessments which are no longer accurate must be revised. The case record must document that the IDT has reviewed the assessments and determined which need updating.

Assessments which must be reviewed by the IDT and revised as recommended by the IDT are:

- d. Sensorimotor, affective and cognitive development;
- e. Adaptive behaviors and independent living skills; and
- f. Vocational and prevocational development as applicable.

12. OCCUPANCY REPORTS

To assist in appropriate use of available beds, the facility must complete the Monthly Facility Occupancy Report indicating the actual census as of the first day of each month. This report is due by the fifth day of each month. The occupancy report may be submitted by fax to Division of Health Care Financing and Policy (DHCFP), Continuum of Care Unit, (775) 687-8724.

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13. INCIDENT REPORTS

Incidents involving any potential harm to a resident in or around the facility must be:

- a. Recorded on an adequate form;
- b. Reported to the resident's physician or his alternate immediately if there is serious harm;
- c. Reported to the family member, authorized representative or legal guardian; and
- d. Evaluated by a nurse.

Incident documentation may be maintained apart from the resident's chart but, upon request, must be made available to authorized representatives of the DHCFP and/or Nevada State Health Division.

A facility must report to the Nevada Medicaid Office by telephone, within 48 hours, any incident in or about the facility that results in the death of or serious injury to any Medicaid resident by other than natural causes.

1603.1C RECIPIENT RESPONSIBILITY

1. Recipients and/or their authorized representative are responsible to apply for and to maintain Nevada Medicaid eligibility by cooperating with the **Division of Welfare and Supportive Services (DWSS)** in providing information necessary to determine eligibility.
2. Application for services is made directly through the service provider in conjunction with the Health Division's Mental Health and Development Services (MHDS).
3. The recipient and the recipient's family/guardian should participate in developing the IPP unless the QMRP documents that such participation is inappropriate or unobtainable. If the recipient is a legally competent adult, he/she may request that his/her family not be involved in the planning process.
4. The recipient is responsible to participate in the active treatment program as described in the IPP.

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1603.1D AUTHORIZATION PROCESS

1. GENERAL REQUIREMENTS

- a. Prior authorization by the **Quality Improvement Organization (QIO-like vendor)** is required for payment for care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- b. Authorization will be given only after a determination by the QIO-like vendor that ICF/MR admission criteria have been met.
- c. Authorization cannot be given for a resident whose eligibility status is pending. However, if eligibility is established retroactively, Medicaid may authorize retroactive payment to the facility for necessary services at the ICF/MR level of care which have been certified by a physician.

2. ICF/MR TRACKING FORM

The facility must submit an ICF/MR Tracking Form within 72 hours of an admission, readmission, discharge, Medicaid eligibility determination or annual continued stay review.

This form is to be submitted to the DHCFP or their QIO-like vendor. Failure to submit the Tracking form may result in a delay or denial of payment.

3. PRE-PAYMENT REVIEW

Pre-Payment Review packets must be submitted to Nevada Medicaid's QIO-like vendor within 45 days of admission, readmission, or newly Medicaid eligible (first time billing).

The below required attachments are referred to as a Pre-Payment Review packet. The pre-payment review packet serves as documentation to assess the appropriateness of placement. Once the Pre-Payment Review packet has been approved the facility will be notified by receiving a Billing Authorization letter. An ICF/MR will not be able to bill for services until they have received the Billing Authorization letter.

- a. Required Attachments for Pre-Payment Review Packets
 1. Copy of the original ICF/MR Tracking Form;
 2. History & Physical Examination (most recent);

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3. Acute Discharge Summary (if there was a hospital stay which lasted longer than 48 hours);
4. The most recent psychological test results documenting the recipient's level of retardation or existence of a "related condition";
5. Minutes of the most recent IDT meeting (Initial, Readmission, or Annual) that includes a dated sign-in sheet, a Nursing Assessment, Nutritional Assessment, Social Services Assessment and documentation of a dental exam within the past year.
6. The current IPP developed by the IDT and Active Treatment Schedule.
7. Physicians admission orders and certification for ICF/MR level of care.

b. Complete Pre-Payment Review Packet

If the packet has information which is incomplete or inaccurate, the packet will be returned to the facility, with the Additional Information form identifying the problem. The facility must review this request, make necessary corrections or provide additional information to assure all areas are addressed prior to resubmitting the packet. A facility staff member(s) must initial any alterations.

4. ANNUAL CONTINUED STAY PAYMENT REVIEW PACKET

Annually, the ICF/MR must submit to Nevada Medicaid documentation verifying the need for a recipient's continued stay.

a. Required attachments for the Annual Continued Stay Payment Review Packets:

1. Most recent annual IDT review with signatures and titles of the participants.
2. The Physician's signed recertification of continued need for ICF/MR level of care.
3. Most recent annual History and Physical with listed diagnoses.
4. Copy of the ICF/MR Tracking form.

Continued payment will not be approved without the annual review packet.

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1603.2 READMISSION PROCEDURES

1603.2A COVERAGE AND LIMITATIONS

Refer to Section 1603.1A of this Chapter.

1603.2B PROVIDER RESPONSIBILITIES

1. HOSPITAL OR NURSING FACILITY DISCHARGE/READMISSION

If a recipient is discharged to a hospital or nursing facility from the ICF/MR and returns to the same ICF/MR, the following procedures are required:

- a. Within 72 hours of the recipient's discharge, the facility must complete and submit to the DHCFP QIO-like vendor an ICF/MR Tracking Form.
- b. Within 72 hours of the recipient's return to the ICF/MR, the facility must complete and submit the ICF/MR Tracking form.
- c. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification and update the physician's orders.
- d. The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

On or prior to the date of admission, the IDT must review and revise the IPP. If the IDT finds the objectives are appropriate and do not need revising, they must so note in the case records. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

- e. The facility must obtain the hospital's discharge summary if the hospital stay was for longer than 48 hours and file it in the recipient's record.
- f. Within 45 days submit the Pre-Payment packet to Nevada Medicaid's QIO-like vendor.
- g. If the recipient has been out of the ICF/MR for more than 30 days, all the requirements for a new admission must be met.

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h. Admission to an ICF/MR from another ICF/MR is a new admission to the accepting facility. Each ICF/MR has a separate Medicaid provider number and each is considered a separate facility even if multiple facilities share a governing body.

2. DISCHARGE/READMISSION TO/FROM HOME OR COMMUNITY BASED PLACEMENT

If a recipient is transferred from an ICF/MR into a residential community based home or home placement, the following procedures apply:

a. The facility must submit the ICF/MR Tracking form to Nevada Medicaid's QIO-like vendor within 72 hours of when the recipient is transferred.

b. If the recipient returns to the ICF/MR within the trial placement period (within 30 days of leaving the ICF/MR) the facility must:

1. Complete the tracking form within 72 hours of the recipient's return and submit it to Nevada Medicaid's QIO-like vendor.

2. On or prior to the date of readmission, the IDT determines whether assessments are still accurate. Assessments which are no longer accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating.

c. If a recipient is transferred from one ICF/MR to another ICF/MR, the following procedures must be followed:

1. The discharging facility must complete an ICF/MR tracking form within 72 hours of discharge and submit to Nevada Medicaid's QIO-like vendor.

2. The discharging facility must develop a final summary of the recipient's developmental, behavioral, social, health and nutritional status and plan to help the recipient adjust to the new placement. With the consent of the recipient/parents (if a minor child)/legal guardian, the summary must be provided to authorized persons and agencies.

3. Within 30 days after admission, the admitting ICF/MR IDT must perform accurate assessments or reassessments as needed (defined in Manual Section 1603.1B11.a.8 of this chapter).

On or prior to the date of readmission, the IDT must review and revise the IPP. If the IDT finds that the objectives are appropriate and do not need

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revising, it must be noted in the case record. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

- a. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification (See Manual Section 1603.1A2) and update the physician's orders.
- b. Within 45 days of the readmission, the facility must submit the Pre-Payment Review Packet, defined in Manual Section 1603.1D.3 of this chapter, to Nevada Medicaid's QIO-like vendor.
- c. If the recipient returns to the ICF/MR after the trial placement period has ended, all the requirements for a new admission must be met with one exception.

The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

1603.3 OUT-OF-STATE ICF/MR PLACEMENT

Nevada Medicaid must prior authorize all out-of-state ICF/MR placements for all Medicaid recipients arranged by any agency, individual, or district office. Nevada Medicaid will issue a Prior Authorization (PA) to the out-of-state facility and the Medicaid District Office may assist to arrange transportation. A recipient residing in an out-of-state facility without Medicaid authorization may place the out-of-state facility at risk for delayed or non-payment of services and the resident may be considered a resident of the state of location.

1603.3A COVERAGE AND LIMITATIONS

PRE-PLACEMENT PROCEDURES

The following pre-placement procedures must be followed before Nevada Medicaid will authorize an out-of-state ICF/MR placement:

1. All appropriate facilities within Nevada must first be contacted for a possible placement. The facilities contacted and reasons for not accepting the recipient must be documented.

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2. Documentation, if applicable, is required from a state or county agency verifying responsibility for payment of educational expenses, since this is not a Medicaid benefit. Documentation is required for recipients under age 22 and who have not completed state schooling requirements.
3. If there is no burial coverage and family is not willing/able to purchase it, a burial guarantee must be obtained from the Division of Child and Family Services (DCFS), or the county of origin.
4. If the individual is incompetent or suffers from diminished capacity and there is no family, legal guardian or significant other involvement, efforts must be made to have the Public Administrator or a guardian appointed to handle possible legal, health or financial matters prior to out-of-state placement.
5. The individual (and family or custodial agency if applicable) must agree in writing to out-of-state placement.
6. The out-of-state ICF/MR must be a Nevada Medicaid provider.

1603.3B PROVIDER RESPONSIBILITY

All of the following are required for authorization for an out-of-state placement:

1. Completed Out-of-State Intake Questionnaire.
2. Current History and Physical exam and list of current medications.
3. Proof of burial coverage or guarantee (if available) and a signed statement from the recipient or responsible party acknowledging that Medicaid benefits end with death of the recipient.
4. Statement from the recipient, if a minor from his/her parent, or from a legal guardian agreeing to an out-of-state placement.
5. A list of all Nevada ICF/MR facilities contacted including date contacted the name of the person at the ICF/MR who denied placement and the reason for denial.
6. A letter verifying coverage of educational costs for a recipient who is under age 22 and has not completed high school.
7. Social history and assessment.

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8. Psychological evaluation verifying the person with mental retardation or with a condition related to mental retardation will benefit from placement in an ICF/MR.

All documents must be sent to the DHCFP, Attention: Out-of-State Placement Coordinator.

1603.4 TRANSPORTATION

Transportation for services that a facility is required to provide is not reimbursable, **such as but not limited to medical appointments, social events and Adult Day Health Care (ADHC) attendance.**

Medicaid will reimburse for **ambulance** transportation in a medical emergency situation.

Refer to **MSM** Chapter 1900, **Transportation Services**, for **further** details on transportation.

1603.5 ABSENCES

1603.5A COVERAGE AND LIMITATIONS

1. Payment for therapeutic leave of absence, or reserved beds, may be made to an ICF/MR, subject to the following conditions:
 - a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;
 - b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;
 - c. An ICF/MR will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of twenty-four (24) days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.
2. An absence for hospitalization or placement in a nursing facility which exceeds the Medicaid authorized maximum is not reimbursable.
3. If a recipient does not return from a home visit or family emergency and if the absence has been appropriately documented by the recipient's physician and the facility, the facility will not be penalized for the recipient's failure to return. This absence will be treated as a discharge effective the day the recipient was expected to return from leave.

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1603.6 PROFESSIONAL SERVICES

In order to qualify for Medicaid reimbursement and provide services necessary to assure a comprehensive Active Treatment Program, ICF/MR employ or contract with individuals who can assess recipient needs, participate in the IPP, and provide appropriate training and habilitation services. These support staff assist in providing those physical and social modifications or interventions allowing the recipient to function and adapt to his/her physical and social environment.

ADHC services may be considered part of an Active Treatment Program. This service is not Medicaid reimbursable outside of the facility's routine per diem rate.

1603.6A COVERAGE AND LIMITATIONS

1. RECREATION

a. Services for Recipients **w**ith Handicapping Conditions

Multiple handicapped or non-ambulatory recipients must:

1. Spend a major portion of the waking day out of bed;
2. Spend a portion of the waking day out of the bedroom area;
3. Have planned daily activity and exercise periods;
4. Move around with various methods and devices whenever possible; and
5. Have recreation areas and facilities designed and constructed or modified so that they, regardless of their disabilities, have access to them.

b. Coordination with the IPP

Recreation services should be a coordinated part of the recipient's IPP.

A recreation assessment must be completed or updated within 30 days of admission into an ICF/MR. If recreation therapy is provided, an annual re-evaluation by the recreational therapist is required. If the IDT recommends during an IDT meeting that a re-assessment be completed by the recreational therapist, one must be completed within 30 days of the recommendation.

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c. Recreation Services Objectives

Recreation services should:

1. Provide activities designed to meet individual, personal, and therapeutic needs in self-expression, social interaction, and entertainment;
2. Develop skills, including physical and motor skills, and interests leading to enjoyable and satisfying use of leisure time; and
3. Improve socialization and increase interaction with others.

d. Recreational Staff Qualifications

1. To be designated as a professional recreation therapist the staff member must have a Bachelor's Degree in recreation, or a related specialty area, such as art, dance, music, or physical education.
2. Sufficient qualified staff and support staff should be available to carry out recreational services in accordance with the stated objective(s) in the IPP.

2. SOCIAL SERVICES

a. Purpose of Social Services

Social Services must be directed toward:

1. Maximizing the social functioning of each recipient;
2. Enhancing the coping capacity of each recipient's family;
3. Asserting and safeguarding the human and civil rights of the recipient and his/her family; and
4. Fostering the human dignity and personal worth of each recipient.

b. Pre-Admission Services

During the evaluation process to determine whether or not admission to the ICF/MR is necessary, social workers must help the recipient and his/her family:

1. Consider alternative services, based on the individual's status and relevant family and community factors; and

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2. Make a responsible choice as to whether and when residential placement is indicated.

c. Ongoing Evaluation and Monitoring of Residents

Social workers must participate in the IDT meetings for each recipient for the purposes of monitoring and following up on program plans.

d. Liaison with Recipient's Family and the Community

The social worker must, as appropriate, provide liaison between the recipient, the ICF/MR, the family, and the community.

e. Discharge Planning

1. In addition to participation in the development of the discharge plan, social workers must:

- a. Help the family participate in planning for the recipient's return to home or other community placement; and
- b. Provide systematic follow-up to assure referral to appropriate community agencies after the recipient leaves the facility.

2. If a recipient is to be either transferred or discharged, the facility must:

- a. Have documentation in the resident's record that the resident was transferred or discharged for good cause.

Transfer means the temporary movement of an individual between facilities or the permanent movement of an individual between living units of the same facility. Discharge means the permanent movement of an individual to another residence that is not under the jurisdiction of the facility's governing body. Moving an individual for good cause means for any reason that is in the best interest of the individual.

The recipient, his/her family, advocate and/or guardian should be involved in any decision to move him/her.

- b. Provide a reasonable time to prepare the recipient and his or her parents or guardian for the transfer or discharge (except in emergencies).

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f. Social Work Staff Qualifications

A social worker must be licensed as an Associate in Social Work or a Social Worker by the Nevada State Board of Examiners for Social Work.

3. PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

a. Purpose of Psychological Services

Psychological services must be provided to:

1. Maximize each recipient's development; and
2. Help recipient's acquire:
 - a. Perceptual skills;
 - b. Sensorimotor skills;
 - c. Self-help skills;
 - d. Communication skills;
 - e. Social skills;
 - f. Self-direction;
 - g. Emotional stability; and
 - h. Effective use of time, including leisure time.

b. Psychological Services

The facility must provide a psychological service program for recipients' which includes:

1. Evaluations which must be done at least every three years for recipients under age 18 and every five years for recipients aged 18 or older. The evaluations must document that the resident has mental retardation. The level of retardation may be two levels if the recipient's functioning is in between them, e.g., moderate-severe.
2. Consultation;

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3. Therapy;
4. Program development;
5. Administration and supervision of psychological services;
6. Staff training;
7. Continuing inter-disciplinary evaluation of each recipient and development of plans for habilitation services; and
8. When appropriate, periodic review and revision of program plans.

c. Psychological Staff Qualifications

1. A psychologist must have at least a Master's degree from an accredited program and experience or training in the field of mental retardation. If hired or subcontracted with after July 1, 1986, the psychologist must be certified by the Nevada State Board of Psychological Examiners.
2. A psychologist who is the facility's QMRP must meet the qualifications in Manual Section 1603.1B.10 of this chapter.

d. Psychiatric Services

1. Psychiatric services should be provided when indicated by the IDT for psychotherapy, medication management and/or consultation.
2. To provide services in an ICF/MR a psychiatrist must be a medical doctor licensed to practice psychiatry in the State of Nevada.

4. DENTAL SERVICES

Through a formal arrangement with a dentist licensed to practice dentistry or dental surgery as defined in Nevada Revised Statutes (NRS) 631.215, the ICF/MR facility must provide:

- a. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within the 12 months prior to admission.
- b. Periodic examination and diagnosis done at least annually for each recipient.

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- c. Necessary access to the services specified under the MSM Chapter 1000, excluding sealants, orthodontia, pharmacy services, fluoride treatments, and fluoride treatments with prophylaxis.
- d. For children under 21 years of age residing in an ICF/MR referred for dental care through the Healthy Kids Program, also known as Early and Periodic Screening Diagnosis and Treatment (EPSDT), a Medicaid dental provider may bill directly to Medicaid.
- e. For adults 21 years and older residing in an ICF/MR, dental treatment for emergency extractions, palliative care, and dentures can be billed to Medicaid by a Medicaid dental provider in accordance with the MSM Chapter 1000 guidelines and limitations.
- f. If appropriate, the dentist or dental hygienist may participate in the development, review, and updating of the IPP as part of the IDT process, either in person or by written report.

5. PHARMACEUTICAL SERVICES

a. Pharmacist Duties

1. Upon admission, the pharmacist or registered nurse must obtain a history of prescription and non-prescription drugs used and enter this in the resident's record. This must be updated yearly.
2. The pharmacist must receive a copy for each resident of the physician's drug treatment order.
3. The pharmacist must maintain for each resident a record of all prescription and non-prescription medications dispensed including quantities and frequency of refills.
4. As appropriate the pharmacist should participate in the ongoing IDT evaluations and development of the individual program plan.
5. The pharmacist must establish quantity specifications for drug purchases and insure that they are met.
6. The pharmacist must review each resident's drug regimen at least quarterly.
7. On a monthly basis the pharmacist must complete the Checklist for Pharmacist Consultant (3232). The facility must retain the checklist for a

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period of three fiscal years from the year to which they pertain (NRS 239.073).

b. Staff or Consultant

1. If a facility does not employ a licensed pharmacist, it must have an agreement, with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal, and recording of drugs and biologicals.
2. Payment for consultant pharmacist services are separate from payment for filling of prescriptions. With the consultant pharmacist, payment is made by the facility for a service to the facility. In the case of prescribed drugs, a provider payment is made by Medicaid to a pharmacy on behalf of the recipient. The individual furnishing consultant pharmacist services to a facility may or may not also be providing prescribed drugs to residents in that facility. However, when it is feasible, separation of consultant services and prescription services is encouraged.

c. Limitations

Nevada Medicaid reimburses the pharmaceutical provider directly for prescriptions that meet the definition of essential in Section 1602.6 of this chapter.

The consultant pharmacist must review every drug ordered for compliance with this definition.

If drug therapy is observed which does not meet the definition of essential as stated in Section 1602.11 of this chapter, future charges for the medication will be denied. Before this sanction is imposed, the facility and the pharmacy will receive advance notice. If Nevada Medicaid does not receive appropriate justification within 10 days from the date of notification, all future charges for the medication will be denied.

6. PHYSICAL AND OCCUPATIONAL THERAPY (OT)

a. Services

1. Physical and OT staff must provide treatment training programs which are designed to:
 - a. Preserve and improve abilities for independent function such as

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range of motion, strength, tolerance, coordination, and activities of daily living; and

- b. Prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.
2. Services must be coordinated with the recipient's physician and other medical specialists.
 3. Services must include:
 - a. Evaluation;
 - b. Participation in developing treatment objectives as part of the IPP;
 - c. Procedures to reach objectives; and
 - d. Revision of objectives and procedures based on progress (or lack of progress).
 - b. Staff and Qualifications
 1. The ICF/MR must have available enough qualified staff and support personnel available either on staff or under contract to carry out the various physical and occupational therapy services in accordance with stated objectives in recipients' individual treatment plans.
 2. Therapy assistants must work under the supervision of a qualified therapist.
 3. To be designated as an occupational therapist, an individual must have a current registration issued by the American Occupational Therapy Association or another comparable body.
 4. To be designated as a physical therapist an individual must have a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners.

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7. SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

a. Services

Speech pathology and audiology services available to the ICF/MR must include:

1. Screening of recipients with respect to hearing functions which is completed by the physician or advanced nurse practitioner as part of the annual physical examination, and screening of recipients regarding speech functions;
2. Comprehensive audiological assessments of recipients as indicated by screening results, which were part of the recipient's physical examination, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;
3. Assessment of the use of amplification;
4. Provision for procurement, maintenance, and replacement of hearing aids, as specified by a qualified audiologist;
5. Comprehensive speech and language evaluations of recipients as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;
6. Participation in the IDT Process and IPP development for individual recipients;
7. Treatment services as an extension of the evaluation process, which include:
 - a. Direct counseling with recipients;
 - b. Consultation with appropriate staff for speech improvement and speech education activities; and
 - c. Work with appropriate staff to develop specialized programs for developing each recipient's communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization, and skills in expression, including improvement in articulation, voice, rhythm, and language;

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8. Participation in in-service training programs for direct-care and other staff.

b. Staff and Qualifications

A speech pathologist or audiologist must be licensed by the State of Nevada Board of Audiology and Speech Pathology and have a current certificate of clinical competence issued by the American Speech and Hearing Association or a comparable body.

8. LABORATORY SERVICES

a. Management Requirements

If a facility chooses to provide laboratory services, the laboratory must:

1. Meet the management requirements specified in 42 CFR 405.1316; and
2. Provide personnel to direct and conduct the laboratory services.

b. Qualifications of Laboratory Director

The laboratory director must be technically qualified to supervise the laboratory personnel and test performance and must meet licensing or other qualification standards established by the State with respect to directors of clinical laboratories. For those States that do not have licensure or qualification requirements pertaining to directors of clinical laboratories the director must be either:

1. A pathologist or other doctor of medicine or osteopathy with training and experience in clinical laboratory services; or
2. A laboratory specialist with a doctoral degree in physical, chemical, or biological sciences, and training and experience in clinical laboratory services.

c. Duties of Laboratory Director

The laboratory director must provide adequate technical supervision of the laboratory services and assure that tests, examinations and procedures are properly performed, recorded, and reported.

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The laboratory director must ensure that the staff:

1. has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;
2. is sufficient in number for the scope and complexity of the services provided; and
3. receives in-service training appropriate to the type and complexity of the laboratory services offered.

d. Other Laboratory Requirements

1. The laboratory must meet the proficiency testing requirements specified in 42 CFR 405.1314(a).
2. The laboratory must meet the quality control requirements specified in 42 CFR 405.1317.
3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved by the Medicare program either as a hospital or an independent laboratory.

1603.7 REIMBURSEMENT RATE AND ALLOWABLE COSTS

1603.7A COVERAGE AND LIMITATIONS

1. PUBLIC ICF/MR – COST REIMBURSEMENT

A public ICF/MR is reimbursed under Medicare principles of retrospective reimbursement described in the Medicaid State Plan, Attachment 4.19D and HCFA Publication 15.

Each facility is paid the lower of either billed charges or an interim rate. In no case will payment exceed audited allowable costs.

2. PRIVATE ICF/MR – SMALL PROSPECTIVE RATE

Non state-operated ICF/MR – Small is defined as a facility having six beds or less.

Private ICF/MR–Small facilities are paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per–patient–day basis. Day training costs and property costs, excluded from the basic prospective rate, are reimbursed under Medicare principles of retrospective cost reimbursement.

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The 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, and active treatment programs.

Day training must be arranged by the ICF/MR, and must be approved by MHDS.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

3. PRIVATE ICF/MR – LARGE

Non state operated ICF/MR-Large (is defined as a facility having more than six beds). It will be paid the lower of 1) billed charges or 2) an all-inclusive prospective per diem rate

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

4. ALLOWABLE COSTS

Any question of an allowable cost that is not addressed within this chapter will be resolved by reference to MSM Chapter 700, Rates and Cost Containment, and the CMS-Publication 15.

Nevada Medicaid allows the costs for nutritional supplements (e.g., Ensure, Pediasure, etc.) when recommended in writing by a registered dietician and prescribed by a physician. The cost is included in the facility cost reports under Raw Food or Dietary.

5. UPPER LIMITS

In no case may Medicaid payment for an ICF/MR exceed the facility's customary charges to the general public.

In no case may Medicaid payment for an ICF/MR caring for more than 6 persons, exceed an upper limit determined by application of principles of reimbursement for provider costs under Title XVIII of the Social Security Act. All payment schedules under Medicaid are subject to the general payment limits imposed in 1861(v) and 1866 of the Act and implemented by regulations at 42 CFR 405.460 and 405.461.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

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6. ANCILLARIES

Medicaid may make direct payment for ancillary services provided to recipients when:

- a. Such services are not directly provided by the facility as part of the rate; and
- b. Required prior authorization has been obtained from the Nevada Medicaid Office.

1603.7B PROVIDER RESPONSIBILITY

COST REPORTING AND AUDIT

To obtain the Uniform Cost Report and instructions for completion contact DHCFP's Rates and Cost Containment Unit. Submission of alternate forms or any forms other than the most current does not constitute an acceptable filing.

A cost report must be submitted according to MSM Chapter 700, Rates and Cost Containment, Section 703.4.

Each facility must maintain financial and statistical records sufficient to substantiate its reported costs for three calendar years after submission. These records must be available upon request.

An annual audit of the facility's cost report will be completed by the DHCFP or its representative.

Refer to MSM Chapter 700, Rates and Cost Containment, for additional details.

PATIENT TRUST FUND MANAGEMENT

The ICF/MR must follow the requirements for appropriate handling of patient trust funds. Refer to MSM Chapter 500, Nursing Facilities, Section 503.8 and 42 CFR 483.420 for direction.

1603.8 PATIENT LIABILITY (PL)

DETERMINATION OF AMOUNT

PL is determined by eligibility personnel in the local DWSS district office.

1603.8A COVERAGE AND LIMITATIONS

The regulations at 42 CFR 435.725 require that the State (Nevada Medicaid) reduce its payment to the nursing facility by the amount of the PL. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds

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the billed charges, no Medicaid reimbursement will be made. PL will also be applied to subsequent claims submitted by providers entitled to PL until monthly obligations are fulfilled.

1603.8B PROVIDER RESPONSIBILITY

A nursing facility must notify the DWSS immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the nursing facility.

When PL is established or changes, the recipient, facility and the fiscal agent are notified of the amount and effective date. Collection of PL is the facility's responsibility. If a nursing facility receives a notice adjusting the amount of the PL and facility has billed and received reimbursement for services, the facility must send a corrected claim to the fiscal agent to receive the appropriate adjustment within 60 days of the notice. The Surveillance and Utilization Review Section will follow-up to assure the appropriate adjustment has been completed.

When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by the Welfare District Office and a notice is sent regarding the PL adjustment. The nursing facility must refund any remaining balance to the recipient or their legal representative as required.

If a Medicaid recipient is transferred during a month from any provider entitled to collect PL, the discharging provider collects the total PL amount up to billed charges. The balance of the established PL must be transferred with the recipient at the time of transfer. The transferring and receiving providers are responsible for negotiating the collection of PL.

The facility may not charge recipients for items and services such as diapers, over the counter drugs (non-legend), combs, hairbrushes, toothbrushes, toothpaste, denture cream, shampoo, shaving cream, laxatives, shaves, shampooing, skin-care items, bedside tissues, disposable syringes, nail care, pads, catheters, laundry, durable or disposable medical equipment/supplies, stipends paid, based on recipient's needs, as part of the active treatment program, or any item covered by Medicaid in reimbursement to the facility or to other providers of care such as pharmacies, therapists, etc.

1603.8C RECIPIENT RESPONSIBILITY

PERSONAL NEEDS

If a recipient so requests, the facility may provide and charge the recipient for such items as cosmetics, after shave lotion, non medical equipment, smoking supplies, stationery, postage, pens, pencils, newspapers, periodicals, alcoholic beverages, personal clothing, professional haircuts, long-distance telephone calls, dry cleaning of personal clothing, and services in excess of program

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limitations. If a recipient is charged for the above, accurate records must be kept including the recipient's authorization for payment.

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1604 HEARINGS

Please reference Chapter 3100 for Medicaid Hearing process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1700 - THERAPY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1700 are being proposed to comply with the transition to International Classification of Disease 10th Revision, Clinical Modification (ICD 10-CM) as required by the Health Insurance Portability and Accountability Act (HIPAA) mandate. In order to be in compliance with this mandate, the Division of Health Care Financing and Policy (DHCFP) is proposing the removal of ICD 9-CM codes and adding verbiage regarding current diagnosis code(s).

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED

MTL 28/15
CHAPTER 1700 - THERAPY

MATERIAL SUPERSEDED

MTL 16/11, 04/14
CHAPTER 1700 - THERAPY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1703.1	Policy	Added the word Registered to Advanced Practitioner of Nursing to now read Advanced Practitioner of Registered Nursing (APRN).
1703.2A.7	Covered Services	Removed ICD-9-CM reference and added with "current"
1703.3A.1	Coverage and Limitations	Removed ICD-9-CM reference and added "coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs".

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1700 INTRODUCTION

Nevada Medicaid reimbursement for outpatient Physical Therapy (PT), Occupational Therapy (OT), Speech/Communication Therapy (ST) and Respiratory Therapy/Care (RT) is based on the provision of medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. Therapy services must be prescribed by a physician, physician's assistant or an Advanced Practitioner of Nursing (APN).

Services related to activities for the general health and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute restorative or rehabilitative therapy services for Medicaid purposes.

Outpatient Physical, Occupational and Speech therapy under 42 Code of Federal Regulations (CFR) 440.110 is an optional service under State Medicaid Programs.

Therapy services provided by the Home Health Agency (HHA) Program is a mandatory home health care benefit provided to recipients in his/her residence. See Medicaid Service Manual (MSM), Chapter 1400 for HHA Therapy coverage.

Nevada Medicaid provides therapy services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Therapy services provided by an outpatient hospital under 42 CFR 440.20 is a mandatory service under State Medicaid Programs.

All Medicaid policies and requirements are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU Manual, Chapter 1000.

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1701 AUTHORITY

1701.1 The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulations (CFR), Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Act.

1701.2 The State Legislature grants authority to the relevant professional licensure boards to set the standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- a. NRS Chapter 640 Physical Therapy (PT)
- b. NRS Chapter 640A Occupational Therapy (OT)
- c. NRS Chapter 637B Audiologists and Speech Pathologists
- d. NRS Chapter 630 Practice of Respiratory Care

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1702 RESERVED

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1703 POLICY

1703.1 Medicaid will reimburse physical, occupational, speech therapy services rendered to eligible Medicaid recipients and eligible participants in the Nevada Check Up (NCU) Program. Therapy must be medically necessary (reference Medicaid Services Manual (MSM) Chapter 100; section 103.1) to restore or ameliorate functional limitations that are the result of an illness or injury which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. It must be rendered according to the written orders of the physician, physician's assistant or an Advanced Practitioner of **Registered** Nursing (APRN) and be directly related to the active treatment regimen designed by the therapist and approved by the professional who wrote the order.

Requests for therapy must specify the functional deficits present and include a detailed description assessing the measurable degree of interference with muscle and/or joint mobility of persons having congenital or acquired disabilities, measurable deficits in skills for daily living, deficits of cognitive and perceptual motor skills and integration of sensory functions. Identify measurable speech and/or communication deficits through testing, identification, prediction of normal and abnormal development, disorders and problems, deficiencies concerning the ability to communicate and sensorimotor functions of a person's mouth, pharynx and larynx.

A written individualized plan addressing the documented disabilities needs to include the therapy frequency, modalities and/or therapeutic procedures and goals of the planned treatment. The primary diagnosis must identify the functional deficit which requires therapeutic intervention for the related illness or injury diagnosis.

Therapy services provided in the community-based and/or hospital outpatient setting are subject to the same coverage and therapy limitations.

Services that are provided within the School Based Child Health Services (SBCHS) Program are covered under MSM Chapter 2800.

1703.2 COVERAGE AND LIMITATIONS

1703.2A COVERED SERVICES

1. Medicaid covers outpatient therapy for individual and/or group therapy services administered by the professional therapist within the scope of their license for the following:
 - a. An individual therapy session may be covered up to a max of one hour when service is provided to the same recipient by the same therapist on the same day.
 - b. Group therapy (comprised of no more than two to four individuals) may be covered up to a max of 90 minutes per session when the service is provided to the

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same recipient by the same therapist on the same day. The leader of the group must be a Medicaid provider. Documentation in the medical record is expected to be available on each Medicaid recipient in the group.

2. Therapy services may be ordered under an EPSDT referral by a physician, physician's assistant or an APN. The examination must identify a functional limitation to either acquire or correct/ameliorate a functional deficit/condition based upon medical necessity, not withstanding in relation to illness or injury which includes realistic and obtainable therapy goals.
3. The application of a modality that does not require direct (one-on-one) patient contact by the licensed therapist may be provided by a licensed therapy assistant under the supervision of the licensed Medicaid therapist.
4. Evaluations administered per therapy discipline within the scope of their license and meets the following criteria:
 - a. Initial evaluations.
 - b. Re-evaluations may be covered when there is a break in service greater than 90 days.
5. To be considered reasonable and medically necessary all of the following conditions must be met:
 - a. Meet the definition of medical necessity in MSM Chapter 100.
 - b. The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's functional deficit/condition.
 - c. The services must be of such a 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 therapist or qualified assistant under the therapist's supervision.
 - d. There must be an expectation that the functional deficit/condition will improve in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient's realistic rehabilitative/restorative potential in consultation with the qualified therapist
 - e. The amount, frequency, and duration for restorative therapy services must be appropriate and reasonable based on best practice standards for the illness or injury being treated.

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6. Cochlear Implant Therapy: Speech and Language Pathologist (SLP) services are covered under cochlear implantation protocol for speech evaluation and therapy services. Codes used by speech therapists will require the appropriate therapy modifier. (Refer to MSM Chapter 2000 for comprehensive cochlear policy.)
7. Therapy for Development Delay disorders may be covered for speech and language, fine motor and/or gross motor skills development when the functional deficit(s), identified by **current** diagnosis code(s) meet all medical necessity requirements.
8. Respiratory therapy is considered reasonable and necessary for the diagnosis and/or treatment of an individual's illness or injury when it is:
 - a. Consistent with the nature and severity of the recipient's medical symptoms and diagnosis;
 - b. Reasonable in terms of modality, amount, frequency and duration of the treatment; or
 - c. Generally accepted by the professional community as being safe and effective treatment for the purpose used.
9. In certain circumstances the specialized knowledge and judgment of a qualified therapist may be covered when medically necessary to establish a safe and effective home maintenance therapy program in connection with a specific disease state.
10. SLP evaluations may be covered according to MSM Chapter 1300, Appendix B for a dedicated speech generating device evaluation and therapeutic services.

1703.2B PRIOR AUTHORIZATION REQUIREMENTS

1. With the exception of initial therapy evaluations and re-evaluations, all therapy services must be prior authorized by the Quality Improvement Organization (QIO-like) vendor.
2. Initial and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be accomplished and submitted with prior authorization requests.
3. To obtain prior authorization for therapy services, all coverage and limitations requirements must be met (Section 1703.2A).

1703.2C NON-COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.

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2. Personal comfort items, which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body part.
3. Services that do not require the performance or supervision of a licensed therapist, even if they are performed or supervised by a licensed therapist.
4. Wound care requested by a therapist or a hospital based therapy department unless it is part of a comprehensive therapy treatment plan, (e.g., whirlpool with debridement & ROM exercises etc.).
5. Reimbursement for licensed nurses when wound care is ordered as a Physical Therapist (PT) or Occupational Therapist (OT) service.
6. Outpatient therapy provided to patients admitted in an acute or rehabilitation hospital.
7. Reimbursement for an all inclusive Respiratory Rehabilitation Program.
8. Medicaid does not reimburse or require re-evaluations to update other third party payer plans of progress for outpatient rehabilitation.

1703.2D PROVIDER RESPONSIBILITY

1. Providers must comply with prior authorization requirements set forth in the MSM, Chapter 100 (Medicaid Program), Section 103.2 (Authorization).
2. The provider will allow, upon request of proper representatives of the Division of Health Care Financing and Policy (DHCFP), access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.
3. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.
4. For Provider Responsibilities refer to MSM Chapter 100.

1703.2E RECIPIENT RESPONSIBILITY

For Recipient Responsibilities refer to MSM Chapter 100.

1703.3 LYMPHEDEMA THERAPY POLICY

Nevada Medicaid will reimburse a qualified lymphatic therapist (OT or PT) for a combination of therapy techniques recommended by the American Cancer Society and the National Lymphedema

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Network for primary and secondary lymphedema.

1703.3A COVERAGE AND LIMITATIONS

1. Complete or Combined Decongestive Physiotherapy (CDP) **coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs** when all of the following conditions are met:
 - a. A treating or consulting practitioner (MD, DO, DPM, APN, and PA), within their scope of practice, documents a diagnosis of lymphedema due to a low output cause and specifically orders CDP therapy;
 - b. The lymphedema causes a limitation of function related to self-care, mobility, and/or safety;
 - c. The recipient or recipient caregiver has the ability to understand and provide home-based CDP;
 - d. CDP services must be performed by a health care professional who has received CDP training;
 - e. The frequency and duration of the services must be necessary and reasonable; and
 - f. Lymphedema in the affected area is not reversible by exercise or elevation.
2. A CDP course of treatment by either OT or PT is considered a once in a lifetime benefit consisting of 90 minutes (six units) per session, three to five times per week for a maximum of three consecutive weeks with prior authorization.

1703.3B PRIOR AUTHORIZATION REQUIREMENTS

1. All lymphedema therapy services must be prior authorized by the QIO-like vendor.
2. To obtain prior authorization for therapy services, all coverage and limitations requirements must be met (Section 1703.2A).

1703.3C NON-COVERED SERVICES

1. Non-covered services include the following:
 - a. Therapy limited to exercise or elevation of the affected area;
 - b. Other services such as skin care and the supplies associated with the compressions wrapping. (they are included in the services and are not paid separately);

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- c. OT and PT services performed concurrently for the therapeutic exercise portion of the session is duplicative (Only one service type per therapeutic session is allowed); and
- d. Therapy designed principally for temporary benefit/without ongoing patient education.

1703.3D PROVIDER RESPONSIBILITIES

For Provider Responsibilities, refer to MSM Chapter 100.

1703.3E RECIPIENT RESPONSIBILITIES

For Recipient Responsibilities, refer to MSM Chapter 100.

1703.4 RESPIRATORY THERAPY POLICY

1703.4A COVERAGE AND LIMITATIONS

Medicaid will reimburse contracted practitioners of respiratory care for individual services provided in the outpatient setting. See MSM Chapter 600 for outpatient services general limitations. The term “respiratory care” includes inhalation and respiratory therapy, diagnostic testing, control and care of persons with deficiencies and abnormalities associated with the cardiopulmonary system.

1703.4B PRIOR AUTHORIZATION REQUIREMENTS

- 1. Respiratory therapy services must be prior authorized by the QIO-like vendor.
- 2. To obtain prior authorization for respiratory therapy services, all coverage and limitations requirements must be met. (Section 1703.2A).

1703.4C NON-COVERED SERVICES

- 1. Reimbursement for an all inclusive Respiratory Rehabilitation Program is not a Medicaid covered benefit, which may include the following:
 - a. Psychological monitoring.
 - b. Therapeutic procedures to increase strength or endurance.
 - c. Procedures to improved respiratory function, increase strength or endurance of respiratory muscles.

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1703.5 MAINTENANCE THERAPY POLICY

The DHCFP will reimburse for skilled therapy necessary to develop and safely implement a maintenance program. During the last visits of a rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program are to maintain functional status at a level consistent with the patient’s physical or mental limitations or to prevent decline in function. Maintenance therapy is a covered service when the specialized skill, knowledge and judgment of a therapist are required to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make necessary reevaluations of the plan.

1703.5A DEFINITIONS

Skilled activities include:

1. Ongoing evaluation of patient performance.
2. Adjustments to the maintenance program that help the patient achieve appropriate functional goals.

Unskilled activities are:

1. Repetitive tasks or exercises that do not involve any variation in complexity, level of cueing or progressive independence.
2. Observations of a patient or caregivers’ performance of a learned activity with no feedback and/or modification of the plan.

1703.5B COVERAGE AND LIMITATIONS

1. Evaluation and development of a maintenance plan without rehabilitative treatment- An initial evaluation of the extent of the disorder, illness or injury is required. If the treating skilled therapist determines after the initial evaluation the potential for rehabilitation is insignificant, prior to discharge an appropriate maintenance program may be established. Services are covered when the skills of the therapist are required for the development of the maintenance program and training of the patient or caregivers.
2. Skilled maintenance therapy for safety- Due to the severity or complexity of the therapy procedures to maintain function, the judgment and skill of a therapist may be necessary to implement the safe and effective delivery of the maintenance program. When the patient’s safety is at risk, those reasonable and necessary services will be covered for the initiation of the maintenance program, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

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3. Maintenance therapy must meet at least one of the following:
 - a. Prevent decline of function;
 - b. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; or
 - c. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

4. Maintenance therapy must have expected outcomes that are:
 - a. Functional;
 - b. Realistic;
 - c. Relevant;
 - d. Transferable to the recipients current or anticipated environment; and
 - e. Consistent with best practice standards and accepted by the professional community as being safe and effective treatment for the purpose used.

5. Documentation requirements
 - a. Plan of care must address a condition for which therapy is an accepted method of treatment as defined by standards of medical practice.
 - b. Plan of care must be for a condition that establishes a safe and effective skilled maintenance program.

6. Management of a maintenance program is covered only when provided by a skilled therapist (reference MSM Section 1701.2).

1703.5C PRIOR AUTHORIZATION REQUIREMENTS

1. All Maintenance therapy services require prior authorization.
2. Services are limited to ten sessions every three years per each recipient, from the date of initial visit. EPSDT is exempt from service limitations.

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1703.5D NON-COVERED SERVICES

1. Services which are not authorized.
2. Services, which do not require the management of a skilled therapist for the oversight of the maintenance program, will no longer be considered reasonable and necessary and are excluded from coverage.
3. Maintenance program is not safe and/or effective.

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1704 HEARINGS

1704.1 Please reference Medicaid Services Manual (MSM) Chapter 3100 for hearings procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 8, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
 FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
 SUBJECT: MEDICAID SERVICES MANUAL CHANGES
 CHAPTER 1800 – ADULT DAY HEALTH CARE

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 1800 are being proposed to clarify policy regarding provider enrollment requirements, retro eligibility authorizations and provider billing.

Current policy requires the DHCFP to conduct onsite reviews and inspections prior to enrollment as a Medicaid provider. However, the Bureau of Health Care Quality and Compliance conducts a similar review when initially licensing the facility. The proposed change will eliminate the need for an additional inspection by the DHCFP.

Retro-eligibility authorization wording is being removed as retro-eligibility authorization is not available for this service. Chapter changes also provide clarification for when it is appropriate to bill a per diem rate versus a unit rate.

There is no anticipated financial impact anticipated from these policy changes.

These changes are effective February 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/15 CHAPTER 1800 - ADULT DAY HEALTH CARE	MTL 15/12, 18/13 CHAPTER 1800 - ADULT DAY HEALTH CARE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.1B.1	Provider Responsibilities	Removed references to initial site review of ADHC facilities by DHCFP as this is completed by the Bureau of Health Care Quality and Compliance (BHCQC) during the initial licensing of the facility.
1803.1E.1	Prior Authorization and Billing	Removed reference to retro-eligibility authorization, as it does not apply to this service.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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1803.1E.2

**Prior
Authorization and
Billing**

Included the following clarification due to rates development of a daily rate and a unit rate:

Providers are responsible for requesting the appropriate number of days or units the recipient requires for attendance.

If a recipient is expected to be in attendance full time which is six or more hours per day, five days per week, the daily rate will be utilized.

If the recipient is expected to be in attendance less than full time, the unit rate will be utilized. The provider must bill for the exact number of units the recipient is in attendance.

The POC must clearly identify the number of days or units a recipient is expected to be in attendance. Claims must reflect dates of service as indicated on the attendance records.

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1800 INTRODUCTION

ADULT DAY HEALTH CARE (ADHC)

Nevada Medicaid reimburses for ADHC services that include health and social services recommended by a physician to ensure the optimal functioning of the recipient.

The goals of ADHC services are:

- a. to safeguard the recipient's safety and well being and maintain and/or enhance his/her quality of life; and
- b. to improve and maintain the recipient's level of functioning or to lessen any decline in functioning due to disease and/or the aging process.

All providers participating in the Nevada Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program.

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1801 AUTHORITY

Adult Day Health Care (ADHC) Services is an optional Medicaid State Plan Service and is authorized under State Plan authority titled “Nevada 1915(i) State Plan Home and Community-Based Services (HCBS)”. The State Plan was amended in 2008 in response to the Deficit Reduction Act, Section 6086. Congress amended the Social Security Act with Section 1915(i) allowing states to provide traditional 1915(c) services as covered State Plan benefits. ADHC was covered under Nevada’s State Plan.

Statutes and Regulations:

- Social Security Act: 1915(i)
- Nevada Revised Statutes (NRS) Chapter 449
- Nevada Administrative Code (NAC) Chapter 449

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1802 RESERVED

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1803 POLICY

1803.1 ADULT DAY HEALTH CARE (ADHC) SERVICES

ADHC Facilities provide medical services on a regularly scheduled basis as specified in the Service Plan. Services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished in four or more hours per day on a regularly scheduled basis. The schedule may be modified as specified in the service plan. Services must take place in a community-based setting and not an institutional setting. Services provided by the appropriate professional staff include the following:

- a. nursing services to include assessment, care planning, treatment and medication administration, evaluation and supervision of direct care staff;
- b. restorative therapy and care;
- c. nutritional assessment and planning;
- d. care coordination to assist the recipient and family to access services needed by the recipient to maintain or improve their level of functioning or to minimize a decline in the level of functioning due to the progression of a disease or other condition that may not be remedied;
- e. recipient training in Activities of Daily Living (ADLs);
- f. medical supervision and assistance to assure the recipient's well-being and that care is appropriate to meet the recipient's needs;
- g. social and recreational activities to enhance the recipient's functioning and/or to maintain or improve the recipient's quality of life; and
- h. meals provided as a part of these services shall not constitute a "full regimen" which is three meals per day.

1803.1A COVERAGE AND LIMITATIONS

1. ELIGIBLE RECIPIENTS

- a. The individual must be Medicaid eligible.
- b. The individual must be 18 years of age or older.

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- c. The individual must meet the eligibility requirements of the “1915(i) Home and Community-Based Services (HCBS) Universal Needs Assessment Tool” or must qualify for a 1915(c) waiver.
- d. The individual must obtain a Physician’s Evaluation identifying the services needed during the time they are present in the facility.
- e. The individual must reside in the community.

An individual is not eligible if they receive Adult Day Care as a waiver service under the Home and Community-Based Waiver (HCBW) for the Frail Elderly.

An individual who is a resident of a State licensed facility, i.e., Group Care, Assisted Living, or other type of residential facility where a daily all inclusive rate is paid to the facility during the course of a covered Medicaid stay may not receive Medicaid reimbursement for ADHC services. This facility daily all inclusive rate includes services such as, but not limited to: nursing services, dietary services, activity programs, medically related social services, active treatment program and day training programs which are services similar to ADHC.

State plan ADHC must not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local and private entities. For ADHC services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

2. ELIGIBLE PROVIDERS

ADHC facilities may receive reimbursement from Medicaid for the care and treatment of eligible persons as described if they are licensed and maintain licensure as an ADHC Facility by the Bureau of Health Care Quality and Compliance (HCQC). Providers must maintain compliance with the criteria set forth in this Chapter, Chapter 100 of the Medicaid Services Manual (MSM) and maintain a current Medicaid Provider Agreement.

3. TRANSPORTATION

Refer to MSM Chapter 1900, Transportation Services, for requirements of the Division of Health Care Financing and Policy (DHCFP) medical transportation program. Medicaid may reimburse for necessary and essential medical transportation to and from medical providers.

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1803.1B PROVIDER RESPONSIBILITIES

1. MEDICAID CONTRACT REQUIREMENTS

In order to qualify as a Medicaid provider, in addition to meeting and maintaining compliance with all state licensure regulations, the ADHC facility must enroll as a Provider Type 39 and enter into the agreement with the Division of Health Care Financing and Policy (DHCFP), through the Quality Improvement Organization (QIO)-like vendor and must submit required licenses, registrations, certificates, etc., as stated in MSM Chapter 100.

If the facility fails to meet the Medicaid requirements at review, the facility will be notified and given 30 days to comply. Otherwise, a Medicaid provider contract will not be issued or if already issued will be subject to termination.

a. Criminal Background Checks

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon enrollment as a Medicaid provider and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services for recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. These requirements are available on the HCQC website: http://healthdev.webtest.nv.gov/HCQC_CriminalHistory.htm.

The DHCFP QIO-like vendor will not enroll any provider agency whose operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients.

The DHCFP QIO-like vendor will also not enroll, as a provider, any applicant convicted of any felony or misdemeanor involving fraud or abuse in any government programs, or has been found guilty of fraud or abuse in any civil proceeding, or entered into a settlement in lieu of convictions for fraud or abuse, within the previous seven years.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an “undecided” result is received. Documentation must be maintained in the employee’s personnel file and submitted to the DHCFP upon request.

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Documentation of the request, and applicable results, must be maintained in each employee personnel record and made available to the DHCFP upon request. Employees must have the criminal background check through the Nevada Department of Public Safety (DPS) initiated by the employee prior to providing any Medicaid reimbursable services to a recipient.

If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the HCQC website at:

http://health.nv.gov/HCQC_CriminalHistory.htm.

b. Tuberculosis (TB) Testing

Before initial employment, an employee must have a:

1. physical examination or certification from a licensed physician that the person is in a state of good health, is free from active TB and any other communicable disease in a contagious stage; and
2. TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmette-Guerin (BCG) vaccination.
 - a. According to Nevada Administrative Code (NAC) 441A.192 "Tuberculosis screening test" is any TB screening test that has been:
 1. Approved by the Food and Drug Administration (FDA); and
 2. Endorsed by the Centers for Disease Control and Prevention (CDC).

Further information about TB testing can be found on the HCQC website at: http://health.nv.gov/CD_HIV_TBManual.htm

If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter.

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An employee with a documented history of a positive TB screening test is exempt from screening with skin tests or a chest x-ray unless he/she develops symptoms suggestive of TB.

A person who demonstrates a positive TB screening test shall submit to a chest x-ray and medical evaluation for active TB.

Annual screening for signs and symptoms of an active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.

The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider:

1. Has had a cough for more than three weeks;
2. Has a cough which is productive;
3. Has blood in his sputum;
4. Has a fever which is not associated with a cold, flu or other apparent illness;
5. Is experiencing night sweats;
6. Is experiencing unexplained weight loss; or
7. Has been in close contact with a person who has active TB.

Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results. Any lapse in the required timelines above will result in a finding of non-compliance with this section.

c. Training Requirements

All employees must participate in a program of general orientation and must receive training on a regular basis, but not less than 12 hours per year.

General orientation training includes, but is not limited to:

1. policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;

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2. record keeping and reporting including daily records and attendance records;
3. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including:
 - a. understanding care goals;
 - b. respecting recipient rights and needs;
 - c. respect for age, cultural and ethnic differences;
 - d. recognizing family relationships;
 - e. confidentiality;
 - f. respecting personal property;
 - g. ethics in dealing with the recipient, family and other providers;
 - h. handling conflict and complaints; and
 - i. other topics as relevant.

NOTE: At least one employee trained to administer first aid and cardiopulmonary resuscitation (CPR) must be on the premises at all times.

2. STAFFING REQUIREMENTS

An ADHC facility must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by Nevada licensed/certified personnel. Copies of current licensure, certificates, education, finger prints, FBI checks and TB tests must be maintained in staff files.

a. REGISTERED NURSE (RN)

The facility must employ a full time RN to oversee and provide medical services ordered by a physician. The RN must have at least one year of experience with the senior population and individuals with disabilities. The RN is responsible for conducting a recipient's health assessment within the first 30 days of admission and is responsible for developing the Plan of Care (POC) and the management of each recipient's care and treatment. An RN or Licensed Practical Nurse (LPN) under the supervision of an RN, will administer medications provided to the

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recipient while in the facility's care. An RN, or LPN under the supervision of an RN, must be on duty during the hours in which a Medicaid Eligible recipient is in attendance at the facility.

b. PROGRAM DIRECTOR

The facility must employ a full time Program Director who has a minimum of two or more years of education and/or experience with the senior population and individuals with disabilities.

The duties of the Program Director will include at a minimum the development of plans and policies for the facility's operation, recruitment, employment and training of qualified staff, supervision and appropriate disciplinary action of staff, maintenance of employee and recipient information and records, maintenance of the facility's physical plant, housekeeping and nutritional services and the development and implementation of an evaluation plan of recipient services and outcomes.

c. DIRECT CARE STAFF

The facility must have direct care staff who observes the recipient's functioning and provide assistance to the recipient in the skills of daily living. Direct care staff must have education, experience and necessary qualifications to work with the senior population and individuals with disabilities.

The facility must also provide for janitorial, housekeeping and activity staff or other staff as necessary to provide the required services and ensure each recipient's needs are met.

3. PHYSICIAN EVALUATION

A recipient must have undergone an evaluation using the Physician Evaluation Form prior to admission to an ADHC Facility by a physician licensed to practice in Nevada. This evaluation must be face-to-face.

The evaluation must include:

- a. primary and other significant diagnosis.
- b. description of mental and physical disabilities.
- c. nutritional status and needs.
- d. medications prescribed including route, frequency and dosage.

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- e. medical history.
- f. TB testing and results.
- g. allergies.
- h. infectious diseases.
- i. physician's order.

A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

The individual performing the assessment must be an independent third party and must not be:

- j. related by blood or marriage to the individual;
- k. any paid caregiver of the individual;
- l. financially responsible for the individual;
- m. empowered to make financial or health-related decisions on behalf of the individual;
- n. service providers or individuals or corporations with financial relationships with any providers.

The physician must re-evaluate the recipient annually within the same month, or when a significant change occurs.

4. UNIVERSAL NEEDS ASSESSMENT

The "1915(i) HCBS Universal Needs Assessment Tool" must be used to evaluate and re-evaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:

- a. The inability to perform two or more ADLs;
 - 1. Bathing/Dressing/Grooming.

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- 2. Mobility.
- 3. Toileting.
- 4. Eating.
- 5. Transferring.
- b. Cognitive and/or behavioral impairments;
- c. Medical needs;
- d. Supervision needs;
- e. Substance abuse; and
- f. Multiple social service system involvements.

This evaluation must be face-to-face.

A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

The individual performing the assessment must be an independent third party and must not be:

- g. related by blood or marriage to the individual;
- h. any paid caregiver of the individual;
- i. financially responsible for the individual;
- j. empowered to make financial or health-related decisions on behalf of the individual;
- k. service providers or individuals or corporations with financial relationships with any providers.

The physician must re-evaluate the recipient's eligibility annually within the same month, or when a significant change occurs.

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5. SERVICE PLAN

A service plan must be completed and submitted as part of the prior authorization process. The service plan requires pre-approval by the QIO-like vendor prior to authorizing services and must include the description of services, amount of time (hourly, daily, weekly) and the title of the staff that will be providing the specific services within the ADHC facility.

The service plan is developed by the ADHC provider using the completed 1915(i) HCBS Universal Needs Assessment Tool and the Physician Evaluation Form, in conjunction with the recipient and/or recipient's legal representative.

The provider must ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. Recipient, family (when appropriate) and/or legal representative participation in service planning must be documented on the service plan.

The service plan must include a written statement that the recipient was offered a choice of ADHC providers and must be kept in a file maintained for the recipient. Additionally, the DHCFP must review a representative sample of participant service plans each year.

The service plan must include the identified needs from the Universal Needs Assessment and the Physician Evaluation.

The recipient must provide a signature on the service plan. 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. A legal representative may sign for the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the POC and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the QIO-like vendor for prior authorization.

6. PLAN OF CARE (POC)

A POC must be developed within 30 days of the first day of attendance for a new applicant to the ADHC and within 30 days of new prior authorizations. Based on the service plan, the 1915(i) HCBS Universal Needs Assessment Tool, and the Physician Evaluation Form, the individualized POC must be developed and meet the requirement of NAC 449.4088.

The POC specifically outlines the services and activities of a recipient and must be available to all staff members in the ADHC Facility.

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The POC:

- a. is developed by the RN using a person-centered process involving the individual, the individual's treating physician, health care or supporting professionals and where appropriate, the individual's family, caregiver, or representative, and the DHCFP care coordinator.
- b. identifies the necessary services to be furnished to the individual,
- c. includes objectives and directives for all medication administration and management, social and recreational activities, case management and nutritional needs,
- d. takes into account the extent of, and need for, any family or other supports for the individual,
- e. prevents the provision of unnecessary or inappropriate care,
- f. is guided by best practices and research on effective strategies for improved health and quality of life outcomes,
- g. is reviewed and updated by the RN annually within the same month, when a new prior authorization has been approved, or as needed when there is significant change in the individual's circumstances.

The POC must be kept in a file maintained for the recipient and must include a signature of the recipient. 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. A legal representative may sign for the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the POC and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the QIO-like vendor for prior authorization.

7. ATTENDANCE RECORD AND PROGRESS/NURSING NOTES

The facility must have documentation of daily attendance and notes that document the health component of this service. This documentation is verification of service provision and may be used to review claims paid.

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

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documented in the recipient file. An authorized representative may sign on behalf of the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the POC and any other signature requirements.

8. EMPLOYEE RECORD REQUIREMENTS

In compliance with NAC 449.40835, the facility must maintain records on each employee.

Employee records must include:

- a. finger prints and background results;
- b. annual TB tests; and
- c. training, required licenses, registrations and certificates.

9. RECIPIENT RECORD REQUIREMENTS

In compliance with NAC 449.40835, the facility must maintain records on recipients including daily records and attendance records. All entries made in the recipient's file must be signed and dated by the employee making the entry. The delivery of specific services including those required by Medicaid must be documented in the daily records. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting the recipient's care.

Recipient records must include:

- a. Medicaid eligibility: The facility must maintain proof of each recipient's Medicaid eligibility. Verification of eligibility is the provider's responsibility. Eligibility should be verified monthly. Refer to MSM, Chapter 100 for additional information regarding verification of eligibility.
- b. Physician Evaluation.
- c. Universal Needs Assessment.
- d. Service Plan.
- e. Statement indicating recipient made an informed choice in providers.

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- f. POC.
- g. Attendance Records.
- h. Progress or Nursing notes.
- i. Annual TB tests.

The facility must maintain an accurate record of the recipient's attendance by using an attendance record. The record must also reflect any absence from the facility by the recipient for purposes of obtaining other services. This record is to include date, duration of absence and destination or purpose for absence.

10. CONFIDENTIALITY AND RELEASE OF RECIPIENT RECORDS

The facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.

11. PROVIDER LIABILITY

Provider liability responsibilities are included in the Medicaid and Nevada Check Up (NCU) Provider Contract and are incorporated in this chapter by reference.

12. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For adults aged 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) contact law enforcement agencies. Individuals or vulnerable persons are defined as a person 18 years of age or older who:

- a. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or

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- b. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.

13. HIPAA, PRIVACY AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other Protected Health Information (PHI).

1803.1C RECIPIENT RESPONSIBILITIES

1. Presenting any forms or identification necessary to utilize other health insurance coverage.
2. Making and keeping medical appointments as required in obtaining the Universal Needs Assessment and Physician Evaluation from their primary physician.
3. Participating in the development of the POC using a person centered process.
4. Obtaining required TB testing per NAC 441.380.

1803.1D RESERVED

1803.1E PRIOR AUTHORIZATION AND BILLING

1. PRIOR AUTHORIZATION PROCEDURE:

ADHC Services must be prior authorized. The ADHC provider must complete the “ADHC Prior Authorization Request Form” and submit the request form with the DHC FP approved Physician Evaluation Form, the DHC FP approved 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of ADHC providers) to the QIO-like vendor before services are provided. All prior authorization requests must be complete and accurate. If insufficient information is provided to support the completion of a request, the ADHC provider must supply the needed information within 72 hours of notification. When complete information is submitted, the QIO-like vendor must make a decision within five business days. **Retro eligibility authorization is not available for this service.**

The QIO-like vendor must review and provide approval for all services plans and provide a written authorization to the ADHC facility which includes a prior authorization number and service authorization. The prior authorization number must be included on all claims.

- g. Types of prior authorization requests include:

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1. an initial prior authorization request must be submitted before providing services to a Medicaid recipient for the first time.
 2. a new prior authorization is required if a recipient requires services beyond the end of the current annual prior authorization. The new prior authorization should be submitted no less than 15 days prior to the end of the current authorization period so an interruption in services may be avoided.
 3. a revised prior authorization must be submitted when a recipient's needs change during the current authorization period, for an increase or decrease in authorized days or hours per day.
- h. The prior authorization request must identify and include all of the following:
1. The recipient meets the eligibility requirements using the 1915(i) HCBS Universal Needs Assessment Tool.
 2. The recipient requires at least one of the services identified in Section 1803.1.
 3. Frequency and duration of the requested services; and
 4. The request must include a copy of the Physician Evaluation and Service Plan.

Prior authorization may be approved for up to one year through the end of the eligibility month. The prior authorization is dependent upon meeting the eligibility criteria using the 1915(i) HCBS Universal Needs Assessment Tool and medical necessity using the Physician's Evaluation. If services are needed after the current authorization ends, the facility must submit a new prior authorization request to the QIO-like vendor and include the same information that is required with an initial prior authorization request.

Services provided without prior authorization are not reimbursable.

2. PROVIDER BILLING:

Providers are responsible for requesting the appropriate number of days or units the recipient requires for attendance. This may be at the daily rate or the unit rate but not both in the same day. (15 minutes equals one unit).

If a recipient is expected to be in attendance full-time, which is six or more hours per day, the daily rate will be utilized. If the recipient is expected to be in attendance less than six

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hours a day the unit rate should be utilized. Some recipient's care plans may include a combination of full and partial days (example: full days Monday/Wednesday/Friday (use the daily rate these days) and half time Tuesday/Thursday (use the unit rate for these days). Occasionally recipients may be present part of the day, but not the full day, due to prescheduled appointments, transportation issues, sudden illness, etc. In these cases, the provider may bill the authorized per diem rate and document the reason for the partial absence in the recipient's attendance log. Providers may not bill for days in which recipients are not present at all.

Should the absences of the recipient become more frequent or the needs of the recipient change, the ADHC provider may request a new prior authorization for the unit rate. A change to the unit rate is required if the recipient attendance has been less than six hours a day for ten days within a two week period. When the unit rate is authorized the provider must bill for the exact number of units the recipient is in attendance. The maximum number of billable units per day is 24 units.

The POC must clearly identify the number of units a recipient is expected to be in attendance. Claims must reflect dates of service as indicated on the attendance records. Periodically, the DHCFP staff may request attendance/daily record documentation to compare to billings submitted.

Reimbursement is not available for services furnished by legally responsible individuals.

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MEDICAID SERVICES MANUAL	Subject: QUALITY ASSURANCE

1804 QUALITY ASSURANCE

The Division of Health Care Financing and Policy (DHCFP) will conduct an annual review to assure the health and welfare, of the recipients served by the Adult Day Health Care (ADHC) Facility. The review will consist of the program requirements identified in this chapter.

Additionally, a review of the providers will be conducted annually to verify that the providers meet requirements established for each service, such as licensure, accreditation, etc, and to ensure claims are paid in accordance with the State Plan and all federal and state regulations. Providers must cooperate with the DHCFP’s annual review process.

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1805 HEARINGS

Reference the Division of Health Care Financing and Policy (DHCFP)'s Medicaid Services Manual (MSM) Chapter 3100, for Medicaid Recipient Hearing procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 10, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1900 - TRANSPORTATION



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1900 - Transportation are being proposed to clarify and define policies as stipulated by contract between the Division of Health Care Financing and Policy (DHCFP) and the transportation broker that provides mandatory, non-emergency transportation (NET) for Medicaid recipients to obtain medical services.

Accessibility to medical services was fundamental to the chapter modifications which included identifying other possible drop off locations in lieu of an emergency room and the provision for recipient transportation to pharmacies. To further enhance accessibility to Medicaid services, policy was added to include per diem reimbursement for recipients and escorts that arrived at a medical facility by emergency transportation. Emergency transportation was clarified as emergency, scheduled emergency and specialty care transportation and the type of authorization required to utilize each service - alleviating confusion for both the broker and providers. Further clarification and revision was required to identify the per diem rates allowed for recipients and their escorts during travel periods, to include the reimbursement of lodging if the recipient had extenuating circumstances that would not allow them to cancel their lodging in a timely manner. Additionally, the chapter was revised to reimburse both parents for travel expenses, if their child is less than 12 months of age and in a medical facility.

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

These changes are effective March 11, 2016.

MATERIAL TRANSMITTED

MTL 06/16
TRANSPORTATION

MATERIAL SUPERSEDED

MTL 17/11
TRANSPORTATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1900	Introduction	Nevada Medicaid was deleted and replaced with the Division of Health Care Financing and Policy (DHCFP)
1901	Authority	DHCFP NET Services Brokerage Contract was deleted Added Health Insurance Portability and Accountability Act (HIPPA) of 1996 (P.L. 104-191)
1903	Policy	Original language addressed emergency transportation only; added language to include specialty care and scheduled emergency transportation.
1903.1	Emergency Medical Transportation	Added reference to the MSM chapter addendum.
1903.1A	Coverage and Limitation, Emergency Medical Transportation	Language was added to clarify that emergency transportation may deliver recipients to destinations other than an emergency room if the facility has the type of physician required to treat the recipient and added that emergency transport cannot be used in lieu of NET. Updated emergency transportation provider enrollment criteria/process. Clarified that provider claims are to be submitted to the FFS fiscal agent or the appropriate MCO. Changed “Fiscal Agent for all” to “FSS fiscal agent or to the appropriate MCO” Identified that routine or special supplies are included in the rates given to emergency transportation providers.
1903.1B	Authorization Process	Added language that a specialty care (SCT) or scheduled emergency transportation provider may need to obtain a Letter of Agreement from the DHCFP’s Rates Unit to transport Medicaid Fee for Service (FFS) or Nevada Check Up (NCU) Fee for Service recipients. Identified prior or post authorization required for Medicaid managed care or Nevada Check Up managed care recipients for specialty care, out-of-state and scheduled emergency transportation. In-state specialty care transport does not require prior authorization. Added language to the use of International

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		<p>Classification of Diseases (ICD) billing codes and current electronic data interchange (EDI) standards for claim submissions.</p>
<p>1903.1C</p>	<p>Specialty Care Transport</p>	<p>Deleted language that stated SCT did not require prior authorization and that SCT is defined as a type of emergency transportation.</p> <p>Revised and moved language regarding prior authorization for out-of-state travel and SCT not requiring authorization, to 1903.1B. Authorization Process.</p>
<p>1903.1D</p>	<p>Scheduled Emergency</p>	<p>Added clarifying language that scheduled emergency transport will be provided by an emergency transportation provider in coordination with the DHCFP or the MCO.</p> <p>Expanded on what exceeds the capabilities of NET – the requirement of medical personnel and/or attachment to medical apparatus that would be considered basic or advanced life support.</p> <p>Changed ‘examples of scheduled emergencies’ from what ‘may’ be handled by the NET to what ‘must’ be handled by NET.</p> <p>Added language that transportation of a live organ donor will be provided, regardless of the donor’s Medicaid or NCU eligibility.</p> <p>Clarified that reimbursement requests are to be submitted to the NET broker and not the DHCFP.</p> <p>Corrected statement on reimbursement for meals and lodging, which is not based on the DHCFP policy but on U.S General Services Administration (GSA) rates or actual costs, whichever is less. Mileage will be reimbursed at the current Internal Revenue Services’ (IRS) rate for medical miles driven.</p> <p>Added language that recipients and escorts are entitled to meals and lodging reimbursement when travel status lasts over specific time periods. Recipients and escorts that arrive by emergency transportation are also entitled</p>

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to reimbursement of meals and lodging.

1903.1F

**Recipient
Responsibility**

Replaced Champus with Tricare.

1904

**Non-Emergency
Transportation**

Added language to identify transportation will be provided to certain Medicaid covered waiver services such as Intensive Supported Living Arrangements (ISLA), Jobs and Day Training (JDT), and/or Adult Day Care.

Added required pick up timeframe for Hospital discharge not to exceed 8 hours; out-of-state and long distance transport will be handled as soon as possible.

Replaced IHS with Indian Health Programs. Added language that clarified that transportation provided by the Indian Health Programs does not need prior authorization from the NET broker and claims are paid at twice the IRS medical transport rate.

Added that All NET claims from the Indian Health Programs are to be submitted to the NET broker.

Deleted "Public" and "Paratransit-Private" from list of transportation services and added Stretcher accommodating vehicle.

Clarified language regarding NET level of care which does not exceed EMT-Basic.

1904.1

**Assessment and
Authorization
Process**

Replace IHS with Indian Health Programs and corrected section reference.

Replaced 'appropriate' level of service with 'required' level of service.

Corrected language to reflect that the recipient receives a level of service assessment from the public paratransit agency.

Added language that if a recipient resides outside the parameter of a paratransit agency, the NET broker will provide transportation to and from the recipient's primary care physician (PCP) at the level of service

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requested; the primary care physician can either complete their own assessment form or one from the broker to indicate the recipient's transportation level.

Deleted language that the broker will mail an application to the recipient and that Medicaid will schedule an assessment.

Added language that the Regional Transportation Commission has 21 days to notify the recipient of the results of the assessment and the NET provider will continue to provide transport at the requested level during that time. If the recipient is dissatisfied with the results, the NET broker will reassess the recipient and provide results within 48 hours. If the decision negatively impacts the recipient, the broker will provide a NOD to the recipient.

Deleted "Until the higher level of transportation is either approved or denied by the Medicaid District Office" and replaced with, "If the recipient requests a hearing, until the higher level of transportation is either approved or denied by the State Fair Hearing process..."

Replaced, "and will provide a copy of new listings to the Medicaid District Office's daily," with "sent to the paratransit service agencies."

Deleted language that the Medicaid Office will maintain lists of assessments; provide broker with recipient's authorization status; and a description of what the assessments should include.

Deleted language that the Medicaid Office would conduct a reassessment and replaced it with language that states that this is the responsibility of the NET broker.

Deleted language that provides for NET to the Medicaid District Office for an assessment.

Deleted the necessity that documentation is required to partake in NET services for medical appointments, prior to the assessment.

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Added that rides will be provided at level requested. In order to travel outside the paratransit area, deleted language: demonstrate a medical necessity and replaced with: to access the nearest appropriate provider.

Deleted language that the NET broker would state the medical condition and the treatment of recipients.

Clarified that only provider information will be supplied to the transportation companies.

Deleted language that the Medicaid District Office will complete assessments and determine the level of service.

Added language that the broker will provide the recipient authorization status and level of service.

Replaced 'states' with 'provides evidence' and added the broker will re-evaluate the recipient and refer to RTC for an assessment.

Changed language from the recipient will not receive a higher level of service prior to assessment, to reflect that they will be provided the level of NET services requested until an evaluation is completed.

Deleted language that recipients will not receive requested level of service for routine appointments.

Deleted redundant language; "Recipients may be reassessed for a greater level of service if they can document a significant change in their condition or circumstance..."

Clarified, that an LRI, that cannot provide transportation, can request transportation services from the broker.

1904.2

Coverage and Limitations

Deleted language describing Free Transportation as the recipient having a vehicle or that the LRI is capable of providing transportation.

Revised Free Transportation to include when the recipient is capable of providing their own

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transportation or able to obtain it from another source.

Removed language that required the recipient or LRI to provide documentation that they are either unable or incapable of providing transportation.

Added language that the broker may not deny transportation to a recipient based on an LRI's unwillingness to provide transportation

Added clarifying language that children may accompany a recipient and the broker is to provide additional bus tickets if necessary. If more than one child will be in attendance, the transportation provider must be notified.

Added language that recipients do not have to ride fixed route public transit if their appointments are outside of the service area.

Replaced 'qualified' with 'required' to ride public transit.

Moved and combined language appearing later in this section regarding freedom of choice when selecting medical providers and that NET may be used to access the nearest appropriate provider.

Defined 'appropriate' provider to include prior relationships and appointment availability. The DHCFFP will assist the broker in making these determinations.

Removed verbiage regarding the 26th mile or the 51st mile mileage reimbursement.

Added language that the NET broker may negotiate a different mileage rate due to limited transportation availability and cost effectiveness.

Clarified that prior authorization must be obtained from the NET broker for reimbursement.

Deleted redundant language that prior authorization must be obtained from the NET broker.

Removed statement regarding Title XXI NCU recipients

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who are no longer under the responsibility of DHCFP.

Clarified NET services for residents are the responsibility of the skilled nursing facilities.

Added language that the examples of circumstances provided for NET, are not all inclusive.

Deleted language regarding NET for out-of-state nursing home admittance.

Added transportation is provided to urgent care clinics.

Added transportation is provided to and from pharmacies for medical necessities.

Clarified that the broker will allow 'at least' one escort and that recipients under 18 do not require an escort when obtaining family planning products.

Clarified that a physician's statement may also determine the need for an escort(s).

Deleted language that the NET broker may not charge for an escort's transportation.

Added language that the broker will cover the costs of the escort(s) travel expenses including transportation, lodging, and meals during travel status of the recipient and while the recipient is receiving medical services.

Added 'products' to family planning services.

Clarified that if a delay of a child's transport may be medically detrimental, a Consent and Release of Liability Form must be signed by a facility case worker.

Added that minor children may be transported on a case by case basis as determined by the DHCFP.

Deleted that NET services may be authorized to transport a minor child with a mental disability to a facility by ambulance.

Deleted that foster or adoptive parents must demonstrate

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a need for public assistance to receive NET.

Clarified that foster/adoptive parents may receive reimbursement for travel expenses at GSA and/or IRS rates, when obtaining medical services for foster/adopted children.

Added that the foster/adoptive parents may also schedule NET services.

Replaced “QIO-like vendor or contracted” to “FSS fiscal agent or the contracted MCO”.

Replaced ‘utilization management’ with ‘fiscal’ agent.

Deleted that recipients are only eligible for out-of-area services if those services are not available locally.

Changed ‘may’ to ‘will’ be granted and added that those detained in a juvenile detention facility are an exception to the 14 day NET broker notification requirement.

Replaced ‘DHC FP travel policy’ with ‘GSA rates’.

Replaced ‘three’ with ‘twelve’ months.

Clarified that multiple trips may be authorized but are limited to no more than 5 trips that may be authorized at one time.

Deleted that multiple trip authorization was for mileage reimbursement only.

Revised age of children that may have two parents as escorts, from ‘three months’ to ‘less than twelve months’.

Deleted language referencing bonding between parents and child.

Replaced ‘QIO-like vendor’ with ‘the DHC FP’s fiscal agent’ throughout the chapter.

Added references to MSM Chapter 400.

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Deleted that a maximum of 24 days per year is allowed for therapeutic absences.

Added language that states that transportation must fall within the maximum allowable therapeutic leave requests which are described in MSM Chapter 1600.

Deleted verbiage regarding residential group care.

Clarified that there may be more than one escort; changed child under three months to under twelve months; replaced DHCFP policy with GSA rates.

If lodging has been reserved and must be cancelled, any charges incurred by the recipient, will be reimbursed by the NET broker. Documentation of why the cancellation was unavoidable must be submitted to the broker. Disputes will be resolved by the DHCFP.

Replaced IHS with Indian Health Programs throughout the chapter.

Deleted language regarding TPL.

Corrected reference from 1903.2A (6) to 1904.21.

Added language that recipients requiring any type of medical care, medical supervision, physical monitoring, the attachment to medical intravenous therapy, EMT-intermediate or paramedic services, etc. during transport are not eligible for non-emergency transportation.

Deleted extra attendant and excise tax.

Deleted "State" and added "DHCFP".

1904.3

**Net Broker
Responsibility**

Deleted language that defines who the prohibition of ownership applies to.

Added language that the broker will work cooperatively with the DHCFP and the Regional Transportation Centers for handling ride cancellations.

Clarified language that the NET broker and the paratransit agencies will assess for requested higher

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levels of service.

Deleted the prohibition of recipients not being able to access a higher level of service if their level of service is unavailable.

Deleted that the Medicaid District office will determine maximum level of service.

Deleted “QIO-like vendor” and replaced with “fiscal agent”.

Changed reference from 45 CFR 160 to 45 CFR 164.

Added reference to the consideration of an existing provider relationship and access to care, along with referencing section 1904.2A (2d).

Added ‘appropriate’ to define Medicaid providers.

Deleted the statement that a referral from a physician to a provider that is not the closest, does not automatically authorize the recipient NET services to that provider. Deleted that the NET broker must obtain a written justification for the exception.

Clarified that the list of Medicaid providers will be provided ‘quarterly’.

Changed ‘will refund’ to ‘may be required to’ refund capitation.

Deleted statement that if we use historical costs to determine rates, inappropriate rides will be disqualified.

Change the transportation wait time from ten (10) to fifteen (15) minutes.

Deleted reference to: NRS 450B.180.

Added NRS 484B.157.

Replaced ‘rear’ with ‘side’ view mirrors.

Added language that if the insurance amount per NAC

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706.191 increases, the amount that is greater of either the Code or the Chapter will be the amount of required coverage.

Changed “Administrator of Nevada Medicaid” to “DHCFP”.

Changed “Administrator” to “fiscal agent”.

Clarified that transportation providers are to provide evidence of or status changes to, insurance policies to the DHCFP.

Changed reference from 103.12A to Chapter 100.

Added language that when the NET broker submits claims for services outside of capitation, the ICD and EDI standards must be utilized.

1904.4

**Recipient
Responsibility NET**

Added clarifying language under free transportation, that a recipient may provide medical documentation to signify that they or their LRI are unable to utilize public transit.

Added language urging recipient to schedule rides not less than five (5) days and no more than 30 days prior to travel.

Deleted language that recipients are to contact public paratransit to cancel rides.

Deleted reference to section 603.3.

Deleted reference to Specialty Care Transport and added ‘scheduled’ emergency. Changed reference from 1903.1 to 1903.1D.

Deleted language referencing the lifting of recipients up or down stairs.

Deleted “contacting the DHCFP Business Lines Unit at (775) 684-3692”.

1904.7

**Enrollment and
Disenrollment**

Added DHCFP Website for reference.

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1905.1	Notice of Decision	<p>Changed CFR reference from 42 CFR 438.10 (h) to 42 CFR 438.10 (g).</p>
		<p>Added language to include transportation to hearings.</p>
1905.2	Recipient Grievances and Provider Disputes	<p>Changed “TTY” to “TDD”.</p>

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1900 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) and its contractors assure the availability of emergency and non-emergency transportation (NET) services for Medicaid recipients, to provide access to covered medically necessary services by all eligible, Title XIX Medicaid recipients. Transportation services are provided to and from Medicaid medical providers pursuant to 42 Code of Federal Regulations (CFR) Part 431.53 and the respective State of Nevada Title XIX State Plan.

The DHCFP and its contractors also assure the availability of emergency and scheduled emergency services for Nevada Check Up (NCU) recipients, to provide access to emergency services by all eligible, Title XXI Children’s Health Insurance Program (CHIP/NCU) recipients. Emergency and scheduled emergency transportation services are provided to NCU recipients pursuant to the State of Nevada Title XXI State Plan.

The DHCFP has comprehensive risk-based contracts with managed care organizations (MCOs), which are contractually required to cover all the emergency transportation needs of their enrollees and are prohibited from requiring prior or post authorization for emergency services, including emergency transportation services originating through “911”. Emergency transportation services provided for Fee for Service (FFS) recipients do not require prior or post authorization. NET services are provided to all Medicaid recipients through the contracted NET broker and must be authorized by the broker. This chapter provides details about covered services, how to access services, and the entities responsible for reimbursing providers and, in some instances, recipients.

All transportation providers, including the DHCFP’s contracted NET broker, must comply with all applicable Nevada Revised Statutes (NRS), the Nevada Administrative Code (NAC), the Code of Federal Regulations (CFRs), the United States Codes, and the Social Security Act, which ensures program and operational compliance. Additionally, pursuant to Medicaid Services Manual (MSM) Chapter 100 transportation providers, the DHCFP’s NET broker and members of the NET broker’s provider network may not discriminate unlawfully against recipients on the basis of race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions). Nondiscrimination and Civil Rights regulations extend to job applicants and employees of service providers as well.

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1901 AUTHORITY

The rules set forth below are intended to supplement, and not duplicate, supersede, supplant or replace other requirements that are otherwise generally applicable to Medicaid programs as a matter of federal statute, laws and regulations. Nevada's non-emergency transportation (NET) broker is not a prepaid ambulatory health plan (PAHP). In the event that any rule set forth herein is in conflict with any applicable federal law or regulation, such federal law or regulation shall control. Such other applicable requirements include, but are not limited to:

- a. 42 Code of Federal Regulations (CFR) Part 431.53 for assurance of medically necessary transportation to providers;
- b. 42 CFR 434.6 of the general requirements for contracts; and Part 2 of the State Medicaid Manual, Centers for Medicare and Medicaid Services (CMS) Publication 45-2;
- c. 45 CFR 92.36 (b)-(f) for procurement standards for grantees and sub grantees;
- d. The Deficit Reduction Act of 2006 (Pub. L. No. 109-171) for provision that the states may use state plan authority to operate a transportation brokerage system;
- e. The requirement that certain entities be excluded from participation, as set forth in §1128 and §1902(p) of the Social Security Act and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- f. Section 1932(b)(2)(D) of the Social Security Act for limits on amount paid to non-contracting providers of emergency services;
- g. Confidentiality and privacy requirements as set forth in 45 CFR Parts 160 and 164;
- h. The requirement of freedom of choice for family planning services and supplies, as set forth in 42 CFR 431.51 and as defined in Section 1905(a)(4)(C) and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- i. The respective State of Nevada Title XIX and Title XXI State Plans;
- j. Nevada Revised Statutes (NRS) Chapter 422 and Chapter 706; and
- k. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191).

These rules are issued pursuant to the provisions of NRS Chapter 422. The Nevada State Department of Health and Human Services (DHHS), acting through the DHC FP, has been designated as the single state agency responsible for administering the Nevada Medicaid

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program under delegated federal authority pursuant to 42 CFR 431. Accordingly, to the extent that any other state agency rules are in conflict with these rules, the rules set forth herein shall control.

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1902 RESERVED

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1903 POLICY

The Division of Health Care Financing and Policy (DHCFP) and its contractors, assure the availability of medically necessary emergency, **specialty care, scheduled emergency** and **non-emergency transportation (NET)** services for eligible Title XIX Medicaid recipients. These transportation services are provided to and from **the DHCFP Fee-for-Service (FFS) medical providers and Managed Care Organization (MCOs) network and non-network providers** pursuant to 42 CFR Part 431, § Part 438, and the respective State of Nevada Title XIX State Plan.

The DHCFP and its contractors assure the availability of emergency, **specialty care,** and scheduled emergency **transportation for Nevada Check Up (NCU) recipients,** to provide access to emergency services by all eligible Title XXI Children’s Health Insurance Program (CHIP/NCU) recipients. Emergency transportation services are provided to NCU recipients pursuant to the State of Nevada Title XXI **State Plan.**

1903.1 EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation does not require prior authorization. Claims must be submitted to **either** the DHCFP’s FFS **fiscal agent** or the recipient’s MCO for processing. According to the Centers for Medicare and Medicaid Services (CMS), emergency response to “911” calls normally result in a **basic life support (BLS)** or **advanced life support level 1 (ALS-1)** service level. Note that emergency medical transportation providers who submit claims coded as **advanced life support level 2 (ALS-2)** must present supporting documentation to verify that the transport included the type of care described in the ALS-2 definition in **the MSM chapter addendum.**

1903.1A COVERAGE AND LIMITATIONS, EMERGENCY MEDICAL TRANSPORTATION

1. Emergency transportation is provided for eligible recipients **that are covered by FFS or an MCO.**
2. The DHCFP has contracts with MCOs that are contractually obligated to cover emergency medical transportation services for their enrollees by applying the prudent layperson standard. For MCO enrolled recipients, claims for emergency transportation are to be submitted to the MCO in which the recipient is enrolled.
3. **Emergency transportation (ambulances) may deliver the recipient to appropriate medical destinations other than a hospital emergency room. Recipients may be transported from any point of origin to the nearest hospital, critical access hospital (CAH), dialysis facility, appropriate specialty clinic (e.g. substance abuse agency, federally qualified health center, rural health clinic, Indian health program), or a physician’s office (when the ambulance must stop in route due to the dire medical need of the recipient). Ambulances may also transport skilled nursing facility (SNF) residents when the required level and**

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type of care for the recipient’s illness or injury cannot be met by the SNF, to the nearest supplier of medically necessary services. The hospital or CAH must have available the type of physician specialist needed to treat the recipient’s condition. However, the utilization of emergency transportation may not be used in lieu of non-emergency transportation.

4. Emergency medical transportation providers must submit all appropriate documentation to the MCOs or to the FFS fiscal agent to register as an emergency medical transportation provider in addition to documentation that demonstrates the appropriate level of service personnel are employed (i.e. BLS, ALS, etc.).
5. Providers are to submit claims for reimbursement of emergency medical transportation to the FFS fiscal agent or to the appropriate MCO. Neither the DHCFP nor its contractors will reimburse the following individual services in connection with emergency medical transportation:
 - a. Response with “Non-transport”;
 - b. Routine or special supplies, including oxygen, defibrillation, IV’s, intubation, ECG monitoring, or air transport excise taxes (agreed upon rates between the DHCFP and specific transportation providers are all inclusive);
 - c. Ambulance charges for waiting time, stairs, plane loading;
 - d. Deadheading (an empty trip to or from a destination); or
 - e. Transportation of deceased persons.

1903.1B AUTHORIZATION PROCESS

No prior or post authorization is required for emergency medical transportation that originates with a “911” call.

Other transportation such as specialty care and scheduled emergency transportation does not require prior or post authorization if the recipient is enrolled in Medicaid FFS or in NCU FFS, from Medicaid’s fiscal agent. However, the transportation company may be required to obtain a Letter of Agreement from the DHCFP’s Reimbursement, Analysis & Payment Unit, for both in-state and out-of-state transport.

Prior or post authorization may be required if the recipient is enrolled in a contracted Medicaid MCO or NCU MCO, from the recipient’s MCO provider. Recipients that are members of a Medicaid MCO or NCU MCO require prior authorization for specialty care, out-of-state transportation and all scheduled emergency transportation services. The transportation provider

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must contact the MCO for direction before providing the service. In-state specialty care transport does not require prior authorization.

1. Transportation vendors must submit claims for service to the DHCFP's fiscal agent or the contracted MCO using the current nationally recognized International Classification of Diseases (ICD) billing codes and current electronic data interchange (EDI) standards.

1903.1C SPECIALTY CARE TRANSPORT

Specialty care transport (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 emergency medical technician (EMT) - intermediate or paramedic.

SCT is not covered by the NET program due to the necessary level of care during transport.

Provider and recipient responsibilities in situations involving SCT are referenced in Sections 1903.1E and 1903.1F.

1903.1D SCHEDULED EMERGENCIES

Scheduled emergency transportation may be arranged by a hospital, physician or an emergency transportation provider or it may be scheduled by the DHCFP's NET broker.

In determining whether scheduled emergency transportation should be the responsibility of the DHCFP's NET broker, distance or cost is not the deciding factor. In-transit care needs and time-critical factors take precedence. The following guidelines provide general direction.

1. When the recipient's care needs during transit exceed the capabilities of a NET provider, scheduled emergencies will be provided by an emergency transportation vendor. This will be done in coordination with either the DHCFP or the responsible MCO.

Examples of exceeding the capabilities of a NET provider include:

- a. Transportation of a critically ill recipient to a location where an organ transplant will occur;
- b. Hospital-to-hospital transfer of a seriously injured or ill recipient when medically necessary tests or treatment are not available at the dispatching hospital and the recipient's care needs during transit requires the attendance of medical personnel and/or the attachment to medical apparatus that would be included in a basic life support or advanced life support vehicle (ambulance); or

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- c. Facility-to-facility transfer of a **Seriously Mentally Ill (SMI)** adult or a **Severely Emotionally Disturbed (SED)** child who qualified health care professionals deem is an imminent danger to self or others and who requires significant chemical or physical restraints and/or the attendance of security personnel during transit.

Scheduled emergency transportation provided under the above circumstances does not require prior authorization **from Medicaid's fiscal agent** when the recipient is covered under **Medicaid FFS** or **NCU FFS**. However, if the recipient is a member of a Medicaid MCO **or an NCU MCO**, prior authorization **is** required. The provider responsible for arranging the transportation must contact the MCO for direction before providing the service.

2. When the recipient's care needs during transit are within the scope of services provided by the DHCFP's NET broker, the NET broker will make every effort to fulfill the transportation request within the required timeframe. Prior authorization **for transportation** by the NET broker will be required.

Examples of scheduled emergencies that **must** be handled by the NET broker include:

- a. Transportation of a medically stable recipient to a location where an organ transplant will occur;
- b. Hospital-to-hospital transfer of a medically stable recipient;
- c. Hospital to mental health facility transfer with a qualified **attendant(s)** of an **SMI** adult, an individual with dementia, or an **SED** child who is not a danger to self or others but whom, during transit, may need minimal chemical or physical restraints that are within the scope of service of an **attendant(s)** who is qualified as an EMT-Basic. This is in accordance with NRS 433; **or**
- d. **Transportation of a live organ donor, regardless of whether the donor is a Medicaid or NCU recipient.**

Provider and recipient responsibilities when scheduled emergency transportation is handled by the DHCFP's NET broker are found in Sections 1903.1E and 1903.1F.

3. Due to the nature of some scheduled emergencies (e.g., time-critical air transportation to another city for organ transplant), it is occasionally necessary for a recipient, or an individual on behalf of a recipient, to pay for transportation costs from personal funds. When this occurs, a reimbursement request may be submitted to the **NET broker**. Documentation that the transportation was medically necessary (e.g., a hospital admitting form) and original receipts for out-of-pocket costs must be attached. **Reimbursement for lodging and meals will be based on the lesser of actual costs or the U.S General Services**

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Administration (GSA) rates. Mileage will be reimbursed at the current Internal Revenue Services' (IRS) rate for medical miles driven.

- a. Reimbursable expenses include ground and/or air transportation, lodging and meals for the recipient and **escort(s)**, if necessary. Reimbursement for lodging, meals, and other necessary items are reimbursed in accordance with current **GSA rates or the actual cost, whichever is less. Mileage will be reimbursed at the current Internal Revenue Services' (IRS) rate for medical miles driven.** Recipients and escorts must present receipts for reimbursement. Recipients and escorts must use low cost accommodations such as the Ronald McDonald House whenever available and reimbursement will not be authorized or reimbursed for higher costs unless the recipient can demonstrate to the NET broker that the low-cost accommodations in the area were unavailable at the time the recipient required them. **Recipients and escorts are entitled to be reimbursed by the NET broker for meals and lodging when travel status to obtain medical services lasts over specific time periods, regardless if the transportation utilized by the recipient was non-emergent or emergent (e.g. air ambulance).**

1903.1E PROVIDER RESPONSIBILITY

The transportation provider is solely responsible for verifying program eligibility, enrollment and assessed levels of NET service for each recipient. Whenever possible, this should be done prior to rendering emergency transportation services. Information concerning eligibility and enrollment verification is located in Chapter 100, of the Nevada Medicaid Services Manual (MSM).

The provider must ensure the confidentiality of recipient medical records and other information, such as the health, social, domestic and financial circumstances learned or obtained in providing services to recipients.

The provider shall not release information related to a recipient without first obtaining the written consent of the recipient or the recipient's legally authorized representative, except as required by law. Providers meeting the definition of a "covered entity" as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

The DHCFP expects that providers will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable.

1903.1F RECIPIENT RESPONSIBILITY

The recipient or legally authorized representative shall:

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1. Provide the emergency transportation provider with a valid Medicaid/NCU Identification card at the time the service is rendered, if possible, or as soon as possible thereafter.
 - a. Recipients shall provide the emergency transportation provider with accurate and current medical information, including diagnosis, attending physician, medication regime, etc., at the time of request, if possible;
 - b. Recipients shall notify the emergency transportation provider of all third party insurance information, including the name of other third party insurance, such as Medicare, **Tricare**, Workman's Compensation, or any changes in insurance coverage at the time of service, if possible, or as soon as possible thereafter;
 - c. Recipients shall not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability, and/or national origin; **and**
 - d. **Recipients shall** participate in and cooperate fully with the NET **broker's** eligibility and level of service assessment.

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1904 NON-EMERGENCY TRANSPORTATION (NET) SERVICES

The DHCFP has contracted with a NET broker to provide transportation to medically necessary Medicaid covered services **including certain Medicaid covered waiver services such as Intensive Supported Living Arrangements (ISLA), Jobs and Day Training (JDT), and/or Adult Day Care.** Although ride scheduling will only be accommodated during customary business hours, transportation may be scheduled for confirmed after-hours medical appointments. After-hours, weekend and holiday rides that are not prior authorized may be reimbursed only when the recipient requires urgent medical care. The transportation must be to an emergency care facility, such as an emergency room or after hours clinic. **The transportation broker provides services on a statewide and out-of-state basis. Transportation services for a Medicaid eligible recipient as a result of a hospital discharge must be provided as soon as possible and in any event is not to exceed an eight (8) hour time span. Out-of-state and long distant transport will be handled and provided as soon as possible.**

All NET services require prior authorization by **the DHCFP's NET broker with the exception of NET services provided by Indian Health Programs. Several tribes and/or Indian Health Programs offer ambulance and/or van services for both emergency and NET. Indian Health Programs and tribal community health representatives (CHRs) may provide NET services to recipients who are eligible for NET services in private vehicles to medically necessary, covered services and are reimbursed at a per mile rate that is double the IRS medical mileage rate. The Indian Health Programs' NET services do not require prior authorization. All Indian Health Program claims for reimbursement for non-emergency transportation services are submitted to the NET Broker for adjudication and payment.** The NET broker is required to authorize the least expensive alternative conveyance available consistent with the recipient's medical condition and needs. Examples of NET services may include the following:

- a. Charter air flight;
- b. Commercial air;
- c. Rotary wing;
- d. Fixed wing;
- e. Ground ambulance;
- f. Bus, local city;
- g. Bus, out of town;
- h. Paratransit;

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- i. Private vehicle;
- j. Taxi; and a
- k. Stretcher accommodating vehicle.

NET never originates from a “911” call. NET is utilized by recipients whose level of care needs do not exceed the scope of service of an EMT-Basic.

1904.1 ASSESSMENT AND AUTHORIZATION PROCESS

- A. With the exception of services provided by Indian Health Programs (see Section 1904), the need for NET services must be assessed as specified in this section, and authorized by the NET broker.
- B. The goal of the combined assessment and authorization processes is to determine the required level of non-emergency transportation services.
- C. Assessment and prior authorization to use NET:
 - 1. Recipients wishing to use NET services will be assessed for the proper level of transportation prior to being authorized access to NET.
 - a. Otherwise appropriate requests for lower levels of ground transportation, i.e. mileage reimbursement, public bus or public paratransit, will be assessed and authorized by the NET broker.
 - b. If the request is for a greater level of ground transportation than mileage reimbursement, public bus or public paratransit, the NET broker should use due diligence in questioning the recipient to see if a lower level transport is acceptable and sufficient for their medical condition. If the recipient agrees to the lower level, then that transport will be authorized by the NET broker.
 - c. If the recipient does not believe the lower level transport is appropriate or acceptable, then they will be referred to the public paratransit services agency for a level of service needs evaluation. If the recipient resides outside the parameter of a paratransit agency, the NET broker will provide transportation to and from the recipient’s primary care physician (PCP) at the level of service requested. The PCP will provide documentation and/or a NET broker form that will identify the correct level of transportation service based on the recipient’s medical needs.

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- d. If the recipient has been authorized for NET, and has been assessed by the public paratransit service, the Regional Transportation Commission (RTC) has 21 days to notify the recipient of the results of the assessment. Until the assessment has been reviewed and submitted to the recipient, the transportation broker will continue to provide transportation at the level of service requested by the recipient. In the event the recipient has been denied the use of paratransit services, and is now receiving a lower level of transportation service than requested, the recipient must inform the transportation broker of their dissatisfaction, if applicable, with the level of service assigned. The transportation broker will then review the assessment as well as the recipient's medical documents and determine if the recipient is eligible for the broker's paratransit or curb-to-curb services. The transportation broker will notify the recipient of their determination within 48 hours of review. If the decision negatively impacts the recipient, the transportation broker will also provide the recipient with a Notice of Decision (NOD).
- e. If the recipient requests a hearing, until the higher level of transportation is either approved or denied by the State Fair Hearing process, the NET broker will provide rides at the requested level of service.
- f. The NET broker will maintain a list of all assessment referrals sent to the paratransit service agencies.
- g. If the NET broker believes that a recipient is receiving unnecessarily expensive transportation, then the broker is expected to conduct a reassessment to determine the correct level of transportation needed.
- h. When recipients contact the NET broker requesting a ride, they will be screened for prior authorization and will be permitted to ride within the level of service authorized.
- i. If the recipient requires NET prior to the time of the assessment including a ride to the paratransit service agency for an assessment, the NET broker will authorize the rides at the level requested.
 - 1. Recipients within the service areas of Clark County, Washoe County, and Carson City's public transit systems and who require transportation above the level of fixed route, must receive an assessment disqualifying them from public paratransit prior to being authorized for a higher level of service.

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2. Once a recipient has been referred to the paratransit service agency for an assessment, the recipient has five (5) days in which to contact the paratransit service agency to schedule an assessment. The paratransit service agency has up to 45 days to complete an assessment. The level of service requested by the recipient will be provided until an assessment has been completed. Failure to complete the paratransit assessment within 45 days will result in the recipient being placed on a fixed route bus service for all NET unless the recipient can show in writing, that paratransit service agency was unable to complete an assessment within the 45 days.
 - j. Recipients may be authorized for mileage reimbursement or private commercial transportation in addition to use of public transit if they must travel outside the public transit system service area to access the nearest appropriate provider.
 - k. For authorization other than the public transit, the NET broker will supply the name of the provider, the provider's location, and the frequency of the transit that the recipient is permitted, to the transportation company.
 - l. Recipients who submit evidence from an assessment showing they do not qualify for public paratransit may be qualified for a higher level of service.
 - m. The NET broker will provide written documentation to the recipient regarding the recipient's authorization status and level of service.
2. If the recipient provides evidence that they are unable to ride at the level of service assigned due to a significant change in condition or circumstance, the recipient will be re-evaluated by the broker who may direct the recipient to the RTC for an assessment.
 - a. Recipients contesting their assessed level of service will be authorized NET at the requested level, pending an evaluation.
 - b. Recipients are required to ride the least expensive transport within a level of service and will not be placed on a higher cost transport because of personal preference or convenience.
 - c. Recipients may be reassessed for a greater level of service if they no longer have access to the assigned transportation level of service.

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- D. A legally responsible individual (LRI) who is unable to provide transportation for a recipient to obtain medical services, may request transportation on behalf of an eligible recipient, from the NET -broker.
- E. The NET broker must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider and/or the DHCFP when appropriate.
- F. The NET broker and the DHCFP must provide standard authorization decisions within reasonable time frames. If the broker determines, or a provider indicates, that the standard service authorization timeframe could seriously jeopardize the recipient's condition or circumstance, the NET broker must make an expedited authorization decision and provide notice as expeditiously as the recipient's health condition requires.

1904.2 COVERAGE AND LIMITATIONS

- A. NET for Medicaid eligible recipients to and from Medicaid medical providers for covered medically necessary services is provided under the following terms:
 - 1. The recipient is unable to provide his/her own transportation:
 - a. Free Transportation: Recipients must use free transportation when it is available. Free transportation includes, but is not limited to, when the recipient is able and capable of providing their own transportation or when an LRI, another individual or an agency is willing to provide transportation to the recipient to obtain eligible Medicaid services.
 - b. The NET broker may not deny transportation to a Medicaid recipient based on an LRI's unwillingness to provide transportation.
 - c. Recipients should make every reasonable effort to find day care for their minor children when they use non-emergency transportation services; however, this may not always be possible. When appropriate care for a minor child cannot be obtained, the minor child may accompany the recipient. The broker must provide bus tickets for minor children unless the minor child is able to accompany the recipient at no additional cost. More than one minor child may accompany the recipient if the transportation provider is notified in advance. This provision abides by the intent of 42 CFR 440.170.
 - 2. The least expensive form of transportation is utilized in accordance with the recipient's medical condition and needs.

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Public Transit: Recipients who do not have free transportation available and live within the service area of the Clark County, Washoe County, or Carson City public transit systems must use public transit where possible and cost-effective.

- a. Recipients are deemed to live within the public transit system service area when they reside within three quarters (3/4) mile of a transit stop. If the recipient qualifies for public paratransit service and this is available in the area where the recipient resides, the recipient is deemed to live within the public transit area, whether or not the recipient resides within three quarters (3/4) mile of the transit stop.
- b. Recipient's who do not have free transportation available must ride fixed-route public transit unless they reside outside the service area; **or their medical appointment is outside of the service area;** they are assessed to be medically unable to board, disembark, or ride buses; or public transit buses cannot accommodate the recipient's wheelchair or other medical equipment that must accompany the recipient in transit.
- c. Recipients who reside within the service area of the public transit system and are assessed to be unable to ride fixed-route buses will be referred for assessment for public paratransit services. If qualified for public paratransit **services**, the recipient will be **required** to ride only public transit services, unless traveling to a destination that is outside the public transit system service area. If traveling outside of the paratransit **service** area, the recipient's **transport** must be authorized by the NET broker.
- d. A recipient who requires frequent travel on fixed route transit will be provided with a multiple-ride pass, **when** this is cost effective. Recipients who are issued passes by the NET broker may use them for purposes other than accessing medical services, as long as this does not incur additional costs to the Medicaid program.
 1. If a recipient who is qualified for public transit level of service requires transport to a medical appointment that is not accessible by public transit, the recipient must receive specific authorization for the transport from the NET broker, who will require evidence of medical necessity for the trip and verify that the recipient is accessing the nearest appropriate provider. **Recipients have freedom of choice when selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider. The nearest health care provider or facility is not always the most appropriate. The NET broker should consider existing relationships between the recipient and their medical**

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provider, or appointment availability, when the provider is within a reasonable distance. The DHCFP will assist the NET broker in making these decisions. The NET broker will assign the recipient to ride with the least expensive transportation provider available.

2. Recipients are required to comply with all policy and rules of the public transit system. Recipients who are suspended from service by public transit agencies because of recipient misbehavior, persistent no-shows, or failure to cancel rides in a timely manner are ineligible for other NET services unless they can provide medical evidence that **their** inability to access medical care during the suspension period will result in serious exacerbation of their medical condition or **pose an** unacceptable risk to their general health. Recipients who have been suspended will not be provided NET for routine medical appointments. Recipients who have been suspended must exhaust the public transit system appeal process before being assessed for another level of service. Recipients who are suspended indefinitely from public transit will be suspended indefinitely from access to NET, except in cases where they can provide medical evidence that **their** inability to access medical care will result in serious exacerbation of their medical condition or **pose an** unacceptable risk to their general health.
3. Mileage Reimbursement: under certain circumstances, recipients, their LRI or volunteer drivers may receive mileage reimbursement for driving a recipient to medical services.
 - a. Recipients assigned to ride only free transportation or their LRIs may be authorized to receive mileage reimbursement **if traveling to access medical services. Compensation** will be at the IRS rate for medical/moving mileage reimbursement.
 - b. Recipients who are assigned to public fixed-route transit or paratransit may receive mileage reimbursement if they are traveling outside the transit system service area and mileage reimbursement is the least expensive mode of transportation.
 - c. Volunteer drivers (private citizens who do not contract with the NET broker) who are not LRIs, nonprofit organizations, or **Indian Health Programs** may receive mileage reimbursement for driving a recipient~~s~~ to medical services,

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when this is the least expensive mode of transportation. Friends, families and neighbors may fall into this category. Reimbursement will be at twice the current IRS rate for medical/moving mileage reimbursement, as found on the IRS website at <http://www.irs.gov>. Mileage reimbursement is provided to the driver for the vehicle's miles actually driven from the point of where a recipient has been picked up and does not exceed twice the IRS medical/moving rate unless a different rate is negotiated by the NET broker due to limited transportation availability and cost effectiveness. In cases of disputes over actual mileage, MapQuest or other geo-mapping software will be used as the final determining factor.

- d. Recipients must have prior authorization from the NET broker for drivers to be eligible for mileage reimbursement.

B. Eligibility

The eligibility functions for Title XIX Medicaid determinations are the responsibility of the Division of Welfare and Supportive Services (DWSS).

Title XXI NCU recipients are not eligible for NET services.

Title XIX recipients who are Medicaid eligible solely for the purpose of payment of Medicare premiums, co-insurance, deductibles, or co-pays i.e., Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Individuals (QI-1s), and "not qualified" non-citizens are not eligible for NET services. Residents of skilled nursing facilities are entitled to NET services through the facility; NET costs are included in the nursing facilities' rate structures. Other Title XIX recipients are eligible for NET services in order to access medically necessary covered services.

Medicaid recipients are eligible for NET services only from the date of determination forward. No payment will be made for NET provided while a recipient's Medicaid application is pending. Retroactive eligibility does not apply to NET services.

Special payment arrangements may be made with the NET broker for special circumstances where it is in the best interest of the DHCFP to provide NET transportation to certain Medicaid recipients. These decisions will be made exclusively by the DHCFP; however the payment rate will be determined mutually by the DHCFP and the NET broker. If the DHCFP decides to 'carve out' an eligibility group from non-emergency

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transportation they may contract **with the NET broker** to provide service on an individual basis at a cost plus payment model.

C. Examples of circumstances for which NET will be provided to eligible recipients include, **but are not limited to the following:**

1. A transplant candidate to be evaluated for services not available in Nevada;
2. The transport from an acute general hospital to an acute psychiatric hospital;
3. Transportation to/from a routine Medicaid-reimbursable medical or dental appointment;
4. **Transportation to an urgent care clinic; and**
5. **Transportation to/from pharmacies for medical necessities.**

Each of these examples assume that the **level of care** required during transit does not exceed the scope of services of an EMT-Basic and that required timeframes allow the NET broker to make appropriate arrangements.

D. The NET broker must allow **at least** one escort, who must be **a minimum of** 18 years of age (or any age if the escort is the parent of a minor child) to accompany a recipient or group of recipients when escort services are determined medically necessary; for those recipients who are minor children; or **for individuals that have been** adjudicated incompetent. A Medicaid recipient who is physically disabled or developmentally disabled may be authorized to be accompanied by an escort(s) during the assessment to access NET services. A person under the age of 18 must be accompanied by one escort unless that person is married, legally emancipated, or obtaining family planning services **and/or family planning products.**

1. During the NET assessment, the assessor **or a physician's statement** will determine whether the recipient requires an escort(s) and specify the circumstances under which an escort(s) may accompany the recipient while **utilizing NET services.**

E. The NET broker **will cover the costs of an escort(s) to accompany the recipient, if necessary, including the expense of the escort's transportation, lodging and up to three (3) meals per day while they are in a travel status during typical meal times. Escort travel is a covered expense during the transport of the recipient to a medical facility; while the recipient is receiving medical services and during the return transport to the escort's/recipient's residence. Should the recipient be detained for further treatment, NET services will continue to be provided to the escort(s).**

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F. NET services may not be authorized for minor children unless a parent (regardless of the parent’s age) or LRI accompanies the child. Exceptions include but are not limited to:

1. A minor child transported for the purpose of obtaining family planning services **and/or products**.
2. **If a delay of a** minor child transport from one facility to another for treatment **is medically detrimental**, and the parent or LRI is not available, **a** Consent and Release of Liability form must **always** be signed by the **facility case worker** prior to the transport.
3. **Other specific exceptions may be made on a case by case basis by the DHCFP.**

In addition and pursuant to Nevada MSM Chapter 3500, **an escort(s) is** available to **accompany a** recipient who **requires** approved **personal care services (PCS) in** route to, or at, a destination to obtain Nevada Medicaid covered, medically necessary services when **an LRI** is unable to accompany them. An escort(s) may be a parent or legal guardian, caretaker, LRI, friend or **a personal care attendant (PCA)** who accompanies the recipient.

Pursuant to 42 CFR 440.250 and the Nevada State Plan, an adoptive parent under the auspices of an Adoption Assistance Program (AAP) agreement or a foster parent of a program eligible child is reimbursed for any travel expenses incurred when obtaining Medicaid eligible medical services for a foster/adopted child such as mileage (utilizing the IRS rate for medical/moving mileage reimbursement), transportation, meals, and lodging through the NET broker, up to GSA rates. The agency that maintains custody of a foster child or the adoptive/foster parents must coordinate ~~the~~medical transportation services through the NET broker.

G. Pursuant to federal regulations, eligible FFS program recipients may obtain covered medically necessary services, with limitations, from any facility, pharmacy, physician, therapist, agency or provider participating under a signed agreement with Nevada Medicaid. Eligible MCO enrollees may obtain covered medically necessary services from a provider who is a member of a contracted MCO’s network of providers or from a provider who has an agreement with a contracted MCO to provide services to a recipient as an out-of-network provider.

H. In those situations in which a recipient has requested out-of-town or out-of-state covered medical services which are determined to be available in the recipient’s community, a referral and justification by the local primary care provider is first required. This referral must then be authorized by the DHCFP’s **FFS fiscal agent or the contracted** MCO before the NET broker may authorize services. NET services will not be authorized in those instances in which a recipient has requested out-of-town and/or out-of-state medical

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services until such time as the NET broker can confirm that authorization and justification for such services has been obtained.

The same provision applies to FFS or MCO recipients who wish to utilize a health care provider or medical facility that is located within the boundaries of his/her city but is not the nearest appropriate health care resource.

I. Out-of-Area and Air Travel: Recipients may be eligible to receive NET for out-of-town, out-of-state or airline travel if certain conditions are met.

1. Recipients must receive prior authorization for out-of-area medical services from the DHCFP's fiscal agent or their MCO prior to requesting authorization for transportation.
2. Recipients must request authorization for out-of-area and airline NET a minimum of 14 days prior to the travel date.
 - a. Exceptions to the 14 calendar day requirement may be granted if the recipient has a medical necessity to travel and could not have known 14 days in advance, as in the case of a donor organ becoming available for a transplant surgery that must occur out of the area.
 - b. Exceptions to the 14 day requirement will be granted for recipients who are discharged to or from an out-of-area acute-care facility; an out-of-state nursing facility; or otherwise detained in a juvenile detention facility.
 - c. Other exceptions may be granted from time to time if they are in the best financial interest of the State.
3. Recipients are required to travel by the least expensive mode of transportation available that will accommodate their medical requirements.
4. Recipients are required to make use of any low-cost accommodations available for out-of-area travel, such as Ronald McDonald houses, and will not be authorized or reimbursed for higher costs unless the recipient can demonstrate to the NET broker that the low-cost accommodations in the area were unavailable at the time the recipient required them.
5. Recipients may incur higher costs for accommodations if they demonstrate that this will reduce the overall cost of out-of-area travel.
6. Out-of-area costs for lodging, meals, and other necessary items are reimbursed by the NET broker in accordance with the current GSA rates with the exception of

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mileage, which is compensated according to the terms of this Chapter. For all travel expenses excluding mileage, the recipient, escort(s) and live organ donor will be reimbursed at actual costs up to limits set by the GSA. The recipient, escort(s), and/or donor must submit receipts documenting expenditures to the NET broker if requesting reimbursement. Two parents may accompany a child under twelve (12) months old, and will receive a single reimbursement for lodging. Meals will be reimbursed for both parents.

7. Recipients and their escorts are not reimbursed for the cost of meals if free meals are available at meal time.
 8. Recipients must submit their request for reimbursement within 60 calendar days after completing the out-of-area trip.
 9. Recipients who have recurring requirements to receive out-of-area trips for a single treatment or multiple treatments for the same diagnoses, may have multiple trips a month authorized but no more than five (5) trips may be authorized at one time.
- J. Transportation services and per diem are covered for new parent(s) to care for a newborn less than twelve (12) months of age receiving treatment on an inpatient basis in a facility.
- K. NET services may be authorized for a recipient residing in an inpatient treatment facility to allow the resident to attend a therapeutic home visit, in-state or out-of-state, when such visits are part of the resident's treatment plan. It is the responsibility of the inpatient treatment facility to obtain transportation for eligible recipients for all therapeutic home visits by calling the NET broker. NET services are not available to family members to visit a recipient residing in an inpatient treatment facility. The NET broker may authorize NET services for therapeutic home visits within the following criteria:
1. Acute care:

The DHCFP's fiscal agent must prior authorize absences beyond eight hours. No prior authorization is required for absences of less than eight hours in duration, per MSM Chapter 400.
 2. Acute rehabilitation:

The DHCFP's fiscal agent must authorize all absences, per MSM Chapter 400.
 3. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID):

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Transportation must fall within the maximum allowable therapeutic leave requests which are described in MSM Chapter 1600.

4. Residential Treatment Center:

At the facility's request and as ordered by the attending physician, a maximum of three (3) 72 hour home therapeutic passes per calendar year is allowed. Please refer to MSM Chapter 400.

- L. Per 42 CFR 440.170, the costs of meals and lodging may also be covered for **more than one escort**, if **more than one escort** is required to ensure that the recipient receives required medical services. As noted in Section 1904.2E (8) above, the cost of meals and lodging may be covered for two **parents** when they are **seeking medical services** for a child **less than twelve (12)** months of age. Costs of meals and lodging for an **escort(s)** will be covered when traveling to and from services or while the recipient is receiving medical care when such travel requires the **escort(s)** to be away from their legal or primary residence over night or as long as medically necessary. Costs will not exceed a per diem rate set forth by **GSA rates**.
- M. **If the recipient has already reserved lodging and unforeseen circumstances arise that result in the unavoidable cancellation of the approved trip, then the recipient may request reimbursement of any charges incurred as a result of the cancelled lodging. The recipient must submit documentation to the NET broker demonstrating why the cancellation was unavoidable. The recipient must make a good faith effort to avoid unnecessary cancellation charges. Disputes must be provided to the DHCFP for final determination.**
- N. Eligible program recipients who live out-of-state may obtain NET services similarly to those eligible recipients who reside within the State of Nevada. Such out-of-state recipients may include foster children, children placed in an adoptive home under the auspices of an Adoption Assistance Program (AAP) agreement, or children in **residential treatment centers (RTCs)**. Authorization of NET services for eligible recipients residing out-of-state is the same as for those eligible recipients who reside within Nevada.
- O. Nevada residents living near the state line or border may be geographically closer to out-of-state providers than to in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the DHCFP refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation.

The primary catchment areas are listed in the MSM Chapter 100.

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- P.** Several tribes and/or **Indian Health Programs** offer ambulance and/or van services for both emergency and NET. Community health representatives (CHR) may provide NET services to recipients who are eligible for NET services in private vehicles to medically necessary covered services and are reimbursed at a per mile rate that is double the IRS medical/moving mileage rate. The **Indian Health Programs'** NET services do not require prior authorization. All claims for reimbursement **by the Indian Health Programs** for non-emergency transportation services are submitted to the NET broker for adjudication and payment.
- Q.** If a recipient is transferred to/from an out of state nursing facility or **Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)** facility during a month where they were eligible for NET, and capitation was paid for them, then that transfer is a covered benefit. If the transfer happens in a month after their initial admission, where no capitation has been paid, then the NET broker will arrange the transportation and will be reimbursed on the mutually agreed upon cost plus payment model.
- R.** Medicaid and NCU funds may not be used to pay for transportation services that are otherwise available without charge to both Medicaid and non-Medicaid recipients. In addition, Medicaid is generally the payor of last resort except for certain Federal programs such as Title V Maternal and Child Health Block Grant funded services or special education related health services funded under the Individuals with Disabilities Education Act (IDEA).
- S.** The following are non-covered NET services:
1. When one or more eligible recipients make the same trip in a private vehicle or van, reimbursement is made for only one recipient;
 2. Transportation to or from any non-covered service, except for exclusion due to Third Party Liability (TPL) coverage under the Medicaid program;
 3. Travel to visit a recipient in an inpatient treatment facility, except in the case of a parent or parents visiting a newborn that is in a facility (see 1904.21);

Transportation between hospitals for outpatient or inpatient care or services (e.g., MRI, CAT scan, etc.); exceptions may be granted when services to treat the recipient's condition are not available at the originating hospital and/or are not part of the all-inclusive prospective rate or the recipient is transferring to a hospital closer to home following an out-of-area hospital stay;
 4. "Deadheading," this refers to a provider's return trip when the eligible recipient travels only one way of a two-way trip;

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5. The cost of renting an automobile for private vehicle transport;
6. A non-transport charge for a recipient who did not show up for their scheduled ride;
7. Wages or salary for **escort(s)**;
8. Charges for waiting time, stairs, plane loading;
9. Routine or special supplies including oxygen. **Special services such as: defibrillation; IVs; intubation or ECG monitoring. Recipients requiring any type of medical care, medical supervision, physical monitoring, attachment to medical intravenous therapy, EMT-intermediate or paramedic services, etc. during transport are not eligible for non-emergency transportation.**
10. Transportation of a recipient in a personal care attendant's private vehicle is not a reimbursable service;
11. Transportation from a nursing facility to a medical appointment; **and**
12. **Basic life support (BLS), and advanced life support (ALS) transports.**

Stretcher is a covered NET service. Claims for stretcher transport should be submitted to the **DHCFP's** fiscal agent.

1904.3 NET BROKER RESPONSIBILITY

- A. The NET broker provides all or most services ancillary to transporting Medicaid recipients, but provides transportation only through subcontracting or non-contract arrangements with third parties.
 1. **The** NET broker shall not hold ownership in any NET provider with whom the broker sub-contracts or arranges NET through, **as a** non-contractual relationship.
 2. The broker will submit all subcontracts or other documentation pertaining to the terms and conditions for **the** provision of NET **services** by third parties to **the** DHCFP for approval.
 3. The broker shall advise **the** DHCFP in writing of all financial relationships and transactions between itself and NET providers (for instance, loans, grants, etc.) that are not included in the NET instrument, specifying the nature of the relationship and the terms and conditions governing **them**. Such relationships and

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transactions are not permitted without written approval of the DHCFP administrator.

4. The NET broker will work cooperatively with the DHCFP and the Regional Transportation Center for handling ride cancellations.

B. Commercial Transportation Vendors: The NET broker may subcontract with various private vendors to provide transportation to Medicaid recipients.

1. The NET broker shall directly facilitate transportation for recipients requiring bus tickets, public paratransit and mileage reimbursement. Recipients who request higher levels of service will need to be assessed for the level of service by the NET broker, and if necessary, the appropriate paratransit services agency.
2. Recipients may not be assigned to ride with a commercial vendor if they have been prior authorized for a lesser level of service, unless the authorized level of service does not provide access to necessary medical care that complies fully with Medicaid's NET policy. For instance, if a recipient is authorized for a bus ticket, but the bus does not pass within 3/4 of a mile of the provider's office, then the NET broker may authorize a higher level of transportation.
3. Recipients must be assigned to the least expensive commercial vendor who provides the level of service and geographic access required.
4. Where there is public transit available in a rural county, and that provider is capable of offering the level of service required by the recipient, commercial vendors may not be used for the convenience of the recipient or the NET broker.

C. Using monthly enrollment downloads from the DHCFP or systems maintained by the DHCFP's fiscal agent, the NET broker is solely responsible for verifying program eligibility for each recipient prior to authorizing and scheduling the NET service. The NET broker must also verify the existence of an appointment and that the appointment is a Medicaid covered service, which may require contacting the health care provider, the DHCFP's fiscal agent, or the contracted MCO, before authorizing transportation.

D. Neither the NET broker nor its providers shall release information related to a recipient without the written consent of the recipient or the recipient's legal or authorized representative, except as required by law or except to verify medical appointments in accordance with policy. The NET broker and any of its providers meeting the definition of a "covered entity" as defined in the HIPAA Privacy Regulations (45 CFR 164) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

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- E. The DHCFFP expects that the NET broker and its provider network will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable, in accordance with NRS 200.508 and 200.509.1. Pursuant to 42 CFR 438.100(c), the NET broker shall ensure that each recipient is free to exercise his or her rights and that by the exercise of those rights, no adverse affect will result in the way the NET broker treats the recipient.
- F. Recipients have freedom of choice when selecting medical providers but are only eligible for NET to access these services if using the nearest appropriate provider **(taking existing relationships between the providers and recipients into account as well as access to care) according to section 1904.2(A)(2)(d) of this chapter.**
1. The NET broker will be responsible for verifying that the recipient is using the nearest **appropriate** Medicaid provider for the applicable services.
 2. The NET broker will develop written procedures, approved by DHCFFP for verifying that the nearest **appropriate** Medicaid provider is being used.
 3. The procedures shall include an exception procedure that specifies the conditions under which the recipient may access a provider other than the nearest, if exception to the requirement might, in some cases, be appropriate.
 4. **The** DHCFFP will provide the NET broker with a **quarterly** list of Medicaid providers and their addresses, including **FFS** providers and providers within each **MCO's** network.
 5. DHCFFP will periodically review rides to verify that the NET broker has transported to the nearest appropriate provider.
 6. **When the** DHCFFP determines that a recipient has employed NET to access a provider other than the provider located nearest to the recipient's residence and there is no justification documented, the NET broker **may be required to** refund the capitation payment for that recipient for all months that the recipient accessed a geographically inappropriate provider.
- G. A transportation provider must wait at least **fifteen (15)** minutes after the scheduled pick-up time before "no-showing" the recipient at the pick-up location. The NET broker or contracted transportation providers shall not charge recipients for transportation services or for no shows.
- H. Recipients who are repeated no-shows or fail to cancel in a timely manner for rides provided by its commercial vendors may be subject to suspensions of services. Recipients who receive a suspension will have the right to a **State Fair Hearing**.

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- I.** Access to transportation services shall be at least comparable to transportation resources available to the general public. Capacity shall include all of the modes of transportation listed in Section 1904 of this chapter.
- J.** The NET broker shall ensure all drivers of vehicles transporting program recipients meet the following requirements:
1. All drivers, at all times during their employment, shall be at least 18 years of age and have a current valid driver's license from the State of Nevada to operate the transportation vehicle to which they are assigned.
 2. Drivers shall have no more than one chargeable accident and two moving violations in the last three years. Drivers shall not have had their driver's license, commercial or other, suspended or revoked in the previous five years. Drivers shall not have any prior convictions for substance abuse, sexual abuse or crime of violence. Approval of any such driver who has been convicted of a felony shall be obtained from the DHCFP before employment by the vendor.
 3. All drivers shall be courteous, patient and helpful to all passengers and be neat and clean in appearance.
 4. No driver or attendant shall use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time. The transportation provider shall not use drivers who are known abusers of alcohol or known consumers of narcotics or drugs/medications that would endanger the safety of recipients.
 5. All drivers and attendants shall wear or have visible, easily readable proper organization identification.
 6. At no time shall drivers or attendants smoke while in the vehicle, while involved in recipient assistance, or in the presence of any recipient.
 7. Drivers shall not wear any type of headphones or use cell phones, except for dispatch purposes, at any time while on duty. Drivers shall not use cell phones while operating vehicles.
 8. Drivers shall assist passengers in the process of being seated and confirm that all seat belts are fastened properly and **that** wheelchairs and wheelchair passengers are properly secured.

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9. Drivers shall provide necessary assistance, support, and oral directions to passengers. Such assistance shall include assistance with recipients of limited mobility and movement, including the storage of mobility aids and wheelchairs.
10. The NET broker shall provide, or ensure that its subcontractors provide, classroom and behind-the-wheel training for all drivers within 30 days of beginning service under this agreement. Driver training shall, at a minimum, include defensive driving techniques, wheelchair securement and lift operation, cultural and disability sensitivity training, passenger assistance techniques, first aid, and general customer service. The training curriculum is subject to the DHCFP's approval.

K. The NET broker shall ensure that all transportation providers maintain all vehicles adequately to meet the requirements of the contract. Vehicles and all components shall comply with or exceed State, Federal, and the manufacturer's safety, mechanical, and maintenance standards for the vehicles. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations. All vehicles shall meet the following requirements:

1. The transportation provider shall provide and use a two-way communication system linking all vehicles used in delivering the services under the contract with the transportation provider's major place of business. Pagers are not an acceptable substitute.
2. All vehicles shall be equipped with adequate heating and air-conditioning.
3. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position when required by law. Each vehicle shall utilize child safety seats when transporting children as prescribed by NRS 484B.157.
4. All vehicles shall have a functioning speedometer and odometer.
5. All vehicles shall have two (2) exterior side view mirrors, one on each side of the vehicle.
6. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.
7. The interior and exterior of the vehicle shall be clean and the exterior free of broken mirrors or windows, excessive grime, major dents or paint damage that detract from the overall appearance of the vehicles.

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8. The vehicle shall have passenger compartments that are clean, free from torn upholstery, floor, or ceiling covering; damaged or broken seats; protruding sharp edges; and be free of dirt, oil, grease or litter.
9. All vehicles shall have the transportation provider's name, vehicle number, and the NET broker's toll free and local phone number prominently placed within the interior of each vehicle. This information and the complaint procedures shall be available in written form in each vehicle for distribution to recipients on request.
10. Smoking is prohibited in all vehicles while transporting program recipients. All vehicles shall have the following signs posted in all vehicle interiors, easily visible to the passengers:

“NO SMOKING”
“ALL PASSENGERS MUST USE SEAT BELTS”

11. All vehicles shall include a vehicle information packet containing vehicle registration, insurance card and accident procedures and forms.
12. All vehicles shall be provided with a fully equipped first aid kit.
13. Each vehicle shall contain a current map of the applicable state(s) with sufficient detail to locate recipients and medical providers.

All vehicles shall have a minimum of \$1,500,000 combined single limit insurance coverage for vehicles at all times during the contract period in accordance with State regulations and contract requirements (NAC 706.191). **If NAC 706.191 minimum insurance coverage is amended, the amount that is greater of either the Code or this Chapter will be the mandated amount of coverage.**

14. Any vehicle or driver found out of compliance with the contract requirements, or any State or Federal regulations shall be removed from service immediately until the NET broker verifies correction of deficiencies. Any deficiencies and actions taken shall be documented and become a part of the vehicle's and the driver's permanent records.
15. The NET broker shall develop and implement an annual inspection process in addition to the applicable State vehicle inspection requirements to verify that vehicles used by **subcontracted** transportation providers meet the above requirements and that safety and passenger comfort features are in good working order (e.g., brakes, tire, tread, signals, horn, seat belts, air conditioning/heating, etc.).

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L. The NET broker shall ensure adequate oversight of subcontracted transportation providers and ensure that providers comply with all applicable State and Federal laws, regulations and permit requirements. This duty includes, but is not limited to verification that each provider maintains at all times:

1. Insurance which complies with the standards at 49 CFR 387 subpart B, NAC §191(1-3), and which provides for notice of the status of the policy to the **DHCFP** upon expiration, termination, or at any time requested by the **DHCFP**;
2. An alcohol and substance abuse testing program which complies with **the** standards **of** 49 CFR. Part 382;
3. Criminal background checks conducted periodically that assure **the** criteria **of** MSM **Chapter** 100 are met;
4. Signage on all vehicles identifying those operating under any exemption from Nevada Transportation Authority (NTA) regulation;
5. Documentation in each vehicle of any exemption from NTA regulation; **and**
6. Current provider agreements with Nevada Medicaid.

As a contracted agent of the Director of the Department of Health and Human Services (DHHS), subject to the requirements of NRS § 422.2705 and NRS § 706.745 **the** NET broker may utilize the services of motor carriers that are exempt from certain certification requirements of the NTA of the Department of Business and Industry. Prior to exercising this option, the NET broker shall, with the assistance of the NTA, establish and utilize an inspection program designed to ensure that vehicles used by these motor carriers, and their operations, are safe. The NET broker shall also require these same motor carriers to submit proof of a liability insurance policy, certificate of insurance or surety which is substantially equivalent in form and is in the same amount or in a greater amount than the policy, certificate or surety required by the Department of Motor Vehicles (DMV) pursuant to NRS 706.291 for a similar situated motor carrier. The NET broker shall certify the transportation providers meet insurance requirements, vehicle safety standards, and driver background and drug tests cited in this chapter before a letter of exemption will be issued by DHCFP for that transportation provider.

M. The NET broker is encouraged and expected to use recipient vouchers and/or volunteer programs to provide the most cost efficient transportation service to the recipient if such transportation is appropriate to meet the needs of the recipient. The broker shall verify and document **that** vehicles and drivers used in reimbursement and volunteer programs

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comply with appropriate State operating requirements, driver's licensure, vehicle registration and insurance coverage **requirements**.

- N. The NET broker will be available as a resource to the DHCFP's **fiscal agent** or contracted MCO when medically necessary covered services must be provided outside a recipient's community. The NET broker will advise the **fiscal agent** or contracted MCO regarding such factors as distance and transportation availability.
- O. **The NET broker must submit claims for service outside of capitation to the DHCFP utilizing the nationally recognized International Classification of Diseases (ICD) and current electronic data interchange (EDI) standards, as approved by the Centers of Medicare and Medicaid Services (CMS).**

1904.4 **NET** RECIPIENT RESPONSIBILITY

The recipient or LRI shall:

- a. Use personal transportation or transportation of a LRI whenever possible;
- b. Explore alternative resources first, and when such a resource exists at no cost to the recipient, use the alternative transportation resource;
- c. If free transportation is not available, use public transportation when residing within 3/4 of a mile of a bus stop **(unless medical documentation is provided to support the recipient's or LRI's physical or mental condition that prohibits the recipient from utilizing public transport)**;
- d. Participate in the assessment process to determine the appropriate level of service needed for transportation. The recipient must follow through when referred for **a** public paratransit evaluation;
- e. If eligible for **paratransit services**, the recipient is required to access available **paratransit** programs;
- f. Make and keep all appointments and travel schedules, and phone to cancel when an unforeseen event makes it impossible to keep an appointment;
- g. Recipients **(or their LRI)** are responsible to schedule rides by contacting the NET broker;
- h. **Recipients are urged to schedule rides (except out-of-the-area travel) not less than five days and no more than 30 days prior to travel;**

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- i. Recipients are required to be ready and available to ride from 15 minutes before the scheduled ride to 30 minutes after the scheduled time;
 - 1. Recipients who are using commercial transportation vendors will follow the NET broker policy concerning late rides.
- j. Notify the NET broker immediately when an urgent service need for NET transportation is discovered;
- k. Notify the NET broker of all third party insurance information, including the name of other third party insurance, or any changes in insurance coverage at the time of service, if possible, or in a timely manner thereafter;
- l. Not refuse service of a provider based solely or partly on the provider's race, color, national origin, sex, religion, disability or age; **and**
- m. Provide car seats, wheelchairs, other devices or equipment, and any extra physical assistance, not required of providers, necessary to make the trip.

1904.5 GEOGRAPHIC AREA

The NET broker provides services statewide and in catchments areas. The NET broker provides services to and from out-of-state facilities.

1904.6 SPECIAL REQUIREMENTS FOR SELECTED COVERED NET SERVICES

A. Out-of-Network Providers

The NET broker generally uses transportation providers who have executed a contract to be part of the NET broker's network. However, occasionally it may be necessary for enrolled recipients to obtain NET services from an out-of-network provider (e.g., the recipient needs specialized transportation for which the NET broker has no such specialist in its network), **in which case** the broker must:

1. Arrange transportation with out-of-network providers with respect to services and payment;
2. Offer the opportunity to the out-of-network provider to become part of the network; and
3. Negotiate a contract to determine the rate prior to services being rendered.

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B. Family Planning Services

Pursuant to policies set forth in Chapter 600 of the Nevada MSM, the NET broker will authorize NET services to family planning services for any eligible recipient to any qualified provider.

C. Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs.

Transplant services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. When a transplant recipient's care needs during transit are within the scope of the NET broker, transportation should be prior authorized and provided through the NET broker. When the recipient's care needs during transit exceed the capabilities of the NET broker and/or the timeframe for transport is less than four hours, transportation may be treated as a **scheduled** emergency. (Refer to Section 1903.1D for guidance.)

D. Paratransit Transportation

Paratransit transportation may be provided based on assessed medical need. When **paratransit** transportation is indicated, such transportation services shall be "curb to curb" or "door-to-door", whichever service is necessary for the recipient. **All** paratransit providers are responsible for assisting riders into and out of **their** vehicles.

1904.7 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of DHCFFP and the DWSS. The NET broker shall accept each recipient who is enrolled in or assigned to the NET broker by DHCFFP and/or its enrollment sections.

Pursuant to **the** State of Nevada's Medicaid State Plan §3.1 for NET Services, eligible recipients do not have the option of disenrolling from the NET broker, nor does the NET broker have the option of disenrolling any eligible recipient. Copies of the State of Nevada Medicaid State Plan §3.1 for NET Services are available **on the DHCFFP'S website at <https://dhcftp.nv.gov>**.

"Pending" Medicaid recipients (those whose applications for assistance have been submitted but not adjudicated) are not eligible for transportation services provided by the NET broker.

The NET broker is not financially responsible for any services rendered during a period of retroactive eligibility.

1904.8 INFORMATION REQUIREMENTS

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The NET broker must have written information about its services and access to services available upon request to recipients. This written information must be available in English and Spanish. The NET broker must make free, oral, Spanish interpretation services available to each recipient, if necessary. The broker may supply telephone interpretation services for other non-English languages. The DHCFP must approve all materials distributed to recipients.

- a. The NET broker's written material must use an easily understood format. The NET broker must also develop appropriate alternative methods for communicating with people with vision or hearing impairments and must accommodate recipients with a physical disability in accordance with the requirements of the ADA. All recipients must be informed that this information is available in alternative formats and how to access those formats.

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1905 NET GRIEVANCES, APPEALS AND PROVIDER DISPUTES

1905.1 NOTICE OF DECISION

The NET broker may take action on a recipient's request for transportation based on **the** DHCFP's coverage policy and guidelines as set forth in the Nevada MSM. The request may be approved, denied, or limited (i.e. denied in part, or reduced) based on these eligibility and coverage policies. The broker shall notify each recipient in writing of the reason for any action which is taken to deny or otherwise limit a recipient's request, within five business days of such action; such notification is called a Notice of Decision (NOD).

Pursuant to 42 CFR 438.10 (g), the NOD shall include information regarding the recipient's right to a State Fair Hearing (see Chapter 3100 of the Nevada MSM), the method for obtaining a State Fair Hearing, and the rules that govern the recipient's right to representation. The broker must also provide a NOD to the requesting provider, if applicable.

The NOD must include the following information:

- a. The action the broker or its network provider has taken or intends to take;
- b. The reasons for the action;
- c. The recipient's right to request a State Fair Hearing;
- d. The method of obtaining a State Fair Hearing;
- e. The rules that govern representation at a State Fair Hearing;
- f. The right of the recipient to request a State Fair Hearing and how to do so;
- g. The right to request to receive benefits while the hearing is pending and how to make this request; and
- h. That the recipient may be held liable for the cost of those benefits if the hearing decision upholds the broker's action.

The NET broker shall provide any reasonable assistance to recipients in filing a State Fair Hearing, **including transportation to the hearing, if necessary.**

The NET broker is required to maintain records of all grievances received and NODs provided, which the State will review as part of the State's contract monitoring and management oversight.

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1905.2 RECIPIENT GRIEVANCES AND PROVIDER DISPUTES

The NET broker must have a process with which to address recipient grievances and provider disputes. The DHCFP will refer all recipient grievances and provider disputes to the NET broker for resolution. The NET broker must provide information about its recipient grievance process to all providers and subcontractors, at the time they enter into a contract.

The NET broker is required to dispose of each recipient grievance and provide notice as expeditiously as the recipient's health condition requires or no more than 90 days from the date the grievance is received by the NET broker or a network provider. The NET broker shall attempt to respond verbally to the recipient, authorized representative, the DHCFP or provider grievances and disputes within 24 hours of receipt of the grievance or dispute. The NET broker shall issue an initial response or acknowledgement to written grievances and disputes in writing within 72 hours.

In addition, the NET broker must:

- a. Provide recipients any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TDD and interpreter capability;
- b. Acknowledge receipt of each recipient grievance;
- c. Ensure that the individuals who make decisions on recipient grievances were not involved in any previous level of review or decision-making; and
- d. Notify the recipient of the disposition of grievances in written format. The written notice must include the results of the resolution process and the date it was completed.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 8, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2000 – AUDIOLOGY SERVICES



BACKGROUND AND EXPLANATION

The Coding and Billing information will be removed from this chapter and moved to the Billing Manual/Guide.

Language concerning Hearing Aid Dispensers will be removed from the definitions section to 2003.3A.5, but there is no change in policy.

All other definitions will be removed as these definitions are included in the Medicaid Services Manual (MSM) Addendum.

Throughout the chapter acronyms have been used and standardized.

These changes are effective May 9, 2012.

MATERIAL TRANSMITTED

MTL 12/09
CHAPTER 2000 – AUDIOLOGY
SERVICES

MATERIAL SUPERSEDED

MTL 12/12
CHAPTER 2000 – AUDIOLOGY
SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2002	Definitions	Moved to MSM Addendum – Definitions.
2003.3A	Hearing Aids – Coverage and Limitations	Hearing Aid Fitting and Dispensing was moved from 2002 Definitions section to the policy section.
2005	References and Cross References	Moved to MSM Chapter 100.

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2000 INTRODUCTION

The Nevada Medicaid Audiology program reimburses medically necessary audiology services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Audiology services are an optional benefit within the Nevada Medicaid program. All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of three areas where Medicaid and NCU policies differ. For further clarification, please refer to the NCU Manual, Chapter 1000.

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2001 AUTHORITY

The citation denoting the amount, duration and scope of services are found in the Code of Federal Regulations (CFR) Part 440.110 and the Nevada Medicaid State Plan Attachment 3.1-A.

The State Legislature grants authority to the relevant professional licensure boards to set the standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- NRS-Chapter 630-Physicians
- NRS-Chapter 637A-Hearing Aid Specialists
- NRS-Chapter 637B-Audiologists and Speech Pathologists

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2002 **RESERVED**

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2003 AUDIOLOGY POLICY

2003.1 COVERAGE AND LIMITATIONS

Audiology services and supplies are covered by Nevada Medicaid for eligible recipients. Audiological services must be performed by a certified and licensed audiologist as described in the **Nevada Revised Statute (NRS)** 637B. Refer to specific coverage and limitations for each service.

2003.1A PROVIDER RESPONSIBILITY

Providers must verify recipient eligibility before rendering services. The presence of a Medicaid and Nevada Check Up (**NCU**) identification card does not guarantee eligibility. It is the provider's responsibility to ask the recipient if there is additional audiology coverage through third party payers.

The provider will allow, upon request of proper representatives of the Division of Health Care Financing and Policy (DHCFP), access to all records which pertain to Medicaid or NCU recipients for regular review, audit or utilization review. Providers must inform Nevada Medicaid of any misuse of the Medicaid or NCU card or inappropriate utilization.

2003.1B RECIPIENT RESPONSIBILITY

Services requested by the recipient, but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid. Prior to service, the recipient must be informed in writing he/she will be responsible for payment. The recipient is responsible for:

1. presenting a valid Nevada Medicaid and NCU card to the provider at each visit;
2. presenting any form or identification necessary to utilize other health insurance coverage;
3. making and keeping appointments with the provider; and
4. notifying providers immediately of any change in eligibility status, e.g., eligibility changes from fee for service to managed care.

2003.2 AUDIOLOGICAL TESTING

2003.2A COVERAGE AND LIMITATIONS

1. Audiological testing is limited to once per 12 rolling months for eligible recipients and must be referred by an M.D.

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2. A physician must examine the hearing aid beneficiary for pathology or disease no more than six months prior to the fitting of the aid(s) and submit a statement certifying the medical necessity of the evaluation to the audiologist.
3. One audiogram testing per 12 rolling months does not require prior authorization. The audiogram should be no more than six months old.
4. To qualify for coverage by Medicaid the report must show levels of hearing loss as follows:
 - a. Adults: at least 30 decibels for the frequency range of 500-3000 Hz.
 - b. Children: at least 20 decibels for the frequency range of 500-3000 Hz.

2003.2B PRIOR AUTHORIZATION

1. A prior authorization request is needed for any hearing aid(s) exceeding the allowed amount of \$350.00 per aid. The audiologist's testing reports must be attached and show the following:
 - a. hearing levels and discrimination scores including the type of hearing loss (conductive or neuron-sensory); and
 - b. a copy of the audiogram which should be no older than six months; and
 - c. patient's capabilities for use of the hearing aid(s), physical dexterity, mental capabilities and motivation; and
 - d. type of hearing aid(s) recommended including the cost.
2. Additional hearing evaluations outside the normal program guidelines must be prior authorized. The audiologist must keep a copy of the referral and test results in the recipient's medical record.

2003.3 HEARING AIDS

2003.3A COVERAGE AND LIMITATIONS

Medicaid will reimburse only licensed physicians, licensed audiologists and certified hearing aid dispensers for hearing aid fitting and dispensing.

1. Hearing aids and related supplies are covered by Nevada Medicaid for eligible recipients. Coverage is limited to once every 24 rolling months. This may be exceeded through

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Healthy Kids (EPSDT) if it is determined to be medically necessary by the **Quality Improvement Organization (QIO)**-like vendor. Refer to Chapter 1500 of the Medicaid Services Manual (**MSM**) for more information.

2. The manufacturer must be willing to accept the payment for the hearing aid(s) from the Medicaid hearing aid dispensers. Such payment constitutes payment in full. Shipping and handling for the hearing aid(s) is not a covered benefit. Recipients are not to be billed for any additional charges.
3. Hearing Aid Batteries: Hearing aid batteries are limited to one package per aid per rolling 30 days. Batteries must be dispensed per rolling 30 days and do not need prior authorization.
4. Ear Molds: Ear molds are to be provided with each new behind-the-ear hearing aid. Replacement for children is covered without prior authorization through Healthy Kids (EPSDT). Replacement for adults and children on Nevada Check Up is covered when medically necessary without prior authorization up to two in 24 months.
5. Hearing Aid Fitting and Dispensing: Hearing aid fitting and dispensing includes selecting, ordering, fitting, evaluating of appropriate amplification and dispensing the hearing aid(s). It also includes an initial supply of batteries. Medicaid reimburses for ear impressions and ear molds as a separate procedure.

Non-audiology providers of hearing aids (Durable Medical Equipment (DME) providers) may provide hearing aids and hearing aid related services and items but no professional audiology services for which an audiologist's academic credentials and licensing are required.

Non-audiology providers of hearing aids are covered to provide hearing aid counseling, hearing aid fitting and sale of the hearing aid(s) itself. Coverage also includes revision of hearing aid accessories, replacement of parts and repairs.

The provider must allow the recipient to have a 30-day trial period with a money back guarantee if the aid(s) does not benefit the patient. A recheck of the patient with the aid(s) must be offered two weeks or sooner following dispensing to determine if there are improved hearing levels and discrimination scores. The visit(s) should also include counseling on the use and care of the hearing aid(s) and ensure proper fit of the ear molds.

6. Warranty: Hearing aids must include a minimum 12 month warranty from the manufacturer that covers repair, damage and loss of the hearing aid(s). The provider must maintain the warranty in the recipient's medical record. A second year warranty or insurance is required. If the manufacturer does not include a second year warranty the provider should request a prior authorization for additional insurance.

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7. Replacement: Hearing aids may be replaced when:
 - a. the current aid(s) cannot be repaired as determined by the Medicaid provider;
 - b. the recipient's hearing deficit requires a different type of device for maximum benefit;
 - c. the manufacturer's warranty has expired; or
 - d. there is no other insurance.

8. Broken or Lost Hearing Aids: If replacement of a hearing aid(s) becomes necessary after 12 rolling months or more, the recipient will have a reevaluation by the audiologist prior to fitting of the replacement aid(s). The replacement aid(s) must be prior authorized if the aid(s) are no longer covered by a manufacturer's warranty or other insurance.

9. Supplies/Accessories: Hearing aid supplies/accessories (i.e. ear hooks, tubes) do not need prior authorization.

10. Testing/Repairs: Reimbursement will not be made for repairs covered by the manufacturer's warranty or other insurance.

If testing/repair of the hearing aid(s) is needed after this time period, it is limited to once every 12 rolling months per aid. The provider will need to identify which aid (right or left) is being repaired. Repairs must be covered by a six month warranty.

Medicaid will reimburse for repairs on hearing aids that were not purchased by Medicaid. Medicaid does not reimburse for repairs if the hearing aid was damaged by tampering or misuse. Recipients are not to be billed for any additional charges.

11. Non-Covered Hearing Aids: Semi-implantable middle ear hearing aids are not a covered benefit as they are considered investigational.

2003.3B PRIOR AUTHORIZATION

1. Hearing aids exceeding the allowed amount of \$350.00 per aid require prior authorization from the QIO-like vendor and need to include medical necessity for the more expensive aids, including cost.

2. Prior authorization with medical necessity is required for any additional aid(s) needed during the 24 rolling month period.

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3. Additional evaluations, fitting and dispensing, ear molds, testing/repair, replacement of broken or lost hearing aid(s), supplies or insurance outside the normal program guidelines will require prior authorization from the QIO-like vendor. Each request must have the appropriate documentation attached.

2003.3C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. routine maintenance.
2. additional batteries beyond the coverage restrictions of one package per aid per rolling 30 days.
3. repairs and replacement of the hearing aid(s) if the recipient loses Medicaid eligibility.
4. picking up the hearing aid(s) and returning for any necessary adjustments within the time allotted for such adjustments.

2003.4 COCHLEAR AND AUDITORY BRAINSTEM IMPLANTS

2003.4A COVERAGE AND LIMITATIONS

1. Bilateral and unilateral cochlear implants are a Nevada Medicaid covered benefit when determined to be medically necessary for eligible recipients with profound hearing impairment. Covered services include but are not limited to:
 - a. otologic examination.
 - b. audiological evaluation.
 - c. physical examination.
 - d. psychological evaluation.
 - e. surgical implantation of the device.
 - f. postoperative follow-up evaluation and rehabilitation.

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2. Coverage is restricted to those recipients, who meet the following audiologic/medical criteria as determined by a physician or audiologist:
 - a. recipient must be referred by an M.D. or Ear, Nose and Throat specialist with documentation to determine medical candidacy for such a device. This is to include recent (within 6 months) results of a CT or MRI scan to evaluate the anatomy of the inner ear; and
 - b. must be at least 12 months of age or older; and
 - c. must suffer from severe to profound pre-or-postlingual hearing loss (70 decibels or greater) confirmed by audiologic testing that obtains limited or no benefit from appropriate hearing aids for six months or greater; and
 - d. must have the cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation; and
 - e. must be free of middle ear infection; and
 - f. must have an accessible cochlear lumen that is structurally suited to implantation; and
 - g. be free of lesions in the auditory nerve and acoustic areas of the central nervous system; and
 - h. have no contraindications for the surgery.
3. Use of the device must be in accordance with the Food and Drug Administration (FDA) approved labeling.
4. There must be good family support with self motivation, as determined by a physician or audiologist. Education of families/caregiver and the recipient must be conducted to ensure understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the therapeutic program and the ability to adequately care for the external equipment.
5. Adults

Cochlear implants may be covered for prelinguistically (before the development of language), perilinguistically (during the development of language), and postlinguistically (after language has fully developed) deafened adults (over age 21). Postlinguistically deafened adults must demonstrate test scores of 40% or less on sentence recognition scores from tape recorded tests in the recipient's best listening condition.

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6. Children

Cochlear implants may be covered for prelinguistically and postlinguistically deafened children from 12 months through 20 years of age. Bilateral profound sensorineural deafness must be demonstrated by the inability to improve on age appropriate closed set word identification tasks with amplification.

7. Rehabilitation Program

A post-cochlear implant rehabilitation program is necessary to achieve benefit from the cochlear implant for both children and adults. The program is performed by an audiologist and speech-language pathologists. The rehabilitation program includes development of skills in understanding running speech, recognition of consonants, vowels and tests of speech perception ability. Refer to Chapter 1700 for Therapy Services of the MSM.

8. Warranty

The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

9. Damage and Loss

Damage and loss insurance is required at the time of implant. Insurance must be all-inclusive for replacement and loss, no deductibles or co-pays are allowed. There must be continuous insurance coverage for five years. Insurance is not to exceed \$250/year.

2003.4B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the cochlear implant.

2003.4C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. wearing a helmet while bicycling, roller blading, playing football and soccer; players must not "head" the ball.
2. keeping equipment out of reach of animals.
3. removing the speech processor and headset before entering a room where an MRI scanner is located.

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4. wearing the special harness that secures the speech processor during active sports. For water sports and activities that generate high levels of static electricity, such as playing on trampoline and plastic slides, the equipment must be removed.

2003.5 AUDITORY BRAINSTEM IMPLANT (ABI)

2003.5A COVERAGE AND LIMITATIONS

1. An Auditory Brainstem Implant (ABI) is a covered benefit as medically necessary when all of the following criteria are met;
 - a. the recipient is 12 years of age or older; and
 - b. the recipients has been diagnosed with Neurofibromatosis Type 2 (NF2); and
 - c. the recipient is undergoing bilateral removal of tumors of the auditory nerves; and
 - d. it is anticipated that the recipient will become completely deaf as a result of surgery; or
 - e. the recipient had bilateral auditory nerve tumors removed and is now bilaterally deaf.
2. Warranty: The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.
3. Rehabilitation Program: The recipient must have multiple sessions with the audiologist to test, adjust the sound processor and learn to interpret new sounds.

2003.5B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the auditory brainstem implant.

The physician who performs the cochlear implant or auditory brainstem implant surgery must obtain prior authorization from the QIO-like vendor before providing the service. Authorization is determined based on medical necessity. Each request must include documentation to show the recipient has met Medicaid guidelines for the procedure.

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2003.6 BONE-ANCHORED HEARING AID (BAHA) SYSTEM

2003.6A COVERAGE AND LIMITATIONS

Bone Anchored Hearing Aid (BAHA) also called an implantable bone conduction hearing aid, is a Nevada Medicaid covered benefit when it is determined medically necessary for eligible recipients five years and older. The BAHA is an alternative hearing device for recipients unable to use conventional hearing instruments.

BAHA Softbands and BAHA Headbands are a covered benefit for children of any age who have conditions that are eligible for a BAHA implant. The BAHA system is designed to treat:

1. Conductive or Mixed Hearing Loss from possible causes of:
 - a. chronic otitis media.
 - b. congenital malformations where the cochlear function is good but there are no ear canals.
 - c. Cholesteatoma.
 - d. middle ear dysfunction/disease.
 - e. external otitis.
2. Unilateral Sensorineural Deafness or Single Sided Deafness (SSD) from possible causes of:
 - a. acoustic neuroma tumors, other surgical intervention.
 - b. sudden deafness.
 - c. neurological degenerative disease.
 - d. Trauma.
 - e. ototoxic treatments.
 - f. genetic.
 - g. Meniere' Disease.

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3. Audiologic/Medical criteria:

Recipients must be referred by an M.D. or Ear, Nose and Throat Specialist with documentation to determine medical candidacy for such a device. This may include a radiology report. Assessment by an audiologist to determine if the type and degree of hearing loss meet the necessary criteria is also required.

a. Mixed and Conductive Hearing Loss with the following criteria:

1. >5 years of age
2. <45 dB HL BC pure tone average (PTA) (measured at 0.5, 1, 2 and 3K Hz)
3. >or equal to 60% speech discrimination scores (using standardized test)
4. bilateral fitting-symmetric bone conduction thresholds are defined as no more than 10 dB difference of the pure tone average (PTA) or less than 15 dB individual frequencies.

b. Single Sided Deafness with the following criteria:

1. >5 years of age
2. normal hearing in contralateral ear. (Normal hearing is defined as pure tone average air conduction (PTAAC) threshold equal to or better than 20 dB HL [measured at 0.5, 2 and 3 kHz]).
3. Functions by transcranial routing of the signal.

c. Additional qualifying criteria should include:

1. sufficient bone volume and bone quality present for successful implant placement; and
2. no contraindications to anesthesia or surgery; and
3. careful consideration given to the recipient's physical, psychological and emotional state as determined by physician or audiologist; and
4. well informed recipients who have the right expectations of the BAHA system and are highly motivated, as determined by physician or audiologist; and

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5. recipients who are able to maintain and clean the skin around the abutment or with the aid of others. For children, the responsibility falls on the parents of guardians; and
 6. recipients trained in the care, use of the device and comfortable with connecting and disconnecting the sound processor from the abutment, prior to the fitting of the speech processor.
4. **Warranty:** The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.
 5. **Follow-Up:** It is important the audiologist provides a follow-up program for the recipient.

2003.6B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the BAHA implant, softband or headband.

The physician who performs the BAHA implant surgery must obtain prior authorization from the QIO-like vendor before providing the service. Authorization is based on medical necessity. Each request must include documentation to show the recipient has met Medicaid criteria for the procedure.

2003.6C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. removing the sound processor prior to bathing, showering, swimming or engaging in any water activities, as it is not water proof;
2. never exposing the sound processor to extreme heat or cold; and
3. avoiding the loss of the sound processor during physical activity by removing it or using the safety line provided.

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2004 APPEALS AND HEARINGS

Please reference Nevada Medicaid Services Manual, Chapter 3100, for Medicaid Recipient Hearings.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 10, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2100, HOME AND COMMUNITY-BASED WAIVER
(HCBW) FOR PERSONS WITH MENTAL RETARDATION AND
RELATED CONDITIONS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2100 are being proposed to bring this chapter in line with the current waiver renewal which was approved on January 10, 2014. Changes to this chapter include a name change throughout the entire chapter from Waiver for Persons with Mental Retardation and Related Conditions to Waiver for Individuals with Intellectual Disabilities and Related Conditions. In addition, changes were made throughout the chapter to change Intermediate Care Facilities for the Mentally Retarded (ICF/MR) to Individuals with Intellectual Disabilities (ICF/ID). These changes bring the State in line with Federal requirements on the correct terminology: Individuals with Intellectual Disabilities.

Many services were reworded and updated for clarity. The provider qualifications and recipients rights sections were streamlined and clarified. Outdated language was either removed or reworded for clarity.

In July of 2013, Mental Health and Developmental Services (MHDS) was merged into Aging and Disability Services Division (ADSD). Throughout the chapter, references to MHDS were changed to ADSD.

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

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED

MTL 20/15
CHAPTER - 2100 HOME AND COMMUNITY -
BASED WAIVER SERVICES FOR
INDIVIDUALS WITH INTELLECTUAL
DISABILITIES AND RELATED CONDITIONS

MATERIAL SUPERSEDED

MTL 08/10, 27/11, 49/10
CHAPTER - 2100 HOME AND
COMMUNITY - BASED WAIVER
(HCBW) FOR PERSONS WITH
MENTAL RETARDATION AND
RELATED CONDITIONS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2100	Introduction	Updated waiver name and appropriate agency here and throughout the entire chapter.
		Consolidated provider responsibilities and recipient responsibilities from multiple sections throughout to one section, with exception to provider specific requirements.
2101	Authority	Removed outdated authorities or authorities that do not have to do with a home and community based waiver.
2103.1A.1	Coverage and Limitations	Clarified - through the Division of Welfare and Supportive Services. Cleaned up language throughout this section.
2103.1A.9		Added reference that legal guardians must provide verification that they cannot provide services and that legal guardian of individuals 18 and over are considered Legally Responsible Individual (LRI's).
2103.1A.11		
2103.2	Waiver Services	Updated wording, no change to policy. Removed #7 – Community Integrations Services, no longer a waiver service and added a new waiver service, Career Planning.
2103.2A	Provider Responsibility	Removed paragraph (number c) reference to participant direction as it no longer offered under this waiver. Clarified enrollment and certification requirements. Many of the requirements are verified by ADSD, so ADSD's certification letter is acceptable for enrollment. Changed and clarified certification, not licensure. Consolidated and moved provider responsibilities to one section. Deleted insurance requirements as these are specific the ADSD certification process. ADSD is currently working with Risk Management to clarify amounts and type of insurance required.

		Clarified criminal background checks and deleted old language, and added new language.
		Added section for documentation requirements for this waiver, and removed reference and requirements for “daily record”. Daily record does not fit the documentation requirements of this waiver. Clarified what needs to be included in provider documentation.
		The Serious Occurrence Form was recently updated the language of this section to match form. This is clarification. This is not a policy change; just a clarification of what is required to be reported.
		Updated language for how to report abuse and neglect by age group.
		Updated language for employee files and what must be included in those files. There is not policy change, just updated language.
2103.2B	Recipient Responsibilities	Updated wording from authorized representative to personal representative in all places in this section and throughout the chapter. This is updated language.
		Updated daily record to service documentation, updated language.
		Included examples of required documents for signature, recipient rights and statement of choice.
2103.3A	Coverage and Limitations	Added reference to MSM 2500, Targeted Case Management.
2103.4	Day Habilitation	Reworded and clarified service description. This is not a change to policy, just updated language.
2103.4A	Coverage and Limitations	Reworded and clarified with updated language.
2103.5	Residential Support Services	Changed the name and reworded service to provide more clear guidance of what this service is intended to do.
2103.5A	Coverage and Limitations	Reworded: Residential Support Services.
		Clarified entire section to provide clarity. Included building of natural support networks.
		Clarified medication administration certification process.

Added g. Providing assistance with support and skill training in health care needs and h. Facilitation of mobility training, survival and safety skills.

Updated and clarified residential support services.

Reworded and clarified host homes.

Reworded and clarified residential support services.

Removed section reference to participant direction as it no longer offered under this waiver.

2103.6A **Prevocational Services**

Reworded: Prevocational Services.

Clarified entire section to provide clarity.

Removed outdated language under coverage and limitation and reworded for clarity.

2103.7 **Supported Employment**

Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says.

2103.8 **Behavioral Consultation, Training and Intervention**

Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says.

Added Functional Behavioral Assessment.

Clarified service limitation and requirements if limit is exceeded.

2103.9 **Community Integration Services**

Removed entire section as this is no longer a service provided under this waiver.

2103.9 **Counseling Services**

Renumbered, new #9. Reworded this section for clarity.

Added: Counseling Services are provided based on the participant's need to assure his or her health and welfare in the community; and Added: individual and group services; assessment/evaluation process; therapeutic intervention strategies; risk assessment; skill development; psycho-educational activities and deleted outdated language.

2103.9A **Coverage and Limitations**

Clarified service limitation and requirements if limit is exceeded.

2103.9B	Counseling Services Provider Additional Qualifications	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
2103.10	Residential Support Management	Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says. Reworded to differentiate the service coordinator (ADSD) from residential support management which is an enrolled provider.
2103.11	Residential Habilitation - Direct Support Management Provider Responsibilities/Quali fications	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
2103.12	Non-Medical Transportation	Reworded and expanded this entire service to provide clarity. This is not a policy change, but rather a policy clarification. This updated language matches the description of what the waiver says. Removed reference to family, friends, and neighbors as only services needed must be prior authorized. Reference to MSM 1900 for State Plan Transportation was added.
2103.12B	Non-Medical Transportation Provider Responsibilities/Quali fications	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
2103.13	Nursing Services	Updated nursing services definition to match definition in the waiver application. Clarified that services must be provided in accordance with Nevada's nurse practice act. Clarified services to be provided under nursing services. Added reference to NRS 632 for licensed nurses. Removed references to participant direction.

2103.14	Nutrition Counseling Services	Added additional information to this service to provide clarity.
		Clarified monthly case notes, not quarterly.
		Added #7 which is the service requirements and limitation. In addition, added requirements if service limit is exceeded.
2103.14B	Nutrition Counseling Services Provider Additional Qualifications	In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
2103.15	Career Planning	This entire section is new as it is a new waiver service.
		Language for this service matches what is outlined in the waiver to include provider qualifications.
		In addition to the consolidated provider section, counseling service providers have additional qualification listed. Removed duplicative provider requirements and left unique requirements.
2103.16A.1	Slot Provision	Reworded section to provide clarity to case managers on how to assess potential recipients on how to assess potential recipients prior to placement on the wait list and the requirements necessary to be eligible for the wait list. It also discussed their requirement to request a Notice of Decision (NOD) from the DHCFP if an individual is not eligible for waiver services.
		Clarified reinstatement process for individuals who are admitted into long term care and may be released back into the waiver.
		Reworded this section to provide clarity to case managers on steps necessary to process new recipients who have been issued a waiver slot from the wait list.
		Clarified prioritization for waiver wait list and the allocation of waiver slots.
		Clarified intake processes once a waiver slot has been assigned.
2103.16A.2	Waiver Referral and Placement on the Wait List	Removed section that referenced self direction as this is currently not in the waiver.

		Added statement regarding application for Medicaid benefits through the DWSS.
		Removed place of reassessment and changed direct to residential.
2103.20A	Coverage and Limitations	Reworded this entire section to include the CMS requirements for waiver reviews.
2104.1	Suspended Waiver Services	Removed section as NODS are no longer sent for suspended waiver services.
2104.1	Denial of Waiver Services	Added clarification of what imminent means.
2104.2	Termination of Waiver Services	Deleted reference to patient liability.
		Added reference for how to track individuals who are admitted to institutional placement, no jail, and how to track those cases in the event that someone is released timely and requests waiver services again.
2104.3.j	Reduction or Denial Waiver Services	Added service limits reason for reduction.
		Removed this statement as it is confusing for providers.
2104.4A	Coverage and Limitations	This is in addition to reference of how to track individuals who are placed in an institutional setting, not jail, and how to place them back on the waiver.
2104.4B	Provider Responsibilities	Clarified ADSD role when someone requests reinstatement within 90 days of being admitted to an institution as they have been discharged timely.
		Clarified ADSD's role in NOD's and timeframes.

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2100 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in Intermediate Care Facilities (ICFs) for Individuals with Intellectual Disabilities (IID) can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

Nevada's Waiver for Individuals with Intellectual Disabilities and Related Conditions originated in 1982. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium, the service needs and the funded slot needs of the waiver program are reviewed by the Aging and Disability Services Division (ADSD) and by the Division of Health Care Financing and Policy (DHCFP) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing individuals with an intellectual disability or a related condition with the opportunity to remain in a community setting in lieu of institutionalization. ADSD and the DHCFP understand that people who have intellectual disabilities or a related condition are able to lead satisfying and productive lives when they are provided the services and supports needed to do so. Both ADSD and the DHCFP are committed to the goals of self-sufficiency and independence.

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2101 AUTHORITY

Section 1915(c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of Home and Community-Based Services (HCBS) to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. The Division of Health Care Financing and Policy's (DHCFP's) Home and Community-Based Waiver (HCBW) for **Individuals with Intellectual Disabilities** and Related Conditions is approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.

The DHCFP has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

- Social Security Act: 1915 (c)
- **Code of Federal Regulations (CFR)** (Title 42) Part 441, Subpart I (Community Supported Living Arrangements Services)
- CFR (Title 42) Part 483.430(a) (Qualified **Intellectual Disabilities** Professional (**QIDP**))
- **Nevada Revised Statute (NRS)** Chapter 435 (**Individuals with Intellectual Disabilities** and Related Conditions)
- Nevada Administrative Code (NAC) Chapter 435 (**Individuals with Intellectual Disabilities** and Related Conditions)

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2102 RESERVED

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2103 POLICY

2103.1 WAIVER ELIGIBILITY CRITERIA

Nevada’s Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions waives certain statutory requirements and offers Home and Community-Based Services (HCBS) to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with **intellectual disabilities** or a related condition and who have been found eligible and have an open case with an **Aging and Disability Services Division (ADSD)** Regional Center. Individuals are eligible if they meet Medicaid’s eligibility requirements and are either in an Intermediate Care Facility for **Individuals with Intellectual Disabilities (ICF/IID)** or are at risk for ICF/IID placement without the provision of HCBS and supports.

2103.1A COVERAGE AND LIMITATIONS

1. Waiver participants must meet and maintain Medicaid’s eligibility requirements **through the Division of Welfare and Supportive Services (DWSS)** for all months waiver services are being provided.
2. The Home and Community-Based Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions is limited by legislative mandate and available matching state funding to a specific number of recipients who can be served through the waiver year. When all waiver slots are full, a wait list is utilized to prioritize applicants who have been presumed to be eligible for the waiver.
3. Wait List Prioritization
 - a. First priority is residents of an **ICF/IID**.
 - b. Second priority is applicants who are at risk of institutionalization due to loss of their current support system or crisis situation.
 - c. Third priority is applicants determined appropriate for waiver services.
4. The Division of Health Care Financing and Policy (DHCFP) must assure the Centers for Medicare and Medicaid Services (CMS) that Medicaid’s total expenditures for waiver and Medicaid State Plan services will not, in any waiver year, exceed 100% of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. The DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

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5. Waiver services must cease when an individual is admitted to a hospital or nursing facility for the duration of the stay. Residential settings that bill per diem may bill the per diem rate for admit and discharge days only when services were provided and documented for some part of the days in question. Residential settings that bill by the unit or hour may bill for services provided and documented on admit and discharge days.

6. The Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions Eligibility Criteria:

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the Waiver for **Individuals** with **Intellectual Disabilities** and Related conditions.

a. Eligibility for the DHCFP's Waiver for **Individuals** with **Intellectual Disabilities** and Related Conditions is determined by the combined efforts of **ADSD**, the DHCFP and the DWSS. Two separate determinations must be made for eligibility for the Waiver:

1. Service eligibility for the waiver is determined by **ADSD's** regional office staff and authorized by the DHCFP's Central Office staff.

a. An **ADSD** Regional Center **psychologist**, based on supporting documentation, establishes the existence of an **intellectual disability** or a related condition.

b. Each applicant/recipient must meet and maintain **Level of Care (LOC)** for admission into an **ICF/IID**. The recipient would require imminent placement in an **ICF/IID** facility (within 30 to 60 days) if HCBW services or other supports were not available.

c. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an **ICF/IID**. Utilization of State Plan Services solely does not support the qualifications to be covered by the waiver.

d. The applicant/recipient must have an adequate support system to provide a safe environment during the hours when HCBS are not being provided. HCBS are not a substitute for natural and informal supports provided by family, friends or other available community resources.

2. Eligibility determination for full Medicaid benefits is made by DWSS.

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- a. Recipients of the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions must be Medicaid eligible for full Medicaid benefits for all months in which waiver services are provided.
 - b. Services from the waiver for **Individuals with Intellectual Disabilities** and Related Conditions cannot be provided until and unless the applicant is found eligible in both determination areas.
7. If an applicant/recipient is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant/recipient must choose one HCBW program and receive services provided by that program.
 8. Recipients of the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Collaborative case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.
 9. An able and/or capable parent or Legally Responsible Individual (LRI) of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes but is not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family. Waiver services are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, are available to supplement those support systems so the child is able to remain in their home. Allowance may be given in individual circumstances when there is no other LRI residing in the home and an able and/or capable parent's employment requirements result in prolonged or unexpected absences from the home, or when such employment requirements require the able and/or capable parent or LRI to work uninterrupted at home in order to meet the requirement of his or her employer, or when employment requirements include unconventional work weeks or work hours. **The LRI must provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or unavailable, due to hours of employment and school attendance, to provide services. Additional verification may be required on a case by case basis. Without this verification, HCBW services will not be authorized.**
 10. LRIs may not be reimbursed for HCBW services.

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11. Legal guardians of individuals age 18 and over are considered LRIs.

2103.1B MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions receive all the medically necessary Medicaid coverable service available under EPSDT. A child’s enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.2 WAIVER SERVICES

ADSD, the operating agency for the waiver, **in conjunction with the DHCFP and the state budget process**, determines which services will be offered under the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions. Providers and recipients must agree to comply with the requirements for service provision in accordance with **ADSD** and **the DHCFP** policies.

Under this waiver, the following services are **available** for individuals who have been **assessed** to be at risk for **ICF/IID** placement without the provision of enhanced supports as identified in the Individual Support Plan (ISP).

- a. Day Habilitation.
- b. Prevocational Services.
- c. Supported Employment.
- d. Behavioral Consultation, Training and Intervention.
- e. Residential Habilitation, **Residential Support Services**.
- f. Residential Habilitation, **Residential Support Management**.
- g. Counseling (Individual and Group).
- h. Non-Medical Transportation
- i. Nursing Services.
- j. Nutrition Counseling Services.

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k. Career Planning.

2103.2A PROVIDER RESPONSIBILITY

1. All Providers:

- a. Must enroll as a Provider Type 38 and maintain an active provider number.
- b. May not bill for services provided by a LRI.
- c. May only provide services that have been identified in the ISP.
- d. Must verify the Medicaid eligibility status of each HCBW recipient each month.
- e. Must be certified by Nevada Developmental Services pursuant to Nevada Revised Statute (NRS) 435 and Developmental Services Policy and Procedures.
- f. Meets all the requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100.
- g. Meets all conditions of participation in MSM Chapter 100, Section 102.
- h. Providers are required to present the following documents upon certification through ADSD and/or enrollment through the DHCFP's fiscal agent. Refer to Development Services Policy and Procedures, and the enrollment checklist located on the fiscal agent's website.

The minimum needed for enrollment through the DHCFP's fiscal agent:

- 1. Signed Statement or verification of Provider Certification from ADSD.
- 2. Signed Master Service Provider Agreement.

The following is part of ADSD's certification process:

- 3. Vendor Registration form.
- 4. Copy of business license(s) per city jurisdiction(s).
- 5. Copy of incorporation, LLC, Assumed/Fictitious Name or DBA (Doing business as) documents (if applicable).

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6. Copy of Professional Liability insurance, if applicable:
7. Copy of Fire Safety Certificate(s) (for each worksite), if applicable.
 - a. Occurrence with \$300,000 aggregate.
8. The State of Nevada as additional insured.
 - a. Coverage for physical and sexual abuse and molestation unless a specific waiver is granted according to Risk Management and Developmental Services.
9. Copy of Wage and Hour Certification(s) (for each worksite), if applicable.
10. Non Profit Organizations must provide copy of Articles of Incorporation, list of Board of Directors and/or organizational chart, if applicable:
11. Submit proof, from insurance agent, that applicable Liability Insurance (as required by State Risk Management) can be written before commencement of contracted services.
12. Worker's Compensation Insurance for Employees *or* Affidavit of Rejection of Coverage.
13. Coverage for Employee Dishonesty (Organizational Providers only).
14. Auto insurance:
 - a. For all Agency Owned or Leased Vehicles (Organizational Providers).
 - b. For vehicle(s) to be used in transporting individuals (if applicable) (Individual Provider).
15. General Liability Insurance with *minimum* coverage limits of:
 - a. Organizational Providers - \$1,000,000 per occurrence with \$2,000,000 aggregate.
 - b. Individual Providers - \$100,000 per occurrence.
 - i. Must have approval from ADSD in order to be compensated for providing services

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to recipients of the Waiver for Individuals with Intellectual Disabilities and Related Conditions.

j. Criminal Background Checks:

A criminal background check is required for all owners, administrators, and employees who provide direct care to recipients.

1. The DHCFP policy requires all owners, administrators, and employees who provide direct care have a fingerprint based criminal history submitted prior to service initiation, and every five years thereafter. Providers may contact the Nevada Department of Public Safety (DPS) and inquire about opening an account under the National Child Protection Act/Volunteer Children's Act (NCPA/VCA). The purpose of the NCPA/VCA is to complete a fingerprint based background check for individuals providing services to children, elderly and the disabled.

NOTE: Internet based background checks are not acceptable as they are not fingerprint based.

2. The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results on file. Hiring and continued employment is at the sole discretion of the provider. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):
 - a. murder, voluntary manslaughter or mayhem;
 - b. assault with intent to kill or to commit sexual assault or mayhem;
 - c. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
 - d. abuse or neglect of a child or contributory delinquency;
 - e. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of Nevada Revised Statutes (NRS);

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- f. a violation of any provision of NRS 200.700 through 200.760;
- g. criminal neglect of a patient as defined in NRS 200.495;
- h. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
- i. any felony involving the use of a firearm or other deadly weapon;
- j. abuse, neglect, exploitation or isolation of older persons;
- k. kidnapping, false imprisonment or involuntary servitude;
- l. any offense involving assault or battery, domestic or otherwise;
- m. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
- n. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or
- o. any other offense that may be inconsistent with the best interests of all recipients.

Refer to MSM Chapter 100 for additional information.

- 3. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An “undecided” result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: <http://dps.nv.gov> under Records and Technology.
 - a. Must have **Cardio Pulmonary Resuscitation (CPR)** and First Aid training within 90 days of hire **if providing direct service**.
 - b. Must complete required training within six months of beginning employment.

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- c. Providers must maintain relevant documentation of services provided on one or more documents, including documents that may be created or maintained in electronic format. This documentation must be kept in a manner as to fully disclose the nature and extent of services delivered.

The documentation must include:

1. Type of service.
2. Date of service.
3. Name of individual receiving service.
4. Individual record number.
5. Name of provider.
6. Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider. For example, an attendance record must have daily initials and documentation of time in and time out.
7. Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.
8. Begin and end time of the delivered service.
9. Initials of the recipient. If the recipient is unable to provide initials due to a cognitive and/or physical limitation, this will be clearly documented in the Individual Support Plan (ISP).
10. Each provider must cooperate with ADSD and/or State or Federal reviews or inspections.
11. Report any recipient incidents or problems to ADSD on a timely basis.
12. All service providers other than ADSD must obtain and

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maintain a service Provider contract with **ADSD** prior to providing services to a waiver recipient.

13. Prior authorization for waiver services is made through the written ISP and the service contracts (agreements) which reflect the ISP.
 14. Serious Occurrences.
4. Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the **ADSD** service coordinator by telephone/fax within 24 hours of discovery. A completed Serious Occurrence report must be made within five working days and maintained **on file by the agency**.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

- a. Unplanned hospitalization **or ER visit**;
- b. **Injury or fall requiring medical intervention**;
- c. **Alleged physical, verbal, emotional, sexual abuse or sexual harassment**;
- d. **Assault, violence, or threat**;
- e. **Suicide threat or attempt**;
- f. **Criminal activity or legal involvement**;
- g. **Alleged theft or exploitation**;
- h. **Medication error per ADSD policy**;
- i. Loss of contact with the recipient for three consecutive scheduled days;
- j. **Elopement of a resident living in a 24-hour setting**;
- k. **Death of the recipient during the provision of Waiver Services, or a significant caregiver (paid or unpaid), if applicable; or**

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1. Other.

5. Notification of Suspected Abuse or Neglect

State law requires that **individuals** employed in certain capacities must make a report to **the appropriate** law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect **the abuse, neglect or exploitation of a minor child, vulnerable adult or older individual**. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults' age 60 and over, **Elder Protective Services within ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. For vulnerable adults, report of abuse, neglect, exploitation and social isolation are to be made to local law enforcement.**

- a. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.
- b. Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, or neglect.
- c. Other Age Groups - For all other individuals or vulnerable **individuals** - (NRS 200.5091 to 200.50995) defined as "a person 18 years of age or older who":
 - 1. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or
 - 2. has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs contact local law enforcement agencies.

6. Complaint Procedure

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response and outcome of the incident.

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The Provider must investigate and respond in writing to all written complaints within **ten** calendar days of receipt.

The Provider will provide the recipient written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the waiver service coordinator at the Regional Center.

7. Health Insurance Portability and Accountability Act (HIPAA), Privacy, and Confidentiality

Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other **Protected Health Information (PHI)**.

8. ADSD:

An Interlocal Contract between **ADSD** and the DHCFP is maintained to outline responsibilities of both agencies in the operation and administration of the HCBW for **Individuals with Intellectual Disabilities and Related Conditions**.

9. Provider Agencies:

a. **All employees must have a separate file** which includes background checks (**initially and every five years**), reference checks, Cardio Pulmonary Resuscitation (CPR)/First Aid **certification** (within 90 days of the beginning of employment **and ongoing**), and **documentation of new employee orientation and ongoing training**.

b. All providers are required to provide annual training to employees on recipient rights, confidentiality, abuse, neglect and exploitation, including definitions, signs, symptoms, and prevention as well as reporting requirements. Providers will also complete established training requirements of the specific Regional Centers.

10. Exemptions from Training

a. The agency, may exempt a prospective service provider from those parts of **the** required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

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- b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.

2103.2B RECIPIENT RESPONSIBILITIES

Applicants or recipients must meet and maintain all criteria to be eligible and to remain on the Waiver for Individuals with Intellectual Disabilities and Related Conditions.

The recipient or the recipient's authorized representative will:

1. Notify the provider(s) and service coordinator of a change in Medicaid eligibility.
2. Notify the provider(s) and service coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.
3. Notify the provider(s) and service coordinator of changes in medical status, service needs, address, and location, or of changes of status of LRI(s)/authorized representative.
4. Treat all staff and providers appropriately.
5. Initial **and/or sign** the provider **service documentation** verifying services were rendered unless otherwise unable to perform this task due to intellectual and/or physical limitations.
6. Notify the provider when scheduled visits cannot be kept or services are no longer required.
7. Notify the provider of missed visits by provider staff.
8. Notify the provider and **ADSD** Service Coordinator of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
9. If applicable, furnish the provider with a copy of their Advance Directives (**AD**).
10. Not request a provider to work more than the hours authorized in the **ISP**.
11. Not request a provider to provide service for a non-recipient, family, or household members.

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12. Not request a provider to perform services not included in the **ISP**.
13. Contact the service coordinator to request a change of provider.
14. Sign all required forms unless otherwise unable to perform this task due to intellectual and/or physical limitations.

2103.3 SERVICE COORDINATION

2103.3A COVERAGE AND LIMITATIONS

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service. This is an integral part of the management of the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions.

Refer to **MSM Chapter 2500** for allowable activities under Targeted Case Management. Administrative waiver activities are not billable under Targeted Case Management.

2103.4 DAY HABILITATION

Day Habilitation Services are regularly scheduled activities in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Services include assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills that include performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skill, building positive social behavior and interpersonal competence, greater independence and personal choice. Services furnished are identified in the individual's ISP.

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's person-centered services and support plans, such as physical, occupational, or speech therapy.

Day habilitation services may also be used to enable individuals to participate in hobbies, clubs and/or senior related activities in the community, specifically for those who choose not to work or are at advanced ages.

2103.4A COVERAGE AND LIMITATIONS

Participants who receive day habilitation services and support may include two or more types of non-residential services. However, different types of non-residential habilitation services may not be billed during the same period of the day.

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Day habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purpose of producing goods or performing services).

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Individuals with Disabilities Education Improvement Act (IDEA) (20 U.S.C. 1401 et seq.).

2103.4B DAY HABILITATION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
 - a. An employee of an agency that provides habilitation services and has met the requirements for certification under NRS and Nevada Administrative Code (NAC) 435 and/or **ADSD** policy must provide documentation to the DHCFP to maintain approved provider status. **ADSD** verifies provider qualifications annually.
 - b. An employee of an agency must have a High School Diploma or equivalent; however this requirement may be waived with approval from **ADSD**.
2. Individual Providers:
 - a. Must meet the requirements for certification according to policy and provide required documentation to the DHCFP to maintain approved provider status. **ADSD** will verify qualification annually.
 - b. Must be at least 18 years of age.
 - c. Must have a High School Diploma or equivalent; however, this requirement may be waived with approval from **ADSD**.
 - d. Must have the ability to implement the recipient's ISP.
 - e. Must have the ability to communicate with and understand the recipient.

2103.5 RESIDENTIAL SUPPORT **SERVICES**

Residential Support Services are designed to ensure the health and welfare of the individual, as well as the welfare of the community at large, through protective oversight and supervision activities and supports to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for individuals to successfully, safely, and responsibly reside in their community.

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Residential Support Services are provided throughout the course of normal ADL, as well as in specialized training opportunities outlined in the participant's ISP. These services are individually planned and coordinated, assuring the non-duplication of services with other State Plan Services.

Residential support services staff is trained and responsible for implementing Individual Habilitation Plans, goals, objectives, and service supports related to residential and community living. These supports include the facilitation of personal care services such as activities of daily living and instrumental activities of daily living. In addition, services include effective communication skills, community inclusion and the development of natural support networks, mobility training, survival and safety skills, support and teaching of interpersonal and relationship skills, making choices and problem solving skills, community living skills, social and leisure skills, money management skills, as well as support and skill training in health care needs, to include medication management. Residential support services emphasize positive behavior strategies, including interventions and supervision designed to maximize community inclusion while safeguarding the individual and general public. Services also support exercising individual rights and protect against rights violations and infringements without due process.

Intermittent supported living services are services provided by an individual or organizational provider to individuals residing in their own homes not requiring one-on-one supervision and/or 24 hour care.

A host home is a supported living arrangement within an integrated community neighborhood which provides residential support services in a family living setting.

Twenty-four hour Supported Living Services are residential support services provided 24 hours per day by an organizational qualified provider. These services are delivered within non-provider owned homes in integrated community neighborhood settings. There are some provider owned homes located in the rural area due to resource limitations.

Residential support services cannot duplicate the scope and nature of State Plan Personal Care Services. Any ADL or IADL that is covered in the Individual Habilitation Plan, whether it is completed for them or the individual is completing the task with supervision as part of their training, cannot be covered under State Plan Personal Care Services.

2103.5A COVERAGE AND LIMITATIONS

1. Residential Support Services staff are trained and responsible for implementing ISPs, goals, objectives and service supports related to residential and community living.

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These **services** include:

- a. the participation in the development of the ISP.
 - b. adaptive skill development.
 - c. facilitation of **personal care and** ADLs.
 - d. facilitation of community inclusion.
 - e. facilitation of IADLs to include teaching community living skills; interpersonal and relationship skills; **building of natural support networks**; choice making skills; social and leisure skills; budgeting and money management skills.
 - f. providing assistance with medication administration **through ADSD staff certified in a Developmental Services (DS) approved Medication Program.**
 - g. **providing assistance with support and skill training in health care needs.**
 - h. **facilitation of mobility training, survival and safety skills.**
2. **Residential Support Services may be provided on a continuum of service delivery model ranging from intermittent to 24 hour supported living arrangements, as determined by the ISP team. Residential support services are provided in either the service recipient's natural family home or in a non-provider owned home or apartment, unless otherwise approved by the regional center director. These settings are fully integrated within community residential neighborhoods and are owned or leased in the service recipient's name or on the behalf of the recipient, with the exception of approved Host Home services. In 24 hour supported living arrangements, protective oversight hours must be shared with other recipients in the home unless clear documentation exists that shows a need for one-on-one supervision due to health and safety needs of the person supported and approved by the agency director or designee.**
 3. Under this service category, the responsibility for the living environment rests with the service agency and encompasses a variety of Supportive Living Arrangements (SLAs):
 - a. **Residential support services in a 24 hour setting are limited to four recipients unless otherwise authorized by the Regional Center Director. Host Home SLA's are limited to two service recipients residing in one home, unless otherwise authorized by the DS Regional Center Director.**

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Individual SLA homes do not require state licensure; however, individual providers and provider agencies must be approved and certified by **ADSD** in order to render services to **individuals** with **intellectual disabilities** and related conditions.

2103.6 **RESIDENTIAL SUPPORT SERVICES PROVIDER RESPONSIBILITIES**

A. Individual Providers – Provider Managed:

1. Must be at least 18 years of age.
2. Must have a High School Diploma or equivalent (may be waived with **ADSD** approval).
3. Must have First Aid and CPR training within 90 days of hire.
4. Must have the ability to implement the recipient’s ISP and Habilitation Plan.
5. Must have the ability to communicate with and understand the recipient.
6. Provider qualifications will be reviewed by **ADSD** on initial application, within the first year as part of certification review and at least every two years thereafter as part of re-certification review.

B. Individual Providers – Participant-Directed:

1. Must be at least 18 years of age.
2. Must have the ability to communicate with and understand the participant.
3. Must provide three reference checks in accordance with **ADSD** policy.
4. Must have First Aid and CPR training within 90 days of hire.
5. Must meet the requirements specified in NAC 435 and provide information to the DHCFP to maintain approved provider status.
6. Must have the ability to implement the goals and services as identified in the participant’s ISP.
7. Must have the ability to communicate with and understand the recipient.

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C. Agency Providers – Provider Managed:

1. Individuals providing direct services and support services must be at least 18 years of age.
2. Must have a High School Diploma or equivalent. This requirement may be waived with **ADSD** approval.
3. Must meet all the requirements to be enrolled and maintain status as an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.
4. **ADSD** will verify provider qualification on initial application and provisional certification, within the first year as part of the Quality Assurance (QA) review for certification and at least every three years thereafter as part of the re-certification QA review.

2103.6A PREVOCATIONAL SERVICES

Prevocational Services are **designed to create a path to integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be optimal outcomes for prevocational services. Individuals receiving prevocational services must have employment-related goals in their person-centered ISP; the general habilitative activities must be designed to support such employment goals.**

Services include teaching such concepts as attendance, task completion, problem solving, interpersonal relations and safety, and communication with customers, co-workers, or supervisors. This service provides for learning and work experience, including volunteer work, participation in social and recreational activities to facilitate community integration, classroom style program/training, experience – where an individual can develop general, non-job or task specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as identified in the individual’s ISP.

2103.6B COVERAGE AND LIMITATIONS

The prevocational services provided under this waiver are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the IDEA (20 U.S.C. 1401(16 and 17)). Documentation will be maintained in the file of each individual receiving prevocational services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

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1. Participants who receive prevocational services may include two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

2103.6C PREVOCATIONAL SERVICES PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
 - a. All provider agencies/organizations providing day habilitation services must meet the requirements for Certificate of Qualification in accordance with NRS 435.230 to 435.320, all inclusive or meet **ADSD** rules, regulation and standards and demonstrate a community need.
 - b. An employee of an agency must have a High School Diploma or equivalent, however, this requirement may be waived with approval from **ADSD**.
 - c. Annual certification is required for certified centers meeting requirements under NRS and NAC 435.
 - d. All providers must meet all requirements to enroll and maintain Medicaid provider status according to MSM Chapters 100 and 2100, as applicable.
 - e. Must meet all conditions of participation according to MSM Chapter 100, Section 102.1.

2103.7 SUPPORTED EMPLOYMENT

Supported employment service is a combination of intensive ongoing supports and services that prepare recipients for paid employment.

Supported employment services are individualized and may include any combination of the following services: Vocational job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefit supports, training and planning, transportation (by the employment provider to any sub-sites or necessary to complete the job), asset development and career advancement services and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Individual employment supports are services for individuals who, because of their disabilities, need intensive ongoing supports to obtain and maintain an individual job in competitive employment or customized employment, or self-employment, in an integrated work setting in the

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general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Customized employment is another approach to supported employment. Customized employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interest of the person with disabilities, and is also designed to meet the specific needs of the employer. Customized employment assumes the provision of reasonable accommodations and support necessary to perform the function of a job that is individually negotiated and developed.

Supported employment small group employment supports may include any combination of the following services: vocational/job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit supports, training and planning, transportation and career advancement services. Other workplace supports may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating in the job setting.

The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level benefits paid by the employer of the same or similar work performed by individuals without disabilities. Small group employment does not include vocational services provided in a facility based work setting.

2103.7A COVERAGE AND LIMITATIONS

1. When supported employment services are provided at a work site in which individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

2. Supported employment may be furnished as expanded habilitation services under the provision of the 1915 (c) of the Act. It is important to note that such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under Section 110 of the Rehabilitation Act of 1973 or, in the case of youth, under the provision of the Individuals with Disabilities Educational Act (IDEA).

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3. Supported employment small group employment support are services and training activities provided in regular business, industry and community settings of two to eight workers with disabilities. Examples include mobile crews and other business-based work groups employing a small group of workers with disabilities in employment in the community. Supported employment small group work employment supports must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
4. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
 - a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
 - b. Payments that are passed through to users of supported employment programs; or
 - c. Payments for vocational training that is not directly related to an individual's supported employment program.

2103.7B SUPPORTED EMPLOYMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Provider Agencies:
 - a. Employees of an agency that provides supported employment services must meet the requirements for certification in accordance with NRS 435 and **ADSD** policy, and provide required documentation to the DHCFP to maintain approved provider status
 - b. Must be at least 18 years of age.
 - c. Must have a High School Diploma or equivalent; however, this may be waived with approval of **ADSD**.
 - d. Must meet all requirements to enroll and maintain enrolled Medicaid provider pursuant to the DHCFP MSM, Chapter 100 and 2100.
2. Individual Providers – Provider Managed:
 - a. Must have a High School Diploma or equivalent; however, this may be waived with approval of **ADSD**.

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- b. Must have the ability to implement the recipient’s ISP.
 - c. Must have the ability to communicate with and understand the recipient **ADSD** will verify provider qualification on initial application and annually thereafter.
3. Individual Providers – Participant-Directed:
- a. Must be at least 18 years of age.
 - b. Must have the ability to communicate with and understand the participant.
 - c. Must provide three reference checks in accordance with **ADSD** policy.
 - d. Must have First Aid and CPR training within 90 days of hire.
 - e. Must meet the requirements specified in NAC 435 and provide information to the DHCFP to maintain approved provider status.
 - f. Must have the ability to implement the goals and services as identified in the participant’s ISP.
 - g. Must have the ability to communicate with and understand the recipient.

2103.8 BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION

Behavioral consultation, training and intervention services **provide behaviorally-based assessment and intervention for participants, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of Individual Support Plans and/or positive behavior support plans, necessary to improve an individual's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. These services are not covered under the State Plan and are provided by professionals in psychology, behavior analysis and related fields.**

2103.8A COVERAGE AND LIMITATIONS

- 1. Behavioral consultation, training and intervention may be provided in the recipient’s home, school, workplace, and in the community. The services include:
 - a. **functional behavioral assessment and an** assessment of the environmental factors that are precipitating a problem behavior.

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- b. development of behavior support plan in coordination with the team **members**.
- c. consultation or training on how to implement positive behavior support strategies and/or behavior support plan.
- d. consultation or training on data collection strategies to monitor progress.
- e. monitoring of recipient and the provider(s) in the implementation and modification of the support plan, as necessary.

Behavioral Consultation, Training and Intervention may not exceed \$5,200.00 per year.

2103.8B BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. In addition to the provider qualification listed in this chapter:

- a. Employees of behavioral provider agencies must have provisional or regular certification per NRS 435 and have a Bachelor's degree in psychology, special education or closely allied field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, monitoring of behavior support plans in applied setting; or
- b. Master's degree in psychology, special education or closely related field with expertise in functional assessment and the provision of positive behavioral supports.
- c. Experience working with **individuals with intellectual disabilities** or related conditions is preferred.
- d. Must meet all requirements to enroll and maintain status as Medicaid provider pursuant to the DHCFP MSM, Chapters 100 and 2100, as applicable.

2. Individual Providers:

- a. Bachelors degree in psychology, special education or closely allied field plus at least one year professional clinical experience using behavior intervention and functional assessment procedures and developing, implementing, monitoring of behavior support plans in applied settings; or

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- b. Master’s degree in psychology, special education or closely allied field with expertise in functional assessment and the provision of positive behavioral supports.
- c. Experience working with individuals with intellectual disabilities or related conditions is preferred.
- d. Must have criminal clearance in accordance with the DHCFP and **ADSD** policy.
- e. **ADSD** will verify qualifications prior to approval of initial provider agreement and annually thereafter.

2103.9 COUNSELING SERVICES

Counseling services provide assessment/evaluation, consultation, therapeutic interventions, support and guidance for waiver participants and/or family members, caregivers, and team members, which are not covered by the Medicaid State Plan and which improve the individual's personal adaptation and inclusion in the community. This service is available to individuals who have intellectual and/or developmental disabilities and provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes, as identified in the participant's ISP.

Counseling services are specialized and adapted in order to accommodate the unique complexities of enrolled participants and include consultation with team members, including family members, support staff, service coordinators and other professionals comprising the participant's support team; individual and group counseling services; assessment/evaluation services; therapeutic interventions strategies; risk assessment; skill development; and psycho educational activities.

Counseling services are provided based on the participant’s need to assure his or her health and welfare in the community and enhance success in community living.

2103.9A COVERAGE AND LIMITATIONS

Counseling services may include:

- 1. individual and group counseling services;
- 2. assessment/evaluation services;
- 3. therapeutic intervention strategies;

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4. risk assessment;
5. skill development; and
6. psycho-educational activities.

Counseling services may not exceed \$1,500.00 per year.

2103.9B COUNSELING SERVICES PROVIDER **ADDITIONAL** QUALIFICATIONS

1. In addition to the provider qualifications listed in this chapter:
 - a. **Providers under this category** must have graduated from an accredited college or university with a Master's degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field. A closely allied field is licensed by the state by appropriate categories. A graduate level intern supervised by a licensed clinician or mental health counselor may provide these services; or
 - b. A graduate level intern who is enrolled in a Master's level program at an accredited college or university that provides at least two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely allied academic field or doctor level program in a clinical field; and
 - c. Are supervised by a licensed clinician or mental health counselor (professional experience in a setting servicing individuals with intellectual disabilities is preferred).
 - d. Professional experience in a setting serving individuals with intellectual disabilities is preferred.
 - e. **ADSD will verify provider qualifications upon enrollment and prior to expiration of the license; the provider will send a copy of the current license to the ADSD.**

2103.10 RESIDENTIAL SUPPORT MANAGEMENT

Residential Support Management is designed to ensure the health and welfare of individuals receiving residential support services from agencies in order to assure those services and supports are planned, scheduled, implemented and monitored as the individual prefers and needs depending on the frequency and duration of approved services. Residential support managers assist the participant with managing their residential supports.

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Residential support managers must work collaboratively with the participant's Targeted Case Manager. Residential Support Management services are different from Targeted Case Management. The Targeted Case manager is responsible for the development of the ISP, which is the overall HCBS plan, in consultation with the ISP team.

The Residential Support Manager is responsible to develop, implement, and monitor the specific residential habilitation plan related to Residential Support Services.

2103.10A COVERAGE AND LIMITATIONS

1. **Residential** Support Management staff will assist the recipient in managing their supports within the home and community settings. This service includes:
 - a. assisting the person to develop his or her goals;
 - b. scheduling and attending **Individual Support Team Planning** meetings;
 - c. **develop habilitation plans specific to residential support services, as determined in the participant's ISP and train residential support staff in implementation and data collection;**
 - d. assisting the **individual** to apply for and obtain community resources and benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Housing and Urban Development (HUD), Food Stamps, housing, etc.;
 - e. assisting the **individual** in locating residences;
 - f. assisting the **individual** in arranging for and effectively managing generic community resources and informal supports;
 - g. assisting the **individual** to identify and sustain a personal support network of family, friends, and associates;
 - h. providing problem solving and support with crisis management;
 - i. supporting the **individual** with budgeting, bill paying, and with scheduling and keeping appointments;
 - j. observing, coaching, training and providing feedback to direct service staff to ensure they have the necessary and adequate training to carry out the supports and services identified in the ISP;

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- k. following up with health and welfare concerns and remediation of deficiencies;
- l. completing required paperwork on behalf of the recipient (as needed);
- m. making home visits to observe the **individual's** living environment to assure health and welfare; and
- n. providing information to the Service Coordinator (Targeted Case Manager) to allow evaluation and assurance that support services provided are those defined in the ISP and are effective in assisting the recipient to reach his or her goals.

2103.11 RESIDENTIAL HABILITATION – DIRECT SUPPORT MANAGEMENT PROVIDER RESPONSIBILITIES/QUALIFICATIONS

A. Agency Providers:

- 1. Employees of an agency that provides direct support management services must be at least 18 years of age;
- 2. Must be certified (including provisional certification according to NAC 435) and provide required information to DHCFP to maintain approved provider status;
- 3. Must have a High School Diploma or equivalent and two years experience providing direct service in a human services field and under the direct supervision/oversight of a Qualified **Intellectual Disabilities** Professional (QIDP) or its equivalent;
- 4. Completion of Bachelor’s degree from an accredited college or university in psychology, special education, counseling, social work, or closely allied field;
- 5. Meet all requirements to enroll and maintain status as an enrolled provider pursuant to the DHCFP MSM Chapters 100 and 2100, as applicable; or
- 6. **ADSD** will verify Direct Service and Support staff qualification upon application for enrollment for provisional certification and within the first year of enrollment as part of initial Quality Assurance certification review. Verification will occur at least every two years thereafter as part of re-certification review.

2103.12 NON-MEDICAL TRANSPORTATION

Non-medical transportation service is offered to enable waiver recipients to gain access to community activities and services that are identified in the recipients ISP. Non-medical

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transportation service allows individuals to engage in normal day-to-day non-medical activities such as going to the grocery store or bank, participating in social events or attending a worship service. Whenever possible, family, neighbors, friends, or community agencies should provide this service without charge.

2103.12A COVERAGE AND LIMITATIONS

1. This service will not duplicate or impact the amount, duration and scope of the medical transportation benefit provided under the Medicaid State Plan. Refer to MSM Chapter 1900 for more information regarding the coverage and limitations of medical transportation.
2. Non-medical transportation services under this waiver must be described or identified in the recipient's ISP and pre-authorized before the service is utilized.

2103.12B NON-MEDICAL TRANSPORTATION PROVIDER RESPONSIBILITIES/QUALIFICATIONS

1. Individual Providers:
 - a. Must have a valid Nevada Driver's License and provide proof of liability insurance.
 - b. Must show evidence of vehicle safety inspection prior to hire and are subject to periodic vehicle safety inspections. Providers are responsible for obtaining safety inspections and providing them to ADSD upon request.
 - c. Must be at least 18 years of age.
 - d. Must have a high school diploma or equivalent.
 - e. Must have at least six months of specialized training and experience in working with individuals with disabilities in a community setting.
 - f. Must have the ability to communicate with and understand the participant.
 - g. Must provide three reference checks in accordance with ADSD policy.
 - h. Must have First Aid and CPR training within 90 days of hire.
 - i. Must meet the requirements specified in NAC 435 and provide information to DHCFFP to maintain approved provider status.

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j. Must have the ability to implement the goals and services as identified in the participant's ISP.

2. Agency Provider – Provider Managed:

a. An employee of an agency must have a valid Nevada Driver's License.

An agency must have uninterrupted liability insurance per Nevada State Risk Management specification and **ADSD** policy; automobile insurance, per State of Nevada requirements including all automobiles owned and leased by the agency; and assurance of routine vehicle safety and maintenance inspection on file.

b. An employee of an agency that provides direct support services must be certified (including provisional certification) in accordance with NAC 435 as a Supported Living Provider.

c. Must meet all requirements to be enrolled and maintain status of an enrolled Medicaid provider pursuant to MSM Chapters 100 and 2100, as applicable.

d. Must meet all conditions of participation in MSM Chapter 100, Section 102.1.

e. **ADSD** will verify provider qualification prior to approval of initial provider agreement and annually thereafter.

2103.13 NURSING SERVICES

There are three components of this service: Direct Services, Comprehensive Medical Community Support Services, and Nursing Assessment.

Direct Services: Direct skilled nursing services are intended to be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in a community setting as described and approved in the recipient's ISP. LPN's must be under the supervision of an RN licensed in the state. Services include skilled medical care that is integral to meeting the daily medical needs of the recipient. These services are intended to allow individuals under this waiver to live safely within an integrated community setting. Services are limited to those that only a licensed professional can provide; not those that unlicensed staff can provide. For example, ADL's are not skilled services. Skilled services include, but are not limited to: medication administration, wound care, nasogastric or gastronomy tube feeding, ostomy care, tracheotomy aspiration care, and catheter care. Direct services will be reimbursed when the procedure can be only be performed safely by a RN or LPN. Factors to consider when determining the need for direct nursing services include: the complexity of the procedure; the recipient's functional and physical

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status; the absence of a caregiver who is trained to perform the function; and that the service is reasonable and necessary.

Comprehensive Medical Community Support Services: These services will be provided by an RN or LPN under the supervision of an RN licensed in the state. Services are geared toward the development of health services support plans; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/assessment of the recipient's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers. This service includes professional observation and assessment, individualized program design and implementation, training of recipients and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that this service relates directly to the medical needs of the individual. In addition, nurses may attend ISP team meetings and physician visits as needed to provide advocacy, resource information and recommendations to team and treating physicians in order to facilitate health supports.

Nursing Assessment: Assessments are completed by an RN and provide the basis for recommendations for medical and mental health care and follow-up; which are shared with the person's team for review and inclusion in the individual's support plan. The assessment includes: an interview with the recipient; identification of diagnoses, including symptoms and signs of condition; assessment of verbal and nonverbal communication skills; a review of medical and social history including current medication and drug history; as well as other information available from either records or interviews with staff and family. The RN will assess vital signs, skin color and condition, motor and sensory nerve function, nutrition, sleep patterns, oral health, physical activities, elimination, and consciousness. Additionally, an assessment of the recipient's social and emotional factors and status will be completed to include; religion, thoughts on health care, mood, and social/support networks.

2103.13A COVERAGE AND LIMITATIONS

1. Routine nursing services are services within the Scope of the Nevada Nurse Practice Act.
2. Services must be provided by an RN or Licensed Practical Nurse (LPN) under the supervision of an RN who is licensed to practice as a nurse in the State of Nevada.
3. Nursing Services may include:
 - a. Medication administration.

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- b. Assessments (including nursing assessment).
 - c. Development of treatment plan or support plan.
 - d. Training and technical assistance for paid support staff to carry out treatment plan or support plan.
 - e. Monitoring of the recipient and the provider in the implementation of the plan and **provide nursing case notes of the services provided and the outcomes of those services.**
 - f. Referrals to **home health care** or other medical providers for certain treatment procedures covered under the Medicaid State Plan.
4. Nursing services may be provided in the recipient’s home, day program, or in other community settings as described in the Service Plan.
5. Medical and health care services such as physician services that are not routinely required to meet the daily needs of waiver recipients are not covered under this service. Nursing services provided in this waiver will not duplicate the nursing services covered under the Medicaid State Plan.

2103.13B NURSING SERVICES PROVIDER **ADDITIONAL** QUALIFICATIONS

- 1. Individual Provider and Provider Managed – Level 1:
 - a. **Must be an RN** in accordance with NRS 632 licensing requirements.
 - b. **May be an LPN** under the supervision of an RN in accordance with NRS 632 licensing requirement.
 - c. **ADSD will verify provider qualifications upon enrollment and annually thereafter. Providers are required to send a copy of the current license to ADSD.**
- 2. Agency Providers:
 - a. Employees of a Home Health Agency (HHA), Nursing Registry, or private service providers must be an RN in accordance with NRS 632.

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2103.14 NUTRITION COUNSELING SERVICES

Nutrition counseling services include assessment of the **individual's** nutritional needs, development and/or revision of recipient's nutritional plan, counseling and nutritional intervention, observation and technical assistance related to successful implementation of the nutritional plan.

These waiver-covered dietitian duties are above and beyond those approved and covered under State Plan Services

2103.14A COVERAGE AND LIMITATIONS

1. Training, education and consultation for recipients and their families or support staff involved in the day-to-day support of the recipient.
2. Comprehensive assessment of nutritional needs.
3. Development, implementation and monitoring of nutritional plan incorporated in the ISP, including updating and making changes in the ISP as needed.
4. Assist in menu planning and healthy menu options.
5. Provide nutritional education and consultation.
6. Provide **monthly case notes on nutritional activities and** summaries of progress on the nutritional plan.

This service requires a physician's order, determination of medical necessity, and the individual's health must be at risk. This service is limited to \$1,300.00 per year, per individual. This service does not include the cost of meals or food items.

2103.14B NUTRITION COUNSELING SERVICES PROVIDER **ADDITIONAL** QUALIFICATIONS

1. **In addition to the provider qualifications listed in this chapter, providers must be:**
 - a. **a registered Dietician as certified by the American Dietetic Association.**
 - b. **licensed to practice in the state of Nevada.**

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2103.15 CAREER PLANNING

Career planning is a person-centered, comprehensive employment planning and support services that provide assistance for waiver recipients to obtain, maintain, or advance in competitive employment or self employment. This service will engage waiver recipients in indentifying a career direction and developing a plan for achieving integrated employment at or above minimum wage.

The outcome of this service is documentation of the individual's stated career objective and career plan used to guide individual employment support. Services include planning for sufficient time and experiential learning opportunities to allow for appropriate exploration, assessment and discovery processes for learning about career options, as well as the participant's skills and interests. Career planning may include informational interviewing, job tours, job shadowing, community exploration, community and business research, benefit supports, job preference inventories, situational and community-based assessments, job sampling, training and planning, as well as assessments for the use of assistive technology in the workplace to increase independence.

2103.15A COVERAGE AND LIMITATIONS

The ISP may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed simultaneously. If a waiver participant is receiving pre-vocational services or day habilitation services, career planning may be used to develop additional learning opportunities and career options consistent with the person's skills and interest. Career Planning will be limited to 40 days and a specified number of hours identified in the ISP.

2103.15B CAREER PLANNING PROVIDER ADDITIONAL QUALIFICATIONS

In addition to the provider qualifications listed in this chapter, providers of Career Planning must have:

1. Education and experience equivalent to a Bachelor's degree in social services, rehabilitation, or business. Experience in working with individuals with intellectual disabilities and related conditions providing employment service and job development. Must demonstrate knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, and knowledge of the business needs of an employer.
2. Valid Nevada driver's license required. Must have access to an operational and insured vehicle and be willing to use it to transport individuals. (Providers will bill Career Planning unit rate for time spent transporting, not a separate rate).

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3. Individual must make a commitment to becoming a certified Employment Specialist through enrollment in national recognized employment courses.
4. Must have the ability to communicate with and understand the recipient.

2103.15C PROVIDER ENROLLMENT PROCESS

1. All providers should refer to the MSM Chapter 100 for enrollment procedures.
2. All providers must comply with all the DHCFP and **ADSD** enrollment requirements, provider responsibilities/qualifications, and the DHCFP and **ADSD** provider agreement and limitations set forth in this chapter.
3. Provider non-compliance with all or any of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

2103.16 INTAKE PROCEDURES

The **ADSD** has developed policies and procedures to ensure fair and adequate access to the HCBW for **Individuals** with **Intellectual Disabilities** and **Related** Conditions.

2103.16A COVERAGE AND LIMITATIONS

1. SLOT PROVISION

- a. The allocation of waiver slots is maintained at the **ADSD** Regional Offices. As waiver slots become available, **ADSD** determines how many slots may be allocated.
- b. **Recipients must be terminated from the waiver when they move out of state, fail to cooperate with program requirements, or request termination, and send a Notice of Decision (NOD). Their slot may be given to the next person on the wait list. If they request waiver services at a later date, they are placed on the bottom of the list by category with a new referral date.**
- c. **When a recipient is placed in a nursing facility, ICF/IID, or hospital, they must be sent a NOD terminating them from the waiver 45 days from admit date. Their waiver slot must be held for 90 days from the NOD date. They may be placed back in that slot if they are released within 90 days of the NOD date, and request reinstatement. They must continue to meet program eligibility criteria. After 90 days, their slot may be given to the next individual on the wait list. If a recipient requests reinstatement after the 90 days is over, they are treated as a new referral.**

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2. **WAIVER REFERRAL AND PLACEMENT ON THE WAIT LIST**

a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant **by contacting the local ADSD Regional Office. Regional center staff will discuss waiver services, including eligibility requirements with the referring party or potential applicant.**

b. **The service coordinator must conduct a Level of Care (LOC) screening to verify eligibility for the wait list.**

NOTE: If the applicant does not meet an LOC, they will receive a NOD which includes the right to a fair hearing.

c. **All applicants who meet program criteria must be placed on the statewide waiver wait list by priority and referral date. The following must be completed before placement on the wait list:**

- 1. The applicant must meet LOC criteria for placement in an ICF/IID.**
- 2. The applicant must require at least one ongoing waiver service.**
- 3. The applicant must meet criteria for IID or a Related Condition.**

Applicants must be sent a NOD indicating “no slot available”. ADSD will notify the DHCFP Central Office Waiver Unit via NMO-2734 when no slot is available. The applicant will remain on the waiting list.

3. **WAIVER SLOT ALLOCATION**

Once a slot **is allocated**, the applicant will be processed for the waiver.

The procedure used for processing an applicant will be as follows:

a. **The ADSD service coordinator will schedule a face-to-face visit with the recipient to complete the full waiver assessment to include diagnostic data, LOC determination, and will obtain all applicable forms, including the Authorization for Release of Information.**

The applicant and/or an authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

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The **ADSD** service coordinator will inform the applicant and/or an authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services (DHHS) may share confidential information without a signed **authorization for release of information**.

The service coordinator will provide an application to apply for Medicaid benefits through DWSS. The recipient is responsible for completing the application and submitting all requested information to DWSS. The case manager will assist upon request.

- b. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an **ICF/IID**. If the applicant and/or legal representative prefers placement in an **ICF/IID**, the service coordinator will assist the applicant in arranging for facility placement.
- c. The applicant/recipient will be given the right to request a hearing if not given a choice between **HCBS** and **ICF/IID** placement.
- d. When the applicant/recipient is approved by **ADSD** for waiver services, the following will occur:
 - 1. A team meeting is held and a written **ISP** is developed in conjunction with the recipient and the Individual Support Team to determine specific service needs **and** to ensure the health and welfare of the recipient.
 - 2. The recipient, the recipient's family, or the legal representative/authorized representative **are included** in the development of the **ISP**.
 - 3. The **ISP** is subject to the approval of the **Central Office** Waiver Unit of the **DHCFP**.
 - 4. Recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in his/her written individual support plan. Current **ISPs** must be given to all service providers and kept in the participant's record.
 - 5. All forms must be complete with signature and dates where required.
 - 6. **ADSD** will forward a completed waiver **packet** and **form NMO-2734** requesting **waiver** approval to the **DHCFP Central Office** Waiver Unit.
 - a. If the **waiver packet** is not approved the following will occur:

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1. A NOD stating the reason(s) for the denial will be sent to the applicant, **the ADSD service coordinator, and DWSS** by the **DHCFP Central Office** Waiver Unit via the Hearings and Policy Unit.

b. If the **waiver packet is** approved the following will occur:

1. **Form NMO-2734** will be sent by the **DHCFP Central Office** Waiver Unit to **the ADSD service coordinator. ADSD is responsible for notifying DWSS of approval to coordinate slot allocation with DWSS approval.**

2. Once the **waiver** has been approved by DWSS, waiver services can be initiated.

4. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, or the waiver eligibility determination date by DWSS, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

In some cases, it may be necessary to begin waiver services on the 1st of the month to coincide with Service Contracts. In that case, the effective date for waiver services approval is the completion date of all the intake forms or the first of the month the waiver eligibility determination is made by DWSS, whichever is later.

Waiver services will not be backdated beyond the **first** of the month in which the waiver eligibility determination is made by DWSS.

5. WAIVER COST

The DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed **100%** of the average per capita expenditures for the institutional **LOC** under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2103.17 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible and only when the service is included in the approved individual support plan.

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2103.17A COVERAGE AND LIMITATIONS

ADSD (Provider Type 38) must complete the CMS 1500 for payment of waiver services. Incomplete or inaccurate provider claims will be returned to **ADSD** by the DHCFP's fiscal agent. If the wrong form is submitted it will also be returned to **ADSD** by the DHCFP's fiscal agent.

2103.18 PERMANENT CASE FILE

- A. For each approved waiver recipient, the service coordinator must maintain a permanent case file that documents services provided under the Waiver for **Individuals with Intellectual Disabilities** and Related Conditions.
- B. These records must be retained for six years from the date of waiver service(s).

2103.19 SERVICE COORDINATOR RECIPIENT CONTACTS

- A. **Contacts**
 - 1. The service coordinator must have **ongoing** contact with each waiver recipient, a recipient's **personal** representative, or the recipient's direct care service provider, **by any means chosen by the recipient or representative. The contact must be sufficient to address health and safety needs of the recipient, and at a minimum, there must be a face-to-face visit with each recipient annually.**
 - 2. **During ongoing contact, the service coordinator will monitor the person's current condition to include health and safety, assess for changes needed, satisfaction with services and supports, whether the habilitation plans are meeting identified goals, and provide any necessary follow up on needs or concerns.**
- B. **Reassessment**
 - 1. Recipients must be reassessed annually.
 - 2. The recipient must be reassessed when there is a significant change in his/her condition.
 - 3. **Scope, frequency, and duration must be identified on the ISP, with the exception of Residential Support Management. Providers cannot exceed the maximum allowed as indicated on the ISP.**

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4. When the recipient service needs increase, due to a temporary condition or circumstance, the service coordinator must thoroughly document the increased service needs in their case notes. The ISP does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.
5. **Residential support management** hours are defined in the ISP. A temporary increase in the **residential support management** hours for the participant must receive prior authorization from **ADSD** and be justified based on health, safety and welfare concerns. If an increase is warranted to exceed a 30 day period, there must be a re-assessment based on thorough documentation in the **residential support managers** case notes reflecting the health, safety and welfare concerns and the ISP must be revised.

a. Reassessment Procedures

During the reassessment process, the service coordinator should:

1. Re-affirm the recipient meets the waiver criteria outlined in Section 2103.1A.6 of MSM Chapter 2100.
2. Re-assess the recipient's ability to perform ADLs, his/her medical and mental status and support systems.
3. Re-evaluate the services being provided and progress made toward the goal(s) stated on the individual support plan.
4. Develop a new individual support plan and review the waiver costs.
5. Re-assess the recipient's LOC.

2103.20 DHCFP ANNUAL REVIEW

The State will have in place a formal system by which it assures the health and welfare of the recipients served on the waiver, the recipient's satisfaction with the services and the cost effectiveness of these services.

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2103.20A **COVERAGE AND LIMITATIONS**

The DHCFP (administrative authority) and **ADSD** (operating agency) will collaboratively conduct an annual review of the waiver program to assess quality of life, functional independence, and health and welfare of recipients receiving waiver services. The State must operate this waiver in accordance with certain “assurances” identified in Federal regulations. CMS has designated six waiver assurances that states must include as part of an overall quality improvement strategy, which are:

1. **Level of Care:** Recipients enrolled meet level of care criteria consistent with individuals residing in institutional settings.
2. **Service Plan:** A recipient’s needs and preferences are assessed and reflected in a person centered service plan.
3. **Qualified Providers:** Provider agencies and workers providing services are qualified either through licensure or certification.
4. **Health and Welfare:** Recipients are protected from abuse, neglect and exploitation and receive supports to address identified needs.
5. **Financial Accountability:** Verification that reimbursement is only made for services that are approved and provided, and the cost of those services does not exceed the cost of institutional care on a per person or aggregate basis (as determined by the state).
6. **Administrative Authority:** The DHCFP is fully accountable for HCBS waiver design, operations and performance.

2103.20B **PROVIDER RESPONSIBILITIES**

Providers must cooperate with the DHCFP’s annual review process.

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2104 HEARINGS

2104.1 DENIAL OF WAIVER APPLICATION

Reasons to deny an applicant for waiver services:

- a. The applicant does not meet the criteria of being diagnosed with **intellectual disability** or having a condition related to **an intellectual disability**.
- b. The applicant does not meet the Level of Care (LOC) criteria for placement in an **Intermediate Care Facility (ICF)/ Individuals with Intellectual Disabilities (IID)**.
- c. The applicant has withdrawn their request for waiver services.
- d. The applicant fails to cooperate with the service coordinator or the **Home and Community-Based Services (HCBS)** providers in establishing and/or implementing the **Individual Support Plan (ISP)**, implementing waiver services, or verifying eligibility for waiver services.
- e. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. **HCBS** services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
- f. The agency has lost contact with the applicant.
- g. The applicant fails to show a need for **Home and Community-Based Waiver** services.
- h. The applicant would not require imminent placement in an ICF/**IID** if HCBS were not available. (**Imminent placement means within 30 to 60 days.**)
- i. The applicant has moved out of state.
- j. Another agency or program will provide the services.
- k. **ADSD** has filled the number of slots allocated to the HCBW for **Individuals with Intellectual Disabilities** and Related Conditions. The applicant has been approved for the waiver waiting list and will be contacted when a slot is available.

When the application for waiver services is denied the service coordinator will send a notification (Form NMO-2734) to the DHCFP **Central Office** Waiver Unit identifying the reason for denial. The Waiver Unit will send a **Notice of Decision (NOD)** for Payment Authorization

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Request (Form NMO-3582) to the applicant or the applicant's **personal** representative. The service coordinator will submit the form within **five** days of the date of denial of waiver services.

2104.2 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

- a. The recipient no longer meets the criteria of **an intellectual disability** or having a related condition.
- b. The recipient no longer meets the **LOC** criteria for placement in an ICF/IID.
- c. The recipient has requested termination of waiver services.
- d. The recipient has failed to cooperate with the service coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
- e. The recipient's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. Home and Community-Based services are not a substitute for natural and informal supports provided by family, friends or other available community resources.
- f. The recipient fails to show a continued need for HCBW services.
- g. The recipient no longer requires imminent ICF/IID placement if HCBS were not available. (Imminent placement means within 30 to 60 days.)
- h. The recipient has moved out of state.
- i. Another agency or program will provide the services.
- j. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, **ICF/IID**, or incarcerated). ******See below.**
- k. **ADSD** has lost contact with the recipient.
- l. The recipient has not utilized any waiver services over a 12 month period.

When a recipient is scheduled to be terminated from the waiver program, the service coordinator will send a notification (Form NMO-2734) to the DHCFP **Central Office** Waiver Unit identifying the reason for termination. The waiver unit will send a NOD to the recipient or the

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recipient's legal representative. The form must be mailed by the DHCFP to the recipient at least 13 calendar days before the Date of Action (DOA) on the NOD. Refer to MSM Chapter 3100 for exceptions to the advance notice.

****Service coordinators must track recipient stays in hospitals, nursing facilities, or ICF/IID's. Five days prior to the 45th day, the service coordinator will send a notification (Form NMO-2734) to the DHCFP Central Office Waiver Unit identifying the 60th day of inpatient status which is the termination date for waiver services.

Waiver slots must be held for 90 days, from the 45th day, which will be the date the NOD is sent to the recipient indicating termination or institutional placement, in case they are released and need waiver services upon release.

2104.3 REDUCTION OR DENIAL OF WAIVER SERVICES

Reasons to reduce or deny waiver services:

- a. The recipient no longer needs the number of service/support hours/days which were previously provided.
- b. The recipient no longer needs the service/supports previously provided.
- c. The recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child.
- d. The recipient's support system is providing the service.
- e. The recipient has failed to cooperate with the service coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.
- f. The recipient has requested the reduction of supports/services.
- g. The recipient's ability to perform tasks has improved.
- h. Another agency or program will provide the service.
- i. Another service will be substituted for the existing service.
- j. **The recipient has reached their service limit either annually or number of units.**

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2104.4 REAUTHORIZATION WITHIN 90 DAYS

2104.4A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated **due to placement in an institutional setting (hospital, nursing facility, or ICF/IID) the recipient may be eligible for readmission to the waiver if they have a discharge date and they request re-approval within 90 days of the NOD date (which is the 45th day).**

The service coordinator must complete the following:

- a. **Complete Form NMO-2734 indicating the date waiver services will begin again.**
2. If a recipient **has been** terminated from the waiver for more than 90 days, **they are treated as a new referral.**

2104.4B PROVIDER RESPONSIBILITIES

ADSD will forward all necessary forms to the DHCFP **Central Office** Waiver Unit **as required.**

When a NOD is required to be sent to a recipient, the service coordinator will send a notification (Form NMO-2734) to the DHCFP Central Office Waiver Unit identifying a denial, termination, reduction, along with the reason. The DHCFP Central Office Waiver Unit will send a NOD Form, NMO-3582 to the recipient or the recipient's legal representative. The form must be mailed by the agency to the recipient at least 13 calendar days before the Date of Action on the NOD for a termination or reduction. Denials do not require 13 days.

There are no responsibilities for service providers.

2104.5 HEARINGS PROCEDURES

Please reference MSM Chapter 3100, Hearings, for hearings procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 11, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE 

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2200 – HOME AND COMMUNITY BASED WAIVER
(HCBW) FOR THE FRAIL ELDERLY

BACKGROUND AND EXPLANATION

Revisions have been made to MSM Chapter 2200 to update language with regards to criminal background checks. References to NRS 449.176 to 449.188 were removed as these references do not include waiver providers. The criminal background requirement was re-worded to be consistent with MSM Chapter 100. Additional changes include removing case manager requirements to do cost projections, as this is no longer a waiver requirement. The requirement to complete functional assessments which are used for State Plan Personal Care Services were also removed.

These changes are effective September 12, 2012.

MATERIAL TRANSMITTED

MTL 22/12
CHAPTER 2200 – HOME AND
COMMUNITY BASED WAIVER (HCBW)
FOR THE FRAIL ELDERLY

MATERIAL SUPERSEDED

MTL 38/11
CHAPTER 2200 – HOME AND
COMMUNITY BASED WAIVER (HCBW)
FOR THE FRAIL ELDERLY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.1A	Administrative Case Management Activities - Coverage and Limitations	Removed reference to functional assessments by case manager; this will be completed by HPES. Removed reference to cost projections, as they are not required.
2203.3B.g	Waiver Services - Provider Responsibilities – Criminal Background Checks	Removed references to NRS 449.176 to 449.188 as these references do not include waiver providers. Clarified the existing language to match background check policy in Chapter 100.

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2200 INTRODUCTION

The Home and Community-Based Waiver (HCBW) Program recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of institutional care.

The Division of Health Care Financing and Policy's (DHCFP) Waiver for the Frail Elderly originated in 1987. The provision of waiver services is based on the identified needs of the waiver recipient. Every biennium the service needs and the funded slot needs of the waiver program are reviewed by the Aging and Disability Services Division (ADSD) and by the DHCFP (also known as Nevada Medicaid) and presented to the Nevada State Legislature for approval. Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization. Nevada understands that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. The Division is committed to the goals of self sufficiency and independence.

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2201 AUTHORITY

Section 1915 (c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. The DHCFP Home and Community-Based Waiver (HCBW) for the Frail Elderly is an optional service program approved by the Centers for Medicare and Medicaid Services (CMS). This waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

The DHCFP has the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations:

- Social Security Act: 1915 (c) (HCBW)
- Social Security Act: 1916 (e) (Cost Sharing – Patient Liability)
- Social Security Act: 1902 (w) (State Plan for Medical Assistance)
- Omnibus Budget Reconciliation Act of, 1987
- Balanced Budget of Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- 42 CFR Part 441, Subparts G and H (Home and Community-Based Services (HCBS): Waiver Requirements; HCBS Waivers for Individuals Age 65 or Older: Waiver Requirements)
- 42 CFR Part 418 (Hospice Care)
- 42 CFR Part 431, Subpart B and E (General Administrative Requirements; Fair Hearing for Applicants and Recipients)
- 42 CFR Part 440 (Services: General Provisions)
- 42 CFR Part 489, Subpart I (Advanced Directives)

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- State Medicaid Manual, Section 4440 (HCBW, Basis, Scope and Purpose)
- Nevada's Home and Community Based Waiver for the Frail Elderly Control Number
- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 629 (Healing and Arts Generally)
- Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 441A (Communicable Diseases), 449 (Medical and Other Related Facilities)

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2202 RESERVED

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2203 POLICY

2203.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities are performed by Aging and Disability Services Division (ADSD) case managers and refer to data collection for eligibility verification, Level of Care (LOC) evaluation, Plan of Care (POC) development, and other case management activities that are not identified on the POC.

2203.1A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;
3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
 - a. The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.
 - b. The recipient's level of care, functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit.
 - c. If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.
4. Issuance of Notices of Actions (NOA) to the Division of Health Care Finance and Policy (DHCFP) Central Office Waiver Unit staff to issue a Notice of Decision (NOD) when a waiver application is denied;

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5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;
6. Documentation for case files prior to applicant's eligibility;
7. Case closure activities upon termination of service eligibility;
8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;
9. Communication of the POC to all affected providers;
10. Ensure completion of prior authorization form, if required, for all waiver services documented on the POC for submission into the Medicaid Management Information System (MMIS).

2203.1B PROVIDER RESPONSIBILITIES

1. Administrative case management providers (social workers, nurses, certified case managers, etc.) must be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or as a Registered Nurse by the Nevada State Board of Nursing.
2. Must have a valid driver's license and the ability to conduct home visits.
3. Must adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements.
4. Must have a **Federal Bureau of Investigation (FBI)** criminal history background check.

2203.1C RECIPIENT RESPONSIBILITIES

1. Applicant/recipients and/or their authorized representative must cooperate with the ADSD by assisting with the assessment and reassessment process, accurately representing skill level needs, wants, resources and goals.
2. Applicants/recipients together with the case manager must develop and/or review the POC.

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2203.2 WAIVER ELIGIBILITY CRITERIA

The DHCFP's Home and Community-Based Waiver (HCBW) for the Frail Elderly waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in their own homes or community.

2203.2A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or nursing facility) within thirty (30) days or less. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver.
2. The HCBW for the Frail Elderly is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.
3. When funding becomes available, the applicant will be processed for the program based on LOC score, risk factors, and date of referral. Applicants will be considered for a higher advancement on the Wait List based on whether they meet additional criteria. The following criteria may be utilized:
 - a. Applicants currently in an acute care or nursing facility and desiring discharge;
 - b. Applicants with the highest LOC score indicating greatest functional deficits;
 - c. Applicants requiring services due to a crisis or emergency such as a significant change in support system;
 - d. Applicants transitioning from another waiver;
 - e. Applicants with a terminal illness; or
 - f. Applicants requiring at least minimal essential personal care assistance (bathing, toileting, and eating) as defined by NRS 426.723.
4. Waiver services may not be provided while a recipient is an inpatient of an institution.
5. HCBW for the Frail Elderly Eligibility Criteria:
 - a. Eligibility for Medicaid's HCBW for the Frail Elderly is determined by the DHCFP, ADSD, and the Division of Welfare and Supportive Services (DWSS).

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These three State agencies collaboratively determine eligibility for the Frail Elderly Waiver as follows:

1. Waiver benefit plan eligibility is determined by ADSD and authorized by the DHCFP Central Office Waiver Unit by confirming the following criteria:
 - a. Applicants must be 65 years of age or older;
 - b. Each applicant/recipient must meet and maintain a level of care for admission into a nursing facility and would require imminent placement in a nursing facility (within 30 days or less) if HCBW services or other supports were not available;
 - c. Each applicant/recipient must demonstrate a continued need for the services offered under the HCBW for the Frail Elderly to prevent placement in a nursing facility or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver;
 - d. The applicant/recipient must require the provision of one (1) waiver service at least monthly;
 - e. The applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when home and community-based services are not being provided; and
 - f. Applicants may be placed from a nursing facility, an acute care facility, another HCBW program, or the community.
 - g. Residential facility for groups:

In addition to the requirements listed above:

1. Applicant/recipient must meet the criteria for placement in a Category 1 or 2 Residential Facility for Groups or have the appropriate endorsement for the admission from HCQC.

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2. Waiver applications must be approved by the DHCFP Central Office Waiver Unit to ensure the level of care criteria is met.
3. DWSS validates the applicant is eligible for Medicaid waiver services using institutional income and resource guidelines.
 - a. Recipients of the HCBW for the Frail Elderly must be Medicaid eligible for full Medicaid benefits for each month in which waiver services are provided.
 - b. Services for the HCBW for the Frail Elderly shall not be provided and will not be reimbursed until the applicant is found eligible for benefit plan services, full Medicaid eligibility, and prior authorization as required.
 - c. Medicaid recipients in the HCBW for the Frail Elderly may have to pay for part of the cost of the waiver services. The amount they are required to pay is called patient liability.
4. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBW program and receive services provided by that program.
5. Recipients of the HCBW for the Frail Elderly who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

2203.2B PROVIDER RESPONSIBILITIES

1. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.
2. Providers are responsible for assuring prior authorization is established before services are provided.

2203.2C RECIPIENT RESPONSIBILITIES

Applicants/recipients must meet and maintain all eligibility criteria to become eligible and to remain on the HCBW for the Frail Elderly.

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2203.2D MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Recipients of this waiver are not eligible for EPSDT.

2203.3 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCBW for the Frail Elderly. Providers and recipients must agree to comply with all program requirements for service provision.

2203.3A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the POC as necessary to avoid institutionalization.

1. Direct Service Case Management.
2. Homemaker Services.
3. Chore Services.
4. Respite Care Services.
5. Personal Emergency Response System (PERS).
6. Adult Day Care Services.
7. Adult Companion Services.
8. Augmented Personal Care (provided in a residential facility for groups).

2203.3B PROVIDER RESPONSIBILITIES

1. All Service Providers:
 - a. Must obtain and maintain a HCBW for the Frail Elderly provider number (Provider Type 48 or 57 as appropriate) through the DHCFP's QIO-like vendor.
 - b. In addition to this Chapter, the provider must also comply with rules and regulations for providers as set forth in the MSM Chapter 100.

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- c. Must understand the authorized service specification on the POC, record keeping responsibilities and billing procedures for provided waiver services.
- d. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC and will not be made to legally responsible individuals for furnishing waiver services.
- e. All providers may only provide services that have been identified in the POC and that, if required, have a prior authorization.
- f. Providers must verify the Medicaid eligibility status of each HCBW for Frail Elderly recipient each month.
- g. Criminal Background Checks

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and FBI background check upon licensure and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred (ADSD personnel must follow State of Nevada policy regarding required background checks) **and the safety of recipients is not compromised.**

1. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.
2. Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at:
<http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf>
3. The employer is responsible for reviewing the results of the employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests

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of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):

- a. murder, voluntary manslaughter or mayhem;
- b. assault with intent to kill or to commit sexual assault or mayhem;
- c. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexual related crime;
- d. abuse or neglect of a child or contributory delinquency;
- e. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of the NRS;
- f. a violation of any provision of NRS 200.700 through 200.760;
- g. criminal neglect of a patient as defined in NRS 200.495;
- h. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
- i. any felony involving the use of a firearm or other deadly weapon;
- j. abuse, neglect, exploitation or isolation of older persons;
- k. kidnapping, false imprisonment or involuntary servitude;
- l. any offense involving assault or battery, domestic or otherwise;
- m. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
- n. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or
- o. any other offense that may be inconsistent with the best interests of all recipients.

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Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an “undecided” result is received. **If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: <http://dps.nv.gov> under Records and Technology.**

Providers must be able to: perform the duties of the job; demonstrate maturity of attitude toward work assignments; communicate effectively; work under intermittent supervision; deal with minor emergencies arising in connection with the assignment and act accordingly, reporting these to the proper supervisor; demonstrate ability to understand, respect and maintain confidentiality in regards to the details of case circumstances.

- h. Each provider must have a file for each recipient. In the recipient’s file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The documentation will include the recipient’s initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the POC. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider’s responsibility for providing accurate and verifiable documentation indicating the scope and frequency of services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient’s file or make available upon request.

Periodically, Medicaid Central Office/ADSD staff may request this documentation to compare it to submitted claims. These records must be maintained by the provider for at least six (6) years after the date the claim is paid.

- i. Must have a separate file for each employee. Records of all the employee’s training, required health certificates, first aid and cardiopulmonary resuscitation certifications and documents which are evidence that the employee has been tested for tuberculosis must be in the file. Please refer to NAC 449.200 for additional requirements.

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- j. The number of hours specified on each recipient's POC, for each specific service listed (except Case Management), will be considered the maximum number of hours allowed to be provided by the caregiver and paid by the DHCFP's QIO-like vendor, unless the case manager has approved additional hours due to a temporary condition or circumstance.
- k. Services for waiver recipients residing in a residential facility for groups should be provided as specified on the POC and at the appropriate authorized service level.
- l. If fewer services are provided than what is authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.
- m. Cooperate with ADSD and/or State or Federal reviews or inspections.
- n. Serious Occurrence Report (SOR):

Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed SOR form report must be made within five (5) working days and maintained in the agency's recipient record.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

- 1. Suspected physical or verbal abuse;
- 2. Unplanned hospitalization;
- 3. Neglect, exploitation or isolation of the recipient;
- 4. Theft;
- 5. Sexual harassment or sexual abuse;
- 6. Injuries requiring medical intervention;
- 7. An unsafe working environment;
- 8. Any event which is reported to Elder Protective Services or law enforcement agencies;
- 9. Death of the recipient during the provision of waiver services; or

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10. Loss of contact with the recipient for three (3) consecutive scheduled days.
11. Medication errors resulting in injury, hospitalization, medical treatment or death.

The State of Nevada has established mandatory reporting requirements of suspected incidents of Elder Abuse, Neglect, Isolation and Exploitation. ADSD and local law enforcement are the receivers of such reports. Suspected elder abuse must be reported as soon as possible, but no later than 24 hours of identification/suspicion. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

- o. Adhere to HIPAA requirements.

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.

- p. Obtain and maintain a business license as required by city, county or state government, if applicable.
- q. Providers for residential facility for groups must obtain and maintain required HCQC licensure.

2. Aging and Disability Services Division (ADSD):

In addition to the provider responsibilities listed in Section 2203.3B, ADSD must:

- a. maintain compliance with the Interlocal Agreement with the DHCFF to operate the HCBW for the Frail Elderly.
- b. comply with all waiver requirements as specified in the HCBW for the Frail Elderly.

3. Qualification and Training:

- a. All service providers must arrange training for employees who have direct contact with recipients of the HCBW programs and must have service specific training prior to performing a waiver service. Training at a minimum must include, but not limited to:

1. policies, procedures and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;

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2. procedures for billing and payment;
3. record keeping and reporting including daily records and SORs;
4. information about the specific needs and goals of the recipients to be served; and
5. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant.

b. Residential facility for groups:

In addition to the requirements listed above:

1. Caregivers of a residential facility for groups must be at least 18 years of age; be responsible and mature and have the personal qualities which will enable him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; must possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility and annually receive no less than eight (8) hours of training related to providing for the needs of the residents of a residential facility for groups; must be knowledgeable in the use of any prosthetic devices or dental, vision or hearing aids that the residents use and must understand the provisions of NAC 449.156 to NAC 449.27706, inclusive, and sections 2 and 3 of the regulation, and sign a statement that he/she has read those provisions.
2. If a caregiver assists a resident of a residential facility for groups in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.037, which must include, at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than four (4) hours of practical training, and obtain a certificate acknowledging the completion of such training; receive annually at least eight (8) hours of training in the management of medication and provide the residential facility for groups with satisfactory evidence of the content of the training and his or her attendance at the

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training; complete the training program developed by the administrator of the residential facility for groups pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and annually pass an examination related to the management of medication approved by the HCQC.

3. Within 30 days after a caregiver is employed at the facility, he/she must be trained in First Aid and Cardiopulmonary Resuscitation (CPR) as described in NAC 449.231 and be able to recognize and appropriately respond to medical and safety emergencies.
4. Caregivers must have training specific to the waiver population being cared for at the residential facility for groups, including the skills needed to care for recipients with increasing functional, cognitive and behavioral needs.
5. Service providers/employees must complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. Thereafter, each service provider/employee must receive a QFT-G blood test or one step TB skin test annually, prior to the expiration of the initial test. If the service provider/employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the service provider/employee must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient.

If the service provider/employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the service provider/employee must have documentation annually which demonstrates no signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider as defined in NAC 441A.110.

- a. Has had a cough for more than three (3) weeks;
- b. Has a cough which is productive;
- c. Has blood in his sputum;
- d. Has a fever which is not associated with a cold, flu or other apparent illness;

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- e. Is experiencing unexplained weight loss; or
- f. Has been in close contact with a person who has active tuberculosis.

Annual screening for signs and symptoms of active disease must be completed prior to the one (1) year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the service provider/employee file.

Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results, and maintained in the service provider/employee's file. Any lapse in the required timelines above results in non-compliance with this Section.

In addition, providers must also comply with the tuberculosis requirements outlined in NAC 441A.375 and NAC 441A.380.

- c. Exemptions from Training for Provider Agencies:
 - 1. The provider agency may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.
 - 2. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the employee's file.
 - 3. ADSD/DHCFP may review exemptions for appropriateness.

2203.3C RECIPIENT RESPONSIBILITIES

The recipient or, if applicable, the recipient's authorized representative will:

- 1. notify the provider(s) and the ADSD case manager of any change in Medicaid eligibility;
- 2. notify the provider(s) and the ADSD case manager of current insurance information, including the name of the insurance coverage, such as Medicare;

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3. notify the provider(s) and the ADSD case manager of changes in medical status, support systems, service needs, address or location changes, and/or any change in status of authorized or legal representative;
4. treat all providers and their staff members appropriately;
5. initial and sign the daily record(s) to verify that services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the POC;
6. notify the provider or the ADSD case manager when scheduled visits cannot be kept or services are no longer required;
7. notify the provider agency or ADSD of any missed appointments by the provider agency staff;
8. notify the provider agency or the ADSD case manager of any unusual occurrences, complaints regarding delivery of services, specific staff or to request a change in caregiver or provider agency;
9. furnish the provider agency with a copy of his or her Advance Directive;
10. not request any provider to work more than the hours authorized in the POC;
11. not request a provider to work or clean for a non-recipient, family or household members;
12. not request a provider to perform services not included in the POC;
13. contact the case manager to request a change of provider agency;
14. complete, sign and submit all required forms on a timely basis; and
15. be physically available for authorized waiver services, quarterly home visits, and assessments.

2203.4 DIRECT SERVICE CASE MANAGEMENT

Direct service case management is provided to eligible recipients in the HCBW program when case management is identified as a service on the POC. The recipient has a choice of direct service case management provided by ADSD or provider agencies.

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2203.4A COVERAGE AND LIMITATIONS

These services include:

1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as needed medical, social, educational and other services regardless of the funding source;
2. Coordination of multiple services and/or providers when applicable;
3. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;
4. Monitoring and documenting the quality of care through monthly contact:
 - a. The case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every three months. More contacts may be made if the recipient has indicated a significant change in his or her health care status or is concerned about his or her health and/or safety.
 - b. When recipient service needs increase, due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed thirty (30) days. If the recipient is utilizing a private case management agency, this information must be communicated to ADSD for prior authorization adjustment.
 - c. During the monthly contact, the case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. The case manager also assesses the need for any change in services or providers. If the recipient is utilizing a private case management agency, this information must be communicated to ADSD for prior authorization adjustment.
 - d. During scheduled visits to a residential facility for groups, the case manager is responsible for reviewing the POC and daily logs as applicable for feedback from the recipient to help ensure services are delivered as authorized in the POC. In addition, the case manager is responsible for reviewing the medication log to ensure appropriate administration and documentation is completed timely.

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5. Making certain that the recipient retains freedom of choice in the provision of services;
6. Notifying all affected providers of changes in the recipient's medical status, services needs, address, and location, or of changes of the status of legally responsible individuals or authorized representative;
7. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;
8. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
9. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency; and
10. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an "as needed" service. Case managers must continue to have monthly contact with recipients and/or the recipients authorized representative of at least fifteen (15) minutes, per recipient, per month. The amount of case management services billed to the DHCFP must be adequately documented and substantiated by the case manager's notes.
11. Monitoring to assure providers of residential facility for groups meet required program standards.
12. Arranging for the relocation of the recipient, if necessary, when an alternative placement is requested or needed.

2203.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Case Managers must:

1. be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers or licensure as a Registered Nurse by the Nevada State Board of Nursing.
2. have a valid driver's license and means of transportation to enable home visits.

In addition to the requirements listed above, private case managers must:

- a. have one year experience of working with seniors in a home based environment.

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- b. also provide evidence of taxpayer ID number, Workman's Compensation Insurance, Unemployment Insurance Account, Commercial General Liability, Business Automobile Liability Coverage and Commercial Crime Insurance.
- c. be employed by a private case management provider agency.

2203.4C RECIPIENT RESPONSIBILITIES

- 1. Each recipient and/or his or her authorized representative must cooperate with the implementation of services and the implementation of the POC.
- 2. Each recipient is to comply with the rules and regulations of the DHCFP, ADSD, DWSS and the HCBW for the Frail Elderly.

2203.5 HOME MAKER SERVICES

2203.5A COVERAGE AND LIMITATIONS

- 1. Homemaker services are provided by agencies enrolled as a Medicaid provider.
- 2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution. Services must be directed to the individual recipient and related to their health and welfare.
- 3. The DHCFP/ADSD is not responsible for replacing goods which are or become damaged in the provision of service.
- 4. Homemaker services include:
 - a. meal preparation: menu planning, storing, preparing, serving of food, cutting up food, buttering bread and plating food;
 - b. laundry services: washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.) excludes ironing. Recipient is responsible for all laundromat and/or cleaning fees;
 - c. light housekeeping: changing the recipient's bed linens, dusting, vacuuming the recipient's living area, cleaning kitchen and bathroom areas;
 - d. essential shopping to obtain: prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient; or

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- e. assisting the recipient and family members or caregivers in learning homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present.
5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:
- a. transporting the recipient in a private car;
 - b. cooking and cleaning for the recipient's guests, other household members or for the purposes of entertaining;
 - c. repairing electrical equipment;
 - d. ironing and mending;
 - e. giving permanents, dyeing or cutting hair;
 - f. accompanying the recipient to appointments, social events or in home socialization;
 - g. washing walls and windows;
 - h. moving heavy furniture, climbing on chairs or ladders;
 - i. purchasing alcoholic beverages that were not prescribed by the recipient's physician;
 - j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance; or
 - k. care of pets except in cases where the animal is a certified service animal.

2203.5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Homemaker Providers must:

- 1. arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment; and
- 2. inform recipients that the DHCFP or its QIO-like vendor is not responsible for replacement of goods damaged in the provision of service.

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2203.6 CHORE SERVICES

2203.6A COVERAGE AND LIMITATIONS

1. This service includes heavy household chores in the private residence such as:
 - a. cleaning windows and walls;
 - b. shampooing carpets;
 - c. tacking down loose rugs and tiles;
 - d. moving heavy items of furniture in order to provide safe access;
 - e. packing and unpacking for the purpose of relocation;
 - f. minor home repairs; or
 - g. removing trash and debris from the yard.
2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.
3. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver program covered services.

2203.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, individuals performing chore services must:

1. be able to read, write, and follow written or oral instructions;
2. have experience and/or training in performing heavy household activities and minor home repair; and

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3. maintain the home in a clean, sanitary and safe environment if performing heavy household chores and minor home repair services.

2203.7 RESPITE CARE

2203.7A COVERAGE AND LIMITATIONS

1. Respite care is provided on a short-term basis because of the absence or need for relief of the primary caregiver.
2. Respite care may occur in the recipient's private home.
3. Respite care is limited to 336 hours per waiver year.

2203.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Respite Providers must:

1. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their private home;
2. have the ability to read and write and to follow written or oral instructions;
3. have had experience and/or training in providing for the personal care needs of people with functional impairments;
4. demonstrate the ability to perform the care tasks as prescribed;
5. be tolerant of the varied lifestyles of the people served; and
6. arrange training in personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transferring, ambulating, feeding, dressing and use of adaptive aids and equipment, homemaking and household care.

2203.8 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

2203.8A COVERAGE AND LIMITATIONS

1. PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to the recipient's phone and programmed to signal a response center once a "help" button is activated.

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2. PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day in that residence, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. The recipient must be physically and cognitively capable of using the device in an appropriate and proper manner.
3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

2203.8B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, PERS Providers must:

1. be responsible for ensuring that the response center is staffed by trained professionals at all times;
2. be responsible for any replacement or repair needs that may occur;
3. utilize devices that meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards, and be in good standing with the local Better Business Bureau; and
4. inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2203.8C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider and the ADSD case manager if the equipment is no longer working.
2. The recipient must return the equipment to the provider when the recipient no longer needs or utilizes the equipment, when the recipient terminates from the waiver program or when the recipient moves from the area.
3. The recipient must not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

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2203.9 ADULT DAY CARE SERVICES

2203.9A COVERAGE AND LIMITATIONS

1. Adult day care facilities provide services in a non-institutional community-based setting on a regularly scheduled basis. The emphasis is on social interaction in a safe environment. It is provided for four (4) or more hours per day, one (1) or more days per week, and is provided in accordance with the goals in the recipient's POC. The POC must indicate the number of days per week the recipient will attend.
2. It is provided in an outpatient setting.
3. It encompasses social service needs to ensure the optimal functioning of the recipient.
4. Meals provided are furnished as part of the program but must not constitute a "full nutritional regime" (i.e., three meals per day).
5. Service utilization and billing method (per diem/unit rate) will be prior authorized as indicated on the recipient's POC. The per diem rate is authorized when the recipient is in attendance for six (6) or more hours per day, and the unit rate is authorized for attendance less than six (6) hours per day. Providers must bill in accordance with the approved PA, even if the recipient occasionally attends less than six (6) hours. If the recipient's overall pattern changes and consistently attends less than six (6) hours a day, a new POC and PA will be required to update the service utilization and billing method.
6. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.
7. Reference MSM Chapter 1900 for transportation policies.

2203.9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.3B, Adult Day Care Providers must:

1. Meet and maintain specifications as an adult day care provider as outlined in NAC 449 "Facilities for Care of Adults During the Day".
2. Comply with the provisions regarding tuberculosis as outlined in NAC 441A.375 and 441A.380.

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2203.10 ADULT COMPANION SERVICES

2203.10A COVERAGE AND LIMITATIONS

1. Provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which may provide temporary relief for the primary caregiver.
2. Adult companions may assist the recipient with such tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Companion Services and must be incidental to the care and supervision of the recipient.
3. The provision of Adult Companion Services does not entail hands-on medical care.
4. This service is provided in accordance with a goal in the POC and is not purely diversional in nature.
5. Transportation is not a covered service.

2203.10B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, Adult Companion Providers must:

1. be able to read, write and follow written or oral instructions; and
2. have experience or training in how to interact with recipients with disabling conditions.

2203.11 AUGMENTED PERSONAL CARE

Augmented personal care provided in a licensed residential facility for groups is a 24-hour in home service that provides assistance for functionally impaired elderly recipients with basic self care and activities of daily living that include as part of the service:

- a. Homemaker Services;
- b. Personal Care Services;
- c. Chore Services;
- d. Companion Services;

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- e. Therapeutic social and recreational programming;
- f. Medication oversight (to the extent permitted under State Law); and
- g. Services which will ensure that residents of the facility are safe, secure, and adequately supervised.

This care is over and above the mandatory service provision required by regulation for residential facility for groups.

2203.11A **COVERAGE AND LIMITATIONS**

1. Augmented personal care in a licensed residential facility for groups provides assistance for the functionally impaired elderly with basic self-care 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.
2. This service includes 24 hour in home supervision to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence.
3. There are three service levels of Augmented Personal Care. The service level provided is based on the recipient's functional needs to ensure his/her health, safety and welfare in the community.
 - a. Level One

Provides supervision and cueing to monitor the quality and completion of basic self care and ADLs. Some basic self care services may require minimum hands on assistance. This service level provides laundry services to meet the recipient's needs. If needed this service provides in home supervision when direct care tasks are not being completed.
 - b. Level Two

Provides minimal physical assistance with completion of basic self care and ADLs. Some basic self care may require a moderate level of assistance. This service level provides laundry services to meet the recipient's needs. If needed this service provides in home supervision with regularly scheduled checks if needed.

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c. Level Three

Provides moderate physical assistance with completion of basic self care and ADLs. Some basic self care may require a maximal level of assistance. This service level provides laundry service to meet the recipient's needs. If needed this service provides direct visual supervision or safety systems to ensure recipient safety when supervision is not direct.

4. Federal Financial Participation (FFP) is not available to subsidize the cost of room and board furnished in a residential facility for groups.
5. Nursing and skilled services (except periodic nursing evaluations) are incidental, rather than integral to the provision of group care services. Payment will not be made for 24-hour skilled care or supervision.
6. Other individuals or agencies may also furnish care directly, or under arrangement with the residential facility for groups. However, the care provided by these other entities supplements what is being provided, but does not supplant it.

2203.11B AUGMENTED PERSONAL CARE PROVIDER RESPONSIBILITIES

In addition to the responsibilities listed in section 2203.3B providers must:

1. Be licensed and maintain standards as outlined by the Health Division, HCQC under NRS/NAC 449 Residential Facility for Groups.
2. The provider for a residential facility for groups must:
 - a. Notify ADSD within three (3) working days when the recipient states that he or she wishes to leave the facility.
 - b. Participate with ADSD in discharge planning.
 - c. Notify ADSD within one working day if the recipient's living arrangements have changed, eligibility status has changed or if there has been a change in his or her health status that could affect his or her health, safety or welfare.
 - d. Notify ADSD of any occurrences pertaining to a waiver recipient that could affect his or her health, safety or welfare.
 - e. Notify ADSD of any recipient complaints regarding delivery of service or specific staff of the residential facility of groups.

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- f. Provide ADSD with at least a 30-day notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge.
- g. Be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.
- h. Provide care to a newly placed recipient for a minimum of thirty (30) days unless the recipient's condition deteriorates and warrants immediate discharge.
- i. Conduct business in such a way that the recipient retains freedom of choice.
- j. Provide transportation to and from the residential facility for groups to the hospital, a nursing facility, routine medical appointment and social outings organized by the facility.
- k. Accept only those residents who meet the requirements of the licensure and certification.
- l. Provide services to waiver eligible recipients in accordance with the recipient's plan of care, the rate, program limitations, and procedures of the DHCFP.
- m. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the HCBW for the Frail Elderly except by written consent of the recipient, his or her authorized or legal representative or family.
- n. Have sufficient number of caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The facility must comply with HCQC staffing requirements for the specific facility type (for example, an Alzheimer facility).
- o. There must be 24-hour on site staff to meet scheduled or unpredictable needs and provide supervision, safety and security, and transportation if one or more residents are present.
- p. Not use Medicaid waiver funds to pay for the recipient's room and board. The recipient's income is to be used to cover room and board costs.

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2203.11C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the providers of residential facility for groups in the delivery of services.
2. Recipients are to report any problems with the delivery of services to the residential facility for group administrator and/or ADSD case manager.

2203.12 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all the DHCFP provider enrollment requirements, provider responsibilities/qualifications, and the DHCFP provider agreement limitations. Provider non-compliance with any or all of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

2203.12A COVERAGE AND LIMITATIONS

All providers are to refer to the MSM Chapter 100 for enrollment procedures.

2203.12B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B:

1. All providers must meet all federal, state and local statutes, rules and regulations relating to the services being provided.
2. ADSD must have an Interlocal Agreement with the DHCFP in order to provide services.
3. All Other Service Providers must apply for and maintain a contract with the DHCFP through its Fiscal Agent.

2203.13 INTAKE PROCEDURES

ADSD has developed policies and procedures to ensure fair and adequate access to the Home and Community-Based Waiver for the Frail Elderly.

2203.13A COVERAGE AND LIMITATIONS

1. Referral
 - a. A referral or inquiry for the waiver may be initiated by phone, mail, fax, in person or by another party on behalf of the potential applicant.

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- b. ADSD will make phone/verbal contact with the applicant/representative within seven working days of the referral date. If a potential applicant appears to be eligible, a face to face visit is scheduled to assess eligibility including a level of care screening.
- c. If the intake worker determines during the referral process that the potential applicant does not appear to meet the waiver criteria of financial eligibility, level of care, or waiver service need, the applicant will be referred to other agencies for any needed services or assistance.
- d. Even if the potential applicant does not appear eligible or if no slot is available for the HCBW for the Frail Elderly, he or she must be verbally informed of the right to continue the Medicaid application process through DWSS. If DWSS determines the applicant to be ineligible for Medicaid, the applicant may have the right to a fair hearing through the DWSS.

2. Wait List/No Waiver Slots Are Available

- a. Once ADSD has identified that the potential applicant appears eligible and there are no waiver slots available:
 - 1. The applicant will be placed on the waiver wait list and be considered for a higher advancement based on whether they meet additional criteria. Refer to Section 2203.2A.3.
 - 2. If it has been determined no slot is expected to be available within the 90 day determination period, ADSD will notify the DHCFP Central Office Waiver Unit to deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the wait list.

3. A Waiver Slot is Available

Once a slot for the waiver is available, the applicant will be processed for the waiver.

- a. The procedure used for processing an applicant is as follows:
 - 1. The ADSD case manager will make certain that the Medicaid application, through DWSS, has been completed or updated and will assist in this process as needed.
 - 2. The ADSD case manager will schedule a face-to-face interview with the applicant to complete the assessment.

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3. An Authorization for Release of Information form is needed for all waiver applicants and provides written consent for ADSD to release information about the applicant to others.

The applicant and/or authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

4. The applicant will be given the right to choose waiver services in lieu of placement in a nursing facility. If the applicant and/or legal representative prefers placement in a nursing facility, the case manager will assist the applicant in arranging for facility placement.
5. The applicant will be given the right to request a hearing if not given a choice between HCBW services and nursing facility placement.
6. ADSD will forward an initial assessment (IA) packet to the DHCFP Central Office Waiver Unit which will include:
 - a. LOC screening;
 - b. Social Health Assessment;
 - c. a written POC is developed in conjunction with the applicant/authorized representative based on the assessment of the applicant's health and welfare needs;
 - d. the Statement of Understanding/Choice (SOU) must be complete with signature and dates; and
 - e. a HCBW Eligibility Status Form (Form NMO-2734) requesting the DHCFP's Central Office Waiver Unit approval with the date of approval indicated.
7. Applicants will be given free choice of all qualified Medicaid providers of each Medicaid covered service included in his/her written POC. Current POC information as it relates to the services provided must be given to all service providers.
8. The POC is subject to the approval by the DHCFP Central Office Waiver Unit staff.

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9. All required forms must be complete with signature and dates where required.

If the DHCFP Central Office Waiver Unit approves the application, the following will occur:

- a. Form NMO-2734 is sent by the DHCFP Central Office Waiver Unit to ADSD and DWSS stating the application has been approved; and
- b. Once the DHCFP Central Office Waiver Unit and DWSS have approved the application, waiver service can be initiated;

If the application is not approved by the DHCFP Central Office Waiver Unit, the following will occur:

- c. A NOD stating the reason(s) for the denial will be sent to the applicant by the DHCFP Central Office Waiver Unit via the DHCFP Hearings and Policy Unit; and
- d. Form NMO-2734 will be sent to ADSD and DWSS by the DHCFP Central Office Waiver Unit stating that the application has been denied and the reason(s) for that denial.

10. If the applicant is denied by ADSD for waiver services, the following will occur:

- a. The ADSD case manager will send a NOA to the DHCFP Central Office Waiver Unit;
- b. The DHCFP Central Office Waiver Unit will send a NOD to the applicant via the DHCFP Hearings and Policy Unit stating the reason(s) why the application was denied by ADSD; and
- c. The DHCFP Central Office Waiver Unit will send Form NMO-2734 to ADSD and DWSS stating that the application was denied and the reason(s) for the denial.

4. Effective Date for Waiver Services

The effective date for waiver services is determined by eligibility criteria verified by ADSD, intake packet approval by the DHCFP, and financial eligibility approval date by DWSS, and the residential facility for groups placement move in date, whichever is later.

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If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

5. Waiver Cost

The DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2203.14 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC, and prior authorization is in place when required.

2203.14A COVERAGE AND LIMITATIONS

All providers (Provider Types 48 and 57) for the HCBW for the Frail Elderly must submit claim forms to the DHCFP's QIO-like vendor. Claims must meet the requirements in the CMS 1500 Claim Form. Claims must be complete and accurate. Incomplete or inaccurate claims will be returned to the provider by the DHCFP's QIO-like vendor. If the wrong form is submitted it will also be returned to the provider by the DHCFP's QIO-like vendor.

2203.14B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.3B, all Providers must:

1. refer to the QIO-like vendor Provider Billing Procedure Manual for detailed instructions for completing and submitting the CMS 1500 form; and
2. maintain documentation to support claims billed for a minimum of 6 years from the date the claim is paid.

2203.15 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies give their clients information about their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM 100 for further information.

ADSD will provide information on Advance Directives to each applicant and/or the authorized/legal representative. The signed form is kept in each applicant's file at the local ADSD office. Whether an applicant chooses to write his or her own Advance Directives or complete the

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Advance Directives form in full is the individual choice of each applicant and/or each applicant authorized/legal representative.

2203.16 ANNUAL WAIVER REVIEW

The DHCFP and ADSD have formal systems in place to conduct annual reviews. The purpose of the review is to assure the health and welfare of the recipients, the recipients' satisfaction with the waiver services and providers, the qualifications of waiver providers to deliver services/supports, and assurance of the cost effectiveness of these services.

2203.16A COVERAGE AND LIMITATIONS

The State conducts an annual review, which is collaboratively conducted by ADSD and the DHCFP, with the DHCFP being the lead agency. The DHCFP:

1. provides CMS annually with information regarding the impact of the waiver on the type, amount, and cost of services provided under the waiver and under the State plan, and through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;
2. assures financial accountability for funds expended for HCBW services;
3. evaluates that all provider standards are continuously met, and that the POCs are periodically reviewed to assure that the services furnished are consistent with the identified needs of the recipients;
4. evaluates the recipients' satisfaction with the waiver program; and
5. further assures that all problems identified by this monitoring will be addressed by the provider in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

2203.16B PROVIDER RESPONSIBILITIES

ADSD and waiver providers must cooperate with the DHCFP's annual review process.

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2204 HEARINGS

2204.1 SUSPENDED WAIVER SERVICES

- a. A recipient's case may be suspended, instead of closed if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital, nursing facility or ICF/MR). After receiving written documentation from the case manager (Form NMO-2734) of the suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be sent to the recipient by the DHCFP Central Office Waiver Unit.
- b. Waiver services will not be paid for the days that a recipient's case is in suspension.
- c. If at the end of the 45 days the recipient has not been removed from suspended status, the case must be closed. ADSD sends a NOA to the DHCFP Central Office Waiver Unit on or before the 45th day of suspension, identifying the 60th day of suspension as the effective date of termination and the reason for the waiver termination.
- d. The DHCFP Central Office Waiver Unit sends a NOD, via the DHCFP Hearings Unit, to the recipient or the recipient's authorized representative advising him or her of the date and reason for the waiver closure/termination.

2204.2 RELEASE FROM SUSPENDED WAIVER SERVICES

If a recipient has been released from the hospital or nursing facility before 60 days have elapsed, within five working days of the recipient's discharge, the case manager must:

- a. assess the LOC for continued eligibility and complete a new form if it appears the recipient no longer meets a LOC;
- b. complete a reassessment if there has been a significant change in the recipient's condition or status;
- c. complete a new POC if there has been a change in services (medical, social or waiver). If a change in services is expected to resolve in less than 30 days, a new POC is not necessary. Documentation of the temporary change must be made in the case manager's notes. The date of resolution must also be documented in the case manager's notes; and
- d. contact the service provider(s) to reestablish services.

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2204.3 DENIAL OF WAIVER APPLICATION

Basis of denial for waiver services:

- a. The applicant is under the age of 65 years.
- b. The applicant does not meet the LOC criteria for nursing facility placement.
- c. The applicant has withdrawn his or her request for waiver services.
- d. The applicant fails to cooperate with ADSD or HCBW service providers in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services. (The applicant's or their authorized representative's signature is necessary for all required paperwork.)
- e. The applicant's support system is not adequate to provide a safe environment during the time when HCBW services are not being provided.
- f. ADSD has lost contact with the applicant.
- g. The applicant fails to show a need for HCBW services.
- h. The applicant would not require nursing facility placement within 30 days or less if HCBW services were not available.
- i. The applicant has moved out of state.
- j. Another agency or program will provide the services.
- k. ADSD has filled the number of positions (slots) allocated to the HCBW for the Frail Elderly. The applicant has been approved for the waiver wait list and will be contacted when a slot is available.
- l. The applicant is in an institution (e.g. hospital, nursing facility, correctional, ICF/MR) and discharge within sixty (60) days is not anticipated.
- m. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider.
- n. There are no enrolled Medicaid providers or facilities in the applicant's area.

When the application for waiver services is denied, the case manager sends a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit sends a NOD to the

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applicant, via the DHCFP Hearings Unit letting them know that waiver services have been denied and the reason for the denial.

2204.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver wait list:

- a. The recipient has failed to pay his/her patient liability.
- b. The recipient no longer meets the level of care criteria for nursing facility placement.
- c. The recipient no longer meets other eligibility criteria.
- d. The recipient/authorized representative has requested termination of waiver services.
- e. The recipient has failed to cooperate with ADSD or HCBW service providers in establishing and/or implementing the POC, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary on all required paperwork).
- f. The recipient's support system is not adequate to provide a safe environment during the time when HCBW services are not being provided.
- g. The recipient fails to show a continued need for HCBW services.
- h. The recipient is no longer at risk of imminent placement in a nursing facility within 30 days or less if waiver services were not available.
- i. The recipient has moved out of state.
- j. The recipient has signed fraudulent documentation on one or more of the provider time sheets and/or forms.
- k. Another agency or program will provide the services.
- l. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, correctional facility or intermediate facility for persons with mental retardation).
- m. ADSD has lost contact with the recipient.
- n. The environment in a residential facility for groups is not safe for the recipient.

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- o. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition. Residential facilities for groups are not licensed to provide skilled services. Recipients with a g-tube must be competent and manage their tube feeding or they are prohibited by HCQC licensure to be admitted into a residential facility for groups.
- p. The recipient has been placed in a residential facility for groups that does not have a provider agreement with the DHCFP.
- q. The recipient of a residential facility for groups chooses to return to independent community living which may not be a safe environment.

When a recipient is terminated from the waiver program, the ADSD case manager sends the DHCFP Central Office Waiver Unit a NOA stating the date of termination and the reason(s) for the termination. The DHCFP Central Office Waiver Unit sends a NOD via the Hearings Unit to the recipient or to the recipient's authorized representative. The NOD must be mailed by the DHCFP, Hearings Unit, at least 13 calendar days before the listed date of action on the form. Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.

When a termination from waiver services is due to the death of a recipient, the informed agency (ADSD, DHCFP or DWSS) will notify the other two agencies of the date of death.

2204.5 REDUCTION OF WAIVER SERVICES

Reasons to reduce services are:

- a. The recipient no longer requires the number of service hours/level of service which was previously provided.
- b. The recipient no longer requires the service previously provided.
- c. The recipient's support system is capable of providing the service.
- d. The recipient has failed to cooperate with the ADSD case manager or HCBW service provider(s) in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services (the recipient's or the recipient's authorized representative's signature is necessary on all required paperwork.)
- e. The recipient has requested the reduction of services.
- f. The recipient's ability to perform activities of daily living has improved.
- g. Another agency or program will provide the service.

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- h. Another service will be substituted for the existing service.

When there is a reduction of waiver services, the updated prior authorization will be submitted and a NOD will be generated. A hearing can be requested through the Hearings Unit by the recipient or the recipient's authorized representative. The form must be mailed by the Hearings Unit to the recipient at least 13 calendar days before the Date of Action on the form.

Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.

2204.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

2204.6A COVERAGE AND LIMITATIONS

1. If waiver services have been terminated and the recipient is requesting re-approval within 90 days of closure, the recipient is eligible for readmission provided the request is within the same waiver year, the recipient still meets a LOC and there is an available waiver slot.

If the termination took place in a prior waiver year and the recipient still meets a LOC, slot availability and emergent need will be taken into consideration for readmission into the waiver.

The ADSD case manager completes and sends to the Medicaid Central Office Waiver Unit the following:

- a. A LOC form;
 - b. Social Health Assessment;
 - c. A new SOU if there has been a change in the authorized/legal representative;
 - d. A new POC if services have changed; and
 - e. A Form NMO-2734 requesting the DHCFP Central Office Waiver Unit approval with the date of approval indicated.
 - f. All required forms must be complete with signatures and dates as applicable.
2. If a recipient is terminated from the waiver for more than 90 days, slots are available and the recipient is eligible for readmission to the waiver as defined in Section 2203.13A.3, a complete waiver packet must be forwarded to the DHCFP Central Office Waiver Unit for authorization.

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2204.6B PROVIDER RESPONSIBILITIES

ADSD will forward all necessary forms to the DHCFP Central Office Waiver Unit for approval.

2204.6C RECIPIENT RESPONSIBILITIES

Recipients must cooperate fully with the reauthorization process to assure approval of his/her request for readmission to the waiver.

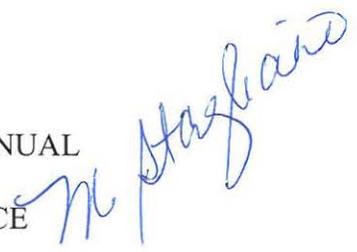
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2205 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 16, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE 
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2300 – HOME AND COMMUNITY BASED WAIVER
(HCBW) FOR PERSONS WITH PHYSICAL DISABILITIES

BACKGROUND AND EXPLANATION

The Chapter revisions coincide with the renewal of this waiver which is effective January 1, 2013 through December 31, 2018. Clarifications were made to existing policy under eligibility criteria and waitlist prioritization. Additional changes include updated language for flexibility of services, types of serious occurrences, background checks, Tuberculosis (TB) testing, Homemaker Services, Chore Services, Respite Care, and Specialized Medical Equipment and Supplies.

Policy was revised under Slot Provisions, Referral Prescreening, Placement on the Waitlist and Waiver Slot Allocation as the process has been updated and streamlined. Policy was revised in the area of Suspended Waiver Services and Release from Suspended Waiver, and Reauthorization of Services as process was clarified.

Five new Denial of Waiver Application reasons were added. Three Reduction in Service reasons that are not utilized were removed, and one was added. One Termination of Services reason that is not used was removed, and one was added.

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

These changes are effective May 17, 2013.

MATERIAL TRANSMITTED

MTL 08/13
CHAPTER 2300 – HOME AND
COMMUNITY BASED WAIVER (HCBW)
FOR PERSONS WITH PHYSICAL
DISABILITIES

MATERIAL SUPERSEDED

MTL 33/10
CHAPTER 2300 – HOME AND
COMMUNITY BASED WAIVER (HCBW)
FOR PERSONS WITH PHYSICAL
DISABILITIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2300	Introduction	Clarified waiver name and removed outdated language regarding funded waiver slots.
2303.1.A	Policy – Administrative Case Management Activities – Coverage and Limitations	Removed two outdated administrative case management activities, cost projections and functional assessments, and added a new activity for travel time to and from home visits.
2303.1C	Policy – Administrative Case Management Activities – Recipient Responsibilities	Removed outdated language about skill level, wants, resources and goals.
2303.2A.2	Policy – Eligibility Criteria – Coverage and Limitations – Persons with Physical Disabilities Waiver Eligibility Criteria	<p>Removed unnecessary language and clarified eligibility criteria.</p> <p>Clarified meet and maintain level of care for admission into a nursing facility within 30 days if services were not available which previously stated “imminent risk”.</p> <p>Removed unnecessary information on waiver assessments that is found further down in the chapter.</p> <p>Added “ongoing”.</p> <p>Reworded financial eligibility requirement through Division of Welfare and Supported Services (DWSS).</p>
2303.2A.4	Policy – Eligibility Criteria – Coverage and Limitations – Wait List Prioritization	Reworded item b and c for clarification.
2303.2A.8	Policy – Eligibility Criteria – Coverage and Limitations	Removed language regarding adequate support system and added statement that waiver services may not address all identified needs.
2303.2B	Policy – Eligibility Criteria – Recipient Responsibilities	This section was moved to 2303.3C.

2303.3B.1.e	Policy – Waiver Services – Provider Responsibilities – All Providers – Flexibility of Service Delivery	The language was reworded as the process has been updated.
2303.3B.1.g	Policy – Waiver Services – Provider Responsibilities – All Providers	All Services must be prior authorized.
2303.3B.2.b.11	Policy – Waiver Services – Provider Responsibilities – Provider Agencies – Individual Providers	Removed entire section as individual providers fall under “all providers”.
2303.3B.2.c	Policy – Waiver Services – Provider Responsibilities – Provider Agencies – Serious Occurrences	The serious occurrence form was revised and updated so policy was revised to coincide with revised criteria.
2303.B.2.e	Policy – Waiver Services – Provider Responsibilities – Provider Agencies – Tuberculosis (TB) Testing	Deleted outdated language and inserted updated language to match Bureau of Health Care Quality Compliance (BHCQC) language.
2303.3B.2.f	Policy – Waiver Services – Provider Responsibilities – Provider Agencies – Background Checks	Deleted references to NRS 449 as it does not apply to waiver providers. Added new language for background requirements for waiver providers and deleted old language.
2303.3C	Policy – Waiver Services – Recipient Responsibilities	Moved from section 2303.2B.
2303.3E.4.c	Policy – Waiver Services – Coverage and Limitations –	Added requirement for case managers to verify daily records for individuals who work directly for the recipient through an Intermediate Service Organization (ISO).

	Monthly Contacts	
2303.4A.3.f	Policy – Homemaker Services – Coverage and Limitations – Homemaker Services	Reworded requirement that transportation is not a reimbursable Medicaid expense.
2303.4A.3.g	Policy – Homemaker Services – Coverage and Limitations – Homemaker Services	Added that walking a pet is not included unless it is a service animal.
2303.4B.1	Policy – Homemaker Services – Homemaker Provider Responsibilities	Removed old language regarding homemaker provider through Division of Aging and Disability Services (ADSD), which recipients of the Work Incentive Program (WIN) no longer use.
2303.5B	Policy – Chore Services – Chore Services Provider Responsibilities	Removed criteria for individuals performing this service as the DHCFP does not verify this.
2303.6A	Policy – Respite Care – Coverage and Limitations	Added “unpaid” to provide clarity to indicate unpaid caregiver at home.
2303.7B.3	Policy – Environmental Accessibility Adaptations – Environmental Accessibility Adaptations Provider Responsibilities	Removed reference to Better Business Bureau as this is not a requirement of enrollment.
2303.8A	Policy – Specialized Medical Equipment	Added “supplies” as the proper name includes supplies.
2303.8B	Policy – Specialized medical Equipment and Supplies – Specialized medical	Revised and updated language for provider responsibility for Specialized Medical Equipment and Supplies.

2303.9A.1	<p align="center">Equipment Provider Responsibilities Policy – Personal Emergency Response Systems (PERS) – Coverage and Limitations</p>	Changed recipient’s phone to landline.
2303.9B.4	<p align="center">Policy – Personal Emergency Response Systems (PERS) – PERS Provider Responsibilities</p>	Removed reference to Better Business Bureau as this is not a requirement of enrollment.
2303.11B.1	<p align="center">Policy – Home Delivered Meals – Home Delivered Meals Provider Responsibilities</p>	Removed old language and added enrolled with the DHCFP through its QIO-like vendor.
2303.12A	<p align="center">Policy – Attendant Care – Coverage and Limitations</p>	<p>Removed nursing care and replaced it with services.</p> <p>12A.1: Clarified Intermediary Services Organization option for Attendant care and added reference. The old references to independent contractors were removed and replaced with ISO. Added sentence that a recipient can chose a provider agency if an ISO is not used.</p> <p>12A.2: Removed a process paragraph that is located in the case manager desk manual.</p> <p>12A.3: (New) deleted reference to flexibility of services and added a reference to previous chapter sections.</p>
2303.14A.1	<p align="center">Policy – Intake Procedures – Coverage and Limitations – Slot Provisions</p>	<p>This process has been changed so updated language to match the process.</p> <p>Clarified process for slot allocation for the slot vacated by a recipient who moves out of state, fails to cooperate, or requests termination.</p> <p>Clarified process for slot allocation for what to do with the slot when someone enters a nursing facility. The slot is held from 90 days from the notice of termination date.</p>

2303.14A.2	Policy – Intake Procedures – Coverage and Limitations – Referral Pre-Screening	Clarified potential applicant and reworded process as the process has changed. Removed the step to mail an application to DWSS and that a level of care screening will be conducted. Clarifies the recipient’s rights if they do not meet level of care.
2303.14A.3	Policy – Intake Procedures – Coverage and Limitations – Placement on the Waitlist	The management of the waitlist has changed so language was updated to match current practice. The applicant must meet a level of care, need one ongoing waiver service, and be physically disabled to go on the waitlist. A Notice of Decision (NOD) will be sent stating no slot is available and they are placed on the waitlist.
2303.14A.4	Policy – Intake Procedures – Coverage and Limitations – Waiver Slot Allocation	The management of the waitlist has changed so language was updated to match current practice. Clarified existing language to include face-to-face home visits will be conducted, and an application will be submitted to DWSS. Changed legally responsible individual to representative and they are included in plan of care development.
2303.14A.5	Policy – Intake Procedures – Coverage and Limitations – Effective Date for Waiver Services	Clarified current process – determination date made by DWSS.
2303.15B	Policy – Billing Procedures – Provider Responsibility	Removed reference to old QIO-like vendor and billing information.
2304.1A	Hearings – Suspended Waiver Services	Clarified existing language of when recipients must be suspended. Clarified existing language that a termination NOD must go out 45 days after admission if they have not been discharged.
2304.1B	Hearings – Release From Suspended Waiver Services	Removed reference to Intermediate Care Facility for the Mentally Retarded (ICF/MR) and clarified within 60 days of the admit date. Removed Social Health Assessment and reference to not meeting level of care as this is in the case manager

desk manual.

Removed reference to cost projections as this is no longer a requirement for case managers.

2304.1C Hearings – Denial of Waiver Services

1C.1: Reword physical disability criteria as determined by the DHCFP’s physician consultant.

1C.12: Added denial reason of failing to provide medical documentation within 45 days.

1C.13: Added denial reason for environmental adaptations as the annual limit is reached.

1C.14: Added denial reason for environmental adaptations as not meeting medical necessity to prevent institutionalization.

1C.15: Added denial reason that the landlord has not approved requested adaptation or modification.

1C.16: Added denial reason that needs can be met by a legally responsible individual.

When a recipient is terminated, they must be given a NOD indicating the reason for the termination. Reworded paragraph.

2304.1D Hearings – Termination of Waiver Services

1D.2: Added as determined by the DHCFP’s physician consultant.

1D.6: Removed this reason as it is not used for a termination reason.

1D.13: Added termination reason that needs can be met by legally responsible individual.

When a recipient is terminated, they must be given a NOD indicating the reason for the termination. Reworded paragraph.

2304.1E Hearings – Reduction of Waiver Services

1E.1: Changed wording, added authorized, removed which were previously provided.

1E.2: Changed provided to authorized.

1E.3: Removed this reduction reason as it is not used.

1E.4: Removed this reduction reason as it is a termination reason, not a reduction reason.

1E.8: Removed this reason as it is confusing to staff and not a reduction reason.

1E.6: Reworded for clarity.

1E.7: Added reduction reason that needs can be met by legally responsible individual.

2304.2.A **Hearings –
Reauthorization
within 90 Days of
Waiver
Termination**

Clarified process for reauthorization of individuals who are terminated from waiver services who become inpatients in a hospital or nursing facility. If the individual is released within 90 days, they can be reinstated to the waiver.

Clarified the items the case manager needs for the reinstatement.

2304.2.B **Hearings –
Reauthorizations
within 90 Days of
Waiver
Termination -**

Clarified once 90 days has past, and the individual requests reinstatement, they are treated like a new referral and placed on the wait list by priority.

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2300 INTRODUCTION

The Home and Community Based Waiver (HCBW) **for Persons with Physical Disabilities** recognizes many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes and communities, preserving independence and ties to family and friends at a cost no higher than institutional care.

The Division of Health Care Financing and Policy's (DHCFP) HCBW for Persons with Physical Disabilities originated in 1990. Waiver service provision is based on the identified needs of waiver recipients. Nevada is committed to the goal of integrating persons with disabilities into the community. Nevada understands persons with disabilities are able to lead satisfying and productive lives, and are able to self-direct care when provided needed services and supports to do so.

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2301 AUTHORITY

Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. The **Division of Health Care Financing and Policy's (DHCFP) Home and Community Based Waiver (HCBW)** for Persons with Physical Disabilities is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The waiver is designed to provide to eligible Medicaid waiver recipients State Plan Services and certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings, when appropriate.

Nevada has the flexibility to design this waiver and select the mix of waiver services best meeting the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support, as well as federal approval.

Statutes and Regulations

- Social Security Act: 1915 (c)
- Social Security Act: 1916 (e)
- Social Security Act: 1902 (w)
- Omnibus Budget Reconciliation Act of 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- State Medicaid Manual, Section 44442.3.B.13
- State Medicaid Director Letter (SMDL) #01-006 attachment 4-B
- Title 42, Code of Federal Regulations (CFR) Part 441, subparts G
- 42 CFR Part 431, Subpart E
- 42 CFR Part 431, Subpart B
- 42 CFR 489, Subpart I

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- Nevada’s Home and Community Based Waiver Agreement for People with Physical Disabilities Nevada Revised Statutes (NRS) Chapter 449, 706, 446, 629, 630, 630a, and 633
- Nevada Administrative Code (NAC) Chapters 441A.375 and 706.

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2303 POLICY

2303.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management occurs prior to an applicant being determined eligible for a waiver and during a re-evaluation or reassessment of eligibility. Administrative case management may only be provided by qualified staff.

2303.1A COVERAGE AND LIMITATIONS

Administrative case management activities include:

1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance for the Aged, Blind and Disabled (MAABD) application and obtaining documents required for eligibility determination;
3. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
 - a. The Plan of Care (POC) identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.
 - b. The recipient's Level of Care (LOC), functional status and needs addressed by the POC must be reassessed annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment is to be conducted during a face-to-face visit.
 - c. If services documented on a POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.
4. Issuance of a Notice of Decision (NOD) when a waiver application is denied;
5. Coordination of care and services to collaborate in discharge planning to transition applicants from facilities;

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6. Documentation for case files prior to applicant's eligibility;
7. Case closure activities upon termination of service eligibility;
8. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid Program;
9. Communication of the POC to all affected providers;
10. If attendant care services are medically necessary, the case manager is then responsible for implementation of services and continued authorization of services;
11. Completion of prior authorization form in the Medicaid Management Information System (MMIS).
12. **Travel time to and from scheduled home visits.**

2303.1B ADMINISTRATIVE CASE MANAGEMENT PROVIDER RESPONSIBILITIES

Employees of the Division of Health Care Financing and Policy (DHCFP), Health Care Coordinator (HCC) I, II, or III are qualified Medicaid case managers for the Waiver. Professional or medical licensure recognized by a Nevada Professional State Board, such as social worker, registered nurse, occupational therapist **or** physical therapist is required. A **Licensed Practical Nurse (LPN)** may complete back up case management, operating under a previously developed LOC and POC under the supervision of the primary case manager.

2303.1C RECIPIENT RESPONSIBILITIES

1. Participate in the waiver assessment and reassessment process.
2. Participate in monthly contacts and home visits with the case manager.
3. Together with the waiver case manager, develop and/or review the POC.
4. If services documented on the POC are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the POC as soon as possible.

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2303.2 ELIGIBILITY CRITERIA

The DHCFP Home and Community-Based Waiver (HCBW) for Persons with Physical Disabilities waives certain statutory requirements and offers **Home and Community-Based Services (HCBS)** to eligible recipients to assist them to remain in the community.

2303.2A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care provided in a hospital or **Nursing Facility (NF)**. Recipients on the waiver must meet and maintain **waiver** eligibility requirements for the waiver.

2. Persons with Physical Disabilities Waiver Eligibility Criteria

Eligibility for the HCBW for Persons with Physical Disabilities is determined by the combined efforts of **the** DHCFP and the Division of Welfare and Supportive Services (DWSS).

The following determinations must be made for eligibility **purposes**. Services **will not** be provided unless the applicant is found eligible in all areas:

- a. The applicant must be physically disabled.
 1. Applicants must be certified as physically disabled by the DHCFP Central Office Physician Consultant. Disabling impairments must result from anatomical or physiological abnormalities and must be demonstrable by medically acceptable clinical and laboratory diagnostic techniques and be established by competent medical evidence.
 2. The DHCFP Physician Consultant and other health care professionals (Disability Determination Team) review medical and non-medical documentation, and determine whether an applicant qualifies as physically disabled.
- b. The applicant must meet **and maintain an LOC for admission into an NF within 30 days if HCBW services or other supports were not available**.
 1. The applicant must require provision of at least one **ongoing** waiver service monthly to be determined to need waiver services as documented in the POC.
- c. **Applicants must meet financial eligibility for Medicaid as determined by DWSS.**

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3. The HCBW for Persons with Physical Disabilities is limited, by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are full, **the** DHCFP utilizes a wait list for applicants who have been pre-determined to be eligible for the waiver.
4. Wait List Prioritization
 - a. Nursing facility residents.
 - b. Applicants who have a severe functional disability as defined by **Nevada Revised Statute (NRS)** 426.721 to 731. Applicants must **be dependent or** require assistance **in** the functional areas of eating, bathing and toileting as identified on the LOC screening assessment.
 - c. **All other applicants not listed above.**
5. **The** DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that **the** DHCFP's total expenditure for home and community-based and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed one-hundred percent (100%) of the amount that would be incurred by **the** DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. **The** DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.
6. Waiver services may not be provided while a recipient is an inpatient of an institution.
7. Recipients of the HCBW for Persons with Physical Disabilities who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) **Chapter** 3200 for additional information on hospice services.
8. **HBCS** are not a substitute for natural and informal supports provided by family, friends or other available community resources. **Waiver services alone may not address all of the applicant's identified needs.**
9. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more such programs at the same time. The applicant/recipient must choose one HCBW program and receive services provided by that program.

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2303.2B MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the HCBW for Persons with Physical Disabilities receive all medically necessary Medicaid covered services available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service(s) required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2303.3 WAIVER SERVICES

The DHCFP determines which services will be offered under the HCBW for Persons with Physical Disabilities. Providers and recipients must agree to comply with the requirements for service provision.

2303.3A COVERAGE AND LIMITATIONS

Under the waiver, the following services are covered if identified in the POC as necessary to avoid institutionalization:

1. Case Management;
2. Homemaker Services;
3. Chore Services;
4. Respite;
5. Environmental Accessibility Adaptations;
6. Specialized Medical Equipment and Supplies;
7. Personal Emergency Response System (PERS);
8. Assisted Living Services;
9. Home Delivered Meals; and/or
10. Attendant Care Services.

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2303.3B PROVIDER RESPONSIBILITIES

1. All Providers

- a. Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering service.
- b. Providers must meet and comply with all provider requirements as specified in **MSM** Chapter 100.
- c. Must enroll and maintain an active HCBW for Persons with Physical Disabilities provider number (type 58).
- d. May only provide services that have been identified in the recipient POC and, if required, have prior authorization.
- e. **The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.**
- f. Payments will not be made for services provided by a recipient's legally responsible individual.
- g. **All waiver services must be prior authorized.**

2. Provider Agencies

- a. Agencies employing providers of service for the waiver program must arrange training in at least the following subjects:
 1. policies, procedures and expectations of the contract agency relevant to the provider, including recipient's and provider's rights and responsibilities;
 2. procedures for billing and payment, **if applicable**;
 3. record keeping and reporting;

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4. information about the specific disabilities of the persons to be served and, more generally, about the types of disabilities among the populations the provider will serve, including physical and psychological aspects and implications, types of resulting functional deficits, and service needs;
5. recognizing and appropriately responding to medical and safety emergencies;
6. working effectively with recipients including: understanding recipient direction and the independent living philosophy; respecting consumer rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; confidentiality; respecting personal property; active listening and responding; emotional support and empathy; ethics in dealing with the recipient, legally responsible individual and other providers; handling conflict and complaints; dealing with death and dying; and other topics as relevant.
7. Exemptions from Training
 - a. The agency may exempt a prospective service provider from those parts of the required training where the agency verifies the person possesses adequate knowledge or experience, or where the provider's duties will not require the particular skills.
 - b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's and caregiver's case record. Where the recipient or other private third party functions as the employer, such individuals may exercise the exemption authority identified above.
8. Recipients Providing Training
 - a. Where a recipient desires to provide training and the recipient is able to state and convey his/her needs to a caregiver, the agency will allow the recipient to do so.
 - b. Any such decision shall be agreed to by the recipient and documented in the case record as to what training the recipient is to provide.
 - c. Where the recipient or other private third party functions as the employer such individual may exercise the exemption from training authority identified above.

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9. Completion and Documentation of Training

The provider shall complete required training within six months of beginning employment. Training as documented in the MSM 2303.2 B.2.b., except for the service areas requiring completion of Cardiopulmonary Resuscitation (CPR) (as listed in the specific service area sections of this chapter) which should be completed in a six month timeframe, and 2303.2 B.2.b.(6-8), which must be completed prior to service provision.

10. Each provider agency must have a file for each recipient. In the recipient's file, the agency must maintain the daily records. Periodically, the DHCFP Central Office staff may request this documentation to compare to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.

11. Flexibility of service delivery which does not alter medical necessity may occur within a single week period without an additional authorization. **Reference Section 2303B.e.**

c. **All waiver providers** must provide the local DHCFP **District Office** Waiver Case Manager with written notification of serious occurrences involving the recipient within 24 hours of discovery.

Serious occurrences include, but are not limited to the following:

1. Unplanned hospital **or Emergency Room (ER) visit**;
2. **Injury or fall requiring medical intervention**;
3. **Alleged physical, verbal, sexual abuse** or sexual **harrassment**;
4. **Alleged theft or exploitation**;
5. **Medication error**;
6. Death of the recipient **or significant care giver**; or
7. Loss of contact with the recipient for three consecutive scheduled days.

d. State law requires that persons employed in certain capacities must make a report to a child protective service agency or law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect a child has been abused

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or neglected. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults aged 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

1. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.
 2. Elder Abuse - Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.
 3. Other Age Groups - For all other individuals or vulnerable persons (NRS 200.5091 to 200.50995) defined as “a person 18 years of age or older who:
 - a. suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or
 - b. has one or more physical or mental limitations that restrict the ability of the person to perform the normal **ADLs**” contact local law enforcement agencies.
- e. **Before initial employment, an employee must have a:**
1. **Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active Tuberculosis (TB) and any other communicable disease in a contagious stage; and**
 2. **TB screening test within the preceding 12 months, including persons with a history of Bacillus Calmett-Guerin (BCG) vaccination.**

If the employee has only completed the first step of a 2-step Mantoux Tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux Tuberculin skin test or other single-step TB screening test must be administered. A single annual TB screening test must be administered thereafter. An employee who tests positive to either of the 2-step Mantoux Tuberculin skin tests must obtain a chest x-ray and medical evaluation for active TB.

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An employee with a documented history of a positive TB screening test is exempt from skin testing and chest x-rays unless he/she develops symptoms suggestive of active TB.

An employee who is exempt from skin testing and chest x-rays must submit to an annual screening for signs and symptoms of active disease which must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file. The annual screening must address each of the following areas of concern and must be administered and/or reviewed by a qualified health care professional.

1. Has had a cough for more than 3 weeks;
2. Has a cough which is productive;
3. Has blood in his/her sputum;
4. Has a fever which is not associated with a cold, flu or other apparent illness;
5. Is experiencing night sweats;
6. Is experiencing unexplained weight loss; or
7. Has been in close contact with a person who has active TB.

Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.

Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results, and maintained in the employee's file. Any lapse in the required timelines above results in non-compliance with this Section.

In addition, providers must also comply with the TB requirements outlined in Nevada Administrative Code (NAC) 441A.375 and 441A.380.

- f. All waiver providers, including owners, officers, administrators, managers, employees (who have direct contact with recipients) and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon enrollment as a provider and then at a minimum of every five years thereafter to

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ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.

1. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.
2. Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the Health website at: http://health.nv.gov/HCQC_CriminalHistory_Fingerprints.htm.
3. The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):
 1. murder, voluntary manslaughter or mayhem;
 2. assault with intent to kill or to commit sexual assault or mayhem;
 3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
 4. abuse or neglect of a child or contributory delinquency;
 5. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in NRS 454;
 6. a violation of any provision of NRS 200.700 through 200.760;
 7. criminal neglect of a patient as defined in NRS 200.495;
 8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
 9. any felony involving the use of a firearm or other deadly weapon;
 10. abuse, neglect, exploitation or isolation of older persons;
 11. kidnapping, false imprisonment or involuntary servitude;
 12. any offense involving assault or battery, domestic or otherwise;

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13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
14. conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; or
15. any other offense that may be inconsistent with the best interests of all recipients.

- g. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An “undecided” result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: <http://dps.nv.gov> under Records and Technology.

2303.3C RECIPIENT RESPONSIBILITIES

The recipient or the recipient’s authorized representative will:

1. notify the provider(s) and case manager of a change in Medicaid eligibility.
2. notify the provider(s) and case manager of changes in medical status, service needs, address, and location, or of changes of status of legally responsible individual(s) or authorized representative.
3. treat all staff and providers appropriately.
4. if capable, sign the provider daily record to verify services were provided.
5. notify the provider when scheduled visits cannot be kept or services are no longer required.
6. notify the provider agency of missed visits by provider agency staff.
7. notify the provider agency of unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver.
8. furnish the provider agency with a copy of their Advance Directives.
9. establish a back-up plan in case a waiver attendant is unable to work at the scheduled time.

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10. not request a provider to work more than the hours authorized in the service plan.
11. not request a provider to work or clean for a non-recipient, family, or household members.
12. not request a provider to perform services not included in the care plan.
13. contact the case manager to request a change of provider.
14. sign all required forms.

Recipients must meet and maintain all criteria to be eligible, and to remain on the HCBW for Persons with Physical Disabilities.

Recipient may have to pay patient liability. Failure to pay is grounds for termination from the waiver.

2303.3D DIRECT SERVICE CASE MANAGEMENT

Direct Service Case Management is limited to eligible participants enrolled in HCBW services program, when case management is identified as a service on the POC. The recipient has a choice to have direct service case management services provided by qualified state staff or qualifying provider agency staff.

2303.3E COVERAGE AND LIMITATIONS

These services include:

1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as needed medical, social, educational and other services regardless of the funding source;
2. Coordination of multiple services and/or providers;
3. Monitoring the overall provision of waiver services, in an effort to protect the safety and health of the recipient and to determine that the POC goals are being met;
4. Monitoring and documenting the quality of care through monthly contact:
 - a. The direct service case manager must have a monthly contact with each waiver recipient and/or the recipient's authorized representative; this may be a telephone contact. At a minimum, there must be a face-to-face visit with each recipient once every **six** months. More contacts may be made if the recipient has indicated a

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significant change in his or her health care status or is concerned about his or her health and/or safety.

- b. When recipient service needs increase, due to a temporary condition or circumstance, the direct service case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.
- c. During the monthly contact, the direct service case manager monitors and documents the quality of care of the recipient. Quality of care includes the identification, remediation and follow-up of health and safety issues, needs and concerns of the recipient, waiver service satisfaction and whether the services are promoting goals stated in the POC. The direct service case manager also assesses the need for any change in services or providers and communicates this information to the administrative case manager.

NOTE: If a recipient has an independent contractor, the direct service case manager may review the recipient daily record for completion and accuracy. The case manager will provide training to independent contractors in the completion and use of daily records if needed.

- 5. Making certain that the recipient retains freedom of choice in the provision of services;
- 6. Notifying all affected providers of changes in the recipient’s medical status, service needs, address, and location, or of changes of the status of legally responsible individuals or authorized representative;
- 7. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient;
- 8. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
- 9. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency; and
- 10. Case Managers must provide recipients with appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an “as needed” service. Case managers must continue to have monthly contact with recipients and/or the recipients authorized representative of at

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least 15 minutes, per recipient, per month. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

2303.3F DIRECT SERVICES CASE MANAGEMENT PROVIDER RESPONSIBILITIES

Verification of compliance with these administrative requirements must be provided:

1. A fixed business landline telephone number published in a public telephone directory.
2. A business office accessible to the public during established and posted business hours.

Employees of the case management provider agency who provide direct service case management services must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensed as a Registered Nurse by the State of Nevada Board of Nursing, or have a professional license or certificate in a medical specialty applicable to the assignment, have at least one year experience as a case manager and must have a valid driver's license. Employees must pass a State and FBI criminal background check. In addition, providers must meet and comply with all provider requirements as specified in **MSM** Chapters 100 and/or 3500.

2303.3G RECIPIENT RESPONSIBILITIES

1. Participate in the waiver assessment, monthly contacts and reassessment process, accurately representing his or her skill level needs, wants, resources, and goals.
2. Together with the waiver case manager, develop and/or review and sign the POC. If the recipient is unable to provide a signature due to intellectual and/or physical limitations, this will be clearly documented in the recipient file. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record.
3. Choose to have direct service case management provided by qualifying state staff or qualifying provider agency staff.

2303.4 HOMEMAKER SERVICES

2303.4A COVERAGE AND LIMITATIONS

1. Homemaker services are provided by individuals or agencies under contract with **the** DHCFP.
2. Homemaker services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage the home.
3. **The** DHCFP is not responsible for replacing goods damaged in the provision of service.

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Homemaker services include:

- a. general cleaning, including mopping floors, vacuuming, dusting, cleaning the stove, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, keeping bathrooms and the kitchen clean, and washing windows as high as the homemaker can reach while standing on the floor;
 - b. shopping for food and needed supplies;
 - c. planning and preparing varied meals, considering both cultural and economic standards of the recipient, preparing tray meals when needed, and preparing special diets under medical supervision;
 - d. washing, ironing and mending the recipient's personal laundry. The recipient pays any laundromat and/or cleaning fees;
 - e. assisting the recipient and legally responsible individuals or caregivers in learning a homemaker routine and skills, so the recipient may carry on normal living when the homemaker is not present;
 - f. accompanying the recipient to homemaker activities such as shopping or the laundromat. **Any transportation to and from these activities is not reimbursable as a Medicaid expense;**
 - g. routine clean-up after up to **two** household pets. **Walking a pet is not included unless it is a service animal.**
4. Activities the homemaker shall not perform and for which Medicaid will not pay include, but are not limited to the following:
- a. transporting (as the driver) the recipient in a private car;
 - b. cooking and cleaning for the recipient's guests, other household members, or for entertaining;
 - c. repairing electrical equipment;
 - d. ironing sheets;
 - e. giving permanents, dying or cutting hair;
 - f. accompanying the recipient to social events;

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- g. washing walls;
- h. moving heavy furniture, climbing on chairs or ladders;
- i. purchasing alcoholic beverages which were not prescribed by the recipient's physician;
- j. doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow covered areas, and vehicle maintenance.

2303.4B HOMEMAKER PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, please reference section 2303.3B of this chapter regarding Provider Responsibilities.

- 1. Providers are required to arrange and receive training related to household care, including good nutrition, special diets, meal planning and preparation, shopping information, housekeeping techniques, and maintenance of a clean, safe and healthy environment.
- 2. A legally responsible individual may not be paid for homemaker services.
- 3. **The** DHCFP is not responsible for replacement of goods damaged in the provision of service.

2303.5 CHORE SERVICES

2303.5A COVERAGE AND LIMITATIONS

- 1. This service includes heavy household chores such as:
 - a. cleaning windows and walls;
 - b. shampooing carpets;
 - c. tacking down loose rugs and tiles;
 - d. moving heaving items;
 - e. minor home repairs;
 - f. removing trash and debris from the yard; **and**
 - g. packing and unpacking boxes.

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2. Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payer is capable of, or responsible for, their provision and without these services the recipient would be at risk of institutionalization. This is not a skilled, professional service.
3. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver program covered services.

2303.5B CHORE SERVICES PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Provider Responsibilities.

Persons performing heavy household chores and minor home repair services need to maintain the home in a clean, sanitary, and safe environment.

2303.6 RESPITE CARE

2303.6A COVERAGE AND LIMITATIONS

1. Respite care is provided for relief of the primary **unpaid** caregiver.
2. Respite care is limited to 120 hours per waiver year per individual.
3. Respite care is only provided in the individual's home or place of residence.

2303.6B RESPITE CARE PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Provider Responsibilities.

1. Respite providers must:
 - a. perform general assistance with ADLs and IADLs and provide supervision to functionally impaired recipients in their homes to provide temporary relief for a primary caregiver;
 - b. have the ability to read and write and to follow written or oral instructions;

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- c. have had experience and or training in providing the personal care needs of people with disabilities;
- d. meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM **Chapter** 2600 if a respite provider is providing attendant care services that are considered skilled services;
- e. demonstrate the ability to perform the care tasks as prescribed;
- f. be tolerant of the varied lifestyles of the people served;
- g. identify emergency situations and act accordingly, including completion of CPR certification which may be obtained outside the agency;
- h. have the ability to communicate effectively and document in writing services provided;
- i. maintain confidentiality regarding details of case circumstances;
- j. arrange training in personal hygiene needs and techniques for assisting with **ADLs**, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking and household care.

2303.7 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

2303.7A COVERAGE AND LIMITATIONS

- 1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient. Adaptations must be prior authorized and are subject to legislative budget constraints.
- 2. All services, modifications, improvements or repairs must be provided in accordance with applicable state or local housing and building codes.
- 3. Excluded Adaptations
 - a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

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- b. Adaptations which increase the total square footage of the home except when necessary to complete an adaptation, for example, in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair.

2303.7B ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS PROVIDER RESPONSIBILITIES

1. All agencies contracting with **the** DHCFP who provide environmental accessibility adaptation assessments will employ persons who have graduated from an accredited college or university in Special Education, rehabilitation, rehabilitation engineering, occupational or speech therapy or other related fields and who are licensed to practice if applicable and have at least one year experience working with individuals with disabilities and their families or graduation from high school and three years experience working with individuals with disabilities and their families as a technologist and possess a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) Technology Certification.
2. All sub-contractors must be licensed or certified if applicable. Modifications, improvements or repairs must be made in accordance with local and state housing and building codes.
3. Durable **Medical Equipment (DME)** providers must meet the standards to provide equipment under the Medicaid State Plan Program.

2303.8 SPECIALIZED MEDICAL EQUIPMENT **AND SUPPLIES**

2303.8A COVERAGE AND LIMITATIONS

1. Specialized medical equipment and supplies are those devices, controls, or appliances specified in the plan of care that enable recipients to increase their abilities to perform ADLs.
2. This service also includes devices, controls, or applications which enable the recipient to perceive, control, or communicate with the environment in which they live; items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.
3. Items reimbursed with waiver funds shall be, in addition to any medical equipment and supplies, furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient.

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4. All items shall meet applicable standards of manufacture, design, and installation and where indicated, will be purchased from and installed by authorized dealers.

5. Vehicle Adaptations

All modifications and equipment must be purchased from authorized dealers, meet acceptable industry standards, and have payment approved by the case manager.

6. Assistive Technology

All equipment must be purchased from authorized dealers when appropriate. Equipment must meet acceptable standards (e.g., Federal Communications Commission (FCC) and/or Underwriter's Laboratory requirements when applicable, and requirements under the Nevada Lemon Law NRS 597.600 to 597.680).

7. Supplies

Supplies must be purchased through a provider enrolled to provide such services under the existing state Medicaid plan or as otherwise approved by the DHCFP for services under this waiver.

2303.8B SPECIALIZED MEDICAL EQUIPMENT PROVIDER RESPONSIBILITIES

Providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DME, Prosthetic Devices, Orthotic Devices, and Disposable Medical Supplies (DMEPOS). Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements.

2303.9 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

2303.9A COVERAGE AND LIMITATIONS

1. PERS is an electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a landline and programmed to signal a response center once the "help" button is activated.

2. PERS services are limited to those recipients who live alone, who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

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3. The waiver service pays for the device rental and funds ongoing monitoring on a monthly basis.

2303.9B PERS PROVIDER RESPONSIBILITIES

1. The provider must provide documentation showing tax identification number.
2. The provider is responsible for ensuring that the response center is staffed by trained professionals at all times.
3. The provider is responsible for any replacement or repair needs that may occur.
4. Providers of this service must utilize devices that meet FCC standards, Underwriter's Laboratory standards or equivalent standards.
5. Providers must inform recipients of any liability the recipient may incur as a result of the recipient's disposal of provider property.

2303.9C RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.
2. The recipient must return the equipment to the provider when it is no longer needed or utilized, when the recipient terminates from the waiver program, or when the recipient moves out of state.
3. The recipient may not throw away the PERS equipment. This is leased equipment and belongs to the PERS provider.

2303.10 ASSISTED LIVING SERVICES

2303.10A COVERAGE AND LIMITATIONS

1. Assisted living services are all inclusive services furnished by the assisted living provider. Assisted living services are meant to provide all support services needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/ transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility. Services provided by a third party must be coordinated with the assisted living facility. This service

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may include skilled or nursing care to the extent permitted by state law. Nursing and skilled therapy services are incidental, rather than integral to the provision of assisted living services. Payment is not to be made for 24 hour skilled care. If a recipient chooses assisted living services, other individual waiver services may not be provided, except case management services.

2. The service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way promoting maximum dignity and independence, and to provide supervision, safety and security.
3. Assisted living providers are expected to furnish a full array of services except when another Federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living provider, but the care provided by other entities supplements that provided by the assisted living provider and does not supplant it.
4. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep and improvement.

2303.10B ASSISTED LIVING PROVIDER RESPONSIBILITIES

1. The assisted living environment must evidence a setting providing:
 - a. living units that are separate and distinct from each other;
 - b. a central dining room, living room or parlor and common activity center(s) except in the case of individual apartments;
 - c. 24 hour on-site response staff.
2. All persons performing services to recipients from this category must have criminal history clearances obtained from the FBI through the submission of fingerprints to the FBI. In addition, provider agencies are required to conduct routine screenings on all applicants who will perform services to recipients to ensure the health and welfare of recipients and to make every effort possible to prevent recipient abuse. Reference Section 2303.3B2.d.
3. Providers must arrange training in personal hygiene needs and techniques for assisting with **ADLs** such as bathing, dressing, grooming, skin care, transfer, ambulation, exercise, feeding, use of adaptive aids and equipment, identifying emergency situations and how to act accordingly.

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4. Must have current CPR certification which may be obtained outside the agency prior to initiation of services to a Medicaid recipient.
5. Caregiver Supervisors will:
 - a. possess at least one year of supervisory experience and a minimum of two years experience working with adults with physical disabilities, including traumatic brain injury.
 - b. demonstrate competence in designing and implementing strategies for life skills training and independent living.
 - c. possess a bachelor's degree in a human service field preferably, or education above the high school level combined with the experience noted in paragraph (a) above.

Supporting Qualifications of the Caregiver Supervisor are:

1. experience in collecting, monitoring, and analyzing service provision; ability to identify solutions and satisfy staff/resident schedules for site operations.
 2. ability to interpret professional reports.
 3. knowledge of life skills training, personal assistance services, disabled advocacy groups, accessible housing, and long-term care alternatives for adults with physical disabilities and/or traumatic brain injuries.
 4. dependable, possess strong organization skills and have the ability to work independent of constant supervision.
6. Assisted Living Attendants

Assisted living attendants shall provide personal care services, community integration, independent living assistance, and supervisory care to assist the recipient in following the POC. Assisted living attendants shall possess:

 - a. a high school diploma or GED.
 - b. some post-secondary educational experience is desired.
 - c. a minimum of two positive, verifiable employment experiences.
 - d. two years of related experience is desired.

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- e. job experience demonstrating the ability to teach, work independently without constant supervision, and demonstrating regard and respect for recipients and co-workers.
- f. verbal and written communication skills.
- g. the ability to handle many details at the same time.
- h. the ability to follow-through with designated tasks.
- i. knowledge in the philosophy and techniques for independent living for people with disabilities.
- j. if the attendant is providing attendant care services, that include skilled services, the attendant must meet the requirements of NRS 629.091.
- k. a current CPR certificate.

7. Supporting Qualifications of the assisted living attendant are:

- a. dependability, able to work with minimal supervision;
- b. demonstrates problem solving ability;
- c. the ability to perform the functional tasks of the job.

2303.11 HOME DELIVERED MEALS

2303.11A COVERAGE AND LIMITATIONS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

- 1. Home delivered meals must be prepared by an agency, and be delivered to the recipient's home.
- 2. Meals provided by or in a child foster home, adult family home, community based residential facility, or adult day care are not included, nor is meal preparation.

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3. The direct purchase of commercial meals, frozen meals, Ensure, or other food or nutritional supplements is not allowed under this service category.
4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient. More than one provider may be used to meet a recipient's need.
5. Case managers determine the need for this service based on a Standardized Nutritional Profile, or assessment, and by personal interviews with the recipient related to individual nutritional status.
6. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 and 1/3 percent of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.
7. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2303.11B HOME DELIVERED MEALS PROVIDER RESPONSIBILITIES

1. Meals are provided by governmental or community providers who meet the requirements of a meal provider under NRS 446 and who **are enrolled** with the DHCFP **as a Medicaid Provider**.
2. Pursuant to NRS 446: All nutrition sites which prepare meals must have a Food Service Establishment Permit as follows:
 - a. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in **NAC**, Chapter 446, or local health code regulations.
 - b. All kitchen staff must hold a valid health certificate if required by local health ordinances.
 - c. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the DHCFP **District Office** case manager by the next business day.
3. All employees must pass State/FBI background checks.
4. Provide documentation of taxpayer identification number.

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2303.12 ATTENDANT CARE

2303.12A COVERAGE AND LIMITATIONS

Extended State plan personal care attendant 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 **services** 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.

1. Where possible and preferred by the recipient, he/she will direct his/her own service **through** an Intermediary Services Organization (ISO). **Refer to MSM Chapter 2600.** When the recipient recruits and selects a caregiver, the individual is referred to the **ISO** for hire. The recipient may also terminate the assistant. When utilizing **this option**, the recipient will work with his/her case manager to identify an appropriate back up plan. **If this option is not used, the recipient will choose a provider agency that** will otherwise recruit, screen, schedule assistants, provide backup and assurance of emergency assistance.
2. Extended personal care attendant services in the recipient's plan of care may include assistance with:
 - a. eating;
 - b. bathing;
 - c. dressing;
 - d. personal hygiene;
 - e. ADLs;
 - f. 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.
3. Flexibility of Services

Flexibility of service delivery which does not alter medical necessity may occur within a

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single week period without an additional authorization. **Reference 2303.3B.1.e of this chapter.**

2303.12B ATTENDANT CARE PROVIDER RESPONSIBILITIES

In addition to the following requirements listed, reference Section 2303.3B of this Chapter regarding Individual Provider Responsibilities.

1. Personal care attendants may be members of the individual's family. However, payment will not be made for services furnished by legally responsible individuals.
2. When the provision of services includes an unskilled provider completing skilled care, qualifications and requirements must be followed as in NRS 629.091, and MSM Chapter 2600.
3. Providers must demonstrate the ability to:
 - a. perform the care tasks as prescribed;
 - b. identify emergency situations and to act accordingly, including CPR certification which may be obtained outside the agency;
 - c. maintain confidentiality in regard to the details of case circumstances; and
 - d. document in writing the services provided.
4. Provider Agencies must arrange training in:
 - a. procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)
 - b. personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
 - c. home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques and maintenance of a clean, safe and healthy environment.

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2303.13 PROVIDER ENROLLMENT/TERMINATION

All providers must comply with all **the** DHCFP provider enrollment requirements, provider responsibilities/qualifications, and **the** DHCFP provider agreement limitations. Provider non-compliance with all or any of these stipulations may result in Nevada Medicaid's decision to exercise its right to terminate the provider's contract. Refer to MSM Chapter 100 for general enrollment policies.

2303.14 INTAKE PROCEDURES

The DHCFP developed procedures to ensure fair and adequate access to services covered under the HCBW for Persons with Physical Disabilities.

2303.14A COVERAGE AND LIMITATIONS

1. Slot Provisions

- a. The allocation of waiver slots is maintained **statewide based on priority and referral date. Slots are allocated by priority based on the earliest referral date.**
- b. **Recipients must be terminated from the waiver when they move out of state, fail to cooperate with program requirements, or request termination; their slot may be given to the next person on the waitlist.**
- c. When a recipient **is** placed in an **NF** or hospital, **they must be sent a NOD terminating them from the waiver 45 days from admit date. Their waiver slot must be held for 90 days from the NOD date. They may be placed back in that slot if they are released within 90 days of the NOD date and request reinstatement. They must continue to meet program eligibility criteria. After 90 days, their slot may be given to the next individual on the waitlist.**

2. Referral **Pre**-Screening

- A. A referral or inquiry for the waiver may be made by the potential applicant or by another party on behalf of the potential applicant by contacting the local DHCFP **District Office. The DHCFP District Office** staff will discuss waiver services, including the eligibility requirements, with the referring party or **potential** applicant.
- B. **If the case manager determines the applicant does not appear to meet the waiver criteria, the individual may proceed with the application process if they choose to. Once the application is denied, they will receive a NOD which includes the right to a fair hearing. The case manager will provide referrals to other community**

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resources.

- C. If the case manager determines the applicant does appear to meet waiver criteria, a face-to-face home visit is scheduled to conduct an LOC screening and medical records are obtained for a disability determination.

NOTE: If the applicant does not meet LOC, they will receive a NOD which includes the right to a fair hearing.

3. Placement on the Wait List

- A. All applicants who meet program criteria must be placed on the statewide waitlist by priority and referral date. The following must be completed prior to placement on the waitlist.

1. The applicant must meet LOC criteria for placement in an NF.
2. The applicant must require at least one ongoing waiver service.
3. The applicant must be certified as physically disabled by Medicaid's Central Office Disability Determination Team.
4. Applicants must be sent a NOD indicating "no slot available".

4. Waiver Slot Allocation

Once a slot for the waiver is available, the applicant will be assigned a waiver slot and be processed for the waiver.

a. Intake:

1. The DHCFP District Office staff will schedule a face-to-face home visit with the recipient to complete the full waiver assessment.
2. The case manager will obtain all applicable forms, including the Authorization for Release of Information Form.

The applicant or designated representative must understand and agree that personal information may be shared with providers of services and others, as specified on the form.

The case manager will provide an application to apply for Medicaid benefits through the DWSS. The recipient is responsible for completing the

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application and submitting all requested information to the DWSS. The case manager will assist upon request.

3. The applicant is given the right to choose waiver services in lieu of placement in an **NF**. When the applicant or designated legal representative prefers placement in an **NF**, the case manager will assist the applicant in arranging for facility placement.
4. The applicant is given the right to request a hearing if not given a choice between **HCBS** and **NF** placement.
5. When the applicant is approved for the waiver:
 - a. A written POC is developed in conjunction with the recipient by the **DHCFP District Office** case manager for each recipient under the waiver. The POC is based on the assessment of the recipient's health and welfare needs.
 - b. The recipient or **representative is included** in the development of the POC.
 - c. The POC is subject to the approval of the DHCFP's Central Office Waiver Unit.
 - d. Recipients are given free choice of all qualified Medicaid providers for each Medicaid covered service included in the POC. Current POC information as it relates to the services provided must be given to all service providers.
6. All forms must be complete with signature and dates when required.
7. If an applicant is denied waiver services, the case manager sends the NOD.

5. Effective Date For Waiver Services

The effective date for waiver services approval is the completion date of all the intake forms and the Medicaid **determination** date **made by the DWSS**, whichever is later. When the recipient resides in an institution, the effective date cannot be prior to the date of discharge from the institution.

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6. Waiver Costs

The DHCFP must assure CMS the average per capita expenditures under the waiver do not exceed 100% of the average per capita expenditures for the institutional level of care under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2303.15 BILLING PROCEDURES

The DHCFP must assure CMS all claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service(s) are identified on the approved POC, and if the service(s) has been prior authorized.

2303.15A COVERAGE AND LIMITATIONS

Provider Type 58, HCBW for Persons with Physical Disabilities, must complete the CMS 1500 for payment of waiver services. Incomplete or inaccurate claims are returned to the provider by the DHCFP's fiscal agent. If the wrong form is submitted it is also returned to the provider by the DHCFP's fiscal agent.

2303.15B PROVIDER RESPONSIBILITY

Providers must submit claims to the DHCFP's QIO-like vendor.

Providers may also refer to the DHCFP's website for a complete list of codes/modifiers billable under Provider Type 58 (select "Rates" from the main menu, then click on Provider Type 58 – HCBW for Persons with Physical Disabilities).

2303.16 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed provider agencies providing personal care aide services to give clients' information regarding each individual's decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM Chapter 100 for further information.

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2303.17 ANNUAL REVIEW

The State has in place a formal system in which an annual review is conducted to assure the health and welfare of the recipients served on the waiver, the recipient satisfaction with the waiver, and assurance of the cost effectiveness of these services.

The state will conduct an annual review; and

1. provide CMS with information on the impact of the waiver. This includes the type, amount, and cost of services provided under the waiver and provided under the State Plan and the health and welfare of the recipients served on the waiver.
2. assure financial accountability for funds expended for **HCBS**.
3. evaluate all provider standards are continuously met and plans of care are periodically reviewed to assure services furnished are consistent with the identified needs of the recipients.
4. evaluate the recipients' satisfaction with the waiver program.
5. **ensure health and welfare of all recipients.**

2303.17A PROVIDER RESPONSIBILITIES

Providers must cooperate with **the** DHCFP's annual review process.

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2304 HEARINGS

2304.1A SUSPENDED WAIVER SERVICES

1. **Recipients must be suspended when they are** admitted to a hospital or **Nursing Facility (NF)**.
2. If the recipient has not been removed from suspended status **45 days from the admit date**, the case must be closed. A **Notice of Decision (NOD) must be sent** identifying the 60th day of **the admit date** as the effective date **for closure**.

2304.1B RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient is released from the hospital, **an NF or other institutional setting, within 60 days of the admit date**, the case manager **must do the following** within 5 working days:

1. complete a new **Level of Care (LOC)**, if there has been a significant change in the recipient's condition;
2. complete a new **Plan of Care (POC)** if there has been a change in services (medical, social, or waiver). When a change in services is expected to resolve in less than 30 days a new POC is not necessary. Documentation of the temporary change must be noted in the case record;
3. contact the service provider(s) to reestablish services.

2304.1C DENIAL OF WAIVER **SERVICES**

Reasons to deny applicant **request** for waiver services:

1. The applicant does not meet **physical disability criteria as determined by the Division of Health Care Financing and Policy (DHCFP)'s physician consultant**.
2. The applicant does not meet the **LOC** criteria for an **NF** placement.
3. The applicant has withdrawn their request for waiver services.
4. The applicant fails to cooperate with the DHCFP Case Manager or **Home and Community Based Services (HCBS)** providers in establishing and/or implementing the POC, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary for all required paperwork).

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5. The applicant's support system is not adequate to provide a safe environment during the time when home and community based services are not being provided.
6. **The** DHCFP has lost contact with the applicant.
7. The applicant fails to show a need for **Home and Community Based Waiver (HCBW)** services.
8. The applicant would not require **NF** placement if **HCBS** were not available.
9. The applicant has moved out of state.
10. Another agency or program will provide the services.
11. The DHCFP **District Office** has filled the number of positions allocated to the HCBW for Persons with Physical Disabilities. The applicant will be approved for the waiver waitlist and will be contacted when a slot is available.
12. **The applicant has failed to provide adequate medical documentation for a disability determination within 45 days of the request.**
13. **The applicant has reached their annual limit for Environmental Adaptations.**
14. **The requested adaption, equipment or supply is not medically necessary to prevent institutionalization.**
15. **The landlord has not approved requested adaption or modification.**
16. **The recipient's needs can be met by a legally responsible individual.**

When **an** application for waiver services is denied the case manager sends a NOD **indicating the reason for denial.**

2304.1D TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver or to terminate the recipient from the waiver wait list:

1. The recipient has failed to pay his/her patient liability.
2. The recipient no longer meets the physical disability criteria **as determined by the DHCFP's physician consultant.**

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3. The recipient no longer meets the **LOC** criteria for **NF** placement.
4. The recipient has requested termination of waiver services.
5. The recipient has failed to cooperate with the DHCFP case manager or **HCBS** providers in establishing and/or implementing the **POC**, implementing waiver services, or verifying eligibility for waiver services. (The recipient's or the recipient's authorized representative's signature is necessary on all required paperwork).
6. The recipient fails to show a continued need for **HCBW** services.
7. The recipient no longer requires **NF** placement if **HCBS** were not available.
8. The recipient has moved out of state.
9. The recipient has submitted fraudulent documentation on Attendant Care provider time sheets and/or forms.
10. Another agency or program will provide the services.
11. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, **NF**, intermediate facility for persons with mental retardation, or incarcerated).
12. **The DHCFP** has lost contact with the recipient.
13. **The recipient's needs can be met by a legally responsible individual.**

When a recipient is terminated from the waiver program, the case manager sends a NOD **indicating the reason for termination**. The **NOD** must be mailed to the recipient at least 13 calendar days before the Date of Action. Refer to **Medicaid Services Manual (MSM)** Chapter 3100 for exceptions to the advance notice.

2304.1E REDUCTION OF WAIVER SERVICES

Reasons to reduce waiver services:

1. The recipient no longer needs the number of service hours **authorized**.
2. The recipient no longer needs the service previously **authorized**.
3. The recipient has requested the reduction of services.
4. The recipient's ability to perform **Activities of Daily Living (ADLs)** has improved.

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5. Another agency or program will provide the service.
6. The recipient fails to cooperate with the waiver service provider.
7. The recipient's needs can be met by a legally responsible individual.

When there is a reduction of waiver services the case manager will send a NOD **indicating the reason for the reduction**. The **NOD** must be mailed to the recipient at least 13 calendar days before the Date of Action.

2304.2 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

- A. If a recipient is placed in an NF or hospital, and waiver services have been terminated, the recipient may request reinstatement within 90 days of the notice date. The case manager must complete the following:
 1. A new LOC;
 2. A **new** Social/ Health Assessment;
 3. The **new** Statement of Understanding; **and**
 4. The **new** POC.
- B. If 90 days from the notice date has elapsed, the slot is allocated to the next person on the waitlist. An individual who requests reinstatement after 90 days from the notice date must be processed as a new referral.

2304.3 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and participant hearings.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 14, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER – 2400 HOME BASED HABILITATION SERVICES

BACKGROUND AND EXPLANATION

Changes, to this chapter, are a result of revisions made to the Social Security Act, specifically the Deficit Reduction Act, Section 6086, 1915(i) Home and Community-Based Services (HCBS) State Plan Services to incorporate 1915(i) HCBS program services and requirements. This revision makes significant changes to the policy which include the use of a standardized tool called The 1915(i) HCBS Universal Needs Assessment Tool to evaluate functional deficits of individuals. It must be completed annually. This chapter will be renamed Home Based Habilitation Services (HBHS), and was previously called Comprehensive Outpatient Rehabilitation Services.

The prior authorization process has been changed to include 1915(i) program services and requirements. This new process extends prior authorizations annually as long as program criteria are met. It still requires an interdisciplinary team to evaluate the recipient every 30 days.

Person centered planning is incorporated into this chapter with the use of an interdisciplinary team approach in the development of a service plan and plan of care.

Additional changes include a change to the definition of HBHS and the services offered. Updated eligibility criteria for Habilitation Services. In order to bring the chapter in line with 1915(i) State Plan Services, the statement “habilitation services” replaces the statement “rehabilitation” throughout the chapter. The goal is to bring the entire chapter in line with “community based habilitation services” and remove “comprehensive rehabilitation services”.

The definitions section is removed from this chapter and placed in the addendum of the Medicaid Services Manual and the references section will be located in Chapter 100 of the Medicaid Services Manual.

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

These changes are effective February 15, 2012.

MATERIAL TRANSMITTED

MATERIAL SUPERSEDED

MTL 01/12
CHAPTER – 2400 HOME BASED
HABILITATION SERVICES

MTL 26/03
CHAPTER – 2400 HOME BASED
HABILITATION SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2400	Introduction	<p>Throughout the chapter, deleted Comprehensive Outpatient Rehabilitation (COR) and changed to Home Based Habilitation Services (HBHS).</p> <p>Deleted outdated language and added new language.</p>
2401	Authority	<p>Deleted outdated language and added new language and correct citations. The citation which interprets and implements this section of the Act is found in the 42 Code of Federal Regulations (CFR), Part 440.130. Statutes and Regulations: Social Security Act: 1915(i)” and references to 42 CFR and NAC.</p>
2402	Definitions	<p>Removed definitions and placed in Addendum.</p>
2403.1	<p>Home Based Habilitation Services (HBHS) Day Treatment Program</p> <p>Coverage and Limitations</p> <p>Home Based Habilitation Services (HBHS) Provider Responsibility</p>	<p>Renamed Comprehensive Day Treatment (CDT) Program to Home Based Habilitation Services (HBHS) Day Treatment Program.</p> <p>Deleted outdated language and added new language to match 1915 (i) requirements for HBHS services.</p> <p>Added updated requirements for HBHS services to incorporate 1915 (i) HCBS program services and requirements.</p> <p>Deleted outdated language throughout section.</p> <p>Clarified provider and staffing requirements, and initial evaluation language.</p> <p>Added the following information:</p> <ul style="list-style-type: none"> • Requirements for background checks and TB testing. • Universal Needs Assessment section. • Service Plan section. • Plan of Care section. • Records Requirements section. • Confidentiality and Release of Recipient

		Records section.
		<ul style="list-style-type: none"> • Provider Liability section. • Notification of Suspected Abuse and Neglect section.
		Removed outdated language throughout section.
	Recipient Responsibility	Clarified language.
	Prior Authorization	Deleted outdated language.
		Added new process requirements.
2403.2	Residential Habilitation Program (RHP)	Clarified Requirements throughout the entire section.
2403.3	Community Re-integration Services (CRS)	Clarified Requirements throughout the entire section.
		Deleted outdated language
		Included reference to the previous section.
2404	Quality Assurance	Added new section.
2405	Hearings	Renumbered section.
		Removed References and Cross Reference section.

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2400 INTRODUCTION

2400.1 **HOME BASED HABILITATION SERVICES (HBHS)**

Home Based Habilitation Services (HBHS) are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury.

HBHS include 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 settings. HBHS are prescribed by a physician and provided by the appropriate qualified staff.

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2401 AUTHORITY

Home Based Habilitation Services (HBHS) is an optional Medicaid State Plan service authorized by the Nevada Medicaid Program under State Plan authority titled Nevada 1915(i) State Plan Home and Community-Based Services (HCBS). The State Plan was amended in 2008 in response to the Deficit Reduction Act, Section 6086. Congress amended the Social Security Act with Section 1915(i) allowing states to provide traditional 1915(c) services as covered State Plan benefits. Home Based Habilitation was covered under Nevada’s State Plan as Comprehensive Outpatient Rehabilitation (COR) Services.

Statutes and Regulations:

- Social Security Act: 1915(i)
- 42 Code of Federal Regulations (CFR) 440.130
- 42 CFR 440.180
- 34 CFR 300.7
- Nevada Administrative Code (NAC) 388.134

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2402 **RESERVED**

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2403 POLICY

2403.1 HOME BASED HABILITATION SERVICES (HBHS) DAY TREATMENT PROGRAM

HBHS include a day treatment program in which services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Services are prescribed by a physician, provided by the appropriate qualified staff and include the following:

- a. Care Coordination.
- b. Adaptive Skill Development.
- c. Assistance with Activities of Daily Living (ADLs).
- d. Community Inclusion.
- e. Transportation (not duplicative of State Plan Non-Emergency Transportation (NET)).
- f. Adult Educational Supports.
- g. Social and Leisure Skill Development.
- h. Physical Therapy.
- i. Speech Therapy.
- j. Occupational Therapy.

Licensed professionals must perform an initial assessment, develop a plan of care, assess the recipient's progress and assume legal responsibility for the services provided.

2403.1A COVERAGE AND LIMITATIONS

1. Admission Criteria for Day Treatment Programs
 - a. The recipient is Medicaid eligible;
 - b. The recipient has a medically verifiable Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI);
 - c. The individual must meet the eligibility requirements of the 1915(i) HCBS Universal Needs Assessment Tool or must qualify for a 1915(c) waiver;

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- d. The recipient has not previously completed a **habilitation** program for the same condition, unless a substantial intervening event has occurred that would require an abbreviated program to maintain community placement. The decision to impose such an exception is the sole determination of **the Division of Health Care Financing and Policy (DHCFP)** and requires supporting medical rationale;
- e. The recipient's functional or cognitive impairment is the result of an illness or injury within the past 90 days, or 90 days from the original inpatient hospitalization, **or directly after continuous outpatient therapy post the original inpatient hospitalization**, or 90 days from Medicaid eligibility determination, or has a chronic illness or injury with recent exacerbation, or complication which resulted in a change in function, or has a more remote injury with recent improvement in condition and/or advancement in technology;
- f. The recipient must be medically stable for intensive habilitation as evidenced by the absence of medical conditions requiring acute medical interventions (e.g., acute infectious process, uncontrolled irregular heartbeat, unstable diabetes mellitus, etc);
- g. The recipient is willing, and demonstrates capacity for endurance for at least **three (3) hours of habilitation services** per day, five **(5)** days per week;
- h. The recipient has a prognosis and potential to increase his or her functional independence towards returning to independent or assisted living after discharge, achievable within a reasonable period of time, as determined by **the DHCFP** or its QIO-like vendor;
- i. The recipient has sufficient mental alertness and is able to actively participate in a complete therapy program on a daily basis;
- j. The recipient is responsive to verbal or visual stimuli and can consistently follow single step commands in a meaningful way; and
- k. The recipient's functional abilities indicate a potential for **improvement**.

2. Covered Services

- a. Day Treatment programs are provided as Full Day – **six (6) hours** per day of habilitative services or as Half Day – a minimum of **three (3) hours** per day. All programs provide **services** five days per week, **or more**, and may occur in the recipient's home, **inpatient settings who provide HBHS services**, outpatient settings or in other community-based settings.

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b. Day treatment programs must meet the following service requirements, when the specialty area is included in the individual plan of care **approved by the primary physician after any needed consultation with the licensed/certified therapy provider (RN, PT, OT, SLP and case manager)**:

1. Physical Therapy **services**: Only a licensed physical therapist has the knowledge, training and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function. **Implementation of a plan of care should** be carried out pursuant to the Practice Act governing physical therapy.
2. Occupational Therapy **services**: Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function. **Implementation of a plan of care** shall be carried out pursuant to the Practice Act governing occupational therapy.
3. Speech-Language Pathology (**SLP**) **services**: Only a SLP has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore, or compensate for lost function. **Implementation of a plan of care** shall be carried out pursuant to the Practice Act governing speech-language pathology.
4. Case Management **services**: Case management **services** must be provided by a licensed nurse or social worker, or Certified Case Manager (CCM), or other licensed individual eligible to apply for certification or who is working under the direct supervision of a CCM, who has the education, skills abilities and experience to perform case management services. The case manager may also need language skills, cultural sensitivity, and acquired knowledge and expertise unique to a geographic area. The case manager coordinates and implements individualized plans of care in conjunction with recipient's families or legal guardians physicians and others involved in the care **of the individual**.
5. Cognitive Therapy **services**:

The provision of **this service** is included as a component of a habilitation program for the severely neurologically impaired individual such as those

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with TB. Other diagnoses that may require cognitive remediation include, but are not limited to, severe Cerebral Vascular Accident (CVA), anoxic injuries, and intracranial hemorrhage. For these diagnoses, as well as with TBI, major impairments exist in arousal or alerting, perception, selective attention, discrimination, orientation, organization, recall and high level thought processes, including convergent thinking, deductive reasoning, inductive reasoning, divergent thinking, and multiprocess reasoning.

6. Therapeutic Recreation **services**: Therapeutic recreation services are included as a component of a habilitation program when **the service is directly related to the plan of care**.
7. Prosthetic/Orthotic **services**: Refer to **Medicaid Services Manual (MSM)** Chapter 1300 for further information and program requirements.
8. Durable Medical Equipment (**DME**): Refer to MSM Chapter 500 for DME coverage guidelines for recipients who reside in or will be discharged to an extended care facility.

3. Non-Covered Services

The following are not covered benefits under **day treatment** programs and therefore are not reimbursable by Nevada Medicaid:

- a. **A maintenance program** is the point at which the recipient demonstrates no further improvement, or the skills of a qualified therapist are not required to carry out an activity to maintain function at the level to which it has been restored;
- b. Duplicative services are not considered medically justified and will not be covered by Medicaid. An inquiry or referral for services does not indicate the necessity for services. If the Medicaid recipient is receiving services from another provider, it is the responsibility of the evaluating provider to determine if additional services are appropriate and request prior authorization as indicated;
- c. Time spent conducting a team conference is included in the established all-inclusive rate and is not a separately billable service;
- d. Pre-Admission screenings completed in order to determine the appropriateness of the recipient for a particular program is considered a cost of doing business and is not a reimbursable visit;

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- e. Admissions or continued stays for evaluation or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services;
- f. Admissions solely for the convenience of the recipient, their family or the provider, are not covered services;
- g. Pain management services, i.e. relaxation techniques, stress management and biofeedback programs;
- h. Day treatment programs are not covered for individuals who have been admitted to an institutional setting such as a hospital, nursing facility or an intermediate care facility; or
- i. Day treatment programs will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including: Federal, State, local and private entities. For habilitation services, the State includes, within the record of each individual, an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

4. Continued Stay Criteria for Day Treatment **Services**

For continued day treatment services, prior authorization must be submitted to **the DHCFP's QIO-like vendor in time to meet processing timelines so an interruption in services may be avoided.** Supporting documentation must be provided, including the most recent team conference report, which demonstrates that the recipient continues to meet admission criteria and continues to:

- a. **demonstrate an ability to actively participate in the program;**
- b. **have documented progression toward written goals; and**
- c. **continue to need the services provided by the day treatment program.**

Services provided without prior authorization are not reimbursable.

5. Discharge Criteria

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

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stay, when further progress toward the established goals is unlikely or further treatment can be achieved in a less intensive setting.

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

- a. The recipient's needs exceed the scope of the day treatment program so transfer to an inpatient hospital or skilled nursing facility is indicated;
- b. The recipient no longer meets the criteria for the day treatment program;
- c. The specialized knowledge and skills of the interdisciplinary team are no longer required;
- d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three (3) consecutive days;
- e. The recipient has reached his or her goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;
- f. There is limited motivation on the part of the recipient or caregiver which is impacting the individual's progress for over one week; or
- g. The established goals serve no purpose to increase functional or cognitive capabilities towards living in a community based setting.

2403.1B HOME BASED HABILITATION SERVICES (HBHS) PROVIDER RESPONSIBILITY

1. Provider Enrollment

- a. Each provider of HBHS must enroll as a Provider Type 55 and enter into the agreement with the DHCFP, through the QIO-like vendor and must submit required licenses, registrations, certificates, etc., upon request, to determine that conditions of participation, as stated in MSM 100, are met.
- b. Home Based Habilitation providers must hold current accreditation, in good standing, by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission accreditation.

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c. Providers must comply with all **Internal Revenue Service (IRS)**, **Federal Insurance Contributions Act (FICA)** and **Occupational Safety and Health Administration (OSHA)**, Local, State, and Federal regulations and applicable statutes.

d. **Criminal Background Checks**

Under Nevada Revised Statutes (NRS) 449.176 through NRS 449.188, people who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at: <http://leg.state.nv.us/NRS/NRS-449.html> and the requirements applying to agencies are discussed at length at the Bureau of Health Care Quality and Compliance (HCQC) website: http://health.nv.gov/HCQC_CriminalHistory.htm.

Agency personnel, including administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure or accreditation and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

Documentation of the request, and applicable results, must be maintained in each employee personnel record and made available to the DHCFP upon request. Employees must have the criminal background check through their State Department of Public Safety (DPS) or initiated by the hiring/employing agency prior to providing any Medicaid reimbursable services to a recipient.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an “undecided” result is received. Documentation must be maintained in the employee’s personnel file and submitted to the DHCFP upon request.

1. The DHCFP or their designee must not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of the DHCFP.
2. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

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- a. If the Provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, the DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.
- b. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in NRS 449.176 through 449.188 and on the HCQC website, the DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency and the DHCFP in writing. Information regarding challenging a disqualification is found on the HCQC website at: http://health.nv.gov/HCQC_CriminalHistory.htm.

NOTE: Out of state providers must obtain background checks through their local DPS.

e. Tuberculosis (TB) Testing

Employees of provider facilities must complete either a QuantiFERON R-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. If the employee tests negative on initial test, prior to the annual expiration of the initial test, they must receive either a QFT-G blood test or a one step TB skin test. Annually, thereafter, as long as the result is negative, prior to the expiration of the year's previous test, a QFT-G blood or a one step TB skin test must be performed. If the employee tests positive on the initial QFT-G blood test or the two step TB skin test (+10 mm induration or larger), or if the employee has a prior history of a positive test, the individual must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient. Annually, thereafter, prior to the date of initial clearance by the chest X-ray, the individual must have documentation which demonstrates no signs or symptoms of active tuberculosis (see Nevada Administrative Code (NAC) 441A.375).

If the employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest x-ray, the employee must have documentation annually which demonstrates they

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are not exhibiting any signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider:

1. Has had a cough for more than three (3) weeks;
2. Has a cough which is productive;
3. Has blood in his sputum;
4. Has a fever which is not associated with a cold, flu or other apparent illness;
5. Is experiencing night sweats;
6. Is experiencing unexplained weight loss; or
7. Has been in close contact with a person who has active tuberculosis. Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening.

Documentation of the annual screening, when required as defined herein, and the results must be maintained in the employee's file.

Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results. Any lapse in the required timelines above will result in a finding of non-compliance with this section.

2. Staffing Requirements

- a. A provider of HBHS must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by licensed/certified professional. Copies of current licensure, certificates, and education must be maintained in employee files.
- b. Habilitation Aides may provide personal assistance services, supervisory care, direction and guidance to assist recipients, following written plan of care and clinical protocols under the direct supervision of the licensed/certified therapy provider.

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Habilitation aides must have:

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

Supporting Qualifications include:

10. dependability, able to work with minimal supervision;
11. demonstrates problem solving ability;
12. the ability to perform the functional tasks of the job; **and**
13. **the** ability to identify emergency situations and act accordingly including **Cardiopulmonary resuscitation (CPR)** certification, which may be obtained outside the agency.

3. **Initial Evaluation**

The intent of **HBHS** is to increase the individual's functional abilities **in order to eventually live in a community setting**. The initial evaluation must contain all of the following information and be signed by the treating physician to be considered for authorization:

- a. Origin and rationale of referral, including a copy of the order;

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- b. The principal and significant associated diagnosis;
- c. Brief history including the date of onset of illness or injury;
- d. Current medical status and confirmation of medical stability;
- e. Current and pre-morbid functional status, including baseline evaluation, prognosis and potential for improvement;
- f. Indication of medical necessity;
- g. Identified barriers;
- h. **Short and long-term goals that are functional, objective and measurable;**
- i. The composition of the team, the plan of care and the duration of the habilitation program;
- j. Summary of any previous **treatment** received and results of such **treatment**;
- k. Anticipated time for completion of the program;
- l. If the recipient is to participate in any group therapy sessions, documentation must include:
 - 1. **the** description of the purpose of the group;
 - 2. **number** of patients and staff members in group;
 - 3. **the** minimum ratio of staff to patients;
 - 4. **duration** on each session; and
 - 5. **the** number of group sessions anticipated per week.
- m. A viable, written discharge plan with appropriate post placement resources, including the identified support system that will facilitate community re-entry.

The proposed plan of **care** must include specific goals, **how those goals will be achieved** and **the duration of achievement**.

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4. Universal Needs Assessment

a. The 1915(i) HCBS Universal Needs Assessment Tool must be used to evaluate and reevaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:

1. the inability to perform 2 or more ADL's;
 - a. Bathing/Dressing/Grooming;
 - b. Mobility;
 - c. Toileting;
 - d. Eating; and/or
 - e. Transferring.
2. cognitive and/or behavioral impairments;
3. medical needs;
4. supervision needs;
5. substance abuse; and/or
6. multiple social service system involvement.

This evaluation must be face-to-face.

b. A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

The individual performing the assessment must be an independent third party and must not be:

1. related by blood or marriage to the individual;
2. any paid caregiver of the individual;

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3. financially responsible for the individual;
4. empowered to make financial or health-related decisions on behalf of the individual; or
5. service providers or individuals or corporations with financial relationships with any providers.

The physician must re-evaluate the recipient's eligibility annually.

5. Service Plan

The service plan is developed by the service provider. An interdisciplinary team will formulate the plan in conjunction with the recipient. The team must include staff trained in person centered planning, and must include a licensed health care professional and may include other individuals who can contribute to the plan development.

The service plan must include the identified need from the Universal Needs Assessment.

The provider must ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. Recipient, family (when appropriate) and/or legal representative participation in treatment planning must be documented on the service plan. The service plan must include a written statement that the recipient was offered a choice of HBHS providers, if applicable, and must be kept in a file maintained for the recipient.

A service plan must be completed and submitted as part of the prior authorization process. The service plan requires pre-approval by the QIO-like vendor prior to authorizing services and must include the description of services, amount of time (hourly, daily, weekly) and the title of the staff that will be providing the specific services.

The recipient must provide a signature on the service plan. 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. A legal representative may sign for the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the plan of care, and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the DHCFP district office and the QIO-like vendor for prior authorization.

Additionally, the DHCFP must review a representative sample of participant service plans each year.

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The Service Plan must be re-evaluated annually or when a significant change occurs.

6. Plan of Care

A plan of care must be initiated on the day of admission to HBHS. The plan of care must be in agreement with the Service Plan, and the 1915(i) HCBS Universal Needs Assessment Tool. The individualized plan of care must be developed and meet the requirement of NAC 449.4088.

The plan of care specifically outlines the services and activities of a recipient and must be available to all staff members providing home based habilitation services.

The Plan of Care:

- a. is developed by the licensed interdisciplinary habilitation team using a person-centered process involving the individual, and where appropriate, the individual's family, caregiver, or representative, and the DHCFP care coordinator;
- b. identifies the necessary services to be furnished to the individual;
- c. includes objectives and directives for HBHS services needed;
- d. takes into account the extent of, and need for, any family or other supports for the individual;
- e. prevents the provision of unnecessary or inappropriate care;
- f. is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- g. is reviewed and updated by the licensed interdisciplinary habilitation team annually or as needed or when there is significant change in the individual's circumstances.

The plan of care must be kept in a file maintained for the recipient and must include a signature of the recipient. 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. A legal representative may sign for the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the plan of care, and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the DHCFP district office and the QIO-like vendor for prior authorization.

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7. Records Requirements

In compliance with NAC 449.40835, the facility must maintain records on each employee.

a. Employee Records must include:

1. finger prints and background results;
2. annual TB tests; and
3. training, required licenses, registrations, and certificates.

In compliance with NAC 449.40835, the facility must maintain records on recipients including daily records and attendance records. All entries made in the recipient's file must be signed and dated by the employee making the entry. The delivery of specific services including those required by Medicaid must be documented in the daily records.

b. Recipient records must include the following:

1. Medicaid Eligibility - The facility must maintain proof of each recipient's Medicaid eligibility. Verification of eligibility is the provider's responsibility. Eligibility should be verified monthly. Refer to MSM Chapter 100 for additional information regarding verification of eligibility.
2. Universal Needs Assessment.
3. Service Plan.
4. Statement indicating recipient made an informed choice in providers.
5. Plan of Care.
6. Attendance Records.
7. Daily Records.
8. Annual TB tests.

The case manager is responsible for maintaining a record for the recipient.

The facility must maintain an accurate record of the recipient's attendance by using an attendance record as defined in the MSM Addendum. The record must also reflect any absence from the facility by the recipient for purposes of obtaining other services must be

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documented. This record is to include date, duration of absence and destination or purpose for absence.

8. Confidentiality and Release of Recipient Records

The facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.

9. Provider Liability

Provider liability responsibilities are included in the Medicaid and Nevada Check Up (NCU) Provider Contract and are incorporated in this chapter by reference.

10. Notification of Suspected Abuse and Neglect

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For adults aged 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

2403.1C RECIPIENT RESPONSIBILITY

1. Medicaid recipients are required to maintain and provide a valid Medicaid eligibility card to their service providers and to notify their providers of any changes to the type of eligibility, or other insurance benefits that may be in effect such as Medicare.
2. Medicaid recipients are expected to comply with and participate in their **development of their plan of care** including making and keeping medical appointments.
3. The recipient is responsible to notify the provider of changes in medical status, service needs address, and location.
4. In accordance with the Health Insurance Portability and Accountability Act (**HIPAA**) of 1996, protected health information may be disclosed for the purposes of treatment, payment, or health care operations without a signed Authorization for Disclosure from the participant or designated representative. However, most other disclosures require authorization. Additional details about allowable uses and disclosures are available to participants in the DHCFP Notice of Privacy Practices, which is provided to all new enrollees.

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Additionally, in accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the Department of Human Resources in the performance of official duties and with local governments that help the Department carry out official duties as long as the disclosure is related to treatment, payment, or health care operations.

2403.1D **PRIOR AUTHORIZATION**

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

1. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.
2. Prior authorizations are specific to a recipient, a provider, a service code, and established quantity of units, and for specific dates of service.
3. Prior authorization is required for all services and must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.
4. **Prior Authorization Process**

HBHS must be prior authorized. The HBHS provider must submit the completed 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of HBHS providers) and all relevant assessments to the QIO-like vendor before services are provided. All prior authorization requests must be complete and accurate. If insufficient information is provided to support the completion of a request, the HBHS provider must supply the needed information within 72 hours of notification. When complete information is submitted, the QIO-like vendor must make a decision within five (5) business days.

In the case when an individual becomes eligible for Medicaid during the course of treatment or after services were provided, the HBHS provider may request a retro-eligible authorization by submitting the completed 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of HBHS providers) and all relevant assessments to the QIO-like vendor.

The retro-eligible request must be submitted within 90 days of the notice of decision from Division of Welfare and Supportive Services (DWSS) on Medicaid eligibility determination. When complete information is submitted, the QIO-like vendor must make a determination within five (5) days.

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The QIO-like vendor must review and provide a determination for all service plans and provide a written authorization to the HBHS provider which includes a prior authorization number and service authorization. The prior authorization number must be included on all claims.

Types of prior authorization requests include:

- a. An initial prior authorization request must be submitted before providing services to a Medicaid recipient for the first time.
- b. A concurrent prior authorization is required if a provider believes it is medically necessary for additional services to be rendered beyond that of the current authorization. The concurrent prior authorization must be submitted in time to meet QIO-Like processing timelines so an interruption in services may be avoided.
- c. A retro-eligible request may occur when an individual becomes eligible for Medicaid after services have been provided. Retro-eligible requests must be submitted within 90 days from the eligibility determination date (date of decision).
- d. Unscheduled changes to a current prior authorization are required when a recipient's needs change during the current authorization period. If this occurs, a revision prior authorization must be submitted for approval.

Prior authorization may be approved for a maximum of one (1) year through the end of the eligibility month. The prior authorization is dependent upon meeting the eligibility criteria using the 1915(i) HCBS Universal Needs Assessment Tool and medical necessity as described by medical evidence relating to a TBI/ABI. If services are needed after the current authorization ends, the facility must submit a new prior authorization request to the QIO-like vendor and include the same information that is required with an initial prior authorization request.

Services provided without prior authorization are not reimbursable.

A prior authorization number is required on all claims and must correspond directly to all dates of service on the claim. No dates of service billed outside of the dates approved on the corresponding prior authorization will be paid.

The QIO-like vendor will provide a written authorization to the HBHS facility which includes a prior authorization number and service authorization.

Reimbursement is not available for services furnished by legally responsible individuals.

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2403.2 RESIDENTIAL HABILITATION PROGRAM (RHP)

RHPs are a covered benefit when medically necessary services are furnished in a safe, efficient and cost-effective setting to Medicaid eligible recipients who require services 24 hours per day in a normalized living environment.

2403.2A COVERAGE AND LIMITATIONS

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

1. Admission Criteria

In addition to the admission criteria identified in Section 2403.1A, of this Chapter, the following criteria apply for residential habilitation programs:

- a. Eligible recipients are unable to return to independent living due to a significant cognitive or physical impairment which requires intensive, short-term specialized intervention to reintegrate into the community;
- b. A program **must** consist of an interdisciplinary coordinated team approach, based on supporting medical rationale, to improve the recipient's ability to function as independently as possible;
- c. The recipient has a viable discharge plan with appropriate post placement resources, including a support system identified that will facilitate community re-entry and a realistic expectation and plan for non-institutional living post-discharge; and
- d. Documentation is made available, upon request, to support that the **individual's** goals cannot be safely and adequately carried out at a less intensive level such as a day treatment program.

2. Covered Services

- a. A residential habilitation program **must** include a medically necessary day treatment program component focused on community reintegration. **This program may consist of community reintegration training, personal care assistance and supervision** in a 24 hour residential setting.

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- b. The residential component of the **RHP** must provide continued training, supervision and personal care services appropriate in amount and frequency to meet the needs of the recipient in a safe environment 24 hours per day, 7 days per week.
- c. The interdisciplinary team must establish a plan of **care** which is developed and updated **annually, or as needed**, for each resident.
- d. Nevada Medicaid does not reimburse for costs associated with room and board in the residential setting. Arrangements for reimbursement of such costs must be made with the recipient, or their family, prior to the program admission.
- e. **A component of community reintegration includes community visits.** Payment for **community visits must be** properly documented, and prior authorized subject to the following conditions:
 - 1. The purpose of community visits **is for** preparation for discharge to the community.
 - 2. The recipient's primary physician authorizes the **visit** and the plan of care provides for such absences.

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

3. Continued Stay Criteria for Residential **H**abilitation Program

For continued residential habilitation services, prior authorization must be submitted to Medicaid's QIO-like vendor a minimum **in time to meet processing timelines so an interruption in services may be avoided**. To be considered for continued stay, supporting documentation must be provided including the most recent team conference report, which demonstrates that the recipient continues to meet **RHP** admission criteria and continues to:

- a. **demonstrate the ability to actively participate in the program;**
- b. **have documented progression toward written goals;**
- c. **need 24-hour habilitation services as described in 2403.1A and 2403.1A.2.a.**

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

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4. Discharge Criteria

A recipient in a residential habilitation program must be considered for discharge, regardless of the authorized length of stay or program completion, when the following conditions are met:

- a. The recipient's needs exceed the scope of the residential habilitation program so transfer to an inpatient hospital or skilled nursing facility is indicated;
- b. The recipient no longer meets the criteria for the program;
- c. The specialized knowledge and skills of the interdisciplinary team are no longer required;
- d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three consecutive days;
- e. The recipient has reached his or her goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;
- f. There is limited motivation on the part of the recipient or caregiver which is impacting the individual's progress for over one week; or
- g. The established goals serve no purpose to increase functional or cognitive capabilities towards independent or assisted living.

2403.2B PROVIDER RESPONSIBILITY

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

1. Providers must maintain compliance with all regulatory requirements for a residential habilitation provider for the State in which they operate;
2. Providers must maintain either CARF or the Joint Commission accreditation as a residential facility to be in good standing;
3. The provider shall provide qualified habilitation aides at the appropriate staffing ratios as determined by applicable licensure, certification and/or accreditation requirements;
4. Providers establish, maintain and update an emergency plan specific to the recipient, including appropriate emergency information on-site for each recipient at all times;

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

2403.2C RECIPIENT RESPONSIBILITY

In addition to the policies discussed in Section 2403.1C “Recipient Responsibility” of this Chapter, the following policies apply to residents of the Residential **H**abilitation Program:

1. Recipients and their guests must comply with all reasonable and necessary posted “house rules” as established by the provider, in order to maintain a safe environment for all residents.
2. Recipients should notify the provider and **the DHCFP** of any occurrences that may compromise the safety or well being of residents within the home.

2403.2D AUTHORIZATION PROCESS

The policies discussed in Section 2403.1D “Authorization Process” of this Chapter, apply to the Residential **H**abilitation Program.

2403.3 COMMUNITY RE-INTEGRATION SERVICES (CRS)

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

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

2403.3A COVERAGE AND LIMITATIONS

Reimbursement is available for CRS which have been prior authorized by **the DHCFP**’s QIO-like vendor. Services must be ordered by a physician as a reasonable and medically necessary part of the recipient’s treatment plan and must be determined safe, efficient and **cost**-effective by the DHCFP or its QIO-like vendor.

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1. Admission Criteria

- a. The recipient must be eligible for services under Medicaid and must have behaviors which are manageable in the community **re-integration** environment;
- b. Eligible recipients have successfully progressed through their habilitation **plan of care**, but **they** require specialized transition assistance to fully reintegrate into the community;
- c. Community reintegration services are required, based on supporting medical rational, to ensure the recipient's ability to function as independently as possible in the community; and
- d. Documentation is provided, to support that the reintegration goals cannot be safely and adequately carried out utilizing more informal supports, such as willing family members and neighbors;
- e. The recipient has a viable written discharge plan, established by the multidisciplinary team, with appropriate resources in place, including the support system that will facilitate the community reintegration process and a realistic expectation of successful non-institutional living.
- f. The medical condition is stable and compatible with an active reintegration program.

2. Covered Services

- a. Community reintegration services are a covered benefit for recipients admitted within 14 days of completing a habilitation program or from the date determined to be eligible for Medicaid;
- b. Services may be provided in the recipient's residence (non-institutional setting), work environment, or other appropriate community-based setting;
- c. **Habilitation aides** must assist the recipient in utilizing those skills taught by the interdisciplinary team and involve coaching, advising, supporting and cueing recipients in **Instrumental Activities of Daily Living (IADLs)** such as:
 1. household management;
 2. behavioral management;
 3. safety;

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4. navigating in their immediate community using public transportation; and
 5. socialization skills.
3. Service Limitations
 - a. Services must be provided in accordance with **individualized plan of care** under the direction of a habilitation provider;
 - b. Community reintegration services are limited to a maximum of 20 hours per week, and must be prior authorized.
 4. Non Covered Services
 - a. Maintenance Therapy – is defined as the point where the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative aide are not required to carry out an activity or a home program to maintain function at the level to which it has been restored. Services in this category are non-covered.
 - b. Duplicative Services are not considered medically justified and will not be covered by Nevada Medicaid. An inquiry or referral for services does not indicate the necessity for services.
 - c. Community reintegration services solely for vocational, educational or convenience purposes or for developmental or behavioral concerns is not covered services within this program.
 5. Continuing Stay Criteria
 - a. All services must be part of, and specifically related to, an active plan of care that the physician reviews periodically, but not less than every 30 days **or when deemed necessary**;

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of best medical practice;
 - b. The re-integration **plan of care** must incorporate the written discharge plan established during the habilitation program **or re-integration stay**, identifying formal and informal resources that are currently in place, as well as the identified support system that will be facilitating the community re-entry.

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1. The plan **of care** must also contain:
 - a. Identified barriers; and corresponding short and long-term goals that are functional, objective and measurable;
 - b. Specific services to be provided, including the frequency, duration and modalities to be implemented; and
 - c. The proposed plan **of care** must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate “1 to 2 months on an ongoing basis.”

- c. Ongoing documentation of discharge planning including appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge. Since discharge planning is an integral part of any habilitation program and should begin upon the patient’s admittance to the program, an extended period of time for discharge action is not reasonable after established goals have been reached, or a determination made that further progress is unlikely.
- d. The recipient must demonstrate the ability and willingness to actively participate in goal oriented interventions developed with the interdisciplinary team. This shall be evidenced by regular attendance in interventions that are a part of the reintegration action plan and documented progression toward the established goals;
- e. Documentation must reflect that the community reintegration activities are reduced as the recipient’s level of independence increases.

6. Discharge Criteria

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

- b. **The recipient has a safe discharge plan to the community.**
- c. The recipient has **met all of their** established **goals**.
- d. The **recipient requires a more restrictive setting**.
- e. The recipient has an unstable condition that affects **their** ability to participate in community reintegration activities.

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2403.3B PROVIDER RESPONSIBILITY

The policies discussed in Section 2403.1B “Provider Enrollment” of this Chapter, apply to Community Re-integration Services.

2403.3C RECIPIENT RESPONSIBILITY

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

2403.3D **PRIOR** AUTHORIZATION

The policies discussed in Section 2403.1D “**Prior** Authorization” of this Chapter, apply to Community Re-integration Services.

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2404 QUALITY ASSURANCE

The DHCFP will conduct an annual review to assure the health and welfare, of the recipients served by HBHS. The review will consist of the program requirements identified in this chapter.

Additionally, a review of the providers will be conducted annually to verify that the providers meet requirements established for each service, such as licensure, accreditation, etc, and to ensure claims are paid in accordance with the State Plan and all federal state regulations. Providers must cooperate with the DHCFP's annual review process.

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2405 HEARINGS

Please reference Nevada **MSM**, Chapter 3100, for Medicaid Hearing Process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
 FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
 SUBJECT: MEDICAID SERVICES MANUAL CHANGES
 CHAPTER 2500 – CASE MANAGEMENT



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2500 are being proposed to update policy with the removal of references to the Diagnostic Statistical Manual (DSM), Diagnostic Criteria for ages zero to three (DC:0-3) and adding International Classification of Diseases (ICD)-10 CM verbiage.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 22/15 CHAPTER 2500 – CASE MANAGEMENT	MTL 15/15 CHAPTER 2500 – CASE MANAGEMENT

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2502.6.a	Target Group- Non-Seriously Mentally Ill (Non- SMI) Adults	Removing reference to DSM and Axis I diagnosis and V codes. Add current ICD language, Z and R codes.
2502.7.b.1	Target Group- Serious Mental Illness (SMI) Adults	Deleted “DSM-IV” and added “current ICD”.
2502.8.a	Target Group- Non-Severely Emotionally Disturbed(Non- SED) Children and Adolescents	Deleted "DSM IV Axis I" and added " current ICD from the Mental, Behavioral, Neurodevelopmental Disorders section which”.
2502.8.b		Removed "V code" and DSM-IV diagnosis” and

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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added, Z-codes 55-65, R45.850 and R45.851 as listed in the current ICD.

2502.8.d

Deleted “d. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) Axis I diagnosis or DC:0-3 Axis II Parent-Infancy Relationship Global Assessment Scale (PIR-GAS) score of 40 or less”.

2502.9

**Target Group-
Severe Emotional
Disturbance (SED)**

Remove reference to birth thru 48 months, DSM, DC:0-3 Axis I diagnosis, and PIR-GAS.

Clarify age is up to 18.

2502.9.a

Delete “DSM-IV” and added “current ICD”.

Deleted “mental retardation” and added “and other related conditions”.

Replace “V” code with “Z” code.

2509.9.b

Deleted “mental” and added “from the Mental, Behavioral, Neurodevelopmental Disorders section”.

Deleted “DSM-IV or their International Classification of Diseases” and added “current”.

Deleted reference to ICD-9, DSM-IV, and replaced “V” code with “Z” code.

2503.1A.3.c.1

**Target Group-
Non-Seriously
Mentally Ill (Non-
SMI) Adults**

Deleted “Diagnostic and Statistical manual of Mental Disorders (DSM-IV), Axis I diagnosis” and added “A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section”.

Replace “V” code with “Z” code.

Added codes “55-56, R45.850 and R45.851, which does not meet SMI criteria”.

Deleted “DSM-IV” and added “current ICD”.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2503.1A.4.d.1.a	Target Group- Adults With A Serious Mental Illness (SMI)	<p>Deleted “DSM-IV, AXIS I or II” and added “A current ICD”.</p> <p>Replace “V” code with “Z” code.</p> <p>Deleted “DMS-IV” and added “current ICD”.</p>

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CASE MANAGEMENT

2500 INTRODUCTION

Case Management is an optional Medicaid service pursuant to federal regulations. It may be provided without the use of a waiver and the state may limit the provision of services to a specific target group or defined location in the state. States are allowed to limit the providers of case management services available for individuals with development disabilities or chronic mental illness to ensure that these recipients receive needed services. The receipt of case management services does not alter an individual's eligibility to receive other services under the State Plan and recipients must have free choice of any qualified Medicaid provider. A recipient cannot be compelled to receive case management services, services cannot be a condition of receipt of other Medicaid services and other covered services cannot be a condition to receive case management services. Case management services provided in accordance with Section 1915(g) of the Social Security Act (SSA) will not duplicate payments made to public agencies or private entities under State Plan and other program authorities. Case managers cannot authorize, approve or deny the provision of services.

The intent of case management services is to assist recipients eligible under the State Plan in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Case management services do not include the direct delivery of medical, clinical or other direct services. Components of the service include assessment, care planning, referral/linkage and monitoring/follow-up. Case management services are provided to eligible recipients who are residing in a community setting or transitioning to a community setting following an institutional stay.

There are eight target groups eligible to receive this service. These groups are: (1) children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) with a mental illness; (2) children and adolescents who are Severely Emotionally Disturbed (SED); (3) adults who are Non-Seriously Mentally Ill (Non-SMI) with a mental illness; (4) adults who are Seriously Mentally Ill (SMI); (5) persons with intellectual disabilities or related conditions; (6) developmentally delayed infants and toddlers under age three; (7) Juvenile Probation Services (JPS), and (8) Child Protective Services (CPS).

All providers who participate in the Medicaid program must provide services in accordance with the rules and regulations of the Division of Health Care Financing and Policy (DHCFP), all policies and procedures described here in Medicaid Services Manual (MSM) Chapter 2500, as well as state and federal regulations and statutes.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and Nevada Check Up policies differ as documented in the Nevada Check Up Manual, Chapter 1000.

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2501 AUTHORITY

A. In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA) authorizing varying percentages of Federal Financial Participation (FFP) to states that elect to offer medical programs. The state must offer the 11 basic required medical services. FFP is also available, should states elect to cover some optional services. One of these optional services is Case Management.

B. Authorities include:

- Section 190 5(a)(19) of the SSA
- Section 191 5(b) of the SSA
- Section 191 5(c) of the SSA
- Section 191 5(g)(2) of the SSA
- 42 Code of Federal Regulations (CFR) Parts 431, 440, and 441
- 42 CFR 483.430
- Section 60 52 of the Deficit Reduction Act of 200
- The Supplemental Appropriations Act 2008

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2502 TARGET GROUP DEFINITIONS

2502.1 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.

2502.2 TARGET GROUP — CHILD PROTECTIVE SERVICES (CPS)

Child Protective Services are:

- a. Provided to 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.
- b. Provided to 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.

2502.3 TARGET GROUP - DEVELOPMENTALLY DELAYED INFANTS AND TODDLERS UNDER AGE THREE

- A. 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;

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d. Social or emotional development; or

e. Adaptive development.

3. Children also are eligible who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delays.

4. Informed clinical opinion must be used in determining eligibility for services as a result of a development delay.

2502.4 TARGET GROUP — JUVENILE PROBATION SERVICES (JPS)

A. Juvenile Probation 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.

2502.5 TARGET GROUP — PERSONS WITH INTELLECTUAL DISABILITIES OR RELATED CONDITIONS

Persons with intellectual disabilities or related conditions are persons who:

a. Are significantly sub-average in general intellectual functioning (intelligence quotient (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 disabilities 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.

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3. Learning.
4. Mobility.
5. Self-direction.
6. Capacity for independent living.

2502.6 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. 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.
- b. A Level of Care Utilization System (LOCUS) score of Level I or II.

2502.7 TARGET GROUP — SERIOUS MENTAL ILLNESS (SMI) ADULTS

Adults with an SMI are persons:

- a. 18 years of age and older;
- b. 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 within the **current ICD** (excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disabilities, unless they co-occur with another SMI that meets **current ICD** criteria);
 2. That resulted in functional impairment which substantially interferes with or limits one or more major life activities;
- c. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

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2502.8 TARGET GROUP — NON-SEVERELY EMOTIONALLY DISTURBED (NON-SED) CHILDREN AND ADOLESCENTS

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

- a. A **current ICD** diagnosis **from the Mental, Behavioral, Neurodevelopmental Disorders section which** does not meet SED criteria.
- b. **Z-codes 55-65, R45.850 and R45.851, as listed in the current ICD Manual which** does not meet SED criteria.
- c. Child and Adolescent Services Intensity Instrument (CASII) Level of 0, 1, 2, or above.

2502.9 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:

- a. 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 disabilities **and other related conditions** and **Z** codes, unless they co-occur with another SMI 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
- b. These disorders include any disorder **from the Mental, Behavioral, Neurodevelopmental Disorders section** (including those of biological etiology) listed in **current ICD** Clinical Modification (CM) equivalent (and subsequent revisions), with the exception of "**Z**" codes, substance use and developmental disorders, which are excluded unless they co-occur with another diagnosable SED. All of these disorders have episodic, recurrent, or persistent features; however they vary in terms of severity and disabling effects; and
- c. Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

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2502.10 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:

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

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

- a. 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:
 1. Taking client history.
 2. Identifying the needs of the individual and completing related documentation.
 3. 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.
- b. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
 1. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible recipient.
 2. 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.
 3. Identifies a course of action to respond to the assessed needs of the eligible recipient.
- c. 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

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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.

- d. Monitoring and follow-up; activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses 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:
1. Services are being furnished in accordance with the individual's care plan.
 2. Services in the care plan are adequate.
 3. 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.

2502.10A 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. Units, for documentation purposes, are further defined as actual case management activities performed.
 - a. If paid per unit, document date, time, number of units and activities completed.
 - b. If paid per monthly cap rate, document date, time and activities completed.
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.

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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 Quality Improvement Organization (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.

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2503 POLICY

2503.1 CASE MANAGEMENT SERVICES POLICY

2503.1A COVERAGE AND LIMITATIONS

A maximum of 30 hours per target group, per calendar month, per recipient, is allowed for case management services. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate).

1. Case management services are reimbursable when:
 - a. Provided to Medicaid eligible recipients, on a one-to-one (telephone or face-to-face) basis.
 - b. Medically necessary.
 - c. Provided by a qualified provider enrolled to serve the target group in which the recipient belongs.
 - d. Provided by the recipient's chosen provider.
 - e. Contacts by the case manager with individuals who are not eligible for Medicaid when the purpose of the contact is directly related to the management of the eligible recipient's care.
 - f. There are no third parties liable to pay for these services, including as reimbursement under a medical, social, educational or other federally funded program. Third party insurance payments for case management services must be pursued for all recipients.

The provider must determine whether the recipient has other health insurance. Providers may survey health care insurance companies to determine whether case management is a covered benefit. Exception: This is not necessary for Medicare since it is not a covered service. If the health care provider covers case management, it must be billed for all recipients for services provided. For Medicaid recipients, the health care insurance company must be billed before Medicaid is billed. Once payment is received, if the other company did not pay the entire cost of services, Medicaid may be billed. If the health care insurance company will not pay for case management services, documentation of this must be maintained in the recipient's case record.

- g. The service is not an integral component or administrative service of another covered Medicaid service.

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2. Case management services not reimbursable under the Nevada Medicaid Program include, but are not limited to:
 - a. The actual or direct provision of medical services or treatment. Examples include, but are not limited to:
 1. Training in daily living skills;
 2. Training in work skills and social skills;
 3. Grooming and other personal services;
 4. Training in housekeeping, laundry, cooking;
 5. Transportation services;
 6. Individual, group or family therapy services;
 7. Crisis intervention services; and/or
 8. Diagnostic testing and assessments.
 - b. Services which go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:
 1. Paying bills and/or balancing the recipient's checkbook;
 2. Completing application forms, paper work, evaluations and reports including applying for Medicaid eligibility;
 3. Escorting or transporting recipients to scheduled medical appointments; and/or
 4. Providing child care so the recipient can access services.
 - c. Traveling to and from appointments with recipients.
 - d. Traveling to and from appointments (without recipients).
 - e. Case management services provided to recipients between 22 and 64 years of age who are in an Institution for Mental Disease (IMD).
 - f. Using case management codes for billing, when the recipient does not meet the criteria for the target group.

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- g. Recipient Outreach – Outreach activities in which a state agency or other provider attempts to contact potential recipients of a service do not constitute case management services.
- h. The direct delivery of foster care services and therapeutic foster care services. The following activities are not considered to qualify as components of Medicaid case management services:
 - 1. Research gathering and completion of documentation required by the foster care program.
 - 2. Assessing adoption placements.
 - 3. Recruiting or interviewing potential foster care parents.
 - 4. Serving legal papers and attendance at court appearances.
 - 5. Home investigations.
 - 6. Providing transportation.
 - 7. Administering foster care subsidies.
 - 8. Making placement arrangements.
 - 9. Training, supervision, compensation for foster care parents.
- i. If the case manager also provides other services under the plan, the State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals. Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the service.
- j. Services provided as “administrative case management”, including Medicaid eligibility determination, intake processing, preadmission screening for inpatient care, utilization review and prior authorization for Medicaid services are not reimbursable.
- k. Administrative functions for recipients under the Individuals with Disabilities Education Act (IDEA) such as the development of an Individual Education Plan and the implementation and development of an Individual Family Service Plan for Early Intervention Services are not reimbursable as case management services.

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3. Target Group – Non-Seriously Mentally Ill (NON-SMI) Adults

a. Service Eligibility:

The determination for adults with a NON-SMI is made by a licensed, qualified mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Master’s degree psychiatric nurse).

b. Provider Qualifications:

Minimum qualification of a case manager providing services for NON-SMI adults are a service coordinator with a bachelor’s degree in a health-related field, Registered Nurse (RN), Master’s level professional (LSCW or LMFT), Advanced Practice Registered Nurse (APRN) in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

c. Service Criteria:

Admission Criteria includes:

1. A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section including Z-codes 55-65, R45.850 and R45.851, which does not meet SMI criteria (including dementia, intellectual disabilities or primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness that meets current ICD criteria).
2. Recipients require assistance in obtaining and coordinating medical, social, educational and other support services.

d. Continuing Stay Criteria:

1. Continues to meet admission criteria.
2. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.
3. Documentation supports progress towards specific case management goals identified in the established care plan with barriers identified and addressed.

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e. Discharge/Exclusionary Criteria:

1. No longer meets NON-SMI determination.
2. No longer meets the admission and continuing stay criteria.
3. Recipient or family chooses not to participate in the program or is non-compliant.
4. Recipient requires inpatient psychiatric hospitalization, Institution for Mental Diseases (IMD), or Nursing Facility (NF) placement.
5. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admission.

4. Targeted Group – Adult with a Serious Mental Illness (SMI)

a. Reference definition under Section 2502.6.

b. Service Eligibility Determination

The determination for adults with a SMI is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT, or Master's degree psychiatric nurse).

c. Provider Qualifications

Minimum qualifications of a case manager providing services for SMI adults (which can only be provided by a state agency and its employees or contractors or an organization affiliated with the University of Nevada School of Medicine) are a case manager with a Bachelor's degree in a health-related field, Registered Nurse (RN), Master's level professional (LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

d. Service Criteria

1. Admission Criteria:

Must meet of all the following:

- a. **A current ICD** diagnosis (excluding **Z**-codes, dementia, intellectual disabilities or a primary diagnosis of a substance abuse disorder,

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unless these co-occur with another mental illness That meets **current ICD** criteria).

- b. Recipient requires assistance in obtaining and coordinating medical, social, educational and other support services.

2. Continuing Stay Criteria:

Must meet all of the following:

- a. Continues to meet admission criteria.
- b. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.
- c. Documentation supports progress towards specific case management goals identified in the case management care plan, and barriers have been identified and addressed.
- d. Treatment plan and goals must be established.

3. Discharge Criteria:

Must meet at least one of the following:

- a. No longer meets SMI determination.
- b. No longer meets the admission and continuing stay criteria.
- c. Admission into a psychiatric hospital, IMD or NF.
- d. Recipient or family chooses not to participate in the program or is non-compliant.
- e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute treatment.

4. Exclusionary Criteria:

Must meet at least one of the following:

- a. No longer meets SMI determination.

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- b. No longer meets the admission and continuing stay criteria.
 - c. Admission into a psychiatric hospital, NF or IMD.
 - d. Recipient chooses not to participate in the program or is non-compliant.
 - e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute treatment.

- 5. Target Group – Non-Severely Emotionally Disturbed (NON-SED) Children and Adolescents
 - a. Service Eligibility Determination

The determination for children and adolescents with a NON-SED is made by a qualified mental health professional (psychiatrist, psychologist, LCSW, LMFT, or Master’s degree psychiatric nurse).
 - b. Provider Qualifications

The minimum qualifications of a case manager providing services for a NON-SED child are a case manager with a Bachelor’s degree in a health related field, Doctorate degree and license in psychology, RN, Master’s level professional (LCSW or LMFT) APRN in mental health, or a mental health professional who works under the direct supervision of a person listed above, and LCSW or LMFT interns that are supervised within the scope of their license.

- 6. Target Group – Children and Adolescents with a Severe Emotional Disturbance (SED)
 - a. Reference definition under Section 2502.8.
 - b. Service Eligibility Determination

The determination for children and adolescents with a SED is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT or Master’s degree psychiatric nurse).
 - c. Provider Qualifications

Minimum qualifications of a case manager providing services for SED children and adolescents (which can only be provided by a state agency or organization affiliated with the University of Nevada School of Medicine) are a case manager with a Bachelor’s degree in a health-related field, RN, Master’s level professional

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(LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

d. Service Criteria

1. Admission:

Must meet all of the following:

- a. DSM-IV, AXIS I or II, diagnosis (excluding V-codes, dementia, intellectual disability or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM-IV criteria).
- b. Recipient requires assistance in obtaining and coordinating medical, social, educational and other support services.

2. Continuing Stay Criteria:

Must meet all of the following:

- a. Continues to meet admission criteria.
- b. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.
- c. Documentation supports progress towards specific case management goals identified in the case management care plan, and barriers have been identified and addressed. Treatment plan and goals must be established.

3. Discharge Criteria:

Must meet one of the following:

- a. No longer meets SED determination.
- b. No longer meets the admission and continuing stay criteria.
- c. Recipient or family chooses not to participate in the program or is non-compliant.

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- d. Requires inpatient psychiatric hospitalization, NF or Residential Treatment Center (RTC) placement.
- e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admissions.
- 4. Exclusionary Criteria:
 - a. No longer meets SED determination.
 - b. No longer meets the admission and continuing stay criteria.
 - c. Requires inpatient psychiatric, NF or RTC hospitalization.
 - d. Recipient or family chooses not to participate in the program.
- e. Transitional Targeted Case Management
 - 1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.
 - a. Transitional Targeted Case Management services are provided 14 days prior to discharge for an institutional stay.
 - b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.
- 7. Target Group – Persons with Intellectual Disabilities or Related Conditions
 - a. Reference definition under Section 2502.4.
 - b. Service Eligibility Determination

The determination is made by a Qualified Mental Retardation Professional (QMRP) as defined in 42 Code of Federal Regulations (CFR) 483.430.
 - c. Provider Qualifications
 - 1. Employee or contractor of the Division of Mental Health and Development Services (MHDS) or the Division of Child and Family Services (DCFS); and

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- a. Bachelor's level social worker licensed to practice in Nevada.
- b. RN licensed in Nevada to practice professional nursing.
- c. Disabilities specialist with at least a Bachelor's degree in human sciences.
- d. Psychologist licensed to practice in Nevada.
- e. Child development specialist and psychology, nursing, or social work caseworker who works under the direct supervision of a person in classes (a) through (d) above.

d. Service Criteria

1. Admission Criteria:

Meets admission criteria as addressed in Section 2502.4.A.

2. Continuing Stay Criteria:

Continues to meet admission criteria.

3. Discharge Criteria:

- a. Does not meet admission criteria.
- b. Recipient or family chooses not to participate in program or is non-compliant.
- c. Admission into a hospital, NF, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
- d. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria:

- a. Does not meet admission criteria.
- b. Recipient is hospitalized or resides in an ICF/IID.

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- c. Admission into a hospital, NF or CFR/IID.
- e. Transitional Targeted Case Management
 - 1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.
 - a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.
 - b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.
- 8. Target Group – Developmentally Delayed Infants and Toddlers Under Age Three
 - a. Reference definition under Section 2502.2.
 - b. Service Eligibility Determination

Eligibility is determined by a multidisciplinary team consisting of two early intervention professionals and the parent. Eligibility determination must include the following:

 - 1. Be conducted by personnel trained to utilize appropriate methods and procedures;
 - 2. Be based on informed clinical opinions; and
 - 3. Include the following:
 - a. Review of pertinent records related to the child’s current health status and medical history.
 - b. An evaluation of the child’s level of functioning in each of the following developmental areas:
 - 1. Cognitive development.
 - 2. Physical development, including vision and hearing.
 - 3. Communication development.

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4. Social or emotional development.
 5. Adaptive development.
- c. An assessment of the unique needs of the child including the identification of services appropriate to meet those needs.
- c. Provider Qualifications
- Qualifications of a case manager providing services to an infant or toddler with developmental delays in an employee or contractor of the Department of Health and Human Services (DHHS) or one of its qualified Divisions; and
1. An individual with a Master’s degree from an accredited college or university in early childhood special education, childhood human growth and development, psychology, counseling, social work, or a closely related field; or
 2. An individual with a Bachelor’s degree from an accredited college or university with major work in early childhood growth and development, early childhood special education, psychology, counseling, social work or a closely related field, and one year of full-time professional experience in an early integrated preschool program, mental health facility, or a clinical setting providing developmental or special education or treatment-oriented services to preschool or school age children with physical or mental disabilities, or emotional or behavioral disorders.
- d. Service Criteria
1. Admission Criteria:
 - a. Medicaid eligible.
 - b. Meets criteria addressed in Section 2502.1.A.
 2. Continuing Stay Criteria:

Continues to meet admission criteria.
 3. Discharge Criteria:
 - a. Does not meet admission criteria.

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- b. Child has demonstrated age appropriate skills for six consecutive months.
 - c. Child turns age three.
 - d. Meets criteria for admission to an inpatient facility.
 - e. Family chooses not to participate in the program or is non-compliant.
 - f. Has sufficient support system to sustain stability, not requiring unnecessary or frequent acute admissions.
4. Exclusionary Criteria:
- a. Does not meet admission criteria.
 - b. Child is age three or older.
 - c. Meets criteria for admission to an inpatient facility.
 - d. Family chooses not to participate in the program or is non-compliant.
- e. Transitional Targeted Case Management
- 1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.
 - a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.
 - b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.
9. Target Group – Juvenile Probation Services
- a. Reference definition under Section 2502.3.
 - b. Provider Qualifications

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The organization providing case management services for JPS must meet the following requirements:

1. A minimum of five years experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.
2. A minimum of five years experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.
3. A minimum of five years case management experience in coordinating and linking community medical, social, educational, or other resources needed by the target population on a countywide basis.
4. A minimum of five years working with the target population.
5. A minimum of five years experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.
6. A minimum of five years experience of demonstrated capacity in meeting the case management service needs of the target population.
7. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.
8. Qualifications of individual case managers:
 - a. Bachelor's degree in a related field; or equivalent college and field experience; and
 - b. Ability to work in and with legal systems, including the court system; and
 - c. Ability to learn state and federal rules, laws, and guidelines relating to the target population and to gain knowledge about community resources.

c. Eligibility Determination

Medicaid eligible recipient's status is determined by the County Department of JPS.

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d. Service Criteria

Medicaid eligible recipient is under the care of the County Department of JPS. Scope of coverage services must be in accordance with federal regulations.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

10. Target Group – Child Protective Services (CPS)

a. Reference definition under Section 2502.1.

b. Provider Qualifications

The organization providing case management services for CPS must meet the following requirements:

1. A minimum of five years experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.

2. A minimum of five years experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.

3. A minimum of five years case management experience in accordance and linking community medical, social, educational, or other resources needed by the target population on a countywide basis.

4. A minimum of five years working with the target population.

5. A minimum of five years experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.

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6. A minimum of five years experience of demonstrated capacity in meeting the case management service needs of the target population.
7. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.
8. Qualifications of individual case managers:
 - a. Bachelor's degree in a related field; or equivalent college and field experience; and
 - b. Ability to work in and with legal systems, including the court system; and
 - c. Ability to learn state and federal rules, laws, and guidelines relating to the target population and to gain knowledge about community resources.

c. Eligibility Determination

Medicaid eligible recipient's status is determined by the County's Department of Social Services CPS.

d. Service Criteria

Medicaid eligible recipient is under the care of the County's Department of Social Services CPS. Scope of services must be in accordance with federal regulations.

e. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.
 - a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.
 - b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

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2503.1B RECIPIENT RESPONSIBILITIES

1. Medicaid recipients, their families, or legal guardians are required to provide a valid Medicaid eligibility card to their case management service providers.
2. Medicaid recipients, their families, or legal guardians are expected to comply with the recipient's treatment and care plans.

2503.1C AUTHORIZATION PROCESS

Medicaid recipients are entitled to receive a maximum of 30 hours of case management services per target group, per calendar month, per recipient. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate).

If the recipient requires more than 30 hours per month, the case manager must thoroughly document in the recipient's case record the justification for the additional hours and submit a prior authorization request to the QIO-like vendor.

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2504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100, Hearings, for hearings procedures.

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2505 RESERVED FOR FUTURE USE

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 7, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE 

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION
(ISO)

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2600 are being proposed to differentiate and separate policy for the two services that can be self-directed through an ISO; Self-Directed Personal Care Services (SD PCS) and Self-Directed Skilled Services. SD PCS policy is being aligned with current Personal Care Services (PCS) policy in MSM Chapter 3500 and several new sections were added for this purpose. Some sections were combined and/or merged together to create a new section or deleted to remove repetition. Language was moved from some sections and added to others where more appropriate. All licensure requirements have been removed from policy, as oversight for such is the responsibility of the licensing agency. In addition, outdated language and procedures were removed and replaced with current language and procedures where applicable. Overall updates were made to ensure PCS policy and requirements are the same regardless of the delivery model.

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

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective September 8, 2016

MATERIAL TRANSMITTED

MTL 21/16
CHAPTER 2600 – INTERMEDIARY
SERVICE ORGANIZATION (ISO)

MATERIAL SUPERSEDED

MTL 11/12, 37/11,
CHAPTER 2600 – INTERMEDIARY
SERVICE ORGANIZATION (ISO)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2600	Introduction	Updated language to include the two services allowed under Nevada Medicaid's Self-Directed service delivery model and provided through an ISO: Personal Care Services and Skilled Services.
2601	Authority	Section condensed. Deleted Social Security Act definition of PCS along with NRS and Nevada State Plan references. Added list of regulatory oversight.
2602	Reserved	Section renamed "Definitions" and added reference to MSM Addendum for program definitions.
2603	Policy	Section condensed to be an introduction to the two services that can be self-directed through an ISO. Language removed has been incorporated in different sections throughout the chapter where appropriate. Legally Responsible Individual (LRI) language incorporated into new Section 2603.2.
2603.1	Self-Directed (SD) Model	Section renamed "Self-Directed Personal Care Services (PCS)"; added language on type of assistance provided under Self-Directed PCS and clarified other existing language. Subsections 2603.1(a) moved to 2603.1B and 2603.1(b) was deleted and its language incorporated throughout the chapter where appropriate.
2603.1A	Program Eligibility Criteria	Moved from 2603.1A.2 to current Section and renamed "Eligibility Criteria." Additional criteria added to be in line with policy in MSM Chapter 3500. Coverage and Limitations now in 2603.1C.
2603.1B	Self-Directed Model Initiation	Moved from 2603.1(a) to current section and renamed "Initiating Self-Directed Personal Care Services (SD PCS)." Updated language and reworded for clarity, removed reference to obsolete NMO forms. Provider Responsibility now in 2603.8.
2603.1C	Coverage and Limitations	Previously in 2603.1A. Moved to current section and renumbered. Added new subsections for covered services, service limitations and non-covered services to be in line with policy in MSM Chapter 3500. Recipient/Personal Care Representative (PCR) Responsibilities now in 2603.9.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.1D	Authorization Process	Removed reference to MSM Section 3503.1E. Added current PCS authorization procedures to be in line with policy in MSN Chapter 3500.
2603.1 E	Flexibility of Service Delivery	New section added to align with policy in MSM Chapter 3500. Section specifies flexibility of service delivery for recipients.
2603.1F	Conflict of Interest Standards	New section added to align with policy in MSM Chapter 3500. Section specifies conflict of interest standards for providers completing the functional assessment service plan.
2603.2	Legally Responsible Individual (LRI)	LRI language previously in Section 2603 now in current section. This new section specifies LRI policy and requirements for LRIs that are not available and for those not capable of providing care. SD Skilled Services Sections previously in 2603.2 moved and now start in Section 2603.7.
2603.3	Personal Care Representative (PCR)	Previously Section 2603.1A (1). Section language was updated to align with policy in MSM Chapter 3500. PCS IC Model sections previously in 2603.3 moved and now start in Section 2604.
2603.4	Services to Children	New section added to align with policy in MSM Chapter 3500. Section includes policy applicable to children receiving services to align with policy in MSM Chapter 3500. Escort Services Section previously in 2603.4 now starts in Section 2603.10.
2603.5	PCS for Recipients Enrolled in Hospice	New section added to align with policy in MSM Chapter 3500. Section specifies policy for recipients also enrolled in hospice. Transportation Section previously in 2603.5 now in Section 2603.11.
2603.6	Residential Support Services / Supported Living Arrangement (SLA)	New section added to align with policy in MSM Chapter 3500. Section specifies policy for recipients receiving residential supports through SLAs. Quality Assurance Section previously in 2603.6 now in Section 2603.14.
2603.7	Self-Directed (SD) Skilled Services	Updated language and reworded for clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.7A	Program Eligibility Criteria	Moved from 2603.2A (1) to current section. Section renumbered and renamed “Eligibility Criteria” and some language was updated.
2603.7B	Self-Directed (SD) Skilled Services Initiation	Moved from 2603.2 (a) to current section. Section renumbered and renamed “Initiating SD Skilled Services.” Updated section to reflect current process for initiating SD Skilled Services.
2603.7C	Coverage and Limitations	Moved from 2603.2A to current section. Section renumbered, program eligibility criteria subsection was moved to 2603.7A and remaining subsections were rearranged to improve readability.
2603.7D	Authorization	Moved from 2603.2D to current section. Section renumbered, renamed “Authorization Process” and language was updated to reflect current authorization process for Self-Directed Skilled Services.
2603.8	Provider Responsibility	Moved from 2603.1B to current section. Section was renumbered and renamed “Provider Responsibilities,” language was updated and reworded for clarity for various requirements. Provider enrollment requirements were removed and updated to reflect current process. Licensure requirements, such as criminal background checks, tuberculosis testing and training have been removed from section. Several requirements were removed as they are no longer applicable to the provider type for which this policy is written such as time parameters, 24-hour accessibility and referral source agreement. New requirements were added to reflect current processes. Reference to MSM 3500 sections were removed throughout and replaced with current policy for each requirement to align with PCS provider requirements in MSM Chapter 3500. Provider responsibilities previously in Section 2603.2B and 2603.2B (1) were incorporated in this section.
2603.9	Recipient/Personal Care Representative (PCR) Responsibilities	Moved from 2603.1C to current section. Section was renumbered and renamed “Recipient Responsibilities and Rights.” Section now includes responsibilities previously in 2603.2C applicable to those opting to self-direct their skilled services and a new subsection for recipient rights to align policy with MSM 3500.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.10	Escort Services	Moved from 2603.4 to current section. Section renumbered and reference to MSM Section 3503.8 was removed.
2603.10A	Coverage and Limitations	Added new section to align with policy in MSM Chapter 3500. Specifies service conditions.
2603.10B	Authorization Process	Added new section to align with policy in MSM Chapter 3500. Specifies specific authorization process for escort services.
2603.10C	Provider Responsibility	Added new section to align with policy in MSM Chapter 3500. Specifies escort service responsibilities for providers.
2603.11	Transportation	Moved from 2603.5 to current section. Reworded for clarity.
2603.12	Reimbursement	Added new section to align with policy in MSM Chapter 3500. Details some of the costs associated with doing business for which separate reimbursement is not available.
2603.13	Improper Billing Practices	Added new section to align with policy in MSM Chapter 3500. Details some improper billing practices and possible consequences.
2603.14	Quality Assurance	Moved from 2603.6 to current section. Section was reworded and updated to specify current process.
2603.15	Adverse Actions	Added new section to align with policy in MSM Chapter 3500. Specifies when adverse action may be taken by the DHCFP or its designee.
2604	PCS Independent Contractor (IC) Model	Moved from 2603.3 to current section for improved readability and flow. Throughout the section, grammar, punctuation, and capitalization changes were made, acronyms used and standardized, and language reworded for clarity. Provider enrollment requirements were updated to reflect current process. Specific section references were updated throughout to reflect correct section numbers.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2605	Hearings	Moved from 2604 to current section. Updated reference language to include “hearing procedures” and “Medicaid.”
2606	Self-Directed (SD) Skilled Services – Clinical Decision Support Guide	Renumbered from 2605 to 2606.

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2600 INTRODUCTION

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

An Intermediary Service Organization (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.

Under the SD service delivery model, Nevada Medicaid allows for the self-direction of two services through an ISO, Personal Care Services (PCS) and Skilled Services. These services are provided where appropriate, when medically necessary and within service limitations. Services may be provided in settings outside the home, including employment sites.

SD PCS and Skilled Services are available to recipients, including those persons with cognitive impairments, who have the ability and desire to manage their own care. When a recipient does not have the ability to manage or direct their own care, a Personal Care Representative (PCR) may be selected on the recipient's behalf to direct the services.

SD PCS and SD Skilled Services are available to recipients who are not inpatients or residents of a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), institutions for mental disease or other excluded settings.

This Medicaid Services Manual (MSM), Chapter 2600, contains Nevada Medicaid's policy for the SD service delivery model of PCS and Skilled Services provided through an ISO. For policy pertaining to the Provider Agency service delivery model of PCS, refer to Chapter 3500.

All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with Chapter 100 and meet certain qualifications and criteria as discussed later in this chapter.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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2601 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security **Act**.

- **Social Security Act 1905(a)(24)**
- **Title 42, Code of Federal Regulations, Section 440.167**
- **Nevada State Plan Attachment 3.1-A(26)**

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2602 **DEFINITIONS**

Program definitions can be found in the Medicaid Services Manual (MSM) Addendum.

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2603 POLICY

Nevada Medicaid offers two services that can be self-directed by the recipient or their Personal Care Representative (PCR) through an Intermediary Service Organization (ISO): PCS and Skilled Services.

Legally responsible individuals (LRIs) may not be reimbursed for providing Self-Directed (SD) PCS and/or SD Skilled Services.

2603.1 SELF-DIRECTED PERSONAL CARE SERVICES (PCS)

Self-Directed PCS provide assistance to support and maintain recipients living independently in their homes. Services may be provided in the home, locations outside the home or wherever the need for the service occurs. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Services are based on the need of the recipient being served, as determined by a Functional Assessment Service Plan (FASP) approved by the Division of Health Care Financing and Policy (DHCFP). All services must be performed in accordance with the approved service plan and must be prior authorized. The time authorized for services is intended to meet the recipient needs within program limits and guidelines, facilitate effective and efficient service delivery and to augment unpaid and paid supports currently in place. Services are not intended to replace or substitute services and/or supports currently in place, or to exchange unpaid supports for paid services.

Services are available to recipients in need of PCS, including persons with cognitive impairments, who have the ability and desire to manage their own care. When the recipient does not have the ability to manage their own care, a PCR may do so on their behalf.

This option is utilized by accessing services through an ISO. The ISO is the employer of record and the recipient is the managing employer for the PCAs that provide the services.

2603.1A ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;
2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;
3. The recipient does not have an LRI who is available and capable of providing the necessary care;

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4. The recipient must be able to make choices about ADLs, understand the impact of these choices and assume responsibility for them or have a PCR who is willing to assist the recipient in making choices and assumes responsibility for those choices;
5. The recipient or PCR must be cooperative in establishing the need for the provision of services and comply with the approved service plan;
6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee; and
7. The recipient or PCR must be willing and capable of managing all tasks related to service delivery including, but not limited to: recruitment, selection, scheduling, training and directing PCAs.

2603.1B INITIATING SELF-DIRECTED PERSONAL CARE SERVICES (SD PCS)

The recipient, LRI or their PCR indicates interest in self-directing their PCS by contacting their local DHCFP District Office or Aging and Disability Services Division (ADSD) Office directly.

1. The DHCFP District Office or local ADSD Office staff provides information to the recipient or the PCR about the self-directed services available. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.
2. If the recipient elects to self-direct his or her own PCS, the ISO will provide, and the recipient will sign, the Intermediary Service Organization (ISO) Self-Directed Personal Care Services Unskilled Only Recipient Agreement (Form NMO-3434).
3. If the recipient elects a PCR to direct his or her care, the ISO will provide, and the PCR will sign, the Intermediary Service Organization (ISO) Self-Directed Personal Care Services Unskilled Only Personal Care Representative Agreement (Form NMO-3437).

A signed copy of either agreement should be given to the recipient and/or PCR and the ISO shall retain the original for their records.

2603.1C COVERAGE AND LIMITATIONS

1. Covered Services
 - a. Assistance with the following ADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare.

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1. Bathing/dressing/grooming.
2. Toileting needs and routine care of an incontinent recipient.
3. Transferring and positioning non-ambulatory recipients from one stationary position to another, assisting a recipient out of bed, chair or wheelchair, including adjusting/changing recipient's position in a bed, chair or wheelchair.
4. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a walker, cane or crutches or assisting a recipient to stand up or get to his/her wheelchair to begin ambulating.
5. Eating, including cutting up food. Specialized feeding techniques may not be used.

b. Assistance with the following IADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare. See the service limitations section of this chapter for specific eligibility criteria to be considered eligible to receive additional time for assistance with IADLs.

1. Meal preparation, which includes storing, preparing and serving food.
2. Laundry, which includes washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.). Ironing is not a covered service.
3. Light housekeeping, which includes changing the recipient's bed linens, dusting, or vacuuming the recipient's living area.
4. Essential shopping, which includes shopping for prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and nutrition of the recipient.

2. Service Limitations

To be considered eligible to receive additional time for assistance with IADLs, the recipient must be eligible to receive PCS for ADLs and have deficits which directly preclude the individual from completing IADLs. The FASP must demonstrate that the recipient meets the following criteria:

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- a. The recipient has extensive impairments, Level 2 or higher on the FASP in two or more areas of ADLs; and
- b. The recipient has at least one of the deficits listed below:
 - 1. Mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impacts the recipient's ability to safely perform household tasks or meal preparation independently;
 - 2. Cognitive deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently;
 - 3. Endurance deficits directly impacting the recipient's ability to complete a task without experiencing substantial physical stressors;
 - 4. Sensory deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently.

Assistance with the IADLs may only be provided in conjunction with services for ADLs, and only when no LRI is available and/or capable.

3. Non-Covered Services

Duplicative services are not considered medically necessary and will not be covered by Nevada Medicaid. An inquiry or referral for services does not determine the medical necessity for services.

The following are not covered under PCS and are not reimbursable:

- a. A task that the DHCFP or its designee determines could reasonably be performed by the recipient.
- b. Services normally provided by an LRI.
- c. Any tasks not included on the recipient's approved service plan.
- d. Services to maintain an entire household, such as cleaning areas of the house not used solely by the recipient(s).
- e. Services provided to someone other than the intended recipient.
- f. Skilled care services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or

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certified by the State. Services include, but are not limited to, the following:

1. Insertion and sterile irrigation of catheters;
 2. Irrigation of any body cavity. This includes both sterile and non-sterile procedures such as ear irrigation, vaginal douches, and enemas;
 3. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;
 4. Administration of injections of fluids into veins, muscles, or skin;
 5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions, or the instillation of prescribed eye drops (as opposed to assisting with self-administered medication);
 6. Physical assessments;
 7. Monitoring vital signs;
 8. Specialized feeding techniques;
 9. Rectal digital stimulation;
 10. Massage;
 11. Specialized range of motion (ROM);
 12. Toenail cutting;
 13. Medical case management, such as accompanying a recipient to a physician's office for the purpose of providing or receiving medical information; and
 14. Any task identified within the Nurse Practice Act as requiring skilled nursing, including Certified Nursing Assistant (CNA) services.
- g. Chore services.
- h. Companion care, baby-sitting, supervision, or social visitation.
- i. Care of pets except in cases where the animal is a certified service animal.

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- j. Respite care intended primarily to relieve a member of the recipient’s household, a family member or caregiver from the responsibility of caring for the recipient.
- k. A task the DHCFP determines is within the scope of services provided to the recipient as part of an assisted living contract, a supported living arrangement contract or a foster care agreement.
- l. Escort services for social, recreational or leisure activities.
- m. Transportation of the recipient by the PCA.
- n. Any other service not listed under Section 2603.1C.1.

2603.1D AUTHORIZATION PROCESS

PCS authorization requests must be submitted to the QIO-like vendor using the following procedures:

1. Initial Authorization Requests

The recipient, LRI, PCR or an individual covered under the confidentiality requirements of Health Insurance Portability and Accountability Act (HIPAA) may contact the QIO-like vendor to request PCS. Initial requests may not be made by the PCS Agency provider.

The QIO-like vendor validates that the recipient meets PCS criteria, and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient’s functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists’ clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient’s need for PCS.

After completion, the FASP is forwarded to the QIO-like vendor to process.

If the recipient’s request for PCS is approved, the QIO-like vendor will issue a prior authorization number to the recipient’s chosen ISO Provider.

a. At Risk Recipient Requests

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Upon receipt of a request for an initial FASP, the QIO-like vendor will first complete a risk assessment over the phone to identify those recipients for whom PCS are urgent to avoid institutionalization or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient is determined “at risk,” the QIO-like vendor will provide a temporary service authorization. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient’s functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists’ clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient’s need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

The selected ISO Provider is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within 24 hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance.

2. Annual Update Authorization Requests

To prevent a break in service, reassessment requests for ongoing services are recommended to be submitted to the QIO-like vendor at least 60 days, but not greater than 90 days, prior to the expiration date of the current authorization. The request must be submitted on the Authorization Request for PCS form (FA-24). The form must include all required recipient and provider information, as well as the units requested and the dates of service for the service interval requested.

The QIO-like vendor validates that the request meets PCS criteria. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient’s functional abilities.

The assigned physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

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Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the ISO Provider submitting the request.

3. Significant Change in Condition or Circumstance Authorization Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to significant change in the recipient's condition or circumstances must be submitted on the Authorization Request for PCS form (FA-24) and must be accompanied by documentation from the recipient's physician or health care provider. Requesting a reassessment does not guarantee an increase in previously approved PCS.

- a. Significant change in condition may be demonstrated by, for example, 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.
- b. Significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI.
- c. Significant change in condition or circumstances would result in hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

The QIO-like vendor validates that the request meets PCS criteria and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization

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number to the ISO Provider submitting the request.

4. Temporary Service Authorization Requests

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than eight weeks) modification of the current authorization, a new FASP is not required.

Such a modification is considered when additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

The following procedure must be followed for all short-term modifications of the approved service plan:

- a. Documentation must be maintained in the recipient's record of the circumstances that required the short term modification(s) of the approved authorization;
- b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the ISO, and if applicable the appropriate home and community-based waiver case manager. Documentation must include the recipient's name, Medicaid number, and the dates during which the modified service plan will be in effect; and
- c. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FASP is completed due to a significant change in the recipient's condition or circumstance.

5. One-Time Service Authorization Request

The recipient's Provider Agency may submit a single-service authorization request, when the recipient requires an extra visit for an unanticipated need(s), such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the services requested and be the designated provider for the current authorization period. The request must be submitted to the QIO-like vendor no later than seven business days after the service is provided. A new FASP is not required in these single-service situations.

6. Mileage Authorization Request

Mileage for travel to and from a recipient's home or for shopping is not reimbursable to ISO providers, except in hardship situations in remote or rural areas of the state, where failure to reimburse mileage expenses would severely limit available providers. Mileage authorization requests must be submitted in advance to the local DHCFP District Office for review and may be approved on a case-by-case basis. If approved, the DHCFP District

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Office will notify the QIO-like vendor to issue an authorization number for the approved mileage to the provider.

2603.1E FLEXIBILITY OF SERVICE DELIVERY

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The recipient will determine how to use the weekly authorized hours on an ongoing basis. Any changes that do not increase the total authorized hours can be made, for the recipient's convenience, within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider or PCA.

The following requirements must be met:

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how the total weekly authorized hours will be provided to meet the individual's needs.
2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient's file.
3. Any change to the approved service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how hours and tasks will be provided.
4. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.
5. The ISO provider must follow their established policies and procedures in order to meet recipient requests for changes in service delivery in a timely manner.
6. Written documentation of the contact with the recipient regarding any change to the approved service plan must be maintained in the recipient's file.

2603.1F CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers completing the FASPs. Physical and occupational therapists who complete the FASPs must be an independent third party and may not be:

1. related by blood or marriage to the individual, or to any paid caregiver of the individual;
2. financially responsible for the individual;

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3. empowered to make financial or health-related decisions on behalf of the individual;
4. related by blood or marriage to the Provider who provides PCS to the individual.

The therapist completing the FASP must not have an interest in or employment by a Provider.

Note: To ensure the independence of individuals performing the FASPs, providers are prohibited from contacting the physical or occupational therapists directly.

2603.2 LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

LRI's are individuals who are legally responsible to provide medical support. These individuals include spouses of recipients, legal guardians and parents of minor recipients, including stepparents, foster parents and adoptive parents. LRI's may not be reimbursed for providing PCS.

If the LRI is not capable of providing the necessary services/supports, he or she must provide verification to the DHCFP's QIO-like vendor, from a physician, that they are not capable of providing the supports due to illness or injury. If not available, verification that they are unavailable due to hours of employment and/or school attendance must be provided. Without this verification, PCS will not be authorized.

Additional verification may be required on a case by case basis.

2603.3 PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to direct their own care may opt to utilize a PCR. This individual is directly involved in the day-to-day care of the recipient, is available to direct care in the home, acts on behalf of the recipient when the recipient is unable to direct his or her own personal care services and assumes all medical liability associated with directing the recipient's care. A PCR must be a responsible adult.

For the self-directed service delivery model, the PCR is responsible to hire, manage and schedule PCAs, assumes responsibility for training and manages all paperwork functions.

The PCR must:

1. effectuate, as much as possible, the decision the individual would make for himself/herself;
2. accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;
3. give due consideration to all information including the recommendations of other interested and involved parties;

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4. embody the guiding principles of self-determination; and
5. understand that provision of services is based upon mutual responsibilities between the PCR and the ISO.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A recipient's paid PCA cannot be the recipient's PCR. The PCR must meet all criteria outlined in Section 2603.9 of this chapter. In addition, this individual must be present for the provision of care on a consistent basis, as well as sign daily records. For this reason, it is not allowable for individuals such as a paid PCA, care coordinator or case manager to assume this role.

The PCR may reside outside the home if frequent contact can be made by the recipient, the ISO, and other care providers. The PCR must be available to the recipient, the ISO and other care providers as necessary to fulfill the regular elements of Section 2603.9 of this chapter.

Additionally, if a change in PCR becomes necessary, a new personal care representative agreement must be completed and kept in the recipient's provider file. Contact the ISO to make the necessary changes and to obtain form(s).

2603.4 SERVICES TO CHILDREN

An LRI of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid for PCS services.

PCS for children with disabilities may be appropriate when there is no legally responsible, available and capable parent or LRI, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable must be provided upon request.

In authorizing PCS services to Medicaid eligible children, the FASP factors in the age and developmental level of the child as well as the parent or LRI's availability and capability to provide the child's personal care needs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are available to children under the age of 21. EPSDT may provide a vehicle for receiving medically necessary services beyond the limitations of the PCS benefit. Services must be deemed medically necessary.

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Authorization of additional services under EPSDT must take into account the responsibilities of the LRI and age-appropriate service provision as discussed above.

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with an LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to other housekeeping tasks, meal preparation, essential shopping and escort services.

A child's LRI must be present during the provision of services. If the LRI cannot be present during the provision of services, a PCR designated by the LRI, other than the PCA, must be present during the time services are being provided.

All other policies in this chapter apply.

2603.5 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal condition, and the personal care needs exceed the PCS provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of the individual's comprehensive personal care needs to document any needs not met by hospice and which may be provided by the PCA. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting the total personal care needs. PCS provided under hospice will be subtracted from the total authorized PCS hours.

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed program limits and guidelines.

2603.6 RESIDENTIAL SUPPORT SERVICES/SUPPORTED LIVING ARRANGEMENT (SLA)

Recipients on the Home and Community Based Waiver for Individuals with Intellectual Disabilities and receiving residential support services through a SLA may receive State Plan PCS if the services are determined to be medically necessary and are non-duplicative of the residential support services being provided. The FASP will be completed factoring in the residential support services.

2603.7 SELF-DIRECTED (SD) SKILLED SERVICES

SD Skilled Services are skilled services provided to a recipient by an unlicensed personal care assistant. This option is offered by Nevada Medicaid under the authority of NRS 629.091, where a provider of healthcare can authorize an unlicensed personal care assistant to provide certain

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specific **medical, nursing or home health services**, subject to a number of conditions. All skilled services that are **self-directed and provided by an unlicensed personal care assistant** require a **doctor's order and prior authorization**.

2603.7A PROGRAM ELIGIBILITY CRITERIA

In addition to the requirements **listed in Section 2603.1A**, the following requirements must be met to be determined eligible for SD Skilled Services:

1. The primary physician has determined the condition of the person with a disability is stable and predictable;
2. The primary physician has determined the procedures involved in providing the services are simple and the performance of such procedures by the personal care assistant does not pose a substantial risk to the person with a disability;
3. A provider of healthcare has determined the personal care assistant has the knowledge, skill and ability to perform the services competently;
4. The **PCA** agrees with the provider of health care to refer the person with a disability to the primary physician in accordance with NRS 629.091;
5. Services must be **provided** in the presence of the **LRI or PCR** if the recipient is unable to direct their own care, as in the case of a minor or a cognitively impaired adult, in accordance with NRS 629.091.

2603.7B INITIATING SD SKILLED SERVICES

The recipient or their PCR indicates interest in the SD Skilled Services Model by contacting their **local DHCFP or ADSD Office** directly.

1. The **local DHCFP or ADSD Office** staff provides information to the recipient, **the LRI or the PCR** about the **self-directed services available**. If the recipient is interested in self-direction, a list of **enrolled Medicaid ISO providers** is provided to the recipient to choose and initiate contact with the ISO of his or her choice.
2. The ISO will provide the recipient **with the Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C)** for completion.
3. The ISO must fax the **completed Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C)** and all necessary supporting medical documentation specific to the request to the **QIO-like vendor for processing**.

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2603.7C **COVERAGE AND LIMITATIONS**

1. COVERED SERVICES

SD Skilled Services may be approved for recipients who are chronically ill or disabled who require skilled care to remain at home. **The following criteria must be met:**

- a.** The service(s) are medically necessary and required to maintain or improve the recipient’s health status;
- b.** The service(s) performed must be one that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;
- c.** The service(s) must be sufficient in amount, duration and scope to reasonably achieve its purpose;
- d.** **The service(s) must have prior authorization.**

2. Non-Covered Services

In addition to the non-covered services listed in Section 2603.1C3 reimbursement is not available for:

- a.** **Services provided in a physician’s office, clinic or other outpatient setting;**
- b.** **SD Skilled Services provided in the absence of an LRI or PCR for those individuals who are not able to direct their own care; or**
- b.** **Services normally provided by a legally responsible individual or other willing and capable caregiver.**

3. Medical Criteria

Services must be based on supporting documentation provided by the provider of health care that describes the complexity of the recipient’s care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient’s illness or injury within the context of the recipient’s unique medical condition and the standard of practice within the community.

- a.** The following criteria are used to establish the appropriate complexity of skilled interventions. The DHCFP or its designee makes the final determination regarding the reasonable amount of time for completion of a task based on supporting

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documentation, standards of practice, and/or a home health evaluation, as indicated.

1. Limited Skilled Interventions - Interventions that when performed in combination would not reasonably exceed four hours per week. Limited skilled interventions include, but are not limited to: obtaining vital signs or weights; nail care; suprapubic catheter care; attaching a colostomy bag on a wafer or other attachment device that already adheres to the skin; weekly bowel care; skin care, or catheter care; application of oposite, duoderm, or similar product to an abrasion or stage I wound; application of oxygen; monitoring of oxygen saturation levels; nebulizer treatments performed no more frequently than once daily; once a day glucose monitoring; medication set up; administration of non-complex oral medications; suppositories; enemas; subcutaneous or intramuscular injections; eye drops, nose drops, and/or ear drops; application of a medicated patch, or application of a prescription ointment or lotion to **fewer** than two body parts.
 2. Routine Skilled Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed four hours on a weekly basis. Routine skilled interventions include, but are not limited to: bowel care performed more than once a week; daily pulmonary treatments; nebulizer treatments done more than once a day; catheter changes; stage II to IV wound care; digital stimulation; colostomy care that includes both attaching a colostomy bag on a wafer or other attachment device that already adheres to the skin and changing the wafer or attachment device; multiple straight catheterizations daily; and complex medication administration. Complex medication administration includes, but is not limited to, administration of six or more medications on a different frequency schedule, administration of **m**edications through a feeding tube, and glucose testing and insulin administration occurring more than once a day.
 3. Highly Complex Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed one and one-half or more hours per day to perform. Highly complex interventions may include, but are not limited to: tube feedings; special swallow techniques; peritoneal dialysis; stage III or IV wound care; or care of stage II to stage IV wounds in multiple locations. A physician must provide a written rationale for the time requested to perform this intervention.
- b. Interventions performed on a monthly frequency are not included in calculating the total number of interventions being performed unless the performance of this task requires two or more hours and a physician has provided a written rationale to

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explain this request. If authorized, this intervention will equal one routine intervention.

- c. Additional major procedures not listed here may be considered in determining the complexity of skilled intervention. The DHCFP's QIO-like vendor, or their designee, should be contacted with information on what the procedure is and the amount of skilled time needed to perform this procedure or task.
- d. Clinical Decision Support Guide - See Section 2606. The Clinical Decision Support Guide identifies the benefit limitations for individual recipients based upon supporting documentation provided by the physician that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.

The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the clinical decision support guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.

4. Crisis Override

The SD Skilled Services benefit allows, in rare crisis situations, a short term increase of service hours beyond standard limits. A crisis situation is one that is generally unpredictable and puts the individual at risk of institutionalization without the provision of additional hours.

- a. Coverage and Limitations
 - 1. Additional services may be covered up to twenty percent (20%) above program limits.
 - 2. Additional services are limited to one 60-day interval in a three-year period (calendar years).

The provider must contact the DHCFP QIO-like vendor with information in writing regarding the crisis situation and need for additional hours.

2603.7D AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. SD Skilled Services are authorized by the DHCFP's QIO-like vendor. Services must be requested using Code T1019 plus a TF modifier to represent SD Skilled Services.

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If the TF modifier is not requested, reimbursement for SD Skilled Services will not be approved and subsequent claims will be denied.

1. The ISO must fax the completed **Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C)** and all necessary supporting medical documentation **specific to the request to the QIO-like vendor for processing.**
2. The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the Clinical Decision Support Guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.
3. Prior authorizations are specific to the recipient, a provider, specific services, established quantity of units and for specific dates of service.
4. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained with the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

2603.8 PROVIDER RESPONSIBILITIES

ISO providers shall ensure that services to Medicaid and NCU recipients are provided in accordance to the individual recipient's approved service plan and in accordance with the conditions specified in this chapter and the Medicaid Provider Contract.

Additionally, all ISO providers have the following responsibilities:

1. Certification and/or Licensure

In order to enroll as a Nevada Medicaid ISO provider, all providers must be certified and/or licensed by the DPBH as an ISO or an Agency to Provide Personal Care in the Home and also certified as an ISO.

Providers must comply with licensing requirements and maintain an active certification and/or license at all times.

2. Provider Enrollment

To become a Nevada Medicaid ISO provider, the provider must enroll with the QIO-like vendor as an Intermediary Service Organization (provider type 83).

The provider must meet the conditions of participation as stated in the MSM Chapter 100.

The provider must comply with all local, state and federal regulations and applicable

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statutes, including but not limited to Nevada Revised Statutes Chapters 449 and 629, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA) and the Health Insurance Portability and Accountability Act (HIPAA).

3. Employer of Record

The ISO is the employer of record for the PCAs providing services to a Medicaid recipient who chooses the Self-Directed service delivery model. The ISO shall not serve as the managing employer of the PCA.

4. Recipient Education

The ISO may initiate education of the recipient or PCR in the skills required to act as the managing employer and self-direct care. This may include training on how to recruit, interview, select, manage, evaluate, dismiss and direct the PCA in the delivery of authorized services. Education must begin with an accepted recipient referral and continue throughout the duration of the service provision. Verification of recipient education must be maintained in the recipient's file.

5. Personal Care Assistant (PCA) List

The ISO may, upon request, provide a list of PCAs to recipients, their LRI or their PCR. The recipient, their LRI or PCR may reference this list in recruiting potential PCAs.

6. Backup List

The ISO shall maintain and make available to the recipient, their LRI or PCR, on request, a list of qualified PCAs that may be able to provide back-up services. The ISO is not responsible for arranging or ensuring back-up care is provided as this is the responsibility of the recipient, their LRI or PCR.

7. Backup Plan

The ISO may, upon request, assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. This may include providing a current list of PCAs available to assist in providing appropriate back-up services. The ISO is responsible for documenting the back-up plan that is developed, but is not responsible for arranging or ensuring back-up care is provided, as this is the responsibility of the recipient, their LRI or PCR.

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8. Medicaid and Nevada Check Up (NCU) Eligibility

Verification of Medicaid or NCU eligibility **on a monthly basis** is the responsibility of the ISO.

9. Prior Authorization

The ISO shall obtain prior authorization for services prior to the provision of services. All initial and ongoing services must be prior authorized by the DHCFP's QIO-like vendor. Services which have not been prior authorized will not be reimbursed.

10. Service Initiation

Prior to the **start** of services, the ISO staff must review and document with the recipient, **their LRI or PCR** all components of the MSM **Chapter 2600** and the following items:

- a. The ISO **may** initiate education of the recipient or PCR in the skills required to act as managing employer and self-direct care. **This may** include training on how to recruit, interview, select, **manage**, evaluate, dismiss **and direct the PCAs in the delivery of authorized services**. Documentation of this must be maintained in the recipient's file.
- b. The ISO must review with the recipient, **their LRI or PCR** the **approved** service plan, **weekly** hours, tasks **to be provided** and required paperwork.
- c. The ISO must review with the recipient, **their LRI or PCR** his or her responsibility to establish the PCA's schedule and to establish his or her own back-up plan.
- d. The ISO provider must review with the recipient, **their LRI or PCR** the differences between the Agency and the SD **Service Delivery** Model.

11. PCS Not Permitted

The following are some of the activities that are not within the scope of PCS and are not permitted. This is not an all-inclusive list.

- a. **Skilled Care Services** requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials;
- b. **Increasing and/or decreasing time authorized on the approved service plan;**

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- c. Accepting or carrying keys to the recipient's home;
- d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;
- e. Making personal long-distance telephone calls from the recipient's home;
- f. Performing tasks not identified on the approved service plan;
- g. Providing services that maintain an entire household;
- h. Loaning, borrowing, or accepting gifts of money or personal items from the recipient;
- i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient; and
- j. Care of pets, except in the case where the animal is a certified service animal.

12. Supervision

The ISO must review with the recipient, their LRI or PCR, the recipient's approved service plan. This must be done each time a new service plan is approved. The ISO must clarify with the recipient, their LRI or PCR, the recipient's needs and the tasks to be performed. Documentation of the approved service plan review must be maintained in the recipient's record.

13. Provider Liability

Provider liability responsibilities are included in the Medicaid and NCU Provider Contract.

14. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities make a report to a child protective service agency, an aging and disability services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reasonable cause to believe that a child, adult or older person has been abused, neglected, exploited, isolated or abandoned.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults' age 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. For all other

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individuals (other age groups) contact local law enforcement.

The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

15. Serious Occurrences

The ISO must report all serious occurrences involving the recipient, the PCA, or affecting the provider's ability to deliver services. The Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's ADSD office.

Reportable serious occurrences involving either the recipient or PCA include, but are not limited to the following:

- a. Suspected physical or verbal abuse;
- b. Unplanned hospitalization or ER visit;
- c. Neglect of the recipient;
- d. Exploitation;
- e. Sexual harassment or sexual abuse;
- f. Injuries or falls requiring medical intervention;
- g. An unsafe working environment;
- h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
- i. Death of the recipient;
- j. Loss of contact with the recipient for three consecutive scheduled days;
- k. Medication errors;
- l. Theft;
- m. Medical Emergency; or
- n. Suicide Threats or Attempts.

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16. Health Insurance Portability and Accountability Act (HIPAA), Privacy and Confidentiality

Information on HIPAA, privacy and confidentiality of recipient records and other protected health information is found in MSM Chapter 100.

17. Direct Marketing

Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid PCS recipient or their LRI. All marketing activities conducted must be limited to the general education of the public or health care providers about the benefits of PCS. Such literature may be printed with the company's logo and contact information, however, this literature may not be distributed, unsolicited, to any current or potential Medicaid PCS recipient(s) or their LRI. The provider may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or other cold-call marketing activities.

The provider must ensure that marketing, including plans and materials, are accurate and do not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

- a. the recipient must enroll with the provider in order to obtain benefits or in order not to lose benefits; or
- b. the provider is endorsed, certified or licensed by the DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.

18. Records

The provider must maintain medical and financial records, supporting documents, and all other records relating to **services** provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six years from the date of payment for the specified service.

- a. If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims or audit findings have been finally determined.
 - 1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.
 - 2. The Provider must maintain the required record for each recipient who has

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been provided services, regardless of length of the service period.

- b. At a minimum, the Provider must document the following on all service records:
1. Consistent service delivery within program requirements;
 2. Amount of services provided to recipients;
 3. When services were delivered; and
 4. The services provided and the time spent providing the services. The service record must be initialed daily by the PCA and the recipient, their LRI or PCR to verify service provision.

In the case of electronic service records, the recipient does not have to provide a daily initial on the electronic timesheet to verify daily tasks were provided. The recipient's weekly electronic signature, when the electronic records are completed, verifies the amount of services provided weekly by the PCA and that services were provided in accordance with the approved service plan.

- c. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records. This includes electronic service delivery records.

19. Documentation Requirements

In addition to all of the above responsibilities, if Self-Directed Skilled Services are provided it is the responsibility of the ISO to ensure all requirements of NRS 629.091 are met in order to receive reimbursement for these services. All required documentation must be made available to the DHCFP or its designee immediately upon request.

In order to ensure the safety and well-being of the recipient, documentation specific to this option is required and must be signed by all applicable individuals as identified on each form and updated annually with any significant change in condition. Documentation must be maintained in the recipient's file.

All service delivery records completed by the PCA must be reviewed. The provider will only be paid for the hours and tasks which are provided according to the approved service plan and are documented on the service delivery records. This includes electronic service delivery records.

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20. Discontinuation of Provider Agreement

- a. In the event that a Provider decides to discontinue providing PCS to any of their service areas, the Provider shall:
 - 1. provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and included with the notification;
 - 2. provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and
 - 3. continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.
- b. In the event that the DHCFP discontinues the contractual relationship with a Provider, for any reason, the Provider shall:
 - 1. within five calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to all their current Medicaid recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and be included in this notification.
 - 2. provide reasonable assistance to recipients in transferring services to another provider.

Providers who fail to satisfactorily meet the requirements discussed above shall be prohibited from participation in a new application for any other PCS provider agreement for a period of not less than one year.

2603.9 RECIPIENT RESPONSIBILITIES AND RIGHTS

1. Recipient Responsibilities

Participation in the SD service delivery option is completely voluntary and failure to comply with any of the responsibilities listed below may result in termination of the recipient’s participation in this service delivery option.

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The recipient, **their LRI** or PCR will:

- a. notify the provider of changes in Medicaid or NCU eligibility.
- b. notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare.
- c. notify the provider of changes in medical status, service needs, address and location or in changes of status of legally responsible individual(s) or **PCR**.
- d. treat all staff appropriately.
- e. **manage specific documentation and verification functions.**
- f. establish a backup plan in case a PCA is unable to provide services at the scheduled time.
- g. not request a PCA to work more than the hours authorized on the approved service plan.
- h. not request a PCA to work or clean for non-recipients.
- i. not request a PCA to provide services not on the approved service plan.
- j. comply with all Medicaid policies and procedures as outlined in the MSM, all relevant chapters, including Chapters 100 and 3300.
- k. recruit, interview, select, schedule, direct and dismiss PCAs.
- l. develop a backup plan in the event of failure to maintain continuous coverage of regularly scheduled PCAs.
- m. **Verify services were provided according to the approved service plan and/or doctor's orders by, whenever possible, signing or initialing the PCA documentation of the exact date and time the PCA was in attendance and providing services.**
- n. inform the PCA of the existence of advance directive documents, if these are available, **and provide a copy to the ISO, if appropriate.**
- o. notify the ISO and the **recipient's case manager, if applicable, or the local DHCFP District Office when the recipient, their LRI or PCR no longer wish to self-direct their services and request care be provided** through a provider agency.

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- p. cooperate with the DHCFP or its designee in conducting compliance reviews, investigations or audits.
- q. specify any and all specialized training requirements of the PCA and assure that the specified training has been received.
- r. obtain re-certification for continued services according to policy. This may require that a FASP and/or a new authorization request for Self-Directed Skilled Services Form be completed.

In addition to the responsibilities identified above, the following requirements are applicable to all recipients that opt to self-direct their Skilled Services.

- s. The recipient, LRI and/or PCR are responsible to cooperate fully with the physician and other healthcare providers in order to establish compliance with the requirements set forth in NRS 629.091.
- t. When the recipient desires to provide specialized training, and is able to state and convey his/her own needs and preferences to the PCA, information must be documented in the recipient's file identifying the specific training the recipient has provided.
- u. The authorization request for Self-Directed Skilled Services Form is required and must be completed by a qualified provider for each personal care assistant who will perform the skilled services.

2. Recipient Rights

Every Medicaid and NCU recipient receiving PCS or SD Skilled Services, their LRI or PCR, has the right to:

- a. request a change in service delivery model from the Self-Directed model provided through an ISO to the Provider Agency model for their PCS or a Home Health Agency for their skilled services;
- b. receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;
- c. participate in the development process and receive an explanation of authorized services;
- d. receive a copy of the approved service plan;

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- e. contact the local DHCFP District Office, with questions, complaints, or for additional information;
- f. receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;
- g. know that all communications and records will be treated confidentially;
- h. expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;
- i. receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, FASP determinations and the opportunity for fair a hearing;
- j. request a change of provider;
- k. have access, upon request, to his or her Medicaid recipient files;
- l. request a Fair Hearing if there is disagreement with the DHCFP's action(s) to deny, terminate, reduce or suspend services; and
- m. receive upon request the telephone number of the Office for Consumer Health Assistance.

2603.10 ESCORT SERVICES

Escort services may be authorized in certain situation for recipients who require a PCA to perform an approved PCS task en route to or while obtaining Medicaid reimbursable services.

2603.10A COVERAGE AND LIMITATIONS

Escort services may be authorized as a separate billable service when all the following conditions are met:

1. The needed PCS is currently an authorized task on the approved service plan and will be provided during the course of the visit.
2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a

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physician visit.

3. An LRI is unavailable or incapable of providing the personal care task en route to or during the appointment.
4. Staff at the site of the visit (surgery center, physician's office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) is unable to assist with the needed personal care task.

2603.10B AUTHORIZATION PROCESS

1. The provider must contact the QIO-like vendor for prior authorization for escort services.
2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.
3. A new FASP is not required in this situation.

2603.10C PROVIDER RESPONSIBILITY

1. The provider must verify that all conditions above are met when asking for an escort services authorization.
2. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested. The provider must comply with all other policies in Section 2603.1D of this chapter.

2603.11 TRANSPORTATION

Transportation of the recipient in a provider's vehicle, or the PCA's private vehicle or any other vehicle is not a covered service and is not reimbursable by the DHCFP. Recipients who choose to be transported by the PCA do so at their own risk.

Refer to MSM Chapter 1900, Transportation Services, for requirements of the DHCFP medical transportation program. Medicaid may reimburse for necessary and essential medical transportation to and from medical providers.

2603.12 REIMBURSEMENT

Medicaid reimbursement is made directly to the Provider Agency for services billed using Service Code T1019 for PCS or T1019TF for SD Skilled. The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

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1. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consultant;
2. The cost of criminal background checks and TB testing;
3. Travel time to and between recipients home;
4. The cost of basic training, in-service requirements and the CPR and First Aid requirement;
5. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

2603.13 IMPROPER BILLING PRACTICES

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual.

Any provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include, but are not limited to:

1. submitting claims for unauthorized visits;
2. submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipient's residence;
3. submitting claims for visits without documentation to support the claims billed.
 - a. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the recipient's signature, the month, day, year and time in and out of the recipient's home. Providers shall submit or produce such documentation upon request by the DHCFP staff;
4. submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;
5. billing for the full authorized number of units when they exceed the actual amount of

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service units provided; or submitting claims for PCS provided by an unqualified paid PCA.

6. submitting claims for PCS provided by an unqualified paid PCA.

Any PCS or other provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupments listed in the MSM Chapter 3300. All Medicaid overpayments are subject to recoupment.

Any such action taken against a provider by the DHCFP has no bearing on any criminal liability of the provider.

2603.14 QUALITY ASSURANCE

The DHCFP and/or ADSD may conduct reviews, announced or unannounced, to evaluate the provider's compliance with this chapter and any other regulatory requirement.

These reviews may consist of, but are not limited to, a desk review by the DHCFP and/or ADSD staff and/or an onsite review. Providers must cooperate with the review process. Additionally, reviews may be conducted to verify that providers meet requirements established for each service, to ensure services are being provided and billed for accordingly and that claims for those services are paid in accordance with the State Plan, this chapter and all federal and state regulations.

Reviews may also be conducted to ensure the health and welfare, service satisfaction and freedom of choice of the recipients receiving PCS and/or Skilled Services.

2603.15 ADVERSE ACTIONS

An adverse action refers to a denial, termination, reduction or suspension of an applicant or recipient's request for services or eligibility determination.

For the purposes of this Chapter, the DHCFP or their designee may take adverse action when:

1. the recipient is not eligible for Medicaid;
2. the recipient does not meet the PCS eligibility criteria;
3. the recipient, their LRI or the PCR refuses services or is non-cooperative in the establishment or delivery of services;
4. the recipient, their LRI or the PCR refuses to accept services in accordance with the approved service plan;
5. all or some services are no longer necessary as demonstrated by the FASP;

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6. the recipient's needs can be met by an LRI;
7. the recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child;
8. services requested exceed service limits;
9. services requested are non-covered benefits (refer to 2603.1C.3);
10. another agency or program provides or could provide the services.

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2604 PCS INDEPENDENT CONTRACTOR (IC) MODEL

An **individual** may independently contract with the DHCFP to provide SD Skilled Services and PCS in a recipient’s residence or in a location outside the home, except as excluded per 1905(a)(24) of the Social Security Act. An individual may only apply to the DHCFP to become a **PCS IC** when the need and preference for SD Skilled Services exists, where no **PCS Agency** or ISO is available and when the absence of an IC would constitute a hardship for an eligible recipient. A hardship situation is one in which the recipient is considered to be “at risk.”

An application to become an **IC with Nevada Medicaid** is made through the local DHCFP District Office. Each IC providing PCS must comply with all PCS program criteria. The local DHCFP District Office will inform the potential IC of program criteria, training requirements, etc. The local DHCFP District Office will assist in processing the **IC’s** application which must be submitted to the QIO-like vendor. Once the IC is approved, the local DHCFP District Office will **notify** the **appropriate ADSD case manager who will provide the** IC with the recipient’s service plan and authorized service hours.

2604.1 COVERAGE AND LIMITATIONS

All of the policies discussed in the Section **2603.1C and 2603.7C of this chapter** apply to the IC option.

2604.1A AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. PCS is authorized by the ADSD case manager. The IC shall contact the recipient’s ADSD case manager to obtain prior authorization for services.

2604.1B PROVIDER RESPONSIBILITIES

The IC must assist eligible Medicaid recipients with ADLs and IADLs, as identified on the individual recipient’s service plan and in accordance with the conditions specified in this Chapter and the Medicaid Provider Contract, as well as SD Skilled Services pursuant to NRS 629.091.

In order to ensure the safety and well-being of the recipient, documentation specific to the SD Skilled Services option of the program is required and must be signed by all applicable individuals as identified on each form, and updated annually and/or with any significant change in condition. Current forms are available upon request from the DHCFP or the QIO-like vendor.

1. Provider Enrollment

To become a Nevada Medicaid provider, the IC must enroll with the QIO-like vendor as a Provider Type 58, Specialty 189.

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2. The following policies apply to the IC option:

- a. The IC must verify Medicaid Eligibility monthly.
- b. The Provider shall provide PCS in ADLs and IADLs which are medically necessary and approved on the service plan. The services provided must not exceed the PCA scope of services or limitations defined elsewhere in the MSM.
- c. The IC must review the recipient's service plan with the recipient or their PCR prior to the initiation of services. The IC shall review all allowable tasks, excluded activities and recipient back up plan. Documentation must be maintained in the recipient's file that this requirement has been met.

d. 24 Hour Accessibility

The IC should have reasonable phone access either through a cell phone or home telephone for contact by the recipient or PCR. The IC is not required to maintain 24-hour phone accessibility.

e. Backup Mechanism

The IC has no responsibility to establish a back-up mechanism in the event of an unanticipated, unscheduled absence because this is a recipient or PCR responsibility. The IC must notify the recipient at least two weeks in advance of anticipated time off (vacation, elective surgery etc.).

f. Referral Source Agreement

The IC has no responsibility to establish a referral source agreement as there are no provider agencies within the immediate geographical area.

g. Administrative Functions

The IC **is responsible for** complying with all state regulations regarding independent contractors.

h. Service Initiation

Prior to initiation of services and periodically as needed, the IC must review with the recipient or PCR, the following:

- 1. Advanced Directive, including their right to make decisions about their health care, and the right to execute a living will or grant power of attorney

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to another individual. Refer to MSM Chapter 100 for further information.

2. Procedure to be followed when a PCA does not appear at a scheduled visit or when an additional visit is required.
3. The non-covered service/tasks of the PCS program.
4. The procedure and form used to verify PCA attendance.
5. The recipient's service plan or any changes in the service plan, including the following:
 - a. Authorized service hours;
 - b. PCA's schedule;
 - c. PCA's assigned tasks and pertinent care provided by informal supports; and

i. Supervision

The IC is not required to meet the supervisory requirement of the PCS agency. As an IC the provider is required to perform all PCA services.

j. Training

The IC **may be required to obtain training in the following areas, if directed to do so by the recipient.**

1. Basic Training - Basic training shall involve community resources, such as public health nurses, home economists, physical therapists and social workers. An outline of content of each subject shall be maintained by the **IC.**

Basic training shall be a minimum of 16 hours in length. Basic training **may** include content in the following areas:

- a. Orientation to the service plan, community and the DHCFP medical assistance program services;
- b. Body mechanics and transfer techniques;
- c. Bathing, basic grooming and mobility techniques, including simple

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non-prescribed range of motion;

- d. Personal care skills, including PCS permitted and not permitted (refer to **Sections 2603.1C and 2603.8**);
- e. Care of the home and personal belongings;
- f. Infection control, including information on common communicable diseases, blood borne pathogens, infection control procedures, universal precautions and applicable Occupation Safety Hazard Act (OSHA) requirements;
- g. Household safety and accident prevention, including information on general household safety and how to prevent accidents, poisoning, fires etc. and minimizing the risk of falls;
- h. **F**ood, nutrition and meal preparation, including information on a well-balanced diet, special dietary needs and the proper handling and storage of food;
- i. Bowel and bladder care, including routine care associated with toileting, routine maintenance of indwelling catheter drainage system (emptying bag, positioning, etc.), routine care of colostomies (emptying bag, changing bag), signs and symptoms of urinary tract infections and common bowel problems, such as constipation and diarrhea;
- j. Skin care, including interventions to prevent pressure sores, (repositioning, use of moisturizers, etc.), routine inspections of skin, and reporting skin redness, discoloration or breakdown to the recipient or caregiver;
- k. Health oriented record keeping, including written documentation of services provided and time verification records;
- l. Recipient's rights, including confidentiality pursuant to state and federal regulations and consumer rights;
- m. Communication skills, including basic listening and verbal communication skills, problem solving and conflict resolution skills, as well as alternative modes of communication techniques for individuals with communication or sensory impairments;

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- n. Information including overview of aging and disability (sensory, physical and cognitive) regarding changes related to the aging process, sensitivity training towards aged and disabled individuals, recognition of cultural diversity and insights into dealing with behavioral issues;
- o. **D**irectives, including information regarding the purpose of an advance directive and implications for the PCA.

k. Records

The IC must maintain medical and financial records, supporting documents, and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six years from the date of payment for the specified service.

l. HIPAA, Privacy and Confidentiality

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.

m. Notification of Suspected Abuse or Neglect

Reference **Section 2603.8 of this chapter**.

2604.1C RECIPIENT RESPONSIBILITIES

All of the policies discussed in the **Section 2603.9 of this chapter** apply to the IC model.

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2605 **HEARINGS**

Reference MSM Chapter 3100, Hearings, for Medicaid recipient **hearing procedures** and **Medicaid** provider hearing procedures.

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2606 SELF DIRECTED (SD) SKILLED SERVICES – CLINICAL DECISION SUPPORT GUIDE

Level I	Level II	Level III	Level IV	Level V
Not to exceed 4 hours a week	Not to exceed 10 hours a week	Not to exceed 22 hours a week	Not to exceed 30 hours a week	Not to exceed 40 hours a week
+ Limited skilled interventions	++ One or two routine skilled interventions, with or without limited skilled interventions.	Three to five routine skilled interventions, with or without limited skilled interventions; or	Four to six routine skilled interventions, with or without limited skilled interventions; or	Seven routine skilled interventions, with or without limited skilled interventions; or
		+++ One highly complex skilled and one to two routine skilled intervention(s), with or without limited skilled interventions; or	One highly complex skilled intervention and three to four routine skilled intervention(s), with or without limited skilled interventions; or	One highly complex skilled intervention and five to six routine skilled interventions, with or without limited skilled interventions; or
		Two complex skilled interventions, with or without limited skilled services.	Two highly complex skilled interventions, with either routine skilled interventions or limited skilled interventions.	Two highly complex skilled intervention and two to five routine skilled interventions, with or without limited skilled interventions; or
				Three complex highly skilled interventions, with or without additional routine skilled interventions or limited skilled interventions.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 12, 2014

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2800 – SCHOOL BASED CHILD HEALTH SERVICES

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 2800 are being proposed to reflect the requirement in 34 Code of Federal Regulation (CFR) 300.154(d)(2)(iv) that parental consent be on file and to add a parental notification requirement as mandated by 34 CFR 300.154(d)(2)(v).

These changes are effective July 1, 2014.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 10/14 CHAPTER 2800 – SCHOOL BASED CHILD HEALTH SERVICES	MTL 45/10 CHAPTER 2800 – SCHOOL BASED CHILD HEALTH SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2803.1A.4.p	Policy – Coverage and Limitations – Non-Covered SBCHS	Added language “without parental consent and notification documented services are not covered.”
2803.1B.9	Policy – Provider Responsibility – Eligibility Verification	Removed link to the Quality Improvement Organization (QIO)-like vendor.
2803.1B.13	Policy – Provider Responsibility – Parental Notification and Consent	Added the words “Notification And” in the title for parent notification and consent. Added language that includes parental notification in accordance with the new federal regulation and to meet the documentation required to bill for Medicaid.
2803.1D.1	Policy – Authorization Process	Removed link to the QIO-like vendor.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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SCHOOL BASED CHILD HEALTH SERVICES

2800 INTRODUCTION

School Based Child Health Services (SBCHS) are medical services provided through a child's local school district that are designed to meet the health needs of a child toward the appropriate reduction of the impact of a physical or mental impairment and restoration to the child's best possible functional level. SBCHS are provided to a Medicaid eligible student who meets the Individuals with Disabilities Education Act (IDEA) criteria. SBCHS are reimbursable under the Medicaid program to recipients with special needs pursuant to an Individual Education Plan (IEP). Services are provided in the school setting or other site in the community and may include psychological counseling, nursing services, physical therapy, occupational therapy, speech therapy, audiology, and durable medical equipment.

All Medicaid policies and requirements (such as prior authorization, etc.) except for those listed in Section 1003.14 of the Nevada Check Up Manual, Chapter 1000 are the same for Nevada Check Up.

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2801 AUTHORITY

School Based Child Health Services (SBCHS) contain an element of early detection and preventive service delivery. Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a mandatory benefit authorized by 1905(a) and 1903(4)(c) of the Social Security Act.

SBCHS also contains a rehabilitative element of service delivery. These services are optional benefits under the program and may include psychological counseling, nursing services, physical therapy, occupational therapy, speech therapy and durable medical equipment supplies.

Federal regulations governing SBCHS are:

- Social Security Act Section 1903(c)
- Social Security Act Section 1902(a)(30)(A)
- 42 Code of Federal Regulations (CFR) 441.58.c.
- 42 CFR 440.110, 440.130.d and 440.170
- 42 CFR 447.201
- 42 CFR 431.53
- 42 CFR 435
- 34 CFR 300.154(d)(2)(iv)
- 34 CFR 300.300
- NAC 640A.020
- NAC 640.001 to 006
- State Plan Amendment 3.1-A, G and H

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2802 DEFINITIONS

ACCOMMODATIONS

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

ADAPTIONS

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

ANNUAL GOAL

A statement in a student's 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.

ASSISTIVE COMMUNICATION DEVICE (ACD)

Assistive communication device (ACD) is durable medical equipment which helps speech, hearing and verbally impaired individuals communicate.

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.

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.

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.

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DISABILITY

A physical, sensory, cognitive or affective impairment that causes the student to need special education services.

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

Early and Periodic Screening, Diagnosis, and Treatment Services are 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.

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.

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.

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.

LOCAL EDUCATION AGENCY (LEA)

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

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.

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PARENT

Natural, adoptive, or foster parent of a child (unless a foster parent is prohibited by State Law from serving as a parent); a guardian, but not the State if the child is a ward of the State; 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 an individual who is legally responsible for the child's welfare.

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.

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.

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.

REVIEW AND REVISION OF IEP

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

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.

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.

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SUPPORT SERVICES

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

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2803 POLICY

2803.1 POLICY OVERVIEW

It is the policy of the Division of Health Care Financing and Policy (DHCFP) to support the unique health needs to Medicaid eligible students with a disability in the special education setting. Medicaid covers school based services when they are primarily medical and not educational in nature. This chapter establishes a Medicaid provision for medically necessary health care services a school district may provide to students with special health care needs.

For a school district to receive reimbursement for services through the Medicaid School Based Service program, each Medicaid eligible student must receive an Individualized Education Program (IEP) that specifies the services required to treat his or her identified medical condition(s) (through correction and amelioration of any physical and mental disability).

2803.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

Only those services listed in the State Plan Amendment referring specifically to SBCHS are covered benefits.

- a. School Based Child Health Services (SBCHS) are available for eligible Medicaid and Nevada Check Up children between 3 years of age and under the age of 21, in both Fee-For-Service (FFS) and Managed Care. SBCHS for children who are enrolled in Medicaid Managed Care are covered and reimbursed under the FFS Medicaid. The student must be Medicaid eligible when services are provided;
- b. DHCFP does not reimburse for any services considered educational or recreational in nature;
- c. Any Medicaid eligible child requiring SBCHS services may receive these services from the local school district provided:
 1. All SBCHS relate to a medical diagnosis and are medically necessary;
 2. The service performed is within the scope of the profession of the healthcare practitioner performing the service;
 3. All services including the scope, amount and duration of service are documented as part of the child's school record, including the name(s) of the health practitioner(s) actually providing the service(s);

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4. The treatment services are a part of the recipient’s written IEP on file with the local school district. The plan may be subject to review by authorized DHCFP personnel, and must include the signature by the school-based or family designated physician, Advanced Practitioner of Nursing (APN) or Physician’s Assistant substantiating that the treatment services are medically necessary services.
5. All applicable federal and state Medicaid regulations should be followed, including those for provider qualifications, comparability of services and the amount, duration and scope of provisions;

2. LIMITATIONS

The Nevada Medicaid Program pays for SBCHS services conforming to accepted methods of diagnosis and treatment directly related to the recipient’s diagnosis, symptoms or medical history. Limitations are:

- a. Only qualified health care providers will be reimbursed for their participation in the IEP development for medical related services concerning each specific discipline. Nevada Medicaid reimbursement for the participation time in the IEP development meeting is only allowed for medical related services not educational process and goals.
- b. Services are limited to medical and related services described throughout the Chapter and procedure codes listed on the DHCFP website Provider Type 60 SBCHS Fee Schedule at <http://dhcfp.nv.gov/RatesUnit.htm>.
- c. Services can only be reimbursed when the results of the provided services correct or ameliorate any current or discovered deficits and/or conditions through the evaluation and diagnostic process as identified in the IEP.
- d. Services may not be provided to students under the age of three years old or over the age of 20.

3. COVERED SERVICES

SBCHS are medically necessary diagnostic, evaluative and direct medical services to correct or ameliorate any physical or mental disability that meet the medical needs of disabled children and youth. The services are provided as part of a local public school district special education program to meet the health needs of a child and directed at reducing physical or mental impairment and restoration of the child to his/her best

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possible functioning level. The evaluative and diagnostic services which establish the need for treatment are determined through the IEP process.

SBCHS Covered Services include:

- a. Psychological counseling service when provided by a Nevada licensed psychologist to perform diagnostic and treatment services for student's to fully benefit from an educational program. Refer to Section 2803.4 of this Chapter.
- b. Physical therapy service when provided by a Nevada licensed physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function. Refer to Section 2803.6 of this Chapter.
- c. Nursing services when provided by a Nevada licensed nurse to perform assessment, planning, delivery and evaluation of health services for students whose health impairments require skilled nursing intervention to maintain or improve the student's health status. Refer to Section 2803.5 of this Chapter.
- d. Occupational therapy services when provided by a Nevada licensed occupational therapist to improve or restore function. Refer to Section 2803.7 of this Chapter.
- e. Speech therapy services when provided by a Nevada certified or licensed speech pathologist or audiologist for the treatment of speech, learning and language disorders. Refer to Section 2803.8 of this Chapter.
- f. Assistive communication devices, audiological supplies and disposable medical supplies provided to serve a medical purpose, intervention to maintain or improve the student's health status. Refer to Section 2803.9 of this Chapter.

4. NON-COVERED SBCHS

- a. Medical care not related or identified in the IEP e.g. illness, injury care, health education classes and first aid classes;
- b. Evaluation and/or direct medical service performed by providers who do not meet Medicaid provider qualifications;
- c. Information furnished by the provider to the recipient over the telephone;
- d. Services which are educational, vocational or career oriented;
- e. Speech services involving non-diagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for the child's general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services

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for Medicaid purposes and are not to be covered since they do not require performance by a licensed qualified health care provider;

- f. When maximum benefits from any treatment program are reached, the service is no longer covered. There is no payment for services providing maintenance at maximum functional levels;
- g. Dental or related services (these services are available through the Medicaid Dental program);
- h. Treatment of obesity;
- i. Any immunizations, biological products and other products available free of charge from the State Health Division;
- j. Any examinations and laboratory tests for preventable diseases which are furnished free of charge by the State Division of Health;
- k. Any services recreational in nature, including those services provided by an adaptive specialist or assistant; and
- l. Textbooks or other such items that are educational in nature and do not constitute medical necessity.
- m. Transportation of school aged children to and from school, including specialized transportation for Medicaid eligible children on days when they receive Medicaid covered services at school.
- n. Covered medical service(s) listed in an IEP for those dates of service when the IEP has expired.
- o. Covered medical or treatment service(s) which do not have a referral/prescription or certified as medically necessary by a Nevada licensed physician (school based or family designated), an APN or a Physician's Assistant operating within their scope of practice pursuant to Nevada State law.
- p. **Covered medical services listed in an IEP when parental notification and consent are not documented.**

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2803.1B PROVIDER RESPONSIBILITY

1. GENERAL INFORMATION

The provider shall furnish psychological counseling, nursing services and other therapeutic services such as, physical therapy, occupational therapy, speech therapy, etc. as identified in the IEP.

As a condition of participation in the Nevada Medicaid program, all service providers must abide by the policies of DHCFP and state and federal laws and regulations, including but not limited to, the United States Code of Federal Regulations governing the Medicaid Program, and all state laws and rules governing the Department of Education and the DHCFP. All providers must meet the requirements established for being a Medicaid provider. This includes the Local Education Agency's subcontractors who must be enrolled as Medicaid providers. Department of Education Certification is not sufficient under federal regulations to meet Medicaid provider requirements.

All staff providing services to recipients under the SBCHS program must be licensed or certified by the appropriate state entity or national organization and provide services within their scope of practice.

2. ENROLLMENT PROCEDURES AND REQUIREMENTS

To be enrolled in the Nevada Medicaid Program, a school district must enter into an Inter-Local Agreement, signed by the school district and the DHCFP. Participating providers must comply with Medicaid regulations, procedures and terms of the contract.

The provider must allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review. Refer to the Medicaid Services Manual (MSM) Chapter 100 for medical and fiscal record retention timeframes.

3. MEDICAL OR TREATMENT SERVICES

A medical referral/prescription is a Medicaid requirement for reimbursement. A referral/prescription is any document that indicates that the student is in need of one or more health related service(s). A referral/prescription is required for each school based Medicaid covered service and must be recommended and certified as medically necessary by a licensed physician (school based or family designated), an APN or a Physician's Assistant providing services within the scope of medicine as defined by state law and provided through an IEP.

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The referral/prescription services must be renewed at least annually and/or when the scope, amount and frequency or duration of service(s) has changed. An IEP that includes the required components of a referral/prescription for a service that has been reviewed and signed by a Medicaid qualified provider operating within their scope of practice pursuant to State law may serve as the referral/prescription for service(s).

Treatment services are provided by or under the direction of:

- a. a school-based licensed physician;
- b. a licensed physician or psychiatrist in a community-based or hospital clinic;
- c. a licensed private practice physician or psychiatrist; or
- d. an APN or Physician’s Assistant acting within their scope of practice.

Treatment services may also be provided by a community-based private practitioner performing within the scope of his/her practice as defined by state law. In providing SBCHS at a location other than the school campus, the school districts may contract with community-based licensed health professionals and clinics.

4. BY OR UNDER THE DIRECTION OF

“By or under the direction of” means that the Medicaid qualified staff providing direction is a licensed practitioner of the healing arts qualified under State law and federal regulations to diagnose and treat individuals with the disability or functional limitations at issue and is operating within their scope of practice defined in State law and is supervising each individual’s care.

The supervision must include, at a minimum, face to face contact with the individual initially and periodically as needed, prescribing the services provided and reviewing the need for continued services throughout the course of treatment. The Medicaid qualified supervisor must also assume professional responsibility for the services provided and ensure that the services are medically necessary. The Medicaid qualified supervisor must spend as much time as necessary directly supervising the services to ensure the recipient(s) are receiving services in a safe and efficient manner and in accordance with accepted standards of practice. Documentation must be kept supporting the supervision of services and ongoing involvement in the treatment.

5. RESERVED FOR FUTURE USE

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6. INDIVIDUALIZED EDUCATIONAL PROGRAM (IEP)

The IEP can be used as the initial plan of care when certified by the school-based or family-designated physician, an APN or Physician's Assistant.

Each service is to be documented in the specific service area. The IEP serves as a summary of progress documentation. Treatment is authorized during the period covered by the written IEP only.

7. INDIVIDUALIZED EDUCATION PROGRAM (IEP) ASSESSMENT/EVALUATION

An IEP evaluation/assessment is completed by an interdisciplinary team consisting of a minimum of a psychologist, registered nurse and special education teacher to determine a student's need for further testing. Other professional staff such as physical therapists, occupational therapists and speech therapists may provide input, as well as audiology, vision, health, education and the student's parents. As a result of this process, an IEP will be established outlining treatment modalities.

8. ASSESSMENT

EPSDT screening services should be encouraged for all students. Assessment is an evaluation by a primary diagnostician to determine a student's need for a single service.

This assessment should review the following service areas:

- a. Vision Screening;
- b. Hearing Screening;
- c. Audiological Evaluation;
- d. Speech and Language Screening;
- e. Physical Therapy;
- f. Psychological Evaluation;
- g. Occupational Therapy; and
- h. Nursing Services.

The assessment should validate the need for medical services identified on the IEP.

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9. ELIGIBILITY VERIFICATION

Medicaid recipient eligibility is determined on a monthly basis. Therefore, it is important to verify the child's eligibility on a monthly basis. Payments can only be made for covered services rendered to eligible students. If the student was not eligible on the date the service was rendered, payment will be denied.

Eligibility may be verified by accessing the Automated Response System (ARS) or the Electronic Verification System (EVS) or using Health Insurance Portability Accountability Act (HIPAA) compliant electronic transaction. Refer to our QIO-like vender's website for additional information.

10. RECORDS

The evaluative and diagnostic services which determine the need for treatment and the IEP which defines the treatment needs must be documented as part of the child's school record, including the name(s) of the health practitioner(s) actually providing the service(s). The written IEP must be on file with the participating local school district.

All medical and financial records which reflect services provided must be maintained by the school district and furnished on request to the Department or its authorized representative. A school, as a provider, must keep organized and confidential records that detail all recipient specific information regarding all specific services provided for each individual recipient of services and retain those records for review.

SBCHS providers must maintain appropriate records to document the recipient's progress in meeting the goals of the therapy. Nevada Medicaid reserves the right to review the recipient's records to assure the therapy is restorative and rehabilitative.

11. NON-DISCRIMINATION

School Districts must be in accordance with federal rules and regulations, the Nevada State DHCFP and providers of Medicaid services may not discriminate against recipients on the basis of race, color, national origin, sex, religion, age, disability or handicap.

12. THIRD PARTY LIABILITY (TPL)/FREE CARE PRINCIPAL

In 1988, as a result of the Medicare Catastrophic Coverage Act, Medicaid was authorized by Congress to reimburse for Individuals with Disabilities Education Act (IDEA) related medically necessary services for eligible children before IDEA funds are used. Medicaid reimbursement is available for those services under Social Security Act, Section 1903(c) to be the primary payer to the other resources as an exception. Federal legislation requires Medicaid to be the primary payer for Medicaid services provided to eligible recipients

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under IDEA, Children with Special Health Care Needs, Women’s Infants and Children (WIC) program, Title V programs, Indian Health Services (IHS), or Victims of Crimes Act 1984.

Although Medicaid must pay for services before (or primary to) the U.S. Department of Education (School Districts), it pays secondary to all other sources of payment. As such, Medicaid is referred to as the “payer of last resort”.

Medicaid statutory provisions for TPL preclude Medicaid from paying for services provided to Medicaid recipients if another payer (e.g. health insurer or other state or Federal programs) is legally liable and responsible for providing and paying for services.

The Medicaid program is generally the payer of last resort; exceptions to this principle are IEP and related services, Title V, and WIC, as mentioned previously.

Medicaid is required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. If a state has determined that probable liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third-party liability (referred to as “cost avoidance”). If probable liability has not been established or the third party is not available to pay the individual’s medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as “pay and chase”). Nevada Medicaid has elected to pay and chase for SBCHS found to have TPL.

Services provided through the Americans with Disability Act, Section 504 plans may not be billed to Medicaid. Medicaid is the “payer of last resort”. Medicaid will not reimburse for services that are provided free of charge to other students (the “free care” principal). An exception to this principle is for Medicaid eligible children receiving services under IDEA. Medicaid can be the primary payer for covered medical services under a child’s IEP. Refer to Section 1902(a) (30) (A) of the Social Security Act.

13. PARENTAL **NOTIFICATION AND CONSENT**

Nevada Medicaid and Nevada Check Up may cover medically necessary services that are identified on the IEP. Reimbursement for services under the SBCHS does not interfere with the IDEA program.

In order to assure parents of transparency in the use of Medicaid benefits for their child, documentation demonstrating **parental notification and** parental consent to bill Medicaid is required **in accordance with Federal Regulation**. This information is required to be kept on file for review/audit purposes. The intent of parental **notification** is to inform the parent that Nevada Medicaid may be billed for specific services that are identified through

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the IEP process. **Parental consent** allows the parent the opportunity to decline or accept services rendered to be billed to Nevada Medicaid.

In order for children to remain eligible under the Katie Beckett eligibility category, Medicaid must assure Centers for Medicare and Medicaid Services (CMS) that the per capita expenditures under this program will not exceed the per capita expenditures for the institutional level of care under the state plan. Parents with children eligible under the Katie Beckett program may not want the SBCHS to be billed to Nevada Medicaid as this may impact the child’s eligibility or may result in a cost to the parent for services outside of the school arena. Parents with a child eligible under this benefit program are encouraged to work closely with their Medicaid District Office (DO) case manager to assure services do not impact their eligibility status.

Parental notification and consent must be obtained prior to billing for services that have been identified through the IEP process. The annual IEP meeting provides the schools with an opportunity to review services and request consent to bill services to Nevada Medicaid. Refer to Section 2803.1C of this Chapter. Parents have the right to refuse consent to have their Nevada Medicaid insurance billed at any time.

14. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers will be in compliance with all laws relating to incident of abuse, neglect, or exploitation as it relates to students.

2803.1C RECIPIENT RESPONSIBILITIES

The recipient or authorized representative shall:

1. Provide the school district with a valid Medicaid card at the district’s request.
2. Provide the school district with accurate and current medical information, including diagnosis, attending physician, medication, etc.
3. Notify the school district of all insurance information, including the name of other third party insurance coverage.
4. Participate in the IEP development meeting(s).
5. Every student, their Legally Responsible Adult (LRA) or legal guardian is entitled to receive a statement of students or parent/guardian rights from their school district. The recipient, their LRA, or legal guardian should review and sign this document.

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2803.1D AUTHORIZATION PROCESS

1. Prior authorizations are not required for any School Based Health Services that may be reimbursed for a Medicaid-eligible child. Refer to Section 2803.1A in this chapter outlining service coverage and limitations. Services must be deemed medically necessary and appropriate as defined in this chapter. The treatment services must be documented through the IEP and substantiated that the services are medically necessary by a signature by the school based or family designated physician, APN or Physician's Assistant. A referral and signature do not constitute medical necessity. Refer to MSM Chapter 100 for the definition of medical necessity.

A referral for services must be from a physician or other licensed practitioner of the healing arts operating within their scope of practice under State law to make a determination. Proper documentation is required to show the referral/recommendation for services. CMS recognizes an IEP as a referral for such services once reviewed and signed by a physician.

As a method of protecting the integrity of the SBCHS program, Medicaid will perform retro-review activities on claims data to evaluate medical necessity and billing procedures. Services that have been reimbursed but are shown not to have been documented in the IEP and progress notes of the recipient, as outlined in this chapter, may be subject to recoupment.

Refer to the DHCFP website for billable codes <http://dhcfp.nv.gov/RatesUnit.htm>. The School Based billing manual provider type 60 can be found at our QIO-like vendor's website.

2. MISCELLANEOUS PROVISIONS

- a. All payments for SBCHS are made to the school district. Separate payment will not be made to those individual practitioners who actually provide the services.
- b. The school district can submit claims for reimbursement on a monthly basis maintaining adherence to Medicaid's timely filing requirements. Refer to MSM Chapter 100, Eligibility, coverage and limitations.

2803.2 PROVIDER QUALIFICATIONS

In order to be reimbursed by Nevada Medicaid, all school based services must be provided by a licensed health care provider working within their scope of practice under state and federal regulations.

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It is the responsibility of the school district to assure all billed Medicaid covered services are rendered by the appropriately licensed providers. Each school district must maintain documentation of each rendering practitioner's license, certifications, registration or credentials to practice in Nevada. All documentation must be available, if requested by state or federal agencies.

2803.3 PHYSICIAN, PHYSICIAN'S ASSISTANT & ADVANCED NURSE PRACTITIONER SERVICES

Nevada Medicaid reimburses for covered medical services that are reasonable and medically necessary, performed by a physician or under the personal supervision of a physician and that are within the scope of practice of their prognosis as defined by State law. Services must be performed by the physician or by a licensed professional working under the personal supervision of the physician.

2803.3A COVERAGE AND LIMITATIONS

COVERED SERVICES

1. Evaluation and consultations with providers of covered services for diagnostic and preventive services including participation in a multi-disciplinary team assessment;
2. Record review for diagnostic and prescriptive services;
3. Diagnostic and evaluation services to determine a student's medically related condition that results in the student's need for medical services.
4. IEP/IFSP meeting participation time for the development of medical related services. Payment is excluded for participation time of IEP/IFSP development for educational processes and goals.

2803.4 PSYCHOLOGICAL COUNSELING

Psychological services are diagnostic and treatment services involving mental, emotional, or behavioral problems, disturbances, and dysfunction that meet DHCFP's determination of medical necessity. Performed by a Nevada Licensed Psychologist, services include the evaluation, observation, diagnosis and treatment of general cognitive/intellectual functioning or social, emotional or behavioral problems resulting in the student's inability to fully benefit from an educational program. Medicaid State Plan for school based services does not allow these services to be billed by a master's level social worker, marriage family therapist or other mid-level clinician.

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2803.4A COVERAGE AND LIMITATIONS

COVERED SERVICES

1. Mental Health assessment, evaluation and diagnosis by a psychologist to determine the general cognitive/intellectual functioning of a student and/or to determine the presence and extent of social, emotional, or behavioral problems that affect the student's educational performance;
2. Individual services provided to a student and/or a student and his/her family in order to remediate social, emotional and/or behavioral problems necessary to promote the student's ability to benefit fully from an educational program;
3. Group services provided to more than one student and/or students and their families simultaneously in order to remediate social, emotional and/or behavioral problems necessary to promote the student's ability to benefit fully from an educational program;
4. Psychological testing, assessment of motor language, social, adaptive and/or cognitive functioning by standardized development instruments (non-educational cognitive); and
5. IEP/IFSP meeting participation time for the development of medical related services. Payment is excluded for participation time of IEP/IFSP development for educational processes and goals.

2803.5 NURSING SERVICES

Skilled nursing refers to assessments, judgments, interventions, and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the student's care and the frequency of skilled nursing interventions.

Skilled nursing services are a covered service when provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of a registered nurse in accordance with the IEP, to be safe and effective. An LPN may participate in the implementation of the plan of care for providing care to students under the supervision of a licensed RN, or physician, or advanced nurse practitioner that meet the federal requirements at 42 CFR 440.166. Services considered observational or stand-by in nature are not covered. Nursing Services are provided to an individual on a direct, one-to-one basis, on site within the school district setting.

2803.5A COVERAGE AND LIMITATIONS

Nursing Services are provided by a RN or LPN licensed by the State of Nevada under the supervision of an RN and acting within their scope of practice. These services may include, but are not limited to:

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1. Evaluations and assessments (RN only);
2. Care and maintenance of tracheotomies;
3. Catheterization or catheter care;
4. Oral or tracheal suctioning;
5. Oxygen administration;
6. Prescription medication administration that is part of the IEP/IFSP;
7. Tube feedings;
8. Ventilator Care; or
9. IEP/IFSP meeting participation time for the development of medical related services. Payment is excluded for participation time of IEP/IFSP development for educational processes and goals. (RN only)

2803.6 PHYSICAL THERAPY SERVICES

Physical Therapy Services are performed by an appropriately certified or licensed physical therapist who develops a written individual program of treatment. School-based license physical therapist assistants functioning under the supervision of the school-based licensed physical therapist may assist in the delivery of the plan of treatment.

Physical Therapy means services prescribed by a physician or other licensed practitioner of the healing arts operating within the scope of practice under State law and provided to a student by or under the direction of a qualified physical therapist to ameliorate or improve neuromuscular, musculoskeletal and cardiopulmonary disabilities.

Physical Therapy Evaluation, and Treatment includes: assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving treatment.

2803.6A COVERAGE AND LIMITATIONS:

COVERED SERVICES

1. Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments effecting areas such as tone, coordination, movement, strength, and balance;

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2. Individual therapy provided to a student in order to correct or ameliorate the effects of motor delays, disabilities and/or physical impairments;
3. Group Therapy provided to more than one student, but less than seven, simultaneously in order to remediate correct or ameliorate the effects of motor delays, disabilities, and/or physical impairments;
4. Therapeutic exercise, application of heat, cold, water, air, sound, massage and electricity;
5. Measurements of strength, balance, endurance, range of motion; and
6. IEP/IFSP meeting participation time for the development of medical related services. Payment is excluded for participation time IEP/IFSP development for educational processes and goals.

2803.7 OCCUPATIONAL THERAPY SERVICES

Occupational Therapy is provided by an appropriately licensed occupational therapist who evaluates the student's level of functioning and develops a plan of treatment. School-based licensed occupational therapist assistants functioning under the general supervision of the school-based licensed occupational therapist may assist in the delivery of the plan of treatment.

Occupational Therapy Evaluation and Treatment includes: assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation; improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or lost of function; obtaining and interpreting information; coordinating care and integrating services student is receiving.

2803.7A COVERAGE AND LIMITATIONS

COVERED SERVICES

1. Evaluation and diagnosis to determine the extent of a student's disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;
2. Individual Therapy provided to a student to remediate and/or adapt skills necessary to promote the student's ability to function independently;
3. Group Therapy provided to more than one student but less than seven simultaneously to correct or ameliorate and/or adapt skills necessary to promote the students' ability to function independently;

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4. Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits;
5. Exercise to enhance functional performance;
6. IEP/IFSP meeting participation time for the development of medical related services. Payment is excluded for participation time of IEP/IFSP development for educational processes and goals.

2803.8 SPEECH THERAPY AND AUDIOLOGY SERVICES

Speech, hearing and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication or the condition of the student must be such that the services required can be safely and effectively performed only by a qualified therapist.

The practice of audiology consists of rendering services for the measurement, testing, appraisal prediction, consultation, counseling, research or treatment of hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing. Audiology services must be performed by a certified and licensed audiologist.

2803.8A COVERAGE AND LIMITATIONS

COVERED SERVICES

1. Speech and Language evaluation and diagnosis of delays and/or disabilities including, but not limited to, voice, communication, fluency, articulation, or language development. Audiological evaluation and diagnosis to determine the presence and extent of hearing impairments that affect the student's educational performance. Audiological evaluations include complete hearing and/or hearing aid evaluation, hearing aid fittings or re-evaluations, and audiograms.
2. Individual Therapy provided to a student in order to correct or ameliorate delays and/or disabilities associated with speech, language, hearing, or communication.
3. Group Therapy provided to one student, but less than seven, simultaneously in order to correct or ameliorate delays and/or disabilities associated with speech, language, hearing, or communication.

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4. IEP/IFSP meeting participation time for the development of medical related services. Payment is excluded for participation time of IEP/IFSP development for educational processes and goals.

2803.9 AUDIOLOGICAL SUPPLIES, EQUIPMENT, MEDICAL SUPPLIES AND OTHER DURABLE MEDICAL EQUIPMENT

The school district, as a Medicaid provider type 60, may be reimbursed for medically necessary audiology supplies, equipment and medical supplies when shown to be appropriate to increase, or improve the functional capabilities of individuals with disabilities. Refer to the DHCFP website for list of available HCPCS codes: Provider Type 60 SBCHS: Fee Schedule <http://dhcftp.nv.gov/RatesUnit.htm>.

Such services must be reviewed and recommended by the presence of a signature on either the IEP or a prescription by a licensed physician, APN or Physician's Assistant providing services within the scope of medicine as defined by state law and provided through the IEP.

2803.9A COVERAGE AND LIMITATIONS

1. Disposable medical supplies are items purchased for use at school or home which are not durable or reusable, such as surgical dressings, disposable syringes, catheters, tracheotomy dressings, urinary tray, etc. Provider Type 60 may dispense audiological supplies, equipment and medical supplies by their qualified practitioners acting within the scope of their practice under State law.
2. Durable Medical Equipment (DME) is considered items such as assistive communication devices (e.g. Speech Generating Devices), wheelchairs, canes, standers, walkers, etc. Medicaid DME Providers are qualified to dispense and receive reimbursement for medically necessary durable medical equipment, prosthetic, orthotics and supplies. Some services may require prior authorization.
3. DME, assistive communication devices, audiology supplies, equipment and medical supplies are for the exclusive use of the student that can be used at school, at home and is the property of the student.

Refer to Chapter 1300 (DME, Prostheses and Disposable Supplies) for coverage and limitations on durable medical equipment, prostheses and disposable medical supplies.

Refer to Chapter 2000 (Audiological Services) for coverage and limitations on audiological supplies and equipment.

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2804 HEARINGS

Please reference MSM, Chapter 3100 Hearings, for hearing procedures.

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2805 REFERENCES AND CROSS REFERENCES

2805.1 RESERVE FOR FUTURE USE

2805.2 PROVIDER SPECIFIC INFORMATION

Specific information about each provider type can be found in the following MSM and Nevada Check Up Manual Chapters:

Medicaid Services Manual:

Chapter 100	Medicaid Program
Chapter 400	Mental Health and Alcohol Substance Abuse Services
Chapter 600	Physician Services
Chapter 1300	DME, Disposable Supplies and Supplements
Chapter 1500	Healthy Kids Program (EPSDT)
Chapter 1700	Therapy
Chapter 2000	Audiology Services
Chapter 3100	Hearings
Chapter 3300	Program Integrity
Chapter 3600	Managed Care Organization

Nevada Check Up Manual:

Chapter 1000	Nevada Check Up Program
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2805.3 CONTRACTED QIO-LIKE VENDOR AND FISCAL AGENT

Medicaid's fiscal agent is responsible for provider training, claims adjudication, medical review, provider audits, and handling disputed payments. Written correspondence and paper claims must be sent to the following address:

The DHCFP's contracted QIO-like Vendor and fiscal agent is:

Magellan Medicaid Administration, Inc.P.O. BOX 30042

Reno, NV 89520-3042

Toll Free within Nevada (877) NEV-FHSC (638-3472)

Website: <http://nevada.fhsc.com>

ATTACHMENT A

Qualified Nevada Medicaid Providers	Supervisor	Supervisee Bill "Under The Direction of a Supervisor"
PHYSICIAN SERVICES		
Physician licensed by the Nevada State Board of Medical Examiners acting within their scope of practice	✓	
Physician Assistant licensed by the Nevada State Board of Medical Examiners or certification by the Nevada State Board of Osteopathic Medicine to perform medical services supervised by a licensed physician in accordance with professional standards.		✓
PSYCHOLOGY SERVICES		
A Doctorate Degree in Psychology and licensed by the State of Nevada Board of Psychological Examiners.	✓	N/A
NURSING SERVICES		
A Registered Nurse licensed by the Nevada State Board of Nursing.	✓	
A licensed Practical Nurse licensed by the Nevada State Board of Nursing. Supervised by a licensed Registered Nurse in accordance with professional standards.		✓
OCCUPATIONAL THERAPY SERVICES		
A Occupational Therapist licensed by the State of Nevada Board of Occupational Therapy	✓	
An Occupational Therapy Assistant certified by the State of Nevada Board of Occupational Board of Therapy. Supervised by a Licensed Occupational Therapist in accordance with professional standards.		✓
PHYSICAL THERAPY SERVICES		
A Physical Therapist licensed by the State of Nevada Physical Therapy Examiners Board	✓	
A Physical Therapist Assistant licensed by the State of Nevada Physical Therapy Examiners Board. Supervised by a licensed Physical Therapist in accordance with professional standards.		✓
SPEECH PATHOLOGIST SERVICES		
Nevada Board of Examiners for Audiology and Speech Pathology NRS 637B.160 <u>and</u> has Certificate of Clinical Competence from the American Speech and Hearing Association. CCC's	✓	
Nevada Board of Examiners for Audiology and Speech Pathology NRS 637B.160 with no CCC (has master's)	✓	
Licensed Department of Education NAC 391.370 2(b) with CCC or licensed with NV Board of Examiners	✓	
Licensed by Department of Education NAC 391.370 2(a), (c), (d),(e)		✓
Master's degree with no CCC's		✓
Department of Education licensure + CCC + Board of Examiner Licensure	✓	
AUDIOLOGY SERVICES		
Audiologist licensed by the State of Nevada Board of Examiners for Audiology and Speech Pathology	✓	N/A
Durable Medical Equipment		
Licensed with a Medical Device and Equipment and Gas by Nevada State Board of Pharmacy and enrolled as a DME Nevada Medicaid Provider.	N/A	N/A
AUDIOLOGICAL AND MEDICAL SUPPLIES		
Licensed with a Medical Device and Equipment and Gas by Nevada State Board of Pharmacy and enrolled as a DME Nevada Medicaid Provider or Local Education Agency enrolled as a Medicaid provider; or	N/A	N/A
Local Education Agency enrolled as a Medicaid provider being reimbursed for supplies dispensed by qualified practitioners' action within their scope of practice under Federal and State regulations.	N/A	N/A

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 30, 2014

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3000 -INDIAN HEALTH PROGRAM



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3000 are being proposed to increase from three to five face-to-face encounter/visits per recipient per day. The professional groups eligible for an encounter/visit are being proposed for removal and replaced with new verbiage. The verbiage is updated to "healthcare professionals as approved under the Nevada Medicaid State Plan".

These changes are effective January 01, 2015.

MATERIAL TRANSMITTED

MTL 22/14
CHAPTER 3000 - INDIAN HEALTH
PROGRAM

MATERIAL SUPERSEDED

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Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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3003.1

Health Services

Added language "visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan."

Removed professional groups.

Removed language regarding three encounter visits.

Added language regarding five face-to-face encounter visits.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

3000 INTRODUCTION

Medically necessary (as defined in Medicaid Services Manual (MSM) Chapter 100 (Medicaid Program) services are reimbursable when the services are provided by an Indian Health Program to an eligible American Indian or Alaskan Native (AI/AN) Medicaid or Nevada Check Up recipient. Indian Health Programs may be operated by the Indian Health Service (IHS), Tribal Organization, or an Urban Indian Organization – (I/T/U).

Numerous public laws guide federal and state interactions with tribal governments and AI/ANs. A basic understanding of these laws is essential to help facilitate the collaborative relationship between the DHCFP and the tribes within the State of Nevada. Below is a brief summation of these laws.

WORCESTER V. GEORGIA (1832): The Supreme Court of the United States held that the federal government, and not state governments, had exclusive “authority over American Indian Affairs”.

GENERAL ALLOTMENT ACT OF 1877

The Act authorized the President of the United States to partial reservation lands into general allotments. Federal trust land owned or possessed by an AI/AN may be exempt from Medicaid estate recovery.

SNYDER ACT OF 1921

The Act made the federal government responsible for the health care of AI/ANs.

INDIAN CITIZENSHIP ACT OF 1924

The Act granted AI/ANs dual citizenship.

INDIAN REORGANIZATION ACT OF 1934

The Act reversed the General Allotment Act. The Act reinstated self-governance and returned tribal lands to respective tribal governments.

INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT OF 1975

Prior to this Act, the federal government managed, coordinated, and provided health care services for AI/ANs. The Act authorized tribal governments to establish contracts and compacts with the federal government. In general, tribal governments may plan, conduct, and administer their own public programs – to include Indian Health Programs.

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INDIAN HEALTH CARE IMPROVEMENT ACT OF 1976

The Act authorized 100 percent federal reimbursement to states for medical services provided to AI/ANs when provided through the Indian Health Service (IHS) and/or tribal organizations.

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

The Act established:

- Guidelines surrounding the enrollment of AI/ANs in Medicaid Managed Care Organizations (MCO);
- Prohibitions of state Medicaid agencies from charging AI/AN premiums and cost shares for services provided through Indian Health Programs or tribal organizations to AI/ANs;
- Protections of certain properties held by AI/AN from federal or state recovery; and
- Mandates that states seek ongoing advice from Indian Health Programs on issues that are likely to have a direct effect on Indian Health Programs.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Act reauthorized and made permanent the Indian Health Care Improvement Act.

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3001 AUTHORITY

- Public Law (PL) 49-43: General Allotment Act of 1877
- PL 67-85: Snyder Act of 1921
- PL 68-175: Indian Citizenship Act of 1924
- PL 73-383: General Allotment Act of 1934
- PL 93-638: Indian Self-Determination and Education Act of 1975
- PL 94-437: Indian Health Care Improvement Act of 1976
- Social Security Act (SSA), Title XIX (Grants to States for Medical Assistance Programs), Chapter 1905 (Definitions), Section (b)
- SSA, Title XIX, Chapter 1911 (Indian Health Service Facilities)
- SSA, Title XIX, Chapter 1916A (State Option for Alternative Premiums and Cost Sharing)
- SSA, Title XIX, Chapter 1917 (Liens, Adjustments and Recoveries, and Transfers of Assets)
- SSA, Title XIX, Chapter 1932 (Provisions Relating to Managed Care)
- United States Code (USC), Title 25 (Indians), Chapter 14 (Miscellaneous), Subchapter II (Indian Self-Determination and Education Assistance)
- USC, Title 25 (Indians), Chapter 18 (Indian Health Care)
- Code of Federal Regulations, Title 42 (Public Health), Chapter IV (Centers for Medicare & Medicaid Services, Department of Health and Human Services), Section 431.110 (Participation by Indians Health Service Facilities)
- Johnson v. McIntosh (1823)
- Worcester v. Georgia (1832)
- United States v. Wheeler (1978)

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3002 DEFINITIONS

A. American Indians and Alaskan Natives (AI/AN)

In accordance with 25 USC, Section 1602: “The term [eligible] Indians or Indian, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who:

1. Irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member, or
2. Is an Eskimo or Aleut or other Alaska Native, or
3. Is considered by the Secretary of the Interior to be an Indian for any purpose, or
4. Is determined to be an Indian under regulations promulgated by the Secretary.”

B. Children, Eligible

“Any individual who:

1. has not attained 19 years of age;
2. is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and
3. is not otherwise eligible for health services provided by the Indian Health Service (IHS), shall be eligible for all health services provided by IHS on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age.”

C. Indian Descent, Eligible

Indian descendants may be eligible for Indian health services if:

1. They are verifiable descendants of an enrolled tribal member – as established by each tribe;
2. The recipient belongs to an Indian community which may be verified by tribal

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record or census number; and

3. The recipient lives within the established contract health service delivery area.

D. Indian Health Programs

Indian Health Programs include the IHS, Tribal Organizations and Urban Indian Organizations (I/T/U):

1. Indian Health Service: IHS is a federal agency within the Department of Health and Human Services (DHHS).
2. Tribal Organizations: Tribal Organizations are operated by tribal governments.
3. Urban Indian Organizations: Urban Indian Organizations are nonprofit organizations.

E. Pregnant Woman, Non-Indian, Non-Spouse, Eligibility

During the period of her pregnancy through postpartum - a non-Indian, non-spouse pregnant woman with an eligible Indian child is eligible for tribal organization health services on the same basis and subject to the same rules that apply to eligible Indians.

F. Sovereignty, Trust Relationship

Federally recognized tribes are sovereign governments. They may establish their own governments, establish tribal membership guidelines, and create and enforce their own laws.

G. Tribes, Federally Recognized

Any Indian tribe, band, nation, or other organized group or community, which the Federal government recognizes as eligible for programs and services provided by the United States to AI/AN.

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3003 POLICY

It is the policy of the Division of Health Care Financing and Policy (DHCFP) to follow State and Federal laws, uphold the tribal-state consultation process, and promote Indian Health Programs (IHP).

3003.1 HEALTH SERVICES

A. The DHCFP reimburses Indian Health Services (IHS) and Tribal organizations an outpatient encounter rate.

1. Encounter **visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan.** Each **healthcare professional is considered an independent (i.e., separate) outpatient encounter.**
2. Service Limits: Eligible Indians may receive up to **five face-to-face IHS** and/or Tribal Organization outpatient encounter/**visits** per day, per recipient, any provider.
3. Medical Necessity: In order to receive reimbursement, all services must be medically necessary as defined in the Medicaid Services Manual (MSM), Chapter 100 (Medicaid Program).

B. Primary Care Provider (PCP)

In accordance with the American Recovery and Reinvestment Act of 2009, the DHCFP supports eligible Indians in selecting an Indian Health Program as their PCP. These recipients may select an Indian Health Program as their PCP, whether they are enrolled in managed care or fee-for-service (FFS). Indian Health Programs that become PCPs for eligible Indians do not have to be, but may be, enrolled with either of the Managed Care Organizations (MCOs). Services which are referred out by PCPs must follow the service limitation and prior authorization requirements set forth by the applicable benefit plan (i.e., managed care or FFS).

C. Managed Care Enrollment

Eligible Indians are exempt from mandatory enrollment in managed care. In situations where Indians voluntarily enroll in managed care, they may access health care services from Indian Health Programs without restriction. Health care services provided to Indians through the IHS and/or tribal organizations may be reimbursed FFS or through the MCO.

D. Prior Authorizations

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1. Medically necessary services provided by the IHS and/or Tribal Organizations do not require prior authorization when:
 - a. The service is provided to an eligible Indian; and
 - b. The service is provided through IHS or a Tribal Organization.

E. Program Funding

1. Premiums and Cost Sharing

- a. Adults – Age 21 and older: Eligible Indians may not be charged premiums or cost shares when they receive medical services through an Indian Health Program.
- b. Children – Age 20 and younger: Eligible Indian children may not be charged premiums or cost shares for covered Nevada Medicaid and/or Check Up services – regardless if the services are provided through an Indian Health Program, FFS providers or an MCO.

1. Federal Medical Assistance Percentage (FMAP)

The FMAP for services provided by the IHS or Tribal Organizations to eligible Indians is 100 percent. This percentage does not apply to non-emergency transportation services.

2. The FMAP for medical services provided by Urban Indian Organizations to eligible Indians is the established state percentage.

3. Rates

- a. IHS and Tribal Organization Clinics – Provider Type 47 (PT 47): PT 47s are paid the federally established Outpatient Per Visit Rate (i.e., encounter rate). The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.
- b. Tribal Organization Inpatient Hospitals – Provider Type 51 (PT 51): PT 51s are paid the federally established Inpatient Hospital Per Diem Rate. The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.

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- c. IHS Inpatient Hospitals – Provider Type 78 (PT 78): PT 78s are paid the federally established Inpatient Hospital Per Diem Rate. The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.

F. Facility Licensure and Accreditation

1. IHS and Tribal Organizations:

- a. Licensure: Facility licensure is not required.
- b. Accreditation: In accordance with the Indian Health Care Improvement Act, to assure nondiscrimination, Indian Health Programs must follow the same provider enrollment criteria as other similar Medicaid provider types. The DHCFP does not require tribal clinics to be accredited.

G. Staff Licensure and Certification

Health care professionals do not have to be licensed in the State of Nevada if:

- 1. They provide services at an Indian Health Program; and
- 2. They are currently licensed in another state.

H. Transportation

- 1. Non-emergency transportation is not a covered IHS benefit. Indian Health Programs may enroll with the DHCFP’s Non-Emergency Transportation (NET) broker (see MSM Chapter 1900).
- 2. Ambulance, Air or Ground – Provider Type 32: While emergency medical transportation is not a covered IHS benefit, qualified Indian Health Programs may enroll as a Provider Type 32 (see MSM Chapter 1900).

3003.2 TRIBAL GOVERNMENTS

A. Consultations

The DHCFP will consult with Tribes and Indian Health Programs on Medicaid State Plan Amendments (SPAs), waiver requests, waiver renewals, demonstration project proposals and/or on matters that relate to Medicaid and Nevada Check Up programs.

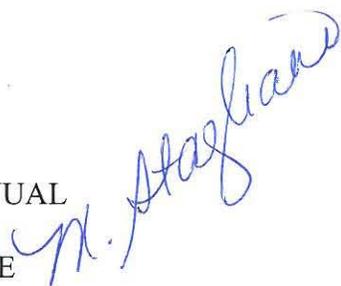
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1. The notification will describe the purpose of the SPA, waiver request, waiver renewal, demonstration project proposal and/or on matters relating to Medicaid and Nevada Check Up programs and will include the anticipated impact on Tribal members, Tribes and/or Indian Health Programs.
2. The notification will also describe a method for Tribes and/or Indian Health Programs to provide official written comments and questions within a time-frame that allows adequate time for State analysis, consideration of any issues that are raised and the time for discussion between the State and entities responding to the notification.
3. Tribes and Indian Health Programs will be provided a reasonable amount of time to respond to the notification. Whereof, 30 days is considered reasonable.
4. In all cases where Tribes and/or Indian Health Programs request in-person consultation meetings, the DHCFP will make these meetings available.
5. The tribe-state consultation process allows for an expedited process for notification of policy changes due to budget cuts prior to changes being implemented. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid SPAs, waiver requests and waiver renewals, which fall within this category to have a notification process prior to these documents being submitted to CMS. Due to this, the State is instituting an expedited process which allows for notification to the Tribes and Indian Health Programs of at least one week notice prior to the changes being implemented as agreed upon in the tribe-state consultation process or two weeks prior to the submission of the SPAs, waiver requests and/or waiver renewals, whichever date precedes.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 12, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3100 – HEARINGS



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3100 were made to allow a recipient to request a Fair Hearing when assigned (locked in) to one pharmacy for all controlled substance prescriptions; to allow a Nevada Medicaid or Nevada Check Up (NCU) provider to request a Fair Hearing for a suspension, sanction, lockout or termination; and to allow a Nevada Medicaid or NCU provider to request a Fair Hearing for a denial of Incentive Payment Program for Electronic Health Records (EHR) enrollment.

Language was clarified to include other third party Plan or Program Administrators as entities that may make an adverse determination against a Nevada Medicaid or NCU provider; are included as an entity that a provider must exhaust any internal grievance process through if such a process is available; and are included as an entity that a Fair Hearing written request may be submitted to the Division of Health Care Financing and Policy (DHCFP) Hearings office by a provider who disagrees with the third party Plan or Program Administrator's determination notification.

Additionally, language was added that all providers or their authorized representatives must sign all requests for a Fair Hearing.

These changes are effective October 1, 2013.

MATERIAL TRANSMITTED

MTL 14/13
Chapter 3100 - Hearings

MATERIAL SUPERSEDED

MTL 18/11
Chapter 3100 - Hearings

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3103.1	Policy	Standardized language.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3104.1A.2	Medicaid Services Fair Hearing	Standardized language.
3104.1A.3	Medicaid Services Fair Hearing	Added pharmacy assignment (lock in) language. Standardized language.
3105.1A	Request For a Medicaid Provider Fair Hearing	Added third party Plan or Program Administrator as an entity that a Nevada Medicaid or Nevada Check Up provider may request a Fair Hearing against when they disagree with an adverse determination taken against them.
3105.1A.3	Request For a Medicaid Provider Fair Hearing	Added suspension, sanction and termination as additional adverse determination reasons that a Nevada Medicaid or Nevada Check Up provider may request a Fair Hearing on when they disagree with the adverse determination taken against them.
3105.1A.6	Request For a Medicaid Provider Fair Hearing	Added a denial of Incentive Payment Program for Electronic Health Record (EHR) enrollment as an adverse determination reason that a Nevada Medicaid or Nevada Check Up provider may request a Fair Hearing on when they disagree with an adverse determination taken against them.
3105.1A	Request For a Medicaid Provider Fair Hearing	Included a third party Plan or Program Administrator as an entity that a provider must exhaust any internal grievance process through if such a process is available.
3105.1C	Request For a Medicaid Provider Fair Hearing	Included a third party Plan or Program Administrator as an entity that a Fair Hearing written request may be submitted to the DHCFP Hearings office by a provider who disagrees with the determination notification.

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3100 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) (also referred to as agency) makes a Fair Hearing process available to any Nevada Medicaid or Nevada Check Up (NCU) recipient who disagrees with: any action resulting in the reduction, suspension, termination, denial or denial-in-part of a Medicaid service; any recipient who makes a request for a service and believes the request was not acted upon with reasonable promptness by DHCFP and/or the Health Plan; and any NCU applicant or authorized representative who chooses to formally aggrieve a denial and/or disenrollment eligibility determination. Also, the DHCFP makes available a Fair Hearing process for any Nursing Facility (NF) resident eviction.

The DHCFP makes available a Fair Hearing process whereby providers may request a hearing for any adverse action taken by the Division or its agents, which affects the provider's participation in the Medicaid program, reimbursement for services rendered to eligible Medicaid recipients recoupment of overpayments or disenrollment.

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

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3101 REGULATORY AUTHORITY

The Fair Hearing process for recipients is a mandated service. The citation denoting the right to a hearing is found in 42 Code of Federal Regulations (CFR), §431, Subpart E; 42 CFR 457.1130 and Nevada Revised Statute (NRS) 422.3045. In addition, the citation denoting the appeals procedure for Nursing Facilities (NF) and Intermediate Care Facility for the Mentally Retarded (ICF/MR) is found in 42 CFR §431, Subpart D.

The Fair Hearing process for providers is cited at NRS Chapter 422.306 – Hearing to review action taken against provider of services under state plan for Medicaid regulations; appeal of final decision.

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3102 RESERVED

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3103 POLICY

3103.1 Pursuant to Code of Federal Regulations (42 CFR) at 431 Subpart E, the Division of Health Care Financing and Policy (DHCFP), will provide an opportunity for a Fair Hearing to any person whose claim for assistance is denied, reduced, suspended, terminated or not acted upon promptly. Pursuant to Nevada Revised Statute (NRS) 422.276, **the** DHCFP will provide an opportunity for a Fair Hearing to any person whose claim for service was not acted upon promptly.

Pursuant to NRS 422.306, **the** DHCFP will provide an opportunity for a Fair Hearing to review an adverse action taken against a provider of services.

The DHCFP provides the Fair Hearing process pursuant to Sections 3104 and 3105 of this Chapter.

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MEDICAID SERVICES MANUAL	Subject: RECIPIENT HEARINGS

- 3104 RECIPIENT FAIR HEARINGS
- 3104.1 FAIR HEARINGS
- 3104.1A MEDICAID SERVICES FAIR HEARING

1. WHO MAY REQUEST

A recipient or his authorized representative may request a Fair Hearing. A request for a Fair Hearing must be made in writing and signed by the recipient or the recipient's authorized representative.

2. DATE OF REQUEST

The date of the request for a Fair Hearing is the date the request is received by the **Division of Health Care Financing and Policy (DHCFP)** office. The request must be received by the DHCFP office within 90 calendar days from the Notice Date, unless a recipient can substantiate "good cause" for not doing so. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

The request for hearing must contain the recipient's name, address, telephone number and Medicaid number as well as the name, telephone number and address of the authorized representative, if applicable.

3. SUBJECT MATTER

The DHCFP must grant an opportunity for a hearing to:

- a. a recipient who requests it because his request for services is denied, reduced, suspended or terminated;
- b. a recipient who requests it because his request for services is not acted upon with reasonable promptness;
- c. a recipient who requests it because he believes the agency or Health Plan has taken an Action erroneously;
- d. any resident of a nursing facility who believes the facility erroneously determined that he must be transferred or discharged;
- e. any recipient who requests it because he believes the State has made an erroneous determination with regard to the Preadmission Screening and Annual Resident Review (PASARR) as outlined in Section 1917(e)(7) of the Social Security Act.;

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- f. any recipient who is assigned (locked in) to using one pharmacy for all controlled substance prescriptions.

This includes an adverse determination that the recipient does not require specialized services as defined in 42 CFR §431.201; 431.206 and 431.220 as determined by a PASARR.

Pursuant to 42 CFR §204, the state will provide a system for a resident of a Nursing Facility (NF) to appeal a notice from the NF of intent to discharge or transfer the resident. Upon receipt of the discharge notice, the resident may request a Fair Hearing in writing by submitting a letter to the DHCFP. The DHCFP will inform the Department of Administration of the resident's request for a Fair Hearing. The DHCFP does not take an adverse action against the resident; rather the facility takes the action via the discharge. DHCFP is not a party to the action.

3104.1B NEVADA CHECK UP ELIGIBILITY FAIR HEARINGS

1. WHO MAY REQUEST

Any Nevada Check Up (NCU) applicant or authorized representative (on behalf of the participant) that wishes to formally aggrieve a denial and/or disenrollment eligibility determination.

2. DATE OF REQUEST

Any individual that wishes to request a NCU hearing must do so in writing within thirty (30) calendar days following the date of the denial and/or disenrollment notice unless the applicant or authorized representative can substantiate "good cause" for not doing so. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

a. Continued Enrollment:

All recipients have the right to continued enrollment throughout the Fair Hearing process. If the authorized representative (on behalf of the participant) chooses to continue enrollment, they must do so in writing no later than ten calendar days following the date of the disenrollment notice. NCU reserves the right to recover any medical costs incurred while the recipient is receiving continued enrollment should the agency's decision be upheld.

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3. SUBJECT MATTER

The agency must grant an opportunity for a hearing to an applicant or authorized representative (on behalf of the participant) in the event:

- a. of a denial and/or disenrollment eligibility decision;
- b. an application is not processed with reasonable promptness; or
- c. one believes that the agency has taken an Action erroneously.

4. HEARING PREPARATION MEETING (HPM)

A HPM will be conducted by NCU. See NCU Chapter 1000 section 1003.17.

3104.2 DISPOSITION OF A FAIR HEARING REQUEST

A. DISMISSAL OF A HEARING REQUEST UPON

1. Withdrawal of a Hearing Request

A recipient may withdraw the request for a hearing at any time before a decision is rendered. Notification of the request for withdrawal will be submitted to the Hearing Officer who will dismiss the hearing request.

2. Abandonment of a Hearing Request

A hearing is considered abandoned and may be dismissed by the Hearing Officer when the recipient fails to appear for a scheduled hearing after having been properly notified. The recipient's request for hearing is considered abandoned unless they submit to the Hearing Officer substantiation for good cause for failing to appear. The Hearing Officer must receive the substantiation within ten (10) calendar days of the date of the scheduled hearing.

3. Agency Action

Medicaid/NCU may reverse its Notice of Decision (NOD) at any time during the hearing process. If a Medicaid/NCU reversal occurs, a report shall be submitted by the person conducting the review detailing the reason(s) for the reversal if a Fair Hearing has been calendared. The report must be forwarded to the Hearing Officer within five (5) business days following the reversal decision date or review date if a fair hearing has been scheduled. The Hearing Officer notifies the recipient the

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request for hearing is dismissed because Medicaid/NCU will not take action or has reversed the decision.

B. Denial of a Hearing Request

A hearing need not be granted when:

1. the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients;
2. the request is not received timely;
3. the agency and/or Health Plan has not taken any Action affecting the recipient, or made an Adverse Determination, nor denied a request for services, or failed to act upon the request within reasonable promptness;
4. a recipient is not Medicaid/NCU eligible, except for PASRR determinations; or
5. the primary insurance policy and access (including appeal/hearing process) has not been exhausted. As Medicaid is the payer of last resort, all remedies under other insurance must be exhausted.

3104.3 HEARING NOTIFICATION, SCHEDULING, AND LOCATION

A. HEARING PREPARATION MEETING (HPM)

Within ten (10) calendar days of a request for a hearing, the DHCFP Hearings Office shall contact the recipient to offer a HPM. The purpose is to provide the recipient an explanation of the action, which is the subject of the hearing request, and attempt to resolve the matter. Every effort is made to reconcile the disagreement without the necessity of a Fair Hearing. The right to a Fair Hearing is not affected by attendance at a HPM. The recipient may allow participation in the HPM by legal counsel, a friend or other spokesperson.

It is important the HPM be held at the earliest possible date, no later than twenty-one (21) working days after receipt of a hearing request. Rescheduling of an HPM shall be kept to a maximum of two (2), assuring completion within twenty-one (21) working days.

A HPM shall be conducted telephonically.

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B. NOTICE OF A FAIR HEARING

The Department of Administration Hearing Officer shall notify all parties by mail as to the time, date and place the hearing has been scheduled. Recipients are given at least ten (10) calendar days advance notice of the scheduled hearing unless the recipient specifically requests a hearing in a shorter period of time based on an emergency.

At the discretion of the Hearing Officer, a Fair Hearing may be postponed if requested by either party.

If the recipient requests a postponement, the number of days postponed will extend the decision due date by an equal number of days.

C. FAIR HEARINGS BY TELEPHONE

Either party may request the Fair Hearing be conducted via telephonically. If a telephone hearing is held, the following procedures apply:

1. The Hearing Officer may hold teleconferences from the assigned Hearing Office. DHCFP representative(s), and/or Health Plan representative(s) must be at the location designated in the scheduling letter.
2. The recipient is advised at the time the hearing is scheduled that all other policies and procedures relative to hearings and program requirements still apply.
3. The Hearing Officer may request DHCFP, the Health Plan and the recipient to provide copies of any evidence or exhibits to be presented during the hearing to the Hearing Officer and the other parties prior to a scheduled telephone hearing. This does not preclude additional information from being presented during the hearing, or if requested, after the close of the hearing.
4. All telephone hearings must be tape recorded by the Hearing Officer over the telephone. This recording is the official record.

3104.4 PROGRAM PARTICIPATION PENDING A HEARING DECISION

A. RECOVERY

If Medicaid/NCU services are continued until a decision is rendered, such cost of services are subject to recovery by DHCFP if the agency's action is sustained or the hearing request is withdrawn by the recipient.

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B. MAINTAINING MEDICAID/NCU SERVICES

If the agency mails the notice as required, and the recipient requests a hearing before the Date of Action, DHCFP or Health Plan will not terminate or reduce services until a decision is rendered after the hearing unless:

1. the Hearing Officer makes a determination the sole issue is one of Federal or State law or policy and the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision; or
2. the recipient requests in writing that benefits not be continued pending a hearing decision; or
3. the request for hearing is denied or dismissed.

C. REINSTATING MEDICAID SERVICES

1. Discretionary:

When a recipient requests a hearing no more than the 10th calendar day after the Date of Action, the agency may reinstate benefits if requested by the recipient. The reinstated services will continue until a hearing decision is rendered unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

2. Mandatory:

The agency must reinstate and continue services until a decision is rendered after a hearing if:

- a. action is taken without the required advance notice;
- b. the agency mails the 10-day or 5-day notice as required under 42 CFR §431.211 or 42 CFR §431.214, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:
 1. it is determined that the sole issue is one of Federal or State law or policy; and
 2. the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

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3104.5 HEARING PARTICIPATION

A. ATTENDANCE

Attendance at a hearing is limited to those directly concerned; namely, the Hearing Officer, recipient(s), and/or their witnesses, counsel or authorized representative(s), interpreter, witnesses and representatives of DHCFP, and if applicable, representatives from the Health Plan. Counsel for the agency and/or Health Plan may also attend as necessary.

Medicaid/NCU assures the availability for recipients, their authorized representatives and witnesses of necessary transportation to and from the hearing.

B. GROUP HEARINGS

A series of recipient requests for a hearing may be consolidated upon agreement of all parties by conducting a single group hearing in cases in which the sole issue involved is one of State and/or Federal law, regulation or policy.

3104.6 PREPARATION/PRESENTATION

A. AGENCY/HEALTH PLAN

It is the responsibility of the agency and/or Health Plan representative to be present at the hearing, in person or telephonically, and to provide testimony and/or evidence regarding the agency's and/or Health Plan's action. This includes the organization of oral and written evidence and preparation of a Basis of Action summary substantiating the decision to be presented at the hearing. This summary becomes part of the record at the end of the hearing.

B. RECIPIENT

1. Before the date of the hearing and during the hearing the recipient may examine and request copies of their own case information. Authorized representatives must provide a current signed release from the recipient to permit release of records. DHCFP and/or Health Plan will provide the copies free of charge. The recipient shall not have access to confidential information.
2. It is the responsibility of the recipient to provide testimony and/or evidence in support of their position either in person or telephonically. If the hearing involves a legal issue only, the recipient's presence, in person or telephonically, is not necessary. Testimony can be provided by a representative.

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Recipients are allowed to bring witnesses and submit evidence to establish all pertinent facts and circumstances relative to the issue and to present arguments without undue interference. They are also allowed to question or refute any testimony or evidence and confront and cross-examine adverse witnesses. New evidence not previously provided to DHCFP or Health Plan, but which is believed to have a bearing on the action taken, must be provided to DHCFP prior to the hearing for evaluation and any necessary action.

3. Recipients are provided a copy of all evidence presented at the hearing by DHCFP.

3104.7 CONDUCT OF HEARING

A. CONTROL

The Hearing Officer controls the hearing and ensures only relevant issues are considered. Disrespectful language or contemptuous conduct, refusal to comply with directions, or continued use of dilatory tactics by any person at the hearing constitutes grounds for immediate exclusion of such person from the hearing by the Hearing Officer and the hearing decision will be based on evidence submitted. The Hearing Officer shall record hearing proceedings. The Hearing Officer's Transcripts of Evidence constitutes the sole official record.

B. OPENING THE HEARING

At the opening of the hearing, the Hearing Officer shall:

1. Introduce their self;
2. Explain the reason for the hearing and the role of the Hearing Officer;
3. Assure all persons in attendance at the hearing are identified by name and purpose of attendance;
4. Advise all persons in attendance that the hearing is being tape-recorded.

C. ADMINISTERING OATHS

Testimony under oath shall be required at the discretion of the Hearing Officer.

D. TESTIMONY AND EVIDENCE

Nevada Rules of Evidence do not apply in the hearing. The Hearing Officer:

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1. Excludes irrelevant, immaterial or unduly repetitious evidence;
2. Provides the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and
3. Collects and logs relevant evidence exhibits.

E. Closing the Hearing

At the close of the hearing, the Hearing Officer advises persons in attendance:

1. When a decision is expected to be made;
2. That the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and
3. The parties will be advised in writing by certified mail of the decision.

3104.8 ACTION ON INCORRECT NOTICE OF DECISION (NOD)

- A. If, prior to the hearing, it becomes apparent the recipient has received an incorrect NOD for Prior Authorization Request from DHCFP or the Health Plan, a corrected notice must be sent to the recipient if the proposed action remains unchanged.
- B. If, after a hearing has begun, it becomes apparent the recipient received an incorrect NOD for Prior Authorization Request (i.e., the notice quotes incorrect factual and legal reason(s) or omits additional factual and legal reason(s) pertinent to the issue), the Hearing Officer may offer the recipient the choice of either accepting the incorrect notice, with the necessary corrections noted for the record and continuing with the hearing; or setting the hearing to a later date to allow DHCFP or the Health Plan time to prepare and serve the corrected NOD.

3104.9 SUBMISSION OF ADDITIONAL EVIDENCE

During a hearing, additional evidence related to the hearing issue may be submitted. The Hearing Officer, recipient, DHCFP or Health Plan may request additional evidence be submitted which is not available at the hearing.

The Hearing Officer shall:

- a. Recess the hearing if additional evidence has been submitted, to allow for review by the recipient, DHCFP or Health Plan; or

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- b. Continue the hearing to a later date and order further investigation or request either party to review or produce the additional evidence; or
- c. Close the hearing, but hold the record open to permit submission of any additional evidence.

3104.10 MEDICAL ISSUES

When the hearing involves medical issues such as those concerning a diagnosis or an examining physician's report, the Hearing Officer may require an additional medical assessment other than that of the person involved in making the original assessment. The request is directed to DHCFP or the Health Plan for evaluation and follow-up. Any additional assessment determined to be necessary is obtained at DHCFP or the Health Plan's expense. The hearing may be held open for a specified length of time pending receipt of such requested information. This additional assessment must be made part of the record.

3104.11 HEARING DECISION

The Hearing Officer's decision must be in writing and comply with Medicaid/NCU program policy. The decision is based exclusively on evidence introduced at the hearing. Changed physical or social factors following the DHCFP or Health Plan action being appealed cannot be considered in rendering the hearing decision.

a. BASIS

Decisions by the Hearing Officer shall:

1. Be based exclusively on the evidence introduced at the hearing;
2. Comply with applicable regulations in effect at the time of the agency or Health Plan's action;
3. Summarize the findings of fact;
4. Identify and cite supporting evidence and regulation;
5. Be submitted in written format, to the Deputy Administrator, DHCFP or designee.

b. APPEAL IS DENIED

Denied decisions are adverse to the recipient. When the appeal is denied, the Hearing Officer will notify DHCFP or the Health Plan and the recipient of the right to judicial review.

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Recipient withdrawals and abandonments are equivalent to a denied appeal. DHCFP may institute recovery procedures against the recipient to recoup the cost of any services furnished by Medicaid/NCU.

c. APPEAL IS SUSTAINED

Sustained decisions are favorable to the recipient. DHCFP or the Health Plan must take corrective action promptly, retroactive to the date an incorrect action was taken. If appropriate, the agency must provide for admission or readmission of a recipient to a facility if the hearing decision is favorable to the recipient or if DHCFP decides in the recipient's favor before the hearing.

d. DECISION DUE DATE

Within ninety (90) calendar days after the date of the request for a hearing has been received by the DHCFP office, the recipient, and the Hearings Unit must be notified of the Hearing Officer's decision specifying the factual and legal reasons for the decision and identifying the supporting evidence relied upon to reach the decision. A copy of the decision must be delivered by certified mail to each party and to their attorney or other authorized representative.

The time period for a hearing decision may be extended for a period equal to the total delay if the recipient requests a delay or postponement of the hearing proceedings and waives his right to have a decision rendered within 90 days after the date of the request for a hearing.

3104.12 RIGHT TO APPEAL HEARING DECISION

The Decision of the Hearing Officer is final. The Hearing Decision may be appealed by any party, within ninety (90) days after the date on which the written notice of decision is mailed, to the appropriate District Court of the State of Nevada. The day after the mailing is the first day of the 90-day period.

3104.13 HEARING RECORD

A. CONTENT

A hearing record is maintained by the Department of Administration, Hearing Office. The record consists of all papers and requests filed in the proceeding, the transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing, all exhibits received or considered and the Decision letter.

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B. RETENTION OF HEARING RECORD

Administrative hearing files and taped recordings must be retained no less than six (6) years from the date the hearing decision was rendered.

If a hearing decision is appealed, the hearing record must be retained until the court action is resolved or the designated retention period, whichever is later.

C. COPYING THE HEARING RECORD

Copies of the Hearing Record are made as follows:

1. The requestor may secure a copy of the recording and/or transcript of a Fair Hearing by written request to the Department of Administration. Please note that the requestor shall be invoiced from the Department of Administration for this service and the requestor is responsible for the payment of these records.
2. An official typed transcription of the recording of the hearing is prepared for the District Court and recipient when a hearing decision is appealed. Within 90 days after the service of the petition for judicial review, DHCFP or its designee shall transmit to the court the original or a certified copy of the entire record of the proceeding under review, including, without limitation, a transcript of the evidence resulting in the final decision of the Hearing Officer.

* The requested recording and/or transcript is free of charge to the recipient in the event that the recipient appeals to District Court.

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3105 MEDICAID PROVIDER HEARINGS

3105.1 REQUEST FOR A MEDICAID PROVIDER FAIR HEARING

A. WHO MAY REQUEST

A Nevada Medicaid/NCU provider may request a Fair Hearing when they disagree with an adverse determination taken against them by the agency, the Quality Improvement Organization (QIO)-like vendor/fiscal agent Health Plan or other third party Plan or Program Administrator. An adverse determination may include, but is not limited to:

1. an outcome of the Fiscal Agent’s provider appeal determination regarding a denied claim;
2. a determination to suspend payment;
3. suspension, sanction, lockout or termination;
4. recoupment of an overpayment; or
5. disenrollment or denied renewal of a provider contract;
6. ineligible determination for the Incentive Payment Program for Electronic Health Record (EHR) enrollment.

The provider must exhaust any internal grievance process available through the QIO-like vendor/Fiscal Agent, Health Plan or third party Plan or Program Administrator prior to a DHCFP Fair Hearing.

B. DATE OF REQUEST

The date of request for a hearing is the date the request is received by the DHCFP Hearings Office. A request for a Fair Hearing must be received by the DHCFP Hearings Office within 90 calendar days from the date of the adverse determination notification. When a determination notification provides a specific timeframe in which a Fair Hearing may be requested, the timeframe specified in the notification is the applicable timeframe. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

C. REQUEST FOR A FAIR HEARING

A request for a Fair Hearing must be submitted to the DHCFP Hearing Office in writing and must include the provider name, Medicaid provider number, correspondence address,

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contact telephone number, the reason(s) why the provider disagrees with the determination and a copy of the determination notification from the agency, Fiscal Agent, Health Plan or third party **Plan or Program Administrator. A request for a Fair Hearing must be signed by the provider or the provider's authorized representative.**

3105.2 DISPOSITION OF A MEDICAID PROVIDER FAIR HEARING REQUEST

A. DISMISSAL OF A HEARING REQUEST UPON:

1. Withdrawal of a Hearing Request

A provider may withdraw a request for a Fair Hearing at any time before a decision is rendered. A request to withdraw a hearing must be submitted in writing to the Hearing Officer who may dismiss the hearing request.

2. Abandonment of a Hearing Request

A provider hearing is considered abandoned and may be dismissed by the Hearing Officer when the provider fails to appear for a scheduled hearing after having been properly notified. The provider's request for hearing is considered abandoned unless they submit to the Hearing Officer substantiation for good cause for failing to appear. The Hearing Officer must receive the substantiation within ten (10) calendar days of the date of the scheduled hearing.

3. Agency, Fiscal Agent or Health Plan Action

The agency, Fiscal Agent or Health Plan may reverse its adverse action determination at any time during the hearing process. If a determination reversal occurs, notification of the reversal must be made to the Hearing Officer, if a Fair Hearing had been scheduled. The Hearing Officer notifies the provider the request for hearing is dismissed because Medicaid, the Fiscal Agent or Health plan will not take the action or has reversed the decision.

B. DENIAL OF A HEARING REQUEST

A hearing need not be granted when:

1. the sole issue is a Federal suspension or ban of regulation at the Federal level effecting providers.
2. the request is not received timely.

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3. the provider has not exhausted the Appeal process available through the Fiscal Agent, the Health Plan or a third party plan administrator.

3105.3 FAIR HEARING NOTIFICATION, SCHEDULING AND LOCATION

A. HEARING PREPARATION MEETING (HPM)

Nevada Medicaid Hearings Office will offer a HPM with the provider to allow an opportunity to have an informal discussion regarding the determination being disputed, and to attempt to resolve the disputed matter. A provider may refuse a HPM if they choose. The right to a Fair Hearing is not affected by attendance at a HPM. A provider may designate participation in the HPM by legal counsel or a representative.

A HPM shall be conducted telephonically.

B. NOTICE OF A FAIR HEARING

The Department of Administration Hearing Officer shall notify all parties by mail as to the date, time and location of the Fair Hearing.

At the discretion of the Hearing Officer, a Fair Hearing may be postponed if requested by either party.

C. HEARINGS BY TELEPHONE

1. A representative of each party must be in attendance at a Provider Fair Hearing.
2. The Hearing Officer may allow testimony from witnesses telephonically.
3. Telephonic testimony is recorded by the Hearing Officer and is part of the official record.

3105.4 HEARING PARTICIPATION

A. ATTENDANCE

Attendance at a hearing is limited to those directly concerned, namely the:

1. Hearing Officer;
2. provider;
3. provider's witnesses, counsel or authorized representative(s) for the provider;

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4. interpreter;
5. witnesses, counsel and representatives of Medicaid; and
6. representatives, counsel and witnesses from the Health Plan.

B. GROUP HEARINGS

At the discretion of the Hearing Officer, a series of provider requests for a hearing may be consolidated by conducting a single group hearing in cases in which the sole issue involved is one of State and/or Federal law, regulation, or policy.

3105.5 PREPARATION/PRESENTATION

A. AGENCY/HEALTH PLAN

1. It is the responsibility of the agency and/or health plan representative to be present at the Fair Hearing, unless permission has been granted prior to the Fair Hearing by the Hearing Officer to participate telephonically.
2. The agency or the Health Plan must provide testimony and/or evidence regarding the agency's and/or Health Plan's action. This includes the organization of oral and written evidence and preparation of a Basis of Action summary substantiating the decision to be presented at the Fair Hearing. This summary becomes part of the record at the conclusion of the Fair Hearing. Witness testimony may be provided telephonically at the discretion of the Hearing Officer.
3. All documents being presented at a Fair Hearing by the agency or Health Plan must be made available to the provider or representative and to the Hearing Officer at least five (5) days prior to the Fair Hearing.

B. PROVIDER

1. It is the responsibility of the provider or representative to be present at the Fair Hearing, unless permission has been granted prior to the Fair Hearing by the Hearing Officer to participate telephonically.
2. Providers must provide testimony and/or evidence in support of their position. Testimony may be provided telephonically at the discretion of the Hearing Officer. Providers may bring witnesses and submit evidence to establish all pertinent facts and circumstances relative to the issue and to present arguments without undue interference. They may also question or refute any testimony or evidence and confront and cross-examine adverse witnesses. New evidence not previously provided to DHCFP or the health plan, but which is believed to have a

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bearing on the action taken, must be provided to all parties prior to the hearing for evaluation and any necessary action.

3. All documents being presented at a Fair Hearing by the provider or representative must be made available to the agency or Health Plan and to the Hearing Officer at least five (5) days prior to the Fair Hearing.

3105.6 CONDUCT OF A FAIR HEARING

A. CONTROL

The Hearing Officer controls the hearing and ensures only relevant issues are considered. Disrespectful language or contemptuous conduct, refusal to comply with directions, or continued use of dilatory tactics by any person at the hearing constitutes grounds for immediate exclusion of such person from the hearing by the Hearing Officer and the hearing decision will be based on evidence submitted. A recorder shall be used by the hearing officer to record hearing proceedings. The Hearing Officer's Transcripts of Evidence constitutes the sole official record.

B. OPENING THE HEARING

At the opening of the hearing, the Hearing Officer shall:

1. introduce their self;
2. explain the reason for the hearing and the role of the Hearing Officer;
3. assure all persons in attendance at the hearing are identified by name and purpose of attendance; and
4. advise all persons in attendance that the hearing is being recorded.

C. ADMINISTERING OATHS

Testimony under oath shall be required at the discretion of the Hearing Officer.

D. TESTIMONY AND EVIDENCE

Nevada Rules of Evidence do not apply in the hearing. The Hearing Officer shall:

1. exclude irrelevant, immaterial or unduly repetitious evidence;

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2. provide the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and
3. collect and log relevant evidence exhibits.

E. CLOSING THE HEARING

At the close of the hearing, the Hearing Officer shall advise persons in attendance:

1. when a decision is expected to be made;
2. that the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and
3. the parties will be advised in writing by certified mail of the decision.

3105.7 ACTION ON INCORRECT DETERMINATION NOTICE

If the agency, fiscal agent or health plan recognizes an incorrect or inaccurate determination Notice has been issued, a corrected Amended Notice will be issued by the agency, Fiscal Agent or Health Plan. The action and effective date remain unchanged unless otherwise notified in the Amended Notice.

3105.8 SUBMISSION OF ADDITIONAL EVIDENCE

During a hearing, additional evidence related to the hearing issue may be submitted. The Hearing Officer, provider, DHCFP or Health Plan may request additional evidence be submitted which is not available at the hearing. The Hearing Officer may:

- a. recess the hearing if additional evidence has been submitted, to allow for review by the provider, DHCFP or Health Plan;
- b. continue the hearing to a later date and order further investigation or request either party to review or produce the additional evidence; or
- c. close the hearing, but hold the record open to permit submission of any additional evidence.

3105.9 HEARING DECISION

The Hearing Officer's decision must be in writing and comply with Nevada Medicaid or the Health Plan's program policy. The decision is based exclusively on evidence introduced at the hearing.

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a. BASIS

Decisions by the Hearing Officer shall:

1. be based exclusively on the evidence introduced at the hearing;
2. comply with applicable regulations in effect at the time of the agency's or health plan's action;
3. summarize the findings of fact;
4. identify and cite supporting evidence and regulation; and
5. be submitted in written format, to the Deputy Administrator, Medicaid or designee.

b. APPEAL IS DENIED

Denied decisions are adverse to the provider. When an appeal is denied, the Hearing Officer will notify DHCFP or the Health Plan and the provider of their right to judicial review.

Provider withdrawals and abandonments are equivalent to a denied appeal. DHCFP may institute recovery procedures against the provider to recoup the cost of any services furnished.

c. APPEAL IS SUSTAINED

Sustained decisions are favorable to the provider. DHCFP or the Health Plan must take corrective action promptly, retroactive to the date an incorrect action was taken. If appropriate, the agency must provide for admission or readmission of a recipient to a facility if the hearing decision is favorable to the provider or if DHCFP decides in the provider's favor before the hearing.

d. DECISION DUE DATE

Within thirty (30) calendar days following the Fair Hearing, or the date the record is closed, whichever is later, the Hearing Officer shall issue a final Decision.

3105.10 RIGHT TO APPEAL HEARING DECISION

Reference NRS 422.306

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3105.11 HEARING RECORD

Reference NRS 442.306

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 13, 2014

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3200 - HOSPICE

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3200 were made to coincide with the Code of Federal Regulations (CFR) Title 42 part 418, Conditions of Participation updates. The Conditions of Participation are mandatory programmatic sections that define Hospice providers operations. The sections define initial and subsequent assessments, physician’s determination and documentation of terminal illness, Plans of Care, Recipient’s Rights, Quality Management, Infection Control and Clinical records. This revision includes the hospice physician’s face-to-face examination and documentation requirements of the hospice patient at the 180th day and every subsequent election period.

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

These changes are effective April 1, 2014.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/14 CHAPTER 3200 – HOSPICE	MTL 40/03, 07/06, 41/10 CHAPTER 3200 – HOSPICE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3200	Introduction	Clarified existing language and added a reference to MSM Chapter 3600 for Managed Care Organization (MCO) recipients and the Nevada Check Up (NCU) Manual for NCU recipients.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1	Policy – Hospice Services	Updated the section to include the Conditions of Participation (COP) as required by 42 CFR 418. The COP is the eligibility, health and safety requirements that all hospices are required to meet. COPs also provide a guide for continuous quality improvement and standards of practice. Added chapter reference for revocation and re-election of hospice benefits.
3203.1A.1	Policy – Coverage and Limitations – Eligibility Requirements	Added chapter reference for certification of terminal illness. Refer to Section 3203.1.B.1.d
3203.1A.2	Policy Coverage and Limitations – Duration of Hospice Care	Re-phrased statement to read: An eligible recipient may receive an unlimited number of subsequent 60 day periods, without a break in care as long as certain criteria is met such as: Revised policy to require a hospice physician or nurse practitioner to have face-to-face encounters when determining continued eligibility prior to the 180 th day recertification. The practitioner must certify that the recipient has a life expectancy of less than six months; the recipient does not revoke hospice election and remains appropriate for hospice care.
3203.1A.3	Policy – Coverage and Limitations – Hospice Care Services	Moved sentence of bereavement counseling to section 3203.1A.3d (Counseling Services). Added policy that the hospice must designate a registered nurse: “to ensure that the nursing needs of the recipient are met as identified in the recipient’s initial assessment, comprehensive assessment, and updated assessment”.
3203.1A.4.b.1	Policy – Coverage and Limitations – Level of Care – Continuous Home Care	Also added language in Counseling Services that indicates the bereavement counseling for the client’s family and significant others as identified in the Plan of Care (POC) is not reimbursable per 42 CFR 418.204 (c).
3203.1A.4.b.1	Policy – Coverage and Limitations – Level of Care – Continuous Home Care	Removed reference to the definition section of the chapter and inserted the definition language for continuous home care into the text of the paragraph.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1A.4.c.3	Policy – Coverage and Limitations – Level of Care – Inpatient Care	Inserted paragraph clarifying respite care and duration limitations for reimbursement.
3203.1B.1	Policy – Provider Responsibility – Recipient Enrollment Process	<p>Changed the requirement of enrollment forms for pending Medicaid eligibility to be submitted to Quality Improvement Organization (QIO)-like vendor from 15 days to 60 days of the date of decision of eligibility determination.</p> <p>Clarified existing policy regarding when the hospice must obtain written certification of a terminal illness and the consequences to reimbursement if the noted time frames are not met.</p> <p>Added the documentation requirements for the certification of terminal illness according to 42 CFR 418 – COP.</p> <p>Added clarifying language indicating that the hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to QIO – like vendor.</p>
3203.1B.2	Policy – Provider Responsibility – Interdisciplinary Group	<p>Moved from section 3203.1B.6 for continuity and clarity. Included that the interdisciplinary group will use an interdisciplinary approach to assessing and meeting the physical, medical, psychosocial, emotional and spiritual needs of the hospice recipient and their families facing terminal illness and bereavement.</p> <p>Moved the section on Role of Interdisciplinary Group from 3203.1B.6 to this section and expanded the policy to address the assessment of the recipient and the participation of the recipient’s attending physician (if any) in the development of the POC and the updating of the POC every 15 days.</p> <p>Added policy regarding the Initial and Comprehensive Assessments to include time limits and content for initial, comprehensive and updated assessments.</p>

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1B.4	Policy – Provider Responsibility – Plan of Care	Expanded requirements in the establishment, content, and review of the POC.
3203.1B.5	Policy – Provider Responsibility – Recipients’ Rights	Added Recipients’ Rights policy. Recipient’s rights are particular to hospice services related to palliative care, relief from pain, and property rights.
3203.1B.6	Policy – Provider Responsibility – Abuse, Neglect or Mistreatment	Removed the policy related to Interdisciplinary Group (moved to 3203.1.B.2) and added policy detailing the requirements for hospice employees and contractors report, investigate, and take corrective actions in cases of alleged or verified abuse, neglect or mistreatment.
3203.1B.7	Policy – Provider Responsibility – Advanced Directives	Removed CFR reference, and added policy which states “The hospice must inform and distribute written information to the recipient concerning its policies on advanced directives.”
3203.1B.8	Policy – Provider Responsibility – Quality Assurance	Added language indicating that the hospice must develop, implement and maintain an effective, ongoing hospice-wide data driven quality assessment and performance improvement program and added responsibilities for the hospice’s governing body to ensure certain program requirements are met. Also added policy that indicates the hospice must maintain written documentation of its quality assessment and performance improvement program and they must be able to demonstrate its operation to the Center for Medicare and Medicaid Services (CMS).
3203.1B.9	Policy – Provider Responsibility – Infection Control	Added policy indicating that the hospice must maintain and document an effective infection control program that protects recipients, families, visitors and hospice personnel by preventing and controlling infections and communicable diseases. The hospice must also provide infection control education to employees, recipients, and family members.
3203.2	Policy – Non-Hospice Services	Removed CFR reference from first paragraph.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.4.a.1	Policy – Revoking the Election of Hospice Care	Reworded existing policy regarding the signed statement from the recipient or representative should they want to revoke the election of coverage for hospice care.
3203.5	Policy – Discharge of a Recipient from Hospice	Added policy indicating that the hospice may discharge a recipient who moves out of the hospice’s service area or transfers to another hospice. Added requirements and recipient protections for discharges for cause, and added that prior to discharge the hospice must obtain a written discharge order from the hospice medical director or if a recipient has an attending physician the attending physician must be consulted and their recommendation or decision must be included in the discharge note.
3203.9	Policy – Clinical Records	Added policy that indicates that the clinical records may be maintained electronically and added clarifying language on what each individual record must contain. In addition, added policy regarding the storage of records after the recipient is discharged or deceased.
3203.10	Policy – DHCFP Review	<p>Changed the title of the section from Medicaid Review to DHCFP Review clarified language and removed the following examples of the methods of review that may be included:</p> <p>(c) Evaluation of comments from patients, families and providers (can be done at onsite reviews)</p> <p>(d) Concurrent (inspection of ongoing care, adherence to plan of care and records) (can be done at onsite reviews).</p>

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3200 INTRODUCTION

The Nevada **Division of Health Care Financing and Policy (DHCFP)** Medicaid Hospice Services program is designed to provide support and comfort for Medicaid eligible recipients who have a terminal illness and have decided to receive end of life care. Covered hospice services address the needs of the individual, their caregivers and their families while maintaining quality of life as a primary focus. The hospice philosophy provides for the physical needs of **recipients** as well as their emotional and spiritual needs. This care is provided in the recipient's place of residence, which could be a specialized hospice facility, an Intermediate Care Facility (ICF) or in his or her own home. Hospice care incorporates an interdisciplinary team approach which is sensitive to the **recipient** and family's needs during the final stages of illness, dying and the bereavement period.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000. **Refer to Medicaid Services Manual (MSM) Chapter 3600 for Managed Care recipients for differences in Hospice enrollment, claims and payment.**

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3201 AUTHORITY

Hospice Services are an optional program under the Social Security Act XVIII Sec. 1905.(o)(1)(A), and are governed by The Code of Federal Regulations (CFR) Title 42, Part 418 and Title 42 Part 489.102, Subpart I.

Effective October 1, 1997, the Nevada Revised Statutes (NRS) Chapter 422.304 mandated reimbursement for hospice care under the Medicaid State Plan.

Patient Protection and Affordable Care Act (PPACA) Section 2302.

Health Care and Education Affordability Reconciliation Act of 2010.

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3203 POLICY

3203.1 HOSPICE SERVICES

Hospice services must be identified in the established plan of care; maintain a high standard of quality and be reasonable and necessary to palliate or manage the terminal illness and related conditions. All services must be provided in accordance with recognized professional standards of practice and within the limitations and exclusions hereinafter specified, as described in the **Centers for Medicare and Medicaid Services (CMS) – State Operations Manual (SOM)** and the Code of Federal Regulations (CFR) Title 42, Part 418 which sets forth the Conditions of Participation (COP). The COP is the eligibility, health and safety requirements that all hospices are required to meet. COPs also provide a guide for continuous quality improvement and current standards of practice.

For children under the age of 21, a voluntary election for hospice services shall not constitute a waiver of any rights of the child to be provided with, or to have payment made for, services that are related to the treatment of the child’s condition for which a diagnoses of terminal illness has been made.

Should a terminally ill adult **recipient** elect to receive hospice care, he or she must waive all rights to Medicaid payments for the duration of the election of hospice care for any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:

- a. Provided (either directly or under arrangement) by the designated hospice;
- b. Provided by the individual’s attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; or
- c. Provided as room and board by a **Nursing Facility (NF)** if the individual is a resident.
- d. Provided by a Home and Community-Based Waiver (HCBW) whose services do not duplicate hospice services.
- e. **Refer to Section 3203.4 for revocation and re-election of hospice benefits.**

A hospice program may arrange for another individual or entity to furnish services to the hospice’s **recipients**. If services are provided under arrangement, the hospice must meet the following standards:

- f. Continuity of Care: The hospice program assures the continuity of **recipient**/family care in home, outpatient, and inpatient settings;

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- g.** Written Agreement: The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:
1. Identification of the services to be provided;
 2. A stipulation that services may be provided only with the express authorization of the hospice;
 3. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
 4. The delineation of the role(s) of the hospice and the contractor in the admission process, **recipient**/family assessment, and the interdisciplinary group care conferences;
 5. Requirements for documenting services are furnished in accordance with the agreement; and
 6. The qualification of the personnel providing the services.
- h.** Professional Management Responsibility: Professional management responsibility. The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications, and in accordance with the **recipient's Plan of Care (POC)** and other requirements.

3203.1A COVERAGE AND LIMITATIONS

Persons who are designated Nevada Medicaid recipients, have been certified as terminally ill and have filed an election statement for hospice care are eligible for hospice benefits.

1. Eligibility Requirements
 - a. Determination of Medicaid eligibility by the **Division of Welfare and Supportive Services (DWSS)**;
 - b. Certification of terminal illness (**refer to Section 3203.1B.1.d**); and
 - c. Election of Hospice Care - an individual who is a designated Nevada Medicaid recipient, and has been certified as terminally ill may file an election statement with a licensed hospice provider who is contracted with **the** Division of Health Care Financing and Policy (DHCFP). If the recipient is physically or mentally incapacitated, his or her representative may file the election statement.

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2. Duration of Hospice Care

a. An eligible recipient may elect to receive hospice care during one or more of the following election periods:

1. An initial 90-day period;
2. A subsequent 90-day period;
3. An unlimited number of subsequent 60-day periods.

b. An eligible recipient may receive an unlimited number of subsequent 60 day periods without a break in care as long as:

1. The recipient is re-certified by the hospice physician;
2. A hospice physician or Nurse Practitioner (NP) has a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the 180th day benefit period recertification and no more than 30 calendar days prior to every subsequent recertification thereafter. These face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.
3. The practitioner certifies that the recipient has a life expectancy of six months or less.
4. The recipient does not revoke the election of hospice; and
5. The recipient in the care of a hospice remains appropriate for hospice care.

3. Hospice Care Services

Nursing services, physician services, and drugs and biologicals must be routinely available on a 24-hour basis; all other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions and provide these services in a manner consistent with accepted standards of practice.

The hospice must designate a Registered Nurse (RN) to: coordinate the implementation of the POC; to ensure that the nursing needs of the recipient are met as identified in the

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recipient's initial assessment, comprehensive assessment, and updated assessments; and coordinate and oversee all services for each **recipient**.

The following services are included in the hospice reimbursement when consistent with the **POC**. The services must be provided in accordance with recognized professional standards of practice.

- a. **Nursing Services:** Nursing services must comply with the following: The hospice must provide nursing care and services by or under the supervision of a qualified **RN**; a qualified **RN** is one who is authorized to practice as an **RN** by the Nevada State Board of Nursing or the licensing board in the state in which the **RN** is employed. **Recipient** care responsibilities of nursing personnel must be specified.
- b. **Medical Social Services:** Medical **Social Services (MSS)** must be provided by a qualified social worker, under the direction of a physician. A qualified social worker is a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed to practice social work in the State of Nevada or the state in which the social worker is employed.
- c. **Physician Services:** In addition to palliative care and management of the terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the **recipients** to the extent these needs are not met by the attending physician.
 1. Reimbursement for physician supervisory and interdisciplinary group services for those physicians employed by the hospice agency is included in the rate paid to the agency.
 2. Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of **POCs** and services, periodic review and updating of **POCs**, and contribute to establishment of governing policies.
 3. Direct **recipient** care provided by the medical director, hospice-employed physician, or consulting physician should be billed in accordance with the usual Medicaid reimbursement and is paid directly to the physician.
 4. Medicaid reimbursement will be paid directly to an independent attending

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physician and will be made in accordance with the usual Medicaid reimbursement methodology for physician services and is not based on whether the services are for the terminal illness or an unrelated condition. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

- d. **Counseling Services:** Counseling services are available to both the individual and the family. Counseling includes bereavement counseling, dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice. Bereavement counseling for the client's family and significant others, **as identified in the POC**, must be provided for up to one year after the **recipient's death and is not reimbursable per 42 CFR 418.204.(c)**.
- e. **Medical Appliances, Supplies and Pharmaceuticals:**
 - 1. Medical supplies include those that are part of the written **POC**. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the client's terminal illness. Equipment is provided by the hospice for use in the **recipient's** home while he or she is under hospice care and the reimbursement for this is included in the rates calculated for all levels of hospice care.
 - 2. Drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid hospice program and are to be billed in accordance with the appropriate Medicaid Services Manual (MSM) chapter for those services.
- f. **Home Health Aide (HHA), Personal Care Aide (PCA) and Homemaker Services:** **HHA** services and homemaker services when provided under the general supervision of an **RN**. Services may include personal care services and such household services which may be necessary to maintain a safe and sanitary environment in the areas of the home used by the **recipient**.
- g. **Physical Therapy (PT), Occupational Therapy (OT), Respiratory Therapy and Speech-Language Pathology Services:** **PT, OT**, respiratory therapy and speech-language pathology when provided for the purpose of symptom control, or to enable the **recipient** to maintain **Activities of Daily Living (ADLs)** and basic functional skills.

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4. Level of Care (LOC)

- a. Routine Home Care: The reimbursement rate for routine home care is made without regard to the intensity or volume of routine home care services on any specific day.
- b. Continuous Home Care:
 1. Continuous home care is only furnished during brief periods of crisis, described as a period in which a recipient requires continuous care to achieve palliation or management of acute medical symptoms, and only as necessary to maintain the terminally ill recipient at home.
 2. Nursing care must be provided by an RN or Licensed Practical Nurse (LPN) and the nurse (RN or LPN) must be providing care for more than half of the period of care. HHA or homemaker services or both may be provided on a continuous basis.
 3. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day.
- c. Inpatient Care (Respite or General):
 1. The appropriate inpatient rate (general or respite) is paid depending on the category of care furnished on any day on which the recipient is an inpatient in an approved facility. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the recipient is discharged. For the day of discharge, the appropriate home care rate is paid unless the recipient is deceased; the discharge day is then paid at the general or respite rate.
 2. Inpatient care must be provided by a facility that has a written contract with the hospice. This may be an approved Nursing Facility (NF), hospital or hospice capable of providing inpatient care.
 3. Respite care is short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine

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home care rate.

4. Time limited for reimbursement: In a **12**-month period the inpatient reimbursement is subject to the following limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Refer to the 42 CFR 418.302 for further information on the calculation of the inpatient limitation.

5. Optional Cap on Overall Hospice Reimbursement

The **DHCFP** may limit overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1st of each year through October 31st of the next year. The total payment made for services furnished to Medicaid beneficiaries during this period is compared to the “cap amount” for this period. Any payments in excess of the cap must be refunded by the hospice.

3203.1B PROVIDER RESPONSIBILITY

1. Recipient Enrollment Process

All Nevada Medicaid recipients, including those with primary insurance such as Medicare or a private insurance, must be enrolled in Nevada Medicaid’s Hospice Program regardless of where hospice services are provided.

NOTE: Enrollment paperwork for hospice recipients who are pending a Nevada Medicaid eligibility determination should not be submitted until Medicaid benefits have been approved. All enrollment forms must be received by the **Quality Improvement Organization (QIO)**-like vendor within **60** days of the date of decision of eligibility determination.

For the initial election period the DHCFP requires the following documentation be received by the QIO-like vendor within **five** working days of the hospice admission:

- a. Hospice Medicaid Information form;
- b. Hospice Ancillary Information form;
- c. Physician Certification of Terminal Illness:

1. **The hospice must obtain** written certification of terminal illness, **within two**

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calendar days of initiation of services, signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician. If the recipient does not have an attending physician, this must be indicated on the Hospice Medicaid Information Form. If the hospice **cannot obtain a written certification within two days** a verbal certification may be obtained within these two days, and a written certification obtained no later than eight days after care is initiated. If these requirements are not met, no payment **will** be made for days prior to the certification. Both the certification and election **of hospice services** statement must be in place for payment to commence. **Ideally, the dates on the certification statement and the election statement should match, but if they differ, the earliest date will be the date payment will begin.**

- d. The certification of terminal illness must meet the following requirements:
1. The certification must specify that the recipient's prognosis is terminal and life expectancy is six months or less.
 2. Clinical information and other documentation that supports the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the recipient's eligibility assessment.
 3. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and re-certification.
- e. A signed hospice election statement which must include the following:
1. Identification of the particular hospice that will provide care to the recipient;
 2. The recipient's or representative's acknowledgment he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;
 3. Acknowledgment that certain otherwise covered services are waived by the election, except for children under the age of 21;
 4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date the election

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statement was executed and the date certification was made; and

5. The signature of the recipient or representative.

The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the QIO-like vendor.

2. Interdisciplinary Group

The hospice must designate an interdisciplinary group or groups composed of individuals who use an interdisciplinary approach to assessing and meeting the physical, medical, psychosocial, emotional and spiritual needs of the hospice recipients and families facing terminal illness and bereavement. The interdisciplinary group provides or supervises the care and services offered by the hospice.

- a. Composition of Group: The hospice must have an interdisciplinary group or groups composed of or including at least the following individuals who are employees of the hospice:
 1. A doctor of medicine or osteopathy;
 2. A registered nurse;
 3. A social worker;
 4. A pastoral or other counselor; and
 5. Trained volunteer.
- b. Role of Interdisciplinary Group: Members of the group interact on a regular basis and have a working knowledge of the assessment and care of the recipient/family unit. The interdisciplinary group is responsible for the following:
 1. Conduct a comprehensive assessment of the recipient and update the assessments at the required times. The group in consultation with the recipient's attending physician (if any) must prepare a written POC for each hospice recipient that reflects recipient and family goals and interventions based on the needs identified in the initial, comprehensive and updated assessments;
 2. Provision of supervision of hospice care and services;

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3. Develop and maintain a system of communication, coordination and integration of services that ensures that the POC is reviewed every 15 calendar days, and updated as needed.
4. Establishment of policies governing the day-to-day provision of hospice care and services.
 - c. If a hospice has more than one interdisciplinary group, it must document in advance the group it chooses to execute the functions for each recipient.
 - d. Coordinator: The hospice must designate an RN to coordinate the implementation of the POC for each recipient.
3. Initial and Comprehensive Assessments
 - a. The hospice RN must complete an initial assessment within 48 hours after the election of hospice (unless the physician, recipient, or representative request that the initial assessment be completed in less than 48 hours).
 - b. A comprehensive and person centered assessment must be conducted no later than five calendar days after the election of hospice care by the hospice interdisciplinary group, in consultation with the recipient's attending physician (if any).
 - c. The comprehensive assessment must identify the recipient's needs for hospice care and the physical, psychosocial, emotional, and spiritual needs related to the terminal illness. All these areas must be addressed in order to promote the hospice recipient's well-being, comfort, and dignity, throughout the dying process.
 - d. An initial bereavement assessment of the needs of the recipient's family and other individuals focusing on the social, spiritual and cultural factors that may impact their ability to cope with the recipient's death. Information gathered from the initial bereavement assessment must be incorporated into the POC.
 - e. An update of the comprehensive assessment must be completed by the hospice interdisciplinary group (in collaboration with the recipient's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information in the recipient's progress towards desired outcomes, as well as a re-assessment of the recipient's response to care. The assessment update must be accomplished as frequently as the condition of the recipient requires, but no less frequently than every 15 days.

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4. Plan of Care

A written **POC** must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

- a. **Establishment of Plan of Care:** All hospice care and services furnished to recipients and their families must follow an individualized written POC established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the recipient or representative, and the primary caregiver(s) in accordance with the recipient's needs if any of them so desire. The hospice must ensure that each recipient and the primary caregiver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and service provided in the POC.
- b. **Content of Plan of Care:** The POC must reflect recipient and family goals and interventions based on problems identified in the initial, comprehensive and updated comprehensive assessments. The POC must include all services necessary for the palliation and management of the terminal illness and related conditions.
- c. **Review of Plan of Care:** The hospice interdisciplinary group (in collaboration with the recipient's attending physician (if any)) must review, revise and document the individualized POC as frequently as the recipient's condition requires, but no less frequently than every 15 days. A revised POC must include information from the recipient's updated comprehensive assessment and must note the recipient's progress towards outcomes and goals specified in the POC.

5. Recipients' Rights

The recipient must be informed of their rights during the initial assessment, and prior to furnishing care, and the hospice must protect and promote the exercise of these rights.

- a. The recipient or their representative must be provided with verbal and written notice of the recipient's rights and responsibilities in a language and manner that the recipient understands.
- b. The hospice must obtain the recipient's or their representative's signature confirming that they have received a copy of the notice of rights and responsibilities.

The recipient has the right to:

1. Exercise his or her rights as a recipient of the hospice;

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2. Have his or her property and person treated with respect;
3. Voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and
4. Not be subjected to discrimination or reprisal for exercising his or her rights.

In addition the recipient has the right to:

1. Receive effective pain management and symptom control from the hospice provider for conditions related to the terminal illness.
 2. Be involved in the development of his or her POC.
 3. Refuse care or treatment.
 4. Choose his or her attending physician.
 5. Have a confidential Clinical record.
 6. To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of the recipient's property.
 7. Receive information about the services covered under the hospice benefit.
 8. Receive information about the scope of services that the hospice will provide and specific limitations on those services.
- c. If a recipient has been adjudicated incompetent, the rights of the recipient are exercised by the person appointed to act on the recipient's behalf. If the recipient has not been adjudicated as incompetent any legal representative designated by the recipient may exercise the recipient's rights.

6. Abuse, Neglect or Mistreatment

In situations of abuse, neglect or mistreatment the hospice must:

- a. Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of the recipient's property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator.

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- b. Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is verified. Investigations and/or documentation of all alleged violations must be conducted within the hospice's established procedures.
- c. Ensure that verified violations are reported and take appropriate corrective action, if the alleged violation is verified by the hospice administrator.

7. Advanced Directives

The hospice must comply with all requirements stipulated in 42 CFR 489, Subpart I regarding Advanced Directives (AD). The hospice must inform and distribute written information to the recipient concerning its policies on ADs.

8. Quality Assurance

The hospice must develop, implement and maintain an effective, ongoing hospice-wide data driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program:

- a. Involves all hospice services (including those services under contract or arrangement);
- b. Focuses on indicators related to palliative outcomes; and
- c. Takes action to demonstrate improvement in hospice performance.

The hospice must maintain written documentation of its quality assessment and performance improvement program and must be able to demonstrate its operation to the CMS.

9. Infection Control

The hospice provider must maintain and document an effective infection control program that protects recipients, families, visitors and hospice personnel by preventing and controlling infections and communicable diseases. The infection control program must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions to include an agency wide program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases.

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The hospice must provide infection control education to employees, contracted providers, recipients and family members, and other caregivers.

3203.1C RECIPIENT RESPONSIBILITY

The Medicaid recipient is responsible for signing the election statement to receive hospice care. The election statement may be signed by the recipient’s representative.

The recipient is responsible to comply with the **POC** as established by the hospice interdisciplinary group.

3203.2 NON-HOSPICE SERVICES

Nevada Medicaid recipients continue to be eligible for applicable state benefits for services unrelated to the terminal illness for which hospice was elected pursuant to Section 3203.1 of this Chapter. “The hospice must develop and maintain a system of communication” to “provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.” Therefore the hospice provider is expected to be the lead case coordinator and maintain communication with other services.

- a. Personal Care Services (PCS) for Recipients Enrolled in Hospice: PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal condition, and the personal care needs exceed the personal care services provided under the hospice benefit.

If a recipient enrolls in hospice, **the** DHCFP or its designee will conduct an evaluation of an individual’s comprehensive personal care needs. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting total personal care needs. PCS provided under hospice will be subtracted from total PCS needs to document any personal care needs not met by hospice services and which may be provided by the Personal Care Agency. The PCS provided by a **personal care agency** to a recipient because of needs unrelated to the terminal condition may not exceed State Plan program limitations. Refer to MSM Chapter 3500 for regulations regarding PCS.

- b. HCBW Services for recipients enrolled in hospice: refer to section 3203.7 of this chapter.

3203.2A COVERAGE AND LIMITATIONS

- 1. Services unrelated to the terminal illness are subject to related program limitations as indicated in the MSM.
- 2. Typical services available that are not covered by the hospice benefit but payable by **the**

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DHCFP may include but are not limited to:

- a. Attending physician care (e.g., office visits, hospital visits, etc.);
 - b. Optometric services;
 - c. Any services, drugs, equipment, or supplies for a condition other than the recipient's terminal illness.
3. Neither the hospice nor Nevada Medicaid is responsible for payment for curative services related to an adult's terminal illness.

3203.2B PROVIDER RESPONSIBILITY

It is essential for all Medicaid service providers to check a recipient's Medicaid eligibility each time a service is provided to identify Medicaid recipients enrolled in the hospice benefit plan.

1. It is the responsibility of the hospice provider to ensure that prior authorization is obtained for services unrelated to the hospice benefit. The hospice agency must coordinate this process with the recipient's non-hospice providers. Request for the prior authorization must be submitted to the QIO-like **vendor**.

3203.2C RECIPIENT RESPONSIBILITY

The recipient is responsible for communicating fully with the hospice agency regarding all services unrelated to the terminal illness to ensure continuity of care.

3203.3 CHANGING THE DESIGNATED HOSPICE

An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

- a. The change of the designated hospice is not a revocation of the hospice election for the period in which it was made.
- b. To change the designation of hospice agencies, the individual or representative must file, with the hospice agency from which care has been received and with the newly designated hospice, a notice of transfer that includes the following:
 1. The name of the hospice from which the individual has received care;
 2. The name of the hospice from which he or she plans to receive care;

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3. The effective date of the transfer of hospice care.
 - c. The transferring hospice agency files the notice in the medical record and faxes one copy to the receiving hospice and faxes one copy to the QIO-like vendor along with a Hospice Medicaid Information form.
 - d. The receiving hospice agency must fax an updated Hospice Medicaid Information form, Hospice Ancillary Information form, a signed election statement, and a signed copy of the physician's certification of terminal illness to the QIO-like vendor.
 - e. If a hospice recipient is residing in an **NF**, the transferring hospice agency is required to submit a copy of the transfer statement to the **NF** for their records.

3203.4 REVOKING THE ELECTION OF HOSPICE CARE

An individual or representative may revoke the election of hospice care at any time during an election period.

- a. To revoke the election of hospice care, the recipient or representative must file with the hospice a statement to be placed in the medical record that includes the following information:
 1. **Signed statement that the recipient or representative revokes the recipient's election for coverage of hospice care** for the remainder of that election period with the date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made);
 2. The hospice agency is required to fax the QIO-like vendor the signed copy of the revocation notice and a Medicaid Hospice Information form/Notice of Revocation within 72 hours, once the revocation notice has been signed.
- b. If the hospice recipient is residing in an **NF**, the hospice agency is required to immediately submit to the **NF** a signed copy of the notice of revocation for their medical records.
- c. An individual, upon revocation of the benefit election of hospice care for a particular election period:
 1. Is no longer covered for hospice care for that election period;
 2. Resumes eligibility for all Medicaid covered services as before the election to hospice; and
 3. May at any time elect to receive hospice coverage for any other hospice election

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periods for which he or she is eligible to receive.

3203.5 DISCHARGE OF A RECIPIENT FROM HOSPICE

With adequate documentation explaining cause, a hospice may discharge a recipient.

- a. Reasons for discharge may include:
 1. Noncompliance with hospice **POC**;
 2. **Moves out of the hospice's service area or transfers to another hospice;**
 3. **No longer meets the criteria for hospice;**
 4. **No longer eligible for Medicaid; or**
 5. **Request of recipient, or representative.**
- b. **The hospice must have policies in place to address disruptive, abusive or uncooperative behavior, on the part of the recipient or other individuals in the home, to the extent that delivery to the recipient or the ability of the hospice to operate is seriously impaired. The hospice must do the following prior to discharge for cause:**
 1. **Advise the recipient that a discharge for cause is being considered.**
 2. **Make a serious effort to resolve the problem(s) presented by the recipient's behavior or situation.**
 3. **Ascertain that the recipient's proposed discharge is not due to the recipient's use of necessary services; and**
 4. **Document the problem(s) and efforts made to resolve the problems(s) and enter this documentation into its medical records.**
- c. **Prior to discharge, the hospice must obtain a written discharge order from the hospice medical director. If a recipient has an attending physician, the physician must be consulted and his/her recommendation or decision must be included in the discharge note.**
- d. **A copy of the signed discharge notice and the Hospice Medicaid Information form/Notice of Discharge are required to be faxed to the QIO-like vendor within 72 hours of the discharge. A copy is retained in the client's record at the hospice.**
- e. **If the hospice recipient is residing in an **NF** the hospice is required to immediately submit**

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a copy of the signed discharge notice to the facility for their records the day the discharge notice has been signed. The hospice agency is required to also verbally inform the **NF** staff of the discharge.

3203.6 HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY

Recipients residing in a Nevada Medicaid approved **NF** are eligible for hospice care pursuant to policies identified in 3203.1.

3203.6A COVERAGE AND LIMITATIONS

The hospice recipient residing in a **Skilled Nursing Facility (SNF)** must not experience any lack of services or personal care because of his or her status as a hospice **recipient**. The **NF** must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The **recipient** has the right to refuse any services.

The **NF** must continue to still comply with all requirements for participation in Medicare and/or Medicaid for hospice-enrolled Nevada Medicaid residents.

3203.6B PROVIDER RESPONSIBILITIES

1. Responsibilities of the hospice and the nursing facility

The hospice agency and the **NF** must have a written agreement under which the hospice is responsible for the professional management of the recipient's hospice care. The **NF** is responsible to provide room and board to the recipient.

a. Room and board includes:

1. Performance of personal care services;
2. Assistance in the **ADLs**;
3. Socializing activities;
4. Administration of medication;
5. Maintaining the cleanliness of a resident's room; and
6. Supervising and assisting in the use of **Durable Medical Equipment (DME)** and prescribed therapies.

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b. Hospice Professional Management includes:

1. Physician services;
2. Nursing services;
3. Medical social services; and
4. Counseling.

2. Nursing Facility Screenings

Refer to **MSM** Chapter 500 for specific guidelines regarding **NF** screenings.

All hospice enrolled recipients must have a Pre-Admission Screening and Resident Review (PASRR) and a LOC Screening prior to admission to an **NF**. Requests for these screenings are done by calling the QIO-like vendor.

The requests can be made by either the **NF** or the hospice agency.

a. The **NF** is responsible for:

1. Ensuring the hospice recipient has:
 - a. A valid PASRR determination, and
 - b. A LOC screening indicating appropriate **NF** placement.
2. Verifies that the necessary screenings are completed prior to admission and must monitor time-limited PASRR and LOC screenings in order to extend Medicaid reimbursement. Medicaid reimbursement is not available when PASRR and LOC screenings are not completed within the specified timeframes, which would be passed on to the **NF**.
3. Submitting a Nursing Facility Tracking Form within 72 hours of occurrence.

b. Prior to **NF** placement, the hospice agency must verify with the QIO-like **vendor** or **NF** that both screenings (PASRR, LOC) have been completed and that the hospice recipient is cleared for placement.

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3203.7 HOSPICE COVERAGE AND WAIVER RECIPIENTS

As part of the admission procedure it is the responsibility of the hospice agency to obtain information regarding recipient enrollment in **HCBW** programs.

3203.7A COVERAGE AND LIMITATIONS

When a Waiver recipient is enrolled in the hospice program there can be no duplication of hospice covered services, such as **PCA** services, homemaker services, home health services, respite, or companion services. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services.

This also includes all HCBW recipients who have Medicare as their primary insurance and Medicare is paying for the hospice services.

3203.7B PROVIDER RESPONSIBILITY

The hospice agency must immediately notify the QIO-like vendor of any new hospice admissions who are receiving services through a Medicaid HCBW.

3203.8 MANAGED CARE AND HOSPICE RECIPIENTS

Managed care participants who elect hospice care must be disenrolled from their managed care program.

- a. The hospice is responsible for notifying the QIO-like vendor in such situations.
- b. The recipient electing the hospice benefit will then return to **Fee-for-Service (FFS)** Medicaid.
- c. There should be no delay in enrolling managed care recipients in hospice services.

3203.9 CLINICAL RECORDS

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. **The clinical record may be maintained electronically.**

Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice.

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Each individual's record **must** contain:

1. The **comprehensive**, initial and subsequent assessments;
2. The **initial and updated** POCs;
3. Identification data;
4. Consent and authorization and election forms;
5. Documentation the client has received **and signed** a statement of “**Recipient Rights**”;
6. A complete drug profile; **responses to medications, symptom management, treatments and services**;
7. Pertinent medical history; **Physicians certification and re-certifications of terminal illness and any Advanced Directives**; and
8. Complete documentation of all services and events (including evaluations, treatments, progress notes, **physician orders** etc.).

The hospice must safeguard the clinical record against loss, destruction, and unauthorized use. **The recipient's clinical record must be retained after the death or discharge of the recipient for a period of six years. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform Medicaid and the CMS Regional office where such clinical records will be stored and how they may be accessed.**

3203.10 **DHCFP REVIEW**

The DHCFP may conduct a review of a hospice provider to ensure appropriateness of care and accuracy of claims.

The methods of review may include but are not limited to:

- a. On-site visits **with recipients** and family at their residence;
- b. Chart reviews at the hospice agency;
- c. Post-payment review of claims data;
- d. **The DHCFP** desk review; and
- e. On-site review in facilities.

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3203.10A PROVIDER RESPONSIBILITY

The hospice provider being reviewed must comply with the DHCFP staff on providing all information requested in a timely manner.

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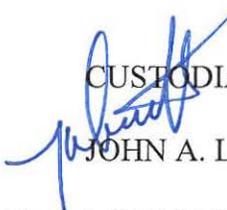
3204 HEARINGS

All Medicaid recipients and providers have rights to hearings regarding reimbursement and treatment issues. Please refer to **Medicaid Services Manual (MSM)** Chapter 3100, Hearings for the hearing process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 19, 2008

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM:  JOHN A. LIVERATTI, CHIEF OF COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3300 – PROGRAM INTEGRITY

BACKGROUND AND EXPLANATIONS

The proposed revision to Chapter 3300 is due to a change in federal regulation regarding the Payment Error Rate Measurement (PERM) program. Chapter 3300 was revised in May 2007 based on information contained in the interim final rule (published in the Federal Register, August 28, 2006) which called for a 90 day timeframe in which providers would be required to submit medical record documentation. The Federal Register of August 31, 2007 contained the final rules for the PERM program. The final rules did not state the exact revised timeframe, but intimated it might be changed to 60 days and indicated that a policy instruction might be issued for clarification. Therefore, in order to provide the most up to date information to medical providers, Chapter 3300 was revised. Additionally, providers have been notified via First Health web messages and information in First Health provider newsletters of the change in submittal timeframes. Since the federal PERM reviews have not started in Nevada, no providers have been impacted by this revised policy.

MATERIAL TRANSMITTED

MTL 04/08
CHAPTER 3300 – PROGRAM
INTEGRITY

Sec. 3302.2B

Added comma after “type”

Added “the timeframes specified in the Payment Error Rate Measurement (PERM) Final Rule (released in the Federal Register on August 31, 2007) or any subsequent policy instruction by CMS.

MATERIAL SUPERSEDED

MTL 19/07
CHAPTER 3300 – PROGRAM
INTEGRITY

Deleted “90 days of the initial request for documentation.”

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3300 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) is responsible for the fiscal integrity of the Medicaid and Nevada Check Up programs and is committed to a program that identifies and reduces fraud, abuse and improper payments. The DHCFP must ensure Medicaid and Nevada Check Up recipients have access to quality care and claims are paid appropriately and in accordance with state statutes and federal laws and regulations, program policies and billing manuals. The DHCFP has three distinct programs to assist in ensuring the fiscal integrity of the programs it administers: the Surveillance and Utilization Review (SUR) program, the Payment Error Rate Measurement (PERM) program and the Financial and Compliance Audit program.

Surveillance and Utilization Review

Federal regulations require the DHCFP to operate a statewide SUR program to safeguard against unnecessary or inappropriate use of services and prevent excess payments in an efficient, economical and effective manner. The DHCFP has methods in place to: identify, investigate and refer suspected cases of provider and recipient fraud and abuse; methods and processes to review provider over-utilization of services and in the case of managed care providers, under-utilization of services and recover improper payments. The DHCFP will conduct reviews to determine if services were billed in accordance with applicable policies and/or regulations. Providers are selected for review based on complaints, referrals and through the use of fraud detection and other analysis. All providers are at risk for review.

The DHCFP must refer all cases of suspected fraud and abuse, pursuant to Nevada Revised Statutes (NRS) 422.540 to 422.570, to the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU). The MFCU has the primary authority and responsibility to fully investigate and prosecute, for civil and/or criminal action, violations of fraud and abuse in the Medicaid and Nevada Check Up programs.

The Division of Welfare and Supportive Services (DWSS) is responsible for all recipient related Medicaid fraud and abuse, including unlawful acts relating to Medicaid cards. To report any fraudulent activity related to Medicaid recipients contact the Investigations and Recovery Unit within the DWSS or fill out a fraud report on-line at <http://welfare.state.nv.us/I&R/ir.htm>.

The DHCFP must ensure the exclusion of certain individuals and entities from participation in the Medicaid and Nevada Check Up programs. For the DHCFP policies and applicable state and federal statutes and regulations relating to this process, refer to the Medicaid Services Manual Chapter 100.

The DHCFP must ensure all entities receiving payments of \$5 million dollars or more from the Medicaid program establish policies for the entity's employees providing detailed information about: the entity's procedures for detecting and preventing fraud, waste and abuse; false claims;

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civil and criminal penalties; and whistle blower protections. For the DHCFP policy relating to this provider requirement, refer to the Medicaid Services Manual, Chapter 100.

Payment Error Rate Measurement (PERM)

The Improper Payments Act of 2002 (IPIA) requires the Centers for Medicare and Medicaid Services (CMS) to estimate improper payments in all state Medicaid and State Children's Health Insurance Programs (Nevada Check Up). CMS must annually calculate and report to Congress the national error rates in each of these programs and the actions it is taking to reduce improper payments in these health care programs. To meet the requirements of the federal mandate, CMS requires each state to undergo a PERM review once every three years. Nevada will be reviewed in federal fiscal year 2008 and every third year thereafter.

PERM reviews consist of a thorough analysis of recipient eligibility, claims processing and medical record or service documentation. Recipient eligibility reviews will be conducted by the DWSS. The claims processing and medical record or service documentation reviews for the mandated PERM program will be conducted by federal contractors.

Financial and Policy Compliance Audits

The DHCFP will conduct regular financial and policy compliance audits of programs and services provided under the Medicaid and Nevada Check Up programs. These audits consist of a thorough review of program policy, claims processing and/or medical or service record documentation.

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3301 REGULATORY AUTHORITY

Provider and recipient fraud, abuse and improper payments are regulated by federal law and state statute, specifically, the Social Security Act (SSA), United States Code (Title 42), Code of Federal Regulation (42 CFR) and the Nevada Revised Statutes (NRS). Specific authorities include, but are not limited to:

Social Security Act (SSA)

- a. The penalty for fraud is regulated by Section 1107.
- b. Section 1128A outlines civil monetary penalties for acts involving federal health care programs.
- c. Section 1128B outlines criminal penalties for acts involving federal health care programs.
- d. Section 1902 and Section 2103 govern the amount, duration and scope of medical assistance for Medicaid and Nevada Check Up recipients, respectively.
- e. Section 1902 (a) (68) describes the requirements for false claims education for entities receiving \$5 million dollars in payments from the Medicaid program. Refer to the Deficit Reduction Act of 2005, Section 6032.
- f. Section 1903 and Section 2105 govern federal and other payments to states for Medicaid and Nevada Check Up programs, respectively.
- g. Section 1903 (q) describes the requirements of state Medicaid Fraud Control Units (MFCU).
- h. Sanctions for non-compliance of provisions relating to managed care are regulated by Section 1932.

Code of Federal Regulations (CFR)

- a. 42 CFR Part 431, Subpart Q – Requirements for Estimating Improper Payments in Medicaid and SCHIP.
- b. 42 CFR 431.54 (e) - Regulates recipient lock-in for recipients over utilizing services.
- c. 42 CFR 431.54(f) - Regulates restrictions such as provider lock-out or suspension for abuse of the Medicaid program.

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- d. 42 CFR 455 Subpart A - Describes the requirements of Medicaid Agency Fraud Detection and Investigation Programs.
- e. 42 CFR 456 Subpart A - Describes the general provisions for utilization control in state or federal health care programs.
- f. 42 CFR 456 Subpart B - Describes the requirements of a statewide Surveillance and Utilization Review control program for all Medicaid services.
- g. 42 CFR 457.915-.935 - Pertains to fraud detection and investigation associated with the State Children's Health Insurance Program (SCHIP).
- h. 42 CFR 1001 - Regulates the mandatory and permissive provider exclusions for state or federal health care programs.
- i. 42 CFR 1002 - Includes regulations for state-initiated exclusions from Medicaid programs.
- j. 42 CFR 1003 - Provides for the imposition of civil money penalties and other applicable regulations regarding exclusion of individuals or entities from federal or state health care programs.
- k. 42 CFR 1005 - Regulates appeals of exclusions, civil money penalties and assessments.

Nevada Revised Statutes (NRS)

- a. NRS 193.120-193.150 - Details the types of crimes and punishments associated with fraudulent acts.
- b. NRS 228.410 - Established the MFCU, including their duties and powers. The MFCU is responsible for the investigation and prosecution of violations of NRS 422.540-422.570.
- c. NRS 357 - Governs false claims submitted to state or local governments.
- d. NRS 422.2374 - Details the required cooperation between the DHCFP and the MFCU involving the suspension or exclusion of provider services under Medicaid.
- e. NRS 422.305 - Regulates confidentiality of information obtained in investigations of provider of services for Medicaid.
- f. Unlawful acts regarding Medicaid cards are regulated by NRS 422.366-422.369.

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- g. Unlawful acts; fraud by person authorized to provide care to holder of stolen, forged, expired, or revoked card; penalty – are regulated by NRS 422.369.
- h. NRS 422.410-422.590 - Covers unlawful acts and penalties related to services provided by or through the DHCFP.

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3302 DEFINITIONS

Definitions apply to this Chapter and do not supersede applicable state or federal law.

3302.1 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 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 Nevada Check Up programs. (42 CFR 455.2)

3302.2 ADMINISTRATIVE ACTION

Administrative Action is an action taken by the DHCFP which includes but is not limited to: the recovery of improper payments; issuance of educational letters; issuance of warning letters; issuance of recoupment/recovery letters; special claims reviews or on-site audits; requests for provider corrective action plans; requests for provider self audits; referral to appropriate civil agencies (licensing bodies); referral to the MFCU; denial of provider applications; suspension and termination of provider status; and other actions as stated in policy 3303.3A. See the Social Security Act Sections: 1128, 1128A, 1128B, and 1903.

3302.3 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)

3302.4 IMPROPER PAYMENT

An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments include but are not limited to: improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits; payments for ineligible recipients; payments for ineligible, non-covered or unauthorized services; duplicate payments; payments for services that were not provided or received; payments for unbundled services when an all-inclusive bundled code should have been billed; payments not in accordance with applicable pricing or rates; data entry errors resulting in incorrect payments; payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts; payments for non-medically necessary services; payments where an incorrect number of units were billed; submittal of claims for unauthorized visits; and payments that cannot

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be substantiated by appropriate or sufficient medical or service record documentation. Improper payments can also be classified as fraud and/or abuse.

3302.5 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)

3302.6 OVERPAYMENT/UNDERPAYMENT

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

3302.7 PERM REVIEW ERRORS

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

3302.8 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.

3302.9 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.

3302.10 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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3303 POLICY

3303.1 IDENTIFICATION OF FRAUD, ABUSE AND IMPROPER PAYMENTS

The DHCFP has methods and criteria to identify and track suspected cases of fraud, abuse and/or improper payments. These methods or criteria must not infringe on the legal rights of persons involved; must afford due process of law; and must comply with federal law and state statutes.

3303.1A COVERAGE AND LIMITATIONS

1. The following activities are the responsibility of the DHCFP:
 - a. Conduct regular investigations or reviews of claims or other payments to determine if improper payments have been made or fraud and/or abuse has occurred;
 - b. Investigate and track referrals from all sources;
 - c. Refer suspected fraud and abuse cases to the MFCU in accordance with the Memorandum Of Understanding (MOU) between the DHCFP and the MFCU and state statutes;
 - d. Request and/or monitor provider self-audits;
 - e. Assist DHCFP administrative staff, as necessary, in clarification or revision of Medicaid and Nevada Check Up policies to aid in preventing or reducing fraud, abuse and/or improper payments;
 - f. Assist with assuring Medicaid recipients receive necessary health or other care services at an appropriate level and quality;
 - g. Process and track recoupment or recovery of improper payments or improperly paid claims;
 - h. Educate providers about the requirements related to provision of service documentation mandated by the PERM program.
 - i. Assist in providing education to providers on proper billing practices;
 - j. Assist in assuring provider compliance with DHCFP program policy, Medicaid Services Manual, Medicaid Operations Manual, provider billing manuals and federal law and state statutes;

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- k. Develop and maintain methodologies to verify services reimbursed by the DHCFP were actually furnished to recipients. The DHCFP fiscal agent sends out approximately 500 notices each month to a random sample of Medicaid and Nevada Check Up recipients receiving services. This is the Verification Of Service (VOS) program. Recipients are asked to notify the DHCFP if the services listed were not received. All recipient responses received by the DHCFP are reviewed and if warranted, investigations are conducted;
 - l. Take all necessary steps to ensure the fiscal integrity and effectiveness of the programs administered by the DHCFP.
2. Fraudulent acts, false claims or abusive billing practices include, but are not limited to:
- a. Knowingly and designedly, by any false pretense, false or misleading statement, impersonation or misrepresentation, obtain or attempt to obtain authorization to furnish services, receive payment for services, receive public assistance, money, property or medical care;
 - b. Submitting a claim or causing a claim to be submitted, knowing the claim to be false, in whole or in part, by commission or omission;
 - c. Make or cause to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission;
 - d. Make or cause to be made a statement or representation for use by another in obtaining goods or services pursuant to the state plan, knowing the statement or representation to be false, in whole or in part, by commission or omission;
 - e. Make or cause to be made a statement or representation for use in qualifying as a provider, knowing the statement or representation to be false, in whole or in part, by commission or omission;
 - f. Concealing or failing to disclose knowledge affecting the initial or continued right to any payment or to secure such payment either in greater quantity than is due or when no such payment is authorized or due;
 - g. Converting part or all of any payment intended for another person to himself/herself;

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- h. Soliciting, receiving, offer or pay any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for, or to induce any person to make:
 - 1. Referral of an individual to a provider;
 - 2. Purchase, lease, order, arrange for or recommend the purchase, lease or order of any item, service good or facility for which payment may be made, in whole or part, under the programs operated by the DHCFP;
 - 3. Submit or cause to be submitted, bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs;
- i. Submit a false application for provider status;
- j. Submitting false information to obtain compensation for services, supplies or equipment the provider is not entitled to from the programs operated by the DHCFP;
- k. Submitting repeated claims for services that are not reimbursable by the DHCFP;
- l. Submitting repeated claims from which required information is missing or incorrect;
- m. Violating any provision in the DHCFP provider agreement (contract between the DHCFP and the provider);
- n. Acts which result in termination, suspension, or exclusion of the provider from other governmental programs;
- o. Any acts which violate professional conduct standards adopted by state medical licensure boards and other medical professional organizations;
- p. Submitting a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source.
- q. Submitting a claim for services or items which were not rendered by the provider or were not rendered to an eligible recipient.
- r. Submitting a claim for services or items which includes costs or charges which are not related to the cost of the services or items.

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- s. Except in emergency situations, dispensing, rendering or providing a service or items without a practitioner's written order and the consent of the recipient.
- t. Submitting a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider.
- u. Submitting a claim for medically unnecessary services;
- v. Coercion of recipients to sign Verification of Service forms for services not provided;
- w. Reporting or billing for hours or services, when services were not provided to the extent reported or billed;
- x. False statements include, but are not limited to:
 - 1. Falsification of medical records;
 - 2. Submitting a bill for a service not provided;
 - 3. Up-coding;
 - 4. Unbundling;
 - 5. Business, fiscal or medical practices which result in unnecessary costs to the programs operated by the DHCFP;
 - 6. Duplicate billing for services, supplies or equipment;
 - 7. Providing medical care, services or equipment which are not medically necessary or which fail to meet professionally recognized standards for health care; and/or
 - 8. Failure to develop and maintain health service records as required by NRS 422.570 and DHCFP policy.

3. Confidentiality of information.

- a. All material gathered during an inquiry of fraud, abuse or improper payment will only be used for the purpose for which it was gathered, and will not be distributed to any individual(s) or organization(s), with the exception of MFCU and/or the

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Office of the Inspector General, the Centers for Medicare and Medicaid Services (CMS) or their sub-contractors.

- b. Any information obtained by the DHCFP or the MFCU in an investigation of a provider of services under the State Plan for Medicaid is confidential unless it is used as evidence at a hearing to enforce the provisions of NRS 422.450 to 422.590 or to review an action by the DHCFP against a provider.
- c. Release of information or evidence is done in compliance with published confidentiality and privacy law, rules and regulations. Materials collected by the DHCFP may be of an extremely sensitive nature. All such materials are kept secure.
- d. The identity of any person reporting fraud, abuse or improper payments is not disclosed unless mandated by court order or the person agrees to the disclosure of their identity.
- e. The identity of any recipient or applicant receiving assistance is always kept confidential unless disclosure is authorized by the recipient or legally responsible adult.
- f. The DHCFP is a covered entity, as defined by the Health Insurance Portability and Accountability Act (HIPAA) regulations (45 CFR Parts 160, 162 and 164), and as such, must comply with all aspects of this federal regulation.

3303.1B PROVIDER RESPONSIBILITY

1. Providers have an obligation to report to the DHCFP any suspicion of fraud or abuse in DHCFP programs, including fraud or abuse associated with recipients or other providers.
2. Providers must adhere to:
 - a. DHCFP policy;
 - b. Provider services and operations manuals;
 - c. Fiscal agent billing manuals;
 - d. All applicable federal law and state statutes; and
 - e. Any other guidance furnished by the DHCFP or their fiscal agent regarding provider requirements and responsibilities.

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3303.1C RECIPIENT RESPONSIBILITY

Recipients have an obligation to report to the DHCFP any suspicion of fraud, abuse or improper payment in DHCFP programs or concerning DHCFP recipients or providers.

3303.2 INVESTIGATIONS OF FRAUD, ABUSE OR IMPROPER PAYMENTS

The DHCFP conducts investigations of all suspected cases of fraud, abuse or improper payments. Investigations continue until an appropriate action is taken or the case is closed.

PERM reviews are done in accordance with the requirements mandated by CMS. PERM reviews are completed by CMS or their sub-contractors every three years starting in FY 2008.

Financial and Policy Compliance audits are performed regularly by the DHCFP and follow the standards and guidelines developed by CMS for the PERM reviews.

Suspected fraud or abuse discovered during the course of a PERM review or a Financial and Policy Compliance Audit will be referred to the MFCU for further investigation or action.

3303.2A COVERAGE AND LIMITATIONS

1. An investigation or review is initiated by the DHCFP when questionable practices are identified or the DHCFP receives complaints of suspected fraud, abuse or improper payments.
2. An investigation consists of a thorough review of the complaint or questionable practice and may include: An analysis of the paid claims; review of provider and recipient reports; review of policy and billing manuals; review of applicable rates; review of medical or other service record documentation; and review of appropriate federal law and state statutes.
3. The Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office is the single state agency responsible for the investigation and prosecution of violations of NRS 422.540 to 422.570, inclusive. (NRS 228.410) All suspected cases of provider fraud and/or abuse are referred to the MFCU in accordance with the MOU between the DHCFP and the MFCU.
4. PERM reviews consist of an analysis of randomly sampled Fee-For-Service (FFS) and managed care claims or line items.
 - a. FFS claims or line items will undergo a medical record or service documentation review and a claims processing review.

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1. At a minimum, the following items will be considered PERM Review Errors resulting from medical reviews:
 - a. No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP.
 - b. Claim billed with incorrect procedure code.
 - c. Provider billed separate procedure codes when a bundled procedure code should have been used.
 - d. The number of units billed was incorrect.
 - e. Service was medically unnecessary.
 - f. Service or procedure was not in agreement with documented policy.

2. At a minimum, the following items will be considered PERM Review Errors resulting from processing reviews:
 - a. Duplicate claims billed for same service, same recipient and same date of service.
 - b. Claim paid for a non-covered service.
 - c. FFS claim paid although the recipient was enrolled in managed care.
 - d. Incorrect rate was used to pay the claim.
 - e. Logical edit issues (e.g. gender and procedure code are incompatible).
 - f. Data entry errors.

- b. Managed care payments will undergo a claims processing review only. The managed care claims reviewed will include monthly capitation payments and condition specific payments such as maternity payments and re-insurance payments. At a minimum the following items will be considered PERM Review Errors resulting from managed care reviews:

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1. Recipient not eligible for enrollment in a Health Maintenance Organization (HMO).
 2. Recipient not enrolled in the HMO that received the capitation or other payment.
 3. Incorrect capitation or other payment – either the wrong rate cell was used to pay the claim or the rate was not consistent with the rate in the HMO contract.
5. Financial and Policy Compliance Audits may utilize random sampling techniques or may target specific provider types, procedures or services. These audits will utilize the guidelines for PERM reviews addressed in 4. of Section 3303.2A above.

3303.2B PROVIDER RESPONSIBILITY

1. Providers are bound by both federal and state statutes and regulations, DHCFP policy and the DHCFP provider agreement to cooperate and provide any and all documentation (e.g., medical records, charts, billing information and any other documentation) requested by the DHCFP or other state and/or federal officials or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP.
2. DHCFP providers are required to keep records sufficient and necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of the services provided to recipients. All services billed to and paid by the DHCFP which cannot be validated by appropriate documentation are subject to recovery.
3. Requested documentation must be provided within timeframes specified by the DHCFP or other state or federal officials.
4. Records, documentation and information must be available regarding any service for which payment has been or will be claimed to determine has or will be made in accordance with applicable federal and state requirements.
5. Providers must make all documentation requested by the DHCFP readily available for review by state and/or federal officials or their authorized agents. Readily available means the records shall be made available at the provider's place of business or, upon written request, forwarded, without charge to the state or federal official requesting the documentation.

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6. For medical record requests associated with DHCFP audits or investigations, providers are required to submit documentation to support the claims under review within 15 calendar days after receipt of a letter from the DHCFP requesting such information.
7. For medical record requests associated with the mandated federal PERM reviews, providers are required to submit documentation to support the claim or line item under review within **the timeframes specified in the Payment Error Rate Measurement (PERM) Final Rule (released in the Federal Register on August 31, 2007) or any subsequent policy instruction issued by CMS.**
8. All records subject to audit or review must be produced at no cost to the DHCFP.
9. Providers must adhere to both federal and state statutes and regulations and DHCFP policy concerning the appropriate and adequate documentation of services billed to the DHCFP.
10. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with DHCFP operations or services manuals and state and federal statutes and regulations.
11. Providers must retain patient records in accordance with state and or federal statutes and regulations or at a minimum for six years from the date of payment for the specified service.

3303.3 ADMINISTRATIVE ACTIONS AND CIVIL AND CRIMINAL PENALTIES

The DHCFP is required and authorized to review identified cases of suspected fraud, abuse and improper payments and impose appropriate actions upon offending parties. The DHCFP is able to impose a variety of Administrative Actions, including referral to the MFCU at the Attorney General's Office. The MFCU has the authority to impose civil monetary and other penalties as well as criminally prosecute offenders.

In determining the appropriate action(s) to recommend in a fraud, abuse or improper payment situation, the following will be considered:

1. Recommendations of the MFCU;
2. Action(s) necessary to eliminate fraud or abuse and to recover payments related to the fraud, abuse or improper payment;
3. Seriousness of the offense(s);
4. Number of current and past violations;

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5. Provider's willingness to cooperate;
6. Past sanctions applied; and
7. Other available services in the area.

3303.3A COVERAGE AND LIMITATIONS

1. Administrative Actions. The DHCFP is authorized to take Administrative Actions to ensure compliance with program policies, state statutes and federal laws and regulations.
2. In response to the discovery of fraud, abuse or improper payments in the Medicaid and Nevada Check Up programs. The DHCFP may initiate more than one Administrative Action at one time, if warranted. (e.g. issuance of a recoupment/recovery letter and request a corrective action plan) The types of Administrative Actions that may be taken by the DHCFP are as follows:
 - a. Issuance of educational letters. The DHCFP or the DHCFP fiscal agent may issue an educational letter to a provider if the results of an investigation indicate the provider was only in need of policy or billing clarification and an improper payment did not occur. This action is used primarily when minor billing errors are detected. The provider Fair Hearing process is not available to dispute an educational letter.
 - b. Issuance of warning letters. The DHCFP may issue a warning letter to a provider if the provider has taken an action which violates or is not in accordance with policy, state statutes, federal laws or regulations, or the terms of the provider contract with the DHCFP. Warning letters will be sent by certified mail, with a return receipt requested. Warning letters are to assist the provider in rectifying improper billing practices and will give notice to the provider that continuation of the activity in question will result in further action. Warning letters may request submittal of sufficient and appropriate documentation to substantiate claims billed to and paid by the DHCFP. Failure of providers to submit appropriate documentation within timeframes specified by the DHCFP in a warning letter may result in payment recoupments/recovery without additional notice. The provider Fair Hearing process is not available to dispute a warning letter.
 - c. Issuance of recoupment/recovery letters. The DHCFP may issue a recoupment/recovery letter to a provider if the results of an investigation indicate the provider was improperly paid for one or more services. A recoupment/recovery letter may also be sent after a provider fails to submit sufficient and appropriate documentation within the timeframes requested in a warning letter. Recoupment/recovery letters will be sent by certified mail, with a return receipt

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requested. The letter will notify the provider of the nature of the improper payment, the amount to be recovered and the method of repayment. The provider Fair Hearing process is available to dispute recoupment/recovery letters unless the recoupment/recovery letter was the result of the provider's failure to provide sufficient and necessary information to establish medical necessity and to fully disclose the basis for the type, extent and level of services provided within the timeframes indicated in the letter that requested such information; or the provider's failure to provide sufficient and appropriate documentation within specified timeframes for the mandated federal PERM reviews.

- d. Recovery of improper payments. The DHCFP may recover improper payments with or without prior notice to the provider. All improper payments discovered may be recovered by the DHCFP. If documentation sufficient to support the amount billed to or paid by the DHCFP is not provided within the timeframes specified by the DHCFP, the associated payments for the service are subject to recovery. All improper payments discovered during the course of mandated federal PERM reviews are subject to recovery.
- e. Special claims reviews or on-site audits. The DHCFP can perform special claims reviews or on-site audits of any provider billing claims for Medicaid or Nevada Check Up programs. The reviews or audits can be conducted with or without prior notice to the provider under review. The provider Fair Hearing process is not available to dispute special claims reviews or on-site audits.
- f. Corrective Action Plan. After the DHCFP conducts an investigation or audit and determines improper payments have been made, the DHCFP may require the provider to complete a Corrective Action Plan (CAP), specifying how, as well as when, the provider expects to achieve compliance. The provider Fair Hearing process is not available to dispute requests for Corrective Action Plans.
- g. Provider self audits. The DHCFP may request a provider or group of providers to perform self audits. This action can be taken with or without the discovery of improper payments, or fraud or abusive billing practices. The DHCFP will accept reimbursement for improper payments, discovered during provider self audits, without penalty, if the improper payment was disclosed voluntarily by the provider and the acts that led to the improper payment were not the result of fraudulent conduct on the part of the provider, its employees or agents. Provider self audits do not relieve the provider of any liability for civil or criminal action by the MFCU, if improper payments were the result of fraud or fraudulent acts. The provider Fair Hearing process is not available to dispute requests for provider self audits.
- h. Referrals to appropriate civil agencies (licensing bodies). If the DHCFP discovers licensing or other regulatory violations while conducting an investigation or audit,

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the DHCFP may make referrals to appropriate licensing or governing entities, such as the Nevada Bureau of Licensure and Certification, the federal Office of the Inspector General, the federal Office of Civil Rights or other such governing entities. The provider Fair Hearing process is not available to dispute referrals to civil agencies or licensing bodies.

- i. Referrals to the MFCU. The DHCFP is required to refer all suspected cases of fraud and abuse to the MFCU. Providers are never notified about this action.
- j. Denials of provider applications. Providers may be denied DHCFP provider status if they are found to be out of compliance with policy, state and/or federal regulations or the terms of the provider contract with the DHCFP. Refer to Chapter 100 of the Medicaid Services Manual for further information.
- k. Suspension and termination of provider status. Termination, lock-out suspension, exclusion, non-renewal of DHCFP provider status are possible actions applied to providers found to be out of compliance with policy, state and/or federal regulations, the terms of the provider contract with the DHCFP, or who commit fraud. Refer to Chapter 100 of the Medicaid Services Manual for further information.
- l. Other action. The DHCFP may impose special requirements on providers as a condition of participation. Other actions include, but are not limited to:
 - 1. Requirement for all services to be prior authorized to be eligible for reimbursement; and/or
 - 2. Requirement for provider to submit all records or documentation to support the services billed prior to payment.

The provider Fair Hearing process is not available to dispute the other actions listed in l.1. and l. 2. above.

- 3. Any administrative action taken by the DHCFP does not eliminate any civil or criminal liability from the provider.
- 4. Withholding of payments to the provider. The DHCFP may withhold payments to the provider, in whole or in part, upon receipt of reliable evidence of fraud or willful misrepresentation under the Medicaid or Nevada Check Up programs. The DHCFP may withhold payment, without first notifying the provider. The DHCFP will send notice to the provider within five days of taking such action, in accordance with 42 CFR 455.23.

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The notice to the provider will:

- a. Specify the claims affected by the withholding action;
 - b. State that the withholding action will be for a temporary period;
 - c. Cite the circumstances under which withholding will be terminated.
 - d. Cite the duration of the withholding;
 - e. Inform the provider of the right to submit written evidence for consideration by the DHCFP; and
 - f. Cite that payments are being withheld in accordance with 42 CFR 455.23.
5. Repayment Requirements. The DHCFP will determine the repayment method for all overpayments or improper payments to providers. Repayment can be made by either direct reimbursement by the provider or the provider may be allowed to make repayment through deductions from future payments. To be acceptable, repayment through reductions to future payments or direct reimbursement must ensure the total overpayment amount will be repaid to the DHCFP within 60 days from the date the provider was first notified of the improper payment, as required by Section 1903 (d) (2) (c) of the SSA. The provider’s request for a Fair Hearing does not suspend the provider’s obligation to repay the amount of the overpayment.
6. Statute of Limitations. Erroneous billing resulting in a benefit overpayment violates the provider contract and brings the issue within the authority of NRS 11.190 Actions Other Than for the Recovery of Real Property. NRS 11.190.1 states: “Within 6 years: ... 1(b) an action upon a contract, obligation or liability founded upon an instrument in writing, except those mentioned in the preceding sections of this chapter”. This statute gives the DHCFP the authority that unless limited by a specific statute, a recovery action may be commenced within a six year period. Additionally, 31 USC 235-Limitation of Suit provides “Every such civil suit shall be commenced within six years from the commission of the act and not afterward.”
7. Civil Monetary and Criminal Penalties

The Social Security Act (SSA) and the Nevada Revised Statutes (NRS) identify certain activities as misdemeanors or felonies and provide for fines and/or imprisonment upon conviction.

- a. The Medicaid Fraud Control Unit (MFCU) of the Nevada Attorney General’s Office can assess civil monetary penalties and criminally prosecute violations of

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- b. NRS 422.540 to 422.570, inclusive. This includes offenses regarding: false claims; mis-statements or mis-representations; and sale, purchase or lease of goods, service materials or supplies associated with payments under the State Plan for Medicaid or the State Children’s Health Insurance Program (Nevada Check Up). Providers can be liable at both the state and federal level and prosecuted by both. Additionally, the provider may be excluded from state and federal health care programs based on a conviction.
- c. State civil monetary penalties are not less than \$5,000 and can equal three times the amount unlawfully obtained in addition to expenses incurred by the State for investigation activities.
- d. State criminal penalties, in addition to the civil monetary penalties, range from a gross misdemeanor punishable by imprisonment in the county jail for not more than one year to a Class D felony punishable by 1-4 years in a State prison. (NRS 193.130 to 193.140)
- e. In addition to State penalties, there are federal penalties associated with false or fraudulent acts involving federal health care programs. Civil monetary and criminal penalties are sought by the Department of Justice (DOJ) according to Section 1128A and Section 1128B of the SSA. Providers who are convicted by a federal court of willfully defrauding the Medicaid or Nevada Check Up program may be subject to a \$25,000 fine or up to five years imprisonment or both.
- f. Any action brought pursuant to NRS 422.540 through 422.580, inclusive, must be commenced within four years of discovery by the aggrieved party.

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3304 REFERENCES AND CROSS REFERENCES

3304.1 FRAUD, ABUSE OR IMPROPER PAYMENT REFERRALS

1. To report alleged fraud, abuse or improper payment to the DHCFP contact:

Phone: (775) 684-3648
 Fax: (775) 684-3643
 E-Mail: npi@dhecfp.nv.gov
 Mail: Division of Health Care Financing and Policy
 Program Integrity Unit
 1100 E. William St., Suite 102
 Carson City, NV 89701

Provide as much identifying information as possible. Include: provider name, address, phone number and details regarding the allegation or nature of the referral. Explain the basics of who, what, when, where, why and how. Include your name and phone number unless you wish to remain anonymous when calling or writing.

The DHCFP will not provide any information regarding actions taken by the DHCFP or others on any allegations reported, even to the person making the referral or allegation. Once the allegation is received, there will be no further communication with the person making the referral.

2. To Report Medicaid Fraud or Abuse to the Medicaid Fraud Unit in the Attorney's Office:

Phone: 1-800-266-8688
 Mail: MFCU
 100 N Carson St.
 Carson city, Nv 89701-4717

3. To report fraud in all federal health care programs, including Medicare, Medicaid and Nevada Check Up contact the Office of Inspector General:

Phone: 1-800-447-8477
 Fax: 1-800-223-8164
 TTY: 1-800-377-4950
 E-Mail: HHSTips@oig.hhs.gov
 By Mail: Office of the Inspector General, DHHS
 Attn: HOTLINE
 330 Independence Ave., SW
 Washington, DC 20201

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The following is the link to the Office of Inspector General (OIG) Hotline website, where there is more information regarding how to make alleged fraud and abuse referrals:

<http://oig.hhs.gov/hotline.html>

3304.2 POLICY REFERENCES

1. For policy information governing services covered under Medicaid and Nevada Check Up programs consult the Medicaid Services Manuals located on the DHCFP Website: <http://www.dhcfp.nv.gov>
2. For billing manuals, web announcements and other information governing services covered under Medicaid and Nevada Check Up programs consult the DHCFP fiscal agent Website: <https://nevada.fhsc.com/>

3304.3 OTHER CONTACTS

1. DHCFP Fiscal Agent

Provider Enrollment Issues:

First Health Services
 Provider Enrollment
 PO Box 300412
 Reno NV 89520-30412

Provider Claims Issues:

First Health Services
 Claims
 PO Box 30042
 Reno NV 89520-3042

2. DHCFP Administration Office

1100 E. Williams Street, Suite 102
 Carson City, Nevada 89703
 Telephone: (775) 684-3600
 Toll free (800) 992-0900 extension 3600

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 26, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3400 – TELEHEALTH SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3400 – Telehealth Services are being proposed to further clarify previous changes and definitions, and ensure alignment with AB 292, a Nevada bill that expanded telehealth to remove restrictions on providers and services. This creates parity between in-person and telehealth appropriate services. Language that described limitations to specific categories for telehealth consultations has been deleted. The chapter was restructured for ease of reading and to eliminate redundancy. Group therapy has been added as an allowable service via telehealth. Clarification is added stating that facilities billing encounters for services can also bill encounters in lieu of the facility fee of the originating site.

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

These changes are effective September 8, 2016.

MATERIAL TRANSMITTED

MTL 22/16
Telehealth Services

MATERIAL SUPERSEDED

MTL 30/15
Telehealth Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 3403 (old)	Policy	Section deleted as unnecessary.
Section 3403 (new)	Telehealth Policy	Replaced “in rural, suburban or urban locations with no geographical restrictions within the state Nevada” to “within the state.”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 3403.1 (new)	Telehealth Originating Site	Renumbered to Section 3403.1; Renamed from “Telehealth Services at Originating Site” to “Telehealth Originating Site.” Provides NRS definition of an originating site; adds HIPAA-compliant requirement for a telehealth telecommunications system. Updated to require originating site to be an enrolled Medicaid provider to be eligible for facility fee reimbursement. States that facilities using encounter reimbursement can be reimbursed an encounter in lieu of a facility fee for ancillary services.
Section 3403.2 (new)	Telehealth Distant Site	Renumbered to Section 3403.2; Renamed from “Telehealth Service Providers at Distant Site” to “Telehealth Distant Site;” Provides NRS definition of distant site. Removes duplicative language pertaining to the distant site.
Section 3403.3 (new)	Synchronous Telehealth Services	New section added. Defines synchronous telehealth services.
Section 3403.4	Asynchronous Telehealth Services	Section name updated from Covered Telehealth Services as unnecessary due to expansion. Defines Asynchronous telehealth services as now covered service under telehealth expansion. Language deleted due to redundancy.
Section 3403.5	Coverage and Limitations	Changed “patient” to “recipient.” Deleted language regarding Subsequent Hospital Care, Subsequent Nursing Facility Care and Inpatient Telehealth Consultations that applied telehealth limitations and are no longer applicable. Removed “individual” from reference to psychotherapy. Moved language up to subsection C from subsection a stating that mental health workers cannot be reimbursed for evaluation and management services, only psychotherapy. Changes “face-to-face” to the correct term, “in-person.” Removes irrelevant language related to smoking cessation policy.
Section 3403.6	Non Covered Services	Removes language that prevents asynchronous telehealth reimbursement. Removed section A. and B. regarding telecommunications and radiology.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 3403.7 (old)	Recipient Responsibility	Section deleted as it is duplicative to prior sections.
Section 3403.7 (new)	Prior Authorization	Renumbered.
Section 3403.8	Hearings	Renumbered.

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MEDICAID SERVICES MANUAL
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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3400
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

3400 INTRODUCTION

Telehealth is the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services and a limited number of other medical services.

All providers participating in the Medicaid and Nevada Check Up (NCU) programs must offer services in accordance with the rules and regulations of the Division of Health Care Financing and Policy (DHCFP).

Telehealth services are an optional benefit within the DHCFP.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for NCU. For further clarification, please refer to the NCU Manual, Chapter 1000.

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MEDICAID SERVICES MANUAL	Subject: AUTHORITY

3401 AUTHORITY

The State Legislature grants authority to the relevant professional licensure boards to set the standard of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following specialists:

- A. NRS-Chapter 449-Hospitals;
- B. NRS-Chapter 629-Healing Arts Generally;
- C. NRS-Chapter 630-Physicians and Physician Assistants;
- D. NRS-Chapter 632-Nursing;
- E. NRS-Chapter 633-Osteopathic Medicine; and
- F. NRS-Chapter 641-Psychologists, Social Workers.

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3402 RESERVED

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MEDICAID SERVICES MANUAL	Subject: POLICY

3403 TELEHEALTH POLICY

The Division of Health Care Financing and Policy (DHCFP) reimburses for telehealth services. The originating site must be located **within the state**. "Telehealth" is defined as the delivery of service from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail. Services provided via telehealth must be clinically appropriate and within the health care professional's scope of practice **as established by its licensing agency**. Services provided via telehealth have parity with **in-person** health care services. Health care professionals must follow the appropriate Medicaid Services Manual (MSM) policy for the specific service they are providing.

- A. Photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis or a treatment plan. Dermatologic photographs (e.g., photographs of a skin lesion) may be considered to meet the requirement of a single media format under this instruction.
- B. Reimbursement for the DHCFP-covered telehealth services must satisfy federal requirements of efficiency, economy and quality of care.
- C. All participating providers must adhere to requirements of the Health Insurance Portability and Accountability Act (HIPAA). The DHCFP may not participate in any medium not deemed appropriate for protected health information by the DHCFP's HIPAA Security Officer.

3403.1 TELEHEALTH ORIGINATING SITE

The originating site is **defined as** the location where a **patient is receiving telehealth services from a provider of health care located at a distant site** (via a **HIPAA-compliant** telecommunications system).

- A. **In order to receive coverage for a telehealth facility fee, the originating site must be an enrolled Medicaid Provider.**
- B. **If a patient is receiving telehealth services at an originating site without an enrolled Medicaid provider onsite, that originating site is not eligible for a facility fee from the DHCFP. Examples of this include, but are not limited to, cellular devices, home computers, kiosks and tablets.**
- C. **Facilities that are eligible for encounter reimbursement (e.g. Indian Health (IH) programs, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs)) may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e. consult with specialist). If, for example, the originating site and distant site**

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are two different encounter sites, then the originating encounter site must bill the telehealth originating HCPCS code and the distant encounter site may bill the encounter code.

3403.2 TELEHEALTH DISTANT SITE

The distant site is defined as the location where a provider of health care is providing telehealth services to a patient located at an originating site. The distant site provider must be an enrolled Medicaid provider.

3403.3 SYNCHRONOUS TELEHEALTH SERVICES

Synchronous telehealth interactions are defined as real-time interactions between a recipient located at an originating site and a health care provider located at a distant site. A provider has direct visualization of the patient.

3403.4 ASYNCHRONOUS TELEHEALTH SERVICES

Asynchronous telehealth services, also known as Store-and-Forward, are defined as the transmission of a patient's medical information from an originating site to the health care provider distant site without the presence of the recipient. The DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees.

3403.5 COVERAGE AND LIMITATIONS

The following coverage and limitations pertain to telehealth services:

- A. The medical examination of the patient is under the control of the health care professional at the distant site.
- B. While the distant physician or provider may request a telepresenter, a telepresenter is not required as a condition of reimbursement.
- C. Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW) and clinical staff employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor, Clinical Social Worker or Psychological Assistant may bill and receive reimbursement for psychotherapy (via a HIPAA-compliant telecommunication system), but may not seek reimbursement for medical evaluation and management services. Refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services, for medical coverage requirements.

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D. End Stage Renal Disease (ESRD)

1. ESRD visits must include at least one **in-person** visit to examine the vascular access site by a provider; however, an interactive audio/video telecommunications system may be used for providing additional visits.
2. Medical records must indicate that at least one of the visits was furnished **in-person** by a provider. Refer to MSM Chapter 600 **Physician Services**, for medical coverage requirements.

3403.6 NON-COVERED SERVICES

- A. **Telephone calls;**
- B. **Images transmitted via facsimile machines (faxes);**
- C. **Text messages;**
- D. **Electronic mail (email); and**
- E. **The following services must be provided in-person and are not considered appropriate services to be provided via telehealth:**
 1. **Basic skills training and peer-to-peer services provided by a Qualified Behavioral Assistant (QBA) as identified in provider qualifications found in MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services;**
 2. **Personal care services provided by a Personal Care Attendant (PCA) as identified in provider qualifications found in MSM Chapter 2600, Intermediary Service Organization and MSM Chapter 3500, Personal Care Services;**
 3. **Home Health Services provided by a Registered Nurse, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist, Dietician or Home Health Aide as identified in provider qualifications found in MSM Chapter 1400, Home Health Agency; and**
 4. **Private Duty Nursing services provided by a Registered Nurse as identified in provider qualifications found in MSM Chapter 900, Private Duty Nursing.**

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3403.7 PRIOR AUTHORIZATION

Telehealth services follow the same prior authorization requirements as services provided in person. Utilization of telehealth services does not require prior authorization, however, individual services delivered via telehealth may require prior authorization. It is the provider’s responsibility to refer to the individual medical coverage policies through the MSM for coverage requirements.

3403.8 HEARINGS

Please reference MSM Chapter 3100, Hearings for Medicaid recipient hearing procedure.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 7, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE D. FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3500 – PERSONAL CARE SERVICES PROGRAM (PCS)



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3500 are being proposed to remove licensure requirements from policy as oversight for such is the responsibility of the licensing agency and to align Personal Care Services (PCS) policy in MSM Chapter 3500 with Self-Directed PCS policy in MSM 2600. As a result, requirements for criminal background checks, tuberculosis testing and training are being removed from policy. Provider enrollment process was updated to reflect the current process. Additional updates were necessary to clarify policies throughout. Some sections were combined and/or merged together to create new ones. Sections were also added to align policies, or deleted to remove duplications or obsolete policy/process.

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

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective September 8, 2016.

MATERIAL TRANSMITTED

MTL 20/16
CHAPTER 3500 – PERSONAL CARE
SERVICES PROGRAM (PCS)

MATERIAL SUPERSEDED

MTL 31/11, 24/12, 01/13
CHAPTER 3500 – PERSONAL CARE
SERVICES PROGRAM (PCS)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3500	Introduction	Language was updated and/or reworded for clarity. Added language on the two distinct PCS delivery models offered by Nevada Medicaid.
3501	Authority	Section condensed. Deleted Social Security Act definition of PCS along with NRS and Nevada State Plan references. Added regulatory oversight list.
3502	Reserved	Section renamed “Definitions” and added reference to MSM Addendum for program definitions.
3503.1	Personal Care Services (PCS)	Language was updated and/or reworded for improved readability and clarity.
3503.1A	Program Eligibility Criteria	Moved from 3503.1A (1) to current section, renamed “Eligibility Criteria” and renumbered. Coverage and Limitations now in 3503.1B.
3503.1B	Coverage and Limitations	Previously in 3503.1A, now in current section. Section was renumbered and language updates were made for clarity. Program eligibility criteria deleted from this section and moved up to 3503.1A. Added list of skilled care services to the non-covered services subsection. Adverse actions removed and now in 3503.10. Provider Responsibility section previously in 3503.1B now in 3503.1H.
3503.1C	Legally Responsible Individual (LRI)	New “Legally Responsible Individual (LRI)” section added to current section to align PCS policies. Specifies LRI policy and requirements for LRIs that are not available and for those not capable of providing care. Recipient Responsibilities section previously in 3503.1C is now in 3503.1I and was renamed Recipient Responsibilities and Rights.
3503.1D	Personal Care Representative (PCR)	New “Personal Care Representative (PCR)” section added to current section to align PCS policies. Specifies PCR requirements and limitations. Conflict of Interest Standards section previously in 3503.1D now in 3503.1G.
3503.1E	Authorization Process	Language was updated and/or reworded throughout section to reflect current authorization request processes for PCS. References to outdated forms and/or processes were removed. Flexibility of services delivery subsection was deleted and moved

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
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to 3503.1F. Reimbursement 3503.1E (6), Improper Billing Practices 3503.1E (7) and Overpayments 3503.1E (8) were all moved out and stand-alone sections created for each in new Sections 3503.7 and 3503.8 which includes language on overpayments.

3503.1F **Flexibility of Services Delivery**

Policy moved out of 3503.1E (2) to current section. Removed point (a) Initial Authorized PCS and (b) Annual Reassessment Update and renumbered list to improve section readability.

3503.1G **Conflict of Interest Standards**

Policy moved out of 3503.1D to current section. Replaced word “performing” with “completing” and the word “perform” with “complete.”

3503.1H **Provider Responsibility**

Moved from 3503.1B to current section and renamed “Provider Responsibilities.” Some of the introduction language condensed to improve readability. Removed language added to the responsibilities. Throughout section language was updated or reworded for clarity. Provider Enrollment requirement was updated to reflect current process; Licensure requirements such as Criminal Background Checks, Tuberculosis Testing, Supervision and Training were removed from policy as oversight for such is the responsibility of the licensing agency. Landline Telephone, Employee Covenants and PCA Employment Standards requirements were also removed. Outdated language was removed or updated. Rearranging and renumbering of responsibilities was required.

Moved from 3503.1B to current section and renamed “Provider Responsibilities.” Some of the introduction language condensed to improve readability. Removed language added to the responsibilities. Throughout section language was updated or reworded for clarity. Provider Enrollment requirement was updated to reflect current process; Licensure requirements such as Criminal Background Checks, Tuberculosis Testing, Supervision and Training were removed from policy as oversight for such is the responsibility of the licensing agency. Landline Telephone, Employee Covenants and PCA Employment Standards

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		requirements were also removed. Outdated language was removed or updated. Rearranging and renumbering of responsibilities was required.
3503.1I	Recipient Responsibilities	Section moved down, previously in 3503.1C. Renumbered and renamed “Recipient Responsibilities and Rights.” Minor changes made to improve flow and readability.
3503.1D	Conflict of Interest Standards	Section moved, now in 3503.1G.
3503.1E	Authorization Process	Section moved from end sections of chapter to the beginning to improve flow and readability. Section number remains same, location now after coverage and limitations.
3503.2	Services to Children – Coverage and Limitations	Section renamed “PCS To Children.” The word “able” was replaced with “available” and the word “ability” replaced with “availability.” Added policy requiring a child’s LRI or designated PCR, other than the PCA, is present during the provision of services.
3503.3	PCS Services for Home and Community-Based Waiver (HCBW) Recipients	Deleted. Not applicable to PCS. Content should be part of HCBW policy which can be found in MSM Chapters 2100, 2200 and 2300.
3503.3	PCS for Recipients Enrolled in Hospice	Section renumbered, was 3503.4, now in place of PCS Services for HCBW Recipients section that was deleted. Minor changes in the wording order were made to clarify intent of policy.
3503.5	Out of State (OOS) Services	Deleted. Not applicable as PCS is only provided in state.
3503.6	Pregnancy	Deleted. PCS eligibility criteria are the same for all recipients including pregnant women. A section for pregnancy alone is not necessary.
3503.4	Supported Living Arrangement (SLA)	Section renumbered, previously 3503.7. Section renamed “Residential Support Services/Supported

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Living Arrangement (SLA).” Language updated/reworded to clarify policy.
3503.5	Escort Services	Section renumbered, previously 3503.8. Changed “to provide” with “or incapable of providing” and added “en route to or” under Coverage and Limitations 3503.5B (3) to clarify policy. Moved Authorization Process section before Provider Responsibility section to improve flow.
3503.6	Transportation	Renumbered, reworded and rearranged paragraphs for clarity.
3503.7	Reimbursement	Previously in Authorization Process section 3503.1E (6), now a new stand-alone section.
3503.8	Improper Billing Practices	Previously in Authorization Process section 3503.1E (7), now a new stand-alone section which includes language previously found in 3503.1E (8) overpayments.
3503.9	Quality Assurance	Renumbered, reworded and updated to clarify current process.
3503.10	Adverse Actions	Moved out of Coverage and Limitations section, previously 3503.1A (5) to create stand-alone section.
3504	Hearings	Added “and Medicaid provider hearing procedures.”

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3500 INTRODUCTION

PERSONAL CARE SERVICES (PCS)

The objective of the PCS program is to assist, support and maintain recipients living independently in their homes. PCS include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables accomplishment of tasks that they would normally do for themselves if they did not have a disability or chronic condition. These services are provided where appropriate, medically necessary and within service limitations. Services may be provided in settings outside the home, including employment sites.

PCS are available to recipients who are not inpatients or residents of a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or institutions for mental disease or other excluded settings.

Nevada Medicaid offers two distinct PCS delivery models: the Provider Agency Model or the Self-Directed Model.

This Medicaid Services Manual (MSM), Chapter 3500, contains Nevada Medicaid's policy for PCS provided through the Provider Agency service delivery model. For policy pertaining to the Self-Directed service delivery model, refer to MSM Chapter 2600.

All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with MSM Chapter 100 and meet certain qualifications and criteria as discussed later in this chapter.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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3501 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security Act.

Regulatory oversight:

Social Security Act 1905(a) (24)

Title 42, Code of Federal Regulations, Section 440.167

Nevada State Plan Attachment 3.1-A (26)

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3502 **DEFINITIONS**

Program definitions can be found in the MSM Addendum.

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3503 POLICY

3503.1 PERSONAL CARE SERVICES (PCS)

PCS provide assistance to support and maintain recipients living independently in their homes. Services may be provided in the home, locations outside the home or wherever the need for the service occurs. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Services are based on the needs of the recipient being served, as determined by a Functional Assessment Service Plan (FASP) approved by the Division of Health Care Financing and Policy (DHCFP). All services must be performed in accordance with the approved service plan and must be prior authorized. The time authorized for services is intended to meet the recipient needs within program limits and guidelines, facilitate effective and efficient service delivery, and to augment unpaid and paid supports currently in place. Services are not intended to replace or substitute services and/or supports currently in place, or to exchange unpaid supports for paid services.

Legally Responsible Individuals (LRIs) may not be reimbursed for providing PCS.

3503.1A ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;
2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;
3. The recipient does not have an LRI who is available and capable of providing the necessary care;
4. The recipient or Personal Care Representative (PCR) must be cooperative in establishing the need for the provision of services and comply with the approved service plan;
5. The recipient is capable of making choices about ADLs or has a PCR who assumes this responsibility;
6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee.

3503.1B COVERAGE AND LIMITATIONS

1. Covered Services

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- a. Assistance with the following ADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare.
1. Bathing/dressing/grooming.
 2. Toileting needs and routine care of an incontinent recipient.
 3. Transferring and positioning non-ambulatory recipients from one stationary position to another, assisting a recipient out of bed, chair or wheelchair, including adjusting/changing recipient's position in a bed, chair or wheelchair.
 4. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a walker, cane or crutches or assisting a recipient to stand up or get to his/her wheelchair to begin ambulating.
 5. Eating, including cutting up food. Specialized feeding techniques may not be used.
- b. Assistance with the following IADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare. See the service limitations section of this chapter for specific eligibility criteria to be considered eligible to receive additional time for assistance with IADLs.
1. Meal preparation, which includes storing, preparing and serving food.
 2. Laundry, including washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.). Ironing is not a covered service.
 3. Light housekeeping, which includes changing the recipient's bed linens, dusting or vacuuming the recipient's living area.
 4. Essential shopping, which includes shopping for prescribed drugs, medical supplies, groceries and other household items required specifically for the health and nutrition of the recipient.

2. Service Limitations

To be considered eligible to receive additional time for assistance with IADLs, the recipient must be eligible to receive PCS for ADLs and have deficits which directly preclude the

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individual from completing IADLs. The FASP must demonstrate that the recipient meets the following criteria:

- a. The recipient has extensive impairments, Level 2 or higher on the FASP in two or more areas of ADLs; and
- b. The recipient has at least one of the deficits listed below:
 1. Mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impact the recipient's ability to safely perform household tasks or meal preparation independently;
 2. Cognitive deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently;
 3. Endurance deficits directly impacting the recipient's ability to complete a task without experiencing substantial physical stressors;
 4. Sensory deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently.

Assistance with the IADLs may only be provided in conjunction with services for ADLs, and only when no LRI is available and/or capable.

3. Non-Covered Services

Duplicative services are not considered medically necessary and will not be covered by Nevada Medicaid. An inquiry or referral for services does not determine the medical necessity for services.

The following are not covered under PCS and are not reimbursable:

- a. A task that the DHCFP or its designee determines could reasonably be performed by the recipient.
- b. Services normally provided by an LRI.
- c. Any tasks not included on the recipient's approved service plan.
- d. Services to maintain an entire household, such as cleaning areas of the house not used solely by the recipient(s).
- e. Services provided to someone other than the intended recipient.

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- f. **Skilled care services** requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. **Services include, but are not limited to, the following:**
1. Insertion and sterile irrigation of catheters;
 2. Irrigation of any body cavity. This includes both sterile and non-sterile procedures such as ear irrigation, vaginal douches and enemas;
 3. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;
 4. Administration of injections of fluids into veins, muscles or skin;
 5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions or the instillation of prescribed eye drops (as opposed to assisting with self-administered medication);
 6. Physical assessments;
 7. Monitoring vital signs;
 8. Specialized feeding techniques;
 9. Rectal digital stimulation;
 10. Massage;
 11. Specialized range of motion (ROM);
 12. Toenail cutting;
 13. Medical case management, such as accompanying a recipient to a physician's office for the purpose of providing or receiving medical information;
 14. Any task identified within the Nurse Practice Act as requiring skilled nursing, including Certified Nursing Assistant (CNA) services.
- g. Chore services.
- h. Companion care, baby-sitting, supervision or social visitation.

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- i. Care of pets except in cases where the animal is a certified service animal.
- j. Respite care intended primarily to relieve a member of the recipient’s household, a family member or caregiver from the responsibility of caring for the recipient.
- k. A task the DHCFP determines is within the scope of services provided to the recipient as part of an assisted living contract, a supported living arrangement contract or a foster care agreement.
- l. Escort services for social, recreational or leisure activities.
- m. **Transportation of the recipient by the PCA.**
- n. Any other service not listed under Section 3503.1.B.1.

3503.1C LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

LRI are individuals who are legally responsible to provide medical support. These individuals include spouses of recipients, legal guardians and parents of minor recipients, including stepparents, foster parents and adoptive parents. LRIs may not be reimbursed for providing PCS.

If the LRI is not capable of providing the necessary services/supports, he or she must provide verification to the DHCFP’s QIO-like vendor, from a physician, that they are not capable of providing the supports due to illness or injury. If not available, verification that they are unavailable due to hours of employment and/or school attendance must be provided. Without this verification, PCS will not be authorized. Additional verification may be required on a case by case basis.

3503.1D PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to provide direction in the delivery of their own care may opt to utilize a PCR. This individual is directly involved in the day-to-day care of the recipient, is available to direct care in the home, acts on behalf of the recipient when the recipient is unable to direct his or her own personal care services and assumes all medical liability associated with directing the recipient’s care. A PCR must be a responsible adult.

The PCR must:

- 1. Effectuate, as much as possible, the decision the individual would make for himself/herself;
- 2. Accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;

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3. Give due consideration to all information including the recommendations of other interested and involved parties;
4. Understand that provision of services is based upon mutual responsibilities between the PCR and the provider agency.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A recipient's paid PCA cannot be the recipient's PCR. The PCR must meet all criteria outlined in Section 3503.1I of this chapter. In addition, this individual must be present for the provision of care on a consistent basis, as well as sign daily records. For this reason, it is not allowable for individuals such as a paid PCA, care coordinator or case manager to assume this role.

The PCR may reside outside the home if frequent contact can be made by the recipient, the provider agency and other care providers. The PCR must be available to the recipient, the provider agency and other care providers as necessary to fulfill the regular elements of Section 3503.1I of this chapter.

Additionally, if a change in PCR becomes necessary, a new personal care representative agreement must be completed and kept in the recipient's provider file. Contact the provider agency to make the necessary changes and obtain necessary form(s).

3503.1E AUTHORIZATION PROCESS

PCS authorization requests must be submitted to the QIO-like vendor using the following procedures:

1. Initial Authorization Requests

The recipient, LRI, PCR or an individual covered under the confidentiality requirements of HIPAA may contact the QIO-like vendor to request PCS. Initial requests may not be made by the PCS Agency provider.

The QIO-like vendor validates that the recipient meets PCS criteria, and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS.

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After completion, the FASP is forwarded to the QIO-like vendor to process.

If the recipient's request for PCS is approved, the QIO-like vendor will issue a prior authorization number to the recipient's chosen PCS Provider Agency.

a. At Risk Recipient Requests

Upon receipt of a request for an initial FASP, the QIO-like vendor will first complete a risk assessment over the phone to identify those recipients for whom PCS are urgent to avoid institutionalization, or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient is determined "at risk," the QIO-like vendor will provide a temporary service authorization.

An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

The selected Provider Agency is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within 24 hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance.

2. Annual Update Authorization Requests

To prevent a break in service, reassessment requests for ongoing services are recommended to be submitted to the QIO-like vendor at least 60 days, but not greater than 90 days, prior to the expiration date of the current authorization. The request must be submitted on the Authorization Request for PCS form (FA-24). The form must include all required recipient and provider information, as well as the units requested and the dates of service for the service interval requested.

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The QIO-like vendor validates that the request meets PCS criteria. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the PCS Provider Agency submitting the request.

3. Significant Change in Condition or Circumstance Authorization Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to a significant change in the recipient's condition or circumstances must be **submitted on the Authorization Request for PCS form (FA-24) and must be** accompanied by documentation from the recipient's physician or health care provider. **Requesting a reassessment does not guarantee an increase in previously approved PCS.**

- a. Significant change in condition may be demonstrated by, for example, 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**.
- b. Significant change in circumstances may include such circumstances as absence, illness or death of the primary caregiver or LRI.
- c. Significant change in condition or circumstances **would result in** hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

The QIO-like vendor validates that the request meets PCS criteria and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

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The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the PCS Provider Agency submitting the request.

4. Temporary Service Authorization Requests

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than **eight** weeks) modification of the current authorization, a new FASP is not required.

Such a modification is considered when additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

The following procedure must be followed for all short-term modifications of the approved service plan:

- a. Documentation must be maintained in the recipient's record of the circumstance(s) that required the short term modification(s) of the approved service plan;
- b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the **Provider Agency**, and **if applicable, the appropriate home and** community-based waiver case manager. Documentation must include the recipient's name, Medicaid number and the dates during which the modified service plan will be in effect; **and**
- c. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FASP is completed due to a significant change in the recipient's condition or circumstance.

5. One-Time Service Authorization Request

The recipient's Provider Agency may submit a single-service authorization request when the recipient requires an extra visit for an unanticipated need, such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the service requested and be the designated provider for the current authorization period. **The request**

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should be submitted to the QIO-like vendor no later than seven business days after the service is provided. A new FASP is not required in these single-service situations.

6. Mileage Authorization Request

Mileage for travel to and from a recipient’s home or for shopping is not reimbursable to PCS Agency providers, except in hardship situations in remote or rural areas of the state where failure to reimburse mileage expenses would severely limit available PCS Agency providers. Mileage authorization requests must be submitted in advance to the local DHCFP District Office for review and may be approved on a case-by-case basis. If approved, the DHCFP District Office will notify the QIO-like vendor to issue an authorization number for the approved mileage to the provider.

3503.1F FLEXIBILITY OF SERVICES DELIVERY

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The recipient will determine how to use the weekly authorized hours on an ongoing basis. Any changes that do not increase the total authorized hours can be made, for the recipient’s convenience, within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider or PCA.

The following requirements must be met:

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how the total weekly authorized hours will be provided to meet the individual’s needs.
2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient’s file.
3. Any change to the approved service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how the hours and tasks will be provided.
4. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.
5. The PCS provider must follow their established policies and procedures in order to timely meet recipient requests for changes in service delivery.
6. Written documentation of the contact with the recipient regarding any change to the approved service plan must be maintained in the recipient’s file.

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3503.1G CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers **completing the FASPs**. Physical and occupational therapists who **complete the FASPs** must be an independent third party and may not be:

1. Related by blood or marriage to the individual or to any paid caregiver of the individual;
2. Financially responsible for the individual;
3. Empowered to make financial or health-related decisions on behalf of the individual;
4. Related by blood or marriage to the Provider who provides PCS to the individual.

The therapist completing the **FASP** must not have an interest in or employment by a Provider.

Note: To **ensure** the independence of individuals **completing the FASP**, providers are prohibited from contacting the physical or occupational therapists directly.

3503.1H PROVIDER RESPONSIBILITIES

PCS providers shall furnish qualified PCAs to assist eligible Medicaid and NCU recipients with ADLs and IADLs, as identified on the individual recipient’s approved service plan and in accordance with the conditions specified in this Chapter and the Medicaid Provider Contract.

Additionally, all PCS providers have the following responsibilities:

1. **Licensure**

In order to enroll as a Nevada Medicaid PCS Provider, a provider must be licensed by the Division of Public and Behavioral Health (DPBH) as an Agency to Provide Personal Care Services in the Home (personal care agency).

2. **Provider Enrollment**

To become a Nevada Medicaid PCS provider, the provider must enroll with the QIO-like vendor as a Personal Care Services – Provider Agency (Provider Type 30).

3. **Time Parameters**

The Provider will implement PCS in a timely manner. The Provider agrees to furnish qualified staff to provide PCS to eligible Medicaid recipients within five working days of

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an accepted referral and within 24 hours of an accepted referral if the recipient is identified as “at risk” by the DHCFP or its designee.

PCS providers must meet the conditions of participation as stated in the MSM Chapter 100.

The Provider must comply with all local, state and federal regulations, and applicable statutes, including, but not limited to, Nevada Revised Statutes Chapter 449, Nevada Administrative Code Chapter 449, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA) and the Health Insurance Portability and Accountability Act (HIPAA).

4. 24-Hour Accessibility

The Provider shall maintain **an available telephone line 24 hours per day**, seven days per week for recipient contact.

5. Backup Mechanism.

The Provider shall have a backup mechanism to **provide a recipient with his or her** authorized service hours in the absence of a regular caregiver due to sickness, vacation or any unscheduled event.

6. Referral Source Agreement

The Provider shall maintain, and utilize as necessary, written referral source agreements with other DHCFP contracted PCS-provider agencies to ensure continuity of care and service coverage for any at risk recipients (on a prospective or back- up basis), who cannot be timely served by the Provider in order to reasonably avoid institutionalization or serious injury to the recipient.

7. Prior Authorization

The Provider shall obtain prior authorization **prior to providing services**. All initial and ongoing services must be prior authorized by **the DHCFP’s QIO-like vendor**. Services which have not been prior authorized will not be reimbursed.

8. Provider Liability

Provider liability responsibilities are included in the Nevada Medicaid and NCU Provider Contract.

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9. Direct Marketing

Providers shall not engage in any unsolicited direct marketing practices with any current or potential **Medicaid** PCS recipient **or their LRI**. All marketing activities conducted must be limited to the general education of the public or health care providers about the benefits of PCS. Such literature may be printed with the company's logo and contact information, however, this literature may not be distributed, unsolicited, to **any current or potential Medicaid PCS** recipient(s)/**or their LRI**. The agency may not, directly or indirectly, engage in door-to-door, telephone, **direct mail, email** or **any other type of** cold-call marketing activities.

The agency must **ensure** that marketing, including plans and materials, are accurate and do not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

- a. The recipient must enroll with the agency in order to obtain benefits or in order not to lose benefits; or
- b. The agency is endorsed, certified or licensed by the DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.

10. Medicaid and NCU Eligibility

Verification of Medicaid or NCU eligibility **on a monthly basis** is the responsibility of the Provider **Agency**.

11. Service Initiation

Prior to initiation of services and periodically as needed, the supervisory staff must review with the recipient or PCR the following:

- a. Advanced Directive, including the right to make decisions about health care, and the right to execute a living will or grant power of attorney to another individual.

Refer to MSM Chapter 100 for further information.

- b. The agency's program philosophy and policies including:
 1. Hiring and training of PCA staff;
 2. Agency responsibilities;

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3. Providing recipient assistance;
 4. Complaint procedure and resolution protocols;
 5. Procedure to be followed if a PCA does not appear at a scheduled visit or when an additional visit is required;
 6. Information about flexibility of authorized hours in order to meet recipient needs;
 7. Non-covered services under PCS;
 8. The requirement that each approved service plan must also be reviewed with the PCA;
 9. The procedures and forms used to verify PCA provision of services.
- c. The recipient's approved service plan or any changes in the service plan, including the following:
1. Authorized **weekly** service hours;
 2. PCA's schedule;
 3. PCA's assigned tasks and pertinent care provided by informal supports;
 4. The recipient's back-up plan.

12. PCS Not Permitted

The Provider is responsible to ensure that all PCAs work within their scope of service and conduct themselves in a professional manner at all times.

The following are some of the activities that are not within the scope of PCS and are not permitted. This is not an all-inclusive list.

- a. **Skilled Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State, are not permitted to be provided by employees of a PCS Agency.** PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials.
- b. Increasing and/or decreasing time authorized on the approved service plan;

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- c. Accepting or carrying keys to the recipient's home;
- d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;
- e. Making personal long-distance telephone calls from the recipient's home;
- f. Performing **tasks** not identified on the approved service plan;
- g. Providing services that maintain an entire household;
- h. Loaning, borrowing or accepting gifts of money or personal items from the recipient;
- i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient;
- j. Care of pets except in the case where the animal is a certified service animal.

13. Supervision

A supervisor (**or other designated agency representative**) must review with the PCA the recipient's approved service plan. **This must be done** each time a **new** service plan is **approved**. Documentation of the **approved service plan's review** must be maintained in the recipient's record.

The supervisor (**or other designated agency representative**) must clarify with the PCA the following:

- a. The needs of the recipient and tasks to be provided;
- b. Any recipient specific procedures including those which may require on-site orientation;
- c. Essential observation of the recipient's health;
- d. Situations in which the PCA should notify the supervisor.

The supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks **which are provided according to the approved service plan and are documented on the service delivery records**.

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14. Complaint Procedure

The Provider must **investigate and** respond **in writing** to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received, **the outcome of the investigation** and the response(s) to the complaint.

15. Serious Occurrences

The Provider must **report all** serious occurrences involving the recipient, the PCA, or affecting the **provider's** ability to deliver services. The **Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's Aging and Disability Services (ADSD) office.**

Reportable serious occurrences involving either the **recipient or** PCA include, but are not limited to the following:

- a. Suspected physical or verbal abuse;
- b. Unplanned hospitalization **or ER visit**;
- c. Neglect of the recipient;
- d. Exploitation;
- e. Sexual harassment or sexual abuse;
- f. Injuries **or falls** requiring medical intervention;
- g. An unsafe working environment;
- h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
- i. Death of the recipient;
- j. Loss of contact with the recipient for three consecutive scheduled days;
- k. **Medication errors**;
- l. **Theft**;
- m. **Medical Emergency**;

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n. **Suicide Threats or Attempts.**

16. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities make a report to a child protective service agency, **an aging and disability services agency** or law enforcement agency immediately, but in no event later than 24 hours after there is **reasonable cause to believe** a child, **adult or older person** has been abused neglected, **exploited, isolated or abandoned.**

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults age 60 and over, the ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. **For all other individuals (other age groups) contact local law enforcement.**

The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

17. Termination of Services

a. The Provider may terminate services for any of the following reasons:

1. The recipient or other person in the household subjects the PCA to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations or threats of physical harm;
2. The recipient is ineligible for Medicaid or NCU services;
3. The recipient requests termination of services;
4. The place of service is considered unsafe for the provision of PCS;
5. The recipient or PCR refuses services offered in accordance with the approved service plan;
6. The recipient or PCR is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;
7. The recipient no longer meets the PCS eligibility criteria;
8. The provider is no longer able to provide services as authorized;

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9. The recipient requires a higher level of services than those provided within the scope of a PCA;
10. The recipient refuses services of a PCA based solely or partly on the basis of race, color, national origin, gender, religion, age, disability (including AIDS and AIDS related conditions), political beliefs or sexual orientation of the PCA. A Provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's PCS. The recipient may choose another provider.

- b. Notification Requirements - The Provider must notify the recipient and all other appropriate individuals and agencies **of the date** when services are to be terminated. The DHCFP District Office Care Coordination Unit should be notified by telephone one **business day prior to the date services will be terminated. If the recipient is on an HCBW the notification should be made directly to the HCBW case manager's ADSD office.**

The Provider **must submit** written notice, **within five working days**, advising the DHCFP District Office Care Coordination Unit or the waiver case manager of the effective date of the action of the termination of service, the basis for the action and intervention/resolution(s) attempted prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

18. Records

- a. The provider must maintain medical and financial records, supporting documents and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State record retention policy, which is currently six years from the date of payment for the specified service.

If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims or audit findings have been finally determined.

1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.
2. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period.

- b. At a minimum, the Provider must document the following on all service records:

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1. Consistent service delivery within program requirements;
 2. Amount of services provided to recipients;
 3. When services were delivered;
 4. Documentation attesting to the services provided, and the time spent providing the service signed or initialed by the PCA and the recipient or PCR.
- c. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records.
19. **Health Insurance Portability and Accountability Act (HIPAA), Privacy and Confidentiality**
Information on HIPAA, privacy and confidentiality of recipient records and other protected health information is found in MSM Chapter 100.
20. Discontinuation of Provider Agreement
- a. In the event that a Provider decides to discontinue providing PCS to any of their service areas, the Provider shall:
 1. Provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS Providers must be obtained from the QIO-like vendor and included with the notification;
 2. Provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation;
 3. Continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.
 - b. In the event that the DHCFP discontinues the contractual relationship with a Provider, for any reason, the Provider shall:
 1. Within five calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to all their current

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Medicaid recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted **PCS** providers must be obtained from the QIO-like vendor and be included in this notification.

2. Provide reasonable assistance to recipients in transferring services to another provider.

Providers who fail to satisfactorily meet the requirements discussed above shall be prohibited from participation in a new application for any other PCS provider agreement for a period of not less than one year.

3503.11 RECIPIENT RESPONSIBILITIES **AND RIGHTS**

1. **Recipient Responsibilities**

The recipient must be able to make choices about ADLs, understand the impact of these choices and assume responsibility for the choices. If this is not possible, the recipient must have a PCR willing to assist the recipient in making choices related to the delivery of PCS.

If the recipient utilizes a PCR, the recipient and the PCR must understand that the provision of services is based upon mutual responsibilities between the PCR and the PCS Provider.

The recipient or PCR is responsible for reviewing and signing all required documentation related to the PCS. The recipient or PCR will:

- a. Notify the provider of changes in Medicaid or NCU eligibility;
- b. Notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare;
- c. Notify the provider of changes in medical status, service needs, address and location or in changes of status of LRI(s) or **PCR**;
- d. Treat all staff appropriately;
- e. Verify services were provided by, whenever possible, signing or initialing the PCA **documentation of** the exact date and time the PCA was in attendance and providing services;
- f. Notify the Provider when scheduled visits cannot be kept or services are no longer required;

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- g. Notify the Provider of missed visits by provider staff;
- h. Notify the Provider of unusual occurrences or complaints;
- i. Give the Provider a copy of an Advance Directive, if appropriate;
- j. Establish a backup plan in case a PCA is unable to provide services at the scheduled time;
- k. Not request a PCA to work more than the hours authorized on the approved service plan;
- l. Not request a PCA to work or clean for non-recipients;
- m. Not request a PCA to provide services not on the approved service plan.

2. Recipient Rights

Every Medicaid and NCU recipient **receiving PCS**, or their PCR, **has the right to:**

- a. Receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;
- b. Participate in the **assessment process** and receive an explanation of **authorized services**;
- c. Receive a copy of the approved service plan;
- d. **Contact** the local DHCFP District Office with questions, **complaints or for additional** information;
- e. Receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;
- f. Know that all communications and records will be treated confidentially;
- g. Expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;

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- h. Receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, **FASP** determinations and **the** opportunity for **a** fair hearing;
- i. Request a change of **provider**;
- j. Request a change **in service delivery method** from **the** Provider Agency **model** to **the Self-Directed model through an Intermediary Service Organization (ISO)**;
- k. Have access, upon request, to his or her Medicaid recipient files;
- l. Request a Fair Hearing if there is disagreement with the DHCFP's action(s) to deny, terminate, reduce or suspend services;
- m. Receive, **upon request**, the telephone number of the **Office for Consumer** Health Assistance.

3503.2 **PCS TO CHILDREN**

An **LRI** of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, PCS are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid.

PCS for children with disabilities may be appropriate when there is no legally responsible, **available** and capable parent **or LRI**, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable must be provided upon request.

In authorizing PCS services to Medicaid eligible children, the **FASP** factors in the age and developmental level of the child as well as the parent **or LRI's availability** and capability to provide the child's personal care needs.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available to children under the age of 21. EPSDT may provide a vehicle for receiving medically necessary services beyond **the** limitations **of the PCS benefit**. Services must be deemed medically necessary. Authorization of additional services under EPSDT must take into account the responsibilities of the LRI and age-appropriate service provision as discussed above.

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Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with an LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to, other housekeeping tasks, meal preparation, essential shopping and escort services.

A child's LRI must be present during the provision of services. If the LRI cannot be present during the provision of services, a PCR designated by the LRI, other than the PCA, must be present during the time services are being provided.

All other policies in **this chapter** apply.

3503.3 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal condition and the personal care needs exceed the PCS provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of an individual's comprehensive personal care needs **to document any needs not met by hospice and which may be provided by the PCA**. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting total personal care needs. PCS provided under hospice will be subtracted from **the total authorized PCS**.

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed program **limits and guidelines**.

3503.4 RESIDENTIAL SUPPORT SERVICES/SUPPORTED LIVING ARRANGEMENT (SLA)

Recipients **on the Home and Community Based Waiver for Individuals with Intellectual Disabilities and receiving residential support services through a supported living arrangement (SLA)** may receive State Plan PCS if **the services are determined to be medically necessary and are non-duplicative of the residential support services being provided**.

The FASP will be completed factoring in the **residential support services**.

3503.5 ESCORT SERVICES

Escort services may be authorized in certain situations for recipients who require a PCA to perform an approved PCS **task** en route to or while obtaining Medicaid reimbursable services.

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3503.5A **COVERAGE AND LIMITATIONS**

Escort services may be authorized as a separate billable service when all the following conditions are met:

1. The needed PCS is currently an authorized task on the approved service plan and will be provided during the course of the visit.
2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a physician visit.
3. An LRI is unavailable **or incapable of providing** the personal care task **en route to or** during the appointment.
4. Staff at the site of the visit (surgery center, physician’s office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) **is** unable to assist with the needed personal care task.

3503.5B **AUTHORIZATION PROCESS**

1. The provider must contact the QIO-like vendor, the ADSD or Waiver for Persons with Physical Disabilities DHCFP case manager, as appropriate, for prior authorization for escort services.
2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.
3. A new **FASP** is not required in this situation.

3503.5C **PROVIDER RESPONSIBILITY**

1. The provider must verify that all conditions above are met when asking for an escort services authorization.
2. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested. The provider must comply with all other policies in Section 3503.1**E**.

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3503.6 TRANSPORTATION

Transportation of the recipient in a provider's vehicle, the PCA's private vehicle or any other vehicle is not a covered service and is not reimbursable by the DHCFP. Recipients who choose to be transported by the PCA do so at their own risk.

Refer to MSM Chapter 1900, Transportation Services, for requirements of the DHCFP medical transportation program. Nevada Medicaid provides necessary and essential medical transportation to and from medical providers.

3503.7 REIMBURSEMENT

Medicaid reimbursement is made directly to the Provider Agency for services billed using service code T1019. The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

1. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consults;
2. The cost of criminal background checks and TB testing;
3. Travel time to and between recipients home;
4. The cost of basic training, in-service requirements and the CPR and First Aid requirement; and/or
5. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

3503.8 IMPROPER BILLING PRACTICES

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual.

Any Provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

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Improper billing practices may include, but are not limited to:

1. Submitting claims for unauthorized visits;
2. Submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipients residence;
3. Submitting claims for visits without documentation to support the claims billed.
 - a. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year and exact time in and out of the recipients home. Providers shall submit or produce such documentation upon request by the DHCFP staff;
4. Submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;
5. Billing for the full authorized number of units when they exceed the actual amount of service units provided; or
6. Submitting claims for PCS services provided by an unqualified paid PCA.

Any PCS or other provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupments listed in the MSM Chapter 3300. All Medicaid overpayments are subject to recoupment.

Any such action taken against a provider by the DHCFP has no bearing on any criminal liability of the provider.

3503.9 QUALITY ASSURANCE

The DHCFP and/or ADSD may conduct reviews, announced or unannounced, to evaluate the provider's compliance with this chapter and any other regulatory requirements.

These reviews may consist of, but are not limited to, a desk review by the DHCFP and/or ADSD staff and/or an onsite review. Providers must cooperate with the review process. Additionally, reviews may be conducted to verify that providers meet the requirements established for each service, to ensure services are being provided and billed for accordingly, and that claims for those services are paid in accordance with the State Plan, this chapter and all federal and state regulations.

Reviews may also be conducted to ensure the health and welfare, service satisfaction, and freedom of choice of the recipients receiving PCS.

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3503.10 ADVERSE ACTIONS

An adverse action refers to a denial, termination, reduction or suspension of an applicant or recipient's request for services or eligibility determination.

For the purposes of this Chapter, the DHCFP or their designee **may** take adverse action when:

1. The recipient is not eligible for Medicaid;
2. The recipient does not meet the PCS eligibility criteria;
3. The recipient, their **PCR** or **LRI** refuses services or is non-cooperative in the establishment or delivery of services;
4. The recipient, their **PCR** or their **LRI** refuses to accept services in accordance with the approved service plan;
5. All or some services are no longer necessary as demonstrated by the **FASP**;
6. The recipient's needs can be met by an **LRI**;
7. The recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child;
8. Services requested exceed service limits;
9. Services requested are non-covered benefits (Refer to **Section 3503.1B**); or
10. Another agency or program provides or could provide the services.

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3504 HEARINGS

Reference MSM Chapter 3100, Hearings, for Medicaid recipient hearing procedures **and Medicaid provider hearing procedures.**

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 27, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
 FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
 SUBJECT: MEDICAID SERVICES MANUAL CHANGES
 CHAPTER 3600 – MANAGED CARE ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3600 are being proposed to incorporate the recent Centers for Medicare and Medicaid Services (CMS) approval that Managed Care Organizations (MCO) could provide services within an alternative inpatient setting, when the facility is licensed by the State of Nevada, and services within the facility are provided at a lower cost than that of services provided within a traditional inpatient hospital setting.

These changes are retroactively applied to align with revised covered services outlined within the managed care contract amendment number five.

These changes are effective November 3, 2014.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/16 CHAPTER 3600 - MANAGED CARE ORGANIZATION	MTL 29/12, 10/13, 06/14 CHAPTER 3600 - MANAGED CARE ORGANIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.4.f	Excluded Services and/or Coverage Limitations-IMDs	Removed language "Mentally Retarded", "MR" and added "Individuals with Intellectual Disabilities", "IID".
3603.4.i	Inpatient Hospital Services	Removed language "Institutions for Mental Disease (IMD)" and added "Inpatient Hospital Services". Revised language to reflect updated inpatient hospital services rules including alternative inpatient settings by Nevada licensed facilities when costs of services are lower than traditional inpatient settings.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.15.A	Enrollment and Disenrollment Requirements and Limitations	Removed language "Situations" and added "A situation".
3603.15.A.6		Removed #6: "Enrollee enters an Institution for Mental Disease; or".

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3600 INTRODUCTION

In 1992, the Nevada State Department of Human Resources (now called the Department of Health and Human Services (DHHS)) initiated the development of a fully capitated, risk based Managed Care Program. The capitated, risk-based Managed Care Program was implemented under a Section 1915(b) Waiver which established a mandatory Managed Care Program, serving recipients in urban Clark County and Washoe County. The mandatory program became effective on January 1, 1996 and served eligible recipients in the programs that were then known as “Aid to Families with Dependent Children/Aid to Dependent Children (AFDC/ADC)” and related programs as well as the Child Health Assurance Program (CHAP) and other child welfare programs. On April 1, 1997, the voluntary Medicaid Managed Care Program was also implemented in Nevada.

Subsequent to the close of the 1997 Nevada Legislature, the U.S. Congress passed the Balanced Budget Act (BBA) of 1997. Under the BBA, states are given the ability to implement managed care programs without a waiver. This generally simplified approval at the federal level. On October 1, 1998, Nevada’s Managed Care Program was approved by the Centers for Medicare and Medicaid Services (CMS), which was formerly known as the Health Care Financing Administration (HCFA) as a state plan amendment.

The State of Nevada Division of Health Care Financing and Policy (DHCFP) oversees the administration of all Medicaid Managed Care Organizations (MCOs) in the state. Nevada Medicaid operates a Fee-for-Service (FFS) and a managed care reimbursement and service delivery system with which to provide covered medically necessary services to its eligible population. MCO contracts are comprehensive risk contracts and are paid a risk-based capitated rate for each eligible, enrolled recipient on a Per-Member, Per-Month (PMPM) basis. These capitated rates are certified to be actuarially sound. There is also a formula for Stop Loss, when costs of inpatient care exceed a threshold during a specified time period; Very Low Birth Weight Newborns (VLBW); and the Primary Care Physician (PCP) enhancements, according to the Patient Protection and Affordable Care Act (ACA) and as approved by the CMS.

The mandatory Managed Care Program is currently available to Medicaid and Nevada Check Up (NCU) recipients in urban Clark and Washoe counties. The DHCFP may, at a future date, designate other geographical locations as mandatory managed care areas in accordance with Nevada Administrative Code (NAC) 695C.160.

All MCOs must be in compliance with all applicable Nevada Revised Statutes (NRS), NAC, the Code of Federal Regulations (CFR), the United States Code (USC), and the Social Security Act (SSA) which assure program and operational compliance as well as assuring services that are provided to Medicaid and NCU recipients enrolled in an MCO are done so with the same timeliness, amount, duration, and scope as those provided to FFS Medicaid and NCU recipients.

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Participating MCOs shall provide to enrolled Medicaid and NCU recipients a benefits package covering inpatient and outpatient hospital care, ambulatory care, physician services, a full range of preventive and primary health care services, and such other services as the DHCFP determines to be in the best interests of the State and eligible recipients to include in benefits package. The MCO is responsible for reimbursing claims of eligible enrollees for services covered under the contract or for each month a capitated payment is made. The DHCFP will continue to provide, on a FFS basis, certain services that are not contained in the MCO contracts or the capitated benefits package.

Currently, the DHCFP contracts with two Health Maintenance Organizations (HMO) as MCOs for the State of Nevada. Enrollment in an MCO is mandatory for the Family Medical Category (FMC) categories of Temporary Assistance for Needy Families (TANF) (Section 1931) and Child Health Assurance Program (CHAP) (poverty level pregnant women, infants, and children) recipients when there is more than one MCO option from which to choose in a geographic service area. Enrollment in an MCO is mandatory for all NCU recipients when there is at least two MCO options in the recipient's geographic service area. The eligibility and aid code determination functions for Medicaid and NCU applicants and eligible populations are the responsibility of the Division of Welfare and Supportive Services (DWSS). The enrollment function is the responsibility of Medicaid Management Information System (MMIS).

All Medicaid policies and requirements (such as prior authorization) are the same for NCU, with the exception of the certain areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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3601 AUTHORITY

The rules set forth below are intended to supplement, and not to duplicate, supersede, supplant or replace other requirements that are otherwise generally applicable to Medicaid managed care programs as a matter of federal statute, regulation, or policy, or that are generally applicable to the activities of Managed Care Organizations (MCO) and their providers under applicable laws and regulations. In the event that any rule set forth herein is in conflict with any applicable federal law or regulation, such federal law or regulation shall control. Such other applicable requirements include, but are not limited to:

- a. Federal contract and procurement requirements applicable to risk comprehensive contracts with an MCO, as set forth in 42 Code of Federal Regulations (CFR) 438 for MCOs and Primary Care Case Management (PCCM); 42 CFR 434.6 of the general requirements for contracts; 42 CFR 438.6 (c) of the regulations for payments under any risk contracts; 42 CFR 447.362 for payments under any non-risk contracts Section 1903 (m) of the Act, for MCOs and MCO contracts; 45 CFR 74 for procurement of contracts and, Part 2 of the State Medicaid Manual, Center for Medicare and Medicaid Services (CMS) Publication 45-2;
- b. Section 1932, provisions relating to managed care, (including Section (a)(1)(A)) of the Act, 42 United States Code (U.S.C.) 1396(a) governing state plans for medical assistance and 42 CFR 438.10 for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities;
- c. MCO licensure and financial solvency requirements, as set forth in Title XIX of the Social Security Act, Part 2 of the State Medicaid Manual, CMS Publication 45-2, and the Nevada Revised Statutes (NRS);
- d. Independent external quality review requirements, as set forth in Part 2 of the State Medicaid Manual, CMS Publication 45-2, and 42 CFR 438;
- e. Restrictions on payments by MCOs of incentives to physicians to restrict or limit services, as set forth in 42 CFR §§ 417.479(d)-(g) and (i) and § 434.70;
- f. Composition of enrollment requirements for MCOs, as set forth in 42 CFR 438 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- g. The requirement that MCOs maintain written policies and procedures with respect to Advance Directives (ADs), as set forth in 42 CFR 438, 42 CFR 431.20 and Section 1902(w)(1);

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- h. Requirements for screening, stabilization, and appropriate transfer of persons with an emergency medical condition, as set forth in the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd and 42 CFR 438;
- i. The requirement that certain entities be excluded from participation, as set forth in §1128 and §1902(p) of the Social Security Act and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- j. The requirement of prior CMS approval for risk comprehensive contracts, as set forth in 42 CFR 438 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- k. The requirements of access to and reimbursement for federally qualified health center services, as set forth in §4704(b) of the Omnibus Budget Reconciliation Act of 1990 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- l. Confidentiality and privacy requirements as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- m. The requirement of freedom of choice for family planning services and supplies, as set forth in 42 CFR 431.51 and as defined in Section 1905 (a)(4)(C) and Part 2 of the State Medicaid Manual, CMS Publication 45-2;
- n. The Nevada - Title XIX and Title XXI State Plans;
- o. The requirements to operate as an Health Maintenance Organization (HMO)/MCO in Nevada as set forth in NRS 695C and 695G;
- p. The requirements for health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH); and
- q. Any other requirements that are imposed as a matter of applicable federal statutes or regulations, or under applicable CMS requirements with respect to Medicaid managed care programs.

These rules are issued pursuant to the provisions of NRS Chapter 422. The Nevada State Department of Health and Human Services (DHHS), acting through the Nevada Division of Health Care Financing and Policy (DHCFP) has been designated as the single state agency responsible for administering the Nevada Medicaid program under delegated federal authority pursuant to 42 CFR 431. Accordingly, to the extent that any other state agency rules are in conflict with these rules, the rules set forth herein shall control.

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3603 POLICY

3603.1 ELIGIBLE GROUPS

A. Mandatory Managed Care Program Recipients:

The State of Nevada Managed Care Program requires the mandatory enrollment of recipients found eligible for Medicaid program coverage under specific categories under the Family Medical Category (FMC) when there are two or more Managed Care Organizations (MCOs) in the geographic service area. These specific categories include the following:

1. Temporary Assistance for Needy Families (TANF);
2. Two parent TANF;
3. TANF – Related Medical Only;
4. TANF – Post Medical (pursuant to Section 1925 of the Social Security Act (the Act));
5. TANF – Transitional Medical (under Section 1925 of the Act);
6. TANF Related (Sneede vs. Kizer);
7. Child Health Assurance Program (CHAP);
8. Aged-out Foster Care (Young adults who have “aged out” of foster care); and
9. New Medicaid Newly Eligibles, defined as childless adults ages 19 – 64, and the expanded parent and caretakers ages 19 – 64, who are made eligible as part of the Patient Protection and Affordable Care Act (PPACA) expansion population and who are receiving the Alternative Benefit Plan.

In addition, the mandatory enrollment of recipients found eligible for Medicaid program coverage include the following categories when there are two or more MCOs in the geographic service:

10. Child Health Insurance Program (CHIP).

B. Mandatory Managed Care Ineligible Program Recipients:

The State of Nevada Managed Care Program makes ineligible the following Medicaid

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program recipients from enrollment in the managed care program:

1. Recipients who are eligible for Medicare;
2. Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI;
3. Children under the age of 19 years who are eligible under Section 1902(e)(3) of the Act;
4. Children under the age of 19 years who are foster care or other out-of-the-home placement;
5. Children under the age of 19 years who are receiving foster care or adoption assistance under Title IV-E; and
6. Recipients with comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased from another organization or agency which cannot be billed by an MCO are exempt from mandatory enrollment.

C. Voluntarily Enrolled Managed Care Program Recipients:

The State of Nevada Managed Care Program allows that although the following Medicaid recipients are exempt from mandatory enrollment, they are allowed to voluntarily enroll in an MCO if they choose:

1. American Indians and Alaskan Natives (AI/AN) who are members of federally recognized tribes except when the MCO is the Indian Health Service (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS;
2. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs (also known as Children with Special Health Care Needs – CSHCN);
3. TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI); and
4. TANF and CHAP children diagnosed as Severely Emotionally Disturbed (SED).

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3603.2 GEOGRAPHIC AREA

The State assures individuals will have a choice of at least two MCOs for the Medicaid Managed Care recipients in each geographic area. When fewer than two MCOs are available for choice in the geographic areas listed, the Managed Care Program will be voluntary.

3603.3 COVERED SERVICES

No enrolled recipient shall receive fewer services in the Managed Care Program than they would receive in the current Nevada State Plans, except as contracted or for excluded services noted in Section 3603.4 below.

Any new services added or deleted from the Medicaid benefit package will be analyzed for inclusion or exclusion in the MCO benefit package.

3603.4 EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS

The following services are either excluded as an MCO covered benefit or have coverage limitations. Exclusions and limitations are identified as follows:

a. All services provided at IHS Facilities and Tribal Clinics

AI/AN may access and receive covered medically necessary services at IHS facilities and Tribal Clinics. If an AI/AN voluntarily enrolls with an MCO and seeks covered services from IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by IHS. If treatment is recommended by IHS and the enrollee seeks the recommended treatment through the MCO, the MCO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by the Division of Health Care Financing and Policy (DHCFP) or other reviewers. The MCO is required to coordinate all services with IHS. If an AI/AN recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the next administratively possible month and the services will then be reimbursed by Fee-For-Service (FFS).

b. Non-emergency transportation

A contracted vendor will authorize and arrange for all medically necessary non-emergency transportation. The MCO must verify medical appointments upon request by the DHCFP or their designee.

c. All Nursing Facility stays over 45 days

The MCO is required to cover the first 45 days of a Nursing Facility admission, pursuant

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to the Medicaid Services Manual (MSM). The MCO is also required to collect any patient liability (pursuant to 42 Code of Federal Regulations (CFR) 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify the DHCFP by the 40th day of any nursing facility stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

d. Swing bed stays in acute hospitals over 45 days

The MCO is required to cover the first 45 days of a swing bed admission pursuant to the MSM. The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify the DHCFP by the 40th day of any swing bed stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

e. School Based Child Health Services (SBCHS)

The DHCFP has an agreement with several school districts to provide selected medically necessary covered services through SBCHS to eligible Title XIX Medicaid and Title XXI Nevada Check Up (NCU) recipients.

Eligible Medicaid enrollees, who are three years of age and older, can be referred to an SBCHS for an evaluation by their private physician, school physician, special education teacher, school nurse, school counselor, parent or guardian, or social worker. If the child is found eligible for these services, then an Individual Education Plan (IEP) is developed for the child. The IEP specifies services needed for the child to meet educational goals. A copy of the IEP will be sent to the child's Primary Care Physician (PCP) within the managed health care plan, and maintained in the enrollee's medical record.

The school districts provide, through school district employees or contract personnel, the majority of specified medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school district contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document why the services are not medically necessary. The documentation may be reviewed by the DHCFP or its designees. Title XIX Medicaid and Title XXI NCU eligible children are not limited to receiving health services through the school districts. Services may be obtained through the MCO rather than the school district, if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

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f. Intermediate Care Facility for **Individuals with Intellectual Disabilities (ICF/ID)**

Residents of ICF/ID facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/ID after MCO enrollment, the recipient will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.

g. Residential Treatment Center (RTC) Limitations

It is the MCO's responsibility to provide reimbursement for all ancillary services (i.e., physician services, optometry, laboratory, dental and x-ray services, and similar services) for enrollees under the Title XXI, NCU, throughout their RTC admission. These enrollees will remain enrolled with the MCO throughout their RTC stay. The RTC bed day rate will be covered by FFS for NCU enrollees commencing the first day of admission.

Enrollees who are covered under Title XIX Medicaid will be disenrolled from the MCO the first day of the next administratively possible month following the RTC admission. It is the MCO's responsibility to provide reimbursement for all RTC charges including admission, bed day rate, and ancillary services until properly disenrolled from managed care. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid recipients.

h. Hospice

Recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. Hospice Services are an optional program under the Social Security Act XVIII Section 1905(o)(1)(A) and are governed by 42 CFR 418 and 489.102(I). Once admitted into hospice care, Medicaid members will be disenrolled immediately. NCU recipients will not be disenrolled. However, payment for NCU hospice services will be billed as FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

i. **Inpatient Hospital Services**

Managed Care Organizations (MCO) may provide inpatient hospital services, to mandatorily enrolled recipients within an alternative inpatient setting, which is licensed by the State of Nevada, in lieu of services in an inpatient hospital. The alternative inpatient setting must be a lower cost than the traditional inpatient setting.

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j. Adult Day Health Care

Recipients who are receiving Adult Day Health Care (ADHC) (Provider Type 39) services are not eligible for enrollment with the MCO. ADHC Services are optional Medicaid State Plan services and authorized under State Plan authority titled “Nevada 1915(i) State Plan Home and Community-Based Services (HCBS)”. If a recipient is made eligible for ADHC after MCO enrollment, the recipient will be disenrolled and the ADHC will be reimbursed through FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

k. Home and Community Based Waiver (HCBW) Services

Recipients who are receiving HCBW Services are not eligible for enrollment with the MCO. If a recipient is made eligible for HCBW Services after MCO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS.

l. All Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments are performed by the State’s Fiscal Agent.

Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the recipient is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission (see #c above).

m. SED/SMI

The MCO must ensure enrollees who are referred for evaluation for SED/SMI or who have been determined SED/SMI by the health plan are obtaining the medically necessary evaluations by an in-network provider and that enrollees are transitioned, as necessary, to another provider in order to obtain their mental health services if such services are not available within the network. The MCO is required to notify the DHCFP if a Title XIX Medicaid recipient elects to disenroll from the MCO following the determination of SED/SMI and forward the enrollee’s medical records to the provider from whom the enrollee will receive the covered mental health services. However, in the event the Medicaid enrollee who has received such a determination chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

The MCO is required to adhere to MSM Chapter 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Such services include, but are not limited to: case management; lab work; prescription drugs; acute in-patient; and, other ancillary medical and mental health services required by the plan of treatment. Title XIX Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI. Title XXI, NCU recipients must remain enrolled with the MCO who is responsible

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for on-going patient care. If a Title XIX eligible recipient elects to disenroll from the MCO following a determination of SED or SMI, the disenrollment will commence the first day of the next administratively possible month and the services will then be reimbursed by FFS.

Nevada Medicaid Newly Eligibles cannot opt out of managed care, where available, based on a determination of Serious Mental Illness (SMI).

3603.5 SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES

A. Out-of-Network Providers

When it is necessary for enrolled recipients to obtain services from out-of-network providers (e.g., the enrollee needs to see a specialist for which the MCO has no such specialist in its network) the MCO must:

1. Coordinate with out-of-network providers with respect to payment;
2. Offer the opportunity to the out-of-network provider to become part of the network; and,
3. Negotiate a contract to determine the rate prior to services being rendered.

B. Emergency Services

The MCO must cover and pay for emergency services regardless of whether the provider who furnished the services has a contract with the MCO. The MCO must pay the out-of-network provider for emergency services applying the “prudent layperson” definition according to the Emergency Medical Treatment and Labor Act (EMTALA) of an emergency, rendered at a rate limited to the amount that would have been paid if the service had been provided under the state’s FFS Medicaid program, unless a lower amount is mutually agreed to between the MCO and the party(ies) rendering service. Pursuant to 1932 (b)(2)(D) of the Social Security Act, a non-contracting provider of emergency services must accept as payment in full no more than it would receive if the services were provided under the state’s FFS Medicaid program. This rule applies whether the non-contracting provider is within the State or outside of the State in which the managed care entity has a contract.

No prior or post-authorization can be required for emergency care provided by network or out-of-network providers. The MCO may not deny payment for treatment obtained when the enrollee has an emergency medical condition and seeks emergency services, applying the “prudent layperson” definition of an emergency; this includes the prohibition against denying payment in those instances in which the absence of

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immediate medical attention would not have resulted in placing the health of the enrollee in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily part or organ. The MCO may not deny payment for emergency services treatment when a representative of the MCO instructs the enrollee to seek emergency services care.

Pursuant to 42 CFR 438.114, the MCO may not limit what constitutes an emergency medical condition as defined in this section on the basis of lists of diagnoses or symptoms nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's PCP, MCO, or the DHCFP of the enrollee's screening and treatment within ten calendar days of the presentation for emergency services.

An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending physician or the provider actually treating the enrollee is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO.

C. Post-Stabilization Services

The MCO is financially responsible for:

1. Post-stabilization services obtained within or outside the network that are pre-approved by a network provider or MCO representative;
2. Post-stabilization services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to the MCO for pre-approval of further post-stabilization care services;
3. Post-stabilization care services obtained within or outside the network that are not pre-approved by a network provider or other MCO representative but administered to maintain, improve, or resolve the enrollee's stabilized condition if the MCO does not respond to a request for pre-approval within one hour or the MCO cannot be contacted or the MCO and the treating physician cannot reach an agreement concerning the enrollee's care and a network provider or other organization representative is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the enrollee until a network physician is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

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Pursuant to 42 CFR 422.113(c)(3), the MCO's financial responsibility for post-stabilization care it has not pre-approved ends when a network physician with privileges at the treating hospital assumes responsibility for the enrollee's care or a network physician assumes responsibility for the enrollee's care through transfer or the MCO and the treating physician reach an agreement concerning the enrollee's care or the enrollee is discharged.

D. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)

The MCO must pay for services provided by an FQHC or an RHC. MCOs may enter into **Error! Bookmark not defined.** contracts with FQHCs or RHCs, provided that payments must be at least equal to the amount paid other providers for similar services and no lower than the Medicaid FFS rates. If the MCO does not have a contract with an FQHC or RHC, the MCO must pay at a rate equivalent to that paid by the DHCFP FFS rate schedule. This does not apply to out of network providers of emergency services. See Section 3603.5.b. The MCO must make a good faith effort to negotiate a contract with these providers. The MCO must report to the DHCFP payments and visits made to FQHCs and/or RHCs.

E. Out-Of-State Providers

When it is necessary for recipients to obtain services from an Out-Of-State (OOS) provider, the MCO must negotiate a contract to determine the rate prior to services being rendered. The MCO must inform the provider to accept the MCO's reimbursement as payment in full. The only exception is for Third-Party Liability (TPL). The provider must not bill, accept or retain payments from Medicaid or NCU recipients. Out-of-state providers of emergency services must accept as payment in full no more than it would receive if the services were provided under the State's FFS Medicaid program, pursuant to 1932(b)(2)(D) of the Social Security Act.

F. Obstetrical/GYN Services

1. Care Coordination for Certain Pregnant Women

The MCO is responsible for the identification and medical management of women identified as having a risk of preterm birth or poor pregnancy outcome.

A pregnancy is defined as "high risk" when there is a likelihood of an adverse outcome to the woman and/or her baby that is greater than the incidence of that outcome in the general pregnant population.

It is the responsibility of the MCO to assess the risk status of all enrolled pregnant women.

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Subsequently, the MCO is responsible for providing medical case management to all enrolled women who have been identified as having a high risk pregnancy.

The MCO is also responsible for referring enrolled pregnant women identified with specified social needs to the Division of Welfare and Supportive Services (DWSS). The DWSS staff is available to provide information regarding available community support programs to enrollees identified as experiencing any of the specified high risk social issues. The DHCFP District Office staff is available to assist in limited care coordination. The DHCFP will verify that appropriate coordination and communication by the MCO case managers/staff with the DWSS and the DHCFP District Office care coordination staff is occurring and that such coordination and communication is effective in intervening on behalf of these enrollees.

2. Obstetrical Global Payment

Length of time that the pregnant woman is enrolled in the health plan is not a determining factor in payment to the obstetrician. Payment to the delivering obstetrician for a normal routine pregnancy shall be based upon the services and number of visits provided by the obstetrician to the pregnant woman through the course of her pregnancy. Payments are determined by Current Procedural Terminology (CPT) codes submitted by the provider. The MCO must provide separate payment for covered medically necessary services required as a result of a non-routine pregnancy.

A Global Payment will be paid to the delivering obstetrician, regardless of network affiliation, when the enrollee has been seen seven or more times. If the obstetrician has seen the enrollee less than seven times, the obstetrician will be paid according to the Medicaid FFS visit-by-visit schedule.

a. Network Providers

For all cases, the MCO must have policies and procedures in place for transitioning the Medicaid or NCU eligible pregnant recipient to a network provider.

b. Non-network Providers

The MCO may reimburse a non-network provider at a negotiated rate less than the FFS rates established for pregnancy-related CPT codes.

c. New Enrollees within the Last Trimester of Pregnancy

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A pregnant woman who is enrolled with the MCO within the last trimester of pregnancy must be allowed to remain in the care of a non-network provider, if she so chooses. The MCO must have policies and procedures for this allowance.

d. Prior Authorization

The MCO's prior authorization policies and procedures must be consistent with the provision of prenatal care in accordance with community standards of practice. The DHCFP, at its discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information. The MCO is required to provide written notification to all affected network providers within 30 days of end of reported quarter regarding the elimination of the prior authorization requirement.

Under no circumstance will visits not covered by Medicaid or NCU be applied toward the minimum number of visits required for a global payment.

3. Certified Nurse Midwife Services

The MCO must make certified nurse midwife services available to enrollees, if such services are available in the MCO's service area. If the MCO does not have a contract for said services, the MCO must pay the certified nurse midwife provider according to the Medicaid FFS schedule for services rendered to the recipient.

4. Maternity Kick Payment (aka Supplemental Omnibus Reconciliation Act (SOBRA) payment)

The MCO will receive a maternity kick payment from the DHCFP to cover the maternity costs of any birth, still born, or miscarriage occurring in the third trimester of pregnancy for which an obstetrical payment has been made and there is an accompanying provider claim for the delivery. The third trimester commences at 27 weeks of gestation. Maternity kick payments will be generated upon submission of encounter data confirming the delivery.

The maternity kick payment is intended to offset most of the costs to the health plans for costs associated specifically with the covered delivery of a child, including prenatal and postpartum care. Ante partum care is included in the capitation rate paid for the mother. Costs of care for the newborn are included in the capitation rate.

The DHCFP will not pay a SOBRA payment in a situation where there is no accompanying provider claim for the delivery.

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5. Family Planning Services

Federal regulations grant the right to any enrollee of child-bearing age to receive family planning services from any qualified provider, even if the provider is not part of the MCO's provider network. The MCO may not require family planning services to be prior authorized. Family planning services are provided to enrollees who want to control family size or prevent unwanted pregnancies. Family planning services may include education, counseling, physical examinations, birth control devices, supplies and Norplant.

Pursuant to MSM Chapter 600, tubal ligations and vasectomies are a covered benefit for recipients 21 years of age or older. In accordance with federal regulations, the recipient must fill out a consent form at least 30 days prior to the procedure. The physician is required to send the consent form to the fiscal agent with the initial claim. Tubal ligations and vasectomies to permanently prevent conception are not covered for any recipient under the age of 21 or any recipient who is adjudged mentally incompetent or is institutionalized.

The MCO must, at a minimum, pay qualified out-of-network providers for family planning services rendered to its enrollees at the FFS rate paid by the DHCFP. The MCO will be responsible for coordinating and documenting out-of-network family planning services provided to its recipients and the amounts paid for such services.

6. Coordination of Care

Pursuant to 42 CFR 438.208(b)(2, 3, and 4) the MCO is required to implement procedures to coordinate services it may provide to the enrollee with the services the enrollee may receive from any other MCO and implement procedures to share with other MCO serving the enrollee the results of its identification and assessment of any CSHCN to ensure services are not duplicated. The MCO must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 164 (HIPAA). The MCO case managers will be responsible for coordinating services with appropriate non-Medicaid programs. This coordination includes referral of potentially eligible enrollees, including women with high risk pregnancies, to appropriate community resources and social service programs. The MCO case managers will also be responsible for coordinating the transition of services for those enrollees transferring to or from FFS, another MCO, and/or the Silver State Health Insurance Exchange (HIX).

7. Freestanding Obstetric/Birth Centers

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Section 2301 of the Affordable Care Act (ACA) requires coverage of services furnished at freestanding birth centers. The MCO is required to provide services at freestanding obstetric/birth centers.

A freestanding birth center is described as a health facility that is not a hospital or physician’s office, where childbirth is planned to occur away from the pregnant woman’s residence. The birth center must be in compliance with applicable state licensure and nationally recognized accreditation organization requirements for the provision of prenatal care, labor, delivery and postpartum care. “Obstetric Center”, Nevada’s legal term for birth center, complies with Section 2301 of the ACA birth center requirements related to the health and safety of recipients provided services by licensed birth centers.

The DHCFP birth center coverage and reimbursement is limited to medically necessary childbirth services which use natural childbirth procedures for labor, delivery, postpartum care and immediate newborn care. Birth center coverage and reimbursement are limited to women admitted to a birth center in accordance with adequate prenatal care, prospect for a normal uncomplicated birth defined by criteria established by the American College of Obstetricians and Gynecologists and by reasonable generally accepted clinical standards for maternal and fetal health. Prior authorization is not required.

Refer to the Maternity Care section of MSM Chapter 600 – Physician Services, for comprehensive maternity care coverage provided by physicians and/or nurse midwives. Refer to Attachment A, Policy #02-01, of MSM Chapter 200 for comprehensive birth center covered services and provider requirements.

G. Essential Community Providers (ECP)

As defined by the ACA and Section 340(B)(a)(4) of the Public Health Service Act, ECPs are providers that have historically provided services to underserved populations and demonstrate 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 (b) 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. The MCOs must make a good faith effort to negotiate a contract with the ECPs who are located in the plan’s geographic service area. The Health Resources and Services Administration (HRSA) provides a non-exclusive list of ECPs; however, the DHCFP reserves the right to modify this list at any time.

3603.6 ADDITIONAL PREVENTIVE SERVICES

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The MCO is encouraged to offer additional preventive or cost-effective services to enrolled recipients, if the services do not increase the cost to the State.

3603.7 DENTAL SERVICES

Dental services are included in the MCO benefit package in geographic areas designated as mandatory managed care areas. The MCO will be responsible for all covered medically necessary dental services pursuant to MSM Chapter 1000 and the State Plan, Section 3.1-A.

3603.8 PRIVATE DUTY NURSING

Private duty nursing services (42 CFR 440.80) are included in the MCO package for recipients who require more individual and continuous care. These services are provided:

- a. By a Registered Nurse (RN) or a Licensed Practical nurse (LPN);
- b. Under the directions of the recipient's physician; and
- c. In the recipient's home.

For additional information, reference MSM Chapter 900.

3603.9 PHARMACY SERVICES

Pharmacy services are included in the MCO benefit package. The MCO may design its own pharmacy formulary based on clinical guidelines. Medications not covered in the MCO's formulary must be available through a non-formulary request process based on physician certification and justification of medical necessity. Pharmacy coverage benefits are based on the State Plan.

The MCO may use generic substitutions unless the physician/dentist justifies the medical necessity of the brand name pharmaceutical.

The MCO must have a policy for transitioning a recipient's prescriptions from FFS, another MCO or the HIX, to the MCO, vendor or HIX. The MCO will not be allowed to terminate a current prescription without first conducting a medical examination of the recipient. The MCO then must document why a drug is not medically necessary, if a current prescription is terminated.

The DHCFP shall approve the MCO's formulary prior to implementation. The MSM Chapter 1200 stipulates the conditions with which a prescriber must comply to certify that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the

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generic form. The procedure of the certification must comply with the following: certification must be in the physician's own handwriting; and, certification must be written directly on the prescription blank and a phrase indicating the need for a specific brand is required (an example would be "Brand Medically Necessary"). Substitution of generic drugs prescribed by brand name must also comply with NRS 639.2583.

3603.10 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS

The MCO benefit package includes certain services for CSHCN and mental health services for adults for which the MCO must reimburse certain types of providers with whom formal contracts may not be in place and coordinate these services with other services in the MCO benefit package.

The MCO must implement mechanisms to assess each enrollee, identified to the MCO as an individual with special health care needs, in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

The MCO must produce a treatment plan for enrollees with special health care needs who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be:

- a. Developed by the enrollee's Primary Care Provider (PCP) with enrollee participation, and in consultation with any specialists caring for the enrollee;
- b. Approved by the MCO in a timely manner, if approval is required by the MCO; and,
- c. In accordance with any applicable State quality assurance and utilization review standards.

For children with special health care needs who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow these enrollees access to a specialist, through a standing referral or an approved number of visits, as appropriate for the enrollee's condition and identified needs.

The MCO is required to adhere to MSM Chapters 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Title XIX Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI, with the exception of the Nevada Medicaid Newly Eligible childless adults ages 19 – 64 and the expanded parent and caretakers ages 19 - 64. Title

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XXI NCU recipients must remain enrolled with the MCO who is responsible for ongoing patient care.

3603.11 TRANSPLANTATION OF ORGANS AND TISSUE, AND RELATED IMMUNO-SUPPRESSANT DRUGS

These services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. The DHCFP via its Title XIX State Plan Attachment 3.1.E covers corneal, kidney, liver and bone marrow transplants and associated fees for adults. For children up to age 21 any medically necessary transplant that is not experimental will be covered. The health plan may claim transplant case reimbursement from the DHCFP for in-patient medical expenses above the threshold of \$100,000 in a one-year period (State Fiscal Year). 75% of the expenses above \$100,000 are reimbursed to the health plan.

At the discretion of the DHCFP administration, an enrollee may be assigned to another MCO at any time and the DHCFP may reimburse the MCO for claims and waive stop loss. The DHCFP may also assign an otherwise FFS child to the MCO for care management. The MCO will be expected to administer these FFS payments with no added markup.

3603.12 TARGETED CASE MANAGEMENT (TCM)

TCM has a specific meaning for Nevada Medicaid and NCU. TCM, as defined by the MSM Addendum, is carved out of the managed care contracts. Case management, which differs from TCM, is required from the contracted MCO.

3603.13 IMMUNIZATIONS

The MCO shall require its network providers to enroll in the Vaccines for Children Program (VFC) which is administered by the Nevada State Health Division. Providers licensed by the state to prescribe vaccines may request to be enrolled in the Nevada State Health Division's VFC Program. The immunization program will review and approve provider enrollment requests. The MCO shall require VFC enrolled providers to cooperate with the Nevada State Health Division for purposes of performing orientation and monitoring activities regarding VFC Program requirements.

Upon successful enrollment in the VFC Program, providers may request state supplied vaccine to be administered to enrollees through 18 years of age in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule and/or recommendation and following VFC program requirements as defined in the VFC Provider Enrollment Agreement.

The MCOs shall require VFC enrolled network providers to participate in the Nevada State Health Division's Immunization Registry to ensure the DHCFP's goal to fully immunize children up to the age of two years. The MCO shall provide appropriate technical support in

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instances where the provider does not have the capability to meet these requirements. The MCO must work within the Health Division to interface directly with the Immunization Registry.

3603.14 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

The MCO is required to conduct Early Periodic Screening Diagnostic and Treatment (EPSDT) screenings of its enrolled recipients under the age of 21 years. The screening must meet the EPSDT requirements found in the MSM as well as 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act, and 42 CFR 441.50 through 441.62. The MCO must conduct all interperiodic screening on behalf of eligible enrolled recipients, as defined in the MSM.

Medically necessary screening, diagnostic and treatment services identified in an EPSDT periodic or interperiodic screening must be provided to eligible children under the age of 21 years if the service is listed in 42 U.S.C. § 1396 d(a). The MCO is responsible for reimbursement of all medically necessary services under EPSDT whether or not the service is in the State Plan. The MCO is responsible for the oral examination component of the EPSDT physical exam and referral to a dental provider, as per the dental periodicity schedule or when medically necessary. The MCO is responsible for the coordination of care in order to ensure all medically necessary coverage is being provided under EPSDT.

The services which need to be provided through the MCO include, but are not limited to the following in accordance with 1905(r) of the Social Security Act and the MSM:

- a. Screening services which include a comprehensive health and developmental history (including assessment of both physical and mental health development);
- b. A comprehensive, unclothed physical exam;
- c. Age appropriate immunizations (according to current American Committee On Immunization Practices – ACIP - schedule);
- d. Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements);
- e. Health education;
- f. Vision services;
- g. Dental services;
- h. Hearing services; and,

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- i. Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Medicaid Plan.

The MCO is not required to provide any items or services which are determined to be unsafe or ineffective, or which are considered experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

The MCO is required to provide information and perform outreach activities to eligible enrolled children for EPSDT services. These efforts may be reviewed and audited by the DHCFP or its designee.

3603.15 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

A. Eligibility and Disenrollment

The eligibility and enrollment functions are the responsibility of the DHCFP and the Division of Welfare and Supportive Services (DWSS). The MCO shall accept each recipient who is enrolled in or assigned to the MCO by the DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by the DHCFP to the MCO. The first date a Medicaid or NCU eligible recipient will be enrolled is not earlier than the applicable date in the MCO's specified contract.

The MCO must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract. The MCO acknowledges that enrollment is mandatory except in the case of voluntary enrollment programs that meet the conditions set forth in 42 CFR 438.50(a). The MCO will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The MCO will not deny the enrollment nor discriminate against any Medicaid or NCU recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the recipient was previously disenrolled from the MCO as the result of a grievance filed by the MCO, the recipient will not be re-enrolled with the MCO unless the recipient wins an appeal of the disenrollment. The recipient may be enrolled with another MCO.

The State reserves the right to recover pro-rated capitation whenever the MCO's responsibility to pay medical claims ends in mid-month. **A situation** where a mid-month capitation recovery may occur includes, but is not limited to:

- 1. Enrollee is in a nursing facility over 45 days;

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2. Enrollee is in an acute hospital swing bed over 45 days;
3. Enrollee is placed in an out of home placement;
4. Medicaid enrollee is placed in a hospice;
5. Enrollees enters an ICF/MR;
6. Enrollee enters an HCBW Program.

The MCO is not financially responsible for any services rendered during a period of retroactive eligibility except in the specific situation(s) described in this Chapter. The MCO is responsible for services rendered during a period of retroactive enrollment in situations where errors committed by the DHCFP or the DWSS, though corrected upon discovery, have caused an individual to not be properly and timely enrolled with the MCO. In such cases, the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. Out-of-state providers in these circumstances will be paid according to a negotiated rate between the MCO and the out-of-state provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. The DHCFP is responsible for payment of applicable capitation for the retroactive coverage. As described in Section 3603.15 (B) (1) of the MSM, the Vendor is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retro-actively enrolled at the date of birth.

The MCO must notify a recipient that any change in status, including family size and residence, must be immediately reported by the recipient to the DWSS eligibility worker.

The MCO must provide the DHCFP with weekly electronic notification of all births and deaths.

B. Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. DWSS notifies the state's fiscal agent who enrolls the applicant. Letters are sent to the new recipients requiring them to select an MCO or an MCO will be automatically assigned. The MCO will be notified of the pregnant woman's choice by the State's fiscal agent. The MCO shall be responsible for all covered medically necessary obstetrical services and pregnancy related care commencing on the date of enrollment.

C. Enrollment of Program Newborns

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The MCO must have written policies and procedures for newborns of enrolled recipients. The MCO is required to electronically report births on a weekly basis to the DHCFP via the Provider Supplied Data file located on the File Transfer Protocol (FTP). The MCO will be responsible for all covered medically necessary services included in the MCO benefit package to the qualified newborn.

Enrollment requirements for program newborns are as follows:

1. Medicaid Eligible Newborns

All Title XIX Medicaid eligible newborns born to enrolled recipients are enrolled effective the date of birth if the mother of the newborn was enrolled with the MCO as of the newborn's date of birth.

The MCO is not financially responsible for any services rendered during a period of retroactive eligibility except in specific situation(s) described in this Chapter. As described herein, the MCO will be responsible for all Medicaid newborns as of the date of birth if the mother of the newborn was enrolled with, or was retroactively enrolled with, the MCO as of the newborn's date of birth. In situations where it is determined that eligibility decisions were made that caused incorrect enrollment decisions, the Medicaid Management Information System (MMIS) may be corrected to show correct enrollment and all payments due the vendor reconciled accordingly. In this situation, the MCO will be responsible for services rendered during this retro-active enrollment timeframe. In such cases, the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. Out-of-state providers in these circumstances will be paid according to a negotiated rate between the MCO and the out-of-state provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date.

2. NCU Newborns

The head of household/mother must notify the MCO and NCU of the pregnancy prior to and within 14 days following the delivery in order to qualify to receive coverage from the date of birth. For all qualified newborns, the MCO shall receive a capitation payment for the month of birth and for all subsequent months that the child remains enrolled with the MCO. If notification is not received as required herein, the newborn will be enrolled as of the first day of the next administrative month from the date of notification.

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If the MCO receives notification of a pregnancy or a birth, they must provide a weekly electronic report to the DHCFP. The report must contain the following information for reporting a pregnancy:

- a. Mother's Name;
- b. Estimated Date of Confinement (EDC); and,
- c. Family ID Number or Mother's Billing Number.

If reporting a birth, the transfer file must contain the following information:

- d. Mother's Name;
- e. Child's (newborn's) Name;
- f. Family ID Number or Mother's billing Number;
- g. Child's Date of Birth;
- h. Sex;
- i. Ethnicity;
- j. Social Security Number of Child (if available); and
- k. Any changes in resident address and/or telephone number.

If the mother has other health insurance coverage that provides for 30 days of coverage of the newborn and she has other children enrolled in the NCU program, the newborn will be enrolled in the MCO as of the first day of the next administrative month.

D. Auto Assignment Process

For Medicaid recipients who do not select a MCO, the DHCFP will assign the recipient to an MCO based upon federally required enrollment default criteria that include:

1. The maintenance of existing provider individual relationships or relationships with traditional Medicaid providers; and
2. Distributing the recipients among the contracted MCOs based upon an algorithm developed by the DHCFP when maintaining such relationships is not possible.

E. Automatic Re-enrollment

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Recipients disenrolled solely due to the loss of Medicaid or NCU eligibility will be auto-assigned to their last known MCO upon re-entry if that MCO remains under contract. Should the MCO no longer be under contract, recipient(s) will be provided with 30 days in which to choose an MCO. After selecting an MCO, recipient(s) have an additional 90 days in which to exercise the option of selecting an alternative MCO.

F. Disenrollment Requirements and Limitations

1. Disenrollment at the Request of the Enrollee

Enrollees eligible in the 90-day “right to change” period may request disenrollment from the MCO without cause at any time during this period. The enrollee is required to notify the DHCFP fiscal agent by mail of his/her decision to disenroll and, if he/she is a mandatory recipient, as defined by the mandatory managed care geographical areas of urban Clark or Washoe County, will be assigned to the other MCO. The effective date of change in the MCO will be based on the monthly administrative cutoff date but not later than the first day of the second month following the month in which the enrollee makes the request to disenroll. After the first 90 days of enrollment, the enrollee will be locked into an MCO until the next open enrollment period. There will be one open enrollment period annually. If the enrollee wishes to disenroll at any time during the lock-in period, they must contact the appropriate MCO and provide good cause for doing so. The MCO will determine good cause as defined in 42 CFR 438.56.

NCU enrollees may request disenrollment from the MCO without cause during the first 90 days of enrollment and are required to contact the NCU office if they request disenrollment from the MCO and if he/she is a mandatory recipient, must select another MCO. After the first 90 days of enrollment, the enrollee will be locked into an MCO for the remainder of the current open enrollment period. There will be one open enrollment period annually. If the enrollee wishes to disenroll at any time during the 12 month lock-in period, they must contact the appropriate MCO and provide good cause for doing so. The MCO will determine if it is good cause using the same criteria as for Medicaid.

2. Disenrollment at the Request of the MCO

The MCO may request disenrollment of a recipient if the recipient has been seen by at least three of the MCO’s PCPs and each PCP provides a written statement to the DHCFP confirming their inability to treat the enrollee due to the enrollee’s serious behavioral non-compliance or disruptive behavior. In addition, the MCO must confirm the enrollee has been referred to the MCO’s Enrollee Services Department and has either refused to comply with this referral or refused to act in

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good faith to attempt to resolve the problem. The MCO may also request disenrollment of an enrollee if the MCO can provide documentation the enrollee has, on at least three separate occasions, demonstrated serious behavioral non-compliance or disruptive behavior toward the MCO's or subcontractor's staff. Prior approval by the DHCFP of a MCO's request for the enrollee's disenrollment is required. If approval is granted, the enrollee will be given notice by the MCO that disenrollment will occur effective the first day of the next month following administrative cut off.

The MCO may request disenrollment of an enrollee for a combination of PCP and MCO serious, behavioral non-compliance or disruptive behavior by an enrollee for a total of at least three separate instances. The same documentation and procedure applies as in the separate PCP or MCO instances. Prior approval of these disenrollments by the DHCFP is required.

The DHCFP reserves the right to review and act upon an MCO's request for disenrollment without the recipient exhibiting the serious, behavioral non-compliance or disruptive behavior three times. The DHCFP will make a determination on such a request within five days. If approval is granted, the enrollee will be given notice by the MCO that disenrollment will occur effective the first day of the next month following administrative cut off.

An MCO may not request disenrollment of an enrollee for any of the following reasons:

- a. An adverse change in the enrollee's health status;
- b. Pre-existing medical condition;
- c. The enrollee's utilization of medical services;
- d. Diminished mental capacity;
- e. Uncooperative or disruptive behavior resulting from his/her special needs (except when continued enrollment of such an enrollee seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees);
- f. An enrollee's attempt to exercise his/her grievance or appeal rights; or,
- g. Based on the enrollee's national origin, creed, color, sex, religion, age, pursuant to the DHCFP Managed Care contract and applicable CFRs.

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Pursuant to 42 CFR 438.56(b)(3) in those circumstances in which the MCO requests disenrollment of an enrollee, the MCO must provide the DHCFP with written assurances that it is not requesting disenrollment for any reason(s) other than those permitted under the DHCFP Managed Care contract.

3. Disenrollment Pursuant to a finding of SED or SMI Status:

See Section 3603.4 (m) of this MSM.

G. Enrollment, Disenrollment and Other Updates

The MCO must have written policies and procedures for receiving monthly updates from the DHCFP of recipients enrolled in, and disenrolled from, the MCO, and other updates pertaining to these recipients. The updates will include those newly enrolled with the MCO. The MCO must incorporate these updates into its management information system.

H. Enrollment Interface

Upon initiation of the implementation process, the MCO must furnish the technical means by which the DHCFP Enrollment Sections can:

1. Determine the number of recipients each enrolled PCP will accept as new patients; and,
2. Transmit beneficiary elections regarding PCP assignment for the forthcoming month.

I. Provider Enrollment Roster Notification

The MCO must establish and implement a mechanism to inform each PCP about any newly MCO enrolled recipients assigned to the PCP on at least a monthly basis. Written or electronic notice to each PCP regarding patient rosters effective for each month must be provided to the provider within five business days of the MCO receiving the recipient file from the enrollment sections. The enrollment sections will pass the membership file through the system for verification of eligibility prior to distribution to the MCO, who will in turn be responsible for keeping individual participating providers informed. The MCO may elect to update its membership file more frequently to keep PCPs informed of the enrollment activity, but this must be done with the understanding that only the membership file that has been confirmed through the DHCFP eligibility system is the accurate version.

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3603.16 CHANGE IN A RECIPIENT'S STATUS

Within seven calendar days of becoming aware of any changes in a recipient's status, including changes in family size and residence, the MCO must electronically report the change(s) to the DHCFP.

3603.17 TRANSITIONING/TRANSFERRING OF RECIPIENTS

A. Transitioning Recipients into MCOs

The MCO will be responsible for recipients as soon as they are enrolled and the MCO is aware of the enrollee in treatment. The MCO must have policies and procedures for transitioning recipients currently receiving services in the FFS program into the MCO's plan.

The MCO must have policies and procedures including, without limitation, the following to ensure a recipient's smooth transition from FFS to the MCO:

1. Recipients with medical conditions such as:
 - a. Pregnancy (especially if high risk);
 - b. Major organ or tissue transplantation services in process;
 - c. Chronic illness;
 - d. Terminal illness; and/or,
 - e. Intractable pain.
2. Recipients who, at the time of enrollment, are receiving:
 - a. Chemotherapy and/or radiation therapy;
 - b. Significant outpatient treatment or dialysis;
 - c. Prescription medications or durable medical equipment (DME); and/or,
 - d. Other services not included in the State Plan but covered by Medicaid under EPSDT for children.
3. Recipients who at enrollment:

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- a. Are scheduled for inpatient surgery(ies);
- b. Are currently in the hospital;
- c. Have prior authorization for procedures and/or therapies for dates after their enrollment; and/or,
- d. Have post-surgical follow-up visits scheduled after their enrollment.

B. Transferring Recipients Between MCOs

It may be necessary to transfer a recipient from one MCO to another or to FFS for a variety of reasons. When notified by the DHCFP that an enrollee has been transferred to another plan or to FFS, the MCO must have written policies and procedures for transferring/receiving relevant patient information, medical records and other pertinent materials to the other plan or current FFS provider. Prior to transferring a recipient, the MCO (via their subcontractors when requested by the MCO) must send the receiving plan or provider information regarding the recipient's condition. This information shall include, without limitation, whether the recipient is:

1. Hospitalized;
2. Pregnant;
3. Receiving dialysis;
4. Chronically ill (e.g., diabetic, hemophilic);
5. Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment;
6. On an apnea monitor;
7. Receiving behavioral or mental health services;
8. Receiving Nevada early intervention services in accordance with an Individualized Family Service Plan (IFSP) provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children this would be the school district and services are provided for the child through an IEP.
9. Involved in, or pending authorization for, major organ or tissue transplantation;

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10. Scheduled for surgery or post-surgical follow-up on a date subsequent to transition;
11. Scheduled for prior authorized procedures and/or therapies on a date subsequent to transition;
12. Name and contact information of Assigned PCP;
13. Referred to a Specialist(s);
14. Receiving substance abuse treatment for recipients 21 and older;
15. Receiving prescription medications;
16. Receiving Durable Medical Equipment (DME) or currently using rental equipment;
17. Currently experiencing health problems; or
18. Receiving case management (including the case manager's name and phone number).

When a recipient changes MCOs or reverts to FFS while hospitalized, the transferring MCO shall notify the receiving MCO, the receiving provider, or the DHCFP Quality Improvement Organization (QIO-like vendor) as appropriate, of the change within five calendar days.

A recipient may need to be transitioned between Medicaid and the State-designated Health Insurance Exchange (HIX), due to changes in eligibility. When notified that a member is being transferred to the HIX, the vendor must have written policies and procedures for transferring/receiving relevant patient information and other pertinent materials to/from the HIX. This must be done in compliance with HIPAA and other privacy laws.

3603.18 INFORMATION REQUIREMENTS

The MCO must have written information about its services and access to services available upon request to enrollees and potential enrollees. This written information must also be available in the prevalent non-English languages, as determined by the State, in its particular geographic service area. "Prevalent" is determined as the primary language spoken by 1,000 or 5% (whichever is less) of the MCO's members. The MCO must make free, oral interpretation services available to each enrollee and potential enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

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The MCO is required to notify all enrollees and potential enrollees that oral interpretation services are available for any language and written information is available in English and all prevalent non-English languages. The MCO must notify all enrollees and potential enrollees how to access this information.

The MCO's written material must use an easily understandable format. The MCO must also develop appropriate alternative methods for communicating with visually and hearing-impaired enrollees, and accommodating physically disabled recipients in accordance with the revised regulations of the Americans with Disabilities Act of 1990 (ADA), ADA Amendments Act of 2008, and Section 504 of the Rehabilitation Act of 1973. All enrollees and potential enrollees must be informed that this information is available in alternative formats and how to access those formats. The MCO will be responsible for effectively informing Title XIX Medicaid enrollees who are eligible for EPSDT services.

If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover to the State with its application for a Medicaid contract and whenever it adopts the policy during the term of the contract. The information provided must be consistent with the provisions of 42 CFR 438.10 and must be provided to potential enrollees before and during enrollment.

Such information must also be provided within 90 days after adopting the policy with respect to any particular service.

a. Enrollee Handbook

The MCO must provide all enrollees with an Enrollee Handbook. The handbook must be written at no higher than an eighth grade reading level and must conspicuously state the following in bold print:

“This Handbook is not a certificate of insurance and shall not be construed or interpreted as evidence of insurance coverage between the MCO and the Enrollee.”

The MCO must submit the Enrollee Handbook to the DHCFP before it is published and/or distributed. The DHCFP will review the handbook and has the sole authority approve or disapprove the handbook and the MCO's policies and procedures therein. The MCO must agree to make modifications in handbook language if requested to do so in order to comply with the requirements as described above or as required by CMS or State law. In addition the MCO must maintain documentation that the handbook is updated at least once per year. These annual updates must be submitted to the DHCFP before publication and/or distribution.

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The MCO must furnish the handbook to all recipients within five business days of receiving notice of the recipient's enrollment and must notify all enrollees of their right to request and obtain this information at least once per year or upon request. The MCO will also publish the Enrollee Handbook on the MCO's internet website upon contract implementation and will update the website, as needed, to keep the Enrollee Handbook current. The MCO shall issue updates to the Enrollee Handbook, 30 days before the intended effective date, as described in 42 CFR 438.10(f)(4), when there are material changes that will affect access to services and information about the Managed Care Program.

At a minimum the information enumerated below must be included in the handbook:

1. Explanation of benefits and how to obtain benefits, including out-of-plan benefits, and how to access them, the address and telephone number of the MCO's office or facility and the days that the office or facility is open and services are available;
2. The role of the PCP;
3. A list of current network PCPs who are and who are not accepting new patients in the enrollee's service area, with their board certification status, addresses, telephone numbers, availability of evening or weekend hours, all languages spoken and information on PCPs, specialists, and hospitals. This list must be updated monthly by the MCO;
4. Any restrictions on the enrollee's freedom of choice among network providers;
5. Procedures for changing a PCP;
6. Enrollee rights and protections as specified in 42 CFR 438.100;
7. The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
8. Procedures for obtaining benefits, including authorization requirements;
9. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers;
10. Procedures for disenrollment;

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11. The extent to which, and how, after hours and emergency coverage are provided including: what constitutes an emergency medical condition, emergency and post stabilization services with reference to the definitions in 42 CFR 438.114; the fact that prior authorization is not required for emergency services; the process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent; the locations of any emergency settings and other locations at which providers and hospitals furnish emergency and post stabilization services under the contract; the fact that, subject to regulatory limitations, the enrollee has a right to use any hospital or other setting for emergency care;

Explanation of procedures for urgent medical situations, non-emergency transportation services and how to utilize services in other circumstances, including the recipient services telephone number; clearly define urgent care, emergency care, and emergency transportation, and clarify the appropriate use of each;

12. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's PCP, including explanation of authorization procedures;
13. How and where to access any benefits that are available under the Title XIX and Title XXI State plans but are not covered under the contract, including any cost sharing, and how transportation is provided.

For a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO need not provide the information on how or where to obtain the service. The MCO must notify the State regarding services that meet this criteria and in those instances, the State must provide the information on where and how to obtain the service;

14. Procedures for accessing emergency and non-emergency services when the recipient is in and out of the MCO service area;
15. Information on grievance, appeals, and fair hearing procedures and information as specified in 42 CFR 438.10(g);
16. Information on procedures for recommending changes in policies and services;
17. The MCO must provide adult enrollees with written information on Advance Directives (AD) policies and include a description of applicable State law. This information must reflect changes in State law as soon as possible but no later than 90 days after the change. The MCO must ensure that a signed copy of the DHCFF's "Acknowledgment of Patient Information on Advance Directives" form

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is included in the recipient's medical record. (A sample form is available online at <http://dhcfp.nv.gov/advancedirectives.htm>);

18. To the extent available, quality and performance indicators, including enrollee satisfaction;
19. The MCO is also required to provide, to the enrollee upon request, information on the structure and operation of the MCO and information about physician incentive plans as set forth in 42 CFR 438.6(h);
20. The enrollee handbook must include a distinct section for eligible recipients which explains the EPSDT program and includes a list of all the services available to children; a statement that services are free and a telephone number which the enrollee can call to receive assistance in scheduling an appointment;
21. Information regarding prescription coverage;
22. Notification of the enrollee's responsibility to report any on-going care corresponding to a plan of care at the time of enrollment and their right to continue that treatment under the MCO on a transitional basis;
23. Notification of the enrollee's responsibility to report any third party payment service to the MCO and the importance of doing so; and
24. How to report Fraud and Abuse.

The MCO must give each enrollee written notice of any significant change, as defined by the State, in any of the enumerations noted above. The MCO shall issue updates to the Enrollee Handbook on a monthly basis when there are material changes that will affect access to services and information about the Managed Care Program; this includes additions and changes to the provider network.

The MCO shall also provide such notices in its semi-annual recipient newsletters and shall maintain documentation verifying handbook updates.

The MCO must give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice. This notice shall be provided to each enrollee who received his/her primary care from, or was seen on a regular basis by, the terminated provider.

b. Identification Cards

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The MCO may choose to issue an identification card to enrollees. The identification card must clearly state that the card does not constitute evidence of insurance coverage or eligibility. The card may include the following information: enrollee's billing number; the MCO's name and member services department telephone number; and, date of issue. The MCO must educate its providers regarding the card issued to enrolled recipients. The MCO may, at its discretion, include a unique member identification number on the card. The MCO must annotate on the card that the number is to be used by its network providers only.

c. Information for Potential Enrollees

The MCO must provide information regarding contracted MCOs to potential enrollees pursuant to CFR 438.10. The information is to be furnished at the time the potential enrollee first becomes eligible to enroll in a voluntary program or is first required to enroll in a mandatory program and, at that time, must be provided within a timeframe which enables the potential enrollee to use the information in choosing among available MCOs. The required information for potential enrollees will be provided to the MCO by the DHCFP and will include:

1. General information about the basic features of managed care, including which populations are excluded, subject to mandatory enrollment, or free to enroll voluntarily in the program, and the responsibilities for coordination of enrollee care;
2. Information specific to each MCO operating in a potential enrollee's service area and a summary of the following information:
 - a. Benefits covered;
 - b. Service area;
 - c. Names, locations, telephone numbers of and non-English languages spoken by current network providers, and including identification of providers that are not accepting new patients;
 - d. Information on PCPs, specialists, and hospitals;
 - e. To the extent available, quality and performance indicators, including enrollee satisfaction; and,
 - f. Benefits that are available under the State Plan but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a

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counseling or referral service that the MCO does not cover because of moral or religious objections, the State will provide information about where and how to obtain the service.

The State is responsible for providing more detailed information to potential enrollees upon request.

d. Medical Records

Complete medical records shall be maintained by the MCO's contracted providers, for each enrolled recipient. The records shall be available for review by duly authorized representatives of the State and CMS upon request of the State, CMS and other federal agencies.

The MCO shall have written policies and procedures to maintain the confidentiality of all medical records; provide accessibility and availability of medical records; ensure adequate record keeping and record review processes. Not more than ten calendar days after submitting a request, the State shall have access to an enrollee's medical record, whether electronic or paper, and has the right to obtain copies at the MCO's expense.

The recipient's medical record is the property of the provider who generates the record. The MCO shall assist the enrollee or the parent/legal guardian of the enrollee in obtaining a copy of the enrollee's medical records, upon written request, from the provider. Records shall be furnished in a timely manner upon receipt of such a request but not more than 30 days from the date of request. Each enrollee or parent/legal guardian of the enrollee is entitled to one free copy of the requested medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile copy and furnish such records.

When an enrolled recipient changes primary care providers and/or health plans, the MCO's contracted provider must forward all medical records in their possession to the new provider within ten working days from receipt of the request.

3603.19 MEDICAL PROVIDER REQUIREMENTS

A. PCP or Primary Care Site (PCS)

The MCO shall allow each enrolled recipient the freedom to choose from among its participating PCPs and change PCPs as requested.

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Each enrolled recipient must be assigned to a PCP or PCS, within five business days of the effective date of enrollment. The MCO may auto-assign a PCP or PCS to an enrolled recipient who does not make a selection at the time of enrollment. If the enrolled recipient desires, the MCO shall allow him or her to remain with his or her existing PCP if the PCP is a member of MCO's primary care network.

B. Assignment of a PCP or PCS

If an enrolled recipient does not choose a PCP, the MCO shall match enrolled recipients with PCPs by one or more of the following criteria:

1. Assigning enrolled recipients to a provider from whom they have previously received services, if the information is available;
2. Designating a PCP or PCS who is geographically accessible to the enrolled recipient per NAC 695C.160;
3. Assigning all children within a single family to the same PCP; and/or,
4. Assigning a CSHCN to a practitioner experienced in treating that condition, if the MCO knows of the condition.

The MCO shall ensure that enrolled recipients receive information about where they can receive care during the time period between enrollment and PCP selection/assignment. The MCO shall notify the enrolled recipient of his or her assigned PCP within five business days of assignment.

C. Changing a PCP or PCS

1. An enrolled recipient may change a PCP or PCS for any reason. The MCO shall notify enrolled recipients of procedures for changing PCPs. The materials used to notify enrolled recipients shall be approved by the DHCFP prior to publication and/or distribution.
2. In cases where a PCP has been terminated, the MCO must notify enrolled recipients in writing and allow recipients to select another primary care provider, or make a re-assignment within 15 business days of the termination effective date, and must provide for urgent care for enrolled recipients until re-assignment.
3. The MCO may initiate a PCP or PCS change for an enrolled recipient under the following circumstances:
 - a. Specialized care is required for an acute or chronic condition;

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- b. The enrolled recipient's residence has changed such that distance to the PCP is greater than 25 miles. Such change will be made only with the consent of the enrollee;
- c. The PCP ceases to participate in the MCO's network; or,
- d. Legal action has been taken against the PCP which excludes provider participation.

The recipient will be given the right to select another PCP or PCS within the MCO network.

- 4. The MCO shall document the number of requests to change PCPs and the reasons for such requests.

3603.20 PROVIDER DIRECTORY

The MCO will publish their provider directory via an internet website upon contract implementation and will update the website on a bi-weekly basis for all geographic service areas. The MCO will provide the DHCFP with the most current provider directory upon contract award for each geographic service area. Thereafter, the MCO will provide monthly electronic updates (including additions/deletions to the network) to the DHCFP.

3603.21 NETWORK MAINTENANCE

- A. Maintenance of the network includes, but is not limited to:
 - 1. Initial and ongoing credentialing;
 - 2. Adding, deleting, and periodic contract renewal;
 - 3. Provider education; and,
 - 4. Discipline/termination
- B. The MCO must have written policies and procedures for monitoring its network providers, and for disciplining those who are found to be out of compliance with the MCO's medical management standards.
- C. The MCO must take appropriate action related to dual FFS and managed care network providers, as follows:

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1. Upon the MCO's awareness of any disciplinary action, sanction taken against a network provider, or any suspected provider fraud or abuse, the MCO shall immediately inform the DHCFP.
2. If the MCO is notified that the Office of the Inspector General (OIG), the DHCFP or another state, federal or local agency has taken an action or imposed a sanction against a network provider, the MCO shall review the provider's performance related to the DHCFP Managed Care Contract and take any action or impose any sanction, including disenrollment from the MCO's Provider Network.

3603.22 RETRO-CAPITATION AND CAPITATION RECONCILIATION

Capitation payments are subject to several types of error. Most often, a capitation payment error is introduced due to an inaccuracy in eligibility or enrollment status. Some errors are corrected automatically by the MMIS, others by manual financial transaction. Depending upon the nature of the error in a particular instance, capitation may be paid or recovered from the MCO. Capitation is also reconciled periodically, typically for a three-month period.

a. Errors automatically corrected by the MMIS

The MMIS automatically adjusts up to three months of capitation for newborns when updated Welfare eligibility data for the current month also includes previously unreported eligibility.

In those instances where an eligibility agent has corrected an estimated date of birth forward in time, the MMIS automatically recovers the incorrectly paid capitation.

Should an error extend beyond three months, the instance must be researched and corrected manually by financial transaction.

b. Errors Corrected Manually by Financial Transaction

The MCO, in order to recover unpaid capitation, is required to submit such instances on a periodic basis via the process described in the Contract (Forms and Reporting Guide).

The Business Lines unit reconciles and authorizes payment of these retro-capitation payment requests on a quarterly basis with sufficient lag time (typically three months) to allow automated MMIS corrections to occur.

The Business Lines unit also reconciles and authorizes capitation recovery in instances where it is discovered that capitation has been incorrectly paid. This may occur on either a periodic or per-instance basis.

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c. Reconciliation of Capitation Payments

The Business Lines unit determines the validity of retro-capitation requests or may use an appropriate sample for a large number of payment requests.

3603.23 THIRD-PARTY LIABILITY (TPL) AND SUBROGATION

For the DHCFP's contracts with MCOs, TPL refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) including group health plans, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 (29 USC and 1167 (1)) service benefits plans and Section 6035 of the Deficit Reduction Act of 2005 that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State (Medicaid) Plan. TPL also includes the Coordination of Benefits (COB) cost avoidance and COB recovery. Under Section 1902(a)(25) of the Social Security Act, the DHCFP is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid and CHIP recipient.

For the DHCFP's contracts with MCOs, subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.

The MCO shall act as the State's authorized agent for the limited purpose of TPL collection, within the limitation of the Fair Debt Collection Practices Act, 15 USC § 1692, of all TPL pursuant to 42 CFR § 433.135 et seq and 42 CFR 433.147. The MCO's capitated payments include an offset in the rates for these collections. The MCO shall vigorously pursue billing prior resources and report their TPL and subrogation collection results to the DHCFP quarterly, as these amounts are considered part of their capitation.

MCOs are required to secure signed acknowledgements from enrolled Medicaid recipients or their authorized representative for any prior resources (Medicare, worker's compensation, private insurance, and similar resources). The MCO must pursue TPL in accordance with 42 CFR 433.139. The MCO must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and CHIP recipients. The MCO is responsible for not only pursuing third party resources that it identifies but also for pursuing third-party resources identified and communicated to the MCO by the DHCFP. All information on the third party, including collections and collection attempts, are to be reported to the DHCFP (including circumstances under which the third party refuses to pay) on the Third Party Quarterly Report Form.

The DHCFP will monitor and evaluate the MCO's TPL and subrogation collection reports to validate collection activities and results. The MCO will then be expected to meet or exceed baseline target collections as determined by the DHCFP and its actuaries. If the MCO does not meet or exceed baseline TPL and subrogation collections, the DHCFP will conduct a review to

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determine if there is a legitimate reason. If there is no legitimate reason as determined by the Division, the difference between baseline and actual collections will be deducted from the MCO's costs before the data is used to set future rates. The DHCFP will prospectively adjust capitation rates downward to account for expected TPL collections.

The vendor is required to obtain TPL information independently of the DHCFP for the purpose of avoiding claim payments or recovering payments made from liable third parties. TPL recovery may be incorporated into the capitated rate development by the DHCFP and its actuary. The vendor has 365 days from claim paid date to recover the TPL payment; after 365 days, the vendor forfeits the right to recovery to the State unless the vendor can provide evidence that the recovery effort is active and/or in dispute.

3603.24 PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES

Pursuant to Section 6505 of the ACA, which amends Section 1902(a) of the Social Security Act (the Act), the vendor shall not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States (U.S.).

Payments for items or services provided under the State Plan to financial institutions or entities such as provider bank accounts or business agents located outside of the U.S. are prohibited by this provision. Further, this Section prohibits payments to telemedicine providers located outside of the U.S. Additionally; payments to pharmacies located outside of the U.S. are not permitted.

Any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the U.S. may be recovered by the State from the Vendor.

For purposes of implementing this provision, Section 1101(a) (2) of the Act defines the term "United States" when used in a geographical sense, to mean the "States." Section 1101(a)(1) of the Act defines the term "State" to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

The phrase, "items or services provided under the State Plan or under a waiver" refers to medical assistance for which the State claims Federal funding under section 1903(a) of the Act. Tasks that support the administration of the Medicaid State Plan that may require payments to financial institutions or entities located outside of the U.S. are not prohibited under this statute. For example, payments for outsourcing information processing related to Plan administration or outsourcing call centers related to enrollment or claims adjudication are not prohibited under this statute.

3603.25 MANAGEMENT INFORMATION SYSTEM (MIS)

- A. The MCO shall operate the MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report MCO's compliance with the

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contract requirements. The MCOs must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for the MCO's requirement.

- B. The MCO shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to the Health Insurance Portability and Accountability Act (HIPAA). The MCO shall provide the DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data from network providers. The MCO shall submit its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations.
- C. The MCO shall have internal procedures to ensure that data reported to the DHCFP are valid and to test validity and consistency on a regular basis.
- D. Eligibility Data
 - 1. The MCO enrollment system shall be capable of linking records for the same enrolled recipient that are associated with different Medicaid and/or NCU identification numbers; e.g., recipients who are re-enrolled and assigned new numbers.
 - 2. At the time of service, the MCO or its subcontractors shall verify every enrolled recipient's eligibility through the current electronic verification system.
 - 3. The MCO shall update its eligibility database whenever enrolled recipients change names, phone numbers, and/or addresses, and shall notify the DHCFP of such changes.
 - 4. The MCO shall notify the DHCFP of any enrolled recipients for whom accurate addresses or current locations cannot be determined and shall document the action that has been taken to locate the enrolled recipients. The MCO shall immediately notify the DHCFP of the births and known deaths of all enrolled recipients.
- E. Encounter and Claims Records
 - 1. The encounter data reporting system should be designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities. The MCO shall use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.

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2. The MCO shall collect and submit service specific encounter data in the appropriate CMS 1500, UB04 and the appropriate ADA Dental Claim format or an alternative format if prior approved by the DHCFP. The data shall be submitted in accordance with the requirements set forth by the American National Standards Institute (ANSI), Accredited Standards Committee (ASC), Electronic Data Interchange (EDI) standards in current use and in the Reporting Guide of the current DHCFP Managed Care Contract. The data shall include all services reimbursed by Medicaid.

F. EPSDT Tracking System

The MCO shall operate a system that tracks EPSDT activities for each enrolled Medicaid eligible child by name and Medicaid identification number. The system shall allow the MCO to report annually on the CMS 416 reporting form. This system shall be enhanced, if needed, to meet any other reporting requirements instituted by CMS or the DHCFP.

3603.26 REPORTING

Adequate data reporting capabilities are critical to the ability of CMS and the DHCFP to effectively evaluate the DHCFP's Managed Care Programs. The success of the Managed Care Program is based on the belief that recipients will have better access to care, including preventive services, and will experience improved health status, outcomes, and satisfaction with the health care delivery system. To measure the program's accomplishments in each of these areas, the MCO must provide the DHCFP and/or its contractors with uniform utilization, cost, quality assurance, and recipient satisfaction and grievance/appeal data on a regular basis. It must also cooperate with the DHCFP in carrying out data validation steps.

The MCO is required to certify the data including, but not limited to, all documents specified by the State as required in the Reporting Guide of the current DHCFP Managed Care Contract, enrollment information, encounter data, and other information contained in contract proposals, as provided in 42 CFR 438.606. The data must be certified by the MCO's Chief Executive Officer (CEO), the MCO's Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.

The MCO must meet all reporting requirements and timeframes as required in the Reporting Guide of the current DHCFP Managed Care Contract unless otherwise agreed to in writing by both parties. Failure to meet all reporting requirements and timeframes as contractually required and all attachments thereto may be considered to be in default or breach of said contract.

a. Encounter Reporting

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Contracted MCOs must submit encounter data for all recipients and all claims paid and denied in accordance with current ANSI, ASC, EDI standards and requirements in the Reporting Guide of the current DHCFP Managed Care Contract, to include any revisions or additions which contain information regarding encounter data, including the DHCFP's media and file format requirements, liquidated damages and submittal timeframes. The MCO must assist the DHCFP in its validation of encounter data.

b. Summary Utilization Reporting

The contracted MCO shall produce reports using the Healthcare Effectiveness Data and Information Set (HEDIS), as specified in the current DHCFP Managed Care Contract. The MCO must submit these reports to the DHCFP in a timely manner pursuant to contract requirements in addition to the other reports required by this contract.

c. Dispute Resolution Reporting

Contracted MCOs must provide the DHCFP with monthly reports documenting the number and types of provider disputes, recipient grievances, appeals and fair hearing requests received. Reports must be submitted within 45 business days after close of the quarter to which they apply.

These reports are to include, but not be limited to, the total number of recipient grievances, the total number of notices provided to recipients, the total number of recipient and appeals requests, and provider disputes filed, including reporting of all subcontractor's recipient grievances, notices, appeals and provider disputes. The reports must identify the recipient grievance or appeal issue or provider dispute received; and verify the resolution timeframe for recipient grievances and appeals and provider disputes.

Comprehensive recipient grievance and appeal information, fair hearing requests, and provider dispute information, including, but not limited to, specific outcomes, shall be retained for each occurrence for review by the DHCFP.

d. Quality Assurance Reporting

Studies will be performed by the contracted MCOs pursuant to guidelines established jointly by the MCOs, the DHCFP, and the External Quality Review Organization (EQRO) as well as those identified in the current DHCFP Managed Care Contract. In addition, the MCO must provide outcome-based clinical reports and management reports as may be requested by the DHCFP. Should the MCO fail to provide such reports in a timely manner, the DHCFP will require the MCO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions.

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e. Recipient Satisfaction Reporting

Each contracted MCO must collect and submit to the DHCFP a statistically valid uniform data set measuring recipient satisfaction prior to the third quarter of each contract year, unless the requirement is waived by the DHCFP due to an EQRO performed survey. This may be done in conjunction with the MCO's own satisfaction survey. The DHCFP may request a specific sample, and/or survey tool, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

Survey results must be disclosed to the State, and, upon State's or enrollee's request, disclosed to enrollees.

f. Financial Reporting

The MCO must meet the financial reporting requirements set forth in the Reporting Guide of the current DHCFP Managed Care Contract including any revisions or additions to the document.

g. Fraud and Abuse Reporting

The MCO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. These arrangements or procedures must include the following:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;
2. The designation of a compliance officer and a compliance committee that are accountable to senior management;
3. Effective training and education for the compliance officer and the organization's employees and subcontractors;
4. Effective lines of communication between the compliance officer and the organization's employees and the rights of employees to be protected as whistleblowers must be included in any employee handbook;
5. Enforcement of standards through well-publicized disciplinary guidelines;
6. Provision for internal monitoring and auditing;
7. Provision for prompt response to detected offenses and for the development of corrective action initiatives relating to the MCO's contract; and

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8. Instructions and details of how to report Fraud and Abuse in the Member Handbook.

The MCO and its subcontractors must provide immediate notification to the DHCFP regarding all suspected recipient and provider fraud and abuse.

Upon the MCO's awareness of any disciplinary action or sanction taken against a network provider or any suspected fraud or abuse, the MCO shall immediately inform the DHCFP.

These reporting requirements shall be included in all MCO subcontracts.

h. Other Reporting

The MCO shall be required to comply with additional reporting requirements upon the request of the DHCFP. Additional reporting requirements may be imposed on the MCO if the DHCFP identifies any area of concern with regard to a particular aspect of the MCO's performance under the current DHCFP Managed Care Contract. Such reporting would provide the DHCFP with the information necessary to better assess the MCO's performance.

3603.27 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

- A. The MCO will be required to provide compatible data in a DHCFP prescribed format for the following functions:
 1. Enrollment;
 2. Eligibility;
 3. Provider Network Data;
 4. PCP Assignment;
 5. Claims Payment; and
 6. Encounter Data.

The MCO must provide an interface with all applicable systems to provide the DHCFP, providers and recipients access to appropriate data.

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- B. Current Environment – A description of the current functional requirements for the following systems can be found in the current MMIS Contract and supporting documentation located at the DHCFP.
1. Enrollment;
 2. Eligibility;
 3. Provider Network Data;
 4. PCP Assignment;
 5. Claims Payment; and
 6. Encounter Data.
- C. The MCO must provide encounter data report files in prescribed data fields to the DHCFP's encounter data processing agent on a monthly basis. The DHCFP will provide the required data fields and data transfer instructions upon execution of the contract.
- D. The MCO is required to provide encounter data from all providers. It is the MCO's responsibility to require this data and enforce the requirement from their providers.

3603.28 SANCTIONS

Pursuant to 42 CFR 438.726, the State has developed a plan to monitor MCO acts and failures to act as specified in Subpart I, 42 CFR 438 and to implement provisions of this subpart. The State will monitor MCO activities to validate:

- a. the extent to which the MCO provides the covered medically necessary services required under the contract with the State;
- b. the imposition of any cost sharing;
- c. the basis of disenrollment or refusal to enroll a recipient;
- d. the accuracy of information furnished by the MCO to CMS or the State and its designees;
- e. the accuracy of information furnished to an enrollee, potential enrollee, or health care provider;
- f. compliance with physician incentive plans as required in the contract;

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- g. prior approval of marketing materials and the accuracy of information provided therein; and
- h. compliance with sections 1903(m) and 1932 of the Act.

The State's monitoring activities include contract requirements which include, but are not limited to, recipient and provider satisfaction surveys, review and confirmation of all financial reports and encounter data, the collection of enrollment and disenrollment reporting data, State prior approval of all MCO policies/procedures as well as all marketing materials proposed by the MCO for distribution, and review and approval of all base provider contracts. If the State determines the MCO violates any prohibition listed in 42 CFR 438.700, the State will provide written notice to CMS of any imposition of sanctions or remedies taken against the MCO pursuant to 42 CFR 438.724(b).

The State will implement provisions of this Subpart through remedies under the MCO contract, which include:

- i. civil penalties in the amounts specified in 42 CFR 438.704;
- j. appointment of temporary management for the contractor as provided in 42 CFR 438.706;
- k. granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- l. suspensions of all new enrollments, including default enrollment, after the effective date of the sanction;
- m. suspension of payment for recipients enrolled after the effective date of the sanction until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or
- n. any additional sanctions allowed under State statute or State regulations that address areas of non-compliance specified in 42 CFR 438.700 as well as additional areas of non-compliance. Additional sanctions may include liquidated damages and imposition of plans of correction in addition to its remedies at law.

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3604 GRIEVANCES, APPEALS AND HEARINGS

The Managed Care Organization (MCO) shall establish a system for enrollees that include a grievance process, an appeal process, and access to the State Fair Hearing system.

a. Enrollee Grievances and Appeals

The MCO's grievance and appeal system must be in writing and submitted to the Division of Health Care Financing and Policy (DHCFP) for review and approval at the time the MCO policies and procedures are submitted. The DHCFP will refer all enrollee grievances and appeals to the MCO for resolution. The MCO must provide information about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. The MCO is required to provide access to state fair hearings in the event an enrollee's MCO appeal is not resolved wholly in favor of the enrollee. An enrollee may file for an MCO appeal or grievance either orally or in writing. A provider, acting on behalf of the enrollee and with the enrollee's written consent, may also file an appeal.

1. Action

The MCO must provide standard authorization decisions as expeditiously as the enrollee's health requires and within the State's established timelines that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or, the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the enrollee's interests.

For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide a Notice of Decision (NOD) as expeditiously as the enrollee's health condition warrants and no later than three working days after receipt of the request for service. The MCO may extend the three working days time period by up to 14 calendar days if the enrollee requests an extension or if the MCO justifies (to the State, upon request) a need for additional information and how the extension is in the enrollee's interest.

2. Notice of Decision (NOD)

The MCO must provide a NOD to the requesting provider and the enrollee when the MCO takes adverse action or makes an adverse determination. Pursuant to 42 Code of Federal Regulations (CFR) 438.404(b) and §438.210(c) the NOD must explain:

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- a. The action the MCO or its contractor has taken or intends to take; for expedited appeal resolution requests, the MCO is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.

The MCO is required to maintain records of grievances and appeals, which the State will review as part of the State's quality strategy.

3. State Fair Hearings Process

The State Fair Hearing process is described in Medicaid Services Manual (MSM) Chapter 3100. An enrollee, enrollee's representative or the representative of a deceased enrollee's estate has the right to request a State Fair Hearing when they have exhausted the MCO's appeal system without receiving a wholly favorable resolution decision. The request for a State Fair Hearing must be submitted in writing within 90 calendar days from the date of the MCO's final NOD. The MCO will participate as the State Contractor in the State fair hearing process requested by their enrollees. The MCO is bound by the decision of the Fair Hearing Officer or the court system if the hearing officer's decision is appealed.

4. Continuation of Benefits While the MCO and the State Fair Hearing are Pending

The MCO must continue the enrollee's benefits if the enrollee or provider files the appeal in a timely manner. Timely means filing the appeal on or before the later of the following: within ten days of the MCO mailing the NOD or not more than ten days after the date of action or intended effective date of the MCO's proposed action according to 42 CFR 431.231. In addition, pursuant to 42 CFR 438.420, the MCO must continue benefits if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and if the services were ordered by an authorized provider; and if the original period covered by the original authorization has not expired; and, if the enrollee requests an extension of benefits.

If, at the enrollee's request, the MCO continues the enrollee's benefits, the benefits must be continued until one of the following occurs:

- a. The enrollee withdraws the appeal;
- b. Ten calendar days after the MCO mails the NOD, providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten day timeframe has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached;

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- c. A State Fair Hearing Officer issues a hearing decision adverse to the enrollee; or
- d. The time period of service limits of a previously authorized service has been met.

If the final resolution of the appeal is adverse to the enrollee, the MCO may recoup the cost of the services furnished to the enrollee, from the recipient or beneficiary, while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with policy set forth in 42 CFR431.230 (b).

If the MCO or Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires. If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO or the State must pay for those services in accordance with State policy and regulations.

3604.1 PROVIDER DISPUTE AND DISPOSITION

The MCO must have an alternative dispute resolution process to dispose of provider disputes including, but not limited to, quality of plan service, policy and procedure issues, denied claims, claim processing time, and other disputes. The written procedures must be submitted to the DHCFP for review and approval at the time the MCO policies and procedures are submitted. The process must include, but not be limited to:

- a. The MCO's final decision to be issued, in writing, no later than 30 days after the provider files the dispute;
- b. A written record in the form of a file or log is to be maintained by the MCO for each provider dispute to include a description of the dispute, date filed, dates and nature of actions taken and final resolution; and,
- c. The MCO shall refer provider appeals to the DHCFP for fair hearings on matters of Medicaid provider enrollment or termination. Matters other than Medicaid provider enrollment or terminations may not be referred for fair hearings until the MCO's dispute resolution process has been exhausted. The DHCFP will not provide fair hearings for contract disputes between the provider and the MCO.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 14, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3800 – CARE MANAGEMENT ORGANIZATION AND
MEDICAL/HEALTH HOMES

BACKGROUND AND EXPLANATION

This is a new Medicaid Services Manual (MSM) Chapter developed for a Care Management Organization (CMO) and Medical/Health Homes. This chapter will outline the requirements and policies under which the vendor is expected to function and perform.

Currently, there is a portion of the Medicaid population whose care is unmanaged. This includes recipients with chronic conditions and those that frequently have high cost/high utilization patterns for medical services that are avoidable by a holistic care management program. The Centers for Medicare and Medicaid Services (CMS) approved the Nevada Comprehensive Care Waiver (NCCW) on June 28, 2013 to the Division of Health Care Financing and Policy (DHCFP) to implement a CMO.

The CMO will assist in linking the recipient to additional community resources helping them overcome potential barriers the recipient may have in maintaining their health. This program will coordinate with the recipients' primary care physicians and provide integrated medical, behavioral and social care management services and monitor care transitions.

These changes are effective November 15, 2013.

MATERIAL TRANSMITTED

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CHAPTER 3800 – CARE MANAGEMENT
ORGANIZATION AND HEALTH HOMES

MATERIAL SUPERSEDED

MTL N/A
N/A – NEW CHAPTER

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3800	Whole Chapter	New Care Management Organization and Health Homes Chapter has been created.

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3800 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) recognizes many individuals who are at risk of hospitalization due to chronic conditions. To assist individuals at risk for costly medical care and connect them to preventative care, the DHCFP has developed a Care Management Organization (CMO) program under the Nevada Comprehensive Care Waiver (NCCW). The CMO program is part of the NCCW program adopted by the State of Nevada within the Section 1115 Research and Demonstration Waiver granted by the Secretary of Health and Human Services. The CMO program is intended to develop another delivery method for care management to targeted recipients that do not currently have any form of care management in the Medicaid Fee-for-Service (FFS) system. The program is targeted at recipients that have chronic conditions, co-morbidities, high-cost and/or high-utilization patterns.

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3801 AUTHORITY

Under authority granted by Nevada Revised Statute (NRS) 422, the Division of Health Care Financing and Policy (DHCFP) has obtained authority under Section 1115 of the Social Security Act that provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. It is intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. The State of Nevada, under Section 1115, has been approved to implement Nevada’s Care Management Organization (CMO) program, under the Nevada Comprehensive Care Waiver (NCCW). This project is funded under Title XIX of the Social Security Act.

The CMO must meet all requirements of the NCCW, as approved by Centers for Medicare and Medicaid Services (CMS). This includes additional requirements or modifications to the NCCW by CMS throughout the life of the NCCW.

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3803 POLICY

3803.1 COVERED SERVICES

No enrolled recipient shall receive fewer services in the Care Management Organization (CMO) program than they would receive in the current Nevada State Plan under Fee-for-Service (FFS).

The CMO provides additional coordination of medical and behavioral health services for targeted recipients in the Nevada Medicaid FFS program. The CMO will perform integrated medical, behavioral and social case management with enrollees. The CMO does not provide any medical diagnosis or make any form of a medical determination for the recipient.

3803.2 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of the Division of Health Care Financing and Policy (DHCFP) and the Division of Welfare and Supportive Services (DWSS). The CMO shall accept each recipient who is enrolled in or assigned to the CMO program by the DHCFP and/or its enrollment sections and/or for whom a payment has been made by the DHCFP to the CMO.

a. Enrollment Process

The DHCFP will work with the CMO to identify Medicaid recipients who meet the criteria for enrollment in the CMO. The DHCFP will provide data files to the CMO on a reoccurring basis.

Prior to enrolling any members in the CMO program, the DHCFP and the vendor must agree on the algorithm used to identify targeted recipients. Once the algorithm has been agreed to by both parties, the vendor will submit a sample list of enrollees to the DHCFP using the algorithm at least 45 days prior to enrolling members. This list must be verified by the DHCFP's contracted actuary prior to enrolling members.

b. Non-Discrimination in Enrollment

The CMO must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the Contract. The CMO will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The CMO will not deny the enrollment nor discriminate against any Medicaid recipients eligible to enroll on the basis of race, color, national origin, religion, sex, age, disability (including HIV/AIDS or related conditions) or any other class status protected by federal or state law or regulation by programs receiving Federal Financial Participation (FFP).

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c. Auto-Assignment Process

Medicaid recipients, who meet the targeted conditions defined in Section 3803.3, will be assigned to the CMO program. The CMO acknowledges that enrollment is mandatory for covered recipients except in the case of allowable disenrollments defined in Section 3803.2.e.

d. Automatic Reenrollment

A recipient who is disenrolled from the CMO solely because he or she loses Medicaid eligibility will be auto-assigned with the CMO once the recipient regains eligibility, if the recipient still meets the CMO program criteria.

e. Disenrollment Requirements and Limitations

1. A recipient who is enrolled in the CMO on a mandatory basis may request disenrollment from the CMO program in order to enroll with a Nevada Medicaid qualified Medical Home/Health Home Provider, if any have been established and approved by the DHCFP. The recipient is required to notify the DHCFP of his/her decision to disenroll and, as a mandatory recipient, will be instructed to select a Medical Home/Health Home provider, if one is available. The DHCFP will document the basis of the recipient's request to disenroll. If the recipient is to be enrolled with a Medical Home/Health Home Provider, the new provider will receive electronic notification of the enrollment.
2. The Awarded vendor must abide by all provisions outlined in 42 Code of Federal Regulations (CFR) 438.56. Except for enrollment with a Medical Home/Health Home provider, a recipient who is enrolled in care management through the CMO on a mandatory basis may only request disenrollment from the CMO for good cause. Good cause for disenrollment is determined solely by the DHCFP and will be determined on a case-by-case basis. An example of good cause would be the transition to a medical/health home. The recipient is required to notify the DHCFP of his/her request to disenroll. The DHCFP will document the basis of the recipient's request to disenroll and make a decision.

If the DHCFP determines the request for disenrollment should first be pursued through the grievance process, the DHCFP will refer the request to the CMO. After the CMO has completed the grievance process and reported the resolution to the DHCFP, the DHCFP will make the determination on the recipient's request for disenrollment. If the DHCFP determines the disenrollment request does not need to be pursued through the grievance process, the DHCFP will provide a notice of decision within 30 days. If the request for disenrollment is approved by the DHCFP, the DHCFP will confirm with the recipient the effective date of disenrollment from the CMO based on the administrative cutoff date.

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3. The CMO may request disenrollment of a recipient if the continued enrollment of the recipient seriously impairs the CMO's ability to furnish services to either this particular recipient or other recipients. In addition, the CMO must confirm the recipient has been referred to the CMO's Enrollee Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem. Prior approval by the DHCFP of the CMO's request for the recipient's disenrollment is required. If approval is granted, the recipient will be given notice by the CMO that disenrollment will occur effective the first day of the next month following administrative cut off. The DHCFP will make a determination on such a request within ten working days. In the event the DHCFP fails to make a disenrollment determination within the timeframes specified, the disenrollment shall be considered approved.
4. The CMO may not request disenrollment of a recipient for any of the following reasons:
 - a. An adverse change in the recipient's health status;
 - b. Pre-existing medical condition;
 - c. The recipient's utilization of medical services;
 - d. Diminished mental capacity;
 - e. Uncooperative or disruptive behavior resulting from his/her special needs (except when continued enrollment of such a recipient seriously impairs the CMO's ability to furnish services to either this particular recipient or other recipients as provided for in section 3803.2.e.3);
 - f. A recipient's attempt to exercise his/her grievance or appeal rights;
 - g. Based on the recipient's national origin, creed, color, sex, religion, age or other factors pursuant to Section 3803.2 and applicable CFR's; or
 - h. A finding of Seriously Emotionally Disturbed (SED) or Severely Mentally Ill (SMI) status or Children with Special Health Care Needs (CSHCN) or the recipient is receiving Mental Health Services.
5. The CMO must have written policies and procedures in place that describe the process to respond to an enrollee who contacts the CMO to request disenrollment. All disenrollments will be determined solely by the DHCFP, except those disenrollment requests by American Indian/Alaskan Natives. If a Nevada Medicaid (Title XIX) eligible American Indian/Alaskan Native elects to disenroll from the CMO Vendor, the disenrollment will be automatic and commence no later than the first day of the second administrative month after which notice is

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provided.

6. The CMO must maintain a waiting list any time it is not enrolling individuals into the program due to reaching the CMS and/or contract maximum allowable number of enrollees at any one time. Potential enrollees will be placed on the waiting list in chronological order of the determination of the individual's eligibility. As enrollment space becomes available, either through attrition or an increase in enrollment, the CMO will re-examine the waiting list, beginning with the individual who has been on the list the longest and continuing in chronological order, to determine if the potential enrollee still meets the program eligibility criteria. Following confirmation of program eligibility, the CMO must work with the DHCFP to notify the individual of his or her enrollment in the program. The CMO must establish the waiting list process in their policy and procedures and submit to the DHCFP for approval.

f. Enrollment, Disenrollment and Other Updates

The CMO must have written policies and procedures for receiving monthly updates from the DHCFP of recipients enrolled in, and disenrolled from, the CMO program, and other updates pertaining to these recipients.

g. Less Than Full Month Enrollment

The DHCFP shall, at its sole discretion, have the ability to enroll Medicaid recipients into, or disenroll Medicaid recipients from, the care management program at any time. In such case where the effective date of enrollment or disenrollment with the CMO is not the first day of the month due to the DHCFP's actions, the CMO could receive a pro-rated payment in accordance with Section 3803.10.

3803.3 ELIGIBLE GROUPS

A. Mandatory CMO Program Enrollees

The CMO program includes the Medicaid eligibility categories of Aged, Blind and Disabled (ABD), Family Medical Category (FMC) which includes Temporary Assistance for Needy Families (TANF), Child Health Assurance Program (CHAP), Parents and Other Caretaker Relatives, Pregnant Women, Infants and Children under age 19, Former Foster Care Children, Transitional Medical, and Post Medical assistance groups in the FFS populations. This population served by the CMO encompasses Medicaid recipients who are high utilizers of treatment, have at least one chronic condition or a serious and persistent mental health condition as defined by the International Classification of Diseases (ICD). The CMO must use the current version of the ICD being used by the DHCFP. The following conditions are eligible for the program:

1. Asthma;

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2. Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis and Emphysema;
3. Diabetes Mellitus;
4. End Stage Renal Disease (ESRD) and Chronic Kidney Disease (CKD);
5. Heart Disease and Coronary Artery Disease (CAD);
6. Neoplasm/tumor;
7. Obesity;
8. Mental Health Disorders including: dementia, psychotic disorders, anxiety disorders, psychosis, paranoia, bipolar disorder, schizophrenia, amnesia, delirium and mood disorders;
9. Substance Use Disorder;
10. HIV/AIDS;
11. Musculoskeletal system: diseases including: osteoarthritis, spondylosis, disc displacement, Schmorl's Nodes, disc degeneration, disc disorder with and without myelopathy, postlaminectomy syndrome, cervical disorders, spinal stenosis, spondylolisthesis, nonappopathic lesion, fracture of the femur and spinal sprain;
12. Pregnancy; and
13. Complex Condition/High Utilizer: individuals with complex conditions incurring high treatment costs exceeding \$100,000 per year in claims.

B. Medicaid Recipients Exempt from CMO Program

Certain Medicaid recipients are excluded from enrollment in the CMO. These recipients include:

1. Recipients who are dually eligible for Medicaid and Medicare coverage (i.e. dual eligibles);
2. Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act (SSA);
3. Recipients of Medicaid Home and Community-Based Services (HCBS) Waiver case management services;
4. Recipients of Medicaid covered targeted case management;

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5. FMC, including TANF and CHAP recipients in service areas that require enrollment in a Medicaid Managed Care Organization (MCO);
6. Recipients enrolled in the State’s Title XXI Children’s Health Insurance Program (CHIP), entitled to Nevada Check Up (NCU);
7. Recipients enrolled in the Intellectual Disabilities/Developmental Disabilities (ID/DD or MR/DD) Section 1915 (c) Waiver;
8. Individuals receiving emergency Medicaid; and
9. Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID).

C. Voluntarily Enrolled CMO Program Recipients:

Although the following Medicaid recipients are exempt from mandatory enrollment in the CMO, they are allowed to voluntarily enroll in the CMO if they choose:

1. Native American Indians, with eligible qualifying conditions, who are members of federally recognized tribes except when the MCO is the Indian Health Service (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS.

3803.4 CHANGE IN A RECIPIENT’S STATUS

The CMO must require a recipient report any changes in the recipient’s status immediately to the DWSS eligibility worker, including family size and residence. The CMO must provide the DHCFP with notification of all deaths. Within seven calendar days of becoming aware of any changes in a recipient’s status, including changes in residence, the CMO must electronically report the change(s) to the DHCFP.

3803.5 TRANSITIONING RECIPIENTS INTO CARE MANAGEMENT

The CMO is responsible for recipients as soon as they are enrolled. The CMO must have policies and procedures for transitioning recipients who are currently receiving certain services in the FFS system with chronic illness into the CMO program. The CMO must have policies and procedures including, without limitation, the following to ensure a recipient’s smooth transition to enrollment with the CMO:

- a. Recipients with medical conditions such as:
 1. Pregnancy;

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2. Major organ or tissue transplantation services in process;
 3. Terminal illness; and/or
 4. Intractable pain.
- b. Recipients who, at the time of enrollment, are receiving:
1. Chemotherapy and/or radiation therapy;
 2. Significant outpatient treatment or dialysis;
 3. Prescription medications or Durable Medical Equipment (DME); and/or
 4. Other services not included in the State Plan but covered by Medicaid under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for children under Title XIX and Title XXI of the SSA.
- c. Recipients who at enrollment:
1. Are scheduled for inpatient surgery(ies);
 2. Are currently in the hospital;
 3. Have prior authorization for procedures and/or therapies for dates after their enrollment; and/or
 4. Have post-surgical follow-up visits scheduled after their enrollment.

3803.6 TRANSFERRING RECIPIENTS BETWEEN MANAGED CARE PROGRAMS

- A. It may be necessary to transfer a recipient from the CMO program to another managed care program for a variety of reasons. When notified that an enrollee has been transferred to another managed care program, the CMO must have written policies and procedures for transferring/receiving relevant patient information, medical records and other pertinent materials to the health plan, Medical Home/Health Home provider, if available, or other managed care program.
- B. Prior to transferring a recipient, the CMO must send the receiving plan or provider information regarding the recipient's condition. This information shall include the nature of the enrollee's chronic illness, nature of care management services received through the CMO, the designated CMO care manager's name and phone number, and name and

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phone number of the Primary Care Physician (PCP), as well as the following information, without limitation, as to whether the recipient is:

1. Hospitalized;
2. Pregnant;
3. Receiving dialysis;
4. Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment;
5. On an apnea monitor;
6. Receiving behavioral or mental health services;
7. Receiving Nevada Early Intervention Services in accordance with an Individualized Family Service Plan (IFSP), which provides a case manager who assists in developing a plan to transition the child to the next service delivery system;
8. Involved in, or pending authorization for, major organ or tissue transplantation;
9. Scheduled for surgery or post-surgical follow-up on a date subsequent to transition;
10. Scheduled for prior authorized procedures and/or therapies on a date subsequent to transition;
11. Receiving care from or referred to a specialist(s);
12. Receiving substance abuse treatment;
13. Receiving prescription medications;
14. Receiving durable medical equipment or currently using rental equipment; and/or
15. Currently experiencing health problems.

3803.7 MEDICAL RECORDS

- A. Appropriate medical records shall be maintained by the CMO for each enrolled recipient. Medical records may be on paper or electronic. The CMO must take steps to promote maintenance of medical records in a legible, current, detailed, retrievable organized and comprehensive manner that permits effective patient care and quality review.

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B. The CMO shall establish standards for enrollee medical records. The records reflect all aspects of care management, including incorporation of health care service delivery information. These standards shall, at a minimum, include requirements for:

1. Patient Identification Information – Each page on electronic file in record contains the patient’s name or patient ID number;
2. Personal/Demographic Data – Personal/biographical data includes: age, sex, race, address, employer, home and work telephone number and marital status;
3. Entry Date – All entries are dated;
4. Provider Identification – All entries are identified as to author;
5. Legibility – The record is legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer;
6. Allergies – Medication allergies and adverse reaction are prominently noted on the record. Absence of allergies (No Known Allergies (NKA)) is noted in an easily recognizable location;
7. Past Medical History – Past medical history is easily identified including serious accidents, operations and illnesses. For children, past medical history relates to prenatal care and birth;
8. Immunization for Pediatric Records (ages 20 and under) – there is a completed immunization record or a notation that immunizations are up to date with documentation of specific vaccines administered and those received previously or (by history);
9. Diagnostic Information;
10. Medication Information;
11. Identification of Current Problems – Significant illnesses, medical conditions and health maintenance concerns are identified in the medical record;
12. Smoking, Alcohol or Substance Abuse – Notation concerning cigarettes, alcohol and substance abuse is present;
13. Consultations, Referrals and Specialist Reports – Notes from any consultations are in the record. Consultation involving significantly abnormal lab and imaging study results have an explicit notation in the record of follow-up plans;
14. Emergency Care;

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15. Hospital Discharge Summaries – Discharge summaries are included as part of the medical record for:
 - a. All hospital admissions that occur while the patient is enrolled with the CMO; and
 - b. Prior admissions, as available.

16. Advance Directives – For medical records of adults, the medical record documents whether or not the individual has executed an advance directive and documents the receipt of information about advance directives by the recipient and confirms acknowledgment of the option to execute an advance directive. An advance directive is a written instruction such as a living will or durable power of attorney for health care relating to the provision of health care when the individual is incapacitated; and

17. Enrollee Care Management Interventions – Documentation of individual encounters must provide adequate evidence of, at a minimum:
 - a. Plan of Care (POC);
 - b. Assessment and periodic reassessment;
 - c. Consultation with the PCP and other members of the Health Care Team;
 - d. Education and other targeted interventions directly with the enrollee;
 - e. Referrals and results thereof; and
 - f. All other aspects of care management, including ancillary services.

- C. The CMO shall have written policies and procedures to maintain the confidentiality of all medical records and for sharing medical records when an enrolled recipient changes PCPs or transfers between managed care programs.

- D. The CMO shall assist the enrollee or the parent/legal guardian of the enrollee in obtaining a copy of the enrollee’s medical records pursuant to Nevada Revised Statute (NRS) 629.061. Records shall be furnished in a timely manner upon receipt of such a request but not more than 30 days from the date of request. Each enrollee or parent/legal guardian of the enrollee is entitled to one free copy of the requested medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile copy.

- E. The CMO must have a system for record review to assess the content of medical records for legibility, organization, completion and conformance to the DHCFP’s standards.

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F. The records shall be available for review by duly authorized representatives of the Secretary of the United States Department of Health and Human Services (the Secretary), the DHCFP, or agents thereof. Not more than ten calendar days after submitting a request, the State shall have access to an enrollee’s medical record, whether electronic or paper, and has the right to obtain copies at the CMO’s expense.

1. The CMO shall have policies and procedures, subject to the DHCFP’s approval, related to retention and disposal of medical records in accordance with Medicaid Services Manual (MSM) Chapter 100, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and applicable NRS.

3803.8 INFORMATION REQUIREMENTS

The CMO must have written information about its services and access to services available upon request to enrollees and potential enrollees. This written information must also be available in the prevalent non-English languages, as determined by the State, in its particular geographic service area. The current prevalent languages are English and Spanish. The CMO must make free, oral interpretation services available to each enrollee and potential enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent. All written material directed to enrollees and potential enrollees shall be approved by the DHCFP prior to distribution.

The CMO is required to notify all enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages. The CMO must notify all enrollees and potential enrollees how to access this information.

The CMO’s written material to enrollee’s and potential enrollee’s must use an easily understood format not to exceed an eighth grade reading level. The CMO must also develop appropriate alternative methods for communicating with visually and hearing-impaired enrollees, and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All enrollees and potential enrollees must be informed that this information is available in alternative formats and how to access those formats. The CMO will publish materials for enrollees and potential enrollees on the CMO’s website upon contract implementation and will update the website, as needed, to keep materials current. The CMO is responsible for effectively informing Title XIX Medicaid and Title XXI NCU enrollees who are eligible for EPSDT services.

The CMO must abide by all marketing regulations outlined in 42 CFR 438.104.

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The CMO must work with the DHCFP to develop and send a Notice of Enrollment letter prior to beginning services to all new enrollees, including new enrollees who are added throughout the length of the program.

a. Enrollee Handbook

1. The CMO must provide all enrollees with an Enrollee Handbook. The handbook must be written at no higher than an eighth grade reading level and must conspicuously state the following in bold print:

“THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE CARE MANAGEMENT ORGANIZATION AND THE ENROLLEE.”

2. The CMO must submit the Enrollee Handbook to the DHCFP before it is published and/or distributed. The DHCFP will review the handbook and has the sole authority to approve or disapprove the handbook and the CMO’s policies and procedures. The CMO must agree to make modifications in handbook language if requested by the DHCFP, in order to comply with the requirements as described above or as required by the Centers for Medicare and Medicaid Services (CMS) or State law. In addition, the CMO must maintain documentation that the handbook is updated at least once per year. Thereafter, annual updates must be submitted to the DHCFP for approval before publication and/or distribution.
3. The CMO must furnish the handbook to all enrollees within five business days of receiving notice of the recipient’s enrollment and must notify all enrollees of their right to request and obtain this information at least once per year or upon request. The CMO will also publish the Enrollee Handbook on the CMO’s internet website upon contract implementation and will update the website, as needed, to keep the Enrollee Handbook current. At a minimum, the information enumerated below must be included in the handbook:
 - a. Explanation of services, how to obtain those services and access to them, including the address and telephone number of the CMO’s office or facility, and the days the office or facility is open and services are available; this includes the definition of an emergency medical condition, as well as how to access emergency services at all times, regardless if that provider has a relationship with the CMO;
 - b. The role of the PCP and description of the CMO’s process for confirmation of the enrolled recipient’s selection of a PCP and the process for assisting the enrolled recipient in finding a PCP. The CMO’s care manager will have access to the FFS provider lists and will be able to assist the enrollee with selecting a provider based on the recipient’s needs,

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including diagnosis, location, cultural competency (spoken language), specialty, and any Americans with Disabilities Act (ADA) modifications (as necessary);

- c. Enrollee and disenrollment rights and protections, including information of the CMO's grievance procedures required in Section 3804 and the enrollee's right to be treated respectfully with dignity and privacy and receive information on alternative treatment options in a manner they can understand;
 - d. Information on procedures for recommending changes in policies and services;
 - e. To the extent available, quality and performance indicators, including enrollee satisfaction;
 - f. The CMO must provide adult enrollees with written information on advance directives policies and include a description of applicable State law. This information must reflect changes in State law as soon as possible but no later than 30 days after the effective date of the change. The CMO must ensure that a signed copy of the DHCFP's "Acknowledgment of Patient Information on Advance Directives" form is included in the recipient's medical record. (A sample form is available online at <http://dhcfp.state.nv.us/advancedirectives.htm>);
 - g. The Enrollee Handbook must include a distinct section for eligible recipients which explains the EPSDT program and includes a list of all the services available to children; a statement that services are free and a telephone number which the enrollee can call to receive assistance in scheduling an appointment; and
 - h. The CMO must give each enrollee written notice of any significant change, as defined by the DHCFP, at least 30 days in advance of the intended effective date of the change, in any of the enumerations noted above. The CMO shall issue updates to the Enrollee Handbook as directed by the DHCFP when there are material changes that will affect access to services and information about the Care Management Program.
- b. Client Identification and Prioritization
- 1. The CMO must establish and maintain a system for prioritizing the target population by risk and level of need to determine how to tailor care intervention.

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2. At a minimum, the CMO must employ tools and strategies to stratify the target population, as provided by the DHCFP, which shall include, but may not be limited to, the following:
 - a. Diagnostic classification methods that assign primary and secondary chronic conditions to enrollees;
 - b. Predictive models that identify enrollees at risk for future high utilization, adverse events, and/or costs based upon the detailed administrative data; and
 - c. Stratification of enrollees that incorporates health risk assessment into predictive modeling in order to tier enrollees into high need categories for intensive/face-to-face intervention.
3. The CMO must document their predictive modeling processes for stratifying the enrolled population by current and future risk level. The CMO must identify the specific risk classification method or methods (e.g., Chronic Illness and Disability Payment System, Hierarchical Condition Categories, other) to be used and how results of health risk assessments will factor into risk stratification.

c. Enrollee Assessment

1. The CMO must determine each enrollee's needs for care and for coordination, including physical, as well as social situation, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services.
2. The CMO must conduct a comprehensive assessment of each enrollee which, at a minimum, shall include, but may not be limited to, the following:
 - a. Review and analysis of all claims data;
 - b. Verification of primary language, and communication or mobility accommodations;
 - c. Collection of additional/alternative phone number(s) and email(s);
 - d. Assessment/establishment of a routine source of care, which may include verification of a PCP identified through claims analysis;
 - e. Standardized general health screening/subjective evaluation of health;
 - f. Assessment of readiness to change;

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- g. Lifestyle assessment (nutrition, physical activity);
 - h. Functional assessment;
 - i. Depression screening;
 - j. Substance abuse screening;
 - k. Medication inventory, including over-the-counter (OTC) and prescription use;
 - l. Identification of medical conditions which are likely to trigger special health assessments; and
 - m. Evaluation of home/social environment for levels of common environmental triggers.
3. The CMO must document their assessment processes, including whether the CMO will use a single comprehensive assessment or separate assessments performed over a defined period of time. The CMO should also specify any standardized assessment instruments (e.g., Chronic Illness and Disability Payment System, Hierarchical Condition Categories, etc.) to be used. The CMO should provide samples of enrollee assessments for similar care management programs for Medicaid populations.
- d. Primary Care Provider Selection
- 1. The CMO is responsible for establishing a usual source of primary care for all enrollees. Upon initial assessment, the CMO must validate the enrollee's PCP or facilitate the selection of a PCP if the enrollee does not have a routine source of primary care.
 - 2. The CMO must have a process to facilitate the PCP selection among enrollees, including analytical methods to assess whether an enrollee has a routine source of primary care identified from administrative data and methods for validating PCP when interacting with enrollees during the assessment process.
 - 3. The CMO will provide counseling to those enrollees who do not have a routine PCP in order to facilitate selection of a PCP by those enrollees. In assisting an enrollee in the selection of a PCP, the CMO will consider the following criteria:
 - a. Providers from whom they have previously received services, as evidenced by a receipt of a claim for services rendered by a PCP to the enrollee if the information is available in claims data;

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- b. Providers who are geographically accessible to the enrolled recipient per Nevada Administrative Code (NAC) 695C.160 (25 Mile Rule);
 - c. Providers who act as a PCP to other family members as appropriate;
 - d. Providers who are experienced in treating the chronic condition(s) known by the CMO;
 - e. Providers who are willing to serve as PCPs; and
 - f. Providers ability to meet the recipient's needs in terms of diagnostic, location, cultural competency (spoken language), specialty and any ADA modifications (as necessary).
4. The CMO shall send written confirmation of the enrollee PCP selection within five business days of verification. The CMO must also provide notice to each PCP, either electronically, telephonically or by mail, within five business days of the CMO verification of PCP selection. The CMO must establish and implement a mechanism to inform each PCP about all enrollees that have selected the provider as their PCP on at least a monthly basis.
 5. The CMO shall not assign enrollees to PCPs but must provide enrollees who do not have a routine source of primary care information about the importance of establishing a PCP.
 6. An enrolled recipient may change a PCP for any reason. The CMO shall notify enrolled recipients of procedures to notify the CMO of PCP changes. The materials used to notify enrolled recipients shall be approved by the DHCFP prior to publication and/or distribution.
 7. In cases where the CMO has been informed that a PCP has been terminated by the DHCFP, the CMO must notify enrolled recipients in writing within 15 business days of the receipt of Provider Data Files from the DHCFP in order to facilitate selection of another PCP.
- e. Care Plan Development
1. The CMO must establish and maintain a care plan, jointly created and managed by the Health Care Team defined in Section 3803.8.e.2 which outlines the enrollee's current and expected needs and goals for care, and identifies coordination gaps. The plan is designed to fill gaps in coordination, establish care for enrollees and, in some cases, assist in establishing set goals for the enrollee's providers. Ideally, the care plan anticipates routine needs and tracks current progress toward enrollee goals.

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2. The Health Care Team involved in the development of a care plan must consist of a multi-disciplinary care planning team which, at a minimum, includes:
 - a. The enrollee and/or the enrollee's designee;
 - b. A care manager, assigned by the CMO to the enrollee to oversee and coordinate chronic care management activities;
 - c. The enrollee's identified PCP;
 - d. A Nevada licensed psychiatrist, psychologist or a Nevada licensed/certified mental health specialist based on identified client needs;
 - e. A pharmacist based on identified client needs;
 - f. A nutritionist based on identified client needs; and
 - g. Other key clinicians and caregivers identified as necessary to the enrollee's care.
3. The CMO must document their process for care plan development and monitoring, including the composition of a multi-disciplinary care planning team. The CMO must also specify criteria for when an enrollee's Health Care Team may require inclusion of a licensed psychiatrist, psychologist or licensed/certified mental health specialist, a pharmacist and/or a nutritionist to participate in care plan development.
4. The CMO must establish and maintain mechanisms for the enrollee and/or the enrollee's designee to be actively involved in the development of a care plan and participate fully in decision-making regarding the enrollee's care.
5. The CMO must establish and maintain mechanisms for the enrollee's PCP and other treating providers to be actively involved in the development of a care plan and ensuring the enrollee's PCP is informed in advance of all proposed interventions conducted by the CMO, when possible.
6. The CMO must establish and maintain mechanisms to coordinate with treating providers and the CMO's Medical Director.
7. The CMO must establish and maintain mechanisms for appropriate referral and scheduling assistance for enrollees needing specialty health care or transportation services.
8. The CMO, subject to the DHCFP's approval, may develop and implement a payment mechanism to PCPs for care plan input and/or approval.

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9. The CMO must, jointly with the enrollee/designee, periodically assess progress toward care and coordination goals and monitor care delivery and coordination. The CMO must refine the care plan as needed to accommodate new information or circumstances and to address any issues impacting the care plan through follow-up care on behalf of the enrollee.
10. The CMO must establish and maintain mechanisms for care plan monitoring and reassessment in which the frequency of review/reassessment is driven by severity of the enrollee's condition and/or direction from the enrollee's PCP.
11. The CMO must establish and maintain mechanisms for the enrollee or the enrollee's designee, the PCP, CMO Care Manager and other members of the Health Care Team to be actively involved in periodic reviews of the care plan.
12. The CMO must provide feedback to the enrollee's PCP and/or other treating provider(s) regarding the enrollee's adherence to the care plan.
13. The CMO must monitor referral and follow-up of enrollees in need of specialty care and routine health care services.
14. The CMO must include medication monitoring in its approach to care plan monitoring and reassessment for all enrollees.
15. The CMO must routinely provide and collect pertinent clinical information to and from the enrollee's PCP.
16. The CMO must provide feedback on gaps between recommended care and actual care received by the enrollee to the enrollee's PCP and/or other treating provider(s).
17. The CMO must monitor and provide reminders to enrollees and the enrollee's PCP and/or other treating provider(s).
18. The CMO must facilitate care manager selection among enrollees between a minimum of not less than two care managers. The care managers must be registered nurses. Enrollees may change care managers at any time.

f. Disease Management Interventions

1. The CMO must establish and implement a program targeted to the chronic population with such diseases as cardiac arterial disease, chronic heart failure, chronic obstructive pulmonary disease, diabetes mellitus and asthma. These conditions are long-lasting and the CMO's management strategy must be

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appropriate based on the enrollee's age and severity of the underlying conditions based on risk stratification required in Section 3803.8.b.

2. The CMO must use, to the extent available, health information technology and health information exchange, claims, eligibility and other non-administrative source of data (like self-reported information from enrollees) to create information on various gaps-in-care, such as medication non-adherence, screening/testing non-compliance, and preventative care like physician visits annually for covered chronic conditions. The CMO must coordinate with the enrollee and the enrollee's PCPs and/or other responsible providers to address the gap in care identified, including medication non-adherence.
3. The CMO must provide health coaching to facilitate behavioral changes by the enrollees to address underlying health risks such as obesity or weight management.
4. The CMO must provide one-to-one health coaching using licensed clinical professionals, and may also use online coaching tools, to set up targets and intervention actions that can lead to fulfillment of enrollee goals.

g. Care Management Interventions

1. The CMO must establish and implement a program of clinical care management interventions due to escalating acute care needs of people with high risks. This must include typical co-morbid conditions. The CMO must provide nurse-intensive interventions over a defined period of time to resolve exacerbation from co-morbid conditions impacting enrollee health care issues.
2. The CMO must document, in detail to the DHCFP, how it provides care management interventions, including: the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO is intervening with the enrollees; the co-morbid conditions being addressed; the expected duration of services; and, how the CMO is collaborating with various provider types, including PCPs, specialists and other providers in the provision of these services.

h. Complex Condition Management

1. The CMO must establish and implement a program for enrollees with certain types of conditions such as transplants, burn, and other high-cost, high-risk conditions. Enrollees must be targeted early enough in their disease or condition to improve their health outcomes and reduce or prevent further progression of the disease or condition. The management of these enrollees is very nurse-intensive

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and addresses not only relatively rare types of conditions, but also those enrollees which involve a very high treatment cost, often exceeding \$100,000 per year.

2. The CMO may identify enrollees for this program who are contemplating more invasive procedures or treatments which do not have well documented treatment protocols and represent significant variations in care for such treatments. The CMO may educate enrollees regarding various options which may lead to equal or better outcomes than the one that the enrollee is contemplating.
 - i. Oncology Management Program
 1. The CMO must identify enrollees for this program that can be only managed in a program which focuses on specific-cancer related treatment protocols. This program may refer patients to certain defined facilities or networks of providers. The CMO must work intensively with identified enrollees through multiple interactions conducted by a nurse expert in oncology treatment protocol and specialty.
 2. The CMO must document, in detail, how it provides oncology management program interventions, including: the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO Health Care Team is intervening with the enrollees; how the CMO Health Care Team is collaborating with various provider types in the provision of these services; and how the CMO Health Care Team has established a defined network of facilities and providers for referral and coordination.
 - j. Chronic Kidney Disease Program
 1. The CMO must identify enrollees with Chronic Kidney Disease (CKD) for case management. Case management is expected to retard the progression of the disease and delay the need for dialysis or transplant, and help to prepare enrollees for dialysis therapy in the least costly setting. The CMO shall implement interventions to include education with regard to options for treatment, diet, lifestyle changes and preparation for dialysis including dialysis access placement and in-patient or home dialysis options, standardized evidence-based care pathways and coordinated care processes and protocols which may be accomplished through referrals to, and coordination with a defined network of providers.
 2. The CMO must document, in detail, how it provides CKD program interventions, including: the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO is intervening with the enrollees; how the CMO is collaborating with various provider types in

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the provision of these services; and how the CMO has established a defined network of facilities and providers for referral and coordination.

k. Mental Health Program

1. The CMO must identify enrollees for this program who have a serious and persistent mental health condition, acute mental health problems or mental health co-morbidity associated with acute and/or chronic conditions.
2. The CMO Health Care Team must complete an initial assessment and provide follow-up management for behavioral issues like depression and other psychiatric problems that hamper patients' ability to cope with acute and chronic conditions effectively.
3. For individuals who have a mental health condition, the CMO Health Care Team shall promote communication between PCPs and behavioral health providers to help ensure that services are coordinated, that duplication is eliminated, and that coordination supports primary care based management of psychiatric medications as medically appropriate.
4. The CMO Health Care Team shall take affirmative steps to ensure the prevention of readmission to hospitals of enrollees with a mental health condition. These approaches and activities must be documented, in detail.
5. The CMO Health Care Team shall take affirmative steps to ensure that enrollees with a mental health condition have access to evidence-based mental health treatment and mental health rehabilitative services, such as Assertive Community Treatment (ACT) and other models supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the establishment of referral protocols and treatment guidelines.
6. The CMO must document, in detail, how it provides: mental health program interventions, including the criteria for which enrollees receive this service; the minimum frequency of contact by risk level and manner by which the CMO Health Care Team is intervening with the enrollees; how the CMO Health Care Team is collaborating with various provider types, including PCPs, behavioral health providers and other providers in the provision of these services; how the CMO is promoting coordination and integration of medical and behavioral health care; and how it is promoting access to evidence-based behavioral health services.

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1. **Maternity and Neo-Natal Program**

1. The State may identify enrollees in order to manage pregnant mothers in the earliest trimester(s) to manage risk factors for a better outcome both before and after the birth. The CMO shall implement interventions to reduce incidence and severity of preterm births through pre-natal education, pre-natal care management and education and proactive case management of pregnancies. The program assists enrollees by facilitating access to maternal and child health programs.

m. **Enrollee Education**

1. The CMO must have a health education system that includes programs, services, functions and resources necessary to provide health education, health promotion and patient education.
2. The CMO must provide health education, health promotion and patient education for all enrollees which, at a minimum, shall include, but may not be limited to, the following:
 - a. Assistance and education about appropriate use of health care services;
 - b. Assistance and education about health risk-reduction and healthy lifestyle including tobacco cessation;
 - c. Education to encourage use of the CMO's nurse call services;
 - d. Assistance and education about self-care and management of health condition, including coaching;
 - e. Assistance and education about EPSDT, for Title XIX enrollees under age 21 and Title XXI enrollees through the age of 18;
 - f. Assistance and education about teen pregnancy, maternity care programs and services for pregnant women; and
 - g. Assistance and education about any new services the DHCFP implements.
3. The CMO must establish and maintain an internet website at which the enrollees can access health information and evidence-based health education.
4. The CMO must provide health education materials in formats easily understood by the client population and written no higher than an eighth grade reading level

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reflecting cultural competence and linguistic abilities.

5. The CMO shall use, to the greatest extent practical, existing materials from state disease councils and coalitions where applicable (such as the U.S. Department of Health and Human Services, the Agency for Healthcare Research and Quality).
6. The CMO must track the number of educational materials mailed to enrollees, as well as the number of returned items. The CMO must have mechanisms to address new/corrected address information for enrollees, recognizing that the DWSS may not update enrollee address information in the Nevada Operations of Multi-Automated Data System (NOMADS) or Medicaid Management Information System (MMIS).

n. Nurse Triage and Nurse Advice Call Services

Nurse Triage is the assessment and disposition of symptom-based calls. Nurse Triage call services do not involve making diagnoses by telephone. Nurses do not diagnose but rather collect sufficient data related to the presenting problem and medical histories, recognize and match symptom patterns to those in the protocol and assign acuity. Nurses provide for the safe, timely disposition of health-related problems. Nurse Triage aids in getting the enrollees to the right Level of Care (LOC) with the right provider in the right place at the right time by assessing the severity of the enrollee's symptoms and then guiding the enrollee to the appropriate LOC.

Nurse Advice is a telephonic information service that offers answers to general healthcare questions. Nurse Advice call services provide an opportunity to engage enrollees one-on-one about their health by providing general health information and self-care instructions, as well as guidance on whether to see a doctor and referrals to other appropriate health services.

The CMO must document the system of nurse call services, including clinically based protocols and mechanisms for physician backup. The CMO must document how nurse triage is distinguished from other nurse advice call services. The CMO must specify qualifications for nurse triage/nurse advice staff and include position descriptions for each type of nurse triage/nurse advice position that is employed.

1. The CMO must establish and implement a system to provide nurse call services 24 hours/7 days a week through a toll-free number accessible to all enrollees in the service area.
2. The CMO shall have a properly functioning toll free telephone number for enrollees to call to access nurse triage and nurse advice call services, and access other enrollee services and resources specified in Section 3803.8.q. Recipients

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shall not incur a charge for placing a call, other than those applicable for local calls.

3. The CMO must staff its call center with licensed Registered Nurses (RNs) who use clinically-based protocols for triage services provided to enrollees, including call back for all referrals made by the CMO's triage staff to self-care, urgent care, emergency room or 911. The CMO must provide physician access and back up for call center nurses at all times.
4. The CMO shall have sufficient and appropriate staff to handle all calls and provide nurse triage services in a timely, responsive and courteous manner. The staffing shall be adequate to fulfill the following standards of promptness and quality:
 - a. Ninety percent (90%) of telephone calls shall be answered within five rings;
 - b. A call pick-up system that places the calls in queue shall be used;
 - c. Blocked call rate (busy signal received) of five percent or less on an average daily basis; and
 - d. Ninety percent (90%) of calls in the queue shall be answered by a live operator in less than two minutes and measured on a daily basis.
5. The CMO shall install and maintain a functioning Automatic Call Distribution system (ACD) and call reporting system that records and aggregates the following information, at a minimum, on an hourly, daily, weekly and monthly basis for the call center as a whole and for individual operators:
 - a. Total number of incoming calls;
 - b. Number of answered calls by the CMO staff;
 - c. Average call wait time;
 - d. Maximum call wait time;
 - e. Percentage of calls answered by a live operator in under two minutes;
 - f. Average talk time;
 - g. Number of calls placed on hold and length of time on hold;

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- h. Number of abandoned calls and length of time until call is abandoned;
- i. Number of outbound calls; and
- j. Number of available operators by time.

This system should have the capability of automatically routing calls to back-up part-time operators when target wait times are exceeded. The CMO must document automatic call distribution system processes for monitoring and enforcing call center standards.

- 6. The CMO shall develop operational procedures, manuals, forms and reports necessary for the smooth operation of the nurse triage and nurse advice call services. A demonstration of the CMO's telephone system and staffing capability is required as part of the readiness review prior to the effective date of any CMO contract implementation.
 - 7. The CMO shall develop a complete monitoring, supervision, and enforcement plan to ensure that nurse triage and nurse advice call services performance and customer service standards are maintained. The DHCFP must have the ability to monitor calls on a random basis to ensure quality service is being offered. Callers will be notified that calls may be monitored.
- o. Continuity of Care Transitions
- 1. The CMO must establish and implement programs that facilitate specific transitions, which occur when information about or accountability for some aspect of an enrollee's care is transferred between two or more health care entities. Facilitation of such transitions by the CMO Health Care Team must be achieved through activities designed to ensure timely and complete transmission of information or accountability.
 - 2. The CMO must conduct provider outreach that shall target providers from the entire spectrum of medical care, including hospitals, PCPs, pharmacies and specialists in order to establish relationships and develop referral processes with, but not necessarily limited to, PCPs, discharge planners, facility staff and community agencies.
 - 3. The CMO Health Care Team must coordinate hospital discharge planning that includes post-discharge transition services designed to prevent avoidable re-hospitalizations by improving care coordination at the interfaces between care settings.

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4. The CMO must initiate care transition services no later than 24 hours prior to discharge and must establish and maintain mechanisms to encourage and track PCP follow-up within seven days of discharge and within 30 days of discharge.
5. The CMO must provide care transition services that are grounded on an evidence-based care transition model that, at a minimum, provides for:
 - a. Timely, culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;
 - b. Assistance to ensure timely and productive interactions between enrollees, the enrollee's PCP and other post-acute and outpatient providers;
 - c. Patient-centered self-management support and relevant information specific to the enrollee's condition; and
 - d. Comprehensive medication review and management including if appropriate, counseling and self-management support.
6. The CMO must document their care transitions programs, including provider outreach, collaboration in discharge planning and processes for encouraging and tracking follow-up PCP visits. The CMO must also specify evidence-based care transition interventions (e.g. Care Transitions Intervention, Transitional Care Model, other) to be used. The CMO must specify the degree to which care management staff is outposted at hospitals or other facilities and the CMO's approach to identifying targeted facilities and establishing outposted staff.

p. **Emergency Department Redirection Management**

The CMO must establish and implement programs that redirect inappropriate use from hospital Emergency Departments (EDs) for enrollees accessing EDs for non-emergent care that can be addressed in a primary care setting. The CMO's management of these enrollees must include linking ED users to PCPs, with appropriate follow-up and monitoring access patterns to primary care.

1. The CMO must document, in detail, how it provides ED redirection management programs, including the criteria for which enrollees receive this service, targeted communications to enrollees after identification of ED visits, methods for linking enrollees to PCPs for primary care, appropriate referral to disease, case or behavioral health management programs and, how the CMO Health Care Team will collaborate with various provider types, including PCPs and hospitals' EDs in the provision of these services. The CMO must specify the degree to which care

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management staff are outposted at hospital EDs and the CMO's approach to identifying targeted facilities and establishing outposted staff.

q. Linking to Community Resources

1. The CMO must provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support enrollees' health and wellness or meet their care goals.
2. The CMO must develop and maintain a directory of community resources available to assist enrollees. Community resources are services or programs outside the health care system that may support enrollees' health and wellness.
3. The CMO must establish and maintain mechanisms to assist enrollees with coordinating care for non-Medicaid covered services, which include determining the need for non-covered services and referring enrollees for intake and assessment, as appropriate.
4. The CMO must have an approach to linking enrollees to community resources, including processes for identifying additional resources available in the community that may benefit enrollees, maintaining and/or utilizing a directory of community resources (such as teaching and facilitating the use of Nevada 2-1-1, a community resource lifeline), and assisting enrollees in accessing non-Medicaid covered services.

r. Advance Directives Requirements

1. The CMO must have written policies and procedures consistent with Section 1902(w)(1) of the Social Security Act and the Patients Self-Determination Act of 1990, with respect to Advance Directives (AD) for all adult enrollees receiving care management from the CMO. Specifically, the CMO's policies and procedures must provide for:
 - a. Written information to each enrollee at the time of enrollment concerning the enrollee's rights, under State law, to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate ADs;
 - b. Documentation in the enrollee's medical record whether the enrollee has executed an advance directive;
 - c. Not conditioning the provision of care of otherwise discriminating against an individual based on whether or not the individual has executed an

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advance directive;

- d. Ensuring compliance with requirements of State laws regarding advance directives, including informing enrollees that any complaints concerning the advance directives requirements may be filed with the appropriate State agency which regulates the CMO; and
 - e. Educating CMO staff, PCPs and the community on issues concerning ADs, at least annually.
2. Sample AD policies, procedures and forms, as well as patient information concerning Nevada law are available on the DHCFP's website: <http://dhcfp.state.nv.us/advancedirectives.htm>.
 3. The CMO must have processes in place for informing enrollees of ADs and documenting whether enrollees have executed ADs.
- s. Enrollee Services Department
1. The CMO shall maintain an Enrollee Services Department (AKA Member Services Department) that is adequately staffed with qualified individuals who shall assist enrolled recipients, enrolled recipients' family members or other interested parties (consistent with HIPAA compliance and laws on confidentiality and privacy) in obtaining information and services.
 2. At a minimum, Enrollee Services Department staff must be responsible for the following:
 - a. Explaining the operation of the CMO;
 - b. Assisting enrollees in selecting and/or changing PCPs;
 - c. Explaining care management services and covered benefits;
 - d. Assisting enrollees to make appointments and obtain services;
 - e. Resolving, recording and tracking enrollee grievances in a prompt and timely manner; and
 - f. Responding to enrollee inquiries.
 3. While the Enrollee Services Department will not be required to operate after business hours, the CMO must provide for phone coverage 24 hours per day,

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seven days per week. The CMO must have written policies and procedures describing how to respond to enrollees in need of urgent care and emergency services after business hours and on weekends.

4. The Enrollee Services Department is to be operated at least during the hours of 8:00 AM to 5:00 PM (Pacific Time) Monday-Friday except national holidays. The CMO must specify the regular business hours for their Enrollee Services Department (at a minimum of 8:00 AM to 5:00 PM Pacific Time). The CMO may propose alternative hours, subject to approval of the DHCFP for operation of the Enrollee Services Department.
5. The CMO will work with the DHCFP to educate stakeholders, government agencies, providers and the community across the state of the CMO's program, both prior to enrolling recipients in the program and throughout the life of the contract. The DHCFP may accompany the CMO's representative on any or all of these meetings.

The CMO must submit a comprehensive provider and community outreach communication plan to the DHCFP for approval. The outreach plan must identify and include outreach activities to include:

- a. Individual and Group Providers;
- b. Community organizations including those who directly work with the target enrollee population;
- c. Hospitals;
- d. Health fairs;
- e. Public agencies; and
- f. Key stakeholders.

The outreach plan must include a detailed timeline for these activities which must include a combination of formal presentations and individual provider, organization and association meetings as well as targeted meetings with key stakeholders, public agencies and interested stakeholders. The CMO will develop this schedule in coordination with the DHCFP. The CMO must submit quarterly reports on the outreach program as well as plan for continued education to the DHCFP.

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3803.9 PROVIDER SERVICES

A. Provider Policy and Procedures

1. The CMO must prepare, subject to the approval of the DHCFP, a Provider Manual. The CMO shall document the approval of the Provider Manual by the CMO's Medical Director and shall maintain documentation verifying that the Provider Manual is reviewed and updated at least annually. The Provider Manual and subsequent updates must be approved by the DHCFP prior to distribution.
2. The CMO will also publish the Provider Manual on the CMO's internet website and will update the website, as needed, to keep the Provider Manual current. The manual shall include, at a minimum, the following information:
 - a. The policies and procedures to be implemented by the CMO Health Care Team that impact or require coordination with providers;
 - b. The procedures governing verification of recipient eligibility and the process for receiving and disseminating recipient enrollment data to participating providers;
 - c. The benefits and limitations available to enrollees under the Care Management Program; and
 - d. Policies and procedures to be implemented by the CMO to promote quality improvement and cost-effective enrollee service utilization.
3. The CMO must give each provider written notice of any significant change as defined by the DHCFP in any of the enumerations noted above. The CMO shall issue updates to the Provider Manual as directed by the DHCFP when there are material changes that will affect coordination with providers and information about the Care Management Program.

B. Provider Announcements and Notices

1. The CMO may, subject to the prior review and approval of the DHCFP, publish announcements, notices, newsletters or other information of use to providers. Any announcements, notices or newsletters must be published on the CMO's website.
2. The CMO must provide a draft copy of all announcements, notices and newsletters to the DHCFP for approval prior to publication and distribution. The DHCFP must prior approve all provider announcements, notices and newsletters,

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regardless of method of dissemination. If the DHCFP does not respond within 20 days the information will be considered approved.

C. Provider Education

1. The CMO must conduct comprehensive outreach and ongoing education campaigns reaching providers on utilizing current guidelines for prevention and treatment of chronic diseases in support of a Chronic Care Model. The CMO's education and training system for providers on use of evidence-based practice guidelines must at a minimum include:
 - a. Developing and/or disseminating guidelines to providers; and
 - b. Resource tools to facilitate the use of evidence-based practice guidelines by the providers.
2. The CMO must use designated practice guidelines and protocols mutually agreeable to the CMO and the DHCFP. Prior to the dissemination of any guidelines, the CMO shall identify the practice guidelines it intends to use and submit such guidelines to the DHCFP for approval. The DHCFP shall accept or reject within ten business days of receipt.
3. The CMO must adopt practice guidelines and protocols which:
 - a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - b. Consider the needs of the CMO's enrollees;
 - c. Are adopted in consultation with participating PCPs and other health care professionals in Nevada; and
 - d. Are reviewed and updated periodically as needed to reflect current practice standards.
4. The CMO, subject to the DHCFP's approval, may develop and implement a program of practice facilitation for providers identified as at-risk for non-compliance with evidence-based care guidelines.
5. The CMO's education and training system for providers must include:
 - a. Provider education on various types of chronic conditions and disabilities prevalent among Medicaid clients;

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- b. Provider education on physical, sensory, communication disabilities, developmental or mental health needs;
 - c. Provider education on evaluation and appropriate treatment or referral of mental health issues;
 - d. Provider education on Medicaid services authorization request processes;
 - e. Provider education on identification and utilization of community resources;
 - f. Provider education on scope of benefits, including how to refer people to services covered by other state agencies; and
 - g. Provider education on disability, cultural competency and sensitivity training.
6. The CMO must have a system for provider outreach and education, including approaches to offering Continuing Medical Education (CME) to providers. The CMO must specify educational material and other resource tools to promote evidence-based practice guidelines.
7. The CMO must have tools and resources that will help providers educate clients about self-management and empowerment.

D. Provider Feedback/Profiling

- 1. The CMO must establish and implement a performance-based program for assessing the professional behaviors of individual practitioners using established clinical guidelines. Provider profiling must be designed to influence future care patterns and to enhance health outcomes of individuals accessing services through reports and data on service utilization.
- 2. The CMO Health Care Team must provide feedback on gaps between recommended care and actual care received by the enrollees attributed to an identified PCP.
- 3. The CMO Health Care Team must provide feedback to the PCP regarding the enrollee's adherence to the care plan developed by the enrollee's Health Care Team.
- 4. The CMO must measure PCP's improvement of adherence to clinical guidelines and performance on a key process and outcome measures relative to chronic care

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management.

5. The CMO must identify and recognize providers with best practices and the best performance on use of clinical guidelines and achievement on key process and outcome measures relative to chronic care management.
 6. The CMO Health Care Team must identify, through assessment of utilization and other indicators, provider performance that suggests patterns of potential inappropriate utilization.
 7. The CMO, subject to the DHCFP's approval, may develop and implement pay-for-performance payment mechanisms to PCPs.
- E. The CMO must specify the degree to which care management staff is outposted at primary care practices to help manage enrollee care and the approach and activities used to identify targeted practices and establish outposted staff.
1. The CMO may maintain a program of practice facilitation for providers identified as at-risk for non-compliance with evidence-based care guidelines. If such a program is implemented, the CMO must document the qualification of practice facilitators; the approach to identifying targeted practices; the frequency and duration of interventions and the extent of activities to assist practices such as, enhancing documentation and delivery of clinical interventions, particularly preventive services, developing reminder systems for recalling and tracking patients, developing evidence-based behavioral interventions and implementing Health Information Technology (HIT). This program will require the DHCFP's approval prior to implementation.
 2. The CMO may maintain pay-for-participation program(s) with payment mechanisms to PCPs for certain activities such as enrollee care plan input and/or approval. The CMO may maintain a pay-for-performance program(s) with payment mechanisms to PCPs that encourage the achievement of quality targets. If such a program is implemented, the CMO must document the structure of such programs, who is eligible for incentives under such programs and the performance required to receive an incentive payment under such programs. This program will require the DHCFP's approval prior to implementation.
 3. The CMO shall operate a Management Information System (MIS) capable of maintaining, providing, documenting and retaining information sufficient to substantiate and report the CMO's compliance with the contract requirements. The CMO must facilitate the meaningful use of HIT and Health Information Exchange and make use of resources such as the Electronic Health Record (EHR) incentive program, Health Insight as Nevada's federally-designated EHR

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Regional Extension Center and the Department of Health and Human Services’
Office of Health IT, as appropriate.

3803.10 PAYMENT

Consideration shall be paid in a manner negotiated with the CMO. The DHCFP will review and may revise the rates periodically.

3803.11 MEDICAL/HEALTH HOME INFRASTRUCTURE ADMINISTRATION

- A. The CMO shall support and assist the DHCFP in its efforts to develop Patient-Centered Medical Homes (PCMHs) and comprehensive Medicaid health homes. CMS approval is required prior to the implementation of any PCMH program under the CMO. PCMHs are an approach to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual members and their personal providers and, when appropriate, the member’s family. The focus in this person-centered approach is on the person who has a disease or illness, and how the disease or illness impacts their life, rather than on the illness or disease itself. If implemented successfully, this approach results in better informed enrollees who are better able to participate in their care, ultimately leading to better clinical outcomes. The provision of medical homes may allow better access to health care, increase satisfaction with care and improve health. Health Homes are medical home providers who meet higher standards for care coordination and also function as comprehensive care management providers across behavioral, social and long-term care systems.

- B. The CMO shall support and assist the DHCFP in its efforts to develop PCMHs and comprehensive Medicaid health homes. CMS approval is required prior to the implementation of any PCMH program under the CMO. PCMHs are an approach to providing accessible, continuous, coordinated and comprehensive primary care that facilitates partnerships between individual members and their personal providers, and when appropriate, the member’s family. The focus in this person-centered approach is on the person who has a disease or illness and how the disease or illness impacts their life, rather than on the illness or disease itself. If implemented successfully, this approach results in better informed enrollees who are better able to participate in their care, ultimately leading to better clinical outcomes. The provision of medical homes may allow better access to health care, increase satisfaction with care and improve health. Health Homes are medical home providers who meet higher standards for care coordination and also function as comprehensive care management providers across behavioral, social and long-term care systems:
 - 1. Provide quality-driven, cost-effective, culturally appropriate and person-and family-centered health home services;

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2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports including referral to community, social support and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health care related needs and services;
10. Demonstrate a capacity and use HIT to link services, facilitate communication among team members and between the health team, individual and family caregivers and provide feedback to practices as feasible and appropriate; and
11. Establish a continuous quality improvement program, collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes and experience of care outcomes and quality of care outcomes at the population level.

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3803.12 PROGRAM REPORTING AND REVIEWS

The CMO must provide the DHCFP with uniform utilization, cost, quality assurance, recipient satisfaction and grievance data on a regular basis. It must also cooperate with the DHCFP in carrying out data validation steps.

a. Enrollee Stratification Reporting

The CMO must provide the DHCFP with monthly reports documenting the CMO's initial claims-based risk assignment of the Membership File showing a comprehensive stratification of the enrolled population. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or External Quality Review Organization (EQRO), as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Enrollee Stratification report prior to development of the first such report.

b. Enrollee Contact Reporting

The CMO must provide the DHCFP with monthly reports documenting the CMO's case management services rendered and encounters for all enrollees. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Enrollee Encounter report prior to development of the first such report.

c. Call Center and Nurse Triage Reporting

The CMO must provide the DHCFP with monthly reports documenting the CMO's call center statistics. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Call Center Statistical report prior to development of the first such report.

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d. **Provider Engagement Reporting**

The CMO must provide the DHCFP with monthly reports documenting the CMO's engagement with providers regarding care coordination for enrollees. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to the current CMO contract requirements in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Provider Engagement report prior to development of the first such report.

e. **Summary Enrollee Utilization Reporting**

The CMO must provide the DHCFP with annual reports documenting the patterns of health care service utilization among enrollees. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the Enrollee Service Utilization report prior to development of the first such report.

f. **Provider Profiling Report**

The CMO must provide the DHCFP with quarterly reports documenting the patterns of professional behaviors of individual practitioners using established clinical guidelines as required in Section 3803.9.D.

g. **Quality Assurance Reporting**

Quality-related studies will be performed by the contracted CMO pursuant to guidelines established jointly by the CMO, the DHCFP and the DHCFP's contracted EQRO, as well as those identified in the current CMO Contract. In addition, the CMO must provide outcome-based clinical reports and management reports as may be requested by the DHCFP. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements, in addition to the other reports required by the current CMO contract. Should the CMO fail to provide such reports in a timely manner, the DHCFP will require the CMO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions. The CMO must obtain the DHCFP's approval of the format and content of all Quality Assurance reports prior to development of the first such reports.

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h. Grievance, Complaint and Dispute Resolution Reporting

The CMO must provide the DHCFP with quarterly reports documenting the number and types of enrollee grievances, provider complaints and disputes received by the CMO Health Care Team. The content of these reports are pursuant to guidelines established by the CMO, the DHCFP and the DHCFP's contractors, including the DHCFP's contracted actuary and/or EQRO, as well as those components identified in the current CMO contract. The CMO must submit these reports to the DHCFP in a timely manner pursuant to current CMO contract requirements in addition to the other reports required by the current CMO contract. The CMO must obtain the DHCFP's approval of the format and content of the grievance and the complaint and dispute resolution report prior to development of the first such report. Comprehensive records pertaining to enrollee grievances, provider complaints and dispute information, including but not limited to, specific outcomes, shall be retained for each occurrence for review by the DHCFP.

i. Satisfaction Reporting

1. The CMO must collect and submit to the DHCFP a statistically valid uniform data set measuring recipient satisfaction in a timeline that meets CMS reporting requirements, unless the requirement is waived by the DHCFP due to an EQRO performed survey. This may be done in conjunction with the CMO's own satisfaction survey. The DHCFP may request a specific sample, and/or survey tool. Survey results must be disclosed to the State and, upon request, disclosed to enrollees.
2. The CMO must monitor enrollees and providers regarding satisfaction including completion of annual satisfaction surveys.

j. Fraud and Abuse Reporting

The CMO is responsible for informing the DHCFP of any suspected recipient fraud or abuse. The CMO must provide immediate notification to DHCFP Business Lines Unit and Surveillance and Utilization Review (SUR) Unit regarding all suspected recipient and provider fraud and abuse pursuant to 42 CFR 455.17. These reporting requirements shall be included in all CMO subcontracts.

k. Disenrollment Reporting

The CMO must submit a monthly report to the DHCFP on the number of program disenrollments and the reasons for disenrollment.

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l. Non-Compliance Reporting

The CMO must submit a monthly report to the DHCFP on the number of recipients who have been categorized as noncompliant.

m. Re-Assessment Reporting

The CMO must complete a demonstration eligibility re-assessment for beneficiaries already enrolled in the CMO at least annually. The CMO must report to the DHCFP the names of all individuals for whom a re-assessment is completed. The CMO must report to the DHCFP all individuals not referred for enrollment and the reason the individual was not referred.

n. Other Reporting

The CMO shall be required to comply with additional reporting requirements upon the request of the DHCFP. Additional reporting requirements may be imposed on the CMO if the DHCFP identifies any area of concern with regard to a particular aspect of the CMO's performance under the CMO Contract or if CMS requires any additional reports. Such reporting would provide the DHCFP with the information necessary to better assess the CMO's performance.

3803.13 OPERATIONAL REQUIREMENTS

A. Operating Structure and Staffing

1. The CMO must assure the DHCFP that the organization is adequately staffed with experienced, qualified personnel. The CMO shall provide the DHCFP with an updated organizational chart, every six months or whenever a significant change in the organization occurs. The organizational chart must follow guidelines established by the CMO and the DHCFP, as well as those components identified in the current CMO contract.
2. The CMO must have in place the organizational, management and administrative systems capable of fulfilling all contract requirements.

B. Subcontractors

The CMO must abide by all requirements related to subcontractors in the current CMO contract. The DHCFP reserves the right to review the form of all subcontracts, including administrative services. All subcontracts shall be submitted to the DHCFP for approval prior to their effective date.

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3803.14 MANAGEMENT INFORMATION SYSTEM (MIS)

- A. The CMO shall operate an MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report the CMO’s compliance with the current CMO contract requirements.
- B. The CMO shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The CMO shall provide the DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data to and from participating providers. The CMO shall submit its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations.
- C. The CMO shall have internal procedures to ensure that data reported to the DHCFP are valid and to test validity and consistency on a regular basis.
 - 1. The CMO shall ensure that the operation of its systems and handling of confidential information is performed in accordance with state and federal regulations related to security and confidentiality, and meet all privacy and security requirements of HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). All Protected Health Information (PHI) that is accessed, used, stored or transmitted shall be in accordance with HIPAA. Furthermore, all social security numbers, employer taxpayer identification numbers, drivers license numbers and any other numbers or information that can be used to access a person's financial resources are “personal identifying information” that must be protected in accordance with NRS.
- D. Eligibility and Claims Data
 - 1. The DHCFP or its fiscal agent will exchange eligibility and claims data and disenrollment data with the CMO. The CMO is required to establish and maintain an MIS that accurately captures recipient and provider data and that the operation of its systems and handling of confidential information is performed in accordance with state and federal regulations related to security and confidentiality, and meet all privacy and security requirements of HIPAA and the HITECH. All PHI that is accessed, used, stored or transmitted shall be in accordance with HIPAA.
 - 2. The CMO will utilize data maintained in its MIS to help determine what care management services are appropriate for each enrollee to receive and those enrollees and associated providers who should receive outreach services.

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3. The CMO's MIS shall be capable of linking records for the same enrolled recipient that are associated with different Medicaid identification numbers; (e.g., recipients who are re-enrolled and assigned new numbers).
4. The CMO shall update its MIS whenever enrolled recipients change names, phone numbers, and/or addresses and maintain such changes in its MIS.
5. The CMO's MIS must capture and store the provider, recipient, prior authorization, and claims data that is sent from the MMIS and/or other systems by the DHCFP or its fiscal agent.
6. The CMO's MIS system will store service utilization data regarding each enrollee/provider and perform analysis on the data that is captured and provide the DHCFP with analysis results via reports required in Section 3803.12.

E. Services and Contact Records

1. The CMO is required to establish and maintain an MIS that enables it to administer and manage the functions required in the current CMO contract. The CMO's MIS shall have an electronic tracking application that has the capability to track each contact made with an enrollee, enrollee's authorized designee or provider including phone calls, care management activities, clinical interventions and outcomes, profiling and education information, linkages and care coordination across providers and referrals.
2. The CMO's MIS must not overlay previous entries for tracking contact data. Once an entry has been captured [saved], any additional information must be treated as a new entry or additional comment. Each contact incident must be date/time stamped to create an audit trail.
3. The CMO's MIS shall identify/capture services provided to each enrollee (such as case management, disease management, care coordination, etc.) and transmit and report information to the appropriate parties.
4. The CMO's MIS must be capable of sharing health information with providers to ensure that all involved parties have a comprehensive picture of an enrollee's health status.
5. The CMO's MIS shall be capable of generating reports to the DHCFP as described in Section 3803.12. The system must also have the functionality to provide ad hoc reports.

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6. The CMO must document MIS reporting capabilities to include description of all standard reports available and processes for defining and producing ad hoc reports.

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3804 GRIEVANCES, APPEALS AND FAIR HEARINGS

The Care Management Organization (CMO) shall establish a system for enrollees, which includes a grievance process. The appeal process and access to the State Fair Hearing system is administered by the Division of Health Care Financing and Policy (DHCFP). The CMO shall establish a similar system to resolve disputes with providers. The CMO must provide information about these systems to enrollees at the time of enrollment and to providers and subcontractors. The CMO must submit to the DHCFP quarterly reports that document the grievance activities. The CMO is required to maintain records of grievances, complaints and disputes, which the State will review as part of the State's quality strategy.

a. Enrollee Grievances

1. A grievance is an expression of dissatisfaction about any matter. Possible issues for grievances include, but are not limited to, access to services, quality of services, interpersonal relationships between the CMO staff and enrollees and failure to respect an enrollee's rights.

The CMO's enrollee grievance system must be in writing and submitted to the DHCFP for review and approval at the time the CMO's Policies and Procedures are submitted and at anytime thereafter when the CMO's enrollee grievances policies and procedures have been revised or updated (not including grammatical or readability revisions or updates). The CMO may not implement any policies and procedures concerning its enrollee grievance system without first obtaining the written approval of the DHCFP. Grievances are not eligible for referral to the State Fair Hearing process.

An enrollee may file a grievance either orally or in writing. If a grievance is filed orally, the CMO is required to document the contact for tracking purposes and to establish the earliest date of receipt. There is no requirement to track routine telephone inquiries. For tracking purposes, an oral grievance is differentiated from a routine telephone inquiry by the content of the inquiry.

2. An enrollee or an enrollee's representative (including a provider on behalf of an enrollee) may file a grievance directly with the DHCFP. However, such grievances will be referred to the CMO for resolution.
3. In handling grievances, the CMO must meet the following requirements:
 - a. Acknowledge receipt of each grievance;
 - b. Ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision-making; and

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c. Ensure that the individuals who make decisions on grievances have the necessary levels of experience and authority.

4. In handling grievances, the CMO must meet the following requirements:

a. The CMO is required to dispose of, and resolve, each grievance within the State's established timeframes specified as follows:

1. Standard disposition of grievances: The CMO is allowed no more than 90 days from the date of receipt of the grievance.

b. An enrollee or an enrollee's representative (including a provider on behalf of an enrollee) may file a grievance directly with the DHCFP. However, such grievances will be referred to the CMO for resolution. In the event a provider files a grievance on the enrollee's behalf, the provider must first obtain the enrollee's written permission.

c. The CMO must keep a written or electronic record of each filed grievance to include a description of the issue, the date filed, the dates and nature of actions taken and the final resolution.

b. Notice of Decision/Handling of Appeals

The DHCFP provides a written notice of action to the enrollee when the DHCFP takes action or makes an adverse determination affecting the enrollee, per Medicaid Services Manual (MSM) Chapter 100, "Medicaid Program".

For certain actions, an enrollee may have the right to appeal. Information on the appeals process is located in MSM Chapter 3100, "Hearings,".

c. Handling of Provider Complaints and Disputes

The CMO must document how they have established and maintained a system for addressing provider complaints and disputes, including processes for accepting, tracking and disposing of complaints and disputes from providers.

1. The CMO must establish and maintain a process to resolve any provider complaints and disputes that are separate from, and not a party to, grievances submitted by providers on behalf of enrollees.

2. Written procedures must be included, for review and approval, at the time the CMO policies and procedures are submitted to the DHCFP and at anytime thereafter when the CMO's provider complaint and dispute policies and

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procedures have been revised or updated. The CMO may not implement any policies and procedures concerning its provider complaint and dispute system without first obtaining the written approval of the DHCFP.

3. The CMO must accept written or oral complaints and disputes that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP. The CMO must staff a provider services unit to handle provider complaints and disputes.
4. The CMO must keep a written or electronic record in the form of a file or log for each provider complaint or dispute to include the nature of it, the date filed, dates and nature of actions taken and final resolution.
5. The CMO must resolve eighty percent (80%) of written, telephone or personal contacts within 30 calendar days of the date of receipt.
6. The CMO must resolve one hundred percent (100%) of written, telephone or personal contacts within 90 calendar days of the date of receipt.

d. **Enrollee Rights**

The vendor must maintain policies and procedures regarding enrollee rights and protections. The vendor must demonstrate a commitment to treating recipients in a manner that acknowledges their rights and responsibilities. This must include the enrollee's right to be treated with respect and due consideration for his or her dignity and privacy, as well as their right to receive information on their health options in a manner appropriate to the enrollee's condition and ability to understand.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 12, 2012

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE *M. Stagliano*
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3900 – HOME AND COMMUNITY – BASED WAIVER
(HCBW) FOR ASSISTED LIVING

BACKGROUND AND EXPLANATION

MSM Chapter 3900 has been revised to update language regarding criminal background checks. References to NRS 449.176 to 449.188 were removed as these references do not include waiver providers. This requirement was re-worded to be consistent with the background check policy noted in MSM Chapter 100.

Changes are effective July 13, 2012.

MATERIAL TRANSMITTED

MTL 18/12
CHAPTER 3900 – HOME AND
COMMUNITY – BASED WAIVER
(HCBW) FOR ASSISTED LIVING

MATERIAL SUPERSEDED

MTL 29/10
CHAPTER 3900 – HOME AND
COMMUNITY – BASED WAIVER (HCBW)
FOR ASSISTED LIVING

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3903.3B.5	All Provider Responsibilities – Criminal Background Checks	Removed references to NRS 449.176 to NRS 449.188 as these references do not include waiver providers. Clarified the existing language to match the background check policy in MSM Chapter 100.

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3900 INTRODUCTION

The Home and Community-Based Waiver for Assisted Living (AL Waiver) recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes or communities, preserving independence and ties to family and friends at a cost no higher than that of institutional care.

Division of Health Care Financing and Policy's (DHCFP) AL Waiver originated in 2006. The provision of the AL Waiver services is based on the identified needs of the waiver recipient. Every biennium, the service needs and the funded slot needs of the AL Waiver are reviewed by the Aging and Disability Services Division (ADSD) and the DHCFP, and presented to the Nevada State Legislature for approval. The state of Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization and to be self sufficient. The state of Nevada also understands that people who are elderly are able to lead satisfying and productive lives when appropriate services and supports are provided.

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3901 AUTHORITY

Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. The Home and Community-Based Waiver for Assisted Living (AL Waiver) is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The AL Waiver is designed to provide Medicaid State Plan services and certain extended Medicaid covered services unique to this waiver to eligible Medicaid waiver recipients. The goal is to allow recipients to live in a community setting when appropriate.

Nevada has the flexibility to design the AL Waiver and select the mix of Home and Community-Based Waiver (HCBW) services that best meet the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support as well as federal approval.

Statutes and Regulations:

- Social Security Act: 1915(c) (Home and Community-Based Waiver)
- Social Security Act: 1916(e) (No denial for inability to share costs)
- Social Security Act: 1902(w) (Eligibility)
- Omnibus Budget Reconciliation Act of 1987
- Balanced Budget Act of 1997
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- State Medicaid Manual, Section 4440 (Home and Community-Based Waiver, Scope, and Purpose)
- Title 42 Code of Federal Regulations (CFR) Part 431, Subpart B (General Administrative Requirements)
- Title 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Recipients)
- Title 42 CFR 440.40
- Title 42 CFR 440.169 (Case Management Services)

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- Title 42, CFR Part 441, Subparts G and H (Home and Community-Based Services: Waiver Requirements; Home and Community-Based Services Waivers for Individuals Age 65 or Older: Waiver Requirements)
- Title 42 CFR 441.305(a) (Replacement of Recipients in Approved Waiver Programs)
- Title 42 CFR 489, Subpart I (Advance Directives)
- Title 42 CFR 440.155 (Nursing Facility Services)
- Nevada's Home and Community-based AL Waiver Control Number 0452
- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person); 232 (Department of Health and Human Services); 319 (Assistance to Finance Housing); 422, (Health Care Financing and Policy); 427A (Services to Aging Persons); 439 (Fund for a Healthy Nevada); 449 (Medical and Other Related Facilities); 616A (Industrial Insurance Administration); 629 (Healing Arts Generally)
- Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 449 (Medical and Other Related Facilities); 441A.375 (Tuberculosis)

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3903 POLICY

The Home and Community-Based Waiver (HCBW) for Assisted Living (AL Waiver) waives certain statutory requirements and offers HCBW services to all recipients enrolled in this waiver to assist them to remain in the community.

Division of Health Care Financing and Policy (DHCFP) must provide assurance to Centers for Medicare and Medicaid Services (CMS) that the state's total expenditures for HCBW services and other Medicaid State Plan services for all recipients will not exceed, in any waiver year, 100 percent of the amount that would be incurred by Medicaid for all these recipients in an institutional setting in the absence of the waiver. DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

3903.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

Administrative case management activities are performed by the Aging and Disability Services Division (ADSD) case managers and refer to data collection for eligibility verification, Level of Care (LOC) evaluation, Plan of Care (POC) development, and other case management activities that are not identified on the POC.

3903.1A COVERAGE AND LIMITATIONS

1. Intake referral;
2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application, obtaining documents required for eligibility determination;
3. Provision of the written POC document to the Assisted Living provider;
4. Complete prior authorization form prior to submission to Medicaid Management Information Systems (MMIS);
5. Determine cost effectiveness of waiver services for each applicant;
6. Monitor Assisted Living providers to assure compliance with the AL Waiver provider goals and provision of services;
7. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:
 - a. Complete recipient's reassessment of the LOC, functional status and needs addressed by the POC annually or more often as needed. The recipient must also

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be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment should be conducted during a face-to-face visit.

- b. The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.
8. Arrange for the relocation of the recipient, if necessary, when an alternative placement is requested or needed;
9. Issuance of Notices of Actions (NOA) to DHCFP Central Office Waiver Unit staff, to issue a Notice of Decision (NOD) when a waiver application is denied;
10. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid program;
11. Documentation for case files prior to recipient eligibility;
12. Case closure activities when the recipient's waiver eligibility is terminated; and
13. If the POC is approved by the applicant/recipient and the case manager, but the applicant/recipient's signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the applicant/recipient. Case managers must document the applicant/recipient's verbal approval in the case notes and obtain the applicant/recipient signature on the POC as soon as possible.

3903.1B ADMINISTRATIVE CASE MANAGEMENT PROVIDER RESPONSIBILITIES

1. Possess current licensure as a social worker or associate in Social Work from the Nevada Board of Examiners for Social Workers, or meet the criteria for licensure as a social worker but currently licensed in another capacity which qualifies for exemption per NRS 641.040, or who has licensure as a Registered Nurse from the Nevada State Board of Nursing.
2. Have, or be supervised by someone who has one year of experience working with seniors in a home-based environment.
3. Conform to Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.

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3903.1C ADMINISTRATIVE CASE MANAGEMENT RECIPIENT RESPONSIBILITIES

The applicant/recipient will cooperate in the assessment/reassessment process as well as participate in the development and review of the POC. The applicant/recipient or his/her legally responsible individual or authorized representative must sign the POC.

3903.2 ELIGIBILITY CRITERIA

Recipients must meet and maintain all criteria to be eligible during the period of time the recipients receive services under the auspices of the AL Waiver.

Eligibility for the AL Waiver is determined by the combined efforts of the DHCFP, ADSD, and the Division of Welfare and Supportive Services (DWSS). These three state agencies collaboratively determine eligibility.

- A. Applicants must be 65 years of age or older.
- B. Applicant/recipient must meet and maintain a level of care category for admission to a nursing facility. If the AL Waiver services or other supports were not available, the applicant/recipient would require imminent placement in a nursing facility (within 30 days). The administrative case manager assesses a LOC according to the guidelines specified in Medicaid Services Manual Chapter 500.
- C. Applicants/recipients must demonstrate a continued need for the AL Waiver services to prevent placement in a nursing facility or other institutional setting. Utilization by the applicant/recipient of Medicaid State Plan services only is not in itself sufficient to support the eligibility of the applicant/recipient for AL Waiver services.
- D. Applicants who are currently in an acute care facility, a nursing facility, in another HCBW, or in the community may be evaluated for the AL Waiver services.
- E. Financial eligibility for Medicaid benefits is determined by DWSS.
- F. Recipients must be Medicaid eligible each month in which AL Waiver services are provided.
- G. DHCFP Central Office Waiver Unit reviews and authorizes all waiver applications prior to the start of service provision.
- H. Services cannot be provided nor be reimbursed by DHCFP until and unless the applicant is found eligible in all three determination areas, as established by ADSD, DHCFP, and DWSS.

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3903.2A COVERAGE AND LIMITATIONS

1. Services are offered to eligible applicants who, without waiver services, would require institutional care provided in a hospital or nursing facility within 30 days or less.
2. Recipients on this waiver must maintain Medicaid eligibility requirements.
3. The AL Waiver is limited by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are filled, a wait list is utilized to prioritize applicants who have been screened for waiver eligibility.
4. The Wait List is managed based on priority, slot availability, available budget authority, and date the waiver application is received by ADSD.

Applicants who, at the time of application, are in a nursing facility or an acute care setting will be prioritized and processed before those applicants placed on the Wait List by date of application. This priority facilitates the provision of services in the most integrated setting appropriate to the needs of the applicant.

5. Waiver services may not be provided while a recipient is an inpatient of any institution.
6. Applicants must require the provision of one waiver service at least monthly to be determined eligible for the AL Waiver.
7. Recipients of the AL Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.
8. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more programs at the same time. The applicant must choose one HCBW program and receive services provided by that program.

3903.2B PROVIDER RESPONSIBILITIES

1. All waiver service providers, including case managers, are responsible for verifying the Medicaid and the AL Waiver eligibility monthly.
2. Providers are responsible for maintaining all required provider qualifications per DHCFP and ADSD policy.

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3. Providers are responsible for assuring prior authorization is established prior to initiating services.

3903.2C RECIPIENT RESPONSIBILITIES

Recipients/applicants must meet and maintain all eligibility criteria to be eligible for and to remain on the AL Waiver.

3903.3 AL WAIVER SERVICES

DHCFP determines which services will be offered under the AL Waiver. Providers and recipients must agree to comply with the requirements for service provision.

3903.3A COVERAGE AND LIMITATIONS

Under this waiver, the following services are provided as necessary to avoid institutionalization:

1. Direct Service Case Management:

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

2. Augmented Personal Care Services:

Augmented Personal Care Services provided by Assisted Living Facilities include assistance with basic self care and activities of daily living (ADL), homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. This care is over and above the mandatory service provision required by regulation for residential facilities for groups. There are three levels of augmented personal care based on the recipient's functional status.

3903.3B ALL PROVIDER RESPONSIBILITIES

1. All providers may only provide services identified in the recipient's POC. For those services requiring prior authorization, a prior authorization must be obtained before service provision.
2. Payment for services will be based on the level of care and the specific tasks identified on the POC.

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3. Payments will not be made for services provided by a recipient's legally responsible individual.
4. Providers must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The daily record is documentation completed by a provider, indicating the scope and frequency of services provided. The documentation will include the recipient's initials daily with a full signature of the recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation indicating the scope and frequency of the services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Periodically, the DHCFP Central Office staff may request this documentation to compare it to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.
5. Criminal Background Checks:

All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and **Federal Bureau of Investigation (FBI)** background check upon licensure as a provider and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred **and the safety of recipients is not compromised.**

- a. **The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.**
- b. **Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at:
<http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf>**

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c. The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):

1. murder, voluntary manslaughter or mayhem;
2. assault with intent to kill or to commit sexual assault or mayhem;
3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
4. abuse or neglect of a child or contributory delinquency;
5. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of the NRS;
6. a violation of any provision of NRS 200.700 through 200.760;
7. criminal neglect of a patient as defined in NRS 200.495;
8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;
9. any felony involving the use of a firearm or other deadly weapon;
10. abuse, neglect, exploitation or isolation of older persons;
11. kidnapping, false imprisonment or involuntary servitude;
12. any offense involving assault or battery, domestic or otherwise;
13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;
14. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or

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15. any other offense that may be inconsistent with the best interests of all recipients.

- d. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An “undecided” result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: <http://dps.nv.gov> under Records and Technology.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an “undecided” result is received. Documentation must be maintained in the employee’s personnel file and submitted to the DHCFP upon request.

6. Serious Occurrence Report (SOR):

Providers must report any recipient incidents, or issues regarding the provider/employee’s ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed **Serious Occurrence Report (SOR)** form must be made within five (5) working days and maintained in the agency’s recipient record.

Serious occurrences/incidents include, but are not limited to the following:

- a. Suspected physical or verbal abuse;
- b. Unplanned hospitalization;
- c. Neglect of recipient;
- d. Exploitation;
- e. Sexual harassment or sexual abuse;
- f. Injuries requiring medical intervention;
- g. An unsafe working environment;
- h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;
- i. Death of the recipient during the provision of services;

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- j. Medication error;
- k. Loss of contact with the recipient for three consecutive scheduled days.

The State of Nevada has established mandatory reporting requirements of suspected incidents of elder abuse. Refer to Section 3904.1 regarding elder abuse and neglect.

7. Aging and Disability Services Division (ADSD):

Maintains compliance with the Interlocal Agreement with DHCFP to operate the AL Waiver.

8. Assisted Living Providers:

a. Providers are responsible for maintaining certification, including the use of tax credits, as an assisted living facility in accordance with the provisions of NRS 319.147.

b. Training:

1. Assisted Living providers must arrange training for employees who have direct contact with the AL Waiver recipients. Assisted Living staff providing direct care and support to residents will be trained in the functional care skills needed to care for each recipient. Training will include, but not be limited to, techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and cardiopulmonary resuscitation (CPR).
2. Within 60 days of employment, the Assisted Living staff must receive not less than 4 hours of training related to the care of the residents. Additionally, Assisted Living staff must receive annually not less than eight (8) hours of training related to providing for the needs of the residents of the Assisted Living facility.
3. If an Assisted Living staff assists a resident of the Assisted Living facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must receive training in medication administration/management. The training must include not less than three (3) hours of instruction in medication administration/management. The caregiver must receive such training at least every three (3) years, and must provide the facility with the documentation that the training requirements were satisfactorily met.

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For more information regarding qualifications and training for caregivers in a residential/assisted living facility, refer to NAC 449.196.

- c. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient's rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflicts and complaints and other topics that are pertinent.

- d. Assisted Living staff providing direct care and support to recipients must: be at least 18 years of age, be responsible, mature, and have the personal qualities enabling him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the Assisted Living facility; and must be knowledgeable about the use of any prosthetic devices or dental, vision, or hearing aids that the recipient is using.

- e. Tuberculosis Testing:

Providers are responsible for ensuring that their employees complete either a QuantiFERON®-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for the AL Waiver recipients. Thereafter, each employee must receive a QFT-G blood test or a one step TB skin test annually, prior to the expiration of the initial test. If the employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the employee must have clearance by a chest X-ray prior to initiation of services for the AL Waiver recipients.

If the employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the employee must have documentation annually which demonstrates no signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider.

1. Has had a cough for more than 3 weeks;
2. Has a cough which is productive;
3. Has blood in his sputum;

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4. Has a fever which is not associated with a cold, flu or other apparent illness;
5. Is experiencing night sweats;
6. Is experiencing unexplained weight loss; or
7. Has been in close contact with a person who has active tuberculosis.

Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.

Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results, and maintained in the employee's file. Any lapse in the required timelines above results in non-compliance with this section.

3903.3C RECIPIENT RESPONSIBILITIES

The recipient or the recipient's authorized representative will:

1. Notify the Assisted Living provider and case manager of any change in Medicaid eligibility;
2. Notify the provider and case manager of current insurance information, including the name of the insurance coverage, such as Medicare;
3. Notify the provider and case manager of changes in medical status, service needs, address or location changes, and/or any change in status of legally responsible individual or authorized representative;
4. Treat all staff and providers appropriately;
5. Notify the provider and/or case manager of any unusual occurrences or complaints regarding delivery of services, specific staff, or to request a change in caregiver or provider agency;
6. Complete, sign and submit all required forms;
7. Not request any provider to perform services not outlined and authorized in the POC; and

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8. Furnish the provider with a copy of any existing advance directives.

3903.4 DIRECT SERVICE CASE MANAGEMENT

3903.4A COVERAGE AND LIMITATIONS

Direct service case management is provided to eligible recipients in the AL Waiver when case management is identified as a service on the POC. The recipient has a choice of direct service case management provided by ADSD staff, an agency or an independent private provider, who are enrolled as Medicaid providers with the QIO-like vendor. These services include:

1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as medical, social, educational and other services regardless of the funding source;
2. Monitoring the overall provision and quality of care of waiver services, in order to protect the health, welfare and safety of the recipient, and to determine that the POC goals are being met;
3. Making certain that the recipient retains freedom of choice in the provision of services;
4. Notifying all affected providers of changes in the recipient's medical status, services' needs, address and location or changes on the status of legally responsible individual or authorized representative;
5. Notifying all affected providers of any unusual occurrence or change in the recipient's health status;
6. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;
7. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency;
8. Coordination of multiple service/providers;
9. Case Managers must provide recipients with an appropriate amount of case management services to ensure the recipient is safe and receives sufficient services. Case management is considered an "as needed" service. The case manager is to have monthly contact with each recipient or recipient's authorized representative or legally responsible individual at least 15 minutes per recipient, per month. The amount of case management services billed to the DHCFP must be adequately documented and substantiated by the case manger's notes. This may be a telephone contact;

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10. There must be a face to face contact in the place of residence where services are provided to each recipient at least every three months or more often if the recipient has indicated a significant change in his or her health care status or if he or she is concerned about health or safety issues. When a recipient service needs increase due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days;
11. During the monthly contact, the case manager assesses the recipient's satisfaction with services and determines if there are any issues with the service provision. The case manager also assesses the need for any changes in services or providers and determines whether the services are promoting the goal(s) stated on the POC, and communicates this information to the ADSD administrative case manager.

3903.4B DIRECT SERVICE CASE MANAGEMENT PROVIDER RESPONSIBILITIES

In addition to all provider responsibilities listed on Section 3903.3B:

1. Providers must meet and maintain the minimum qualifications per the State of Nevada Board of Examiners for Social Workers and the Nevada Board of Nursing for Registered Nurses.
2. Providers must have the ability to conduct home visits. If applicable, Provider Agency must have a business license as required by city, county or state government.
3. Case managers must have one year of experience working with seniors in a home based environment. The case manager does not have to have this experience if the agency supervisor or administrator who supervises the case manager meets these qualifications.
4. Provide evidence to DHCFP of a State/FBI criminal history background check.
5. Conform to HIPAA of 1996 requirements.

3903.4C RECIPIENT RESPONSIBILITIES

1. Each recipient and/or his or her authorized representative must cooperate with the implementation of services and the implementation of the POC.
2. Each recipient is to comply with the rules and regulations of the:
 - a. Assisted Living facility;

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- b. ADSD;
- c. DWSS;
- d. DHCFP; and
- e. AL Waiver.

3903.5 AUGMENTED PERSONAL CARE SERVICES

3903.5A COVERAGE AND LIMITATIONS

1. Augmented personal care services provided in an AL facility include assistance with the basic self-care and ADLs, homemaker, chore, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised.
2. The AL facility provides 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides supervision, safety and security.
3. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it. The AL facility is the only entity that can enroll as a Medicaid provider and bill for the AL Waiver services.
4. There are three levels of augmented personal care. The level provided is based on the recipient's functional needs to ensure his or her health, safety and welfare in the assisted living facility. Qualified administrative case managers determine the service level and prior authorization for services as an administrative function.
 - a. Level One - Provides supervision and cueing to monitor the quality and completion of basic self-care and activities of daily living. Some basic self-care services may require minimal hands-on assistance. This is not a skilled level service, so the ability of the recipient to swallow must be intact. This service level provides laundry services once a week, basic weekly homemaking, assistance with grocery shopping, and community access. This service also provides access to social and recreational programs. This service provides indirect supervision when direct care tasks are not being completed.
 - b. Level Two - Provides minimal physical assistance with completion of basic self-care and activities of daily living. Some basic self-care may require a moderate

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level of assistance. This service level provides laundry services twice a week if needed, daily assistance with homemaking related to self-care, assistance with grocery shopping, and community access. This service provides once daily assistance with in-apartment meal preparation if requested. This service also provides access to and physical assistance with social and recreational programs, and provides indirect supervision with regularly scheduled checks when direct care tasks are not being completed.

- c. Level Three - Provides moderate physical assistance with all basic self-care needs. Some basic self-care may require a maximal level of assistance. This service includes assistance with feeding, if needed. This is not a skilled level service, so the recipient's ability to swallow must be intact. This service level provides laundry service, including changing of linens daily if needed. It includes daily homemaking for clean up after basic self-care tasks and weekly homemaking for general cleaning. This service provides completion of or assistance with grocery shopping and community access. If requested, this service provides up to twice daily assistance with in-apartment meal preparation, access to and physical assistance with social and recreational programs, and direct supervision or safety systems to ensure participant safety when supervision is not direct.

- 5. Federal Financial Participation (FFP) is unavailable to subsidize the cost of room and board.

3903.5B AUGMENTED PERSONAL CARE SERVICES PROVIDER RESPONSIBILITIES

In addition to provider responsibilities listed in Section 3903.3B:

- 1. Maintain licensure and standards as outlined by the Health Division, HCQC under NRS 449.037 (Adoption of Standards, Qualifications and other Regulations).
- 2. Maintain certification from the Department of Business and Industry, Nevada Housing Division.
- 3. An AL provider may not impose additional fees on the recipient for services covered by Medicaid.
 - a. Before authorizing a recipient to move into the facility, the facility must make a full written disclosure to the recipient, regarding what services of personalized care will be available to the recipient and the amount that will be charged for those services throughout the resident's stay at the facility.
 - b. The assisted living environment must evidence a setting that provides:

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- c. The residents of the facility reside in their own living units which:
1. contain private toilet facilities;
 2. contain a sleeping area or bedroom;
 3. include a kitchenette; and
 4. are shared with another occupant only upon consent of both occupants.
- d. The facility provides personalized care to the residents of the facility and the general approach to operating the facility incorporates these core principles:
1. The facility is designed to create a residential environment that actively supports and promotes each resident's quality of life and right to privacy;
 2. The facility is committed to offering high-quality supportive services that are developed by the facility in collaboration with the resident to meet the resident's individual needs;
 3. The facility provides a variety of creative and innovative services that emphasize the particular needs of each individual resident and his personal choice of lifestyle;
 4. The operation of the facility and its interaction with its residents supports, to the maximum extent possible, each resident's need for autonomy and the right to make decisions regarding his or her own life;
 5. The operation of the facility is designed to foster a social climate that allows the resident to develop and maintain personal relationships with fellow residents and with persons in the general community;
 6. The facility is designed to minimize and is operated in a manner which minimizes the need for its residents to move out of the facility as their respective physical and mental conditions change over time; and
 7. The facility is operated in such a manner as to foster a culture that provides a high-quality environment for the residents, their families, the staff, any volunteers and the community at large.
- e. The assisted living provider must:
1. Notify the case manager within three working days when the recipient states that he or she wishes to leave the facility;

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2. Participate with the case manager in discharge planning;
3. Notify the case manager within one working day if the recipient's living arrangements or eligibility status has changed or if there has been a change in his or her health status that could affect his or her health, safety or welfare;
4. Notify ADSD of any occurrence pertaining to a waiver recipient that could affect his or her health, safety or welfare;
5. Notify ADSD of any recipient complaints regarding delivery of service or specific Assisted Living facility staff;
6. Provide ADSD with at least a 30-day notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge;
7. Be responsible for any claims submitted or payment received on the recipient's behalf; such claims shall be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws;
8. Provide care to a newly placed recipient for a minimum of thirty (30) days unless the recipient's condition deteriorates and warrants immediate discharge;
9. Conduct business in such a way that the recipient retains freedom of choice;
10. Comply with rules and regulations for providers as set forth in Medicaid Services Manual Chapter 100;
11. Provide assisted living services to AL Waiver eligible recipients in accordance with the recipient's POC, the rate, program limitations and procedures of the DHCFP;
12. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the AL Waiver except by written consent of the recipient, his or her authorized representative or legally responsible individual;
13. Have sufficient number of caregivers present at the facility to conduct activities and provide care and protective supervision for the residents;

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14. Provide at least one caregiver on the premises of the facility if one or more residents are present;
15. Not use Medicaid waiver funds to pay for the recipient's room and board. The recipient's income is to be used to cover room and board costs;
16. Comply with Medicaid regulations in accepting Medicaid payment as payment in full for services rendered, and not contacting the recipient or members of the recipient's family for additional sums related to those services. (MSM Chapter 100);
17. Not bill for services when the recipient is not in the facility or is in suspended status with the AL Waiver ; and
18. Comply with ADSD Assisted Living provider qualifications and standards per Appendix C-1/C-3: "Provider specification for Service" of the approved waiver.

3903.5C RECIPIENT RESPONSIBILITIES

1. Recipients are to cooperate with the AL facility in the delivery of services.
2. Recipients are to report any problems with the delivery of AL services to the AL facility administrator and the case manager.

3903.6 INTAKE PROCEDURES

ADSD has developed procedures to ensure fair and adequate access to the AL Waiver services.

3903.6A COVERAGE AND LIMITATIONS

1. Slot Provision:
 - a. The allocation of waiver slots is maintained by ADSD Central Office, with sub-lists maintained at each local ADSD office. ADSD determines the number of slots allocated to each local ADSD office.

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- b. If an AL Waiver recipient voluntarily or involuntarily terminates from the waiver and then at a later date wants to reapply for the waiver, the following will be taken into consideration:
 1. If the termination took place 90 days or less prior to the request for reinstatement, the recipient will be reinstated on the AL Waiver providing:
 - a. The request is within the same waiver year.
 - b. The recipient meets all requirements for waiver eligibility.
 2. If the termination took place in a prior waiver year, the following is taken into consideration for reinstatement onto the AL Waiver:
 - a. Slot availability;
 - b. Emergent need; and
 - c. The recipient meets all waiver eligibility requirements.

If the recipient is eligible for reauthorization of waiver services, the administrative case manager will forward all necessary forms to the DHCFP Central Office Waiver Unit for approval. Recipients must cooperate with the reauthorization process.

2. Referral To AL Waiver:
 - a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting any ADSD office.
 - b. If the applicant is not currently a Medicaid recipient, information is provided regarding the Medicaid eligibility process.
 - c. Even if the applicant does not appear to meet the functional eligibility criteria for the AL Waiver, he or she must be informed of the right to continue the Medicaid application process through DWSS and, if still deemed ineligible, the right to a fair hearing through DWSS.
3. Wait List:
 - a. If the case manager informs ADSD that the applicant appears to meet functional eligibility criteria and no waiver slots are available, the applicant is placed on the AL Waiver Wait List.

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b. At the time of Wait List placement, applicants are notified by ADSD of other options that may be available, such as other HCBW services.

c. If it has been determined that no slot is expected to be available within the 90 day determination period, ADSD will notify DHCFP Central Office Waiver Unit to deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the waiting list.

4. Waiver Slots Available:

Once a waiver slot is available, the applicant is allowed the right to choose waiver services in lieu of placement in a nursing facility. If the applicant or authorized representative or legally responsible individual prefers placement in a nursing facility, the case manager will assist the applicant in arranging for nursing facility placement. The applicant has the right to request a hearing if not given a choice between AL Waiver services and nursing facility placement.

5. Effective Date For AL Waiver Services:

The effective date for AL Waiver service approval is the completion date of all the required forms in the application packet, the Assisted Living facility move-in date, or the Medicaid eligibility date, whichever date is last. If the applicant is in an institution, the effective date cannot be before the date of discharge from the institution.

6. AL Waiver Per Capita Expenditures:

DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the Medicaid State Plan that would have been made in that fiscal year, had the waiver not been granted.

3903.6B DENIAL OF AL WAIVER APPLICATION

Basis of denial for waiver services:

1. The applicant is under the age of 65 years.
2. The applicant does not meet the level of care criteria for nursing facility placement, i.e. the applicant would not require nursing facility placement if AL Waiver services were not available.
3. The applicant has withdrawn his or her request for waiver services.

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4. The applicant fails to cooperate with his or her case manager in establishing the POC or verifying eligibility for waiver services.
5. The applicant fails to cooperate with his or her administrative case manager or assisted living service provider in implementing the POC.
6. The case manager, ADSD, DHCFP, or DWSS has lost contact with the applicant.
7. The applicant fails to show a need for AL Waiver services.
8. The applicant has moved out of state.
9. Another agency or program will provide the services.
10. ADSD has filled the number of slots allocated to the AL Waiver. The applicant will be placed on the waiver wait list and will be contacted when a slot is available.
11. There is no Assisted Living facility where the applicant can be placed appropriately and safely. The applicant will be referred to other services.
12. The applicant is in an institution (e.g. hospital, nursing facility, ICF/MR) and discharge within 45 days is not anticipated.
13. The applicant has been placed in an Assisted Living facility that does not have a provider agreement with the DHCFP.
14. The applicant chooses to remain at home.

When an application for waiver services is denied, the case manager will send a Notice of Action (NOA) to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the applicant or the applicant's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been denied and the reason for the denial.

3903.6C SUSPENDED WAIVER SERVICES

1. If it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital or nursing facility), a recipient's case is suspended and not closed.
2. An Assisted Living facility is not paid for services on the days that a recipient's case is suspended.

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3. If at the end of 45 days the recipient has not been removed from suspended status, the case is closed and the recipient is removed from the waiver.

When waiver services are suspended, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been suspended and the reason for the suspension.

4. Release From Suspended Waiver Services:

If a recipient has been released from the hospital or nursing facility before 60 days of suspension of waiver services, within five working days, the administrative case manager must:

- a. Complete a new LOC assessment if there has been a significant change in the recipient's condition;
- b. Complete a reassessment if there has been a significant change in the recipient's condition or status;
- c. Complete a new POC if there has been a change in medical, social or waiver services expected to last longer than 30 days.
- d. ADSD will coordinate with the case manager and contact the Assisted Living facility to reestablish services.

3903.6D REDUCTION OF WAIVER SERVICES

A waiver service or services are reduced when:

1. The recipient no longer needs the previously provided level of waiver service(s).
2. The recipient's support system is providing the service(s).
3. The recipient has failed to cooperate with the case manager or the Assisted Living provider in establishing and/or implementing the POC, implementing waiver service(s) or verifying eligibility for waiver service(s).
4. The recipient has requested a reduction in service(s).
5. The recipient's ability to perform activities of daily living has improved.

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6. Another agency or program will provide the service(s).

When waiver services are reduced, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been reduced and the reason for the service reduction.

3903.6E TERMINATION OF AL WAIVER SERVICES

A recipient will be terminated from the AL Waiver services if:

1. The recipient does not meet the level of care criteria for nursing facility placement;
2. The recipient would not require nursing facility placement if home and community-based services were not available;
3. The recipient has requested termination of waiver services;
4. The recipient fails to cooperate with the case manager or the Assisted Living provider in establishing and/or implementing waiver services;
5. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition;
6. The recipient fails to show a need for the AL Waiver services;
7. The recipient has moved out of state;
8. Another agency or program will provide the services;
9. The recipient has been placed in an Assisted Living facility that is not a Medicaid provider;
10. The recipient chooses to return to independent community living;
11. The recipient does not qualify for the AL Waiver services because of institutionalization (e.g. hospital, nursing facility, correctional, ICF/MR), and discharge within 60 days is not anticipated at this time; and
12. The case manager, ADSD, DHCFP or DWSS has lost contact with the recipient.

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When waiver services are terminated, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that the waiver services have been terminated and the reason for the termination.

When a termination of waiver services is due to the death of a recipient, any agency receiving this information will notify appropriate agencies of the date of death. No NOD is sent.

3903.7 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC or Service Plan, and prior authorization is in place when indicated.

3903.7A COVERAGE AND LIMITATIONS

All providers (Provider Type 59) for the AL Waiver must submit claim forms to DHCFP's Fiscal Agent. Claims must meet the requirements in the CMS 1500 Claim Form. Claims must be complete and accurate. Incomplete or inaccurate claims will be returned to the provider by DHCFP's fiscal agent. If the wrong form is submitted it will also be returned to the provider by DHCFP's fiscal agent.

3903.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 3903.3B:

1. Providers must refer to the QIO-like vendor Provider Billing Procedure Manual for detailed instructions for completing the CMS 1500 form.
2. Providers must maintain documentation to support claims billed for a minimum of 6 years from the date of service.

3903.8 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed agencies providing personal care services to give their clients information about their decision-making rights about health care, declarations (living wills), and durable powers of attorney for health care decisions. Refer to MSM Chapter 100.

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3903.9 DHCFP ANNUAL REVIEW

DHCFP has in place a formal system in which an annual review of all AL Waiver service providers is conducted, assuring the health and welfare of the individuals served by AL Waiver service providers, the recipient's satisfaction with services, and the cost effectiveness of these services.

The review:

- a. Provides CMS annually with information on the impact of the waiver on the type, amount, and cost of services provided under the AL Waiver and the Medicaid State Plan. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;
- b. Assures financial accountability for funds expended for home and community-based services;
- c. Evaluates all provider standards are continuously met, and the POC are reviewed to assure that the services furnished are consistent with the documented needs of the recipients;
- d. Evaluates the recipient's satisfaction with the AL Waiver services; and
- e. Further assures that all problems identified by the review will be addressed in an appropriate and timely manner, consistent with the severity and nature of any deficiencies.

3903.9A PROVIDER RESPONSIBILITIES

Providers must cooperate with DHCFP's annual review process.

3903.9B RECIPIENT RESPONSIBILITIES

Recipients and/or legally responsible individual must cooperate with DHCFP's annual review process.

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3904 APPEALS AND HEARINGS

Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.

3904.1 ELDER ABUSE

All members of the ADSD staff, waiver services case managers, and employees of the Assisted Living facility are mandatory reporters of suspected elder abuse. NRS 200.5093 states that anyone “who, in his professional or occupational capacity, knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated...” must report the abuse, exploitation, neglect (including self-neglect) or isolation to the Elder Rights Unit of the ADSD, the local police department or the county’s protective services unit in Clark County (if the suspected action occurred in Clark County). This applies to all employees of the ADSD. This report must be made as soon as possible, but no later than 24 hours after the Division employee knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated. NRS 200.5093(1)(b).

- a. For the purposes of elder protective services, abuse means willful:
 - 1. Infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;
 - 2. Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person.
- b. Neglect means the failure of:
 - 1. A person who has assumed legal responsibility or a contractual obligation for caring for an older person, or who has voluntarily assumed responsibility for his or her care, to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person, or
 - 2. An older person to provide for his or her own needs because he or she is unable to do so. (NRS 200.5091-200.50995 et seq.)
- c. Exploitation means any act taken by a person who has the trust and confidence of an older person or any use of the power of attorney or guardianship of an older person to obtain control, through deception, intimidation or undue influence, over the older person’s money, assets, or property with the intention of permanently depriving the older person of the ownership, use, benefit or possession of his or her money, assets or property. As used in this subsection, undue influence does not include the normal influence that one member of a family has over another. (NRS 200.5091-200.50995 et seq.)

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- d. Isolation means willfully, maliciously and intentionally preventing an older person from having contact with another person by:
1. Intentionally preventing the older person from receiving his or her visitors, mail or telephone calls, including, without limitation, communicating to a person who comes to visit the older person or a person who telephones the older person that the older person is not present or does not want to meet with or talk to the visitor or caller, knowing that the statement is false, contrary to the express wishes of the older person and intended to prevent the older person from having contact with the visitor; or,
 2. Physically restraining the older person to prevent the older person from meeting with a person who comes to visit.

The term does not include an act intended to protect the property or physical or mental welfare of the older person or an act performed pursuant to the instructions of a physician who is treating the older person. (NRS 200.5091-200-50995)

It is Division policy that any life-threatening elder abuse must be reported by Division staff to the Elder Rights Unit immediately, either by telephone, in person, or in writing.

Any person making a good faith report of suspected elder abuse is immune from civil or criminal liability for reporting. (NRS 200.5096)

NRS 200.5093 (9) provides that anyone who knowingly and willfully violates the mandatory reporting law is guilty of a misdemeanor.

Recipient safeguards include initiation of investigation by local law enforcement and/or Elder Protective agency, provision of protective services to the older person if they are able and willing to accept them. If the person who is reported to have abused, neglected, exploited or isolated an older person or a vulnerable person is the holder of a license or certificate issued pursuant to chapters 449, 630 to 641B, inclusive, or 654 of NRS, information contained in the report must be submitted to the board that issued the license.

Any employee of the ADSD who knows or should have known that an elderly person is being abused, neglected, exploited or isolated and does not report this to the Elder Rights Unit, Clark County Protective Services (if the suspected action occurred in Clark County), or to law enforcement is subject to disciplinary action, including possible termination. Additionally, the licensing board for any professional employee who fails to report suspected elder abuse would be notified.

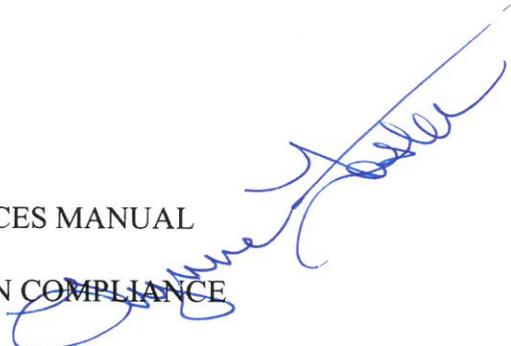
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The HCQC also receives complaints regarding the facilities they license. ADSD staff receives training regarding the role of the HCQC and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 12, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER - ADDENDUM



BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter Addendum are being proposed to update, delete or add definitions.

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

These changes are effective May 13, 2016.

<u>MATERIAL TRANSMITTED</u>	<u>MATERIAL SUPERSEDED</u>
MTL 12/16 ADDENDUM	MTL 23/15 ADDENDUM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section A	Administrative Days	Updated language
	Ambulatory Surgical Centers (ASCs)	Updated language
Section C	Concurrent Review	Updated language
	Critical Access Hospital (CAH)	Updated language
Section D	Dialysis	Added definition

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section E	End Stage Renal Disease (ESRD)	Added definition
Section H	Hemodialysis	Added definition
	Hospital	Updated language
Section I	Informed Sterilization Consent Form Meeting Federal Requirements	Added definition
	Inpatient	Moved definition above Inpatient Hospital Services
	Inpatient Rehabilitation Hospital	Updated language – moved from Rehab Hospital
	Intermediate Administrative Days	Added definition
Section L	Leave of Absence (LOA)	Added definition
	Level I Trauma Center	Added definition
	Long-Term Acute Care (LTAC) Specialty Hospital	Updated language
Section N	Newborn/Neonate	Added definition
Section O	Observation Services	Added definition
	Outpatient Hospital	Added definition
Section R	Rehabilitation (Rehab) Specialty Hospital	Moved to Section I – Inpatient Rehabilitation Hospital
	Retrospective Review	Updated language

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Rollover Admission	Added definition
Section S	Skilled Administrative Days	Added definition
	Swing Bed	Added definition
	Swing Bed Hospital	Updated language
Section T	Therapeutic Leave of Absence (LOA)	Updated language
Section U	Utilization Review	Added definition

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24-HOUR CARE AT HOME

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

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

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

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ABLE

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

ABLE CAREGIVER

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

ABUSE

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

ACCESS

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

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

ACCOMMODATIONS

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

ACQUIRED BRAIN INJURY (ABI)

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

1. a cerebral vascular accident;

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

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

ACT

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

ACTION

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

ACTIVE TREATMENT

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

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

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

Active treatment includes:

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

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

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

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

ACTIVITIES OF DAILY LIVING (ADLs)

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

For purposes of evaluation, the ADLs are defined as:

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

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

ACTUAL ACQUISITION COST (AAC)

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

ADAPTIONS

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

ADMINISTRATION FEE

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

ADMINISTRATIVE ACTION

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

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

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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

Has the administrative authority over four HCBS waivers:

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

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

ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES

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

ADMINISTRATIVE COSTS

There are two separate cost components in administrative costs:

1. Non-Medical Administrative Costs: Those costs (both direct and indirect) necessary to administer the Medicaid managed care program.
 - a. Direct Expenses: Those expenses that can be charged directly as a part of the overall administrative costs; and

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- 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 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:

- 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 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.

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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 (4) or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting. Adult Day Care services include, supervision, monitoring of general well-being and social interaction through scheduled activities and peer contact.

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

ADULT DAY CARE FACILITY

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

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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 an Emergency Medical Technician (EMT)-Basic.

ADVANCED LIFE SUPPORT LEVEL 1 (ALS-1)

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

ADVANCED LIFE SUPPORT LEVEL 2 (ALS-2)

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

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

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

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

ADVANCE NOTICE OF ACTION (NOA)

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

ADVERSE DETERMINATION

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

AGE/SEX RATES

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

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AGING AND DISABILITY SERVICES DIVISION (ADSD)

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

AIR AMBULANCE

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

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.

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)

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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 Home and Community-Based Waivers (HCBW), annual means in the same month each year.

ANNUAL GOAL

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

APPEAL

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

APPLICANT

An individual who is applying for waiver services.

APPROPRIATE

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

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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 received within 24 hours.

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ATTENDANCE RECORD

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

ATTENDANT CARE (AC)

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

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

2. HCBW WEARC:

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

ATTENDING PHYSICIAN

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

AUDIOGRAM

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

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AUDIOLOGIST

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

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

AUDIOLOGY TESTING

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

AUDITORY BRAINSTEM IMPLANT

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

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

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

AUGMENTED PERSONAL CARE SERVICES (PCS)

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

AUTHORIZATION

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

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Medicaid allows post-service authorization of payment in special circumstances involving life-threatening health complications and NF recipients.

AUTHORIZATION NUMBERS

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

AUTHORIZED REPRESENTATIVE

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

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BASIC LIFE SUPPORT (BLS)

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

BEHAVIORAL HEALTH COMMUNITY NETWORK (BHCN)

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

BENEFIT

Benefit means a service authorized by the Managed Care plan.

BEREAVEMENT COUNSELING

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

BILLING AUTHORIZATION

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

BONE ANCHORED HEARING AID (BAHA)

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

BUDGET AUTHORITY

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

BURDEN OF PROOF

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

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

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE (HCQC)

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

BUS

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

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CAPABLE

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

CAPABLE CAREGIVER

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

CAPITAL RENOVATIONS/REMODELING PROJECT

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

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

Said Project may involve new construction, reconstruction and/or renovation. Allowable costs include, but are not limited to, the costs of land, buildings, machinery, fixtures, furniture and equipment. Certain 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 twenty four (24) months. Further, in order to be considered as part of the Fair Rental Value rate setting process for a given facility in a given rate year, the sum of the costs for all Projects submitted for consideration must exceed \$1,000 per licensed bed.

CAPITATION PAYMENT

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

CARDHOLDER

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

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CARE COORDINATION

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

CARE COORDINATOR

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

CAREGIVER

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

CASE MANAGEMENT

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

CASE MANAGEMENT SERVICES

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

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

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

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

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

CASE MIX

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

CASE-MIX INDEX

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

CASE RECORD DOCUMENTATION

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

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

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

CENSUS INFORMATION

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

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CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

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

CERTIFICATION OF TERMINAL ILLNESS

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

CERTIFIED SLEEP STUDY TECHNOLOGIST

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

CHILD

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

CHILD AND FAMILY TEAM

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

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

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

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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CHORE SERVICES

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

CHRONIC MENTAL ILLNESS (CMI)

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

CLAIM

Claim is defined as:

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

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

CLINIC SERVICES

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

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

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CLINICAL LABORATORY

A laboratory which uses:

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

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

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) PROGRAM

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

CLINICAL SUPERVISION

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

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

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

CLINICAL SUPPORT GUIDE

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

COCHLEAR IMPLANT

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

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CODE OF FEDERAL REGULATIONS (CFR)

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

COLD-CALL MARKETING

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

COMMERCIAL TRANSPORTATION VENDOR

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

COMMON OWNERSHIP

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

COMMUNITY MENTAL HEALTH CENTER (CMHC)

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

COMPANION CARE SERVICES

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

COMPARABILITY OF SERVICES

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

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COMPOUND DRUGS

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

COMPREHENSIVE FUNCTIONAL ASSESSMENT

Comprehensive function assessments identify all of the recipients:

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

CONCURRENT CARE

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

CONCURRENT REVIEW

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;

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

CONTINUITY OF CARE

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

CONTINUUM OF SERVICES

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

CONTRACT

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

CONTRACT PERIOD

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

CONTRACTOR

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

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COST

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

COUNSELING SERVICES

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

COVERED SERVICES

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

CRIMINAL CLEARANCE

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

CRITICAL ACCESS HOSPITAL (CAH)

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

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

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context for the people being served. The Surgeon General defines cultural competence in the most general terms as “the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values.” In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the needs of diverse communities, including racial and ethnic minorities.

CURRENT DENTAL TERMINOLOGY (CDT)

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

CUSTODIAL CARE

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

CUSTOM FABRICATED ORTHOSIS

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

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DAILY RECORD

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

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

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

DATE OF ACTION (DOA)

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

DAY HABILITATION

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

DAYS

Refers to calendar days, unless otherwise specified.

DENIED SERVICE

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

DENTAL CONSULTANT

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

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DENTAL DIRECTOR

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

DENTAL HYGIENIST

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

DENTAL RELATED SERVICES

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

DENTAL SERVICES

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

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

DENTIST

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

DENTURES

Dentures include both complete and partial prostheses replacing missing teeth.

DEPARTMENT OF JUSTICE (DOJ) PRICING

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

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DIAGNOSIS

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

DIAGNOSTIC AND STATISTICAL MANUAL (DSM) 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

QMHP or QMHA may function as Direct Supervisors. Direct Supervisors must have the practice specific education, experience, training, credentials, and/or licensure to coordinate an array of mental and/or behavioral health services. Direct Supervisors assure servicing providers provide services in compliance with the

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established treatment/rehabilitation plan(s). Direct Supervision is limited to the delivery of services and does not include Treatment and/or Rehabilitation Plan(s) modification and/or approval. If qualified, Direct Supervisors may also function as Clinical Supervisors. Direct Supervisors must document the following activities:

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

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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- 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:

- the anticipated duration of the overall services;
- discharge criteria;
- required aftercare services;
- the identified agency(ies) or Independent Provider(s) to provide the aftercare services; and
- a plan for assisting the recipient in accessing these services.

DISCHARGE SUMMARY

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

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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.

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DURABLE MEDICAL EQUIPMENT (DME)

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

DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR (DME MAC)

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

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

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

DURATION

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

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EAR IMPRESSIONS

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

EAR MOLDS

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

EARLY

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

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

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

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

ELECTION PERIOD

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

ELECTION STATEMENT

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

ELECTRODIAGNOSTIC TESTING/NEUROPHYSIOLOGICAL STUDIES

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

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ELECTRONIC VERIFICATION OF SERVICES (EVS)

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

ELIGIBILITY

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

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

ELIGIBILITY NOTICE OF DECISION (NOD)

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

ELIGIBILITY STAFF

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

EMERGENCY 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.

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EMERGENCY MEDICAL TRANSPORTATION

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

EMERGENCY SERVICES

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

EMPLOYEE

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

EMPLOYER AUTHORITY

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

EMPLOYER OF RECORD

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

ENCOUNTER

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

ENCOUNTER DATA

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

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.

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ENROLLEE

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

ENTITY

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

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

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

ESCORT/ATTENDANT

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

ESCORT SERVICE

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

ESSENTIAL COMMUNITY PROVIDERS

A healthcare provider that:

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

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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 brief occasional trips in the local community to shop for food, medical necessities, and household items required specifically for the health and care of the recipient.

ESTIMATED ACQUISITION COST (EAC)

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

EXCEPTION TO ADVANCE NOTICE

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

1. The agency has factual information confirming the death of a recipient;
2. The agency receives a clear written statement signed by a recipient that:
 - a. He/She no longer wishes services; or
 - b. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information.
3. The recipient has been admitted to an institution where he/she is ineligible under the plan for further services;
4. The recipient's whereabouts are unknown and the post office returns agency mail directed to him/her indicating no forwarding address (see §431.231(d) of this subpart for the procedure if the recipient's whereabouts become known);
5. The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
6. A change in the level of medical care is prescribed by the recipient's physician;

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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 5 days before the DOA if:

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

EXISTING PROVIDER-RECIPIENT RELATIONSHIP

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

EXPERIMENTAL

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

EXPERIMENTAL SERVICES

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

EXPLANATION OF BENEFITS (EOB)

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

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

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

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FACTOR

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

FAMILY

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

FAMILY INVOLVEMENT

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

FAMILY MEMBER

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

FAMILY PLANNING SERVICES

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

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

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FEDERAL FINANCIAL PARTICIPATION (FFP)

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

FEDERAL UPPER LIMIT (FUL)

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

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

<http://www.cms.hhs.gov/FederalUpperLimits>.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

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

FRAUD

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

FREE APPROPRIATE PUBLIC EDUCATION (FAPE)

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

FULL TIME (F/T)

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

FUNCTIONAL ABILITY

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

FUNCTIONAL ASSESSMENT

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

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FUNCTIONAL IMPAIRMENT

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

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GENDER, NUMBER AND TENSE

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

GENERAL PUBLIC

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

GEOGRAPHIC SERVICE AREA

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

GOALS

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

GRIEVANCE

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

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GROUP CARE FACILITIES

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

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HABILITATION SERVICES

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

HANDICAPPING LABIOLINGUAL DEVIATION INDEX (HLD)

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

HEALTH CARE PLAN

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

HEALTH CARE PROFESSIONAL

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

HEALTH CARE PROVIDER

A qualified medical professional licensed in accordance with state regulation.

HEALTH CARE RECORDS

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

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HEALTH CARE SERVICES

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

HEALTH EDUCATION

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

HEALTH MAINTENANCE ORGANIZATION (HMO)

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

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)

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

HEALTHY KIDS

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

HEARING

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

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HEARING OFFICER

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

HEARING PREPARATION MEETING (HPM)

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

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)

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

HOME HEALTH AIDE

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

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HOME HEALTH SERVICES

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

HOMEBOUND

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

HOMEMAKER SERVICES

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

HOSPICE

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

HOSPICE HOME CARE

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

HOSPICE PROGRAM

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

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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.

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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IMPROPER PAYMENT

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

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

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

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

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

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

INCAPABLE CAREGIVER

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

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

INDEPENDENT CLINICAL LABORATORY

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

INDEPENDENT CONTRACTOR (IC)

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

INDIAN HEALTH CARE SERVICES

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

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INDIVIDUAL BUDGET

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

INDIVIDUAL PROGRAM PLAN (IPP)

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

INDIVIDUAL PROVIDERS

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

INDIVIDUAL SUPPORT PLAN (ISP)

ISP is a document and working tool that identifies:

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

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

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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

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INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

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

INFORMED CONSENT

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

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 preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

INTENSITY OF NEEDS DETERMINATION

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

These components include:

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

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:

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

INTERDISCIPLINARY TEAM (IDT)

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

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

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

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

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

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

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

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

INTERMEDIATE CARE SERVICES FOR THE MENTALLY RETARDED

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

INTERMITTENT SERVICES

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

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INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)

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

INTERPERIODIC

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

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KICKBACKS

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

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LEAD CASE MANAGER

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

LEAST RESTRICTIVE SETTING

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

LEAVE OF ABSENCE (LOA)

Absences for special circumstances (e.g. and 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.

LEGAL REPRESENTATIVE FOR SELF-DIRECTED SKILLED CARE

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

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

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

LEVEL 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 (24) 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.

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LEVEL OF CARE (LOC) SCREENING

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

LICENSURE

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

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
- DHCFP for multiple source drugs under the State Maximum Allowable Cost (SMAC).

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

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

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MEDICAID BILLING NUMBER (BILLING NUMBER)

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

MEDICAID ESTATE RECOVERY (MER)

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

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

MEDICAL CARE ADVISORY COMMITTEE (MCAC)

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

MEDICAL CARE PLAN

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

MEDICAL DIRECTOR

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

MEDICAL DOCUMENTATION

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

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MEDICAL EMERGENCY

Medical Emergency is 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 SUPERVISION

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

MEDICAL SUPERVISOR

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

MEDICAL TRANSPORTATION

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

MEDICARE SAVINGS PROGRAM

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

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

MEDICOACH, MEDIVAN, MEDICAR

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

MENTAL HEALTH AND DEVELOPMENTAL SERVICES (MHDS)

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

MENTAL HEALTH SERVICES

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

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identified in 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:

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.

MENTAL RETARDATION

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

MENTALLY INCOMPETENT INDIVIDUAL

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

MILEAGE REIMBURSEMENT

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

MINIMUM DATA SET (MDS)

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

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MINIMUM ESSENTIAL PERSONAL ASSISTANCE

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

MOLDED TO PATIENT MODEL ORTHOSIS

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

MULTIDISCIPLINARY CONFERENCE (MDC)

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

MULTIPLE SLEEP LATENCY TEST (MSLT)

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

MULTIPLE SOURCE DRUGS

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

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

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NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAMS (NCPDP)

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

NATIONAL DRUG CODE (NDC)

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

NEUROLOGY

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

NEVADA DIVISION OF WELFARE AND SUPPORTIVE SERVICES (DWSS)

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

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

NEVADA HEALTH NETWORK (NHN)

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

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

NON-EMERGENCY TRANSPORTATION (NET) BROKER

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

NON-LEGEND DRUGS

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

NOTICE OF DECISION (NOD)

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

NURSING FACILITY (NF)

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

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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
 - 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

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planning, emergency services, out-of-network obstetrical and gynecological providers for recipients within the last trimester of pregnancy, and prior-authorized specialty services rendered to its recipients at the rate paid by DHCFP according the Medicaid FFS rate schedule.

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.

PAYMENT AUTHORIZATION REQUEST (PAR)

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

PERFORMANCE INDICATORS

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

PERIOD OF CRISIS

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

PERIODIC

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

PERM REVIEW ERRORS

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

PERSON-CENTERED TREATMENT PLANNING

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

PERSON WITH MENTAL RETARDATION OR A RELATED CONDITION

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

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

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

Attributable to:

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

PERSONAL CARE ATTENDANT (PCA) SERVICES

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

PERSONAL CARE REPRESENTATIVE (PCR)

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

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

PERSONAL CARE SERVICES (PCS)

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

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

PCS is an optional state plan service.

PERSONAL CARE SERVICES (PCS) FUNCTIONAL ASSESSMENT (FA)

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

PERSONAL CARE SERVICES (PCS) PROVIDER AGENCY

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

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

PERSONAL NEEDS ALLOWANCE

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

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PHARMACEUTICALS

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

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

PHARMACY AND THERAPEUTICS (P & T) COMMITTEE

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

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

PHYSICAL DISABILITY

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

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

PHYSICAL EVALUATION

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

PHYSICAL THERAPIST

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

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

PHYSICAL THERAPY

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

PHYSICAL THERAPY ASSISTANT (PTA)

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

PHYSICIAN ASSISTANT

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

PHYSICIAN OFFICE LABORATORY

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

PHYSICIANS IN TEACHING HOSPITALS

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

PICTURE DATE

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

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PLAN OF CARE (POC)

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

PLAN OF CORRECTION

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

POINT OF SALE (POS)

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

POLYSOMNOGRAM/POLYSOMNOGRAPHY (PSG)

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

POST-STABILIZATION SERVICES

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

PRACTITIONER OF RESPIRATORY CARE

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

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

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

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

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

PREFABRICATED ORTHOSIS

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

PREFERRED DRUG LIST (PDL)

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

PREGNANCY RELATED SERVICES

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

PREPAID BENEFIT PACKAGE

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

PRESENT LEVELS OF EDUCATIONAL PERFORMANCE

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

PRIMARY CARE CASE MANAGEMENT (PCCM)

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

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

PRIMARY CARE PROVIDER (PCP)

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

PRIMARY CARE SITE (PCS)

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

PRIMARY CAREGIVER

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

PRIMARY DIAGNOSIS

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

PRIOR AUTHORIZATION (PA)

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

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

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

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PRIOR RESOURCES

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

PRIVATE DRIVERS

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

PRIVATE DUTY NURSING (PDN) SERVICES

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

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

PROCEDURE CODE

A code used for billing purposes which identifies services rendered.

PROFESSIONAL MANAGEMENT RESPONSIBILITY

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

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PROGRAM POLICY

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

PROGRESS

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

PROGRESS MONITORING

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

PROGRESS NOTE

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

PROSPECTIVE DRUG UTILIZATION REVIEW (PRO-DUR)

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

PROSTHETIC DEVICES

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

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

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

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PROVIDER

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

PROVIDER DISPUTE

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

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

PROVIDER EXCLUSION

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

PROVIDER RESPONSIBILITY

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

PRUDENT LAYPERSON

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

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PSYCHOLOGICAL TESTING

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

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

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QUALIFIED MEDICARE BENEFICIARY (QMB)

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

QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)

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

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

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QUALIFIED PERSONAL CARE ASSISTANT (PCA)

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

QUALIFIED RECIPIENTS

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

QUALIFYING SERVICE

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

QUALITY ASSURANCE (QA)

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

QUALITY IMPROVEMENT

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

QUALITY IMPROVEMENT ORGANIZATION (QIO)-LIKE VENDOR

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

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

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RADIOLOGIC TECHNOLOGIST

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

RADIOLOGIST

A Radiologist is a physician who specializes in radiological medicine.

RADIOLOGY

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

RADIOLOGY LABORATORY

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

RADIONUCLIDE STUDIES

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

REASONABLE PROMPTNESS/TIMELINESS

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

RECIPIENT

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

RECIPIENT RESPONSIBILITY

Recipients are responsible for the following:

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

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

RECORDS

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

RECOUPMENT/RECOVERY

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

REEVALUATIONS

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

REFERENCE LABORATORY

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

REFERRAL

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

REFERRING LABORATORY

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

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REHABILITATION PLAN

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

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

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

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4. Rehabilitation goals and objectives are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal and objectives as defined in the rehabilitation plan. The plan must be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative mental and/or behavioral health services to an individual with the individual's condition(s). The written rehabilitation plan must ensure that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. Rehabilitation plans are living documents and therefore must evolve in concert (show progressive transformations in the amount, duration, and scope of services provided) with the recipient's functional progress. The rehabilitation plan must also demonstrate that the services requested are not duplicative (redundant) of each other. The written rehabilitation plan must:
- a. be based on a comprehensive assessment of an individual's rehabilitation needs including 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;
 - i. indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service;
 - j. specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than every 90 days or more frequently if needs change;
 - k. document that the individual, the individual's family (in the case of legal minors), or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and

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

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

- Self Care;
- Understanding and use of language;
- Learning;
- Mobility;
- Self-direction; and/or
- 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.

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REPRESENTATIVE

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

REQUEST FOR HEARING

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

RESIDENCE

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

RESIDENT ASSESSMENT INSTRUMENT (RAI)

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

RESIDENT ASSESSMENT INSTRUMENT (RAI) USER'S MANUAL

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

RESIDENT ASSESSMENT PROTOCOLS (RAPs)

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

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.

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RESIDENT PHYSICIAN

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

RESIDENTIAL FACILITY FOR GROUPS

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

RESIDENTIAL TREATMENT CENTER (RTC)

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

RESOURCE UTILIZATION GROUPS

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

RESPIRATORY THERAPY

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

1. therapeutic and diagnostic use of medical gases, humidity and aerosols and the maintenance of associated apparatus;

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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. 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.

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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.

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.

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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 available from a donor and the recipient must be present at the transplant facility within the timeframe determined by the surgeon or the transplant coordinator. (See also Urgent Services.)

SCHOOL OF MEDICINE

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

SCOPE

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

SCREENING

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

SELF DETERMINATION

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

SELF-DIRECTED MODEL (SD)

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

SELF-DIRECTED SKILLED SERVICES

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

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

SERIOUS MENTAL ILLNESS (SMI)

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

1. have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified in the current ICD (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, 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.

SERVICE PLAN

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

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SEVERE EMOTIONAL DISTURBANCE (SED)

1. 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, mental retardation, 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.

SIGNIFICANT CHANGE OF CONDITION OR CIRCUMSTANCE

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

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

SIGNIFICANT PRACTICAL IMPROVEMENT

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

SINGLE SOURCE DRUG

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

SITTERS

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

SKILLED 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 se-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
6. tracheotomy care.

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SKILLED SERVICES

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

SLEEP STUDY

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

SLOT

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

SPECIAL CHILDREN'S CLINIC (SCC)

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

SPECIAL EDUCATION

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

SPECIALTY CARE TRANSPORTATION (SCT)

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

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

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STEP THERAPY

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

STRETCHER

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

STUDENT THERAPIST

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

SUBCONTRACTOR

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

SUPPLEMENTAL OMNIBUS BUDGET RECONCILIATION ACT OF 1996 (SOBRA)

Legislation of the OBRA of 1986.

SUPPLEMENTAL REBATES

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

SUPPORT BROKER

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

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SUPPORT SERVICES

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

SUPPORTED LIVING ARRANGEMENT (SLA)

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

SWING-BED

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

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

TARGET GROUP – JUVENILE PROBATION SERVICES (JPS)

JPS 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 mental retardation, 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 – PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS (MRRC)

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

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

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

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

TARGET GROUP -- SERIOUS MENTAL ILLNESS (SMI) ADULTS

Adults with a SMI are persons:

1. 18 years of age and older; and;
2. Who currently, or at any time during the past year (continuous 12 month period);
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 mental retardation, 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;

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

TARGET GROUP - SEVERE EMOTIONAL DISTURBANCE (SED)

Children 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 mental retardation 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.

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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.

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.

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 services are prescribed, the provider must develop a Rehabilitation Plan (see definition). The Treatment Plan is based on a comprehensive assessment and includes:

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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.

TRAINING AND HABILITATION SERVICES

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

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

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URGENT SERVICES

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

ULTRASONOGRAPHY

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

UNAVAILABLE

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

UNBUNDLING

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

UNDERPAYMENT

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

UNIT DOSE

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

UNIVERSAL NEEDS ASSESSMENT

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

UP-CODING

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

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URBAN

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

USUAL CHARGE

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

UTILIZATION

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

UTILIZATION CONTROL

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

UTILIZATION MANAGEMENT AGENCY

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

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.

VISIT

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

VOLUNTEER

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

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

VOLUNTEER DRIVER

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

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WAIT LIST

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

WHEELCHAIR LIFTS AND TIE DOWNS

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

WOUND

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

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X-RAY

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

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