ANNUAL STATEWIDE 1915(i) HOME & COMMUNITY BASED SERVICES (HCBS) STATE PLAN ADULT DAY HEALTH CARE (ADHC) & HABILITATION SERVICES (HS) FINAL REPORT

HCBS serving individuals enrolled in ADHC and HS Quality Assurance (QA) review to ensure the services continue to meet all statutory assurances and effectively meet the recipient's needs.

State of Nevada
Division of Health Care Financing and Policy
Quality, Access & Availability Unit

April 2025

State Plan Year (SPY) 5

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ANNUAL STATEWIDE 1915(i) HCBS STATE PLAN ADHC & HS FINAL REPORT

STATE PLAN YEAR 5

Background/Introduction

The State Plan Amendment (SPA) renewal of the Adult Day Health Care (ADHC) and Habilitation Services (HS) are contingent on the Centers for Medicare and Medicaid Services (CMS) determining that the state has effectively assured the health and welfare of state plan recipients during the period the SPA has been in effect.

The state is required under 1915(i)(1)(H)(i) to ensure that the provision of state plan Home Based Habilitation Services (HCBS) meets federal and state guidelines for quality assurance. In addition, under 42 Code of Federal Regulation (CFR) §441.745: "States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the state plan HCBS benefit and the number of individuals to be served." CMS must assess each state plan HCBS benefit to determine that the state requirements are met. The assessment also serves to inform CMS in its review of the state's request for renewal of these services.

CMS conducts quality reviews, requiring states to demonstrate their use of performance measures to collect HCBS data and address how they conduct discovery, remediation, and quality improvement activities.

A state must demonstrate oversight through performance measures included in its §1915(i) state plan HCBS benefit. When a performance measure falls below the threshold of eighty-six percent (86%), further analysis is required to determine the cause and the Quality Management Activities implemented unless the state provides acceptable justification clarifying why system improvement is not necessary.

Performance Measures

CMS evaluates the state's oversight and monitoring systems according to outcome-based evidence in the form of performance measures. Well-crafted performance measures indicate whether the state is meeting the federal requirements for the approved SPA benefit. The performance measures drive the state's Quality Improvement Strategy (QIS) and form the basis of the evidence provided to CMS.

The state's performance measures are assessed by CMS based on the following seven criteria:

1. The performance measure is stated as a metric (e.g., number or percent), and specifies a numerator and denominator (i.e., is the performance measure measurable?).
2. The performance measure has face validity (i.e., Does the performance measure truly measure the requirement?).
3. The performance measure data is based on the correct unit of analysis (e.g., participants, providers, claims, etc.). The unit of analysis should be linked to the requirement measured.
4. The performance measure data is based on a representative sample of the population. The performance measure data should have at least a ninety-five percent (95%) confidence level with a +/- ten percent (10%) margin of error. If the state chooses to stratify a sample to allow for a representative sample of subgroups, the state must "re-weight" the data in order to make estimates for the population as a whole.
5. The performance measure must provide data specific to the state plan benefit undergoing evaluation.
6. The performance measure data demonstrates the degree of compliance for each period of data collection.
7. The performance measure determines the health of the system, (e.g., does the performance measure evaluate the anticipated outcome of the requirement as opposed to measuring a beginning step in the process?).

Aims & Objectives

The annual review monitoring activities provides the foundation for quality improvement by generating information regarding compliance, potential problems, and individual corrective actions. The results can be aggregated and analyzed to measure the overall system performance by meeting the service assurances.

Methodology

CMS quality requirements are founded on an evidence-based approach. CMS requests evidence from the state that it meets the assurances and applies a continuous quality improvement approach to the assurances. The Division of Health Care Financing and Policy (DHCFP) Quality Assurance (QA) Unit implemented a monthly process to allow the state to achieve higher administrative efficiency, a natural process of current and continuous quality improvement, and prevent duplication. The DHCFP QA unit uses a representative sample. Effective March 29, 2023, CMS approved an amendment to the State Plan Administration (SPA) allowing a ten percent (10%) sample size of all recipients active/inactive during the review period. The sample size is used to determine the required number of recipient cases that DHCFP's QA and LTSS 1915(i) units evaluate throughout the review year. The total number is distributed evenly over the year. All recipients' cases selected will be evaluated using the twelve (12) months

immediately preceding the month the review is conducted. The ten percent (10%) sample is also used to determine the required number of financial reviews DHCFP QA unit will complete. The financial review is conducted at the end of the State Plan Year (SPY), once all the recipients have been selected.

The annual review for the HCBS state plans ADHC & HS for the State of Nevada was conducted from March 1, 2024, through February 28, 2025. The ten percent (10%) sample size requirement resulted in one hundred thirty-six (136) reviews required. The DHCFP QA unit reviewed a random sample of sixty-eight (68) case files for ADHC and HS combined with sixty-eight (68) reviews completed by the DHCFP LTSS 1915(i) unit. Out of the one hundred thirty-six (136) recipient reviews DHCFP QA unit reviewed, one hundred twenty-nine (129) recipient financial claims, as seven (7) had no billed claims. This resulted in one hundred forty-seven (147) financial claim reviews in the months selected from December 1, 2023, through November 30, 2024.

The following areas were evaluated during this year's annual review:

Case File Review:

1. State Plan Eligibility
2. State Plan Service Received
3. Prior Authorization (PA)
4. DHCFP Plan of Care (POC)
5. Statement of Choice (SOC)

Financial Review:

1. PA
2. Claim
3. Daily Record
4. Payment

At the beginning of the SPY review, both the case file and financial review forms were updated to ensure all review elements were supported in policy, having removed any obsolete questions no longer supported with policies within the one year look back.

Listed below are the specific 1915(i) ADHC and HS, Medicaid Services Manual (MSM), State Plan, Code of Federal Regulations (CFR), Final Rule CMS, Nevada Administrative Code (NAC), Nevada Revised Statutes (NRS) and Policy and Procedure (P&P) used in the implementation of this annual review:

- MSM Chapter 100 Medicaid Program (Effective 08/28/2019, Updated 04/26/2023)
- MSM Chapter 1800 HCBS State Plan Option Adult Day Health Care and Habilitation

(Effective 02/01/2023, Amended 01/01/2024)

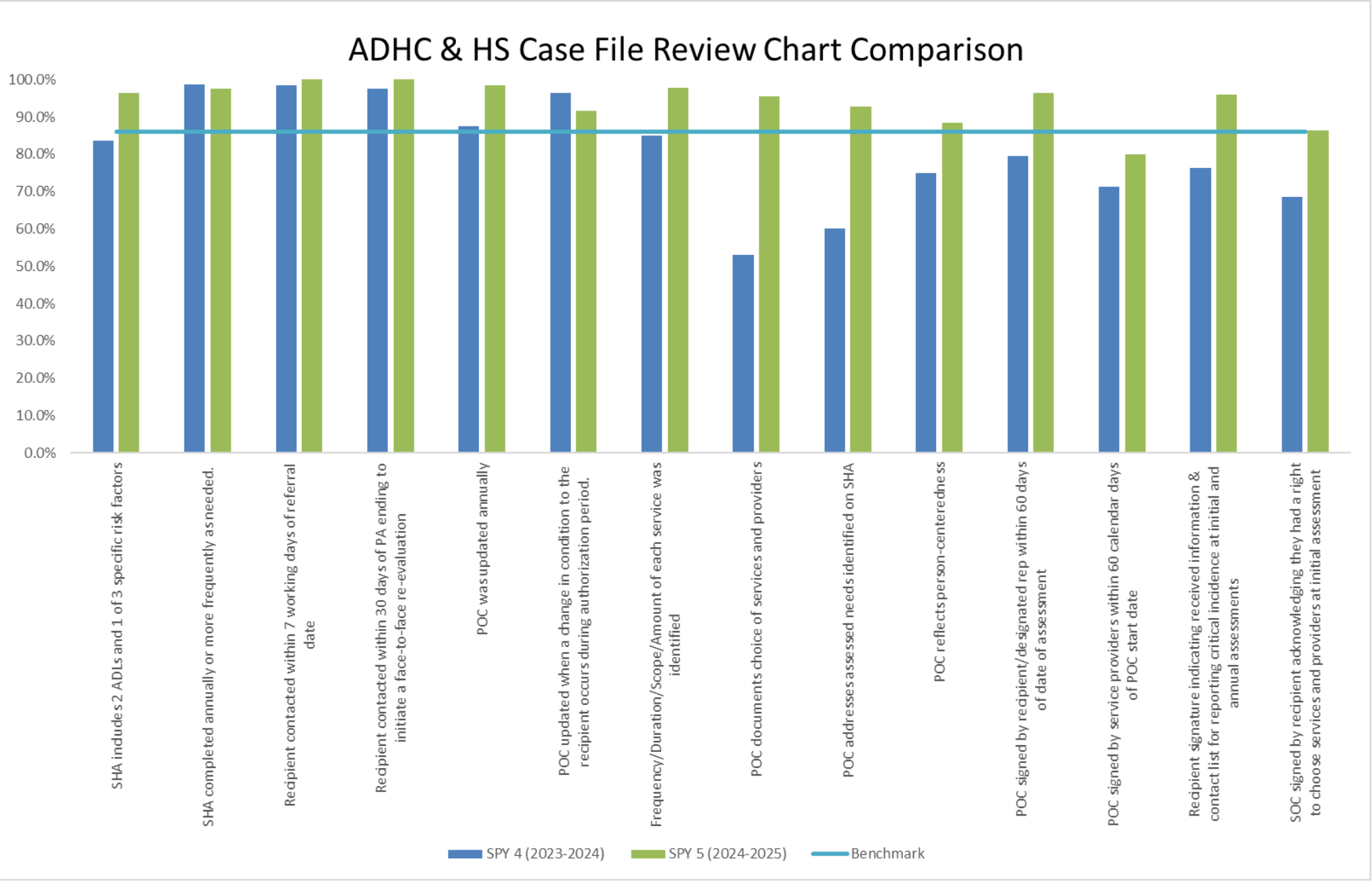
- MSM Chapter 3300 Program Integrity (Effective 05/01/2019)
- State Plan: 1915(i) HCBS State Plan Services (Effective 03/01/2020, Amended 01/01/2024)
- 42 CFR 441.301(c)(1) – (c)(5), 441.540, and 441.710-730
- NAC Chapter 449
- NRS Chapter 449
- Social Security Act: 1915(i) (1)(a) through (j)
- Policy and Procedure (P&P) Adult Day Health Care and Habilitation Policy and Procedure Memo 2024-1

** Note: Percentages noted throughout this annual report have been calculated by the total number provided and correct over the total number required.*

SPY 5 (2024-2025) Case File Review Results for ADHC & HS

Eligibility	
Social Health Assessment (SHA) includes 2 ADLs & 1 of 3 specific risk factors	96.3%
SHA completed annually or more frequently as needed	97.6%
Recipient contacted within 7 working days of referral date	100%
Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation	100%
DHCFP Plan of Care (POC)	
POC was updated annually	98.5%
POC updated when a change in condition to the recipient occurs during authorization period.	91.7%
Frequency/Duration/Scope/Amount of each service was identified.	97.8%
POC documents choice of services and providers.	95.5%
POC addresses assessed service needs identified on SHA.	92.7%
POC reflects the following person-centeredness: **overall compliance percentage for areas noted within a-g below*	*88.3%
a. Setting chosen by recipient	91.4%
b. Opportunities to access community/employment	89.0%
c. Reflects strengths and preferences (including cultural considerations)	86.7%
d. Identifies goals and desired outcomes	99.0%
e. Reflect risk factors	90.5%
f. POC is understandable	100%
g. Recipient's back up plan/strategies	88.2%
POC signed by recipient/designated rep with documentation within 60 days of date of assessment.	96.3%
POC signed by service providers within 60 calendar days of POC start date.	80.0%
Forms	
Recipient/des rep signature for reporting critical incidents at initial/annual assessments.	96.0%
SOC signed by recipient/des rep at initial/annually.	86.4%

SPY 5 (2024-2025) Case File Review Chart Comparison



Case File Review Findings

For SPY 5 (2024-2025), improvement is noted for twelve (12) components from the previous SPY 4 (2023-2024) review period. The areas and percentage of increase are as follows:

- SHA includes 2 ADLs and 1 of 3 specific risk factors: 13%
- Recipient contacted within 7 working days of referral date: 2%
- Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation: 2%
- POC was updated annually: 11%
- Frequency/Duration/Scope/Amount of each service was identified: 13%
- POC documents choice of services and providers: 42%
- POC addresses assessed needs identified on SHA: 33%
- POC reflects person-centeredness: 13%
- POC signed by recipient/designated rep within 60 days of date of assessment: 17%
- POC signed by service providers within 60 calendar days of POC start date: 9%
- Recipient signature indicating received information & contact list for reporting critical incidence at initial and annual assessments: 20%
- SOC signed by recipient acknowledging they had a right to choose services and providers at initial assessment: 18%

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the SPY 5 (2024-2025) review period, only one (1) element has been identified as needing further analysis:

- POC signed by service providers within 60 calendar days of POC start date: currently at 80.0% and has been steadily climbing in compliance. This element is not a mandatory reporting requirement for CMS, however, is tied to internal policies and therefore within review. This element is outside the control of Health Care Coordinators (HCC), as is on the providers to sign the POCs timely.

Recommendation:

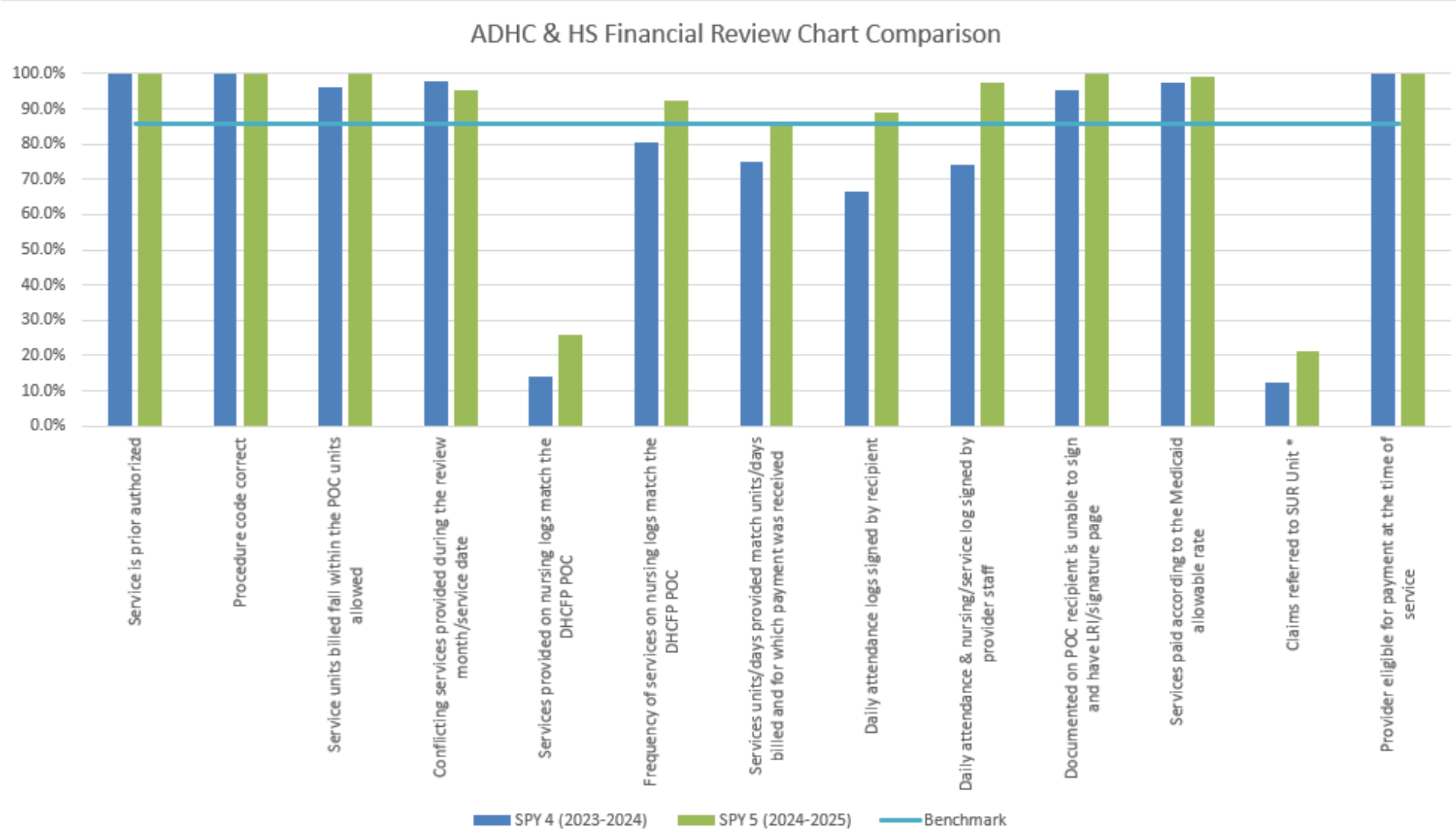
- Use a calendar alert system to track time sensitive documentation. This will remind HCCs to follow up on any documentation that has not been signed or received.

SPY 5 (2024-2025) Financial Review Results for ADHC & HS

Prior Authorization	
Is service prior authorized	100%
Claim	
Procedure code correct	100%
Service units billed fall within the POC units allowed	100%
No conflicting services provided during the review month/service dates	95.2%
Daily Records	
Services provided on nursing logs match the DHCFP POC	25.9%
Frequency of services on nursing logs match the DHCFP POC	92.5%
Service units/days provided match units/days billed and for which payment was received	85.0%
Daily attendance log signed by recipient	89.1%
Daily attendance & nursing/service log signed by provider staff	97.3%
Documented on POC recipient is unable to sign and have LRI/signature page	100%
Payment	
Services paid according to the Medicaid rate	99.3%
Referral made to SUR Unit	*78.9%
Provider eligible for payment at time-of-service provision	100%

**Denotes measures for which a lower number suggests a higher compliance rate.*

SPY 5 (2024-2025) Financial Review Chart Comparison



**Denotes measures for which a lower number suggests a higher compliance rate.*

Financial Review Findings

For SPY 5 (2024-2025), improvement is noted for eight (8) components from the previous SPY 4 (2023-2024) review period. The areas and percentage of increase are as follows:

- Service units billed fall within the POC units allowed: 4%
- Services provided on nursing/service logs match the DHCFP POC: 12%
- Frequency of services on nursing logs match the DHCFP POC: 12%
- Service units/days provided match units/days billed and paid: 10%
- Daily attendance logs signed by recipient: 23%
- Daily attendance & nursing/daily log signed by provider staff: 23%
- If applicable, provider submitted signature page: 5%
- Services paid according to the Medicaid allowable rate: 2%

CMS requires quality improvement projects/remediation when the threshold of compliance is below eighty-six percent (86%). For the SPY 5 (2024-2025) review period, two (2) elements are identified as needing further analysis:

- Services provided on nursing/service logs match the DHCFP POC: currently at 25.9% and has been steadily climbing in compliance. This element is not a mandatory reporting requirement for CMS, however, is tied to internal policies and therefore within review.
- Services units/days provided match units/days billed and for which payment was received: currently at 85.0% and has been steadily climbing in compliance.

Recommendations:

- Ensure the only services noted on the DHCFP POC are services that will be provided/rendered to the recipient while at ADHC and/or HS.
- Remind providers to verify they are billing the correct unit(s)/dates/times that recipients are receiving services away from the residence and/or not overlapping with times the recipient is noted as asleep.
- Ensure all providers are aware of the requirement to comply with the reviews and are submitting requested logs/attendance documentation timely.

Quality Improvement Strategy (QIS) Project Performance

Percentages are calculated by the total number provided and correct over the total number required.

* QIS noted below are elements reviewed and reported to by DHCFP QA. Elements not addressed below are reported directly to, or from, DHCFP LTSS 1915(i) unit.

Requirement 1: Plan of Care (POC)
a) address assessed needs of 1915(i) participants; b) are updated annually; c) document choice of services and providers.

1-a Service plans address assessed needs of 1915(i) participants.

ADHC & HS Combined 92.7%

- **Question 9: POC addresses assessed service needs identified on SHA**- In comparison to SPY 4 (2023-2024), this question shows a thirty-three percent (33%) increase in compliance. This element has come into compliance.

  Implementation: This element was historically out of compliance as two sets of plans were required, DHCFP POC and Provider SP, wherein not only was there a duplication of efforts but one was out of the control of the HCCs. Additionally, DHCFP QA's review process included an in-depth review of all documentation, meaning both years' worth of plans. When the MSM was amended on January 1, 2024, to no longer require the Provider SP, DHCFP QA updated the review process to more accurately track all the implemented changes in policy by completing an in-depth review on only the current year's documentation. Lastly, DHCFP LTSS 1915(i) unit implemented a desk manual for HCCs to use to complete their assessments and POCs. The desk manual has been updated several times throughout the year to ensure current policy requirements and best practices are being followed.

1-b Service plans are updated annually.

ADHC & HS Combined 98.5%

- **Question 5: POC was updated annually**- In comparison to SPY 4 (2023-2024), this question shows an eleven percent (11%) increase in compliance. This element remains in compliance.

1-c Service plans document choice of services and providers.

ADHC & HS Combined 95.5%

- **Question 8: POC documents choice of services and providers**- In comparison to SPY 4 (2023-2024), this question shows a forty-two percent (42%) increase in compliance. This element has come into compliance.

  Implementation: MSM was amended on January 1, 2024, policy no longer required

the provider SP to be reviewed. The DHCFP POC was amended to include verbiage ensuring choice of services and providers are addressed with the recipient.

Requirement 2: Eligibility Requirements
a) an evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is a reasonable indication that 1915(i) services may be needed in the future; b) the process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and c) the 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the state plan for 1915(i) HCBS.

2-b The process and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately

ADHC & HS Combined 96.3%

- **Question 1: SHA includes 2 ADLs and 1 of 3 specific risk factors**- In comparison to SPY 4 (2023-2024), this question shows a thirteen percent (13%) increase in compliance. This element has come into compliance.

  Implementation: DHCFP LTSS 1915(i) unit created a desk manual for HCCs to use to complete the SHA and ensure risk factors are addressed, which was the primary cause within last year's failure to meet compliance. The desk manual has been updated several times throughout the year to ensure current policy requirements and best practices are being followed.

2-c The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.

ADHC & HS Combined 97.6%

- **Question 2: Meets needs-based criteria annually**- In comparison to SPY 4 (2023-2024), this question shows a one percent (1%) decrease in compliance. This element remains in compliance.

Requirement 6: Financial Accountability

6-a The State Medicaid Agency (SMA) maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

ADHC & HS Combined 100%

- **Question 14: Provider eligible for payment at time-of-service provision**- In comparison to SPY 4 (2023-2024), this question remains at one hundred percent (100%) compliance.

6-b Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan.

ADHC & HS Combined 85.0%

- **Question 7: Service units/days provided match units/days billed and for which payment was received**- In comparison to SPY 4 (2023-2024), this question shows a ten percent (10%) increase in compliance. This element remains out of compliance.

  Recommendation: Providers have been ensuring they are submitting all logs as well as verifying the units match the service times prior to billing. It was observed that there were occasions where a log was missing, or the billed units conflicted with what units were listed on the logs, however, this element is anticipated to come into compliance within the next reporting period.

Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation

7-a Number and percent of 1915(i) recipients who receive information/education about how to report abuse, neglect, exploitation and other critical incidents.

ADHC & HS Combined 96%

- **Question 14: Recipient signature indicating received information & contact list for reporting critical incidence at initial and annual assessments** - In comparison to SPY 4 (2023-2024), this question shows a twenty percent (20%) increase in compliance. This element has come into compliance.

  Implementation: DHCFP LTSS 1915(i) unit created a desk manual for HCCs to use to ensure all required documentation was noted, addressed and completed at specified required intervals. The desk manual has been updated several times throughout the year to ensure current policy requirements and best practices are being followed.

As part of the consolidated review process, DHCFP's LTSS 1915(i) and QA units gather bi-monthly for a Consolidated State Plan Quality Improvement (QI) Committee meeting that goes over case file review findings and quarterly priority grid reviews addressing elements that are below the CMS mandated threshold of eighty-six percent (86%) needing improvement.

DHCFP LTSS 1915(i) unit continues to conduct Provider Reviews and enters information into ALiS (Online Provider Review System) database to be tracked and flagged for deficiencies. Depending on the deficiencies, DHCFP LTSS 1915(i) unit will send referrals to the appropriate state agency for review and create a corrective action plan, if necessary.

Observations

- DHCFP LTSS 1915(i) unit is working with ADSD and Therap on the creation of a new case management database. It is a collaborative effort to validate and ensure all elements required to safeguard the health, safety, needs and services of the recipient are captured, including alerts to mandatory fields so information is not missed or overlooked.
- Ensure all needed documents are signed and uploaded into OnBase or added within the Therap system beginning 07/01/2025.
- Ensure only appropriate services for the selected provider(s) are documented on the DHCFP POC.
- Continue to have quarterly meetings with providers to ensure understanding and importance of adherence to new policies, procedures and timely response to requests.
- DHCFP LTSS 1915(i) unit ensured all referrals and reassessments were completed accurately and timely.
- DHCFP LTSS 1915(i) unit held in-service trainings on needs-based criteria, specific risk factors, DHCFP POCs, frequency/duration/scope, and signatures as follows:
    - 04/16/2024 QA Overview with HCCs
    - 05/20/2024 New Hire Training
    - 10/14/2024 Refresher Training
    - 11/05/2024 HCC Home Visit Scheduling & Communications with Recipient Training
    - Provider Type (PT) 55 monthly meetings held to address any issues, settings, signatures, etc.
    - PT 39 quarterly meetings held to address any issues, settings, signatures, etc.
- DHCFP LTSS 1915(i) unit held quarterly meetings and trainings with all HCCs to focus on issues identified during the DHCFP QA priority grid review.
- DHCFP LTSS 1915(i) unit held individual meetings and trainings with HCCs, as needed, on new referrals, ongoing cases, deficiencies and made remediation plans when necessary.

1915(i) ADHC CASE FILE REVIEW REQUIREMENTS

Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM

	ELIGIBILITY
1) SHA includes 2 ADLs and 1 of 3 specific risk factors.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 2(b) (effective 07/01/2020 & 03/01/2025):** Eligibility Requirements: The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately. **CFR § 441.720, Independent assessment (a) (effective 01/03/2017 & 03/11/2024):** Requirements. For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. **CFR § 441.720, Independent assessment (a)(7) (effective 01/03/2017 & 03/11/2024):** Include in the assessment, for individuals receiving habilitation services, documentation that no Medicaid services are provided which would otherwise be available to the individual, specifically including but not limited to services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004. **§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility, (5) HCBS Eligibility Criteria (effective 03/01/2020):** A recipient must need assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors: At risk of social isolation due to lack of family or social support. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or A history of aggressive behavior if not supervised or if medication is not administered by a registered nurse. **§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility, (5) HCBS Eligibility Criteria (effective 03/01/2025):** A recipient must need hands-on assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors: • At risk of social isolation due to lack of family or social supports; or • At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or • At risk of aggressive behavior if not supervised by a registered nurse or if medication is not administered by an appropriate staff; or • At risk of their medical condition worsening, a person with a brain injury requires supervision by a trained direct care staff. **§1915(i) State Plan HCBS, Home and Community-Based Settings, (1) HCBS Eligibility Criteria (effective 03/01/2020):** Day Treatment facility – A setting that provides treatment to recipients with TBI or ABI outside their homes or residential facilities. Residential Group Homes for TBI or ABI - This setting is for individuals with TBI or ABI, who require services 24 hours per day in a normalized living environment and are not ready to live independently due to their functional or cognitive impairments. **§1915(i) State Plan HCBS, Home and Community-Based Settings, (1) HCBS Eligibility Criteria (effective 03/01/2025):** • Day Habilitation – A setting that provides treatment to recipients with TBI or ABI outside their homes or residential facilities. • Residential Habilitation – A setting for individuals with TBI or ABI, who require services 24 hours per day in a normalized living environment and are not ready to live independently due to their functional or cognitive impairments. The SMA will assess and determine that all 1915(i) settings initially meet all of the HCBS requirements through the provider enrollment process where prior to enrollment, the state will conduct an initial review of providers to ensure settings requirements are met prior to providing 1915(i) services. Additionally, providers must review and sign the HCBS Final Regulation Declaration.

	MSM Chapter 1800, Section 1803.1 (effective 02/01/2023): The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria consider the individual's support needs and risk factors. In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors: 1. At risk of social isolation due to lack of family or social supports; 2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or 3. A history of aggressive behavior if not supervised or if medication is not administered by an RN. The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations. **MSM Chapter 1800, Section 1803.1 (effective 02/01/2025):** The DHCFP 1915(i) HCBS State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors. In order to be eligible, a recipient must need hands-on assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors: 1. At risk of social isolation due to lack of family or social supports; or 2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or 3. At risk of aggressive behavior if not supervised by an RN or if medication is not administered by appropriate staff; or 4. At risk of their medical condition worsening, a person with a brain injury requires supervision by a trained direct care staff. The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations. **MSM Chapter 1800, Section 1803.1A(2)(b) (effective 02/01/2023 & 03/01/2025):** Day Habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI) as diagnosed by a physician. **MSM Chapter 1800, Section 1803.1A(2)(c) (effective 02/01/2023 & 03/01/2025)** Residential Habilitation-targeted to individuals with TBI or ABI as diagnosed by a physician.
2) SHA completed annually or more frequently as needed.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 2(c) (effective 07/01/2020 & 03/01/2025):** The 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS. **CFR § 441.720, Independent assessment (b) (effective 01/03/2017 & 03/11/2024):** Reassessments. The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan. **§1915(i) State Plan HCBS, Evaluation/Reevaluation of Eligibility, (4) Reevaluation Schedule (effective 03/01/2020 &03/01/2025):** Needs-based eligibility reevaluations are conducted at least every twelve months. **MSM Chapter 1800, Section 1803.6(A)(2)(a) & (b) (effective 02/01/2023 & 03/01/2025):** Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization. a. Prior to the 12-month authorization period ending, the HCC will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment or via telehealth under certain circumstances, to determine whether the recipient meets the needs-based criteria. b. If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC, as applicable.

3) Recipient contacted within 7 working days of referral date.	**MSM Chapter 1800, Section 1803.6(A)(1)(d) (effective 02/01/2023 & 03/01/2025):** If an applicant appears to meet program criteria, a face-to-face assessment or via telehealth under certain circumstances, will be scheduled to determine needs-based eligibility using the Comprehensive Social Health Assessment (CSHA) tool. The DHCFP HCC will contact the applicant/representative within seven (7) working days of the referral date to schedule a time to conduct an assessment.
4) Recipient contacted within 30 days of PA ending to initiate a face-to-face re-evaluation.	**MSM Chapter 1800, Section 1803.6(A)(2)(a) (effective 02/01/2023 & 03/01/2025):** Prior to the 12-month authorization period ending, the HCC will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment or via telehealth under certain circumstances, to determine whether the recipient meets the needs-based criteria.
DHCFP PLAN OF CARE (POC)	
5) POC was updated annually.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 1(b) (effective 07/01/2020 & 03/01/2025):** Plan of Care are updated annually. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (3) (effective 03/01/2020 & 03/01/2025):** The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. **MSM Chapter 1800, Section 1803.6(A)(2)(a) & (b) (effective 02/01/2023 & 03/01/2025):** Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization. a. Prior to the 12-month authorization period ending, the HCC will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation includes a face-to-face assessment or via telehealth under certain circumstances, to determine whether the recipient meets the needs-based criteria. b. If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC, as applicable.
6) POC updated when changes to the recipient occur during authorization period.	**CFR § 441.725, Person-Centered Service Plan (c) (effective 01/03/2017 & 03/11/2024):** Reviewing the person-centered service plan. The person-centered service plan must be reviewed and revised upon reassessment of functional need as required in § 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (3) (effective 03/01/2020 & 03/01/2025):** The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. **MSM Chapter1800, Section 1803.6(A)(2)(b) (effective 02/01/2023 & 03/01/2025):** If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC, as applicable.
7) Frequency/ Duration/Scope/Amount of each service was identified.	**CFR § 441.725, Person-Centered Service Plan (b) (effective 01/03/2017 & 03/11/2024):** Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit. **§1915(i) State Plan HCBS, Services, Adult Day Health Care, Day Habilitation and Residential Habilitation (effective 03/01/2020 & 03/01/2025):** Adult Day Health Care: Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. Day Habilitation: Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group.

	MSM Chapter 1800, Section 1803.6(C)(6) (effective 02/01/2023 03/01/2025): The POC identifies the services required, including type, scope, amount, duration and frequency of services.
8) POC documents choice of services and providers.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 1(c) (effective 07/01/2020 & 03/01/2025):** Plan of Care document choice of services and providers. **CFR § 441.540, Person-centered service plan (a)(6) (effective 01/03/2017 & 03/11/2024):** Person-centered planning process. The person-centered planning process is driven by the individual. The process …. Offers choices to the individual regarding the services and supports they receive and from whom. Includes a method for the individual to request updates to the plan. Records the alternative home and community-based settings that were considered by the individual. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (7) Informed Choice of Providers (effective 03/01/2020 & 03/01/2025):** The POC includes a section that the recipient or their AR signs to acknowledge the choice of services and providers. The information reviewed with the recipient/personal representative include: process for development of the POC, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time. **MSM Chapter 1800, Section 1803.4 (effective 02/01/2023 & 03/01/2025):** Day Habilitation: Services are identified in the recipient's 1915(i) POC according to recipient's need and individual choices. **MSM Chapter 1800, Section 1803.5 (effective 02/01/2023 & 03/01/2025):** Residential Habilitation: Services are identified in the recipient's 1915(i) POC according to recipient's need and individual choices.
9) POC addresses assessed needs identified on SHA.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 1(a) (effective 07/01/2020 & 03/01/2025):** Plan of Care address assessed needs of 1915(i) participants. **CFR § 441.725, Person-Centered Service Plan (a) (effective 01/03/2017 & 03/11/2024):** Person-centered planning process. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020 & 03/01/2025):** A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. **MSM Chapter 1800, Section 1803.6(C)(2) (effective 02/01/2023 & 03/01/2025):** The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative, and anyone else the recipient chooses. The Health Care Coordinator (HCC) documents this information in the CSHA narrative.
10) POC is person centered.	**CFR 441.725, Person-Centered Service Plan (a) (effective 01/03/2017 & 03/11/2024):** Person-centered planning process. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized rep if applicable). The person-centered planning process is driven by the individual. **CFR § 441.725, Person-Centered Service Plan (a)(4) (effective 01/03/2017 & 03/11/2024):**

	Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter. **CFR § 441.725, Person-Centered Service Plan (b)(7) (effective 01/03/2017 & 03/11/2024):** Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (2) Person-Centered Planning & Service Delivery (effective 03/01/2020 & 03/01/2025):** The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b). **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (8) Process of Making Person-Centered Service Plan to Approval of the Medicaid Agency (effective 03/01/2020 & 03/01/2025):** The POC is developed and implemented by the SMA HCC using a person-centered process. The HCC contacts all service providers to arrange for the agreed upon services. **MSM Chapter 1800, Section 1803.6(C)(2) (effective 02/01/2023 & 03/01/2025):** The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative and anyone else the recipient chooses. The HCC documents this information in the CSHA narrative.
a) Setting chosen by recipient. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(1) (effective 01/03/2017 & 03/11/2024):** Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in.
b) Opportunities to access community/ employment. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(1) (effective 01/03/2017 & 03/11/2024):** Supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. **§1915(i) State Plan HCBS: Person-Centered Planning & Service Delivery (6) (effective 03/01/2020 & 03/01/2025):** Planning includes…community integration and opportunities to participate in integrated settings/seek employment or volunteer activities.
c) Reflects strengths and preferences. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(2) (effective 01/03/2017 & 03/11/2024):** Reflect the individual's strengths and preferences. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020 & 03/01/2025):** Planning includes…personal preferences. **MSM Chapter 1800, Section 1803.6(C)(2) (effective 02/01/2023 & 03/01/2025):** The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative and anyone else the recipient chooses. The HCC documents this information in the CSHA narrative.
d) POC identifies the personalized goals of the POC.	**CFR § 441.725, Person-Centered Service Plan (b)(4) (effective 01/03/2017 & 03/11/2024):** Include individually identified goals and desired outcomes. **CFR § 441.725, Person-Centered Service Plan (b)(5) (effective 01/03/2017 & 03/11/2024):** Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including

	natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020 & 03/01/2025):** The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. **MSM Chapter 1800, Section 1803.6(C)(2) (effective 02/01/2023 & 03/01/2025):** The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative and anyone else the recipient chooses. The HCC documents this information in the CSHA narrative.
e) Reflects risk factors.	**CFR § 441.725, Person-Centered Service Plan (b)(6) (effective 01/03/2017 & 03/11/2024):** Reflect risk factors and measures in place to minimize them. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020 & 03/01/2025):** The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided. **MSM Chapter 1800, Section 1803.6(C)(4) (effective 02/01/2023 & 03/01/2025):** The POC development process considers risk factors, equipment needs, behavioral status, current support system and unmet service needs (this list is not all inclusive). The personalized goals are identified by the recipient and documented in the POC and each time the POC is updated with information obtained during the contacts with the recipient.
f) POC is understandable. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(7) (effective 01/03/2017 & 03/11/2024):** Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Plan (effective 03/01/2020 & 003/01/2025):** Planning includes…use of plain language.
g) Recipient's back up plan/strategies. (effective 03/17/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(6) (effective 01/03/2017 & 03/11/2024):** Reflect individualized back-up plans and strategies when needed.
11) POC signed by recipient/designated rep with documentation within 60 days of date of assessment. (effective 02/01/2023)	**CFR § 441.725, Person-Centered Service Plan (b)(9) (effective 01/03/2017 & 03/11/2024):** Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. **MSM Chapter 1800, Section 1803.6(C)(7)(a-c) (effective 02/01/2023 & 03/01/2025):** A recipient will receive a copy of the POC which must be signed within 60 calendar days of the date of assessment. a. If the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. b. The HCC shall document the recipient's verbal approval in the CSHA narrative and obtain the signature and date on the finalized POC. c. If the recipient authorizes an individual to be their designated representative, then the Designated Representative Attestation form must be completed and signed. **NRS 719.100** Defines "Electronic signature" as an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. In regard to the verification that would require a "security procedure" which is defined in NRS 719.160 as a procedure employed for the purpose of verifying that an electronic signature, record or performance is that of a specific person or for detecting changes or errors in the information in an electronic

	record. The term includes a procedure that requires the use of algorithms or other codes, deifying words or numbers, encryption or callback, or other acknowledgment procedures.
12) POC signed by service providers within 60 calendar days of the POC start date. (effective 02/01/2023)	**MSM Chapter 1800, Section 1803.6(C)(8) (effective 02/01/2023 & 03/01/2025)** The service providers are given a copy of the recipient's POC which must be signed and dated within 60 calendar days of the POC start date. The HCC ensures the provider returns a signed copy of the POC and Service Plan for the case file. **NRS 719.100** Defines "Electronic signature" as an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. In regard to the verification that would require a "security procedure" which is defined in NRS 719.160 as a procedure employed for the purpose of verifying that an electronic signature, record or performance is that of a specific person or for detecting changes or errors in the information in an electronic record. The term includes a procedure that requires the use of algorithms or other codes, deifying words or numbers, encryption or callback, or other acknowledgment procedures.
13) Recipient/ designated representatives' signature for reporting critical incidences at initial and annual assessments.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 7 (effective 07/01/2020 & 03/01/2025):** During initial and annual assessment, potential recipient/recipient will be educated and sign the acknowledgement form indicating they were given information on how report and provided a list of contacts for reporting critical incidence. The form will be kept in the case file for LTSS 1915(i) supervisor review monthly and for SMA QA review annually. **§1915(i) State Plan HCBS, Person-Centered Planning & Service Delivery (6) Supporting the Participant in Development of Person-Centered Service Plan (effective 03/01/2020 & 03/01/2025):** During the initial assessment, and development of the person-centered POC, the potential recipient, family, support systems, and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible. The person-centered planning process is driven by the individual, designated representative, legal guardian or other supports chosen by the individual and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible.
14) SOC signed by recipient/designated rep at initial assessment/annually. (effective 02/01/2023)	**MSM Chapter 1800, Section 1803.6(C)(5) (effective 02/01/2023 & 02/01/2025):** Facilitation of individual's choice regarding services and supports and who provides the services is given during the assessment. The recipient must sign the Statement of Choice (SOC) they had the right to choose the services and providers.
FINANCIAL REVIEW REQUIREMENTS	
Quality Improvement Sub Requirement, NAC, CFR, State Plan, MSM	
PRIOR AUTHORIZATION	
1) Is service prior authorized.	**MSM Chapter 1800, Section 1803.6(A)(2) (effective 02/01/2023 & 03/01/2025):** Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization. **MSM Chapter 100 Medicaid Program, Section 103.2(D) (effective 04/26/2023):** If a PA is required, it is the responsibility of the provider to request before providing services. **MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019)** Improper payments include but are not limited to: non-covered or unauthorized services. **MSM Chapter 3300 Program Integrity, Section 3303.3A(2)(l)(1) (effective 05/01/2019):** Requirement for all services to be prior authorized to be eligible for reimbursement.
CLAIMS	
2) Procedure code correct.	**§1915(i) State Plan (HCBS), Methods and Standards for Establishing Payment Rates (1) Rate Methodology (03/01/2020):** 7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

	MSM Chapter 100, Section 105.1(F) (effective 08/28/2019): Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the 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. **MSM Chapter 100, Section 105.1(F) (effective 04/26/2023):** All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines. **MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019):** Improper payments include but are not limited to: payments where the incorrect procedure code was billed (up-coding). **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(b) (effective 05/01/2019)** Claim billed with incorrect procedure code.
3) Service units billed fall within the POC units allowed.	**MSM Chapter 1800, Section 1803.6(C)(6) (eff. 02/01/2023 & 03/01/2025)** The POC identifies the services required, including type, scope, amount, duration and frequency of services. **MSM Chapter 100 Medicaid Program, Section 103.2(E) (effective 04/26/2023):** 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. It is the provider's responsibility to monitor PA utilization in accordance with the applicable policy. **MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019)** Improper payments include but are not limited to: payments where an incorrect number of units were billed. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(d) (effective 05/01/2019)** The number of units billed was incorrect.
4) Are there any conflicting services provided during the review month/service dates (Institutional care).	**§1915(i) State Plan (HCBS), Administration and Operation (8) Non-duplication of services (effective 03/01/2020 & 03/01/2025):** State plan HCBS 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 Education 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. **MSM Chapter 1800, Section 1803.1A(3)(a-e) (effective 02/01/2023 & 03/01/2025):** The following services are not covered benefits under the 1915(i) HCBS State Plan Option and are therefore not reimbursable: a. Services provided to an individual who is not eligible for Nevada Medicaid. b. Services rendered to a recipient who no longer meets the needs-based eligibility criteria. c. Services rendered to a recipient who is no longer in the community setting but is institutionalized (hospital, nursing facility, correction or Intermediate Care Facility (ICF) for intellectual or developmental disabilities). d. A recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible. e. For Day Habilitation or Residential Habilitation, services provided to an individual who does not have a TBI or ABI diagnosis. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(2)(a) (effective 05/01/2019)** Duplicate claims billed for same service, same recipient and same date of service.
	DAILY RECORDS
5) Services provided on	***Adult Day Health Care:***

service logs match the POC.	**MSM Chapter 1800, Section 1803.3B(3)(b) (effective 02/01/2023 & 03/01/2025):** The delivery of specific services required by the 1915(i) POC, must be documented in the nursing log. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting in the recipient's file. ***Day Habilitation*:** **MSM Chapter 1800, Section 1803.4B(2)(b) (effective 02/01/2023)** **MSM Chapter 1800, Section 1803.4B(3)(b) (effective 03/01/2025)** The delivery of specific services required by the 1915(i) POC must be documented in the daily service log and maintained in the recipient's file. ***Residential Habilitation*:** **MSM Chapter 1800, Section 1803.35(2)(a) (effective 02/01/2023):** **MSM Chapter 1800, Section 1803.35(3)(a) (effective 03/01/2025):** The delivery of specific services required by the 1915(i) POC must be documented in the daily service log and maintained in the recipient's file. **MSM Chapter 100 Medicaid Program, Section 105.1(L) (effective 01/12/2019):** 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). **MSM Chapter 3300 Program Integrity, Section 3303.2B(1) (effective 05/01/2019):** The 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.
6) Frequency of services provided matches the DHCFP POC.	**§1915(i) State Plan HCBS, Services, Adult Day Health Care, Day Habilitation and Residential Habilitation (effective 03/01/2020 & 03/01/2025):** Adult Day Health Care: Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. Day Habilitation: Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. **MSM Chapter 1800, Section 1803.6C(6) (effective 02/01/2023 & 03/01/2025):** The POC identifies the services required, including type, scope, amount, duration and frequency of services.
7) Service units/days billed match the delivery times/days services were provided and in accordance with the 1915(i) POC approved units.	**§1915(i) State Plan HCBS, Quality Improvement Requirement 6(b) (effective 03/01/2020 & 03/01/2025):** Percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. **MSM Chapter 100 Medicaid Program, Section 103(B)(4) (effective 04/26/2023)** Claims submitted are only for services rendered. **MSM Chapter 3300 Program Integrity, Section 3303.1A(2)(x)(2) (effective 05/01/2019)** False statements include: submitting a bill for a service not provided. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(a) (effective 05/01/2019)** No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP. **MSM Chapter 3300 Program Integrity, Section 3303.2A(4)(a)(1)(d) (effective 05/01/2019):** The number of units billed was incorrect.
8) Recipient signed	***Adult Day Health Care:*** Nursing Logs: Do not require signature from recipient.

attendance log daily and/or signed service log monthly.	**MSM Chapter 1800, Section 1803.3B(3)(c)(2-3) (effective 02/01/2023 & 03/01/2025):** Signatures: 2. The recipient must sign or initial the attendance log. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in Section 1803.6C(7)(c). ***Day Habilitation:*** Attendance Logs: **MSM Chapter 1800, Section 1803.4B(2)(a) (effective 02/01/2023 & 01/01/2024):** The facility must have documentation of daily attendance logs which includes: recipient's full name, date, time-in, time-out, and recipient's initials or signature. **MSM Chapter 1800, Section 1803.3B(3)(c)(2) (effective 02/01/2023 & 03/01/2025):** In addition to a provider's SP, the recipient must also sign or initial the attendance log. Service Logs: **MSM Chapter 1800, Section 1803.3B(3)(c)(3) (effective 02/01/2023 & 03/01/2025):** If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in 1803.6C(7)(c). **MSM Chapter 1800, Section 1803.4B(2)(c)(1-2) (effective 03/01/2023):** The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Director of the facility or designated acting Director. ***Residential Habilitation:*** **MSM Chapter 1800, Section 1803.5B(2)(b)(1-3) (effective 02/01/2023):** 1. The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Administrator or the employee designated to be in charge of the facility when the administrator is absent. 2. In addition to a provider's SP, the recipient must also sign the service log at minimum on a monthly basis. 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 designated representative may sign on behalf of the recipient as referenced in 1803.6C(7)(c). 3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the service log and any other signature requirements. **MSM Chapter 1800, Section 1803.2(D) (effective 02/01/2023 & 01/01/2024):** Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations. **MSM Chapter 3300 Program Integrity, Section 3303.1A(2)(v) (effective 05/01/2019):** Fraudulent acts, false claims or abusive billing practices include, but are not limited to: Coercion of recipients to sign Verification of Service forms for services not provided. **NRS 719.100** Defines "Electronic signature" as an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. In regard to the verification that would require a "security procedure" which is defined in NRS 719.160 as a procedure employed for the purpose of verifying that an electronic signature, record or performance is that of a specific person or for detecting changes or errors in the information in an electronic record. The term includes a procedure that requires the use of algorithms or other codes, deifying words or numbers, encryption or callback, or other acknowledgment procedures.

9) Attendance and service logs signed by provider staff at least monthly.	***Adult day Health Care:*** **MSM Chapter 1800, Section 1803.3B(3)(b)(2) (effective 02/01/2023 & 03/01/2025):** Nursing Logs: An appropriate provider staff member must sign and date the nursing log at minimum on a monthly basis indicating services were provided. **MSM Chapter 1800, Section 1803.3B(3)(c)(1) (effective 02/01/2023 & 03/01/2025):** Signatures: 1. The appropriate staff member includes, but not limited to: the RN, the LPN under the direct supervision of the RN, or the Program Director. ***Day Habilitation:*** **MSM Chapter 1800, Section 1803.4B(2)(a)(2) (effective 02/01/2023 & 03/01/2025):** Service Logs: An appropriate provider staff member must sign and date the service log at minimum on a monthly basis indicating services were provided. **MSM Chapter 1800, Section 1803.4B(2)(c)(1) (effective 02/01/2023 & 03/01/2025):** Signatures: The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Director of the facility or designated acting Director. ***Residential Habilitation:*** **MSM Chapter 1800, Section 1803.5B(2)(a)(2) (effective 02/01/2023 & 03/01/2025):** Service Logs: An appropriate provider staff member must sign and date the service log at minimum on a monthly basis indicating services were provided. **MSM Chapter 1800, Section 1803.5B(2)(b)(1) (effective 02/01/2023 & 03/01/2025):** Signatures: The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Administrator or the employee designated to be in charge of the facility when the administrator is absent. **MSM Chapter 100 Medicaid Program, Section 103.3(D) (effective 04/26/2023):** Medical Records; The actual rendering provider must complete and sign the documentation before they, or the billing provider (whether an individual or an organization), submits a claim to Medicaid for reimbursement.
10) If applicable, documented by CM recipient is unable to sign due to cognitive &/or physical limitations (cannot be signed by provider).	***Adult Day Health Care:*** **MSM Chapter 1800, Section 1803.3B(3)(c)(2-3) (effective 02/01/2023 & 03/01/2025):** Signatures: 2. The recipient must sign or initial the attendance log. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in Section 1803.6C(7)(c). 3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the attendance log and any other signature requirements. ***Day Habilitation:*** **MSM Chapter 1800, Section 1803.4B(3)(c)(3-4) (effective 02/01/2023 & 03/01/2025):** 3. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in Section 1803.6C(7)(c). 4.The facility may create a signature page which a designated representative should sign on behalf of the recipient signature for the attendance log and any other signature requirements. ***Residential Habilitation:***

	MSM Chapter 1800, Section 1803.5B(3)(b)(2-3) (effective 02/01/2023 & 03/01/2025): 2. The recipient must sign the service log at minimum on a monthly basis. 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 designated representative may sign on behalf of the recipient as referenced in Section 1803.6C(7)(c). 3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the service log and any other signature requirements.
	PAYMENTS
11) Services paid according to the Medicaid allowable rate.	**MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 08/28/2019):** Appropriate billings must include the current year procedure codes and ICD diagnostic codes or the 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. **MSM Chapter 100 Medicaid Program, Section 105.1(F) (effective 08/28/2019):** All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines. **MSM Chapter 3300 Program Integrity, Section 3302.4 (effective 05/01/2019)** Improper payments include but are not limited to: Payments over Medicaid allowable amounts. **MSM Chapter 3300 Program Integrity, Section 3302.6 (effective 05/01/2019):** 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. **MSM Chapter 3300 Program Integrity, Section 3303.2A(2)(d) (effective 05/01/2019):** Incorrect rate was used to pay the claim.
12) Referral made to Surveillance and Utilization Review (SUR) unit.	**MSM Chapter 100 Medicaid Program, Section 106.5(C) (effective 04/26/2023):** 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): c. Nevada Medicaid Surveillance Utilization and Review (SUR) staff. **MSM Chapter 3300 Program Integrity, Section 3302.4 (05/01/2019):** 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 be substantiated by appropriate or sufficient medical or service record documentation. Improper payments can also be classified as fraud and/or abuse.
13) Provider eligible for payment (active) at time-of-service provision.	**MSM Chapter 1800, Section 1803.1B(1) (effective 03/01/2020 & 02/01/2023):** In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service. **MSM Chapter 1800, Section 1803.3B(1) (effective 03/01/2023 & 03/01/2025):** Each provider of ADHC services must obtain and maintain licensure as required in the 1915(i) State Plan and NAC Chapter 449. Furthermore, providers must adhere to all requirements of NAC 449 as applicable to licensure. **MSM Chapter 100 Medicaid Program, Section 102(2) (effective 04/26/2023):** All individuals/entities who provide services to Nevada Medicaid recipients under the FFS and/or Medicaid Managed Care Organization (MCO) program shall be enrolled as a Nevada Medicaid provider in order to receive payment for services rendered

Acronyms & Definitions

ABI- ACQUIRED BRAIN INJURY
Refers to impaired brain functioning due to a medically verifiable incident including, but not limited to: 1. a cerebral vascular accident; 2. a ruptured aneurysm; 3. anoxia; or 4. hypoxia and brain tumors. Not all acquired brain injuries require or meet criteria for comprehensive rehabilitation services**.**

ADHC ADULT DAY HEALTH CARE
An organized program of services during the day in a group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being.

ADL- ACTIVITIES OF DAILY LIVING
Self-care activities routinely performed daily, such as bathing, dressing, grooming, toileting, transferring, mobility, continence and eating.

ADSD- AGING AND DISABILITY SERVICES DIVISION
A state agency that is part of Nevada's Department of Health and Human Services (DHHS) and is the operating agency of the Home and Community Based Services (HCBS) Waivers for the Frail Elderly, Physically Disabled, and Individuals with Intellectual Disabilities.

ALiS- ONLINE PROVIDER REVIEW SYSTEM
The Online Provider Review System (ALiS) allows users to schedule, complete, and provide results of an annual inspection for Nevada Medicaid's Home and Community Based Services (HCBS) providers.

ASA- ANNUAL SOCIAL ASSESSMENT
An assessment that is annually reviewed and addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

CFR- CODE OF FEDERAL REGULATIONS
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.

CM- 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 in certain areas of the state under the authority of Section 1905(a)(19) of the Social Security Act

CM- CASE MANAGER
A case manager is a specialized social worker and healthcare professional who oversees and coordinates the continued care of clinical patients. They often work with patients with long-term or chronic illnesses, ensuring that these patients receive effective care.

CMS- CENTERS FOR MEDICARE AND MEDICAID SERVICES
The Federal government entity that monitors state programs to assure minimum levels of public health service are provided, as mandated in the 42 CFR.

DTP- DAY TREATMENT PROGRAM
Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided at least two days a week by a multidisciplinary staff under the clinical supervision of a mental health professional.

DH- DAY HABILIATION
A program of scheduled activities, formalized training, and staff supports that promote skill development in self-help, socialization, and adaptive skills. It enables participants to increase or maintain their capacity for independent functioning and decision-making.

DHCFP- DIVISION OF HEALTH CARE FINANCING AND POLICY
A state agency that is part of Nevada's Department of Health and Human Services (DHHS) that works in partnership with the Centers for Medicare & Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources.

DME- DURABLE MEDICAL EQUIPMENT
Medically necessary durable medical equipment that a doctor prescribes for use in the home.

FPL- FEDERAL POVERTY LEVEL
The Federal Poverty Level (FPL) is a set income thresholds used to determine eligibility for various government assistance programs, such as Medicaid, food stamps, and subsidies. It is updated annually by the Department of Health and Human Services (HHS).

GER- GENERAL EVENT REPORT
A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates a substantial or serious harm to the safety or wellbeing of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient during the provision of waiver services (PCS), or loss of contact with the recipient for three consecutive scheduled days.

HS- HABILITATION SERVICES
Habilitation services (HS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCBS- HOME AND COMMUNITY-BASED SERVICES
Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

HCC- HEALTH CARE COORDINATOR
Health care coordinators, also called medical or health service managers, oversee the organizational aspects of patient care in healthcare organizations.

HCQC- HEALTH CARE QUALITY COMPLIANCE
The Bureau of Health Care Quality and Compliance (HCQC) licenses the following health facility types in Nevada.

HIPAA- HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

HHS- HEALTH AND HUMAN SERVICES
The United States Department of Health and Human Services is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services.

IA- INITIAL ASSESSMENT
This assessment is conducted as an administrative function of the waiver program and evaluates service needs based on functional deficits, support systems and imminent risk of institutionalization.

IADL- INSTRUMENTAL ACTIVITIES OF DAILY LIVING
Activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication, and money management.

ICD- INTERNATIONAL CLASSIFICATION DISEASE
ICD serves a broad range of uses globally and provides critical knowledge on the extent, causes and consequences of human disease and death worldwide via data that is reported and coded with the ICD.

ID- INTELLECTUAL DISABILITY
A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

LRI- LEGALLY RESPONSIBLE INDIVIDUAL
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.

LTSS- LONG TERM SERVICES AND SUPPORTS
A unit within the Division of Health Care Financing and Policy that provides services specifically to Medicaid eligible recipients. This includes services for a diverse group of Nevadans including the elderly and people living with disabilities and special health care needs. LTSS provides both institutional and home and community-based care.

MD- MEDICAL DOCTOR

A licensed medical practitioner.

MFCU- MEDICAID FRAUD CONTROL UNIT
Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities and board and care facilities and of Medicaid beneficiaries in noninstitutional or other settings.

MMIS- MEDICAID MANAGEMENT INFORMATION SYSTEM
A computer system designed to help managers plan and direct business and organizational operations.

MSM- MEDICAID SERVICES MANUAL
The policies that govern Medicaid services.

NAC- NEVADA ADMINISTRATIVE CODE
The Nevada Administrative Code (NAC) is the codified administrative regulations of the Executive Branch. The Nevada Register is a compilation of proposed, adopted, emergency and temporary administrative regulations, notices of intent and informational statements.

NF- NURSING FACILITY
NF is a general Nursing Facility, free-standing or hospital-based, which is licensed and certified by the Division of Public and Behavioral Health, Health Care Quality and Compliance, and provides both skilled and intermediate nursing services.

NMO- NEVADA MEDICAID OFFICE
The Nevada Medicaid Office is responsible for policy, planning and administration of the Nevada Medicaid program; also known as the Division of Health Care Financing and Policy.

PA- PRIOR AUTHORIZATION
Prior Authorization Request Nevada Medicaid and Nevada Check Up Adult Day Health Care (ADHC/DH-RH) request prior authorization for ADHC/DH-RH services through the Nevada Medicaid program.

PCA- PERSONAL CARE ASSISTANT
Personal care assistants, also known as caregivers, home health or personal care aides, give assistance to people who are sick, injured, mentally or physically disabled, or the elderly and fragile.

PCP- PERSON CENTERED PLANNING
An assessment and service planning process are directed and led by the individual, with assistance as needed or desired from representatives or other persons of the individuals choosing. The process is designed to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.

PCS- PERSONAL CARE SERVICES
Hands-on assistance with activities of daily living (ADLs) (such as eating, bathing, dressing, and bladder and bowel requirements) or instrumental activities of daily living (IADLs) (such as taking medications and shopping for groceries).

PCSP – PERSON CENTERED SERVICE PLAN
A written plan that reflects the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit

POC- PLAN OF CARE
A written plan that reflects the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit

P&P- POLICY & PROCEDURE
A transmittal issued on policies adopted by the DHCFP to provide clarification and guidance within the boundaries of that policy.

QA- QUALITY ASSURANCE
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.

QI- QUALITY IMPROVEMENT
A critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

QIO- QUALITY IMPROVEMENT ORGANIZATIONS
A Quality Improvement Organization (QIO) is a group of health quality experts, clinicians, and consumers organized to improve the quality of care delivered to people with Medicare.

QIS- QUALITY IMPROVEMENT STRATEGY
An approach to change. It provides a framework and tools to plan, organize, and then to monitor, sustain, and spread the changes that data show are improvements.

RN- REGISTERED NURSE
A healthcare provider who works with doctors and others to give you the best possible care.

RH- RESIDENTIAL HABILITATION
Formalized training and supports provided to clients who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the client's ability to independently reside and participate in an integrated community.

SAMS- SOCIAL ASSISTANCE MANAGEMENT SOFTWARE
Social Assistance Management Software or SAMS® manages consumer (recipient) and service data for social assistance organizations.

SC- SERVICE COORDINATOR
Responsible for monitoring and documenting the provision of waiver services, as well as recipient health and welfare. The Developmental Specialist or Psychiatric Caseworker qualified by educational background or training to assist, advise, direct, and oversee services to eligible individuals.

SHA – SOCIAL HEALTH ASSESSMENT
An assessment that addresses the recipient's activities of daily living (ADLs), which are self-care activities, such as bathing, dressing, grooming, transferring, toileting, ambulation, and eating. Instrumental activities of daily living (IADLs), which capture more complex life activities, are also assessed, including meal preparation, light housework, laundry, and essential shopping. In addition, this assessment includes information regarding the recipient's medical history and social needs. The assessment includes risk factors, back-up plans, equipment needs, behavioral status, current support system and unmet service needs.

SMA- STATE MEDICAID AGENCY
Medicaid agency or agency means the single State agency administering or supervising the administration of a State Medicaid plan.

SOC- STATEMENT OF CHOICE
A form given to all applicants describing the services offered under the waiver during the intake process. The assigned Service Coordinator informs the applicant of their choice between waiver services and placement in an ICF/ID, in addition to their choice of qualified providers.

SOR- SERIOUS OCCURRENCE REPORT
A report of any actual or alleged event or situation involving either the provider/employee or recipient that relates a substantial or serious harm to the safety or wellbeing of the provider/employee or recipient. Serious occurrences may include, but are not limited to the following: suspected physical or verbal abuse, unplanned hospitalization, neglect of the recipient, exploitation, sexual harassment or sexual abuse, injuries requiring medical intervention, an unsafe working environment, any event which is reported to Child or Elder Protective Services or law enforcement agencies, death of the recipient during the provision of waiver services (PCS), or loss of contact with the recipient for three consecutive scheduled days.

SP- SERVICE PLAN
Health care service plan means a plan that undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

SPA- STATE PLAN AMENDMENT
A Medicaid and 1915(i) state plan is an agreement between a state and the Federal government describing how that state administers its Medicaid and 1915(i) programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities.

SUR- SURVEILLANCE AND UTILIZATION REVIEW
A statewide program that safeguards against unnecessary or inappropriate use of services by preventing excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR unit analyzes claims data to identify potential fraud, waste, overutilization and abuse; collects provider overpayments and refers

appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution.

TBI- TRAUMATIC BRAIN INJURY

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.

TCM- TARGETED CASE MANAGEMENT

Targeted case management is case management services provided only to specific classes of individuals, or to individuals who reside in specific areas of the state (or both). Presently, Nevada State Medicaid has “targeted” case management services to specific classes of individuals.