



DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL  
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## NURSING FACILITIES

### 500 INTRODUCTION

Nursing Facility (NF) services for individuals age 21 and older is a mandatory Medicaid benefit. NFs are institutions that provide a full range of nursing services from intermediate care at the lower level up to and including skilled nursing services. NFs provide health related care and services on a 24-hour basis to individuals who, due to medical disorders, injuries, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. NF services include services for people who cannot live on their own because they need assistance with certain activities of daily living such as bathing, dressing, eating, toileting and transferring. NFs also provide skilled nursing care and related services for individuals who require medical or nursing care and/or rehabilitation services.

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

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501 AUTHORITY

In 1965, Congress authorized the Medicaid Program by adding Title XIX to the Social Security Act. Title XIX of the Social Security Act requires that in order to receive Federal matching funds, certain basic services including Nursing Facility (NF) services for individuals age 21 and older must be offered to the categorically needy population in any State program. As an optional service, Nevada Medicaid also provides NF services for individuals under the age of 21.

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503 POLICY

503.1 PROVIDER REQUIREMENTS

A Nursing Facility (NF) must comply with the following requirements in order to be eligible to participate in the Nevada Medicaid program. All in-state NFs must:

- a. Be licensed by the Division of Public and Behavioral Health (DPBH), Bureau of Health Care Quality and Compliance (BHCQC) in accordance with the Nevada Revised Statute (NRS) and the Nevada Administrative Code (NAC).
- b. Be certified by the Centers for Medicare and Medicaid Services (CMS) which assures that the NF meets the federal requirements for participation in Medicaid and Medicare per 42 Code of Federal Regulations (CFR) 483.
- c. Be enrolled as an NF provider in the Nevada Medicaid program as described in Chapter 100 of the Medicaid Services Manual (MSM).
- d. Accept payment in full for covered services, the amounts paid in accordance with Medicaid policy and not charge a Medicaid recipient for any services covered by Medicaid reimbursement.
- e. Assure that all claims submitted to Nevada Medicaid's fiscal agent for NF services are accurate and timely.
- f. Comply with all federal and state mandated staffing requirements in order to maintain Medicare/Medicaid certification.

Continued participation as a Nevada Medicaid provider will be subject to recertification and compliance with all Federal and State laws, rules and regulations.

Nevada Medicaid will terminate an NF provider contract upon notice that the NF is no longer licensed and/or certified to provide NF services.

Nevada Medicaid will honor, abide by and impose any and all State and Federal sanctions as directed by BHCQC and/or CMS.

Nevada Medicaid staff will refer any possible non-compliance with state and/or federal regulations to the BHCQC for investigation and follow-up.

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503.2 PROGRAM PARTICIPATION

- A. All Medicaid participating NFs must provide or arrange for services including nursing services, social services, rehabilitative services, pharmacy services, dietary services, activity programs, and emergency and routine dental services to the extent covered under the State Plan. In accordance with the federal statutory and regulatory requirements under 42 CFR 483 and the state regulations under NRS 449 and NAC 449, NFs must also provide treatment and services required by individuals with intellectual disabilities not otherwise provided or arranged for by the State, and all other ancillary and supportive services necessary to improve and/or maintain the overall health status of its residents.
- B. The NF must ensure that each Medicaid recipient is admitted to the facility by a physician and has the benefit of continuing health care under the supervision of a physician. The NF is responsible to ensure that upon admission, the physician provides to the facility sufficient information to validate the admission and develop a medical Plan of Care (POC). The POC must include diet, medications, treatments, special procedures, activities and specialized rehabilitative services, if applicable, the potential for discharge. Physician's visits must be conducted in accordance with federal requirements. Physician's visits made outside the requirements must be based upon medical necessity criteria.
- C. The NF must maintain records on each recipient in accordance with accepted professional standards and practices. Recipient records must be complete, accurately documented, organized and readily available. At a minimum, the record must contain sufficient information to identify the recipient, a record of the recipient's assessments, the POC and services ordered and provided the results of the Pre-Admission Screening and Resident Review (PASRR) screenings, the results of the Level of Care (LOC) Assessment screening, and progress notes. The record must also contain relevant documentation to support the Minimum Data Set (MDS) coding. All entries must be signed and dated with the professional title of the author.
- D. Documentation of specialized services provided or arranged for, and the resident's response to such services must remain in the active medical record as long as the resident is recommended to receive specialized services. This documentation must be available for state and federal reviewers.
- E. The facility must report their census information by midnight on the fifth day of each month. This will include the number of vacant beds in the facility which are available for resident occupancy.
- F. The facility is responsible for ensuring the census information is accurate, complete and submitted timely.



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- G. The facility must submit this report to Nevada Medicaid Central Office by the fifth day of the month reported. For example, the January 1<sup>st</sup> census information must be reported to the Nevada Medicaid Central Office by January 5<sup>th</sup>.
- H. If the number of certified beds has changed, the facility must submit a copy of the certification to Nevada Medicaid.
- I. The provider must provide for the safekeeping of personal effects, funds, and other property of the recipient. The provider must develop policies and procedures to minimize the risk of theft or loss of the personal property of residents. Recipients and their legal representatives must be notified of these policies and procedures. The NF must be adequately covered against liabilities and purchase a surety bond or otherwise provide assurance of the security of all personal funds deposited with the facility.

### 503.3 RECIPIENT RESPONSIBILITY

The recipient, upon request, must present:

- a. a valid Medicaid card; and
- b. any form of identification necessary to utilize other **health insurance coverage for any and all services.**

### 503.4 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

#### AUTHORITY

Authority to maintain a PASRR program comes from Public Law 100-203 (OBRA 87) in Subtitle C - Nursing Home Reform Part 2 - Section 1919(b3)(F); Title 42, CFR section 483.100 – 483.138; an Interagency Agreement between the Division of Health Care Financing and Policy (DHCFP) - Nevada Medicaid, the Department of Public and Behavioral Health (DPBH) and the Aging and Disability Services Division (ADSD); the Nevada State Plan, Attachment 1.2-B, page 10; NAC 449.74425 and NRS 449.037.

The DHCFP, Nevada Medicaid, is responsible for development of policies and procedures and the oversight of all operations related to the PASRR program. The DHCFP contracts with the Quality Improvement Organization (QIO)-like vendor to conduct Level I Identification screenings and PASRR Level II determinations. The DHCFP acts as the mental health/intellectual disabilities authority for PASRR's through a Memorandum of Understanding (MOU) with DPBH, and ADSD. The DPBH is designated to provide and/or follow up on all specialized services. The BHCQC monitors and investigates compliance with PASRR through the survey process.

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Compliance with all state and federal PASRR regulations is required. Non-compliance with the PASRR screening requirements may be referred to CMS and/or the BHCQC for investigation.

The provider must assure that every resident is screened in accordance with state and federal PASRR regulations.

The provider must ensure that facility staff is knowledgeable regarding the PASRR process and the implications of a facility's failure to comply with state and federal regulations. The provider must ensure staff participates in state and federal sponsored PASRR-related training.

The provider must present to state and federal reviewers the active medical record containing the applicable proof of Level I, and when indicated, Level II screenings completed prior to admission and the most recent screenings if the individual experienced a significant change in his/her physical/mental condition.

The provider must provide to state and federal reviewers, documentation supporting the provision of any specialized services for any individual identified as needing specialized services. This may include the DPBH or ADSD case manager documentation in the record.

a. DEFINITIONS

LEVEL I IDENTIFICATION SCREENING

A Level I Identification screening must be completed by a licensed health care professional on all applicants to an NF, without exception and regardless of payment source, prior to placement in a Medicaid-certified NF. The licensed health care professional completing the Level I Identification Screening form attests that the individual (or appropriate family and/or guardian) has been informed that he/she is being considered for NF placement. This screening is also required for residents of an NF any time a Level II screening is requested; such as, when a current NF resident experiences a significant change in his/her physical or mental status or a prior PASRR Level II needs to be updated. The purpose of this screening is to identify any indicators of mental illness, intellectual disabilities, or a related condition and to make referrals for PASRR Level II screenings.

The Level I determination identifies that the individual either has or does not have indicators of mental illness, intellectual disabilities, or a related condition. If there are no indicators of mental illness, intellectual disabilities, or a related condition, the individual is cleared through PASRR screening for admission to an NF. The QIO-like vendor will issue a determination letter to the requestor.

If there are indicators of mental illness, intellectual disabilities, or a related condition a determination letter is given to the requestor and the individual screened and/or their legal representative that they are being referred for a PASRR Level II screening. A PASRR

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Level II screening must be completed to determine the appropriateness of placement in an NF prior to admission to an NF.

It is the responsibility of the discharging facility to request and obtain a Level I screening, and when indicated, a PASRR Level II screening prior to discharging the individual to any NF placement.

b. LEVEL II SCREENING

When an individual has been identified with possible indicators of mental illness, intellectual disabilities or related condition, a PASRR Level II screening must be completed to evaluate the individual and determine if NF services and/or specialized services are needed and can be provided in the NF.

There are two types of PASRR Level II screenings. The Pre-Admission Screening (PAS) refers to a PASRR Level II screening completed on an applicant for NF placement. The Resident Review (RR) refers to a PASRR Level II screening completed on a current resident of an NF who experiences a significant change in his/her physical or mental condition, or had previously been exempted from or was time-limited under a prior PASRR Level II screening. Within the Level II screening, there are two processes, a categorical determination or an individual evaluation and determination.

c. PASRR LEVEL II INDIVIDUAL EVALUATION AND DETERMINATION

If a PASRR Level II Individual Evaluation and Determination screening is indicated through the Level I Identification screening process, the QIO-like vendor's clinical reviewers will make the necessary arrangements for the screening and will notify the requestor.

When the PASRR Level II screening is completed, a Summary of Findings will be provided by the QIO-like vendor to the requestor in the same manner it was requested. (i.e. If the request was faxed in, it will be faxed back, if the request was submitted online, the requester will be able to print the results when completed).

When the facility identifies a significant change in status, as defined in the Resident Assessment Instrument (RAI) User's Manual for either the mental or physical status of a resident, a Resident Review (RR) must be requested, through the submission of a Level I screening request. The QIO-like vendor will review the information and determine whether an RR is necessary. If needed, the QIO-like vendor will proceed with the arrangements for the PASRR Level II evaluation.

The provider must not admit the potential resident until the facility receives confirmation from the QIO-like vendor of the completion of Level II screening.

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If the facility admitted a resident under the Exempted Hospital Discharge, for a less than 30 day stay, and the resident is later found to require more than 30 days of NF care, the facility must request the PASRR Level II (RR) by submitting a completed Level I identification screening to the QIO-like vendor by the 25<sup>th</sup> day of the admit date.

The provider must track limitation dates on Exempted Hospital Discharges and Categorical Determinations. Before any PASRR limitation date, request the PASRR Level II (RR) by submitting a completed Level I Identification to the QIO-like vendor in a time frame that allows completion of the PASRR II prior to the limitation date.

The provider must assess all residents on an ongoing basis to identify if a resident (1) develops mental illness, or (2) a resident who was not previously identified through the Level I Identification screening as having indicators of MI, IID or RC and is now displaying indicators, or (3) the facility has identified the need for a “Significant Change in Status Assessment” (SCSA) MDS. Any of these may indicate the need for a PASRR Level II screening (RR).

Within 14 days of the identification of a significant change in status, the facility must complete and submit a Level I identification screening to the QIO-like vendor clinical reviewers. The QIO-like vendor clinical reviewers will review the information to determine if a PASRR Level II screening (RR) is indicated. The provider may accept verbal determinations from the QIO-like vendor.

The provider must not admit an individual who has been determined to not need NF services.

The provider must report all discharges directly related to a PASRR determination that an individual is not appropriate for NF services to the Medicaid office on the Nursing Facility Tracking Form.

### 503.5 EXEMPTED HOSPITAL DISCHARGE

The only exemption from a PASRR Level II screening is when the Level I Identification screening showing indicators of mental illness, intellectual disabilities, or related condition identifies the individual meets *all* the following criteria for an exempted hospital discharge:

- a. Is to be admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital (this does not include admissions from emergency rooms, observation beds, or rehabilitation units);
- b. Requires NF services for the condition for which he or she received care in the hospital; and

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- c. The attending physician has certified before admission to the NF that the individual is likely to require less than 30 days of NF services.

This determination will be made only by the QIO-like vendor's clinical reviewers. If a facility is requesting to admit under the Exempted Hospital Discharge, supporting proof of the above three requirements must be submitted with the Level I Identification screening form to the QIO-like vendor clinical reviewers.

#### 1. ADVANCED GROUP CATEGORICAL DETERMINATIONS

Before proceeding with a PASRR Level II Individual Evaluation, the QIO-like vendor's clinical reviewers will determine that an individual requires NF services, and meets any one of the following criteria for an Advanced Group Categorical Determination:

- a. Convalescent Care from an acute physical illness which required hospitalization and does not meet all the criteria for an exempted hospital discharge.
- b. Terminal Illness in which a physician has certified that life expectancy is six months or less.
- c. Severity of Illness limited to: comatose, ventilator dependent, functioning at brain stem level, Chronic Obstructive Pulmonary Disease (COPD), Severe Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis (ALS), or Congestive Heart Failure (CHF). In addition to having one or more of these diagnoses, due to the severity of the illness, it is anticipated the individual is not expected to benefit from specialized services.
- d. Provisional Admission for cases of:
  1. delirium where an accurate diagnosis cannot be made until the delirium clears; or
  2. emergency situations requiring protective services with placement in the NF not to exceed seven days; or
  3. respite to in-home caregivers to whom individuals with MI or IID is expected to return following a brief NF stay.

If it is determined the individual meets one of the above criteria, the QIO-like vendor's clinical reviewer will make a categorical determination. If the determination is for an advanced group categorical determination, the determination effective dates may be limited and will require an updated PASRR

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Level II (RR) if the individual's stay is expected to exceed the limitation date (see below).

## 2. COORDINATION AND/OR PROVISION OF SPECIALIZED SERVICES

The provider must provide or arrange for the provision of specialized services when an individual has been recommended for such services through the Level II screening process.

The provider must ensure an interdisciplinary team (which includes a physician, qualified mental health professionals (which may include DPBH and ADSD staff) and other professionals) develops and supervises an individualized POC which addresses the ongoing mental health needs of the resident and results in appropriate treatment.

The provider must notify the DPBH/ADSD upon receiving any Level II screening determination that indicates an individual needs specialized services, to arrange for those services.

The provider must cooperate with DPBH/ADSD PASRR coordination staff who are providing or monitoring the provision of specialized services. DPBH/ADSD staff may contact the facility to arrange for periodic on-site visits with the resident, participate in interdisciplinary care conferences, document each on-site visit and care conference in the active medical record (indicating progress or lack of progress with the specialized services prescribed), and make recommendations for changes to the specialized services needed based on progress or lack of progress.

### 503.6 ADMISSIONS FROM OTHER STATES

It is the responsibility of the transferring state/facility to ensure the individual has had a Level I screening and when indicated, a PASRR Level II screening completed in the state they are transferring from, prior to sending the individual to a Nevada facility.

It is the receiving Nevada facility's responsibility to obtain a copy and verify the completion of the out-of-state screening. The receiving Nevada facility must also complete and submit a Level I Identification Screening form to the QIO-like vendor to obtain a Nevada screening within one business day of the admission.

### 503.7 DISCHARGES OR TRANSFERS

The provider must forward copies of the most recent Level I and, when applicable, Level II screening to the receiving facility upon discharge or transfer of a resident.

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The provider must notify the DPBH PASRR coordination staff of a discharge of any resident who has been receiving specialized services and provide them with information about where the individual is being discharged to.

#### 503.7A REIMBURSEMENT

Federal regulation prohibits Medicaid reimbursement to NFs under certain circumstances, such as but not limited to:

1. An individual is admitted to an NF without a Level I screening. Medicaid reimbursement is not available until the date a Level I screening is completed, if there are no indications of MI, MR, or RC.
2. An individual with indicators of MI, MR or RC is admitted to an NF before the completion of the PASRR Level II evaluation; unless an Exempted Hospital Discharge has been approved through Level I process (see below). Medicaid reimbursement is not available until the date the Level II screening is completed indicating NF placement is appropriate.
3. A provider who fails to obtain a completed PASRR Level II screening by day 30 of an admission under the Exempted Hospital Discharge. Medicaid reimbursement is not available until the date of the PASRR II evaluation is completed indicating NF placement is appropriate.
4. A provider fails to obtain an RR Level II individual evaluation prior to the limitation date of a previously limited categorical determination. Medicaid reimbursement is not available until the PASRR II evaluation is completed indicating NF placement is appropriate.
5. A provider fails to request a Nevada screening with one business day of admission when a resident is admitted to a Nevada NF from out-of-state. No Medicaid reimbursement is available until the date the Nevada Level I and, when indicated, the Level II is completed.
6. For individuals who have been determined, through the PASRR process, to not need the services of an NF.

#### 503.7B PASRR HEARINGS

In accordance with 42 CFR 483.204 Subpart E, an individual who has been adversely affected by any PASRR determination made by the State in the context of either an PAS or an RR, has the right to appeal that determination.

Please reference Nevada MSM Chapter 3100, for Medicaid recipient hearing policy.

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503.8 LEVEL OF CARE (LOC)

If the individual is Medicaid eligible, an LOC screening must be completed prior to NF admission. This includes individuals utilizing other insurance as a primary pay source at the time of admission.

If the recipient becomes Medicaid eligible after NF admission, the LOC screening must be completed prior to obtaining a billing authorization for Medicaid reimbursement.

If an individual becomes Medicaid eligible after death or discharge from an NF, the LOC screening may be requested and determined retroactively.

The requestor must submit an LOC screening form with the required documentation to the QIO-like vendor. An LOC determination must be completed by the QIO-like vendor. The NF must receive a copy of the screening indicating the Medicaid eligible individual has a nursing facility level of care prior to admission.

LOC determinations may be time-limited. Reasons for time limitations may include, but are not limited to: total hip or knee replacement, compound fracture, pneumonia, or recent wound care. These determinations may be limited to 90 days. The provider must monitor LOC determinations that are time-limited and request an updated LOC determination prior to the expiration date.

It is the NF's responsibility to verify an LOC determination has been made and the recipient meets an NF LOC. The NF may contact the QIO-like vendor to obtain verification of the determination and a copy of the determination letter.

The provider must request an updated LOC determination if a recipient's condition changes significantly. For example, if a recipient who was previously determined to meet an NF Standard or Pediatric Specialty Care I later becomes ventilator dependent, the NF must request a new LOC determination to establish Ventilator Dependent or Pediatric Specialty Care II. Conversely, if a recipient's condition improves and the recipient was previously determined to meet a Pediatric Specialty Care II, the NF must request a new determination to establish the appropriate LOC.

If it is later discovered that the recipient's condition warranted an updated screening and the facility failed to obtain the determination, the fiscal agent may recoup funds paid to the facility inappropriately.

In the event a recipient is discharged to a community based setting and is later readmitted to the NF, the NF must contact the QIO-like vendor screening office to determine whether the LOC determination is still valid (based on the recipient's current condition), or if a new LOC determination is needed.



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When a recipient does not meet a nursing facility LOC and an NF chooses to admit the recipient, Medicaid reimbursement will not be authorized for that NF.

On initial and subsequent screenings, the QIO-like vendor determines whether the LOC provided or to be provided should be approved based on medical necessity. There are four possible LOC categories based on the care needs and nursing requirements for each individual as determined by the LOC assessment. These include:

- a. NF Standard;
- b. NF Ventilator Dependent;
- c. Pediatric Specialty Care I; and
- d. Pediatric Specialty Care II.

Each of these categories is associated with a provider specific rate for each free-standing NF.

After an LOC has been established, the NF may also request approval the Behaviorally Complex Care Program; which also has associated rates.

NF Ventilator Dependent is limited to recipients who are dependent on mechanical ventilation for a minimum of six out of the 24 hours per day and is an all-inclusive rate. NF and respiratory therapists are not allowed to bill separately for ventilator management services, small volume nebulizer treatments, tracheostomy changes, etc.

NF Ventilator Dependent Rate: a physician's order specifying the ventilator support must accompany the screening request. Current medical records must verify that the ventilator support is required for a minimum of six hours within a 24 hour period. The medical records must also include the date the recipient was placed on the ventilator.

#### 503.9 PEDIATRIC SPECIALTY CARE

Pediatric Specialty Care I and II are limited to recipients who are children from birth to 21 years of age who require specialized, intensive, licensed skilled nursing care beyond the scope of services provided to the majority of NF recipients.

The QIO-like vendor must determine the recipient meets both an NF LOC as well as a Pediatric Specialty Care LOC prior to authorization. Pediatric Specialty Care rates are approved for a maximum of six months but may be extended with an updated LOC screening and supporting documentation. If a new authorization is not obtained prior to expiration of the previous specialty care authorization, the NF will be reimbursed at the NF standard rate until such time a new pediatric specialty care LOC is determined.

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Documentation must be submitted with request to support all treatment and services listed above. Time limited treatments may be authorized up to 90 days. Requests for extension may be granted with supporting documentation.

503.9A PEDIATRIC SPECIALTY CARE I:

The patient's condition requires 24 hour access to nursing care by a Registered Nurse (RN) and the recipient has one or more of the following items (a-c): (a) A tracheostomy that requires suctioning, mist or oxygen and at least one treatment listed in the treatment procedures section below; (b) dependence on Total Parenteral Nutrition (TPN) or other Intravenous (IV) nutritional support and at least one treatment listed in the treatment procedure section below; (c) administration of at least two treatment procedures below. See Treatment Procedures below.

503.9B PEDIATRIC SPECIALTY CARE II

The patient's condition requires 24 hour access to nursing care by an RN and the recipient has one or more of the following items (a-c): (a) A tracheostomy that requires mechanical ventilation a minimum of six hours out of 24 hours per day; (b) patient is on a ventilator weaning program (approval will be time limited); (c) administration of at least three treatment procedures below.

503.9C TREATMENT PROCEDURES

1. Intermittent suctioning at least every eight hours and mist or oxygen as needed;
2. Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy);
3. IV therapy involving:
  - a. Administration of continuous therapeutic agents; or
  - b. Hydration; or
  - c. Intermittent IV drug administration of more than one agent.
4. Peritoneal dialysis treatments requiring at least four exchanges every 24 hours.
5. Tube utilization (nasogastric or gastrostomy; Foley, intermittent catheterization; PEG, rectal tube).
6. Complex wound care (including stage III or IV decubitous wound or recent surgical or other recent wound) requiring extensive dressing or packing approval will be time limited).

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7. Seizure precautions.
8. Moderate behavior issues (including self-abuse) – describe the problem.
9. Central or Peripherally Inserted Central Catheter (PICC) line management.
10. Maximum assist required (quadriplegia or Hoyer lift).
11. Other special treatment(s) not listed above. The provider must describe in detail.

Provider Qualifications for Pediatric Specialty Care Rates:

In addition to Medicaid contractual obligations and all other provider rules contained in MSM Chapters 100 and 500, a free-standing NF must meet specified criteria to qualify for Pediatric Specialty Care rates. An on-site visit by the DHCFP staff is made to verify the NF meets the following criteria:

12. Physical facility requirements:
  - a. Pediatric Specialty Care must be provided in a distinct, identifiable unit or area of the NF.
  - b. The accommodating beds include contiguous rooms, wing, floor, or building of the NF.
13. Staffing Requirements:
  - a. The NF must employ an RN as the Pediatric Specialty Care Unit’s head nurse. The head nurse must have specialized pediatric training and at least one year’s experience in pediatric nursing.
  - b. The NF must ensure that an RN with pediatric training and experience is on duty 24 hours per day on the Pediatric Specialty Care Unit.

503.10 BEHAVIORALLY COMPLEX CARE PROGRAM

The Behaviorally Complex Care Program (BCCP) is for those Nevada Medicaid recipients with a severe, medically-based behavior disorder. Medically-based disorders may include (not all inclusive) traumatic/acquired brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgment, or a resident, who meets the Medicaid criteria for nursing facility level of care and who has a medically-based mental health disorder or diagnosis and exhibits significant behaviors. Those facilities that request and are approved to administer the

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BCCP are reimbursed with a tiered rate established with the intention of providing in-state care that addresses the recipient's needs.

Nursing Facilities must demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff as documented by one or more of the following behaviors:

- a. The resident engages in verbally abusive behavior where he threatens, screams or curses at others;
- b. The resident presents a threat of hitting, shoving, scratching, or sexually abusing other residents.
- c. The resident engages in socially inappropriate and disruptive behavior by doing of one of the following:
  - (i) Makes disruptive sounds, noises and screams;
  - (ii) Engages in self-abuse acts;
  - (iii) Inappropriate sexual behavior;
  - (iv) Disrobes in public;
  - (v) Smears or throws food or feces;
  - (vi) Hoards; and
  - (vii) Rummages through others belongings.
- d. The resident refuses assistance with medication administration or activities of daily living.

Presence of elopement or wandering behaviors alone, not in conjunction with aggressive or assaultive behaviors exhibiting a danger to self or others, does not qualify a recipient for the BCCP. The BCCP is not appropriate for those caring for suicidal individuals. Individuals who are suicidal should be transferred to an acute facility to ensure their safety and appropriate LOC. The BCCP may be requested while the recipient is in an acute placement if there is sufficient documentation to the support a medically based behavior disorder.

#### 503.10A PROVIDER RESPONSIBILITY

Facilities must demonstrate competency to adequately address the individual's behavior. All behavior intervention programs must:

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1. Be part of an individualized behavior modification plan;
2. Apply a precisely planned systematic application of the methods and findings of behavioral science with the intent to reduce observable negative behaviors;
3. Incorporate processes and methodologies that are the least restrictive alternatives available for producing the desired outcomes;
4. Be conducted following only identification and, if feasible, remediation of environmental and social factors that likely precipitate or reinforce the inappropriate behavior;
5. Incorporate a process for identifying and reinforcing a desirable replacement behavior.

Behavior modification programs include, but are not limited to:

1. Staff Training
2. Sensory Stimulation
3. Behavior Management
4. Cognitive Emotion Oriented Therapy
5. Environmental Modification
6. Clinically-Oriented Therapy

Documentation supporting the service need must be provided to the Facilities Unit in DHCFP Long Term Support Services (LTSS) by a person professionally qualified in the field of psychiatric mental health as defined in NRS 433.209 and clearly document the severe medically based behavior disorder or other medical condition prompting the approval of the BCCP.

Tiered rates have been established to cover the broad milieu of accommodations to meet patient needs. Behaviors and their frequency of occurrence will assist in establishing/requesting the appropriate Tier Level. The following is a guide for requesting:

- Tier 1: Behaviors requiring a minimal amount of intervention or assistance.
- Tier 2: Serious behaviors requiring moderate intervention.
- Tier 3: Extreme behaviors exhibiting danger to themselves or others requiring frequent intervention.

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The BCCP care level requires prior authorization. If approved, reauthorization will be required. Reauthorization timeframes are based on the approved tier. Refer to the Billing Guidelines for frequency of reauthorization. In addition, facilities are also required to report to the DHCFP, any change in recipient condition or Tier.

The requested tier will be evaluated based on the frequency and degree of the behaviors exhibited utilizing the Behaviorally Complex Care Program Evaluation Tool. The behaviors must be categorized as follows:

- Always** the recipient always (daily) requires intervention for behaviors.
- Usually** the recipient requires interventions four or more days per week.
- Usually Not** the recipient requires interventions, but fewer than four days a week.
- Never** the recipient does not have behaviors that require interventions.

Each response has a weighted value that must be supported by the medical evidence submitted. Always = 3; Usually = 2; Usually Not = 1; Never = 0 Maximum weighted value =18

- Tier I 3 to 7 points
- Tier II 8 to 13 points
- Tier III 14 to 18 points

Facilities may request the BCCP by submitting **NMO-7079** and supporting documentation to the DHCFP. Supporting documentation may include: the face sheet, medication administration records (MAR), primary care provider progress notes, psychiatric notes and/or group therapy note, nurses notes, behavioral plan, care plan, behavior monitor logs, interdisciplinary team notes, behavior management team review, and sleep logs. Absence of the listed documentation does not disqualify approval of the BCCP; the DHCFP staff in the LTSS Facilities Unit or the DHCFP QIO-like vendor will review all materials submitted to determine whether there is sufficient medical documentation and justification for the BCCP. After review, the facility and recipient will receive a Notice of Decision (NOD). The NOD may indicate that:

1. **The request is approved at the tier requested;**
2. The request is approved for a higher tier than requested;
3. The request is approved for a lower tier than requested; or
4. The request is denied.

Should the BCCP not be approved, the NF will receive the base rate for the applicable quarter. The BCCP care level is determined independently of any NF LOC.

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503.10B HEARINGS FOR BCCP

Upon receipt of the BCCP NOD, facilities or recipients may ask the DHCFP to perform a re-review of the original request. The re-review must be based on information and/or documentation not submitted with the original request. Should the facility not agree with the re-review, a fair hearing may be requested per MSM Chapter 3100.

503.11 NURSING FACILITY TRACKING FORM

Before an NF can receive reimbursement for services rendered for a Nevada Medicaid recipient, the facility must submit a Nursing Facility Tracking Form in order to receive authorization to bill. The purpose of this form is to notify the Medicaid Central Office of any admission, service level change, discharge or death for all Medicaid eligible recipients and to initiate and/or update the system with necessary information prior to billing.

A Nursing Facility Billing Authorization Letter that indicates specific billing days will be sent to the Nursing Facility. Upon receipt of this letter, the facility may submit a billing claim form to the fiscal agent for payment. If it is later discovered that the billing authorization was made in error, the provider will be subject to recoupment for claims submitted and paid in error. Receipt of a Billing Authorization Letter does not guarantee payment.

The facility must review all information on the Nursing Facility Billing Authorization Letter to verify it contains the correct information. If discrepancies are noted, contact the Medicaid office immediately to avoid delayed payment. If more than 30 days have elapsed since the tracking form submission and the facility has not received a Nursing Facility Billing Authorization Letter or been contacted by Medicaid staff, contact the Nevada Medicaid office.

The facility must submit the Nursing Facility Tracking Form to the Nevada Medicaid Central Office upon each occurrence for Medicaid eligible individuals:

- a. Any admission;
- b. Service level update and/or change;
- c. New or retro-eligibility determinations;
- d. Medicaid Managed Care disenrollment;
- e. Hospice enrollment or disenrollment; or
- f. Discharge or death.

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If the resident becomes eligible after admission, the tracking form must be submitted upon notification of the eligibility determination.

Failure of the facility to submit the tracking form may result in payment delays or denials. This form may be accessed on the DHCFP website at <http://www.dhcfp.nv.gov>, which includes completion and submission instructions. The facility should retain a copy for their records.

Billing authorizations become invalid immediately upon discharge from the facility, death, service level change, enrollment to Hospice coverage, or if the recipient becomes ineligible for Medicaid. Nevada Medicaid does not reimburse NFs for the date of discharge or date of death.

#### 503.11A PROVIDER RESPONSIBILITY

The facility must determine if the recipient has other resources including other insurance coverage for any and all services and supplies.

It is the facility's responsibility to verify the recipient's eligibility status monthly by accessing the Eligibility Verification System (EVS). Refer to MSM Chapter 100 regarding eligibility information.

If eligibility is determined for prior months (for service dates prior to the existing billing authorization), the facility must submit another tracking form indicating the eligibility has been determined retroactively. This will initiate another billing authorization for those service dates.

#### 503.12 THERAPEUTIC LEAVE OF ABSENCES

##### 503.12A COVERAGE AND LIMITATIONS

NFs will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of the unused leave days may be carried over into the next calendar year. The facility must maintain accurate leave day records on the recipient's chart, for review by Medicaid staff.

A therapeutic leave must include therapeutic or rehabilitative home and community visits with relatives and friends. Therapeutic leave also includes leave used in preparation for discharge to community living. Therapeutic leave days are considered overnight stays. Therapeutic leave does not apply when a recipient is out on pass for short periods of time for visits with family/friends, to attend church services or other social activities. Therapeutic leave does not include hospital emergency room visits or hospital stays.



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The absence of a Medicaid recipient from the facility for the purpose of therapeutic leave must be authorized in writing by the recipient’s attending physician and included in the recipient’s plan of care.

In those instances where a Medicaid recipient resides in more than one NF within a calendar year, the receiving facility must determine the number of therapeutic leave days that have been exhausted by the sending facility within the same calendar year. A record of any leave days must be a part of the information provided to the receiving facility as part of the transfer documents.

Therapeutic leave days must be authorized by the physician for specific dates. If a recipient fails to return to the facility within the specified timeframe, Medicaid reimbursement is not available for dates beyond the physician’s order.

Each therapeutic leave of absence must be authorized by the attending physician’s order to ensure the recipient is medically stable and capable of safely tolerating the absence.

The physicians order should specify:

1. The dates the recipient will be out of the facility;
2. Authorize the facility to send necessary medications; and
3. Provide instructions for the family member/friend on how and when to administer the medications.

A physician’s order such as “may go out on pass” is not acceptable for this purpose. The NF must provide care instructions for the responsible person who will be accompanying the recipient during their therapeutic leave of absence.

The NF must reserve and hold the same room and bed for the Medicaid recipient on a therapeutic leave. The bed may not be occupied by another individual during the period of time in which the Medicaid recipient is on such leave.

When billing for therapeutic leave of absence days, revenue code 183 is used on the billing claim form. See Provider Billing Manual for specific instructions.

The recipient is responsible to abide by the physician’s order and to return to the facility by the date authorized by the physician’s order. The recipient must contact the facility to advise them of any change in the plan regarding therapeutic leave.

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503.13 PATIENT INCOME CHANGES AND PATIENT LIABILITY (PL)

503.13A COVERAGE AND LIMITATIONS

Patient Liability (PL) is determined by the Division of Welfare and Supportive Services (DWSS). The regulations at 42 CFR 435.725 require that the State (Nevada Medicaid) reduce its payment to the NF by the amount of the PL. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made. PL will also be applied to subsequent claims submitted by providers entitled to PL until monthly obligations are fulfilled.

503.13B PROVIDER RESPONSIBILITY

An NF must notify DWSS immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the NF.

DWSS is responsible for determining the amount of PL the resident is responsible for.

When PL is established or changes, the recipient, facility and the fiscal agent are notified of the amount and effective date. Collection of PL is the facility's responsibility and should be done on a monthly basis. If an NF receives a notice adjusting the amount of the PL and the facility has billed and received reimbursement for services, the facility must send a corrected claim to the fiscal agent to receive the appropriate adjustment within 60 days of the notice.

No PL is to be taken during the first 20 days of a Medicare covered stay. Medicaid reimbursement will be reduced by the PL amount for all claims including Medicare co-insurance days 21-100 if applicable. PL is also applied to all other Third Party Liability (TPL) co-insurance claims.

When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by DWSS and a notice is sent regarding the PL adjustment. The NF must refund any remaining balance to the recipient or their legal representative as required.

If a Medicaid recipient is transferred during a month from any provider entitled to collect PL, the discharging provider collects the total PL amount up to billed charges. The balance of the established PL must be transferred with the recipient at the time of transfer. The transferring and receiving providers are responsible for negotiating the collection of PL.

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503.14 PERSONAL TRUST FUND MANAGEMENT

503.14A COVERAGE AND LIMITATIONS

An NF resident has the right to manage his or her financial affairs. An NF may manage resident's funds upon written authorization from the resident.

503.14B MANAGING RESIDENT FUNDS

NFs must have a system for managing residents' funds that, at a minimum, fully complies with the requirements established by Federal law and State regulations.

An NF may not require residents to deposit their personal funds with the NF. The facility must obtain prior written authorization from the recipient prior to the facility assuming management from the resident.

A recipient's personal funds may not be commingled with the NF funds or with the funds of another person. A recipient's personal funds that do not exceed \$50 may be maintained in a non-interest bearing account, interest bearing account or petty cash fund. If a recipient has funds in excess of \$50, these monies must be maintained in an interest bearing account in a local bank insured by the Federal Deposit Insurance Corporation (FDIC). Interest earned must be credited to the recipient's account. The NF must notify each recipient when the amount in the recipient's personal fund account reaches \$200 less than the Supplemental Security Income (SSI) resource limit for one person.

A recipient's personal needs money is for the exclusive use of the recipient, as desired. The recipient's personal funds must not be used to purchase items covered by Medicaid either directly or indirectly as part of the facility's daily rate including nursing services, dietary services, room/bed maintenance, routine personal hygiene items (hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry) or medically related services. However, should a resident request a certain brand or product type, not otherwise supplied, the recipient's personal needs money may be used to purchase those items.

Upon a recipient's request, specialty items not covered by Medicaid may be purchased for the recipient. Allowable expenditures are outlined in 42 CFR§ 483.10 but may include a personal telephone, television, personal comfort items, personal clothing, reading material, gifts purchased on behalf of the recipient, flowers and plants, and decorative items. The facility must not require a recipient (or his or her representative) to request any item or service as a condition of admission or continued stay. In addition, the facility must obtain written authorization from the recipient that

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states what the charge will be. In the event the recipient is unable to sign, the NF must obtain two signatures from NF staff and accurate accounting records must be kept accounting for each purchase.

Statements regarding a recipient's financial record must be available upon request to the recipient or to the recipient's legal representative.

Within 30 days of the death of a recipient, the NF must convey the recipient's funds and a final accounting of those funds to the individual or probate jurisdiction administering the recipient's estate.

#### 503.14C PERSONAL FUND AUDITS

The Division or its representative will periodically audit recipients' personal trust funds to assure federal and state laws, regulations and Medicaid policies are met.

If, as a result of an audit, discrepancies are identified and reported, the facility must submit a plan of corrective action within 30 days of the report of findings to the auditing agency.

If discrepancies are found at audit, the NF must make restitution to the recipient's funds improperly handled, accounted for or dispersed.

A report of the audit findings may be sent to BHCQC and the Medicaid Fraud Control Unit (MFCU), for follow-up regarding potential deficiencies related to state or federal regulations.

Misuse of residents' monies is subject to prosecution under the NRS.

#### 503.14D RECIPIENT RESPONSIBILITY

The recipient has the choice to either manage their own personal funds, or to request that the facility manage their personal funds. If the recipient desires the facility to manage their personal funds, the recipient must provide the facility with written authorization to do so.

Medicaid recipients may choose to spend their personal funds on items of personal care such as professional beauty or barber services or specialty items not covered by Medicaid. In this instance, the recipient must authorize payment for the specialty items in writing.

#### 503.15 TRANSPORTATION

#### 503.15A COVERAGE AND LIMITATIONS

NFs are responsible for ensuring that all recipients receive appropriate medical care and related services.

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It is the responsibility of the NF to provide non-emergency transportation (NET) for Medicaid recipients for all off-site medical and dental appointments and other medically necessary services after admission and prior to discharge. Medically necessary non-emergency transportation costs are included in the NF's rate structure. The NF does not have to provide NET back to the facility after a hospital admission/discharge.

When a recipient is being admitted to an out-of-state NF, the discharging facility must contact the DHCFP Out-of-State Coordinator for authorization prior to the admission.

Refer to MSM Chapter 1900, for transportation policies.

503.16 ROUTINE SERVICES AND SUPPLIES

503.16A COVERAGE AND LIMITATIONS

Routine services and supplies are included in per diem rates. Routine NF services include regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen, the use of equipment and facilities, and other routine services. Examples of routine services and supplies include, but are not limited to:

1. All general nursing services including: the administration of oxygen and related medications; the collection of all laboratory specimens as ordered by a physician such as blood and urine; injections; hand feeding; incontinency care; normal personal hygiene which includes bathing, skin care, hair care or nail care (excluding professional barber and beauty services), shaving, oral hygiene, enemas, etc.
2. Social work services and activity programs: NF staff will provide these services as necessary in order to carry out the plan of care for the Medicaid recipients.
3. Maintenance therapy programs: facility staff will assist the Medicaid recipients as necessary under the guidelines of the recipient's restorative therapy program. Programs are intended to maintain and/or restore specific function(s).
4. Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins, bedpans, etc.
5. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually such as alcohol, applicators, cotton balls, band aids, disposable gloves, incontinency care products including disposable diapers, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, IV equipment, T.E.D. (antiembolism) stockings, hydrogen peroxide, over the counter enemas, tests (Clinitest, Testape, Ketostix, Accu-chek), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or

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specialized cleansing agents, razor, shaving cream, denture adhesive, dental floss, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, sanitary napkins and related supplies, etc).

6. Items which are used by individual residents but which are reusable and expected to be available, such as canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, Intermittent Positive Pressure Breathing (IPPB) machine, electric nebulizers, other durable medical equipment, oxygen concentrators, ventilators, etc.
7. Laundry services, including personal clothing.

503.16B ITEMS INCLUDED IN THE PEDIATRIC SPECIALTY CARE RATE

All services, durable medical equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria including, but not limited to respiratory services, tracheostomy and related services; developmental services, nutritional services, ambulatory aids, support surfaces, and bathing/toiletry services.

Oxygen, and all related equipment and supplies necessary for administration including positive and negative pressure apparatus.

This includes all oxygen therapy equipment, i.e., oxygen-conserving devices (oxymizer and nebulizer (pulmoaide); respiratory equipment, supplies, and services; respiratory therapy; tracheostomy and related services; ventilators, including humidifiers, in-line condensers, in-line temperature measuring devices, and calibration and maintenance services.

1. Feeding pumps and equipment and services necessary for tube feedings.
2. Tracheostomy speaking valves.
3. Equipment and supplies for continuous IV therapy.
4. Ambulatory assistance equipment, supplies and services, including but not limited to canes and wheelchairs.
5. Support surfaces, equipment, supplies and services, i.e., alternating pressure pads, wheelchair cushions, and gel pressure and air fluidized mattresses.
6. Bathing/toileting assistance equipment, supplies, and services, commodes, lifts.
7. Developmental services.

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8. Physical, occupational and speech therapies provided within a supportive or maintenance program.

#### 503.16C PROVIDER RESPONSIBILITY

The NF must provide routine services and supplies and not charge the Medicaid recipient or Nevada Medicaid for these services.

The NF must not charge the Medicaid recipient for any item or service not requested by the recipient.

The facility must inform the Medicaid recipient (or his/her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and the amount of the charge.

#### 503.17 SERVICES AND SUPPLIES NOT INCLUDED IN PER DIEM RATES

#### 503.17A COVERAGE AND LIMITATIONS

Certain services and supplies are not considered part of the NF's Medicaid per diem rate. Payment for these services and supplies may be made to non-NF providers when the criteria for coverage as outlined in the appropriate MSM is met. The provider of the service or supply may be required to obtain prior authorization. Reference MSM Chapter 1200 for Pharmacy Services and MSM Chapter 1300 for DME and Supplies.

Items not included in the Medicaid per diem rate include:

1. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.
2. Nutritional supplements in conjunction with tube feedings.
3. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.
4. Non-standard wheelchairs including power-operated vehicles, wheelchair seating systems, including certain pressure reducing wheelchair cushions needed for the Medicaid recipient's permanent and full time use, etc.
5. Air fluidized bed units and low air loss bed units.
6. Emergency transportation.

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7. Physical, Occupational and Speech therapy services.
8. Physician services.
9. Laboratory, portable x-ray and other diagnostic services.
10. Repair of medical equipment and appliances which belong to the recipient.

503.17B PROVIDER RESPONSIBILITY

1. Non-NF providers must reference the appropriate MSM for specific coverage and limitation policies related to the services and supplies not included in the NF per diem. Providers must abide by the associated rules and prior authorization guidelines before providing an item or service to a recipient.
2. Provider must check for a valid Medicaid card and question the recipient/legal representative about other insurance coverage.

503.17C RECIPIENT RESPONSIBILITY

1. Furnish providers with any forms of identification necessary to utilize other health insurance coverage for any and all services and supplies.
2. Provide written authorization to the provider and NF if purchasing services and supplies not covered in the per diem.

503.17D AUTHORIZATION PROCESS

Refer to the appropriate chapter of the MSM for the authorization processes related to specific services and supplies.

503.18 DISCHARGE REQUIREMENTS

The NF must notify the Nevada Medicaid Central Office of a Medicaid recipient's discharge or death by sending the Nursing Facility Tracking form.

The NF must provide copies of the recipient's medical record to those responsible for post-discharge care including a copy of his or her Advance Directive (AD) (declaration/living will and/or durable power of health care decision).

Facility to facility transfer: To transfer any Medicaid recipient from one facility to another, the transferring facility must:

- a. Obtain the physician's written order for transfer;



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- b. Obtain written consent from the recipient, his/her family and/or guardian;
- c. Notify the Medicaid Central Office of the transfer by sending the Nevada Medicaid Nursing Facility Tracking form;
- d. Transfer necessary medical/social/LOC/PASRR information to the receiving facility;
- e. The discharging facility collects the total PL amount up to billed charges. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made and the balance of the collected PL must be transferred to the receiving NF with the recipient at the time of transfer;
- f. Document the transfer in the recipient’s medical record.

The admitting facility must submit the NF Tracking form to the Nevada Medicaid Central Office upon admission.

If it is determined that a Medicaid recipient no longer meets a nursing facility LOC, the facility will be notified and must facilitate discharge planning and promote appropriate placement. Should the discharge planner need further assistance, a referral can be made to the FOCIS program. Program staff can be reached through the DHCFP District Offices. If an NF intends to discharge a resident, they must provide to the resident/legal representative with a 30 day written notice and include the name and address of the person to whom the resident/legal representative may appeal the discharge.

503.19 FREE-STANDING NURSING FACILITY – RUG CASE MIX

The MDS/Resource Utilization Groups (RUG), system is used to classify residents and objectively determine a free-standing NF’s Case Mix Index (CMI). The RUG classification system was developed by the CMS and is the basis for resident classification for the Medicare prospective payment system and numerous other states’ Medicaid systems. Nevada uses the 34-group version that collapses the special rehabilitation category into four groups. CMS recommends this version for use with Medicaid NF resident populations. CMS has also developed standard CMI indices which will be the basis for calculating the average CMI, or score, for each NF under Nevada’s case-mix system.

Free-standing NFs are reimbursed according to a price-based system. Individual facility rates are developed from prices established from three separate cost centers: operating, direct health care and capital. The direct health care component utilizes each facility’s CMI which is calculated four times per year for residents in the facility on the first day of each calendar quarter (called the “picture date”).

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Refer to MSM Chapter 700, Rates, for detailed information regarding free-standing NF reimbursement.

503.19A PROVIDER RESPONSIBILITY

The provider must assure that each resident's assessment data is complete and accurate in accordance with federal regulations and the *CMS Resident Assessment Instrument (RAI) Users' Manual*.

Comprehensive assessments, quarterly assessments, significant change assessments and annual assessments using the MDS current version must be conducted in accordance with the requirements and frequency schedule found at 42 CFR Section 483.20.

The provider must assure that the Occupancy Report is accurate and submitted within the specified time limit every month.

503.20 FREE-STANDING NURSING FACILITY CASE MIX AND MDS VERIFICATION REVIEW DESCRIPTION

Nevada Medicaid reimburses free-standing NFs based on the facility's overall CMI identified from the MDS. RUG items are identified on the MDS and used to establish each facility's CMI. In order to validate that Medicaid reimbursement to NFs is accurate and appropriate, a periodic review of MDS coding and corresponding medical record documentation is conducted to verify the information submitted on the MDS to the national repository accurately reflects the care required by, and provided to residents.

503.20A COVERAGE AND LIMITATIONS

RNs from Medicaid District Offices conduct Case Mix and MDS Verification reviews at every free-standing Medicaid certified NF at least annually. The review consists of a comparison of medical record documentation and the coding reported on the MDS, specifically the RUG items coded with a positive response. On-site resident reviews may also be conducted to verify documentation and/or information coded on the MDS.

Facilities may be reviewed more frequently when the facility's error rate is greater than 40%, or when any significant increase in errors is identified.

Prior to the review, a sampling of residents is determined using the most recently submitted MDS data and resident listing information. The sampling is selected based on the RUG category of each resident.

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NFs are contacted by the lead nurse approximately one week prior to a scheduled review. Upon notification of an upcoming review, facilities are required to provide a current, accurate census of all residents regardless of their payment source.

A brief entrance meeting is conducted upon the review team's arrival at the facility. The administrator or their designated representative, director of nurses and MDS staff are expected participants in the entrance meeting. Other staff may participate as deemed appropriate by the facility administrator and the lead nurse.

During the review, as questions arise, reviewers will work with facility staff (primarily the MDS Coordinator) to obtain clarification and assistance in locating documentation which supports the reported codes on the MDSs. At this time, review staff may also provide one-to-one training to facility staff.

Upon completion of the record reviews, review staff will conduct a brief exit meeting to discuss the findings of the team. A copy of the findings showing the percentage and types of errors identified will be given to the administrator or their designated representative.

If it is identified that a facility coded an MDS inaccurately, which resulted in the provider being paid more monies than a correctly-coded MDS would have allowed, Medicaid may require the facility to submit a corrected MDS to the national repository. Additionally, Medicaid may recoup monies paid inappropriately.

#### 503.20B PROVIDER RESPONSIBILITY

1. The provider must possess thorough knowledge of the RAI process including the MDS, Resident Assessment Protocols (RAPs) and Care Plans.
2. The provider must maintain current knowledge of the federal MDS Utilization Guidelines.
3. The provider must maintain current knowledge of the Nevada Medicaid Documentation Guidelines which may be obtained by accessing the DHCfp website at: <http://www.dhcfp.nv.gov>.
4. The provider must promptly provide information requested by the review team.
5. The provider must make certain the appropriate staff attends the entrance and exit meetings.
6. The provider must prepare in advance and provide to review staff at the beginning of the entrance meeting:

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- a. copies of the selected MDS' (containing the attestation statement and completion signatures of staff) which review staff will use during the review and keep as a permanent part of the facility's review packet;
  - b. the active medical records selected for review; and
  - c. thinned/purged files and records maintained by the facility in various workbooks which contain information that supports the coding of the MDS.
7. Facility staff responsible for the MDS must be available to Medicaid review staff during the review process.
  8. The provider must analyze the error reports with the appropriate facility staff responsible for coding the MDS.
  9. The provider must identify and make corrections to processes that contribute to inaccurate MDS coding and maintain documentation supporting the current MDS in the active medical record.
  10. The provider must anticipate and prepare for more frequent reviews when the facility's error rate is 40% or higher, or when any significant increase in errors occurs.

503.21 HOSPITAL-BASED NURSING FACILITY

503.21A COVERAGE AND LIMITATIONS

All policies described in this chapter apply to hospital-based NFs with the exception of those specifically identified for free-standing NFs.

Hospital-based NFs are paid under Medicare reasonable cost-based reimbursement principles including the routine cost limitation, and the lesser of cost or charges. Payment will follow any and all applicable Medicare upper payment limitation requirements such that payments will not exceed the upper payment limitation. The routine cost limit is applied at the time of cost settlement. Each facility will receive interim payments of the lower of 1) billed charges; or 2) an interim payment percentage that is the ratio of costs to charges from the facilities most recently audited cost report.

Refer to the MSM Chapter 700, Rates, for specific details related to hospital-based NF reimbursement.

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503.21B PROVIDER RESPONSIBILITY

The hospital-based NF charges for services provided to Medicaid recipients should not exceed the provider's customary charges to the general public for these services. Hospital-based NFs may bill for ancillary services in addition to room and board.

The provider must assure that each claim submitted to the Nevada Medicaid's fiscal agent for NF services is accurate and timely.

Refer to the Provider Billing Manual for specific billing instructions.

503.22 OUT-OF-STATE NURSING FACILITY PLACEMENT

To request approval for out-of-state placement, the in-state provider, such as a hospital or nursing facility, completes the questionnaire identified as Out-of-State Questionnaire and submits the following documentation to Nevada Medicaid, Out-of-State Coordinator:

- a. Documentation supporting that all the appropriate NFs in Nevada were contacted for in-state placement and placement was denied. The documentation should include the reasons Nevada NFs denied admission.
- b. If the recipient was denied admission to in-state NFs due to severe behavior symptoms, a current psychosocial narrative is required.
- c. A PASRR screening indicating NF placement is appropriate.
- d. LOC screening indicating the recipient meets NF placement criteria.
- e. Written statement from the recipient (recipient's family/guardian) concurring with out-of-state placement, indication of who will be responsible for making health care decisions on the recipient's behalf, and that the recipient's (recipient's family/guardian) acknowledge that Medicaid benefits end with death.
- f. The written statement must also include the understanding that burial and funeral arrangements must be made outside of Medicaid intervention. Documentation to show that every effort was made to purchase/obtain a burial policy if the individual does not have funeral or burial coverage.

1. OUT-OF-STATE NURSING FACILITY

The out-of-state NF must be enrolled as a Nevada Medicaid provider.

- a. Admission/Discharge:

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The out-of-state provider must adhere to Nevada Medicaid’s in-state pre-admission, admission and discharge policies as described in this chapter.

b. Eligibility:

Verification of Medicaid eligibility is the provider’s responsibility. Eligibility should initially be verified by validating the recipient’s Medicaid card. Thereafter, eligibility should be verified monthly by utilizing EVS.

The facility is not required to submit the Nursing Facility Tracking Form until the eligibility determination is issued; however, the out-of-state provider should contact the Nevada Medicaid Central Office, Out-of-State Coordinator, when an individual is admitted with a pay source other than Nevada Medicaid, but an application for Nevada Medicaid has been submitted.

To prevent disruption of Nevada Medicaid eligibility due to a change of address by Social Security (Nevada Medicaid recipients must remain residents of Nevada), when contacting Social Security for any reason, facility staff must reiterate that the recipient is a Nevada resident who has been placed out-of-state by Nevada Medicaid.

c. Reimbursement:

Out-of-state NFs are generally reimbursed at their own state’s Medicaid rate.

If a recipient has a severe medically based behavior disorder or another medical condition for which care in Nevada was not available, an out-of-state provider may request a differential “add-on rate” by contacting the Out-of-State Coordinator at the Medicaid Central Office.

Requests for a differential rate require additional documentation which justifies the need for additional reimbursement. The documentation must include a detailed explanation of how the additional reimbursement will be used for the recipient’s specific care needs including items such as but not limited to additional staffing, specific behavioral programs, specialized treatments, etc.

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d. Billing/Payment Process:

Out-of-state NFs must adhere to Medicaid’s billing policies. Refer to the Provider Billing Manual and MSM Chapter 100 for complete billing instructions.

If a differential rate is approved, a prior authorization (PA) number will be issued. The PA number must be entered on the billing claim form.

503.22A RECIPIENT RESPONSIBILITY

The recipient (recipient’s family/guardian) must concur with the out-of-state placement.

The recipient (recipient’s family/guardian) must provide any necessary documentation requested by DWSS to maintain Medicaid eligibility and or utilize other health insurance coverage for any and all services.

503.22B AUTHORIZATION PROCESS

1. IN-STATE PROVIDER

Out-of-state NF admission requires approval from Nevada Medicaid.

To request approval for out-of-state NF placement, the in-state provider must complete the Out-of-State Questionnaire and submit it with the necessary information to Nevada Medicaid’s Central Office, Out-of-State Coordinator.

When the out-of-state placement is approved, verbal authorization will be given to the requestor and written authorization will follow. After receiving the verbal approval, the provider may contact the transportation vendor to arrange transportation.

2. OUT-OF-STATE PROVIDER

After a recipient is approved for an out-of-state placement, Medicaid staff will notify the out-of-state provider by telephone. In addition, written approval will be sent to the provider.

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504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100 Hearings, for hearings procedures.





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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard “no information” code (a dash, “-”) to indicate that the information is not available because it could not be assessed.	
<b>C1000</b> Cognitive Skills for Daily Decision Making  (7-day look back)	-Impaired Cognition (Contributes to ES count)	<p>Observations should be made by staff across all shifts and departments and others with close contact with the resident. Focus on the resident’s actual performance.</p> <p>Includes choosing clothing, knowing when to go to meals; using environmental clues to organize and plan (e.g. clocks, calendars, posted event notices). In the absence of environmental cues seeks information appropriately (not repetitively) from others in order to plan their day; using awareness of one’s own strengths and limitations to regulate the day’s events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.</p> <p><b>Does NOT include:</b> Resident’s decision to exercise his/her right to decline treatment or recommendations by staff.</p>	<p>Document the resident’s actual performance in making everyday decisions about tasks or activities of daily living (ADL’S). Does not include financial decision making or statements relating to diagnosis (i.e. dementia). Decisions should relate to the residents life in the facility. Documentation needs to include the observing staff member’s title and As Evidenced By (AEB) examples of the decisions made by the resident within the observation period.</p> <p>If all residents’ needs are anticipated, then an AEB is required. The example needs to be specific not just a reference to the residents safety awareness etc.</p>
<b>D0300</b> Total Severity Score (PHQ-9)  (7-day look back)	-Clinically Complex	<p><b>Total Security Score defined:</b></p> <ul style="list-style-type: none"> <li>• Sum of all frequency items (D0200 Column 2).</li> <li>• Total Severity Score range is 00-27.</li> <li>• Score &gt;=10 resident is depressed.</li> <li>• Score &lt;=10 resident is not depressed.</li> </ul> <p><b>Total Severity Score interpreted:</b></p> <ul style="list-style-type: none"> <li>• 20-27; severe depression.</li> <li>• 15-19; moderately severe depression.</li> <li>• 10-14; moderate depression.</li> <li>• 5-9; mild depression.</li> <li>• 1-4; minimal depression.</li> </ul>	<p>Document date and signature of the professional clinical staff (i.e. licensed nurse or licensed social worker) conducting the interview within the observation period in the medical records.</p> <p>The interview completion date (the date the interview was actually conducted) must be date specific if written in a quarterly, annual, or summary note.</p> <p>The interview completion date in the medical records must match the signature date for the interview section entered at Z0400.</p> <p>The PHQ-9 score coded on the MDS should match the score reported by professional clinical staff.</p>
<b>D0500A, Column 2</b> Staff assessment Little interest or pleasure in doing things (14-day look back)	-Clinically Complex	<p>If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J).</p> <ul style="list-style-type: none"> <li>• Example that demonstrates resident’s lack of interest or pleasure in doing things.</li> </ul>	<p>Document As Evidenced By (AEB) example within the observation period – must include frequency.</p>

































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(14-day look back)		<ul style="list-style-type: none"> <li>IV medications administered only during chemotherapy or dialysis.</li> </ul>	
<b>O0100I, either as not a resident (1) or as a resident (2)</b> Transfusions (14-day look back)	-Clinically Complex (Contributes to ES count)	Documentation must include transfusions of blood or any blood products administered directly into the blood stream. <b>Does NOT include:</b> <ul style="list-style-type: none"> <li>Transfusions administered during dialysis or Chemotherapy.</li> </ul>	Documentation must include product infused, signature/credentials of clinician in the medical record to support the MDS coding.
<b>O0100J, either as not a resident (1) or as a resident (2)</b> Dialysis (14-day look back)	-Clinically Complex (Contributes to ES count)	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. <b>Does include:</b> <ul style="list-style-type: none"> <li>Hemofiltration.</li> <li>Slow Continuous Ultrafiltration (SCUF).</li> <li>Continuous Arteriovenous Hemofiltration (CAVH).</li> <li>Continuous Ambulatory Peritoneal Dialysis (CAPD).</li> </ul> <b>Does NOT include:</b> <ul style="list-style-type: none"> <li>IV, IV medication and blood transfusion during dialysis</li> </ul>	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility.  Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.
<b>O0400A, 1, 2 &amp; 3</b>  <b>O0400B, 1, 2 &amp; 3</b>  <b>O0400C, 1, 2 &amp; 3</b>  Therapy minutes	-Rehabilitation  <u>Individual therapy</u> -Treatment of one resident at a time  <u>Concurrent therapy</u> -Treatment of 2 residents at the same time in line-of-sight for Part A only. Residents may not be treated concurrently for Part B—instead report under Group therapy. <u>Group therapy</u> -Treatment of 2 or 4 residents at the same time - Part A only. -Treatment of 2 or more residents at the same time -Part B only.	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. <ul style="list-style-type: none"> <li>Only therapy provided while a resident in the facility.</li> <li>Skilled therapy ONLY.</li> <li>Physician order, treatment plan and assessment.</li> <li>Actual therapy minutes ONLY.</li> <li>Time provided for each therapy must be documented separately.</li> </ul> <b>Does include:</b> <ul style="list-style-type: none"> <li>Subsequent reevaluations.</li> <li>Set-up time.</li> <li>Co-treatment when minutes are split between disciplines and do not exceed the total time.</li> <li>Therapy treatment inside or outside the facility.</li> </ul> <b>Does NOT include:</b> <u>Therapy services not medically reasonable and necessary.</u> <ul style="list-style-type: none"> <li>Therapy provided prior to admission.</li> <li>Initial evaluation.</li> <li>Conversion of units to minutes.</li> <li>Rounding to the nearest 5<sup>th</sup> minute.</li> <li>Therapy services that are not medically reasonable and necessary.</li> <li>Therapy provided as restorative nursing.</li> </ul>	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided.  Includes: <ul style="list-style-type: none"> <li>Only therapy provided while a resident in the facility.</li> <li>Skilled therapy ONLY.</li> <li>Therapy that is physician ordered, treatment planned and assessed.</li> <li>Actual therapy minutes ONLY.</li> <li>Time provided for each therapy must be documented separately.</li> </ul> <u>Accepted documentation for therapy minutes can only be the computer generated therapy log/grid that is submitted for billing to CMS.</u>

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		<ul style="list-style-type: none"> <li>• Services provided by aides.</li> <li>• Services provided by a speech-language pathology assistant.</li> </ul>	
O0400A4  O0400B4  O0400C4 Therapy days (7-day look back)	-Rehabilitation	Documentation of direct therapy days with associated initials/signatures(s) to be cited in the medical chart on a daily basis to support the total number of days of direct therapy provided. <ul style="list-style-type: none"> <li>• Treatment for 15 minutes or more during the day.</li> </ul> <b>Does NOT include:</b> <ul style="list-style-type: none"> <li>• Treatment for less than 15 minutes during the day.</li> </ul>	Documentation includes number of days, signature/credentials of clinician in medical record to support MDS coding.  <u>Accepted documentation for therapy minutes can only be the computer generated therapy log/grid that is submitted for billing to CMS.</u>
O0400D, 2 Respiratory Therapy days  (7-day look back)	-Special Care (Contributes to ES count)	<b>A day of therapy is defined as 15 minutes or more of treatment in a 24-hour period.</b> <b>Does include:</b> <ul style="list-style-type: none"> <li>• Subsequent reevaluation time.</li> <li>• Set-up time.</li> </ul> <b>Does NOT include:</b> <ul style="list-style-type: none"> <li>• Therapy provided prior to admission.</li> <li>• Time spent on documentation or initial evaluation.</li> <li>• Conversion of units to minutes.</li> <li>• Rounding to the nearest 5<sup>th</sup> minute.</li> <li>• Therapy services that are not medically necessary.</li> </ul> Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse	Documentation of therapy days with associated initials/signature(s) to be cited in the medical record on a daily basis to support MDS coding. <ul style="list-style-type: none"> <li>• Only therapy provided while a resident in the facility.</li> <li>• Therapy must be physician ordered, treatment planned, and assessed.</li> </ul> Oxygen on its own is not a respiratory therapy.
O500A-J Restorative Nursing Programs	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must include the five criteria to meet the definition of a restorative nursing program: <ul style="list-style-type: none"> <li>• Measurable objectives and interventions must be documented in the care plan and in the medical record.</li> <li>• Evidence of periodic evaluation by a licensed nurse must be present in the resident's medical record. Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period.</li> <li>• Staff must be trained in the proper techniques to promote resident involvement in the activity.</li> <li>• Restorative nursing program activity must be supervised by an RN or LPN. No more than 4 residents per supervising staff personnel.</li> </ul>	"Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding.  Program validation must include initials/signature(s) on a daily basis to support the total days and minutes of nursing restorative programs provided. Evaluation by a licensed nurse is required within the observation period.

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(7-day look back)		<p><b>**When residents are part of a group, provide documentation to identify the group, program, minutes and initials of person providing program.</b></p> <p><b>Does NOT require:</b> Physician orders</p>	<p><b>Includes:</b></p> <ul style="list-style-type: none"> <li>• Days for which 15 or more minutes of restorative nursing was provided within a 24-hour period for a minimum of 6-days.</li> <li>• Time provided for each restorative program must be documented separately.</li> </ul> <p>MDS review staff may ask to review the training records of the facilities restorative program staff.</p> <p>When residents are part of a group, provide documentation to identify the number of residents in the group and how many staff members are assisting. At least one staff member must be a Restorative Nursing Assistant (RNA) or licensed staff person.</p>
(14-day look back)	-Clinically Complex (Contributes to ES count)	<p>Documentation must include evidence of an exam by the physician or other authorized practitioners. <b>Record the number of days that a physician progress note reflects that a physician examined the resident (or since admission if less than 14 days ago).</b></p> <p><b>Does include:</b></p> <ul style="list-style-type: none"> <li>• Partial or full exam in facility or in physician's office.</li> </ul> <p><b>Does NOT include:</b></p> <ul style="list-style-type: none"> <li>• Exams conducted prior to admission or readmission.</li> <li>• Exams conducted during an ER visit or hospital observation stay.</li> <li>• Exam by a Medicine Man.</li> </ul>	<p>Document the number of days a physician or other authorized practitioner examined the resident. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.</p>
(14-day look back)	-Clinically Complex (Contributes to ES count)	<p><b>Does include:</b></p> <ul style="list-style-type: none"> <li>• Written, telephone, fax, or consultation orders for new or altered treatment.</li> <li>• Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.</li> </ul> <p><b>Does NOT include:</b></p> <ul style="list-style-type: none"> <li>• Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes.</li> <li>• Activation of a PRN order already on file.</li> <li>• Monthly Medicare certification.</li> <li>• Orders written by a pharmacist.</li> <li>• Orders for transfer of care to another physician.</li> </ul>	<p>Document the number of days a physician or other authorized practitioner changed the resident's orders. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician.</p> <p>Does not include sliding scale dose change based on guidelines already ordered.</p>

### Review Procedures

**Nevada Supportive Documentation Guidelines**

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**Supporting Documentation Related to the MDS/Case Mix Documentation Review:**

- a) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction within the observation period.
- b) A quarterly, annual, or summary note will not substitute for documentation which is date specific to the observation period.
- c) Improper or illegible corrections will not be accepted for the MDS case mix documentation review.
- d) All documentation, including corrections, must be part of the original legal medical record.
- e) Any and all MDS coding and interpretation questions shall be referred to the local State RAI Coordinator.
- f) Late entry documentation more than 72 hours from the ARD will not be accepted.

**Signature Date at Z0400:**

- a) Interview items (BIMS and PHQ-9) must be conducted during the observation periods stated in the RAI Manual and the signature date entered at Z0400 must be prior to or on the ARD.
- b) The signature date for these interview items entered at Z0400 must match the date the interview was actually conducted in the medical records. If these dates do not match, facility will not receive credits for these interview items due to conflicting documentation.
- c) In the rare situation that interview items were collected (completed) by two people or by the same person but on different dates, (e.g. half of the interview questions were conducted on the next day), each person must enter the signature date at Z0400 and indicate specific interview questions conducted (e.g. D0200 2.A through D; D0200 2.E through I and D0300) in “Sections.”
- d) The definition of “date collected” and “date completed”: date information was collected and coding decision were made. They are one, the same date. This is not the same as the data entry date.

**Electronic Health Records (EHR)**

**Nevada Supportive Documentation Guidelines**  
**Available online at: <http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing> (Resources/MDS Guidelines)**  
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- a) The facility must grant access to requested medical records in a read-only or other secure format.
- b) The facility is responsible for ensuring data backup and security measures are in place.
- c) Access to EHR must not impede the review process.
- d) Medicaid recipients must have their PASRR and LOC in the active EHR.