MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 25, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER - ADDENDUM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Addendum are being proposed.

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: All enrolled Nevada Medicaid provider types.

Financial Impact on Local Government: No impact on local government known.

These changes are effective April 26, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL MSM ADDENDUM	MTL 10/17, 07/19, 23/15, and 12/16 MSM ADDENDUM

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section C	**Convicted**	Added new definition for Convicted.
Section E	**Emergency Medical Condition**	Updated definition of Emergency Medical Condition.
Section F	**Fiscal Agent**	Updated definition of Fiscal Agent.
Section M	**Medical Director**	Updated definition of Medical Director.

Section Q	**Quality Improvement Organization (QIO)-Like Vendor**	Updated definition of Quality Improvement Organization (QIO)-Like Vendor

4. An explanation of:

   a. The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

   b. In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

5. An explanation of the circumstances under which services are continued if a hearing is requested.

CONTINUITY OF CARE

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

CONTINUUM OF SERVICES

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

CONTRACT

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

CONTRACT PERIOD

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

CONTRACTOR

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

CONVICTED

1. A judgment of conviction has been entered against an individual or entity by a Federal, State, or local court regardless of whether:

a. There is a post-trial motion or an appeal pending, or

b. The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

2. A Federal, State, or local court has made a finding of guilt against an individual or entity;

3. A Federal, State, or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or

4. An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

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 Individuals with Intellectual Disabilities (ICF/IID).

3. Reasonable Cost: A reasonable cost is one that does not exceed that incurred by a prudent and cost-conscious facility operator.

COUNSELING SERVICES

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

COVERED SERVICES

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

CREDIBLE ALLEGATION OF FRAUD

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

1. Fraud hotline complaints;

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. This is a higher degree of need than one implied by the words "medically necessary" and requires a physician's determination that it exists.

EMERGENCY MEDICAL TRANSPORTATION

Emergency medical transportation is ground or air ambulance, as medically necessary, to transport a recipient with

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~~ Fee for Service claims for payment of covered services in accordance with policies and procedures established by Nevada Medicaid.

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.~~3. supply provider education and provider services; and

~~5.~~4. other administrative services.

FOR CAUSE

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

FRAUD

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

FREE APPROPRIATE PUBLIC EDUCATION (FAPE)

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

FULL TIME (F/T)

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

FUNCTIONAL ABILITY

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

FUNCTIONAL ASSESSMENT SERVICE PLAN (FASP)

MEDICAID BILLING NUMBER (BILLING NUMBER)

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

MEDICAID ESTATE RECOVERY (MER)

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

MEDICAID INTEGRITY

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

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

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

MEDICAL CARE ADVISORY COMMITTEE (MCAC)

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

MEDICAL CARE PLAN

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

MEDICAL DIRECTOR

~~The Medical Director must be a hospice employee who is a doctor of medicine or osteopathy. The Medical Director assumes overall responsibility for the medical component of the hospice's recipient care program. The Medical Director must be an approved Medicaid provider if he/she provides direct patient care services in order to bill for direct Medicaid reimbursement.~~ A Medical Director is a licensed provider who is allowed to be a Medical Director based upon their specific industry's scope of practice which is defined by Nevada Revised Statutes, Nevada Administrative Code, licensing board, or any other regulatory body.

MEDICAL DOCUMENTATION

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).

Throughout the Medicaid Services Manual (MSM), the term "QIQ-like vendor" is utilized. This term refers to either the Fee-for-Service (FFS) or Managed Care Organization (MCO) vendor that manages the coverage for the Nevada Medicaid recipient.