Medicaid Services Manual
Transmittal Letter

March 25, 2025

To: Custodians of Medicaid Services Manual

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Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 100 – Medicaid Program

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 100– Medicaid Program are being proposed to Sections 102 Provider Enrollment – Conditions of Participation, 103 Provider Rules and Requirements, 106 Contract Terminations, and 107 Re-enrollment.

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 (PT).

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

These changes are effective March 26, 2025.

Material Transmitted		Material Superseded
MTL 07/25		MTL 19/15, 3/23
MSM Chapter 100 - Medicaid Program		MSM Chapter 100 - Medicaid Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102(A)(5)	**Provider Enrollment – Conditions of Participation**	Language updated to reflect 30-day timeframe for reporting any negative action.
102(D)(4)		Language updated to reflect 30-day timeframe for reporting change of ownership and wording changed from ‘shall’ to ‘may’ regarding termination for listed items.
102.2(A)(1)(o)	**All Providers and Applicants –**	Removed Skilled Nursing Facilities (SNF) from limited categorical risk.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Conditions of Participation	
102.2(A)(2)(d)		Added revalidating hospice organizations as moderate risk.
102.2(A)(2)(l)		Added revalidating SNF.
102.2(A)(3)(f-g)		Added newly enrolling hospice organizations and newly enrolling SNF.
102.2(F)(1-2)		Language added to include action taken should a provider be listed within Data Exchange System (DEX) or excluded for cause from any Medicaid or Medicare program.
102.2(G)		Language added regarding crimes/offenses which may preclude enrollment as well as the disclosure of these convictions.
102.2(H)		Language added regarding disclosure of other negative events/circumstance and the case-by-case basis of evaluation of such disclosure.
103.3(A-B)	**Provider Reporting Requirements**	Language updated to reflect new reporting timeframes and requirements.
103.4(A)	**Conditions of Reporting**	Language updated to reflect new reporting timeframes and requirements.
106.2(A)	**Conditions of Contract Terminations**	Federal mandate language added as it relates to immediate terminations.
106.2(B)		Language added regarding potential for extension of the 20-day notice of termination.
106.3	**Sanction Periods**	Language added regarding review of sanctions imposed due to conviction or provider conduct.
106.4A(4-5)	**Administrative Contract Terminations**	Grammatical updates, addition of National Provider Identifier (NPI) deactivation.
107.1(A)	**Re-enrollment, Conditions of Re-enrollment**	Language added regarding provider sanction and subsequent addition to the Nevada Exclusions List evaluation.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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MEDICAID PROGRAM

100 INTRODUCTION

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

The Medicaid Services Manual (MSM) has additional chapters regarding covered services, policies, and procedures for all enrolled providers. Additionally, this publication has an Addendum that defines terms such as Fiscal Agent, Quality Improvement Organization (QIO)-like Vendor, Conviction, etc. All chapters of the MSM, including the Addendum, can be found at: https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/.

A. The mission of the Nevada DHCFP (Nevada Medicaid) is to:

1. purchase and provide quality health care services to low-income Nevadans in the most efficient manner;

2. promote equal access to health care at an affordable cost to the taxpayers of Nevada;

3. restrain the growth of health care costs; and

4. review Medicaid and other State health care programs to maximize potential federal revenue.

B. For the purposes of this chapter, individuals and/or entities that have never been enrolled with Nevada Medicaid as a provider who submit an initial enrollment application and former Nevada Medicaid providers who submit a re-enrollment application are considered applicants. The term "Applicant" includes:

1. individuals;

2. groups and/or entities;

3. owners having 5% or more direct or indirect ownership or controlling interest in a group and/or entity; and/or

4. authorized agents, authorized users or managing employees acting with authority on behalf of an individual, group, entity and/or owner.

C. For the purposes of this chapter and the *Nevada Medicaid and Nevada Check Up Provider Contract*, individuals and/or entities actively enrolled with Nevada Medicaid are considered providers. The term "Provider" includes:

1. individual providers;

2. groups and/or entity providers;

3. owners having 5% or more direct or indirect ownership in a group and/or entity; and/or

4. authorized agents, authorized users or managing employees acting with authority on behalf of an individual, group, entity and/or owner.

D. DHCFP partners with our Fiscal Agent to conduct enrollment activities, including review of all application types, verification of licensure and certification submissions, maintenance of provider files, among other related activities.

Applicants and providers are required to obtain and maintain an active National Provider Identifier (NPI) before submitting an enrollment request. There are two types of healthcare provider NPI numbers:

1. Type 1 (individual) - A healthcare provider who conducts business as an individual or as a sole proprietor.

2. Type 2 (organizational) - A healthcare provider who conducts business as an organization or a distinct subpart of an organization, such as a group practice, a facility, or a corporation (including an incorporated individual).

Note: A healthcare provider rendering services as an individual and also conducting business as an incorporated entity, must obtain a Type 1 NPI as an individual and also a Type 2 NPI as a corporation or limited liability company (LLC).

100.1 AUTHORITY

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

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

A. Below is a list (not all inclusive) of specific Authorities:

1. Eligibility for Medicaid assistance is regulated by Section 1901(a) of the SSA, 42 CFR §435, and Nevada Medicaid State Plan Section 2.1.

2. Payment for Medicaid services is regulated by Sections 1902(a) and 1923 of the SSA, 42 CFR §447, and Nevada Medicaid State Plan Sections 4.19 and 4.21.

3. Provider contracts/relations are regulated by 42 CFR §431, Subpart C; 42 CFR §483 and Nevada Medicaid State Plan Section 4.13.

4. Safeguarding and disclosure of information on applicants and recipients is regulated by 42 United States Code (USC) 1396a(a)(7), and the associated regulations: 42 CFR §431, Subpart F; the Health Insurance Portability and Accountability Act (HIPAA) and associated regulations: 45 CFR §160, §162 and §164 and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009; Nevada Medicaid State Plan Section 4.3, and NRS 422.290. Penalties for unauthorized use or disclosure of confidential information are found within the HITECH Act and NRS 193.170.

5. Prohibition against reassignment of provider claims is found in 42 CFR §447.10 and Nevada Medicaid State Plan Section 4.21.

6. Exclusion and suspension of providers is found in 42 CFR §1002.203 and Nevada Medicaid State Plan 4.30.

7. Submission of accurate and complete claims is regulated by 42 CFR §455.18 and §444.19.

8. Nevada Medicaid assistance is authorized pursuant to NRS, Chapter 422, DHCFP.

9. Third Party Liability (TPL) policy is regulated by Section 1902 of the SSA, 42 CFR §433, Subpart D, and the Nevada Medicaid State Plan Section 4.22.

10. Assignment of insurance benefits by insurance carriers is authorized pursuant to NRS, Title 57, Insurance, based on the type of policy.

11. Subrogation of medical payment recoveries is authorized pursuant to NRS 422.293.

12. “Advance Directives” are regulated by 42 CFR §489, Subpart I and NRS Chapter 449A, Care and Rights of Patients.

13. Worker’s compensation insurance coverage is required for all providers pursuant to NRS Chapter 616A through 616B.

14. Section 1902(a)(68) of the SSA establishes providers as 'entities' and the requirement to educate their employees, contractors and agents on false claims recovery, fraud and abuse.

15. Offering gifts and other inducements to beneficiaries is prohibited pursuant to Section 1128A(a)(5) of the SSA, enacted as part of the HIPAA.

16. Section 6401(b) of the Affordable Care Act (ACA) amended Section 1902 of the SSA to require states to comply with procedures established by the Secretary of Health and Human Services for screening providers and suppliers. Section 6401(c) of the ACA amended Section 2107(e) of the SSA to make the provider and supplier screening requirement under Section 1902 applicable to the Children's Health Insurance Program (CHIP). The Centers for Medicare and Medicaid Services (CMS) implemented these requirements with federal regulations at 42 CFR §455 Subpart E.

17. Provider Categorical Risk Levels are assigned, in part, under 42 CFR §424.518.

18. Enhanced provider screening can be found under 42 CFR §455.432 for site visits and 42 CFR §455.434 for criminal background checks.

19. Citizenship/Lawfully Residing: Statute SSA 2105(c)(9); SSA 2107(e)(1)(M); CHIP Reauthorization Act of 2009 (CHIPRA) 2009 Sections 211 and 214; 8 U.S.C. Sections 1612, 1613 and 1641; 42 CFR §457.320(b)(6), (d) and (e); and §457.380(b).

20. Suspension of payments in cases of fraud as required in 42 CFR §455.23.

21. Section 245A(h) of the Immigration and Nationality Act.

22. NRS Chapter 162C – Supported Decision-Making Act.

23. NRS Chapter 193 – Criminality Generally.

24. NRS Chapter 197 – Crimes by and Against the Executive Power of This State.

25. NRS Chapter 198 – Crimes Against the Legislative Power.

26. NRS Chapter 199 – Crimes Against Public Justice.

27. NRS Chapter 200 – Crimes Against the Person.

28. NRS Chapter 201 – Crimes Against Public Decency and Good Morals.

29. NRS Chapter 232 – State Departments.

30. NRS Chapter 454 – Poisons; Dangerous Drugs and Hypodermics.

31. NRS Chapter 432 – Public Services for Children.

32. NRS Chapter 449A – Care and Rights of Patients.

33. NRS Chapter 603A – Security and Privacy of Personal Information.

34 NRS Chapter 616D – Industrial Insurance: Prohibited Acts; Penalties, Prosecution.

100.2 CONFIDENTIAL INFORMATION

All individuals have the right to a confidential relationship with DHCFP. All information maintained on Medicaid and CHIP applicants and recipients ("recipients") is confidential and must be safeguarded.

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

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

A. Definition of Confidential Information

For the purposes of this manual, confidential information includes:

1. Protected Health Information (PHI)

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

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

a. the individual's past, present or future physical or mental health or condition;

b. the provision of health care to the individual;

c. the past, present, or future payment for the provision of health care to the individual; or

d. identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.

b. Information which does not meet the requirements of de-identified data defined in 45 CFR 164 § 514(b). This includes all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death.

2. Information on social and economic condition or circumstances.

3. Division/Department evaluation of personal information.

4. Any information received for verifying income eligibility and amount of medical assistance payments.

5. Any information received in connection with the identification of legally liable third-party resources.

6. Personal information as defined by NRS 603A.040.

B. Limitations on Use and Disclosure

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

1. Establishing eligibility;

2. Determining the amount of medical assistance; payment activities as defined by HIPAA;

3. Determining third party liability;

4. Providing services (medical and non-medical) for recipients; treatment as defined by HIPAA;

5. Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Plan;

6. Health care operations as defined by HIPAA, which includes, but is not limited to: quality assessment and improvement activities, including case management, and care coordination, competency assurance activities, medical reviews, audits, fraud and abuse detection, rate setting, business management and general administration;

7. For public interest and benefit activities within limits set under HIPAA, including, but not limited to: disclosures required by law, public health activities, health

oversight activities, judicial and administrative proceedings, essential government functions, to comply with worker's compensation laws, and to avoid serious threats to the health and safety of recipients and others.

8. Per authorizations (as defined by HIPAA) from the recipient or their designated representative.

C. Release of Information

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

1. Disclosure is permitted for purposes directly connected with the administration of Medicaid between covered entities (as defined by HIPAA) for the purposes of treatment, payment, and health care operations and may, in certain circumstances, be done in the absence of an authorization or agreement. Such situations include but are not limited to: verifying information with Medicaid program staff in other states to verify eligibility status, disclosure to Medicare staff for coordination of benefits or communications with providers for payment activities.

2. Access to confidential information regarding recipients will be restricted to those persons or agencies whose standards of confidentiality are comparable to those of DHCFP.

   a. Those standards of confidentiality will be outlined in appropriate agreements which DHCFP may require, including business associate agreements and limited data set use agreements (as defined by HIPAA) data sharing agreements, and other agreements deemed necessary by DHCFP.

3. In accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of DHHS in the performance of official duties and with local governments that help the Department carry out official duties as long as the disclosure is related to treatment, payment or health care operations.

4. DHCFP will make reasonable efforts to follow HIPAA's "minimum necessary" standard when releasing confidential information.

5. Detailed policies and procedures are found in DHCFP HIPAA Privacy and Security Manuals, available for reference in hard copy form in the District Office and on the DHCFP website.

D. Penalties

Penalties for inappropriate use and disclosure of confidential information are:

1. The HITECH Act imposes civil and criminal penalties depending upon the nature and scope of the violation, which range from $100 to $1.5 million dollars and up to ten years in prison. This is enforced by the Office for Civil Rights. State Attorneys General have the authority to bring civil actions on behalf of state residents for violations of HIPAA Privacy and Security Rules.

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

E. Ownership

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

101 OVERVIEW OF PROGRAMS

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

A. Medicaid

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

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

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

B. Nevada Check Up (NCU)

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

C. State Plan Services under 1915(c) of the SSA

Section 1915(c) of the SSA permits states the option to waive certain Medicaid statutory requirements in order to offer an array of Home and Community-Based Services (HCBS) to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. Each 1915(c) Waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services, as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

D. State Plan Services under 1915(i) of the SSA

Section 1915(i) of the SSA allows states to provide traditional 1915(c) services as a covered state plan benefit. 1915(i) services are available to certain Medicaid recipients who meet the needs-based criteria and who reside in the community.

101.1 OUT-OF-STATE SERVICES

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

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

A. needed because of a medical emergency.

B. recipients' health would be in danger by the travel back to Nevada.

C. Nevada Medicaid determines, on the basis of medical advice, that the needed medical service or necessary supplementary resources are readily available in another state; or

D. provided to the children in out-of-state placement for whom Nevada makes adoption assistance or foster care maintenance payments.

E. it is general practice for a recipient in a particular locality to use medical resources in another state:

1. Nevada residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what DHCFP refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation. Refer to the billing manual for a list of catchment areas.

2. The same services that are covered within the state of Nevada are available for payment for any qualified provider, in the catchment area, who is or will be enrolled with the plan.

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

101.2 NEVADA MEDICAID AND NCU CARD

Medicaid and NCU recipients are issued a plastic identification card upon approval for benefits, through the State Medicaid Management Information System (MMIS). The card is issued with his/her full eleven-digit billing number, last name, first name, gender, and date of birth. The card does not identify the category of eligibility, nor does it carry photographic or other individual identifying information and it does not guarantee eligibility for benefits. The recipient is not responsible to return the card when the case is closed, and they may use the same card for any subsequent eligibility. A digital Medicaid card is also available through the NV Medicaid app. All eligible Nevada Medicaid recipients are eligible to download and log into the app to receive this and other information about their healthcare and eligibility. For additional information, please see "NV Medicaid App" in Section 108, References.

101.2A ELIGIBILITY VERIFICATION AND CARD USE

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

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

2. Eligibility is determined on a month-to-month basis. Providers must always verify recipient eligibility prior to providing services, as well as the identity of the individual through a driver's license, Social Security card or photo identification. Recipients must be prepared to provide sufficient personal identification to providers and shall not allow any individual to use their card to obtain medical services.

   Note: Providing services without prior verification of identity is at the risk of the provider. Payments for services rendered to an individual who is not eligible due to misidentification or failure to verify eligibility may be subject to recoupment.

3. Newly approved Medicaid recipients may present a Notice of Decision (NOD) from DWSS as proof of eligibility, prior to the EVS update.

4. Individuals may have more than one active billing number on file at the same time; e.g., a child may be eligible through Child and Family Services and have a Welfare case at the same time. When this happens, the Division's District Office can advise the provider which number to use for billing.

5. Medicaid and NCU have contracts with Managed Care Organizations (MCOs) to provide medical coverage to eligible categories of individuals in Clark and Washoe County. Nevada Medicaid and NCU reimburse managed care providers a capitated monthly rate for each enrollee and cannot reimburse any other provider independently for covered, contracted services. Refer to MSM Chapter 3600, Managed Care for detailed information about the Managed Care program.

6. Recipients enrolled in a Medicaid managed care plan must be sure to seek services only from plan providers. Recipients should notify their providers as soon as they become eligible for managed care. Refer to MSM Chapter 3600.

7. In most cases, managed care eligibility begins the date of approval. Medicaid prior medical months are covered under Fee-for-Service (FFS). Refer to MSM Chapter 3600 for additional information on Managed Care.

101.2B CHILD WELFARE RECIPIENTS

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

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

101.2C RESTRICTIONS

1. Certain recipients who have inappropriately used medical services may have their access to Medicaid services restricted by Medicaid Staff.

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

102 PROVIDER ENROLLMENT – CONDITIONS OF PARTICIPATION (1)

A. The following paragraphs in this section present highlights of detailed information outlined in this chapter. The following information by no means absolves applicants or providers from reading and comprehending this chapter in its entirety, along with any other chapters specific to the services each will provide or currently provides. By signing the Provider Application and/or Contract, or authorizing a person to sign on your behalf, all applicants/providers agree to the Contract terms and to abide by the MSM, the NCU Manual, and the MOM, all inclusive.

1. All applicants and/or providers who sign, or designate a person to sign on their behalf, or present to DHCFP or Fiscal Agent any information or documentation accepts responsibility for the truth and accuracy of the information as well as an ongoing obligation to update such information.

2. All individuals/entities who provide services to Nevada Medicaid recipients under the FFS and/or Medicaid MCO program shall be enrolled as a Nevada Medicaid provider in order to receive payment for services rendered.

3. All healthcare providers shall obtain an NPI number and provide this NPI to Medicaid at the time of application, revalidation and/or change request submission. To obtain an NPI or further information regarding NPI, see the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov.

4. With the exception of emergency services (in-state or out-of-state/out-of-catchment), if an individual and/or entity chooses to provide services to Nevada Medicaid recipients prior to being approved as a Nevada Medicaid provider, the individual and/or entity chooses to do so with the understanding that enrollment, and therefore reimbursement, is not guaranteed and could also be impacted by timing and compliance with other policy requirements.

5. All applicants and providers shall be screened prior to, or for continued, enrollment. Screening methods may utilize professional state boards, public access information, or other state and/or federal databases. Any arrest, conviction, including suspended sentence with probation, exclusion, revocation, or other similar negative action against an applicant or provider as defined in this chapter, regardless of the current status of such action or date of conviction, shall be disclosed for evaluation at the time of application, revalidation, or change, or within 30 working days of such negative action.

6. DHCFP is not obligated to enroll, re-enroll, or re-validate all eligible applicants or providers, and all types of enrollments are at the discretion of DHCFP.

7. Providers whose mail is returned to DHCFP as "undeliverable," "return to sender," "address unknown," "unclaimed," or any other reason noted by the U. S. Post Office as a reason for which DHCFP mail was returned, may be terminated. It is the responsibility of each provider to maintain all provider information including all addresses in the Medicaid online provider enrollment (OPE) system. Provider address information may be provided to CMS under provisions such as Section 1902(a)(27) of the SSA and will be based on current records.

8. All providers who are terminated shall have 90 days from the date of termination to request a Fair Hearing and are required to follow the guidelines outlined in the termination notice and MSM Chapter 3100, Hearings, when requesting a Fair Hearing.

9. For all entities terminated and sanctioned by DHCFP under "for-cause" criterion, the owner, managing employee/agent, and/or board member(s) shall also be terminated, if applicable, and serve the same sanction time frame as the entity.

10. For all individuals terminated and/or sanctioned by DHCFP under "for-cause" criterion, any entity which is enrolled with the sanctioned individual as an owner, managing employee/agent, and/or board member shall also be terminated and serve the same sanction time frame as the individual.

B. Medicaid may reimburse a provider who meets the following conditions:

1. Completes and submits electronically the Nevada Medicaid Provider Application and Contract, and if applicable, submits to and completes the Fingerprint-based Criminal Background Check (FCBC) process and/or adheres to the requirements of Provisional Enrollment;

2. Provides their NPI number on the application and requests for payment, maintains their NPI in "Active" status in the NPPES Registry and updates all data elements, per NPPES guidelines, when changes occur;

3. Meets all the professional credentialing requirements or other conditions of participation for the provider type (PT);

4. Meets all the criteria to operate a business in Nevada or in the state in which the business exists. This may include, but is not limited to, an active business license, insurance binder with appropriate limits, agency licensure, permits, certifications, and authority;

5. Receives notice from Nevada Medicaid that the credentialing requirements have been met and the provider agreement has been accepted; and

6. Electronically submits timely, complete, and accurate claims and obtains Prior Authorization (PA) approval as outlined and required in policy.

C. CHANGE OF OWNERSHIP (CHOW)

A CHOW typically occurs when a Medicaid provider is purchased or leased by another organization and or individual. A CHOW also includes a change in Board Member(s) and/or anyone having 5% direct/indirect interest. The following list indicates examples (not all inclusive) of a CHOW:

1. Partnership: In the case of a partnership, the removal, addition, or substitution of a partner as permitted by applicable State law.

2. Unincorporated sole proprietorship: Transfer of title and property to another party.

3. Corporation: The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. This includes the requirement to report changes to corporate structure relating to ownership, officers, directors, and/or managers.

4. Leasing: The lease of all or part of a provider facility constitutes change of ownership of the leased portion.

5. Sale/Transfer: The sale, gifting, purchase, or transfer of an existing provider or the assets of an existing provider to an individual, relative and/or group.

6. LLC or Limited Liability Partnership (LLP), including Professional LLCs and LLPs: The election or removal of a "Member" or "Managing Member" as defined in the NRS or as defined by applicable law for an approved out-of-state provider.

7. All differences or discrepancies found in ownership or direct/indirect interest between information submitted to Nevada Medicaid and information found in Provider Enrollment, Chain, and Ownership System (PECOS) shall be reported to CMS, when appropriate, and may delay Nevada Medicaid action on a CHOW or other request. It is the responsibility of providers enrolled with CMS to report to and update all changes with CMS.

D. CHOW Enrollment:

1. is not guaranteed,

2. is considered a new enrollment,

3. must meet all enrollment requirements for the specified PT,

4. must be reported within 30 days of completion.

Providers or applicants having (or formerly holding) a direct or indirect ownership or controlling interest of 5% or more who purchase, sell and/or transfer such interest in an entity in anticipation of (or following) any of the below may be terminated or have enrollment denied and will serve, at minimum, a Tier 4 – 12-Month Sanction, unless a higher tier sanction is applicable. Examples include but are not limited to:

5. a conviction;

6. an imposition of a payment suspension, civil money penalty or assessment;

7. an imposition of an exclusion and/or a "for cause" termination; and/or

8. any negative action against the professional license of an owner or person with direct/indirect interest.

If there is a change in ownership or interest (direct or indirect), the new owner, person with interest or designated agent shall submit a copy of the bill of sale, contract, or assignment, copies of new licenses/certifications and/or verification of a change in the Federal Employer Identification Number (FEIN). The incoming owner, person with interest, or designated agent must also complete/submit an initial enrollment application and meet Nevada Medicaid's fitness criteria to remain enrolled with Nevada Medicaid and any MCO.

When there is a CHOW, the terms and agreements of the original Contract are assumed by the new owner, and the new owners shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined.

If a CHOW is reported and returned with a request from the Fiscal Agent and/or DHCFP with no reply or cooperation, the active provider may be terminated, and the CHOW application denied if/when resubmitted.

E. PROHIBITED FROM ENROLLMENT CONSIDERATION

Applicants who are found to have provided false, untrue, or misleading/deceptive information, who have omitted relevant information and/or have failed to comply with a request for FCBC or permit a site visit are prohibited from enrollment consideration for a period of 12 consecutive months from the date of application denial. Examples may include, but are not limited to:

1. Failure to disclose a judgment of conviction entered by a Federal, State, or local court. The definition of conviction for purposes of Nevada Medicaid is defined in 42 CFR §1001.2 and should be disclosed regardless of whether:

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

   b. The judgement has been expunged, sealed, or otherwise removed; or

   c. The charges were dismissed or set aside as a result of participation and completion of a first offender, deferred adjudication, or other program.

2. Failure to properly and accurately disclose information regarding direct or indirect ownership or controlling interest of 5% or more;

3. Falsified documentation is submitted to the Fiscal Agent or DHCFP with any type of enrollment request;

4. Failure to disclose any exclusion from any state's Medicaid program or the Medicare program, regardless of whether that exclusion period has expired, or the exclusion was stayed;

5. Failure to complete and return the FCBC Consent form and/or complete the FCBC process as requested;

6. Failure to permit a site visit;

7. Failure to properly and accurately disclose any surrender of, or negative action taken against, any professional licensure or certification from any State or governing Board; and/or

8. Failure to disclose current or previous state employment.

F. Actively enrolled providers who submit, or have submitted, any documentation or request which is found through an investigation, audit, review, or survey to meet any of the criteria in Section 102(E) may be terminated and sanctioned.

Providers who voluntarily terminate, are terminated for loss of contact, or who terminate for failure to revalidate while under any form of suspension, investigation, audit and/or review, may be sanctioned based on the results of the suspension, investigation, audit and/or review.

G. Prior to receiving reimbursement, providers must meet the participation standards specified for the program service area for which they are applying and must meet these standards for the duration of the requested enrollment time period. All individuals and entities as defined in this chapter shall comply with all federal, state, and local statutes, rules and regulations

relating to the services being provided and meet business criteria for operation in the state, county, and city in which the provider is located.

H. Providers will not receive reimbursement for services provided outside of the United States per Section 101, Overview of Programs.

I. A moratorium may be implemented at the discretion of the federal DHHS or DHCFP. A new enrollment application is required for enrollment consideration once the moratorium is lifted or expires.

102.1 REQUEST FOR ENROLLMENT, RE-ENROLLMENT AND REVALIDATION – CONDITIONS OF PARTICIPATION (2)

A request for enrollment means an applicant, who has never been a Nevada Medicaid provider, submits an initial enrollment application; re-enrollment means a former Nevada Medicaid provider, whose contract was terminated or deactivated and who is now eligible to "re-enroll," submits an initial enrollment application; and, revalidation means an active Nevada Medicaid provider, who must validate their current enrollment to extend their agreement with Nevada Medicaid, submits a revalidation application. Providers may submit a complete revalidation application up to 365 days in advance of their revalidation due date.

An applicant and/or provider may request enrollment, including re-enrollment and revalidation, in the Nevada Medicaid Program by completing the Enrollment Application and providing the required verifications for their requested PT. All applications and supporting documents must be submitted online through the Provider Portal.

DHCFP is not obligated to enroll all eligible applicants or re-enroll all eligible providers, and all types of enrollments are at the discretion of DHCFP. For additional information regarding enrollment, the provider may contact the Provider Enrollment Unit or the Fiscal Agent. Refer to Section 108, References for contact information.

The effective date of the provider contract is the date a complete enrollment request is received, all verifications are completed, and it is determined the applicant meets all conditions of participation. With the exception of urgent/emergent services, if an applicant renders services to Nevada Medicaid recipients without an active provider contract in place, that individual or entity assumes the responsibility for such services and understands enrollment, and subsequent payment for services, is not guaranteed.

Exceptions to the effective date described in the previous paragraph may be allowed for up to six months of retroactive enrollment to encompass dates on which the otherwise eligible provider furnished services to a Medicaid recipient, if there is an explanation or circumstance as to why the applicant was unable to enroll before services were furnished. If retroactive enrollment is requested, the applicant shall provide a letter of justification and list of claims associated with the retroactive time period. All approved Provider Contracts, unless otherwise withdrawn or

terminated, shall expire 60 months from enrollment date, with the exception of Durable Medical Equipment (DME) Contracts which shall expire 36 months from enrollment date, unless withdrawn or terminated.

If the applicant/provider does not meet all State and Federal requirements at the time of the initial request for participation, the effective date of the provider contract will be the date all requirements are met. If the applicant/provider is serving a sanction period, they are not eligible for enrollment or eligible to own, have interest in, or manage an enrolled entity.

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

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

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

1. on-site inspection prior to enrollment;

2. review of business records;

3. data searches; and/or

4. provisional enrollment.

102.2 ALL PROVIDERS AND APPLICANTS – CONDITIONS OF PARTICIPATION (3)

As a condition of new or continued enrollment, providers and applicants shall consent and submit to criminal background checks, including fingerprinting, when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for the provider.

DHCFP and/or the Fiscal Agent shall screen all initial applications, applications for a new practice location and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of "Limited," "Moderate" or "High." This screening also applies to providers who DHCFP has adjusted to the highest level of risk after enrollment and providers deemed "High" risk who add a person(s) with 5% or more direct or indirect ownership interest in the provider. If a provider could be placed within more than one risk level, the highest level of screening is applicable, and DHCFP has the authority to adjust a provider's risk level to ensure the fiscal integrity of the Medicaid program.

A. The following indicates categorical risk levels for providers:

1. Limited categorical risk:

   a. Physician or non-physician practitioners, including nurse practitioners, Certified Registered Nurse Anesthetists (CRNAs), occupational therapists, speech/language pathologists, and audiologists, and medical groups or clinics.

   b. Ambulatory surgical centers.

   c. End-stage renal disease facilities.

   d. Federally qualified health centers.

   e. Histocompatibility laboratories.

   f. Hospitals, including critical access hospitals, Department of Veterans Affairs hospitals, and other federally owned hospital facilities.

   g. Health programs operated by an Indian Health Program (IHP) or an urban Indian organization that receives funding from the Indian Health Service (IHS) pursuant to Title V of the Indian Health Care Improvement Act.

   h. Mammography screening centers.

   i. Mass immunization roster billers.

   j. Organ procurement organizations.

   k. Pharmacies newly enrolling or revalidating via the CMS-855B application.

   l. Radiation therapy centers.

   m. Religious non-medical health care institutions.

   n. Rural Health Clinics (RHC).

2. Moderate categorical risk:

   a. Ambulance service suppliers.

   b. Community mental health centers.

   c. Comprehensive outpatient rehabilitation facilities.

   d. Revalidating hospice organizations.

e. Independent clinical laboratories.

f. Independent diagnostic testing facilities.

g. Physical therapists enrolling as individuals or as group practices.

h. Portable x-ray suppliers.

i. Revalidating home health agencies.

j. Revalidating DME, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers.

k. Provisionally enrolled providers, unless placement in the "High" categorical risk is applicable.

l. Revalidating skilled nursing facilities (SNF).

3. High categorical risk:

a. Newly enrolling home health agencies.

b. Newly enrolling DMEPOS suppliers.

c. All applicants/providers who fall under a moratorium are High Risk for six months once the moratorium is lifted.

d. Newly enrolling Medicare Diabetes Prevention Program (MDPP) suppliers.

e. Newly enrolling opioid treatment program(s) which have not been fully and continuously certified by Substance Abuse and Mental Health Services Administration (SAMHSA) since October 23, 2018.

f. Newly enrolling hospice organizations.

g. Newly enrolling SNF.

B. Applicants are responsible for the accuracy and veracity of all information and documentation submitted for enrollment consideration. Applicants are not removed from this requirement/responsibility by virtue of assigning another the authority to submit a request for enrollment on their behalf. Applicants who are found to have submitted falsified documentation, provide false information to any question on any application, or who have otherwise failed to properly and accurately disclose requested information, including any person who holds authority, control, or interest of 5% or more in any entity, shall be denied enrollment and serve a 12-month sit-out. The enrollment application is specific in its

questions and does not limit the time frame for which convictions or other negative action should or should not be disclosed. See MSM Addendum for the definition of "Convicted."

C. The Fiscal Agent shall not enroll any provider or applicant (individual or entity having a person with a 5% or greater direct or indirect ownership interest in the provider, including management personnel) who has been convicted of a felony or misdemeanor under Federal or State law for any offense which the State agency determines is inconsistent with the best interest of recipients under the State plan.

D. Applicants/providers are responsible for the accuracy and veracity of all information and documents submitted for enrollment and continued enrollment.

E. Failure to disclose a judgment of conviction entered by a Federal, State, or local court. The definition of conviction for purposes of Nevada Medicaid is defined in 42 CFR §1001.2 and should be disclosed, regardless of whether:

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

2. The judgment has been expunged, sealed, or otherwise removed; or

3. The charges were dismissed or set aside as a result of participation and completion of a first offender, deferred adjudication, or other program.

F. Nevada Medicaid shall not enter into Contract with or shall terminate the active Contract with any provider listed in the CMS Data Exchange System (DEX) where DEX indicates an active enrollment bar (exclusion) under the following circumstances:

1. Any person with a 5% or more direct or indirect ownership interest who did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR §455.416(a);

2. Provider is terminated or revoked for cause under separate Medicaid or Medicare enrollment. Where the provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program and such termination has been published in the DEX, the State Medicaid Agency shall terminate the provider's enrollment in its program. 42 CFR §455.416(c), §455.101.

G. The following list, though not exhaustive, provides examples of crimes and/or offenses which indicate a provider or applicant may not be eligible for new or ongoing participation. Providers and applicants are required to disclose convictions as requested on the Nevada Medicaid application and required by policy and provide documentation for evaluation. All convictions shall be evaluated on a case-by-case basis.

Any conviction of the following:

1. Murder, voluntary manslaughter or mayhem;

2. Sexual assault, sexual seduction or any sexually related crime;

3. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission of the crime;

4. Abuse or neglect of a child or contributory delinquency;

5. False imprisonment, involuntary servitude or kidnapping;

6. Abuse, neglect, exploitation or isolation of any older persons or vulnerable persons, including a violation of any provisions of NRS Chapter 200, Crimes Against the Person, or a law of any other jurisdiction that prohibits the same or similar conduct;

7. Any offense involving assault or battery, domestic or otherwise;

8. Conduct hostile or detrimental to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;

9. Conviction related to that person's or entity's involvement in any program established under Medicare, Medicaid, CHIP (NCU) or the Title XX services program or any other state or federally funded assistance program; or

10. Is a person who holds, or previously held, 5% or more direct or indirect control or ownership in an entity which was convicted under any program established under Medicare, Medicaid, CHIP (NCU) or the Title XX services program, or any other state or federally funded assistance program.

H. The following list, though not exhaustive, provides examples of events and/or circumstances which may indicate a provider or applicant may not be eligible for new or ongoing participation. Providers and applicants are required to properly disclose negative events or circumstances as requested on the Nevada Medicaid application and as required by policy. All disclosures shall be evaluated on a case-by-case basis. Events and/or circumstances which shall be disclosed and/or reported include, but are not limited to, the following:

1. Any entity or individual who incurs an overpayment or has an existing overpayment which results in an outstanding balance with DHCFP and has not entered into a State approved re-payment plan or an entity or individual who had an overpayment, failed to enter into or defaulted on a re-payment plan and that debt was referred for collection;

2. An entity or individual has been placed on the Office of the Inspector General (OIG) List, Excluded Parties List System (EPLS) exclusion list, any state's exclusions list, or is reported to CMS as being excluded;

3. An entity or individual has been terminated for cause, excluded, revoked, or is under any form of suspension from a DHCFP contracted MCO Plan, Medicare, Medicaid, CHIP (NCU), Title XX services program or any other State or Federally funded assistance program;

4. An entity or individual using a financial institution outside of the United States of America (excluding Guam, Puerto Rico, Mariana Islands and American Samoa);

5. An applicant or provider who is serving a sanction, suspension, or exclusion period from any state or federally funded program;

6. A provider fails to provide information specific to the conditions of participation, a PT or for continued enrollment. Re-enrollment may be considered upon receipt of the requested information and following the submission of a new, complete application for evaluation;

7. A provider fails, or refuses, to fully cooperate with any DHCFP request, investigation, audit, review, or survey within the stated time frame;

8. An applicant or provider has a professional or other license or credential required for enrollment restricted by a governing Board or entity;

9. An applicant or provider has been placed on a payment suspension for a credible allegation of fraud (CAF) or willful disregard of policy or is a person or entity who hold 5% direct or indirect control of an entity placed on payment suspension for a CAF or willful disregard of policy;

10. Mail sent from DHCFP or the Fiscal Agent to a provider is returned with or without a forwarding address, or any DHCFP Unit or the Fiscal Agent cannot make contact with the provider through methods supplied by the provider, i.e. phone number or e-mail address, and the provider has not attempted to update contact information;

11. DHCFP becomes aware that an applicant or provider has supplied false/falsified information or documentation to DHCFP or Fiscal Agent to become enrolled in or maintain enrollment with Nevada Medicaid;

12. DHCFP becomes aware that a provider has failed to report any change in circumstance as outlined in MSM Chapter 100, all inclusive;

13. DHCFP becomes aware that a provider is utilizing a non-enrolled servicing provider to render services to Medicaid recipients; or

14. The provider, as identified in the Chapter, is a person who holds, or previously held, 5% or more direct or indirect controlling interest or ownership in an entity which was convicted under any program established under Medicare, Medicaid, CHIP (NCU) or the Title XX services program, or any other state or federally funded assistance program.

15. The Fiscal Agent shall not enroll a provider or applicant who has been convicted within the preceding ten years of (not all inclusive) any of the following (Note all convictions shall be disclosed for evaluation, regardless of conviction date, expungement, or removal):

    a. Any offense involving arson, fraud, theft, embezzlement, burglary, fraudulent conversion or misappropriation of property;

    b. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in Chapter 454 of the NRS;

    c. Any offense involving the use of a firearm or other deadly weapon; or

    d. Conviction of a criminal offense related to that person's involvement in any state or federally funded assistance program, this includes providers, applicants, owners, managing employees, Board members and/or agents.

I. The Fiscal Agent shall not enroll a public institution unless it is a medical institution. The Fiscal Agent shall never enroll a penal or correctional institution. This shall not preclude Nevada Medicaid from enrolling a sister agency or other state agency.

J. The Fiscal Agent shall not enroll a group provider which is not structured according to the group's licensure as issued by the Secretary of State or other governing body. Applicants and providers have the duty and responsibility to understand their own business model and the appropriate and required local, state, and federal certifications and licenses necessary to conduct business and to meet criteria required for enrollment. Applicants who are found to have applied for enrollment with an incorrect NPI number and/or business structure will be denied.

K. All providers must provide and maintain workers' compensation insurance as required by law and provide proof of insurance as required through 616D, inclusive, of the NRS.

L. The enrollment of Out-of-State/Out-of-Catchment (OOS/OOC) area providers is at the discretion of DHCFP, with the exception of Urgent/Emergent enrollment. As such, OOS/OOC enrollment or revalidation requests are reviewed for Program and recipient need. Applicants and providers are not guaranteed enrollment with Nevada Medicaid, and although full enrollment may be requested (at initial and/or revalidation), enrollment is at the discretion of DHCFP. Example: an OOS provider, fully enrolled at initial application

may have, at revalidation, enrollment limited to cross-over claims only. Conversely, an OOS provider initially enrolled for cross-over claims only may be fully enrolled at revalidation, if requested, all conditions of participation are met, and full enrollment is in the best interest of the Nevada Medicaid Program and its recipients.

M. Providers may report circumstances which may require additional DHCFP staff oversight, such as a pending court case, balance owed to DHCFP or other state agency, regulatory or state agency investigation, or negative action taken against a business or professional license required for continued enrollment. At such times, DHCFP may elevate a provider's risk level and/or notify the provider of Provisional Enrollment status.

N. All Nevada Medicaid providers must comply with information reporting requirements of the Internal Revenue Code (26 U.S.C. 6041) which requires the filing of annual information (1099) showing aggregate amount paid to provider's service identified by name, address, Social Security Number (SSN), Tax Identification Number (TIN) or FEIN. A TIN/FEIN is the preferred identifier for entities, and an SSN is the preferred identifier for individual servicing providers and those self-employed individuals in a sole proprietorship who do not have a TIN/FEIN.

O. The provider is responsible for understanding and abiding by the requirements of this Chapter, the Provider Contract and the Chapter governing their PT as stated in the Nevada MSM, along with all local, state, and federal requirements. The provider should also be familiar with MSM Chapter 3100 – Hearings and MSM Chapter 3300 - Program Integrity.

P. Providers are required to retain adequate documentation for services billed to the Division and, upon request, must submit the documentation in a timely manner. Failure to do so may result in recoupment/recovery of payments for services not adequately documented, and may result in the suspension, termination, and/or sanction of the provider (as defined) from participation with Nevada Medicaid

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

CANS reports are legally mandated and maintained by the Nevada DCFS. Names of individuals are checked against names in the central registry to identify any substantiated perpetrators of abuse. CANS employer information is limited to provision of the substantiated status of a report and is released only by the Nevada DCFS (NRS 432.100). Information may be released to an employer under NRS 432.100(3).

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

Nevada Division of Child and Family Services
Attn: Child Abuse and Neglect Records Check

4126 Technology Way, 1st Floor
Carson City, NV 89706

For additional information and authorization forms please contact:

Nevada Division of Child and Family Services
(775) 684-7941

R. Site visits shall be conducted on all providers and/or applicants designated as "Moderate" or "High" categorical risk. The purpose of the site visit is to verify that the information submitted to the Fiscal Agent or DHCFP is accurate, the facility is operational and to determine compliance with Federal and State enrollment requirements. Site visits may be:

1. conducted pre- or post-enrollment;

2. announced and/or unannounced; and/or

3. conducted as needed in conjunction with a Corrective Action Plan.

S. In addition to any other authority it may have, DHCFP may exclude an individual or entity (applicant or provider) from participation in the Medicaid program for any reason for which the secretary could exclude that individual or entity from participation in Medicare.

102.3 ENHANCED PROVIDER SCREENING – CONDITIONS OF PARTICIPATION (4)

A. CATEGORICAL RISK

Providers shall be placed in one of the following risk levels and submit to the necessary screening, not all inclusive, for each risk level as follows:

1. Limited categorical risk:

   a. provider meets applicable federal regulations and/or state requirements for the PT;

   b. provider's license(s) is current, including in states other than Nevada;

   c. there are no current limitations or restrictions on the provider's license; and

   d. provider initially and continues to meet enrollment criteria for their PT.

2. Moderate categorical risk:

   a. provider meets the "Limited" screening requirements; and

b. site visits, whether announced or unannounced, for any and all provider locations.

3. High categorical risk:

a. provider meets the "Limited" and "Moderate" screening requirements;

b. provider consents to a criminal background check; and

c. provider submits a set of fingerprints in accordance with instructions from DHCFP.

B. RISK LEVEL ADJUSTMENT

Once enrolled, providers or any person with a 5% or more direct or indirect ownership interest in the provider, may have their categorical risk level adjusted from "Limited" or "Moderate" to "High" for the following reason and/or reasons (not all inclusive):

1. A payment suspension on the individual or entity was imposed based on a credible allegation of fraud, waste, or abuse. The risk level elevation shall include all persons having 5% direct or indirect interest in the suspended entity and, therefore, extend to any additional entities of which the person holds 5%, or more, interest. The provider's risk remains "High" for 10 years beyond the date of the payment suspension;

2. A provider (individual or entity) incurs a Medicaid overpayment and has not entered into a repayment plan or has defaulted on an agreed repayment plan; or

3. DHCFP or CMS in the previous six months lifted a temporary moratorium for the particular PT and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

C. Within 30 days of notification, providers and/or individuals or any person with 5% or more ownership or direct or indirect interest in the provider whose risk level is elevated to "High," and any out-of-state provider required to submit to FCBC shall consent to and provide proof of fingerprint capture and submission per the instructions provided by DHCFP.

D. Approved providers whose categorical risk level is "High" shall complete the FCBC requirements for any new person(s), having 5% or more ownership or direct or indirect interest, who is added and/or not previously screened.

E. Providers subject to FCBC will be responsible for all costs associated with fingerprint collection.

F. Providers screened and placed in the "High" risk category by the Fiscal Agent or DHCFP may be found to have met the FCBC requirements when the provider enrolled with Medicare. DHCFP may rely upon Medicare's screening if all of the following are verified:

1. The date of Medicare's last screening of the provider occurred within the last five years; and

2. The provider's Medicaid enrollment information is a "positive match" with the Medicare enrollment record.

102.4 PROVISIONAL ENROLLMENT – CONDITIONS OF PARTICIPATION (5)

A. At the discretion of DHCFP, the Fiscal Agent may provisionally enroll applicants who meet one or more of the following conditions (not all inclusive):

1. The applicant is part of an approved repayment program for an outstanding debt owed to:

   a. any State or the Federal Government;

   b. Medicare;

   c. Medicaid;

   d. an MCO; and/or

   e. a Prepaid Ambulatory Health Plan (PAHP).

2. The applicant discloses a conviction which would not automatically preclude the applicant from enrollment.

3. The applicant is under investigation by any law enforcement, regulatory or state agency at the time of application.

4. The applicant has an open or pending court case which is reported on the enrollment application.

5. The applicant has been denied malpractice insurance or has ever had any professional business or accreditation license/certificate denied, suspended, surrendered, restricted or revoked.

6. All applicants for a PT for which a moratorium was lifted in the preceding 12 months.

7. Other circumstances which would not preclude enrollment but would require additional oversight as documented.

B. DHCFP may elevate an active provider to provisionally enrolled status if one or more of the following occurs (not all inclusive):

1. The outcome of an open or pending court case or investigation by any law enforcement, regulatory or state agency reported on the enrollment application indicates a conviction for an offense not listed in Section 102.2(F), All Providers and Applicants – Conditions of Participation (3).

2. The provider's Categorical Risk level is elevated to "Moderate" or "High" after enrollment has occurred.

3. The provider's license required for enrollment with Medicare and/or Medicaid (in Nevada or any other State) is restricted by the issuing Board or agency.

4. A Change of Ownership is reported and any of the purchasing and/or new owners/officers report any conditions noted in Section 102.

5. Preliminary information is discovered where conditions under Section 102 would not warrant termination but would require provisional enrollment.

C. At the discretion of DHCFP, the Fiscal Agent may provisionally enroll a re-validating provider who meets one or more of the following (not all inclusive):

1. The provider is part of an approved repayment program for an outstanding debt owed to:

   a. any State or the Federal Government;

   b. Medicare;

   c. Medicaid;

   d. an MCO; and/or

   e. a PAHP

2. The provider discloses a conviction which would not automatically preclude the provider from enrollment.

3. The provider is under investigation by any law enforcement, regulatory or state agency at the time of re-validation.

4. The provider has an open or pending criminal court case.

5. The provider has been denied malpractice insurance or has ever had any professional, business or accreditation license/certificate denied, suspended, restricted, or revoked.

D. Provisional enrollment will be for a period not more than 24 consecutive months for each enrollment application. During the provisional enrollment period, the provider shall be required to comply with all requirements within the MSM, including, but not limited to, the following:

1. Permit site visits (announced or unannounced);

2. Provide any and all requested information regarding billing, billing practices and/or policies and procedures in a complete and accurate manner by due date;

3. Attend provider training recommended by DHCFP;

4. Cooperate and comply with all terms of a corrective action plan by the due date; and/or

5. Cooperate and comply with all quality of care compliance reviews.

D. Providers who fail to meet provisional enrollment requirements will be terminated "for cause" and serve a Tier 4 – 12-Month Sanction unless termination criteria require a higher level of sanction.

E. Backdating for provisionally enrolled providers shall not be permitted.

F. Revalidation date shall be the first day of full enrollment.

102.5 OUT OF STATE PROVIDER PARTICIPATION – CONDITIONS OF PARTICIPATION (6)

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

Out-of-state enrollments may be temporary, full enrollment or enrollment for Medicare cross-over claims only, and all enrollments are at the discretion of DHCFP. Please review the Conditions of Participation in the Chapter for more information and Section 105.1(O), Medicaid Payment to Providers, Letters of Agreement for details on payment to out-of-state providers.

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

A. The provider is providing a service which is not readily available within the state;

B. The provider is providing services to Medicaid recipients in a catchment (border) area; or

C. The provider is providing services to Medicare cross over recipients only.

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

102.6 URGENT/EMERGENT SERVICES OUTSIDE THE STATE OF NEVADA – CONDITIONS OF PARTICIPATION (7)

A provider outside of the State of Nevada who furnishes authorized goods and services under the Nevada medical assistance program to eligible Nevada residents visiting another state and urgently requiring care and services shall be exempt from the full enrollment process as long as that provider is properly licensed to provide health care services in accordance with the laws of the provider's home state and enrolled as a Medicaid provider in the provider's home state to furnish the health care services rendered. The intent of Urgent/Emergent enrollment is to pay claims to an out-of-state provider who renders services to a single Nevada Medicaid recipient for a single instance of care. Refer to the Provider Enrollment Information Booklet for enrollment instructions.

102.7 FACILITY DISCLOSURE – CONDITIONS OF PARTICIPATION (8)

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

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

A. Documents subject to disclosure include:

1. survey reports, including a statement of deficiencies;

2. official notifications of findings based on the survey;

3. written plans of correction submitted by the provider to the survey agency;

4. ownership and contract information specified below; and

5. reports of post-certification visits and summaries of uncorrected deficiencies.

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

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

1. name and address of each person with an ownership or control interest in the discloser, or in any subcontractor in which discloser has direct or indirect ownership of 5% or more;

2. whether any of the persons named is related to another as spouse, parent, child, or sibling; and

3. name of any other disclosing entity in which a person with an ownership or controlling interest in the discloser also has ownership or controlling interest.

C. Within 35 days of the date of request by the Secretary of DHHS, or the Medicaid agency, a provider must submit full and complete information about:

1. ownership of any contractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of request.

102.8 PROVIDER DISCLOSURE – CONDITIONS OF PARTICIPATION (9)

A. To enter into and/or maintain a provider contract with the Medicaid or NCU programs, the provider or any person who has ownership or a controlling interest (direct or indirect) of 5% or more, or who is an agent or managing employee of the provider must disclose and/or report (if status changes during enrollment) any information listed below including, but not limited to the following:

1. conviction of any offense related to that individual's or entity's involvement in any program established under Medicare, Medicaid, CHIP (NCU), or Title XX services program since the inception of the programs;

2. denial of enrollment or termination for cause, exclusion or any form of suspension from Medicare, Medicaid, CHIP (NCU), any federal health care program or Title XX services program since the inception of the programs;

3. conviction of any offense. Providers and/or applicants reporting convictions other than those listed in Section 102.2(B), All Providers and Applicants – Conditions of

Participation (3), are not automatically precluded from enrollment. The Fiscal Agent will forward these applications or change forms to DHCFP Provider Enrollment Unit for consideration on a case-by-case basis. Providers and/or applicants must provide information, documentation, and explanation regarding each conviction;

4. any current or previous investigation by any law enforcement, regulatory agency or state agency, or restricted professional license. The Fiscal Agent will forward these applications or change forms to DHCFP Provider Enrollment Unit for consideration on a case-by-case basis. Providers and/or applicants must provide information, documentation, and explanation regarding the investigation;

5. any current open/pending court cases;

6. any current or previous affiliation with a provider (as defined in this chapter), or supplier who has uncollected debt in Nevada, or any other State;

7. if billing privileges have ever been denied or revoked with a federal or state health care program;

8. if the provider's and/or applicant's license(s) required for enrollment with Medicare and/or Nevada Medicaid has ever had negative action taken against it or has been suspended, surrendered, inactivated and/or revoked by any licensing Board or State; or

9. any change in contact information, including mail to and service addresses, phone number, or e-mail address (changes must be reported within five business days).

102.9 DISPOSITION OF CONTRACT FOR PROVIDERS – CONDITIONS OF PARTICIPATION (10)

The Fiscal Agent and/or DHCFP will review the completed provider application to determine if the applicant meets all the conditions of participation as stated in the Nevada MSM for the specified PT/specialty and Nevada MSM Chapter 100, all inclusive.

Provisional licensure will be allowed based on Nevada State Board requirements of the specific specialties within the scope of practice for licensed professionals. Provisional licensure will apply only to licensed level professionals. Credentialed and paraprofessional level providers do not meet the requirement for provisional licensure.

102.10 CERTIFICATION STATEMENT – CONDITIONS OF PARTICIPATION (11)

A. By signing the enrollment application, change form, checklist or any document submitted for evaluation, or by authorizing someone to sign on your behalf, the provider attests and agrees to all of the following:

1. That payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

2. Under penalty of perjury, certifies as "true" information on the enrollment application and/or Change Form to become enrolled in, maintain enrollment in and/or update enrollment information with the Nevada Medicaid program.

3. With regard to provider groups, the group's representative has the authority to bind all member providers and agrees to provide Nevada Medicaid with the name(s) of the individual(s) with authority to sign on behalf of the group.

4. With regard to groups which have multiple owners, Board members, or others with 5% or more direct/indirect interest, that the group's representative has the authority to bind all to the Enrollment Application, Change Form, Revalidation, Change of Ownership Application, and/or Provider Contract.

5. With regard to submission of claims for payment, the provider represents as following:

    a. I certify that all information is true, accurate and complete, all submitted claims represent services which comply with Medicaid policy and that I am responsible for any and all claims submitted by employees and other person(s) acting on my behalf; and

    b. I certify that no individual other than the one whose NPI number appears on the claim provided the services for the submitted claim.

6. With regard to remittance and receipt of payment, the provider agrees and acknowledges:

    a. to accept Medicaid payments as payment in full for services rendered and under no condition, except for lawful patient liability, contact the patient or members of the patient's family for additional sums; and

    b. that they have examined the remittance advice that accompanied the payment, the payment represents amounts due, and the services listed thereon have been rendered by the provider whose NPI number was noted on the claim.

102.11 CONTRACT APPROVAL

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

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

102.12 CONTRACT DENIAL

Denial means denial of an enrollment application submitted to Nevada Medicaid from any applicant, including an individual, entity or group. DHCFP is not obligated to enroll all eligible applicants/providers, and all types of enrollments are at the discretion of DHCFP.

A. DHCFP will refuse to enter into a contract with an applicant for provider enrollment in the Medicaid program if the applicant:

1. does not meet the conditions of participation as stated in this Chapter, all inclusive;

2. does not meet all the professional credentialing requirements or other conditions of participation as required by the Nevada MSM for the specified PT;

3. has been terminated for cause, excluded or suspended, leading to revocation of an agreement or contract with a provider by any other governmental or State program;

4. fails to submit information requested by DHCFP and/or Fiscal Agent;

5. submits false or falsified information;

6. fails to consent to the FCBC process and/or submit FCBC forms and fingerprints as requested and instructed by the Fiscal Agent and/or DHCFP;

7. requests to enroll a new business, PT, or additional location and has a documented history of "Waste" or "Abuse" as defined in the Addendum or is currently assigned by DHCFP a Corrective Action Plan (CAP); or

8. fails to permit DHCFP staff or its agent(s) access to its facility or service location to conduct a scheduled or unscheduled site visit.

B. The Fiscal Agent or DHCFP Provider Enrollment Unit will notify the provider of the contract denial and dispute rights, if applicable. Refer to MSM, Chapter 3100 - Hearings.

102.13 VOLUNTARY TERMINATION

Nevada Medicaid may impose a sanction on any provider as defined in this chapter who requests to voluntarily terminate, fails to revalidate, or terminates for any reason other than "for cause" while under investigation, audit, review, survey, or payment suspension.

102.14 ORDERING, PRESCRIBING, OR REFERRING (OPR) PROVIDERS

Ordering, prescribing, or referring (OPR) providers do not bill Nevada Medicaid for services rendered, but may order, prescribe, or refer services/supplies for Nevada Medicaid recipients. For Medicaid to reimburse for services or medical supplies resulting from a practitioner's order, prescription, or referral, the OPR provider must be enrolled in Nevada Medicaid. Enrolling as an OPR provider is appropriate for practitioners who:

A. May occasionally see an individual who is a Medicaid recipient who needs additional services or supplies that will be covered by the Medicaid program;

B. Do not want to be enrolled as another Nevada Medicaid PT; or

C. Do not plan to submit claims for payment of services rendered.

102.15 ENROLLMENT WITH MANAGED CARE ORGANIZATION (MCO) PROVIDERS

MCO, Prepaid Inpatient Health Plans (PIHP), PAHP, and Dental Benefits Administrator (DBA).

A. Applicants or providers who wish to contract with a Nevada Medicaid network provider and who are eligible for enrollment with Nevada Medicaid are required to enroll with Nevada Medicaid prior to enrolling with a network provider.

B. All network provider enrollments are at the discretion of the network Plan, with the exception of network adequacy requirements, and the individual network Plan is not obligated to credential, recredential or contract with a Nevada Medicaid enrolled provider, regardless of eligibility.

C. Providers (individuals/entities) who are terminated for cause from the Nevada Medicaid program shall be terminated immediately from all network Plans.

D. Providers (individual/entities) shall be terminated immediately from all network Plans upon the expiration of the 120-calendar day period while awaiting an enrollment decision from Nevada Medicaid or immediately during this period upon notification from Nevada Medicaid that the provider does not meet the state's enrollment requirements or will not be enrolled, re-enrolled, or revalidated.

103 PROVIDER RULES AND REQUIREMENTS

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

A. If the provider has knowledge of over-utilization, inappropriate utilization, inappropriate fraudulent business practices, use of the Nevada Medicaid card by a person not listed on the card, unreasonable demands for services, or any other situation that the provider feels is a misuse of medical services by a recipient, the provider shall inform the Nevada Medicaid office within 48 hours of discovery via email to NPI@dhcfp.nv.gov .

B. A Medicaid provider who accepts a Medicaid recipient for treatment accepts the responsibility to make certain the recipient receives all medically necessary Medicaid covered services. This includes, but is not limited to, the following assurances:

1. referrals to other Medicaid providers are appropriate.

2. ancillary services are delivered by an actively enrolled Medicaid provider.

3. recipient(s) receives all medically necessary Medicaid covered services at no cost to the recipient(s).

4. claims submitted are only for services rendered.

C. In addition, when the services require a PA and a PA number is obtained, the provider must give that number to other relevant providers rendering service to the recipient.

D. All Medicaid providers who accept Medicaid reimbursement for treatment accept responsibility for understanding and comprehending their provider contract and all chapters of the MSM that pertain to their individual PT and services they provide. This applies to all institutions and medical groups as well.

E. When termination occurs, those terminated providers as identified in the MSM, have the obligation to refer recipients to other providers for ongoing services and/or care.

103.1 MEDICAL NECESSITY

A. Medical Necessity is a health care service or product provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to:

1. diagnose, treat or prevent illness or disease;

2. regain functional capacity; or

3. reduce or ameliorate effects of an illness, injury, or disability.

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

1. the type, frequency, extent, body site, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.

2. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.

3. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.

4. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider.

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

103.2 AUTHORIZATION

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

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

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

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

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

B. For Medicare and Medicaid dual eligible, there is no requirement to obtain Medicaid PA for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's PA guidelines. PAs are not necessary for recipients who are eligible for QMB only as Medicaid pays only the co-pay and deductible. If Medicare benefits are exhausted (i.e. inpatient) a PA from Medicaid's appropriate QIO-like vendor must be obtained within 30 days of the receipt of the Medicare Explanation of Benefits (EOB).

C. Medicaid Eligibility may be determined for up to three months prior to an application for assistance. Services provided during a period of retroactive eligibility are evaluated on a case-by-case basis. The provider can verify eligibility through the EVS. Covered services that meet the definition of "emergency services" reimbursed. A retrospective review for services which require PA by Medicaid's appropriate QIO-like vendor will determine authorization for payment based on clinical information that supports medical necessity and/or appropriateness of the settings.

D. If a PA is required, it is the responsibility of the provider to request before providing services. Waiting until the claim is due before securing an approved PA will not override the stale date. See Section 105.2B, Billing Time Frames (Stale Dates) for definition of Stale Date. The PA number is required on the claim. See the appropriate MSM chapter for program specific PA policy. All PA and supporting documents must be submitted online through the Provider Portal.

E. Once an approved PA request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates. It is the provider's responsibility to monitor PA utilization in accordance with the applicable policy.

F. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both) of the current authorization, the provider is responsible for the submission of a new PA request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period so the newly authorized service may start immediately following the expiration of the existing authorization. Exception: the 15-day recommendation does not apply to concurrent, inpatient hospital stay authorizations.

G. It is the provider's responsibility to submit the necessary paperwork to support the PA request. PA requests submitted lacking the required information for the service/item will be denied with a NOD to the recipient.

103.3 PROVIDER REPORTING REQUIREMENTS

A. Medicaid providers are required to report in writing, through the method described in the online *Provider Enrollment Information Booklet* and within 30 calendar days, any change and/or correction to address, addition or removal of practitioners or any other information pertinent to the receipt of Medicaid funds. Change in ownership, including but not limited to the removal, addition and/or substitution of a partner, must be reported within 30 calendar days by completing and submitting an enrollment application along with all required documentation. Failure to report as outlined may result in termination of the contract at the time of discovery. Refer to Section 102, Provider Enrollment, for further guidance on CHOW.

B. Within 30 calendar days, providers are required to report changes which may affect enrollment status. All changes are to be reported through the method described in the online *Provider Enrollment Booklet*. All reported changes shall be evaluated to ensure the conditions of participation continue to be met and no possible further action is required. Below are examples of changes effective after enrollment which shall be reported (not all inclusive):

1. change to licensure status;
2. indictment, arrest, criminal charge and/or conviction, with the exception of minor traffic offenses (NRS 62A.220);
3. open and/or pending court case;
4. change in familial association with regard to ownership, managing employee and/or authorized user or agent;
5. enrollment/disenrollment in another State's Medicaid program;
6. enrollment/disenrollment with Medicare;
7. denial of malpractice insurance;
8. open investigation by any law enforcement, regulatory or state agency; and/or
9. provider becomes a state or government employee.

103.4 CONDITIONS OF REPORTING

A. All changes must be reported in writing within 30 calendar days through the method described in the online *Provider Enrollment Information Booklet* and require the signature of the provider. If the provider is a business, the change must include the signature of the owner or administrator. Medicaid will not change any provider record without proper signatures. Annual 1099 forms reflect the information in Medicaid's records and may be incorrect if changes are not reported timely.

B. Correct address, including email, banking information, phone numbers and other information are necessary to assure receipt of all payments and provider notifications from Nevada Medicaid. Address changes are required for any change, including the suite number. Returned mail may be used by Medicaid to administratively terminate the provider due to "loss of contact."

C. When there is a change in ownership, the contract may be automatically assigned to a new owner, as well as the payment amounts that may be due or retrospectively become due to, or from Nevada Medicaid, by the prior owners. The assigned contract is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.

If there is a change in ownership, the provider must provide a copy of the bill of sale, copies of new licenses/certifications and/or verification of a change in FEIN. The provider must also complete/submit an initial enrollment application.

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

103.5 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

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

A. These providers are required to:

1. adhere to federal and state regulations, and the provider agreement or contract, to establish written policy of dissemination to their staff;

2. ensure policies are adopted by any contractor or agent acting on their behalf;

3. educate staff on the regulations. Dissemination to staff should occur within 30 days from the date of hire, and annually thereafter;

4. provide signed Certification Form, signed provider agreement, copies of written policy and employee handbook, and documentation staff has been educated, within the required timeframes;

5. maintain documentation on the education of staff, and make it readily available for review by state or federal officials; and

6. provide requested re-certification within required timeframes to ensure ongoing compliance.

103.6 COVERAGE AND LIMITATIONS

A. DHCFP has a program to identify providers that fit the criteria of being an entity and will identify additional or new providers fitting the criteria at the beginning of each federal fiscal year.

B. DHCFP will issue a letter advising an entity of the regulations and require the entity to:

1. submit a certification stating they are in compliance with the requirements;

2. sign a provider agreement or Managed Care Contract Amendment incorporating this requirement;

3. provide copies of written policies developed for educating their staff on false claims, fraud and abuse and whistleblowers protections under law; and

4. provide documentation of employees having received the information.

C. Re-certification of existing entities will be done annually for ongoing compliance.

D. DHCFP is authorized to take administrative action for non-compliance through non-renewal of provider or contract or suspension or termination of provider status.

103.7 SAFEGUARDING INFORMATION ON APPLICANTS AND RECIPIENTS

Federal and state regulations including HIPAA of 1996, the HITECH Act of 2009 and confidentiality standards within 42 CFR §431.301 – §431.305 restrict the use or disclosure of information concerning applicants and recipients. The information providers must safeguard includes, but is not limited to, recipient demographic and eligibility information, social and economic conditions or circumstances, medical diagnosis and services provided, and information received in connection with the identification of legally liable TPL)resources.

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

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

103.8 MEDICAL AND PSYCHOLOGICAL INFORMATION

A. Any psychological information received about an applicant or recipient shall not be shared with that person. This ruling applies even if there is a written release on file from his or her physician. If the applicant/recipient wishes information regarding his or her psychological condition, he or she must discuss it with his or her physician.

B. Medical information, regardless of source, may be shared with the applicant or recipient upon receipt of their written request. However, any other agency needing copies of medical information must submit a Medicaid release stating what information is requested and signed by the applicant or recipient in question or their authorized representative.

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

C. The HIPAA of 1996 Privacy Rules permit the disclosure of a recipient's health information without their authorization in certain instances (e.g. for treatment, payment, health care operations or emergency treatment; to make appointments to DHCFP business associates; to recipient's personal representatives; as required by law; for the good of public health; etc.)

D. The HIPAA Privacy Rules assure the recipient certain rights regarding their health information (e.g. to access/copy, to correct or amend, restrict access, receive an accounting of disclosures and confidential communications).

E. A provider may not disclose information concerning eligibility, care or services given to a recipient except as specifically allowed by state and federal laws and regulations.

103.9 NON-DISCRIMINATION AND CIVIL RIGHTS COMPLIANCE

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA) of 1990 and Nevada Law prohibit discrimination on the basis of race, color, national origin, religion, sex, age, mental or

physical disability (including acquired immune deficiency syndrome (AIDS) or related conditions), religious beliefs, veteran status, pregnancy, genetic testing, gender expression, gender identity, or any other class status protected by federal or state law or regulation by programs receiving Federal Financial Participation (FFP). DHCFP service providers must comply with these laws as a condition of participation in the Nevada Medicaid program in offering or providing services to the Division's program beneficiaries or job applicants and employees of the service providers.

All service providers are required to follow and abide by DHCFP's non-discrimination policies. In addition, hospitals, nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) will be reviewed by Medicaid periodically to assure they follow requirements specific to them. Requirements for compliance:

A. Hospitals, nursing facilities and ICF/IIDs must designate an individual as having responsibility for civil rights coordination, handling grievances, and assuring compliance with all civil rights regulations. This person will serve as coordinator of the facility's program to achieve nondiscrimination practices, as well as be the liaison with Medicaid for Civil Rights compliance reviews.

B. Notices/signs must be posted throughout a facility, as well as information contained in patient and employee handouts, which notifies the public, patients and employees that the facility does not discriminate with regards to race, color, national origin, religion, gender, age or disability (including AIDS and related conditions) in:

1. admissions;

2. access to and provisions of services; or

3. employment.

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

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

D. Medical facilities must have policies prohibiting making improper inquiries regarding a person's race, color, national origin, religion, sex, age, or disability (including AIDS and

related conditions) prior to making the decision to admit the person. Supervisory staff must be aware of this policy and enforce it.

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

Monitoring, tracking, evaluation, and reporting of services to Limited English Proficiency (LEP) individuals is required per NRS 232.0081. The facility must assure equal availability of all services to persons with LEP, hearing and sight-impaired patients and persons with other communication limitations. For example, when a provider determines that a particular non-English language must be accommodated, vital documents must be available at no charge in the recipient's preferred language. The provider must maintain a list of vital documents and a definition of vital documents (a definition that may be used as a guide can be found in Vital Documents in Section 108, References). All public forms and documents considered vital will include information in multiple "safe harbor" languages regarding how to obtain the documents in non-English languages. For a definition of "safe harbor," see the Vital Documents in Section 108, References. With regard to sight-impaired individuals, the provider's library or other reading service must be made equally available through Braille, Large Print books or Talking books.

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

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

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

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

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

G. All providers (including medical facilities) must maintain a list of community-registered sign language interpreters. These interpreters may be in-house and/or community based. This list must be reviewed and revised, if necessary, at least annually. Facilities must also have policies outlining how persons with hearing impairments and/or language barriers are identified as needing interpretation services, and how these services can be accessed at no cost to the recipient. These policies, lists, and reviews shall be provided at no cost to DHCFP upon request.

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

1. identify the non-English languages that must be accommodated among the population served and identify the points of contact where language assistance is needed;

2. develop and implement a written policy that ensures accurate and effective communication;

3. take steps to ensure staff understands the policy and is capable of carrying it out; and

4. annually review the LEP program to determine its effectiveness and provide the LEP review at no cost to DHCFP upon request.

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

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

103.10 ADVANCE DIRECTIVE (AD)

An AD is written instruction by an individual who is 18 years of age or older which is completed in advance of a serious illness or medical condition. An AD allows the individual to direct their health care decisions in the event of incapacitation. It may be in the form of a Living Will, Power of Attorney for health care including psychiatric care, do-not-resuscitate order, or a Provider Order for Life-Sustaining Treatment. More information can be found in NRS 449A, Care and Rights of Patients.

A. Administration of Advance Directives

1. Hospitals, Skilled Nursing Facilities, Home Health Agencies (HHA), Personal Care Attendants (PCA) providers and hospices must maintain written policies and procedures concerning ADs and provide written information to all adult individuals (age 18 or older) upon admission or service delivery concerning the:

   a. individual's rights under Nevada law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate ADs at the individual's option. Providers must update and disseminate amended information as soon as possible but not later than 90 days from the effective date of changes per Nevada law; and

   b. written policies of the service provider respecting implementation of such rights, including a clear and precise statement of limitation if the service provider cannot implement an AD on the basis of conscience.

2. At a minimum, a service provider's statement of limitations must:

   a. Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

   b. Identify the state legal authority permitting such objections (which in Nevada is NRS 449A.457 and requires the prompt transfer of care of the individual to another physician or provider of health care); and

   c. Describe the range of medical conditions or procedures affected by the conscience objection.

3. Document prominently in the individual's medical records whether or not the individual has an AD.

4 Providers cannot apply conditions to provisions of care or otherwise discriminate against an individual based on whether or not they have executed an AD.

5. Ensure compliance with the requirements of Nevada law regarding ADs and inform individuals that any complaints concerning AD requirements may be filed with the state survey and certification agency.

6. Must ensure education of staff concerning its policies and procedures on ADs (at least annually).

7. Provide for community education regarding issues concerning ADs as set forth in paragraph (A)(1)(a) of this section (at least annually). This may be in concert with other providers or organizations or directly. At a minimum, education presented should define what constitutes an AD, emphasize an AD is designed to enhance an individual's control over medical treatment, and describe applicable Nevada law concerning ADs. A provider must be able to document its community education efforts.

8. Providers in this section are not required to provide care that conflicts with a valid AD.

9. Providers must have follow-up procedures in place to provide the required information about ADs to individuals directly if others are informed at the time of admission or at the start of care under 42 USC §489.102E (2003).

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

103.11 SUPPORTED DECISION-MAKING

Supported Decision-Making (SDM) is a written agreement between an adult with disabilities (the Principal) and one or more trusted Supporters to assist in making personal, health care, financial or other decisions per NRS 162C, Supported Decision-Making Act. The Principal is the ultimate decision-maker but is provided support from one or more persons who can provide assistance in the making and communicating of decisions.

A. SDM aims to:

1. Provide person-centered and directed assistance to an adult with a disability to gather and assess information as well as make informed decisions and communicate those decisions;

2. Give Supporters legal status to be with the Principal and participate in discussion with others when the Principal is making decisions or seeking to obtain information; and

3. Enable Supporters to assist in making and communicating decisions for the Principal but not to substitute as a decision-maker for the Principal.

4. Support services are a coordinated system of social or other services designed to maintain the Principal's independence and may involve certain Medicaid services.

B. Service providers must interpret SDM Agreements under the following principles:

1. An adult should be able to live in the manner they wish and accept or refuse assistance as long as they do not harm others and can make decisions about such matters;

2. An adult should be able to be informed and, to the best of their ability, participate in the management of their affairs;

3. An adult should receive the most effective, yet least restrictive and intrusive, form of assistance if unable to manage their affairs alone; and

4. The values, beliefs, wishes, cultural norms and traditions the adult holds should be respected in the management of their affairs.

C. Providers are encouraged to include education regarding SDM in the education required by Section 103.10(A)(6) and upon admission or provision of care for adults with disabilities.

103.12 MUTUAL AGREEMENT IN PROVIDER CHOICE

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

103.13 MEDICAL RECORD DOCUMENTATION

A. Medical record documentation encompasses all records used to document any Medicaid-billable service, as well as any documentation required by Nevada Medicaid policy and/or state and federal statutes and regulations. Examples include, but are not limited to, service records, progress notes, consent forms, plans of care, assessments, prescriptions, medical orders, DME invoice, delivery receipts, and PA requests and approvals.

B. Providers are required to complete and maintain patient medical records which adhere to professional standards of practice to ensure continuity of care for Medicaid recipients. Documentation must be completed as soon as practicable after the service is provided in order to maintain an accurate and complete medical record. Records of services performed must be maintained and accessible for a minimum of six years from the date of payment for the specified service.

C. For all PTs, documentation must be completed and signed by the actual rendering provider. This is true even for certain services and PTs that have specific billing rules where the actual rendering provider is not necessarily included on the claim. If different components of the service are performed by different individuals, each individual must complete and sign the documentation for the components they performed. Additionally, if a supervisor or team leader signs documentation for a service they did not personally perform, it must clearly state the role in which they are signing.

D. Appropriate documentation is a necessary element of service provision. 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. The provider who receives payment from Medicaid is required to maintain all medical record documentation.

E. Providers are required to keep records sufficient to establish medical necessity and to fully disclose the basis for the type, extent and level of the services rendered to recipients. The MSM includes specific PT policies, and these records must be in accordance with those policies as well as state and federal statutes and regulations. Submitting claims and receiving payment for services which the provider cannot validate with appropriate documentation may lead to consequences such as recoupment of improper payments, payment suspension, termination of Medicaid provider contract, enrollment sanctions, and in some cases, criminal prosecution.

F. Records must be legible, with all original content visible, and should include, at a minimum:

1. Recipient’s name;

2. Date of service;

3. Place of service;

4. Modality, such as telehealth audio-visual, audio-only, in-person;

5. Start and end time of service, as performed;

6. Procedure code or type of service provided;

7. Any additional requirements in the specific MSM PT policy and billing guides;

8. Name, credentials and signature of the actual rendering provider, including date of signature; and

9. If the record consists of multiple pages, the recipient's name, date of service and page number must appear on each page.

G. Documentation may be recorded and maintained as either paper records or electronic health records (EHR).

1. Paper records require original ink signatures. Signature stamps are not allowed. The completed, signed document may be scanned and maintained as an electronic file such as a PDF. This is not considered EHR.

2. EHRs must be documented and maintained with specialized EHR software which records the date, time, and author of each entry in an unalterable form.

3. If a provider is using EHR, all authorized users must have individual usernames and passwords. Each user must sign an acknowledgement that they will not share their login credentials. The provider organization must maintain this acknowledgement in the employee's/contractor's file.

H. Regardless of whether documentation is a paper record or an EHR, documents must clearly identify all original content, without deletion. Documents containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction, or delayed entry as such; and

2. Clearly indicate the date and author of any amendment, correction, or delayed entry; and

3. Clearly identify all original content, without deletion; and

4. If the amendment, correction, or delayed entry is made by someone other than the original author:

a. The original author must also cosign and date the change; or

b. Documentation must be maintained with the record indicating why the original author did not acknowledge the change.

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

Medicaid is generally the payer of last resort whenever there are any other responsible insurers or programs for payment of health care services. Other Health Care Coverage (OHC) includes, but is not limited to: Medicare, worker's compensation insurance, private or group insurance, any self-insured plans, and any adoption or surrogacy agreement/contracts between recipients and adoptive/biological parent(s).

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

A. Providers should question all patients carefully regarding any other possible medical resources. If coverage has lapsed, or if insurance is discovered when none is indicated on the EVS, AVRS, or swipe card, please contact the necessary vendor found on the Nevada Medicaid website, Contact Us page. See Section 108, References.

B. Providers are required to bill a recipient's OHC prior to billing Medicaid.

C. Medicaid MCO is not considered an OHC. Providers should refer recipients enrolled in a Medicaid MCO plan to the contact that is identified by the Fiscal Agent's EVS or swipe card vendor unless the provider is authorized to provide services under the plan.

D. If the provider does not participate in a recipient's OHC plan, the provider must refer the recipient to the OHC. Nevada Medicaid will deny payment for OHC services if the recipient elects to seek treatment from a provider not participating in the OHC plan. If the Medicaid recipient is informed by a provider not authorized by the OHC that both the OHC and Medicaid may deny payment for the services, and the recipient then documents in writing that they voluntarily elect to receive services from a provider who does not participate in the recipient's OHC plan, the recipient assumes the responsibility to pay for the services personally.

E. The provider must inform the recipient, or responsible individual, before services are provided that they will be financially responsible for the cost of services. If the recipient chooses to continue with the service, the provider must secure a written and signed statement at the time of the agreement which includes the date, type of services, cost of service and the fact that the recipient, or responsible individual, has been informed Medicaid will not pay for the services and agrees to accept full responsibility for the payment. This agreement may not be in the form of a blanket authorization secured only once (for example, at the time of consent for all treatment). It must be specific to each

incident or arrangement for which the recipient, or responsible individual, accepts financial responsibility.

F. A Medicaid provider cannot refuse to provide Medicaid covered services to a Medicaid eligible recipient due to potential TPL coverage.

G. Providers are required to bill Medicare for services provided to Medicare beneficiaries and must accept assignment if the recipient is a Medicare beneficiary and eligible for Medicaid, including Medicare/Medicaid (dual eligible) and QMBs.

H. If providers are unable to pursue TPL, assistance may be requested within one year from the date of service through the Fiscal Agent's TPL Unit. See Section 108 References, for contact information. Providers are requested to contact the Fiscal Agent's TPL Unit within four weeks after the date of service or TPL date of discovery. In many instances this prompt action will result in additional insurance recoveries.

I. Providers should not release itemized bills to Medicaid patients. This will help prevent prior resources from making payment directly to the patient. Providers are encouraged to accept assignment whenever possible to lessen insurance problems by receiving direct payments.

J. A pregnant recipient or gestational surrogate who is eligible for Nevada Medicaid is entitled to Medicaid coverage for antepartum, labor and delivery, and postpartum care. If the recipient chooses to put their baby up for adoption or is acting as a surrogate, the adoptive parent(s)/biological parent(s) may be contractually obligated to cover the costs of the pregnant recipient's care, as adoption/surrogacy agreements/contracts often include a provision stating that the adoptive parent(s)/biological parent(s) will cover the costs of medical care for the pregnant recipient.

Nevada Medicaid will take all reasonable measures to ascertain the legal liability of third parties, including adoptive parent(s)/biological parent(s) who are obligated by agreement/contract, to pay for care and service under the Nevada Medicaid State Plan and to seek reimbursement to the extent of the TPL. Additionally, the pregnant recipient, as a condition of receiving Medicaid benefits, has assigned to Nevada Medicaid their right to payment for medical care by the third party.

Nevada Medicaid shall review the adoption/surrogate agreement/contract to determine the nature and extent of any contractual liability to pay for the pregnant recipient's health care. If Nevada Medicaid determines that such liability exists, it shall utilize the third-party resource, either through cost avoidance or pay and chase claims processing, depending on the claims processing requirements for the type of service as specified in 42 CFR §433.139.

104.1 PAYMENT LIMITS AND EXCEPTIONS

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

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

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

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

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

1. the service(s) is/are not covered by the OHC plan;

2. the service is an emergency and the recipient is not given an option to choose/select where they are taken; or

3. the recipient resides outside the service area of the OHC and accesses the nearest Nevada Medicaid provider.

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

G. If a provider is billing Nevada Medicaid a provider-specific encounter rate, the provider must bill Nevada Medicaid for the encounter rate minus any TPL payment(s).

H. After receiving payment or a denial letter from the OHC, providers must submit the claim to Nevada Medicaid with the appropriate information from the OHC. Billing information can be found on the Fiscal Agent's website at https://medicaid.nv.gov/. Providers are required to maintain documentation to support the OHC's determination per the retention schedule. The current retention schedules can be located on the website for the Nevada State Library and Archives at https://nsla.nv.gov/state-records-services/retention-schedules.

I. If it is known that a specific service is not a covered benefit under the OHC policy, it is only necessary to bill the OHC once per calendar year. For billing information, please refer to the Fiscal Agent's website at https://medicaid.nv.gov. If the recipient's OHC is Medicare and the service is not a covered Medicare service, the provider is not required to contact Medicare.

J. Providers must bill Medicaid for all claims, regardless of the potential for tort actions, within the specified time frame from the date of service or date of eligibility determination, whichever is later. Time frames are according to the Medicaid stale date period when no TPL resource has been identified; or 365 days, when a TPL resource exists. If there are delays in pursuing payment from the OHC at no fault of the provider, Medicaid will allow an additional 60 days from the date of the OHC's explanation of benefits (EOB) to submit a claim to the Fiscal Agent. See Section 105.2B, Billing Time Frames (Stale Dates) for definition of Stale Date.

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

L. Exceptions to the TPL rule are:

1. IHS;

2. Children with Special Health Care Needs; and

3. State Victims of Crime.

4. Recipients receiving services as per an Individualized Education Program (IEP) and related programs, Title V, and WIC as per the SSA 1903(c).

Medicaid is primary payer to these three programs; however, this does not negate the provider's responsibility to pursue OHC. For specific information on Indian Health Service Tribal 638 Health Facilities, please refer to MSM Chapter 3000 - Indian Health.

104.2 SUBROGATION – COST SAVINGS PROGRAM

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

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

Pursuant to NRS 422.293, subrogation cases are considered to be recovery of medical cost incurred and are unusual in that collection is often not a straight-forward process. Subrogation is a Cost Savings Program and resides in the Nevada MOM Chapter 800.

http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MOM/MOMHome/

104.3 HEALTH INSURANCE PREMIUM PAYMENTS (HIPP)

Nevada Medicaid may pay insurance premiums through Employer-Based Group Health Plans for individuals and families when it is cost effective for the agency. The HIPP program outline can be found in DHCFP MOM 900.

105 MEDICAID BILLING AND PAYMENT

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

A. A provider may use a billing agent to complete Medicaid billing only if the compensation for this service is:

1. related to the actual cost of processing the billing;

2. not related on a percentage or other basis to the amount that is billed or collected; and

3. not dependent on the collection of the payment.

B. Medicaid payment for an individual practitioner may be made to:

1. the employer of a practitioner if the practitioner is required, as a condition of employment, to turn over his fees to his employer;

2. the group if the practitioner and the group have a contract in place under which the group submits the claims;

3. the facility in which the services are provided, if the practitioner has a contract under which the facility submits the claims; or

4. a foundation, plan or similar organization operating an organized health care delivery system if the practitioner has a contract under which the organization submits the claims. An “organized health care delivery system” may be a public or private HMO.

C. Payments will be from federal and state funds and any falsification, or concealment of a material fact, may be prosecuted under federal and state law. Providers agree and accept responsibility to:

1. accept Medicaid payments as payment in full for services rendered and under no condition, except for lawful patient liability, contact the patient or members of the patient’s family for additional monies; and

2. examine all remittance advices for accuracy and report to Medicaid within five days any discrepancy found.

105.1 MEDICAID PAYMENTS TO PROVIDERS

A. As specified in federal regulations and the terms of all provider agreements, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. This includes, but is not limited to, situations where the provider's claim is denied by Medicaid for failure to bill timely, accurately or when Medicaid payment equates to zero because a third party's payment exceeds Medicaid's allowable amount.

B. Medicaid utilizes the CMS developed National Correct Coding Initiative (NCCI) to control improper coding that leads to inappropriate payments. The NCCI edits are defined as edits applied to services performed by the same provider for the same beneficiary on the same date of service. Section 6507 of the Affordable Care Act requires each State Medicaid program to implement compatible methodologies of the NCCI, to promote correct coding and to control improper coding leading to inappropriate payment.

C. Nevada Medicaid utilizes a clinical claims editor program to enhance the adjudication process for Nevada Medicaid/Check Up claims for professional services. The claims editor program employs a nationally recognized standardized method of processing claims for professional services using clinical logic based on the most recent Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD), American Medical Association (AMA), CMS and specialty societal guidelines. The claim editor results in consistent claims adjudication for all providers of professional services and increased claims payment turnaround time.

D. If an individual is pending Medicaid, it is requested that the provider await an eligibility decision before billing for the service. If the provider decides not to wait for the decision, he or she may request payment from the recipient while the decision is pending. Once the recipient is found eligible for Medicaid, and the date of service for which payment was collected is covered, the provider must return the entire amount collected to the recipient before billing Medicaid. The payment subsequently received from Medicaid is payment in full and no additional payment may be requested from the recipient, and no part of the payment made by the recipient may be retained by the provider.

E. Providers are to bill their usual and customary fees unless otherwise specified in Medicaid policy. For exceptions, refer to individual chapters. Billings are submitted according to established Medicaid policies.

F. 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.

G. Claims for payment are to be submitted electronically to Nevada Medicaid's Fiscal Agent.

H. It is the provider's responsibility to submit clean, accurate and complete claims to assure accurate payment within Medicaid billing time frames (Stale Date) as outlined in this chapter. See Section 105.2B, Billing Time Frames (Stale Dates) for definition of Stale Date.

Claims not meeting this criterion will be denied by the Fiscal Agent to the provider.

I. "Incident to" billing is not a reimbursable billing mechanism under the Nevada Medicaid Program. Nevada Medicaid will neither accept nor reimburse professional billings for services or supplies rendered by anyone other than the provider under whose name and provider number the claim is submitted (e.g., a claim for an office visit submitted by a physician when another physician, pharmacist, psychologist, or other personnel actually provided the service). Individuals who do not meet Medicaid criteria for PTs cannot have their services billed as through a physician/dentist to the Medicaid program for payment. All providers must enroll into their designated PT and bill for the services they provided. This does not include medical assistants or other qualified health care professionals who are allowed to perform services under and for their supervising physician.

J. Medical residents do not meet Medicaid criteria for provider status. No service provided by a medical resident is to be submitted by another licensed physician/dentist to the Medicaid program for payment except by the teaching physician under the policy guidance in MSM Chapter 600 - Physician Services.

K. Payments are made only to providers. (Recipients who provide transportation for themselves and/or other recipients may be reimbursed as providers under certain circumstances.) A provider cannot request payment from Medicaid recipients assuming Medicaid will reimburse the recipient. Optional reimbursement to a patient is a characteristic of the Medicare program, not the Medicaid program. Refer to MSM Chapter 1900 - Transportation Services for more specific guidance.

L. Providers are required to keep any records necessary to disclose the extent of services the provider furnishes to recipients, in accordance with policy and the provider/DHCFP Contract, and to provide these records, upon request, to the Medicaid agency, the Secretary of HHS, or the state Medicaid Fraud Control Unit (MFCU).

M. When payment appears to be unduly delayed, a duplicate billing labeled "duplicate," or "tracer" may be submitted. Failure to indicate "duplicate" or "tracer" may be interpreted as a fraudulent practice intended to secure improper double payment.

Group practices should make certain that rebilling shows the same service codes, the same physician's name, and the same Medicaid provider number. If it should be necessary to alter the billing to show different codes or descriptors, providers are to submit an adjusted or voided claim to the Fiscal Agent through the Provider Portal.

N. Not all improper billings can be detected at the time of payment. All payments are subject to post payment review.

O. Letters of Agreement

Pursuant to the conditions and limitations prescribed in the Nevada Medicaid State Plan, DHCFP may negotiate reimbursement rates for out-of-state providers to serve FFS Nevada Medicaid recipients. The services of these providers are often necessary to ensure access to services for Nevada Medicaid and NCU recipients that may not otherwise be available from in-state providers or in those instances where a recipient is in need of emergency care while outside of the State of Nevada.

The following procedure will be used for all out-of-state providers requesting a provider-specific rate. The procedure is applicable to out-of-state inpatient and outpatient acute, psychiatric, and specialty hospital services and other services associated with such treatment, including transportation and physician services.

All providers must complete a provider enrollment application and be approved as a Nevada Medicaid provider in order to be reimbursed for services. All services provided under the Letter of Agreement (LOA) must comply with any requirements set forth in the MSM or claims submission requirements.

It is the provider's responsibility to request an extended or additional LOA for continuing care. Renewal requests must be submitted to the Rate Analysis and Development (RAD) Unit prior to the expiration date listed on page one of the LOA. Late requests will not be backdated, and providers will be reimbursed on the same basis as in-state providers for the same service(s). Subsequent LOAs will require approval by DHCFP Administration.

A retroactive LOA will only be provided for emergencies or if the service occurred over the weekend. It is the provider's responsibility to request the LOA within three business days of the service. The retroactive LOA will need to be approved by DHCFP Administrator.

This letter does not exempt providers from the PA requirements and TPL reimbursement policies defined in MSM Chapter 100.

The RAD Unit of DHCFP is responsible for administering the provision of this section. The RAD Unit will negotiate a provider-specific reimbursement agreement within the constraints of the Medicaid State Plan and the MSM. All agreements under this section are not final until they are fully executed by the Division's Administration. Additional and detailed information related to LOA is available in MSM Chapter 700, Section 705, LOAs or inquiries can be submitted to rates@dhcfp.nv.gov.

105.1A EXTENDED SERVICES

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

1. The discharge date or the last day of the month which service was provided, whichever comes first, is considered the date of service for inpatient/residential claims. Each interim monthly billing must be received no later than the stale date. See Section 105.2B, Billing Time Frames (Stale Dates) for definition of Stale Dates.

2. Physicians, individual practitioners and clinics providing prolonged or extended treatment should submit interim billings for each calendar month; e.g., therapists whose services have been prior authorized for several months; and home health agencies authorized for ongoing, long-term care.

3. A global payment will be paid to the delivering obstetrician when the pregnant woman has been seen seven or more times by the delivering obstetrician and must be billed following the delivery. The delivery date is considered the date of service in this instance. Bill all other obstetrical claims as follows:

    a. Prenatal laboratory panels must be billed before the stale date under rules of clinical laboratory services;

    b. Prenatal visits (three or fewer) must be itemized and submitted before the stale date;

    c. Prenatal visits (four to seven or more) must be billed using appropriate obstetrical codes and submitted before the stale date; and

    d. If delivery is performed by someone other than the prenatal provider, prenatal care is billed as above before the stale date.

105.2 REIMBURSEMENT

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

105.2A LIMITATIONS

1. Medicaid pays global or per diem rates to facilities.

2. Most individual practitioners are paid computer-generated maximum allowable amounts that are the result of multiplying a specific dollar amount times the relative unit value assigned to a specific procedure code. Procedure code value lists and/or dollar factors are available on DHCFP website at http://dhcfp.nv.gov.

3. Reimbursement for most providers is Medicaid's maximum allowable amount or billed charges, whichever is less.

4. Provider Preventable Conditions

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

   a. Wrong surgical or other invasive procedure performed on a patient.

   b. Surgical or other invasive procedure performed on the wrong body part.

   c. Surgical or other invasive procedure performed on the wrong patient.

   d. Foreign object retained after surgery.

   e. Air embolism.

   f. Blood incompatibility.

   g. Surgical site infection following:

      1. Coronary artery bypass graft.

      2. Bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery).

      3. Orthopedic procedures (spine, neck, shoulder and elbow).

   h. Stage III and IV pressure ulcers.

   i. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock).

j. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity).

k. Catheter-associated urinary tract infection.

l. Vascular catheter-associated infection.

m. Deep vein thrombosis/pulmonary embolism associated with total knee replacement or hip replacement surgery other than in pediatric and/or obstetric patients.

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

Providers can request an appeal via the appropriate QIO-like vendor if they disagree with an adverse determination related to a PPC. The appropriate QIO-like vendor appeal process must be exhausted before pursuing a Fair Hearing with DHCFP. Refer to MSM Chapter 3100, Section 3105, Medicaid Provider Hearings for additional information on Fair Hearings.

Individual agreements between managed care organizations and their providers may vary from FFS limitations.

5. Nevada Medicaid may suspend Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual and/or entity. This action may be taken without first notifying the provider. Further information on payment suspensions is detailed in MSM Chapter 3300 – Program Integrity.

105.2B BILLING TIME FRAMES (STALE DATES)

Providers must bill Medicaid for all claims within the specific time frame set by Medicaid. To be considered timely, claims must be received by the Fiscal Agent within 180 days from the date of service or the date of eligibility decision, whichever is later. For out-of-state providers or when a TPL resource exists, the timely filing period is 365 days. Any claims submitted after the stale date will be denied for payment. Providers have the right to appeal any claim denials. This section is not related to WRAP Supplemental Payment Program. Federally Qualified Health Centers

(FQHC) and RHCs, must refer to the respective Billing Guides for WRAP Supplemental Payment Program timely filing guidelines.

Stale date criteria are strictly adhered to whether the claim is initially received or being appealed for a stale date override. Re-submitted claims with one or more of the following criteria may be authorized for payment:

1. The provider submits documentation that they delayed submitting the claims for payment to Nevada Medicaid because they were pursuing payment from a TPL resource.

    a. The Medicaid claim must be submitted within 60 days from the date the provider was reimbursed or notified of non-coverage/denied services by the TPL vendor; and

    b. The provider must still submit the EOB and/or documentation from the primary insurance carrier.

    c. These TPL claims only have up to two years from the ending date of service to submit these claims.

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

105.2C DISPUTED PAYMENT

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

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

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

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

1. Providers who request an appeal must follow the appeal process outlined in the Billing Manual for Nevada Medicaid and NCU.

2. A NOD will be sent by the Fiscal Agent to the provider advising them of the appeal decision.

3. Claims appealed due to a provider's dissatisfaction with reimbursement for specific procedure codes are first researched by the appropriate QIO-like vendor. If there is a need for policy clarification or a question of policy change, the Fiscal Agent will send the appeal, along with the full documentation of research, to Nevada Medicaid's Compliance Unit.

4. Providers must exhaust the appropriate QIO-like vendor appeal process prior to pursuing a Fair Hearing with the Division.

Refer to MSM Chapter 3100 for additional information on Fair Hearings.

105.3 BILLING MEDICAID RECIPIENTS

A. As specified in federal regulations, terms of all provider agreements, Section 105(C), Medicaid Billing and Payment, and Section 105.1(A), Medicaid Payments to Providers, Medicaid payment is payment in full. Providers may not attempt to collect additional money directly from recipients. Providers are not allowed to bill recipients for any covered services or remaining balances. All covered services must be billed to Nevada Medicaid.

B. A provider may bill a recipient when a Medicare/Medicaid patient elects not to use lifetime reserve days for hospital inpatient stays. In these cases, the patient must be informed that, due to this election, Medicaid coverage will not be available.

C. When a service is provided by a Medicaid provider, which is not a Medicaid covered service, the recipient is only responsible for payment if a signed written agreement is in place prior to the service being rendered. The signed written agreement must include the date, type of service, cost of service, and the fact that the recipient or responsible individual has been informed. Nevada Medicaid will not pay for the services and agrees to accept full responsibility for the payment. This agreement may not be in the form of a blanket authorization secured only once (for example, at the time of consent for all treatment). It must be specific to each incident or arrangement for which the recipient, or responsible individual, accepts financial responsibility.

1. A service not covered by Medicaid includes the following:

a. Any service not currently approved under Nevada Medicaid's State Plan.

b. Any service above and beyond a service limitation that does not meet the medical necessity requirements for an override.

c. Services provided to undocumented/non-citizens that have Federal Emergency Services Program (also known as Emergency Medicaid Only) that are not covered under this plan.

1. Refer to MSM 200 - Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for policy regarding Emergency Medicaid Only and the services this aid category covers.

2. Refer to ICD-10-CM Emergency Diagnosis Codes for Non-Citizens with Emergency Medicaid Only Coverage for a list of ICD codes that are automatically covered. This list can be found at https://www.medicaid.nv.gov/Downloads/provider/ICD-10_Emergency_Diagnosis_Codelist.pdf.

d. Follow-up care to non-covered services such as surgical procedures deemed experimental, not well established, or not approved by Medicare or Medicaid. See list of definitive non-covered services in MSM 603.11(F)(3). However, if an emergency medical situation arises from a non-covered service, the emergency condition may be covered if medically necessary.

2. Providers cannot require a recipient to receive a non-covered service, for which they must pay, in order to receive a covered service.

D. When all of the criteria under Subsection 1. or 2. below are met, a patient may be billed for all or a portion of an acute hospital admission.

1. Preadmission Denial – The appropriate QIO-like vendor issues a denial for the admission as not being medically necessary or not a Medicaid benefit; and

a. The physician chooses to admit the patient, nonetheless;

b. The recipient is notified in writing before services are rendered that he or she will be held responsible for incurred charges; and

c. A document signed by the recipient or designee acknowledging the responsibility is accepted by a recipient.

2. Denial of a portion of the admission – the appropriate QIO-like vendor issues a denial for a portion of the admission as no longer medically necessary for acute care; and

a. The recipient is furnished with the denial notice prior to services being rendered which are to be billed;

b. The physician orders the discharge of the patient;

c. No requested administrative days have been approved by the appropriate QIO-like vendor; and

d. The recipient refuses to leave.

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

1. The admitting physician fails to acquire a PA from the appropriate QIO-like vendor in cases other than emergency, except when the hospital admission comes directly from the emergency department.

2. The appropriate QIO-like vendor has reduced the level of care from acute to an administrative level.

3. The hospital and patient receive a retrospective denial by the appropriate QIO-like vendor after service has been rendered.

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

F. If the payment for services is made by the recipient's other health care coverage directly to the recipient or his or her parent and/or guardian, he or she is responsible to submit the payment to the provider. If the recipient, or his or her guardian, fails to do so, the provider may bill the recipient for the services, but may not collect more than the exact dollar amount paid by the OHC for services rendered.

G. Providers may bill Medicaid recipients when the recipient does not disclose Medicaid eligibility information at the time the service is provided. As a rule, all providers seek payment source information from recipients/patients before services are rendered. Any recipient not declaring their Medicaid eligibility or pending eligibility and thus denying the provider the right to reject that payment source, is viewed as entering into a "private patient" arrangement with the provider.

H. If a provider has billed a Medicaid recipient erroneously, the provider must refund the money to the recipient and bill Medicaid for the amount. Medicaid claims showing a "patient paid" amount, when the recipient was not responsible for payment, will be returned to the provider. Once the refund has been made to the recipient, the claim may be

resubmitted with a copy of the refund check and the Fiscal Agent will process the claim for payment.

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

Termination means termination of the Medicaid Provider Contract (standard or provisional) between Nevada Medicaid and the actively enrolled provider.

A provider whose contract is terminated by Nevada Medicaid may request a fair hearing in accordance with NRS 422.306 and MSM Chapter 3100, Hearings, Medicaid Provider Hearings.

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

Individuals/entities enrolled with Nevada Medicaid who are terminated or who voluntarily terminate shall be terminated by all Medicaid MCO plans and PAHPs.

All entities/individuals who terminate from the Nevada Medicaid program have the responsibility to assist in the care coordination for the Medicaid recipients they serve, to ensure continuity of care and access to needed support services, and to ensure patients have access to their own medical records, this includes PAs.

106.1 TERMINATION FOR CONVENIENCE

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

106.2 CONDITIONS OF CONTRACT TERMINATIONS

A. Immediate Terminations

Unless mandated by state or federal policy, DHCFP may decide to immediately terminate a provider contract if any of the following occurs, is discovered, or reported:

1. The provider is convicted of a criminal offense related to the participation in the Medicare/Medicaid program.

2. The provider's professional or business license, certification, accreditation, or registration is inactive, surrendered, suspended, revoked, expired, or enrollment with CMS or any State is revoked, terminated for cause, or suspended.

3. DHCFP is notified that the provider is placed on the OIG's Exclusion List (42 CFR 1002), revoked by CMS or any State's licensing Board, or terminated/sanctioned by any State's Medicaid program.

4. The provider is deceased.

5. DHCFP, the Nevada DHHS, or any agency within DHHS, has determined that the quality of care of services rendered by the provider endangers the health and safety of one or more recipients.

6. The provider is no longer licensed in Nevada or, through a Settlement, has been ordered or agrees, to stop doing business in Nevada.

7. The provider has failed to disclose or report information or circumstance listed in MSM Chapter 100, Section 102, Provider Enrollment – Conditions of Participation and all sub sections, and Section 103, Provider Rules and Requirements and all sub-sections.

8. The identity of the provider cannot be proven.

9. The provider has been terminated for cause by an MCO plan and/or PAHP contracted with DHCFP.

10. The provider, or any person with a 5% or greater direct or indirect ownership or interest in the provider, fails to consent to FCBC and/or to submit sets of fingerprints in the form and manner as instructed by the Fiscal Agent and/or DHCFP.

11. Credible allegations of fraud, waste, or abuse have been discovered and/or reported and immediate action is deemed necessary.

12. The provider has been convicted of a misdemeanor and/or felony that is incompatible with the mission of DHCFP.

13. DHCFP becomes aware that the provider failed to provide required information and/or provided false information on the enrollment application.

14. The provider is convicted of any offense related to participation in a Social Services program administered by any State or the Federal Government, including, but not limited to, Supplemental Nutrition Assistance Program (SNAP) or TANF.

15. The seller and/or buyer having 5%, or more direct or indirect ownership or interest of any active provider entity/group is found to have sold, transferred, or purchased the provider entity/group in anticipation of (or following) a conviction, imposition of a civil money penalty or assessment or imposition of an exclusion.

16. The provider is owned, operated, or has direct/indirect interest by a sanctioned individual and/or entity.

17. The provider fails to fully cooperate with any DHCFP investigation, audit, review, or survey.

18. The provider has an existing overpayment and has not entered into and/or maintained an approved repayment plan.

19. The provider is the owner of, has direct or indirect interest in, or is the managing employee/authorized agent of a group/entity convicted of any offense related to the participation in a DHHS program administered by any State or the Federal Government.

20. CMS or another State has terminated the provider (individual/owner/group) for-cause.

B. Advance Notice of Termination

An advance Notice of Intent (NOI) to terminate must be mailed no less than 20 days from the intended action date if DHCFP determines to terminate the contractual relationship. If it is in the best interest of the Nevada Medicaid Program or its recipients, DHCFP may extend the 20-day advance notice timeframe.

Advance notice is required for the following reasons (not all inclusive), unless immediate termination is warranted:

1. Termination, exclusion or suspension of an agreement or contract by any other governmental, state or county program is reported or discovered.

2. The provider no longer meets the conditions of participation as stated in Chapter 100 all-inclusive of the Nevada MSM.

3. The provider no longer meets all of the requirements or other conditions of participation as required by the Nevada MSM for the specified PT.

4. The provider fails to submit requested information by the required due date.

5. The provider is under investigation by a law enforcement or state agency for conduct that it is deemed incompatible with the mission of DHCFP, with the rules and governances of their licensure, or with any rule, law, or regulation associated with DHHS.

6. The Division has determined that the results of any investigation, audit, review or survey necessitate termination;

7. An administrative contract termination has been performed;

8. The provider's NPI number is deactivated and/or the provider's data elements in NPPES are no longer current; and/or

9. Providers whose mail is returned to DHCFP as "undeliverable," "return to sender," "address unknown," "unclaimed," or any other reason noted by the U.S. Post Office as a reason for which mail was returned.

106.3 SANCTION PERIODS

Providers who are terminated from the Nevada Medicaid program "for cause" will serve a sanction period that begins with the effective date of the termination. Sanctioned providers will not be reimbursed for any services provided on or after the date of termination, and those sanctioned are ineligible to operate on, or otherwise have interest in any business enrolled with Nevada Medicaid for the duration of their sanction. Providers who have not been permanently sanctioned from the Nevada Medicaid program may resubmit a new Provider Enrollment Application for evaluation at the end of the sanction period.

DHCFP is not obligated to enroll, re-enroll, or re-validate all eligible applicants or providers, and all types of enrollments are at the discretion of DHCFP.

When a sanction is imposed upon an entity, the same tier sanction will also apply to any individual having a 5% or greater direct or indirect ownership or interest in the entity, as well as any individual who functions as an agent or managing employee of the entity.

All sanctions are evaluated on a case-by-case basis. This evaluation includes, at minimum, the level of conviction, nature of conviction, age of conviction, number of convictions, or the provider's conduct. This evaluation does not prevent Nevada Medicaid's authority from imposing a sanction due to a first offense.

When a sanction is imposed upon an individual, the same tier sanction will also apply to any entities in which the sanctioned individual has 5% or greater direct or indirect ownership or interest, or for which the sanctioned individual is an agent or a managing employee.

A. Tier 1 – Permanent Sanction

1. Provider is on the OIG exclusion list.

2. Provider has been convicted of an offense related to that person's or entity's involvement in any program established under Medicare, Medicaid, CHIP (NCU), the Title XX services program or any other state or federally funded assistance program.

3. Provider has been terminated for cause, excluded or is under any form of suspension from Medicare, Medicaid, CHIP (NCU), the Title XX services program or any other state or federally funded assistance program.

4. Provider has been convicted of any offense listed below:

   a. Murder, voluntary manslaughter, mayhem or kidnapping;

   b. Sexual assault, sexual seduction or any sexually related crime;

   c. Robbery, attempt to kill, battery with intent to commit a crime or administration of a drug to aid commission;

   d. False imprisonment or involuntary servitude;

   e. Criminal neglect of patients per the NRS 200.495;

   f. Abuse or neglect of children per NRS 200.508 through 200.5085;

   g. Abuse, neglect, exploitation, isolation, or abandonment of older persons or vulnerable persons under NRS 200.5091 through 200.5099;

   h. Any offense against a minor under NRS 200.700 through 200.760;

   i. Any offense against public decency and good morals under a provision NRS 201.015 through NRS 201.56;

   j. A violation of any federal or state law regulating the possession, distribution or use of any controlled substance, or a violation of any dangerous drug as defined in chapter 454 of NRS.

DHCFP may choose to allow re-enrollment if the United States DHHS or Medicare notifies DHCFP that the provider may be reinstated.

B. Tier 2 – 10-Year Sanction

1. Provider has been terminated due to quality-of-care issues, inappropriate and/or fraudulent billing practices, or willful disregard of policy as identified as a result of an investigation, audit, review, or survey.

2. The provider has failed to produce records as requested while under payment suspension, investigation, audit, review, or survey.

3. Provider has been convicted of any offense listed below:

   a. Assault or battery;

b. Any offense involving arson, fraud, theft, embezzlement, burglary, fraudulent conversion or misappropriation of property;

c. Harassment or stalking;

d. Any offense against the executive power of the State in violation of NRS 197;

e. Any offense against the legislative power of the State in violation of NRS 198;

f. Any offense against public justice in violation of NRS 199; and/or

g. Any other felony involving the use of a firearm or other deadly weapon.

C. Tier 3 – Three-Year Sanction

1. Provider was terminated at revalidation due to omitting information regarding criminal background or ownership and/or supplying false information on the Provider Enrollment Application or any form required for continued enrollment;

2. Provider was terminated as a result of an investigation, audit, review, or survey not related to quality of care or inappropriate fraudulent billing practices;

3. Provider was terminated due to not meeting the conditions of participation as stated in Chapter 100 all-inclusive of the Nevada MSM or other conditions of participation as required by the Nevada MSM for the specified PT;

4. Provider was terminated due to being under investigation by a law enforcement or state agency for conduct that is deemed incompatible with the mission of DHCFP or as outlined in Section 102, Provider Enrollment – Conditions of Participation;

5. Provider was terminated due to conviction of a misdemeanor, gross misdemeanor or felony, not listed in Tier 1 or Tier 2, which is incompatible with the mission of DHCFP or as outlined in Section 102, Provider Enrollment – Conditions of Participation;

6. It is reported or discovered that the provider falsified information on and/or supplied false information/documentation with any Enrollment Application or any document submitted to the Fiscal Agent or DHCFP, unless a higher sanction tier is applicable;

7. It is reported or discovered that the provider omitted information on any Enrollment Application, or any document submitted to the Fiscal Agent or DHCFP, unless a higher sanction tier is applicable;

8. The provider failed to report any change to enrollment as outlined in Chapter 100 (all inclusive);

9. Provider voluntarily terminated, failed to revalidate, or terminated for any other reason while under payment suspension, investigation, audit, review, or survey; and/or

10. Provider was terminated due to an investigation, audit, review, or survey resulting in quality-of-care issues, inappropriate and/or fraudulent billing practices, or willful disregard of policy, unless a higher tier sanction is applicable.

D. Tier 4 – 12-Month Sanction

1. Provider has failed to follow through with their DHCFP approved corrective action plan;

2. Provider has a restriction placed on their professional license;

3. Provider failed to successfully meet Provisional Enrollment conditions of participation;

4. Provider failed to report/provide required information in the time frame set forth in the Enrollment Application, Provider Contract and/or the MSM (all inclusive), such as:

   a. CHOW;

   b. Change to the status of any license required for enrollment or continued enrollment with the Nevada Medicaid program;

   c. indictment, arrest, criminal charge and/or conviction of any provider, owner, agent and/or authorized user (unless a higher tier sanction is applicable); and/or

   d. result(s) of a pending legal case or investigation (as reported on the Enrollment Application or Change Form) resulted in a "for cause" termination not listed in Tier 1, Tier 2 or Tier 3.

5. Provider failed to consent and submit to Enhanced Provider Screening requirements, such as a site visit and/or FCBC.

6. Provider fails to provide required and/or requested information specific to participation for their PT, or a provider voluntarily terminates without providing required and/or requested information specific to participation for their PT.

E. Immediate Re-Application

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

   a. Loss of contact;

   b. No payments made to provider within the prior 24 months; or

   c. When the sole issue is a change in federal law and the law has been repealed.

2. DHCFP is not obligated to enroll, re-enroll, or re-validate all eligible applicants or providers, and all types of enrollment are at the discretion of DHCFP.

106.4 PROCEDURES FOR TERMINATION AND NON-RENEWAL

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

An Immediate Termination Letter, Notice of Intent to Terminate or Non-renew Letter will be sent to the provider at the last known mailing address via U.S. mail. The notice will include:

A. a description of proposed action;

B. the effective date of the proposed action;

C. the basis for the proposed action, citing the appropriate Medicaid policy, federal regulation and/or state law;

D. the effect of the action on the provider's participation in the Nevada Medicaid Program;

E. the provider's right to a fair hearing, in accordance with NRS 422.306; and

F. the tier and length of sanction imposed, if applicable.

106.4A ADMINISTRATIVE CONTRACT TERMINATIONS

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

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

1. death of the provider;

2. loss of contact;

3. no payments made to provider within the prior 24 months;

4. when the sole issue is a change in federal law; and/or

5. Deactivation of a provider's NPI number.

106.5 MEDICAID AGENCY ACTION AFTER REVIEW, AUDIT OR INVESTIGATION

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

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

A. U.S. DHHS;

B. U.S. Department of Justice;

C. Nevada Medicaid SUR staff;

D. MFCU;

E. Nevada Medicaid Program Integrity staff;

F. Nevada Medicaid audit staff;

G. DHCFP Audit Contractors;

H. Fiscal Agent staff;

I. ADSD staff; or

J. Other state and/or county agencies.

Refer to MSM Chapter 3300, Program Integrity for information regarding SUR investigations.

106.5A CORRECTIVE ACTIONS

1. In determining appropriate action to be taken, the following will be considered:

   a. Corrective action necessary to eliminate the problem(s);

   b. Seriousness of the problem(s);

   c. Number of current and past violations;

d. Past sanctions applied; and

e. Other available services.

2. DHCFP may take one or a combination of the possible corrective actions such as, but not limited to:

a. Educational contact may be used when minor errors are detected and may be in the form of a telephone call, on-site visit or a letter by DHCFP or Fiscal Agent staff. Educational contact is made for the purpose of instructing a provider in policy compliance, correct billing procedures, program benefit limitations and to correct identified errors in billing or requests for services not covered by Medicaid.

b. Warning letters may be prepared by DHCFP staff in cases where an investigation or program compliance review has revealed a violation occurred, but the extent of the violation is not substantial enough to warrant stronger administrative action or referral for civil/criminal action. Warning letters are intended to assist the provider in rectifying the problem and will include notice of potential consequence if the problem reoccurs.

c. The agency may impose special requirements on a Medicaid provider as a condition of participation. These include, but are not limited to the following:

1. All services provided to Medicaid recipients must be prior authorized by DHCFP to be eligible for Medicaid reimbursement.

2. Selected provider services must be prior authorized to be eligible for Medicaid reimbursement;

3. Medical records must be submitted with all claims; and/or

4. A second opinion from an independent peer must be obtained to confirm the need for the service to be eligible for Medicaid reimbursement.

d. Suspending the provider from accepting and billing for new Medicaid recipients.

e. Implementing a payment suspension in accordance with 42 CFR 455.23. Refer to MSM Chapter 3300, Program Integrity for further information.

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

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

106.6 SUSPENSION

Suspension means Nevada Medicaid will not reimburse the provider for billed services for a specified period. Alternatively, a provider may be suspended from accepting and billing for new Medicaid recipients as the result of an audit, review or investigation until corrective action is initiated.

A. A provider may be suspended from the Medicaid program when:

1. found to be providing items or services at a frequency or amount not medically necessary;

2. found to be providing items or services of a quality that does not meet professionally recognized standards of health care in a significant number of cases;

3. an audit, review or investigation reveals failure to comply with program policies.

4. a recycle results in a provider negative balance and all attempts to collect are exhausted; or

5. a recycle results in a provider negative balance and the provider stops paying on this balance.

B. Suspension may be applied to any person who has ownership or controlling interest in the provider or who is an agent or managing employee of the provider. All persons affected by the exclusion must be notified in the original notice of exclusion.

C. A provider whose contract is suspended may request a fair hearing pursuant to MSM Chapter 3100, Hearings. Refer to Chapter 3100, Section 3105, Medicaid Provider Hearings for additional information.

106.6A PROCEDURES FOR SUSPENSION

If DHCFP determines through an audit, review, or investigation to suspend a provider contract, a notice of the intended action will be mailed to the provider via U.S. mail to the last known address. The notice will include:

1. a description of proposed action;

2. the effective date of the proposed action;

3. the length of suspension;

4. basis for the proposed action, citing the appropriate Medicaid policy, federal regulation and/or state law;

5. the effect of the action on the provider's participation in the Nevada Medicaid Program; and

6. the provider's right to a fair hearing in accordance with NRS 422.306.

107 RE-ENROLLMENT

A Medicaid provider who has been previously terminated, excluded, or suspended may be evaluated for re-enrollment upon completion of the Provider Enrollment Application, Medicaid Provider Contract, submission of the required verifications and meeting all conditions of participation noted elsewhere in this chapter.

Re-enrollment is at the discretion of the Division and DHCFP is not obligated to enroll, re-enroll, or re-validate all applicants or providers.

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

107.1 CONDITIONS OF RE-ENROLLMENT

A. Providers, owners, those with 5% or more direct or indirect ownership or interest, and/or managing employees who are sanctioned by the Nevada Medicaid program and placed on the Nevada Exclusions List may submit a formal request for re-enrollment consideration at the end of the sanction period. Each request will be evaluated on a case-by-case basis, and through the evaluation process if re-enrollment is approved, the group's and or individual's name listed on the Nevada Exclusions List will be removed.

B. If a termination was for administrative reasons (e.g., loss of contact, failure to return updated agreement, failure to provide requested information to determine whether conditions of participation are met, etc.) Nevada Medicaid may re-enroll the provider upon receipt of a completed updated agreement, information request form and/or any other information requested to determine that conditions of participation are met.

C. If termination, suspension, exclusion or non-renewal was due to fraud, abuse, falsification of information, etc., the length of the sanction will be in accordance to the letter of notification and the provider is eligible to apply for re-enrollment consideration after serving their sanction period.

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

1. Whether the provider has been convicted in a federal, state, or local court of other offenses related to participation in the Medicare or Medicaid programs which were not considered in the development of the Medicaid suspension, exclusion, or termination; and

2. Whether the state or local licensing authorities have taken any adverse action against the provider for offenses related to participation in the Medicare or

Medicaid programs which was not considered in the development of the Medicaid suspension, exclusion, or termination.

D. If the provider has been suspended, excluded, or terminated from Medicare or at the direction of the Secretary of HHS, Nevada Medicaid will not re-enroll the provider until federal HHS notifies Nevada Medicaid it is permissible to do so, and the provider completes all enrollment applications and contracts.

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

F. Nevada Medicaid Fiscal Agent will give written notice to the suspended, excluded, or terminated provider of the status of their re-enrollment request.

108 REFERENCES

Vital Documents definition from Health Resources and Serviced Administration (HRSA):
https://www.hrsa.gov/sites/default/files/hrsa/about/organization/bureaus/ocrdi/written-translation-vital-documents.pdf

NV Medicaid App:
https://dhcfp.nv.gov/Resources/MDPResource/

Nevada DHCFP:
https://dhcfp.nv.gov/

Contact Information:
Please refer to the Contact Us Page on the FFS Nevada Medicaid Website at
https://www.medicaid.nv.gov/contactinfo.aspx
This includes contact information for:

- Managed Care Organizations
- FFS
  - Customer Service Center
  - Electronic Billing
  - General Information
  - PASRR/LOC
  - Pharmacy
  - Prior Authorization
  - Provider Enrollment
  - Provider Training
  - Public Hearings
  - TPL Identification and Recovery

Nevada Medicaid Pharmacy Portal:
https://nevadamedicaid.magellanrx.com/home/contact

DWSS:
https://dwss.nv.gov/
Access Nevada - https://accessnevada.dwss.nv.gov/public/landing-page

CMS:
https://www.cms.gov/
https://www.medicaid.gov/

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For current Nevada Medicaid PTs and specialties, please view the Provider Enrollment Information Booklet at https://www.medicaid.nv.gov/Downloads/provider/NV_Provider_Enrollment_Information_Booklet.pdf.