Medicaid Services Manual
Transmittal Letter

June 24, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres *Casey Angres* Casey Angres (Jul 30, 2025 13:46:59 PDT)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 500 – Nursing Facilities

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 500 – Nursing Facilities (NF) are being proposed to include the addition of a coverage and limitations section and updated formatting for consistency with other MSM chapters. Several sections within the chapter were moved or reorganized for readability and updated to remove redundancies. In addition, outdated language and procedures were removed and replaced with current language and procedures where applicable.

The proposed changes include replacing reference to Nevada Medicaid's "fiscal agent" with "Quality Improvement Organization (QIO)-like vendor" throughout the entire chapter.

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

Entities Financially Affected: NF (provider type (PT) 19).

Financial Impact on Local Government: Unknown at this time.

These changes are effective July 1, 2025.

Material Transmitted	Material Superseded
MTL 16/25 MSM Chapter 500- Nursing Facilities	MTL 09/15 MSM Chapter 500- Nursing Facilities

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 500	**Introduction**	Added language to better define NF service and revised for improved readability.
Section 501	**Authority**	Restructured format of authority citations (Social Security Act (SSA), Code of Federal Regulations

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		(CFR), Nevada Revised Statutes (NRS), Nevada Administrative Code (NAC) with moved authority language from Section 503.4, Pre-admission Screening and Resident Review (PASRR). Correction PASSR citation: Title 19 Section 1919(e)(7). Updated NRS 449.037 Adoption of standards, qualification and other regulations to NRS 449.0302, Board to adopt standards, qualifications and other regulations. Added NRS 449.240 Institution and conduct of prosecutions.
Section 503.1	**Nursing Facilities**	Added new section "Nursing Facilities" to introduce and better define service.
Section 503.1A	**Coverage and Limitations**	Added new section with language on coverage and limitations including: Program Eligibility and Criteria, Covered Services, and Limitations. Moved language from Section 503.17A regarding services not included in per diem rates.
Section 503.1B	**Provider Responsibilities**	Renamed section title to "Provider Responsibilities." Removed language referencing NRS and NAC. Added Skilled Nursing Facility (SNF) and Intermediate Care Facilities (ICF) as facility types licensed by Health Care Quality and Compliance (HCQC). Added language to clarify that ICFs do not require Medicare Certification per HCQC. Removed language regarding providers accepting payment in full and submitting timely claims to QIO-like vendor since referenced in MSM Chapter 100 – Medicaid Programs. Removed Section 503.2 titled "Program Participation" and renumbered language under "Provider Requirements."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed language referencing Medicaid provider contract requirements such as "Medicaid provider will be subject to recertification and compliance with all federal and state laws, rules, and regulations." Removed language regarding covered services and authority language as new authority and coverage sections were added. Removed facility census reporting requirements. Revised language regarding facility reporting certification data to QIO-like vendor. Added language regarding NF responsibility to reimburse nurse aide training costs within the first year of employment after certification.
Section 503.1C	**Recipient Responsibilities**	Renamed section title from "Recipient Responsibility" to "Recipient Responsibilities."
Section 503.2	**Preadmission Screening and Resident Review (PASRR)**	Renumbered section and subsections. Moved SSA, CFR, NAC, and NRS Authority citations to Section 501 and restructured for readability. Deleted language referencing Public Law, Nevada State Plan, and Interagency Agreement between Division of Health Care Financing and Policy (DHCFP), Division of Public and Behavioral Health (DPBH), and Aging and Disability Services Division (ADSD). Added language defining purpose of PASRR. Removed repetitive language regarding Level II evaluation. Moved compliance language below definition of screening levels. Moved language in PASSR Level II individual evaluation and determination. Moved language regarding exempted hospital discharge to related section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Renumbered subsections. Moved language from Section 503.2 that states a provider must not admit an individual who has been determined to not need NF services. Revised language to clarify that DHCFP has a written agreement with DPBH (mental health (MH) Authority) and ADSD (Individuals with Intellectual Disabilities (IID) Authority) for operation of PASRR.
Section 503.2A	**PASRR Level I Identification Screening**	Renumbered section. Revised language in section for readability and conciseness and removed duplicative statement about licensed health care professionals. Added "or other qualified individual" as person who could complete Level I determination. Added requirement to provide written notification to recipient and family/guardian if being considered for NF placement and if Level II evaluation is requested. Removed duplicative statement about purpose of Level I screening and Level II evaluation.
Section 503.2B	**PASRR Level II Identification Evaluation**	Renumbered section and retitled to Level II Identification Evaluation. Moved language stating provider must not admit resident until completion of Level II evaluation. Revised language to remove duplicative descriptions of Level II evaluation process.
Section 503.2C	**PASRR Level II Individual Evaluation and Determination**	Revised language in section for readability and conciseness. Removed introduction sentence identifying two PASRR level II processes. Revised language detailing QIO-like vendor's written notice upon completion of Level II evaluation.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed reference to Resident Assessment Instrument User's Manual. Moved language stating provider must not admit resident until completion of Level II evaluation. Moved language regarding two processes for Level II evaluation. Moved language regarding exempted hospital discharge. Removed duplicative language regarding exempted hospital discharge timeframes. Removed unnecessary language "any of these may indicate the need for a PASRR Level II evaluation Resident Review (RR)." Changed Medicaid Office to QIO-like vendor. Removed "form" from NF Tracking. Removed repetitive language that provider must assure resident screen is in accordance with state and federal PASRR regulations.
Section 503.2D	**PASRR Level II Exempted Hospital Discharge (EHD)**	Revised section title. Added language to define EHD. Removed repetitive language regarding PASRR Level I identification indicators. Moved language from Section 503.2C regarding exempted hospital discharge timeframes.
Section 503.2E	**PASRR Level II Advanced Group Categorical Determinations**	Revised section title. Added language and revised to better define Advanced Group Categorical Determinations (AGCD). Added time limits regarding provisional admission for certain circumstances such as convalescent care, cases of delirium, and respite.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed repetitive language regarding QIO-like vendor clinical review for AGCD. Updated citation reference for determination limitation dates. Reworded language regarding Advanced Group Categorical Determination (AGCD) effective dates for readability.
Section 503.2F	**PASRR Coordination and/or Provision of Specialized Services**	Revised language for readability. Removed repetitive language regarding progress/ lack of progress with Specialized Services. Moved language from within the same section to clarify process. Revised language to specify it is the state's (DPBH/ADSD) responsibility to provide or arrange for the provision of specialized services.
Section 503.2G	**PASRR Admissions from Other States**	Added language to include "in the event the out-of-state discharging facility does not provide a completed screening." Removed repetitive language regarding screening.
Section 503.2H	**PASRR Discharges or Transfers**	Updated "screening" to "evaluation" in regard to PASRR Level II. Reworded section for readability. Added language to specify the state (DPBH/ADSD) remains responsible for continuation of specialized services upon discharge of resident if they were in NF less than 30 consecutive months.
Section 503.2I	**PASRR Provider Responsibilities**	Moved language regarding general PASRR provider responsibilities.
Section 503.2J	**PASRR Reimbursement Limitations**	Retitled section to PASRR Reimbursement Limitations. Removed reference to mental retardation (MR), changed to IID.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Corrected MSM citation for Level I screening. Corrected indication to "indicating." Revised Nevada screening to Level I screening.
Section 503.7B	**PASRR Hearings**	Removed section title and number. Moved language to Section 504 - Hearings.
Section 503.3	**Level of Care**	Moved language to define level of care (LOC). Moved language regarding requirement to do LOC screening prior to NF admission. Added LOC Screening Types subsection, added definitions to screening types, added new screening type "reauthorization." Moved LOC service levels and added Service Levels subcategory, added reference to Behaviorally Complex Care Program (BCCP) with the MSM citation. Removed language referencing BCCP. Removed "screening office" in relation to QIO-like vendor. Removed repetitive language regarding QIO-like vendor LOC determination.
Section 503.3A	**Level of Care Coverage and Limitations**	Added LOC Coverage and Limitations section. Added screening types. Moved language regarding provider responsibilities related to screening types. Moved language regarding LOC determination and obtaining determination verification from QIO-like vendor. Added subcategories with moved language for initial placement, retroactive screening, service level change, time limitation, and reauthorization. Added retro LOC approval language related to provider eligibility.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added submission timeframes for Initial Placement (two business days) and Service Level Change (within 72 hours of change). Added subcategory for service levels; NF Standard and NF Ventilator Dependent. Created subcategory NF Standard Covered Services and Supplies with moved language from Section 503.16A. Removed reference to all-inclusive rate in Ventilator LOC. Added language that NF Ventilator Dependent Rate may be authorized up to 180 days and reauthorization required. Within "Pediatric Specialty Care," removed reference to rates, replaced with "authorizations." Revised subcategories to Pediatric Specialty Care Level I and Pediatric Specialty Care Level II. Added "Pediatric Specialty Care Covered Services and Supplies" as subcategory. Added "under a physician's order" to #b as related to daily respiratory care. Added "and provide adequate documentation, including interventions utilized to reduce or eliminate behaviors" to #8 as related to moderate behavior issues. Moved language regarding items included in the Pediatric Specialty Care Rate. Removed reference to rate in subcategory title. Added "Pediatric Specialty Care" as subcategory. Moved language for provider responsibilities. Removed language stating DHCFP staff makes onsite NF visits.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed language regarding requirement for registered nurse (RN) to be on duty 24 hours per day in the Pediatric Specialty Care Unit. Added subcategory BCCP LOC. Added language to specify BCCP is for recipients aged 21 and over. Removed reference to reimbursement rate based on tier level. Added Coverage and Limitations section. Added word "qualifying" in front of behaviors. Added subcategory "Covered Behaviors." Added subcategory title and language to better define physical aggression, moved language up with examples of physical aggression. Renamed behavior category as "regressive behavior." Added language to define regressive behavior specifying: "The resident's behavior interferes significantly with the stability of the living environment and interferes with other residents' ability to participate in activities or engage in social interactions." Added subcategory title and language to better define some of the individual regressive behaviors, such as hoarding. Removed phrase "socially inappropriate and disruptive behavior." Added subcategory title and language regarding resisting care, better defining behavior of resisting care. Added subcategory and language to better define self-abuse acts, renamed to "self-injury," and provided examples.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Distinguished between intentional and unintentional behaviors. Added subcategory title and language to better define verbal aggression. Moved existing language regarding verbal aggression. Added subcategory "Non-Covered Behaviors" with reworded language for non-covered behaviors such as elopement, and suicidal ideation. Added Subcategory BCCP Authorization Process. Moved and revised language stating BCCP tier request requires prior authorization to be processed by the DHCFP LTSS Unit with NMO 7079 form. Added LTSS email and website for NMO-7079 form. Moved language stating that facilities must submit supporting documentation to DHCFP and restructured supporting documentation examples. Added language better detailing documentation for: Medication Administration Records (MAR), Primary Care Provider (PCP) progress notes, psychiatric notes, nurse notes, and skin/wound assessments. Added daily progress notes for behavior as a type of supporting documentation. Added language to clarify supporting documentation for: behavioral modification plan, behavior monitor logs, and Interdisciplinary Team (IDT) notes. Added language that facilities should ensure recipient behaviors are documented promptly and objectively. Added language for pending BCCP Referrals stating a provider may be pended five days for

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		additional documentation and absence of documentation may result in an adverse action. Added subcategory title "BCCP Authorization Types" and added language to define the five types of authorizations including pre-approval authorization, initial authorization, continued request authorization, authorization change request, and retroactive authorization. Added subcategory "BCCP Tier Levels." Removed reference to rates. Added language to clarify the evaluation process and specify that facilities must submit the NMO-7079 along with supporting documentation. Added subcategory BCCP Tier Evaluation and Timeframes. Moved language regarding tier evaluation from "Provider Responsibilities" and reworded for readability. Changed behavior frequency "Usually Not" to "Sometimes." Revised scoring value and tier point range: Always = 4; Usually = 3; Sometimes = 2; Never = 0. Tier 1 = 3 – 6 points; Tier 2 = 7 – 12 points; Tier 3 = 13 and above. Added language to identify each tier is authorized for 180 days. Added language that facilities can view approved BCCP prior authorization in Electronic Verification of Services (EVS) Provider Portal. Added subcategory BCCP Notice of Decision (NOD). Moved and revised NOD language. Added more detail for types of adverse actions: denial, termination, and modification.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added language stating a BCCP adverse action is independent of NF LOC determination. Revised section title as "BCCP Provider Responsibilities" moved as subcategory. Added language under provider responsibilities to "be part of an individualized behavior modification plan" to specify that the facility must provide detailed documentation identifying the specific modifications and interventions utilized to reduce/eliminate behaviors. Removed line item 2 as it was repetitive of line item 1. Reworded newly numbered line items 2 and 3 for readability. Added language stating DHCFP may audit provider compliance with administering BCCP and may conduct on-site visits or request documentation. Removed language stating documentation supporting service must be submitted to DHCFP Facilities Unit; language already specified in earlier section. Removed repetitive language regarding LTSS reviewing submitted materials. Removed NOD language for approved requests as NODs only sent for adverse action. Moved other NOD language to new subcategory within BCCP Authorization Process. Added new subcategory titled Rates and Reimbursement. Moved language. Added reference to Medicaid State Plan Attachment 4.19-D, MSM Chapter 700 – Rates and Supplemental Reimbursement, and reference to provider billing guide.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed section title and number. Moved BCCP Hearings language to Section 504.
Section 503.4	**Nursing Facility Tracking**	Removed "form" from NF Tracking in section title and language. Added reference to QIO-like vendor and EVS Provider Portal. Removed reference to Medicaid Central Office. Removed reference to billing authorization letter process as it is obsolete. Added timeframe of 72 hours for NF Tracking to be completed for listed occurrences. Removed occurrence reason to submit NF Tracking for Hospice enrollment/Disenrollment as it is not required. Removed reference to DHCFP site. Removed reference to accessing form, submission instructions, and facilities retaining a copy.
Section 503.4A	**Nursing Facility Tracking Provider Responsibilities**	Renamed section title to NF Tracking Provider Responsibilities. Added reference to Provider Portal. Removed "form" in NF Tracking.
Section 503.5	**Therapeutic Leave of Absence**	Added language to define therapeutic leave of absence (LOA). Moved language regarding therapeutic LOAs for community visits and preparation for discharge to community living.
Section 503.5A	**Therapeutic Leave of Absence Coverage and Limitations**	Moved language regarding reimbursement and LOA timeframes to provider responsibilities. Removed specific examples of non-covered short-term absences- visits with family/friends, church

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		services, and other social activities to simplify the section. Restructured for improved readability.
Section 503.5B	**Therapeutic Leave of Absence Provider Responsibilities**	Replaced "receiving" facility with "admitting" facility and "sending" facility with "discharging" facility. Added new section, "Provider Responsibilities." Added moved language regarding reimbursement timeframes and limitations. Renumbered and reworded for readability.
Section 503.5C	**Therapeutic Leave of Absence Recipient Responsibilities**	Added section Recipient Responsibilities with current language. Renumbered for readability.
Section 503.6	**Patient Income Changes and Patient Liability (PL)**	Added language defining Patient Liability (PL).
Section 503.6A	**Patient Income Changes and Patient Liability Coverage and Limitations**	Retitled section. Renumbered for readability.
Section 503.6B	**Patient Income Changes and Patient Liability Provider Responsibilities**	Retitled section. Reworded #1 to add reference to when the NF is the recipient's representative payee. Changed fiscal agent to QIO-like vendor. Added language that facilities must notify Division of Welfare and Supportive Services (DWSS) of any admission or discharge. Added reference to DWSS website.
Section 503.7A	**Personal Trust Fund Management**	Removed subsection title "Managing Resident Funds." Updated resident to recipient.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed exhaustive list of covered services and supplies and included reference to Section 503.1A. Removed duplicative statement regarding recipient request to purchase specialty items. Moved language down to provider responsibilities.
Section 503.7B	**Personal Trust Fund Management Personal Fund Audits**	Renumbered and revised section title. Reworded for readability. Removed "periodically" in relation to auditing recipient's personal trust funds. Added reference to NRS 449.240.
Section 503.7C	**Personal Trust Fund Management Provider Responsibilities**	Added new section 503.7C Provider Responsibilities. Added moved language stating NFs must have system for managing recipient funds. Added language per 42 CFR 483.13(c) that facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Moved and reworded language stating that if NF is managing resident's funds, NF must obtain authorization from recipient for purchases made by NF on recipient's behalf. Moved language regarding instance when recipient is unable to sign authorization to 503.7C(3)(a). Added language stating recipient's financial records must be available upon request. Inserted moved language, revised and added language regarding managing resident's funds upon death to better match language in 42 CFR Section 483.10(f)(10)(v). Added language to state that upon the death of a recipient, the facility must not use remaining funds

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		to pay debts owed from the deceased resident but must follow the state regulation NRS 147.040 to file a claim with the court of jurisdiction for distribution in order of succession. Added reference to Medicaid Estate Recovery policy in Medicaid Operations Manual.
Section 503.7D	**Personal Trust Fund Management Recipient Responsibilities**	Updated Renumbered section. Added language "or their authorized representative" to the recipient's responsibility to notify the facility with written authorization if they want their funds managed by the facility. Removed specific examples of personal care items/services and reworded for readability.
Section 503.8, 503.8A	**Transportation-Coverage and Limitations**	Reworded section for clarity and readability. Changed Non-Emergency Transportation (NET) to Non-Emergency Medical Transportation (NEMT). Added language to specify NEMT may be arranged through the NEMT broker in the following circumstances: initial admission to NF, discharge from the NF, hospital discharge back to the NF. Removed reference to DHCFP Out-of-State Coordinator.
Section 503.9	**Discharge Requirements**	Removed reference to Nevada Medicaid Central Office, changed to QIO-like vendor, and revised "sending" to "updating" and "his or her" to "their."
Section 503.9A	**Facility to Facility Transfer**	Added subcategory "Discharge Facility," reworded for readability. Simplified language for transferring medical records to admitting facility. Removed "form" from NF Tracking. Changed "receiving" to "admitting" facility. Added subcategory "Admitting Facility," and reworded "resident" to "recipient" for readability.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed reference to "Facility Outreach and Community Integration Services (FOCIS)" program.
Section 503.10	**Free-Standing Nursing Facility - Patient Driven Payment Model (PDPM) Case Mix**	Renumbered section.
Section 503.10A	**Provider Responsibilities**	Renumbered section.
Section 503.11	**Free-Standing Nursing Facility Case Mix and MDS Verification Review Description**	Renumbered section.
Section 503.11A	**Coverage and Limitations**	Renumbered section.
Section 503.11B	**Provider Responsibilities**	Renumbered section.
Section 503.12A	**Hospital-Based Nursing Facility Coverage and Limitations**	Updated section title. Added reference to BCCP LOC as exception to relevant policy for Hospital-Based NFs. Moved language regarding reimbursement principles.
Section 503.12B	**Hospital-Based Nursing Facility Provider Responsibilities**	Updated section title. Removed reference to timely claim submission as it is addressed in MSM Chapter100.
Section 503.12C	**Hospital-Based Nursing Facility Rates Reimbursement**	Added new section titled Hospital-Based Nursing Facility Rates and Reimbursement. Moved language that references MSM Chapter 700 - Rates and Supplemental Reimbursement, for specific rates details for hospital-based NF reimbursement and language to reference provider billing guide.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 503.13	**Out-of-State Nursing Facility Placement**	Added language with the purpose of out-of-state placement. Removed reference to Out-of-State Coordinator. Added reference to LTSS unit and inbox and FA-30 OOS NF Placement Packet. Re-worded language regarding recipient consent to out-of-state placement. Removed language regarding acknowledgement of burial and funeral arrangements as it is included on required FA-30 OOS NF Placement Packet.
Section 503.13A	**Out-of-State Nursing Facility Placement Authorization Process**	Retitled section. Moved section and language regarding Authorization Process from Section 503.22B. Retitled section. Renamed "instate provider" to "discharging facility." Removed reference to out-of-state coordinator.
Section 503.13B	**Out-of-State Nursing Facility Placement Provider Responsibilities**	Restructured as a new section. Retitled section. Added "Provider Responsibilities" in the section title. Removed language referencing NF Tracking and central office. Removed reference to out-of-state coordinator.
Section 503.13C	**Out-of-State Nursing Facility Placement Recipient Responsibilities**	Retitled section to "Out-of-State Nursing Facility Placement Recipient Responsibilities" and revised language for readability. Moved language regarding SSA and change of address notification.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 503.13D	**Out-of-State Nursing Facility Placement Rates and Reimbursement**	Added "rates'" to section title. Moved language from Section 503.22. Removed reference to Out-of-State Coordinator and added Nevada Medicaid Rates Unit. Removed Medicaid Central Office. Removed reference to prior authorization and prior authorization number and added language for attaching Letter of Agreement (LOA) with claim submission.
Section 503.14	**Rates and Reimbursement**	Added Rates and Reimbursement section. Added reference to Medicaid State Plan 4.19-D, MSM Chapter 700, and billing guide.
Section 503.16	**Routine Services and Supplies**	Removed Section Title "Routine Services and Supplies" as language regarding covered services and supplies was moved to Section 503.1A. Removed the unmoved language as it was repetitive.
Section 503.16A,	**Coverage and Limitations & Items**	Removed repetitive language regarding covered services and supplies, moved language regarding covered services and supplies to Section 503.1A.
503.16B	**Included in Pediatric Specialty Care Rate**	Moved language regarding items included in Pediatric Specialty Care rate to Section 503.3A(2)(c)(4).
Section 503.17-17A	**Services and Supplies Not Included in Per Diem Rates & Coverage and Limitations**	Removed section titles as all language was moved to Section 503.1A.
Sections 503.17B and 503.17C	**Provider Responsibility and Recipient Responsibility**	Removed section titles and all duplicative language as language is already included in Sections 503.1A, 503.1C, and 503.8D.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 503.17D	**Authorization Process**	Removed section title and reference to authorization for non-covered services as language was moved to Section 503.1A.
Section 504	**Hearings**	Added language to define adverse actions. Added subcategories PASRR Adverse Actions, LOC Adverse Actions, and BCCP Adverse Actions with moved and new language to better define individual hearings processes.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

NURSING FACILITIES

500 INTRODUCTION

Nursing Facility (NF) services for individuals age 21 and older is a mandatory Medicaid benefit. NFs are institutions certified by the state to provide 24-hour medical and skilled nursing care, rehabilitation, or health-related services to individuals who do not require hospital care.. NFs provide health related care and services to individuals with medical disorders, injuries, developmental disabilities, and/or related cognitive and behavioral impairments, and that exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board. NF services include assistance with certain activities of daily living (ADL) such as bathing, dressing, eating, toileting, and transferring.

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.

501 AUTHORITY

In 1965, Congress authorized the Medicaid Program by adding Title XIX to the Social Security Act (SSA). Title XIX of the SSA requires that in order to receive Federal matching funds, certain basic services including 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.

Statutes and Regulations:

- Social Security Act (SSA)
  - Title XIX Section 1919 Requirements for Nursing Facilities
    - Section 1919(e)(7); Requirements Relating to Pre-Admission Screening for Mentally Ill and Mentally Retarded Individuals.
- Code of Federal Regulations (CFR)
  - 42 CFR 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.
  - 42 CFR 440.150 Intermediate Care Facility (ICF)/ Individuals with Intellectual Disabilities (IID) Services
  - 42 CFR 483 Requirements for States and Long Term Care Facilities
    - Subpart I Conditions of Participation for Intermediate Care Facilities for IID
    - Subpart C - 483.100 – 483.138 Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals
- Nevada Revised Statutes (NRS)
  - NRS 433.209 Person professionally qualified in the field of psychiatric mental health defined
  - NRS 449.0302 Board to adopt standards, qualification and other regulations
  - NRS 449.240 Institution and conduct of prosecutions.
- Nevada Administrative Code (NAC)
  - NAC 449.74425 Admission of patient with mental illness (MI) or an intellectual disability (ID)

502 RESERVED

503 POLICY

503.1 NURSING FACILITIES

An NF participating in Nevada Medicaid must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each recipient.

There is no exhaustive list of services an NF must provide, in that, unique recipient needs may require particular care or services in order to reach the highest practicable level of well-being. The services needed to attain this level of well-being are established in the individual's plan of care (POC).

503.1A COVERAGE AND LIMITATIONS

1. Program Eligibility

   a. The recipient must be eligible for Title XIX (Medicaid) or Title XXI (Nevada Check Up (NCU));

   b. The recipient must meet the NF Level of Care (LOC) criteria;

   c. Services must be provided under a POC signed by the physician;

   d. Must have a completed Preadmission Screening and Resident Review (PASRR)

2. Covered Services

   Federal requirements specify that each Medicaid participating NF must provide or arrange for services including:

   a. Nursing and related services;

   b. Medically related social services;

   c. Specialized rehabilitative services;

   d. Pharmaceutical services;

   e. Dietary services individualized to the needs of each recipient;

   f. Medical supplies;

   g. Professionally directed program of activities to meet the interest and needs for the well-being of each recipient;

h. Emergency dental services;

i. Room and bed maintenance services;

j. Routine personal hygiene items and services.

3. Limitations

Services and supplies not covered under the NF Standard LOC include:

a. Drugs available by prescription only;

b. Prescribed medical appliances and devices, (eyeglasses, hearing aids, braces, prostheses, etc.);

c. Non-standard wheelchairs including power-operated vehicles and wheelchair seating systems that cannot be utilized by another recipient due to unique custom features needed for the recipient's permanent, full time use (e.g. custom fabricated molded seating systems, etc.);

d. Air fluidized bed units and low air loss bed units;

e. Emergency transportation;

f. Physical, Occupational, and Speech therapy services;

g. Physician services;

h. Laboratory, portable x-ray, and other diagnostic services;

i. Repair of medical equipment and appliances belonging to the recipient;

j. Private room, unless medically necessary;

k. Specially prepared food, beyond what is generally prepared by the facility;

l. Telephone, television, radio;

m. Personal comfort items;

n. Gifts purchased;

o. Personal items, such as clothing and reading materials;

p. Social events and activities beyond the activity program;

q. Special care services not included in the NF Standard LOC.

503.1B PROVIDER RESPONSIBILITIES

An NF must comply with the following requirements in order to be eligible to participate in the Nevada Medicaid program. All in-state NFs must:

1. Be licensed by the Division of Public and Behavioral Health (DPBH), Bureau of Health Care Quality and Compliance (BHCQC) as either a Skilled Nursing or an Intermediate Care Facility (ICF).

2. 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 CFR 483.

    a. Exception: Facilities licensed as ICFs do not require Medicare Certification per Health Care Quality and Compliance (HCQC); however, for the purposes of this chapter, they are considered an NF.

3. Be enrolled and comply with all requirements for NF providers in the Nevada Medicaid program as described in Medicaid Services Manual (MSM) Chapter 100 - Medicaid Program.

4. Comply with all federal and state mandated staffing requirements in order to maintain Medicare/Medicaid certification.

5. 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.

    a. 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 POC. The POC must include diet, medications, treatments, special procedures, activities, and specialized rehabilitative services, if applicable, the potential for discharge.

    b. Physician's visits must be conducted in accordance with federal requirements.

    c. Physician's visits made outside the requirements must be based upon medical necessity criteria.

6. The NF must maintain records on each recipient in accordance with accepted professional standards and practices.

    a. Recipient records must be complete, accurately documented, organized, and readily available.
    b. 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 Preadmission Screening and Resident Review (PASRR), the results of the LOC Assessment screening, and progress notes.

c. The record must also contain relevant documentation to support the Minimum Data Set (MDS) coding.

d. All entries must be signed and dated with the professional title of the author.

7. Documentation of specialized services provided or arranged for, and the recipient's response to such services must remain in the active medical record as long as the recipient is recommended to receive specialized services. This documentation must be available for state and federal reviewers.

8. If the number of certified beds has changed since enrollment or revalidation, the facility must update the number of certified beds to the QIO-like vendor within 30 days of the change.

9. The provider must provide for the safekeeping of personal effects, funds, and other property of the recipient.

a. The provider must develop policies and procedures to minimize the risk of theft or loss of the personal property of recipients.

b. Recipients and their legal representatives must be notified of these policies and procedures.

c. 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.

10. Nurse Aide Training Cost: NFs are required to reimburse Certified Nursing Assistants (CNAs) if the CNA paid for the training within one year of being employed by the facility and has not previously been reimbursed.

a. The amount NFs are required to reimburse the CNA is limited to the cost of the CNA program, including competency evaluations, class fees, textbooks, and other required course materials.

b. The aide is to be reimbursed after three months of employment in the facility.

503.1C RECIPIENT RESPONSIBILITIES

The recipient, upon request, must present:

1. A valid Medicaid card; and

2. Any form of identification necessary to utilize other health insurance coverage for any and all services.

503.2 PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

PASRR is a federally mandated program which ensures all recipients being admitted to a Medicaid certified NF are screened to identify any indicators of MI, IID, or related conditions (RC). PASRR ensures a recipient is placed appropriately in the least restrictive setting possible and receives specialized services if needed for the management of MI, IID, or RC. The provider must not admit an individual who has been determined to not need NF services.

DHCFP Nevada Medicaid is responsible for the oversight of all operations related to the PASRR Program. DHCFP contracts with the QIO-like vendor to conduct Level I Identification screenings and PASRR Level II evaluations. DHCFP has, in effect, a written agreement with the State mental health authority, Division of Public and Behavioral Health (DPBH), and State intellectual disabilities authority, Aging and Disability Services Division (ADSD), to provide and/or follow up on all specialized services. BHCQC investigates compliance with PASRR through the survey process.

503.2A PASRR LEVEL I IDENTIFICATION SCREENING

The Level I determination, completed prior to admission by a licensed health care professional or qualified individual, determines whether the individual shows indicators of MI, intellectual disabilities (IID), or RC. If no such indicators are found, the individual is cleared through PASRR screening for admission to an NF and the QIO-like vendor will issue a determination letter to the requestor.

The individual completing the Level I Identification Screening must provide written notification to the recipient (or appropriate family and/or guardian) that he/she is being considered for NF placement. Notification is also required for recipients of an NF any time a Level II evaluation is requested, such as when a current NF recipient experiences a significant change in his/her physical or mental status or a prior PASRR Level II evaluation needs to be updated.

It is the responsibility of the discharging facility to ensure a completed Level I screening and, when indicated, a PASRR Level II evaluation is available in the recipient's profile in the Nevada Medicaid Electronic Verification System (EVS) Provider Portal prior to discharging the individual to any NF placement. If the recipient has a Level I screening completed and it is determined there has been no significant change in condition, an additional Level I does not need to be submitted upon admission.

503.2B PASRR LEVEL II EVALUATION

When an individual has been identified with possible indicators of MI, IID, or RC, a PASRR Level II evaluation 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. The provider must not admit the recipient until the facility receives confirmation from the QIO-like vendor of the completion of Level II evaluation.

There are two types of PASRR Level II evaluations.

1. The Preadmission Screening (PAS) completed on an applicant for NF placement.

2. The Resident Review (RR) refers to a PASRR Level II screening completed on a current recipient of an NF who experiences a significant change in physical or mental condition, had previously been exempted from or was time-limited under a prior PASRR Level II evaluation. Within the Level II evaluation, there are two processes, a categorical determination or an individual evaluation and determination.

503.2C PASRR LEVEL II INDIVIDUAL EVALUATION AND DETERMINATION

The QIO-like vendor will arrange the PASRR Level II evaluation.

1. When the evaluation is completed, written notice will be provided by the QIO-like vendor to the requestor.

2. If the facility identifies a significant change in status an RR must be requested. If needed, the QIO-like vendor will arrange the PASRR Level II evaluation.

3. The provider must assess all recipients on an ongoing basis to identify if a recipient:

   a. Develops MI, or

   b. A recipient 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

   c. The facility has identified the need for a "Significant Change in Status Assessment" (SCSA) MDS.

4. 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 an RR is indicated.

5. The provider must report all discharges directly related to a PASRR determination that an individual is not appropriate for NF services to the QIO-like vendor on the NF Tracking.

503.2D PASRR LEVEL II EXEMPTED HOSPITAL DISCHARGE (EHD)

A hospital discharging an individual to an NF is exempted from completing the entire PASRR process if the stay is expected to last no more than 30 calendar days, this is called EHD. EHD is the only exemption that would allow a facility to forgo the full PASRR process; however, a PASRR Level I screening is still required.

1. The individual may be admitted under EHD if they meet all the following criteria upon discharge to an NF.

   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

   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.

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

3. The provider must track limitation dates on EHD and Categorical Determinations. If the facility admitted a recipient under the EHD, for a less than 30 day stay, and the recipient is later found to require more than 30 days of NF care, the facility must request the PASRR Level II evaluation by submitting a completed Level I identification screening to the QIO-like vendor by the 25th day of the admit date.

503.2E PASRR LEVEL II ADVANCED GROUP CATEGORICAL DETERMINATIONS

Advanced Group Categorical Determinations permit facilities to omit the full Level II evaluation in certain circumstances that are time-limited or where the need for NF services is clear. While the evaluation process is abbreviated, the function of the resulting determination is not different from individualized determinations. Advanced Group Categorical Determinations are not 'exemptions.' The QIO-like vendor's clinical reviewers will determine if an individual requires NF services, and meets any one of the following criteria for an Advanced Group Categorical Determination:

1. Convalescent Care from an acute physical illness which required hospitalization and does

not meet all the criteria for an EHD, not to exceed 45 days.

2. Terminal Illness in which a physician has certified that life expectancy is six months or less.

3. 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.

4. Provisional Admission for cases of:

   a. Delirium where an accurate diagnosis cannot be made until the delirium clears, not to exceed 30 days; or

   b. Emergency situations requiring protective services with placement in the NF not to exceed seven days; or

   c. Respite to in-home caregivers to whom individuals with MI or IID is expected to return following a brief NF stay, not to exceed 30 days.

   If an Advanced Group Categorical Determination is made, the effective dates may be limited, requiring an updated RR when the individual's stay is expected to exceed the limitation date (see MSM Section 503.2I PASRR Reimbursement Limitations).

503.2F PASRR COORDINATION AND/OR PROVISION OF SPECIALIZED SERVICES

1. The provider must notify the DPBH/ADSD upon receiving any Level II evaluation that indicates an individual needs specialized services. DPBH/ADSD is responsible to provide or arrange for the provision of specialized services.

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

3. 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.

4. 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 recipient, 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.

503.2G PASRR ADMISSIONS FROM OTHER STATES

1. 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 evaluation completed in the state they are transferring from, prior to sending the individual to a Nevada facility.

2. It is the admitting Nevada facility's responsibility to obtain a copy and verify the completion of the out-of-state screening. In the event the out-of-state discharging facility does not provide a completed screening, the admitting Nevada facility must complete and submit a Level I Identification Screening to the QIO-like vendor within one business day of the admission.

503.2H PASRR DISCHARGES OR TRANSFERS

1. The provider must forward copies of the most recent Level I and, when applicable, Level II evaluation to the admitting facility upon discharge or transfer of a recipient.

2. The provider must notify the DPBH/ADSD PASRR coordination staff of the discharge of any recipient who has been receiving specialized services and provide them with details regarding the individual's discharge destination. For any recipient that has resided in an NF for less than 30 consecutive months, DPBH/ADSD is responsible to ensure specialized services continue, even in the event the recipient no longer meets NF LOC and is discharged to the community.

503.2I PASRR PROVIDER RESPONSIBILITIES

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

2. The provider must ensure that every recipient is screened in accordance with state and federal PASRR regulations.

3. 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.

4. 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 evaluations

completed prior to admission and the most recent screenings, if the individual experienced a significant change in his/her physical/mental condition.

503.2J PASRR REIMBURSEMENT LIMITATIONS

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, IID, or RC.

2. An individual with indicators of MI, IID, or RC is admitted to an NF before the completion of the PASRR Level II evaluation; unless an EHD has been approved through Level I process (see Section 503.2A). Medicaid reimbursement is not available until the date the Level II evaluation is completed indicating NF placement is appropriate.

3. A provider who fails to obtain a completed PASRR Level II evaluation by day 30 of an admission under the EHD. 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 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 submit a Level I screening within one business day of admission when a recipient is admitted to a Nevada NF from out-of-state. No Medicaid reimbursement is available until the date the 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.

503.3 LEVEL OF CARE

NF LOC is a screening to determine if a recipient meets the minimum criteria for NF placement and appropriate services. In addition to PASRR, the 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.

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

A. LOC Screening Types

The following are four LOC screening types used for recipients in NFs and their definitions:

1. Initial Placement: The recipient is admitted to an NF for the first time.

2. Retro Screening: The recipient's LOC requires a retroactive effective date due to the eligibility status of the recipient or the provider, or in cases of emergency placement.

3. Service Level Change: A recipient's service needs have changed. For example, the recipient was not Ventilator Dependent, but now is, or vice versa.

4. Time Limitation: Certain authorizations are time limited and must be reauthorized for continued coverage.

5. Reauthorization: The previous LOC assessment was time limited and is close to expiration. Prior to expiration, the provider must submit Form FA-19 at least five days prior to the expiration date of the current assessment.

B. Service Levels

In addition to the screening type, there are five possible LOC categories based on the care needs and NF requirements. These include:

1. NF Standard;

2. NF Ventilator Dependent;

3. Pediatric Specialty Care I; and

4. Pediatric Specialty Care II.

5. Behaviorally Complex Care Program (BCCP). See Section 503.5 for program description, coverage, and limitations.

503.3A LEVEL OF CARE COVERAGE AND LIMITATIONS

1. Screening Types

a. Initial Placement

The requestor must submit an LOC screening Form (FA-19) with the required documentation through the EVS Provider Portal at least two business days prior to admission. The LOC determination must be completed by the QIO-like vendor. The NF must receive a copy of the LOC screening indicating the Medicaid eligible individual has a NF LOC prior to admission.

b. Retroactive Screening

The LOC screening must be completed prior to obtaining a billing authorization. Retroactive LOC may be authorized under the following conditions:

1. Recipient obtains Medicaid eligibility after admission to the NF.

2. Recipient becomes Medicaid eligible after death or discharge from an NF.

3. Emergency situations requiring protective services with placement in the NF not to exceed seven days. The provider must monitor the time-limited LOC determination and request an updated LOC prior to the expiration date.

4. Provider becomes Medicaid eligible after recipient's admission to the NF.

c. Service Level Change

1. If a recipient's condition changes significantly, the provider must request an updated LOC determination through the EVS Provider Portal, within 72 hours. 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.

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

3. 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.

d. Time Limitation

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 or 180 days. The provider must monitor LOC determinations that are time-limited and request an updated LOC determination prior to the expiration date.

e. Reauthorization

Providers must submit LOC reauthorization requests prior to the current authorization expiration date. If the reauthorization request is received timely and the provider cooperates with any requests for additional information, there will be no lapse in the LOC coverage dates, if approved.

2. Service Levels

It is the NF's responsibility to verify that 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.

a. NF Standard

1. Medical Necessity

In order to meet the NF Standard LOC, the individual's condition requires services for at least three of the following:

a. Medication,

b. Treatment/Special Needs,

c. Activities of Daily Living (ADL),

d. Supervision, or

e. Instrumental Activities of Daily Living (IADL).

Note: IADLs are only evaluated after the recipient has been determined to have at least one ADL need.

2. NF Standard Covered Services and Supplies

a. 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.

b. Social work services and activity programs: NF staff will provide these services as necessary in order to carry out the POC for the

Medicaid recipients.

c. Maintenance therapy programs: facility staff will assist the Medicaid recipients as necessary under the guidelines of the recipient's restorative therapy program.

d. 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, etc.

e. Items which are used by individual recipients, but which are reusable and expected to be available, such as canes, crutches, walkers, wheelchairs, gerichairs, and traction equipment.

f. Laundry services, including personal clothing.

g. Routine personal hygiene items including soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents, razor, shaving cream, denture adhesive, dental floss, toothbrushes, toothpaste, etc.

b. NF Ventilator Dependent

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

2. 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.

3. NF Ventilator Dependent LOC may be authorized for up to 180 days. Reauthorization is required to maintain an NF Ventilator Dependent LOC and must be submitted to the QIO-like vendor prior to the expiration date of the previous authorization.

c. 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 that the recipient meets both an NF LOC as well as a Pediatric Specialty Care LOC prior to authorization. Pediatric Specialty Care authorizations are approved for a maximum of six months (180 days) but may be extended with a reauthorization of the 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 until such time a new pediatric specialty care LOC is determined.

Documentation must be submitted with a request to support all treatment and services listed above. Time limited treatments may be authorized up to 90 days.

Requests for extension must be submitted prior to the current authorization end date and must include supporting documentation.

1. Pediatric Specialty Care Level 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. 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.

2. Pediatric Specialty Care Level 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. 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.

3. Pediatric Specialty Covered Services and Supplies

a. 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) under a physician's order,

3. IV therapy involving:

a. Hydration; or

b. 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; percutaneous endoscopic gastrostomy (PEG), rectal tube).

6. Complex wound care (including stage III or IV decubitus wound or recent surgical or other recent wound) requiring extensive dressing or packing approval will be time limited).

7. Seizure precautions.

8. Moderate behavior issues (including self-abuse) – describe the problem and provide adequate documentation, including interventions utilized to reduce or eliminate behaviors.

9. Central or Peripherally Inserted Central Catheter (PICC) line management.

10. Maximum assist required (quadriplegia or Hoyer lift) per HCQC guidelines.

11. Other special treatment(s) not listed above. The provider must describe in detail.

4. Items Included in the Pediatric Specialty

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 (Pulmo-Aide®)); 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.

a. Feeding pumps and equipment and services necessary for tube feedings.

b. Tracheostomy speaking valves.

c. Equipment and supplies for continuous IV therapy.

d. Ambulatory assistance equipment, supplies and services, including but not limited to canes and wheelchairs.

e. Support surfaces, equipment, supplies and services, i.e., alternating pressure pads, wheelchair cushions, and gel pressure and air fluidized mattresses.

f. Bathing/toileting assistance equipment, supplies, and services, commodes, lifts.

g. Developmental services.

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

5. Pediatric Specialty Provider Responsibilities and Qualifications

a. 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.

b. 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.

c. In addition to Medicaid contractual obligations and all other provider rules contained in MSM Chapters 100-Medicaid Program, and 500-NF, a free-standing NF must meet the following specified criteria to qualify for Pediatric Specialty Care rates:

d. Physical facility requirements:

1. Pediatric Specialty Care must be provided in a distinct, identifiable unit or area of the NF.

2. The accommodating beds include contiguous rooms, wing, floor, or building of the NF.

e. Staffing Requirements:

1. 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 experience in pediatric nursing.

d. Behaviorally Complex Care Program Level of Care

BCCP is for those Nevada Medicaid recipients, aged 21 and older, with a severe, medically based behavior disorder currently residing in a free-standing NF. Medically based disorders may include, but not limited to traumatic/acquired brain injury, dementia, Alzheimer's, Huntington's Chorea, or a recipient who meets the Medicaid criteria for NF LOC with a medically based mental health disorder or diagnosis exhibiting significant behaviors.

1. Covered Behaviors

NFs must demonstrate that the recipient has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from NF staff as documented by one or more of the following qualifying behaviors:

a. Physical Aggression

Behaviors causing or threatening physical harm towards others. Behaviors may include but are not limited to:

1. Hitting
2. Kicking
3. Shoving
4. Scratching
5. Biting
6. Engagement in acts of sexual abuse.
7. Using objects or weapons in a physically aggressive manner toward others
8. Intentionally breaking their possessions, or other recipient's possessions in a physically aggressive manner.

b. Regressive Behavior

For the purposes of BCCP, regressive behavior can be defined as actions typical of early stages of life (infancy or early childhood). The recipients' behavior interferes significantly with the stability of the living environment and interferes with other recipients' ability to participate in activities or engage in social interactions. Behaviors may include but are not limited to:

1. Making disruptive sounds, noises, and screams;
2. Inappropriate sexual behavior in common areas of facility;
3. Disrobing in public areas;
4. Smearing or throwing food or feces;
5. Hoarding - accumulation of clutter disrupting the ability to use living space and substantially compromising the living environment;
6. Rummaging through, or taking, others' personal possessions.

c. Resisting Care

Any recipient behavior which prevents or interferes with the NF staff performing or assisting with medication administration or ADL (bathing, dressing, grooming, eating, and toileting). Frequent instances of resisting care may impact the overall health of the recipient.

Behaviors may include but are not limited to:

1. Pushing or swatting at staff during care
2. Yelling during care
3. Refusing or spitting out medications
4. Interference with medical devices (ex: IV, vent, G-Tube, urinary catheter, colostomy device, etc.)

d. Self-Injury

1. Intentional: Injury to one's own body, and/or the act of deliberately hurting oneself as a coping mechanism. Behaviors may include but are not limited to:
   a. Cutting, or burning skin,
   b. Punching and/or hitting themselves,
   c. Intentional scratching of skin to inflict wounds, not for normal itching due to a rash or other condition.
2. Unintentional: Self-injury from picking, scratching, hitting, etc. that results in the need for wound care.

e. Verbal Aggression

The recipient engages in verbally abusive behavior exhibited by threatening, screaming, or cursing at others. Behaviors may include but are not limited to:

1. Threatening, domineering, or forceful language
2. Expressing extreme hostility or rage which is directed at staff members or other recipients

3. Yelling or screaming with the use of profanity or vulgar language

2. Non-Covered Behaviors

a. 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.

b. The BCCP is not appropriate for individuals with suicidal ideations. Individuals with suicidal ideations 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 support a medically based behavior disorder.

3. BCCP Authorization Process

A BCCP request requires prior authorization on the NMO-7079 BCCP Request Form which can be found at: https://dhcfp.nv.gov/Pgms/LTSS/LTSSNursing/. The form must be completed in its entirety including supporting documentation and can be submitted to the DHCFP LTSS Unit at ltss@dhcfp.nv.gov.

a. Supporting Documentation

Supporting documentation includes but is not limited to:

1. Face sheet – including any pertinent diagnoses.

2. Medication Administration Records (MAR) – shows medication(s) the recipient is prescribed and if the recipient is compliant with medication(s). Must include 60-day history.

3. Primary Care Provider (PCP) progress notes – most recent, but not greater than 180 days, including physical examinations demonstrating pertinent diagnosis to support the requested BCCP tier level. Short visits such as vaccine administration is not applicable.

4. Psychiatric notes and/or group therapy notes – must be pertinent to the diagnosis/documented behavior(s).

5. Nurses' notes – must be pertinent to the diagnosis and documented behavior(s).

6. Skin/Wound Assessments, if applicable.

7. Daily progress notes for behavior(s) – must be descriptive of behavior(s) and document when other clinical staff has been notified of behavior(s). Daily checkboxes of behaviors, without supporting notes, do not meet this requirement.

8. Behavioral modification plan, outlining every behavior displayed and corresponding POC for each behavior.

9. Behavior monitor logs – must include detailed description of behavior occurrences.

10. IDT notes, including the Behavior Management team review, completed, at minimum, within the last 180 days.

Facilities should ensure documentation of recipient behavior is recorded promptly and objectively. Supporting documentation is utilized to determine the appropriate tier level. BCCP requests submitted with insufficient documentation to support the requested tier may be pended for five days to allow for additional documentation to be submitted. Absence of sufficient supporting documentation may result in an adverse action on the BCCP request.

b. BCCP Authorization Types

When completing the NMO-7079, the referring individual must indicate the type of authorization being requested. The following are the five types of BCCP authorizations:

1. Pre-Approval Authorization - A request submitted for a recipient, who is pending NF placement from the community or hospital.

2. Initial Authorization – A request submitted for a recipient that does not have an active BCCP authorization at the time of the request.

3. Continued Request Authorization – a request must be submitted within 10 working days, but no more than 30 days, prior to the current authorization end date. If a continued request is received timely and approved, there will be no lapse in the BCCP LOC. If a continued request is not received, the recipient will no longer be authorized for BCCP.

4. Authorization Change Request - For recipients that have an active BCCP authorization, the following Change Requests can be submitted:

   a. Tier Level Change Request – for a recipient who has an active BCCP authorization, and the facility is requesting to decrease or increase the tier level. If a tier change is approved, the authorization time frame will be in alignment with the new tier.

   b. Facility Transfer – If a recipient transfers to a new facility during the current BCCP authorization period, the tier will be honored through the authorization end date.

5. Retroactive Authorization – In certain circumstances a BCCP request can be retroactively backdated. Examples include issues related to enrollment or discrepancies between the BCCP request and information in the EVS Provider Portal. The BCCP original request date will be honored if the discrepancy is resolved within 45 days.

c. BCCP Tier Levels

Tiers have been established to cover the broad range of accommodations needed to meet recipient needs. Behaviors and their frequency of occurrence will assist in determining the appropriate Tier Level authorized. When submitting the NMO-7079, facilities must indicate the tier level being requested. The following is a guide for how the behaviors are evaluated to determine the appropriate tier level:

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.

d. BCCP Tier Evaluation and Timeframes

After the facility submits the NMO-7079 BCCP Request Form and supporting documentation, the requested tier will be evaluated by LTSS Staff based on the frequency and degree of the behaviors exhibited utilizing the BCCP Evaluation Tool. Each behavior reported

on the BCCP Request Form will be individually assessed for its weekly frequency as follows:

Always — the recipient always (daily) requires intervention for behaviors.

Usually — the recipient requires interventions four or more days.

Sometimes — the recipient requires interventions, but fewer than four days.

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 = 4; Usually = 3; Sometimes = 2; Never = 0.

Tier I — 3 to 6 points.

Tier II — 7 to 12 points.

Tier III — 13 and above.

If the BCCP request is approved, each tier is authorized for 180 days. Facilities can view the approved BCCP PA by accessing the EVS Provider Portal.

e. BCCP Notice of Decision (NOD)

When DHCFP takes an adverse action such as a denial, termination, or modification, the facility and recipient will receive an NOD.

1. Denial for Service: Initial BCCP request is denied.

   The applicant does not meet the BCCP eligibility criteria.

2. Termination of Service: Ongoing BCCP request is terminated. The recipient no longer meets BCCP eligibility criteria.

3. Modification of Service: An initial or ongoing request is reduced. The request is approved but modified for a lower tier than requested.

It should be noted that a BCCP adverse action is independent of a recipient's NF standard or ventilator dependent LOC determination.

f. BCCP Provider Responsibilities

Once a recipient is authorized, facilities must demonstrate competency to adequately address the individual's behavior. All behavior intervention programs must:

1. Be part of an individualized behavior modification plan including detailed documentation detailing modifications and interventions utilized to reduce or eliminate behaviors.

2. Incorporate processes and methodologies that prioritize the least restrictive alternatives available to achieve the desired outcomes.

3. Be conducted only after identifying and, if possible, addressing environmental and social factors that are likely to trigger or reinforce the behavior.

4. Incorporate a process for identifying and reinforcing a desirable replacement behavior.

g. 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

At any time, DHCFP may audit provider compliance with administering the BCCP by conducting on-site visits, or by requesting documentation including, but not limited to, medical records, behavior modification plans and nursing notes.

h. BCCP Rates and Reimbursement

1. Those facilities that request and are approved to administer the BCCP are reimbursed with a tiered rate established with the intention of providing in-state care that addresses the recipient's needs.

2. 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.

3. Refer to Medicaid State Plan Attachment 4.19-D for Payment for Long-Term NF Services Methods and Standards.

4. Refer to MSM Chapter 700 for Rates and Supplemental Reimbursement.

5. Refer to the provider billing guide for billing requirements, instructions and specific billing codes.

503.4 NURSING FACILITY TRACKING

Before an NF can receive reimbursement for services rendered for a Nevada Medicaid recipient, the facility must submit an NF Tracking to the QIO-like vendor through the Nevada Medicaid EVS Provider Portal in order to receive authorization to bill.

The purpose of this form is to notify the QIO-like vendor 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.

The facility must submit the NF Tracking through to the QIO-like vendor within 72 hours of any occurrence listed below 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; or

E. Discharge or death.

If the recipient becomes eligible after admission, the NF Tracking must be submitted upon notification of the eligibility determination.

Failure of the facility to submit the NF Tracking may result in payment delays or denials.

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.

503.4A NURSING FACILITY TRACKING PROVIDER RESPONSIBILITIES

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

2. It is the facility's responsibility to verify the recipient's eligibility status monthly by accessing the EVS Provider Portal. Refer to MSM Chapter 100, Medicaid Program, regarding eligibility information.

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

503.5 THERAPEUTIC LEAVE OF ABSENCE

Therapeutic Leave means a recipient leaves the facility for one or more days for reasons outlined in their POC, but not for purposes of hospitalization or transfer to another facility. 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.

503.5A THERAPEUTIC LEAVE OF ABSENCE COVERAGE AND LIMITATIONS

1. 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 POC.

2. Therapeutic leave days are considered overnight stays. Therapeutic leave does not apply when a recipient is out on pass for short periods of time.

3. Therapeutic leave does not include hospital emergency room visits or hospital stays.

503.5B THERAPEUTIC LEAVE OF ABSENCE PROVIDER RESPONSIBILITIES

1. 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.

2. 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.

3. The physicians order should specify:

a. The dates the recipient will be out of the facility;

b. Authorize the facility to provide necessary medications for recipient use during therapeutic leave; and

c. If the recipient does not have the capacity to administer their own medications, then instructions must be included for the family member/friend on how and when to administer the medications.

4. A physician's order such as "may go out on pass" does not meet the requirements for therapeutic leave of absence. The NF must provide care instructions for the responsible person who will be accompanying the recipient during their therapeutic leave of absence.

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

6. 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.

a. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. No portion of the unused leave days may be carried over into the next calendar year.

b. The facility must maintain accurate leave day records on the recipient's chart, for review by Medicaid staff.

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

8. When billing for therapeutic leave of absence days provider must use therapeutic leave of absence code specified on the Provider Billing Guide.

503.5C THERAPEUTIC LEAVE OF ABSENCE RECIPIENT RESPONSIBILITIES

1. The recipient is responsible to abide by the physician's order and to return to the facility by the date specified on the physician's order.

2. The recipient must contact the facility to advise them of any change in the plan regarding therapeutic leave.

503.6 PATIENT INCOME CHANGES AND PATIENT LIABILITY (PL)

PL is the total amount of the institutionalized recipient's income applied to the cost of long-term care in an NF.

503.6A PATIENT INCOME CHANGES AND PATIENT LIABILITY COVERAGE AND LIMITATIONS

1. PL is determined by the Division of Welfare and Supportive Services (DWSS). Regulations require that the State (Nevada Medicaid) reduce its payment to the NF by the amount of the PL.

2. The established PL will be deducted from the Medicaid reimbursement.

   a. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable.

   b. If the PL exceeds the billed charges, no Medicaid reimbursement will be made.

   c. PL will also be applied to subsequent claims submitted by providers entitled to PL until monthly obligations are fulfilled.

503.6B PATIENT INCOME CHANGES AND PATIENT LIABILITY PROVIDER RESPONSIBILITIES

1. When the NF is the recipient's representative payee, the 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 for which the recipient is responsible.

2. When PL is established or changes, the recipient, facility, and the QIO-like vendor 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 QIO-like vendor to receive the appropriate adjustment within 60 days of the notice.

3. 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.

4. 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. Per DWSS policy, facilities must notify DWSS of any admission or discharge. See dwss.nv.gov for policy details and timeframes.

5. 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 discharging and admitting providers are responsible for negotiating the collection of PL.

503.7 PERSONAL TRUST FUND MANAGEMENT

503.7A PERSONAL TRUST FUND MANAGEMENT COVERAGE AND LIMITATIONS

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

2. An NF may not require recipients to deposit their personal funds with the NF.

3. A recipient's personal funds may not be commingled with the NF funds or with the funds of another person.

4. A recipient's personal funds that do not exceed $50 may be maintained in a noninterest-bearing account, interest-bearing account or petty cash fund.

   a. 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).

   b. 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.

5. A recipient's personal funds are for the exclusive use of the recipient. 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 as outlined in Section 503.1A. However, should a recipient request a certain brand or product type, not otherwise supplied, the recipient's personal funds may be used to purchase those items.

6. 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.

7. The facility must not require a recipient (or their representative) to request any item or service as a condition of admission or continued stay.

503.7B PERSONAL TRUST FUND MANAGEMENT - PERSONAL FUND AUDITS

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

    a. 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.

    b. In addition, the NF must make restitution to the recipient's funds improperly handled, accounted for or dispersed.

2. 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.

3. Misuse of recipients' monies is subject to prosecution under NRS 449.240.

503.7C PERSONAL TRUST FUND MANAGEMENT PROVIDER RESPONSIBILITIES

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

2. Per 42 CFR, section 483.13: "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of recipients and misappropriation of recipient property."

3. If the NF is managing the recipient's funds, the facility must obtain authorization from the recipient for purchases made by the NF on the recipient's behalf.

    a. 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.

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

5. In compliance with 42 CFR, Section 483.10(f)(10)(v), within 30 days of the discharge, eviction or death of a recipient, with personal funds deposited with the facility, the facility must convey the recipient's funds and a final accounting of those funds to the recipient, or in the case of death, the individual or probate jurisdiction administering the recipient's estate, in accordance with State law.

6. Upon the death of a recipient, the facility must not use remaining funds to pay debts owed from the deceased recipient but must follow the State regulation at NRS 147.040 to file a claim with the court of jurisdiction for distribution in order of succession. For the Medicaid Estate Recovery (MER) Program, see Medicaid Operations Manual (MOM), Chapter 800, Section 803.7.

503.7D PERSONAL TRUST FUND MANAGEMENT RECIPIENT RESPONSIBILITIES

1. The recipient has the choice to either manage their own personal funds, or to request that the facility manage their personal funds.

   a. If the recipient desires the facility to manage their personal funds, the recipient or their authorized representative must provide the facility with written authorization.

2. Medicaid recipients may choose to spend their personal funds on services of personal care, or specialty items not covered by Medicaid.

503.8 TRANSPORTATION

503.8A TRANSPORTATION COVERAGE AND LIMITATIONS

1. Nursing Facilities are responsible for ensuring that all recipients receive, at minimum, services outlined in Section 503.1A.

2. It is the responsibility of the NF to provide non-emergency medical transportation (NEMT) for Medicaid recipients for all off-site medical and dental appointments and other medically necessary services.

3. Medically necessary NEMT costs for off-site medical services are included in the NF's rate structure.

4. The NF does not have to provide NEMT under the following circumstances:

   a. Initial admission to NF

   b. Discharge from NF

   c. Hospital discharge back to NF

   For the above scenarios, NEMT may be arranged through the NEMT broker in accordance with MSM Chapter 1900 - Transportation Services.

503.9 DISCHARGE REQUIREMENTS

The NF must notify the QIO-like vendor of a Medicaid recipient's discharge or death by updating the NF Tracking.

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

503.9A FACILITY TO FACILITY TRANSFER

1. Discharging Facility: When a Medicaid recipient needs to transfer from one facility to another, the discharging facility must:

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

   b. Obtain written consent from the recipient, their family and/or guardian;

   c. Notify the QIO-like vendor of the transfer by updating the NF Tracking;

   d. Transfer necessary medical records including PASRR evaluations to the admitting facility;

   e. The discharging facility collects the total PL amount up to the Medicaid maximum reimbursement. The established PL will be deducted from the Medicaid reimbursement.

      1. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable.

      2. If the PL exceeds the billed charges, no Medicaid reimbursement will be made~~,~~ and any outstanding PL, as outlined in Section 503.6, will be transferred to the admitting NF with the recipient at the time of transfer;

   f. Document the transfer in the recipient's medical record.

2. Admitting Facility: The admitting facility must submit the NF Tracking to the QIO-like vendor upon admission.

   a. The admitting facility should evaluate the transferring Medicaid recipient for the appropriate LOC. The facility should submit an updated LOC as appropriate.

   b. PASRR – The discharging facility is responsible for ensuring the admitting facility receives copies of the recipient's most recent PASRR and resident assessment reports. See Section 503.2 for PASRR details.

   c. If an NF intends to discharge a recipient, they must provide the recipient/legal representative with a 30-day written notice and include the name and address of the person to whom the recipient/legal representative may appeal the discharge.

503.10 FREE-STANDING NURSING FACILITY – PATIENT DRIVEN PAYMENT MODEL (PDPM) CASE MIX

The MDS/PDPM system is used to classify recipients and objectively determine a free-standing NF's Case Mix Index (CMI). The PDPM classification system was developed by CMS and is the basis for recipients' classification for the Medicare prospective payment system and numerous other states' Medicaid systems. 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 recipients in the facility on the first day of each calendar quarter (called the "picture date").

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

503.10A PROVIDER RESPONSIBILITIES

The provider must assure that each recipient'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.

503.11 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. PDPM data is 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 recipients.

503.11A 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 PDPM items coded with a positive response. Remote reviews will be conducted to verify documentation and/or information coded on the MDS. If deemed necessary, an on-site record review 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 >40% or when any significant increase in errors is identified.

Prior to the review, a sampling of recipients is determined using the most recently submitted MDS data and recipient listing information. The sampling is selected based on the PDPM data submitted on each recipient.

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 recipients regardless of their payment source.

A brief virtual introduction and procedure review meeting is conducted with the facility at the start of the review. The administrator or their designated representative, director of nurses and MDS staff are expected participants in the introduction 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.

503.11B PROVIDER RESPONSIBILITIES

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 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:

   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 s 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.

503.12 HOSPITAL-BASED NURSING FACILITY

503.12A HOSPITAL-BASED NURSING FACILITY 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, such as the BCCP LOC.

503.12B HOSPITAL-BASED NURSING FACILITY PROVIDER RESPONSIBILITIES

1. 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.

2. Hospital-based NFs may bill for ancillary services in addition to room and board.

503.12C HOSPITAL-BASED NURSING FACILITY RATES AND REIMBURSEMENT

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.

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

4. Refer to the Provider Billing Manual for specific billing instructions.

503.13 OUT-OF-STATE NURSING FACILITY PLACEMENT

Nevada Medicaid will only authorize an Out-of-State Placement when all in-state placement options have been exhausted and an Out-of-State provider can better meet the medical needs of the recipient. To request Medicaid approval for an out-of-state placement, the requesting individual must complete the Out-of-State Nursing Facility Placement Packet (FA-30) and submit the following documentation to Nevada Medicaid, LTSS unit, at ltss@dhcfp.nv.gov.

A. Documentation demonstrating 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 any change in Medicaid eligibility may impact out-of-state placement.

503.13A OUT-OF-STATE NURSING FACILTIY PLACEMENT AUTHORIZATION PROCESS

1. Discharging Facility

   If the out-of-state placement is approved, authorization will be provided to the requestor. After receiving the 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 provide authorization to the out-of-state provider.

503.13B OUT-OF-STATE NURSING FACILITY PLACEMENT PROVIDER RESPONSIBILITIES

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

2. Admission/Discharge:

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

3. 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.

503.13C OUT-OF-STATE NURSING FACILITY PLACEMENT RECIPIENT RESPONSIBILITIES

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

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

3. 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.

503.13D OUT-OF-STATE NURSING FACILITY PLACEMENT RATES AND REIMBURSEMENT

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

2. 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 Nevada Medicaid Rates Unit.

3. 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.

4. Billing/Payment Process:

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

   b. If a differential rate is approved, a Letter of Agreement (LOA) will be issued. The LOA must be attached to all claims submitted.

503.14 RATES AND REIMBURSEMENT

1. Refer to Medicaid State Plan Attachment 4.19-D for Payment for Long-Term NF Services Methods and Standards.

2. Refer to MSM Chapter 700 for Rates and Supplemental Reimbursement.

3. Refer to the provider billing guide for billing requirements, instructions, and specific billing codes.

504 HEARINGS

When DHCFP or the QIO-like vendor takes an adverse action such as a denial, termination, or reduction of services, the provider or recipient may appeal the decision and request a Fair Hearing.

A. PASRR Adverse Actions

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

B. LOC Adverse Actions

When the provider does not agree with the QIO-like vendor's LOC adverse determination for standard, ventilator dependent, pediatric specialty care Level 1, and pediatric specialty care Level 2, a peer-to-peer review or a reconsideration review may be requested prior to pursuing a Fair Hearing.

C. BCCP Adverse Actions

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

Please refer to MSM Chapter 3100 - Hearings, for hearings procedure.