MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 12, 2010

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 500 – NURSING FACILITIES

BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 500 has been revised to clarify the authorization process regarding the nursing facility tracking forms.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity.

These policy changes are effective October 13, 2010.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 38/10 CHAPTER 500 – NURSING FACILITIES	MTL 22/03, 02/09, 24/10 CHAPTER 500 – NURSING FACILITIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
503.5	**Billing Authorization – Authorization Process**	Added clarification to the authorization process and that a provider will be subject to recoupment for claims submitted and paid in error.
505	**References and Cross References**	Updated chapter titles.

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NURSING FACILITIES

500 INTRODUCTION

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

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in the Nevada Check Up Manual, Chapter 1000.

501 AUTHORITY

In 1965, Congress authorized the Medicaid Program by adding Title XIX to the Social Security Act. Title XIX of the Social Security Act requires that in order to receive Federal matching funds, certain basic services including nursing facility services for individuals age 21 and older must be offered to the categorically needy population in any State program. States may also receive Federal funding if they choose to provide other optional services. As an optional service, Nevada Medicaid also provides nursing facility services for individuals under the age of 21.

502 DEFINITIONS

ASSESSMENT REFERENCE DATE

The Assessment Reference Date (ARD) is the common date on which all MDS observation periods end. The ARD is the last day of the MDS observation period and controls what care and services are captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. The ARD is located on the MDS 2.0, Section A3a.

BILLING AUTHORIZATION

Billing Authorization is a notification sent to a provider giving authorization to bill for services within a specified time frame.

BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE

The Bureau of Health Care Quality and Compliance (HCQC) is a state agency located within the Health Division within the Department of Health and Human Services. The HCQC provides both state licensure and Medicare/Medicaid certification to all health facilities in Nevada. They conduct routine surveys and investigate complaints against health facilities. The HCQC monitors the quality of care and quality of life issues related to nursing facility residents based on state and federal regulations.

CASE MIX

Case Mix means a measure of the intensity of care and services used by similar residents in a facility. Case Mix measures the relative resources required to care for a given population of nursing facility residents. Within and between nursing facilities, resident needs may vary widely, from residents requiring near full-time skilled nursing assistance to residents requiring only minimal assistance.

CASE-MIX INDEX

Case-Mix Index (CMI) means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

CENSUS INFORMATION

Census information must be based on a nursing facility’s occupancy as of midnight (00:00 hour) on the first day of every month.

CODE OF FEDERAL REGULATIONS

The Code of Federal Regulations (CFR) is a codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the Federal Government. The Code is divided into 50 titles which represent broad areas subject to Federal regulation. Skilled nursing facilities (SNF) and nursing facilities (NF) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B to receive payment under either the Medicare or Medicaid program.

DIRECT CARE COMPONENT

Direct care component means the portion of Medicaid reimbursement rates that are attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.

ELIGIBILITY NOTICE OF DECISION

Eligibility Notice of Decision is the notification sent to an individual by the Nevada State Welfare Division giving eligibility decisions regarding their application for Medicaid services.

LEVEL OF CARE SCREENING

Level of Care (LOC) Screening is a screening assessment conducted prior to admission for all Medicaid eligible recipients and is used to determine if a recipient's condition requires the level of services offered in a nursing facility or whether the recipient would qualify for a less restrictive service which may be community based.

LEVEL I IDENTIFICATION SCREENING

Level I Identification screening is the initial screening assessment conducted in the PASRR program. It is used to identify individuals suspected of serious mental illness, mental retardation and/or related conditions. Every nursing facility applicant, regardless of payer source, must be screened prior to admission to a nursing facility.

MEDICAID ESTATE RECOVERY

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

MINIMUM DATA SET

Minimum Data Set (MDS) refers to a federally required resident assessment tool. Information from the MDS is used by the Division for determining the Medicaid average CMI to adjust the direct care component of each free-standing nursing facility's rate.

NON-DIRECT CARE COMPONENT

Non-direct care component means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

NURSING FACILITY

Nursing Facility (NF) is a general nursing facility, free-standing or hospital-based, which is licensed and certified by the Health Division, Bureau of Health Care Quality and Compliance (HCQC), and provides both skilled and intermediate nursing services.

NURSING FACILITY TRACKING FORM

The Nursing Facility Tracking Form (tracking form) is the form used as a notification for all nursing facility admissions, service level updates, new or retro-eligibility determinations, Hospice enrollment or disenrollment, Medicaid Managed Care disenrollment, discharges and deaths. The information provided on this form is used in determining how and when a nursing facility will be paid for services rendered.

PASRR LEVEL II

PASRR Level II is the evaluation conducted when the Level I Identification screen indicates the individual may have a mental illness, mental retardation or related condition. PASRR Level II determines (1) whether the individual requires NF services and (2) whether the individual requires specialized mental health services.

PERSONAL NEEDS ALLOWANCE

Personal Needs Allowance is the amount of money deducted from the recipient's monthly income when the cost of care is calculated. The personal needs allowance is $35.00 per month and is intended for the exclusive use of the recipient as he/she desires for personal items such as clothing, cigarettes, hair styling, etc.

PICTURE DATE

Picture Date is a “snapshot” of residents’ MDS data in Nevada’s free-standing nursing facilities and is collected for rate-setting purposes. A CMI report is generated based on the picture date which is the first day of each calendar quarter (January 1, April 1, July 1 and October 1).

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Pre-Admission Screening and Resident Review (PASRR) is a federally mandated program to determine whether nursing facility applicants and residents require nursing facility services and specialized services. Congress developed the PASRR program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities.

RESIDENT

Resident is a person being cared for in a nursing facility.

RESIDENT ASSESSMENT INSTRUMENT

Resident Assessment Instrument (RAI) is a comprehensive assessment of a resident’s needs. At a minimum it includes the MDS and utilization guidelines which include the Resident Assessment Protocols (RAPs).

RESIDENT ASSESSMENT INSTRUMENT USER’S MANUAL

Resident Assessment Instrument User’s Manual (RAI Manual) is the Long Term Care Resident Assessment Instrument User’s Manual issued by the CMS covering the MDS, Resident Assessment Protocols and Utilization Guidelines.

RESIDENT ASSESSMENT PROTOCOLS

Resident Assessment Protocols (RAPs) are structured, problem oriented frameworks for organizing MDS information, and examining additional clinically relevant information about a resident. RAPs are used as the basis of individualized care planning.

RESIDENT LISTING REPORT

Resident Listing Report is a report based on data obtained from the CMS MDS repository and used to ensure accurate input for the payment system. Each free-standing nursing facility is asked to provide input for appropriate corrections to the report on a quarterly basis in conjunction with the rate setting process.

RESIDENT PERSONAL FUNDS

Resident Personal Funds are funds entrusted to a nursing facility by a resident which are in the possession and control of the nursing facility and are held, safeguarded, managed and accounted for by the facility in a fiduciary capacity for the resident.

RESOURCE UTILIZATION GROUPS

Resource Utilization Groups (RUG-III) is a classification system which uses information from the MDS assessment to classify nursing facility residents into a series of groups representing the residents' relative direct care resource requirements. The MDS assessment data is used to calculate the RUG-III Classification necessary for payment. 108 MDS assessment items are used in the RUG-III Classification system to evaluate the resident's clinical condition.

REVENUE CODE

Revenue code is the code used on billing forms which identifies a specific accommodation, ancillary service or billing calculation.

THERAPEUTIC LEAVE OF ABSENCE (LOA)

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

503 POLICY

503.1 PROGRAM PARTICIPATION

503.1A COVERAGE AND LIMITATIONS

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

1. Be licensed by the Nevada State Health Division, Bureau of Health Care Quality and Compliance (HCQC) in accordance with the Nevada Revised Statute (NRS) and the Nevada Administrative Code (NAC).

2. Be certified by the Nevada State Health Division, HCQC and the Centers for Medicare and Medicaid Services (CMS) which assures that the nursing facility meets the federal requirements for participation in Medicaid and Medicare per 42 CFR 483.

3. Be approved to participate as a nursing facility provider in the Nevada Medicaid program as described in Chapter 100 of the Medicaid Services Manual (MSM).

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

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

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

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

503.1B PROVIDER RESPONSIBILITY

The nursing facility provider must maintain current State Licensure and Medicare/Medicaid Certification.

The provider must obtain and maintain a Nevada Medicaid provider number.

The provider must accept as payment in full for covered services, the amounts paid in accordance with Medicaid policy and not charge a Medicaid recipient for any services covered by Medicaid reimbursement.

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

The provider must comply with federally mandated staffing requirements which must be met by the nursing facility in order to maintain Medicare/Medicaid certification.

All Medicaid participating nursing facilities must provide or arrange for services including nursing services, social services, rehabilitative services, pharmacy services, dietary, activity programs, emergency dental services and routine dental services to the extent covered under the State Plan, treatment and services required by the mentally ill and mentally retarded not otherwise provided or arranged for by the State, and all other ancillary and supportive services necessary to improve and/or maintain the overall health status of its residents in accordance with the federal statutory and regulatory requirements under 42 CFR 483 and the state regulations under NRS 449 and NAC 449.

The nursing facility must ensure that each Medicaid recipient is admitted to the facility by a physician and has the benefit of continuing health care under the supervision of a physician. The nursing facility is responsible to ensure that upon admission, the physician provides to the facility sufficient information to validate the admission with a medical plan of care to include diet, medications, treatments, special procedures, activities and specialized rehabilitative services, if applicable, and the potential for discharge. Physician's visits must be conducted in accordance with federal requirements. Physician's visits made outside the requirements must be based upon medical necessity criteria.

The nursing facility must maintain records on each recipient in accordance with accepted professional standards and practices. Recipient records must be complete, accurately documented, organized and readily available. At a minimum, the record must contain sufficient information to identify the recipient, a record of the recipient's assessments, the plan of care and services ordered and provided the results of Pre-Admission Screening and Resident Review (PASRR) screenings, the results of Level of Care (LOC) Assessment screening, and progress notes. The record must also contain relevant documentation to support the Minimum Data Set (MDS) coding. All entries must be signed and dated with the professional title of the author.

The provider must report monthly the census information including the number of vacant beds in the facility which is available for resident occupancy on the day the information is reported.

The provider must provide for the safekeeping of personal effects, funds, and other property of the recipient. The provider must develop policies and procedures to minimize the risk of theft or loss of the personal property of residents. Recipients and their legal representatives must be notified of these policies and procedures. The nursing facility must be adequately covered against liabilities and purchase a surety bond or otherwise provide assurance of the security of all personal funds deposited with the facility.

503.1C RECIPIENT RESPONSIBILITY

Present, upon request, a valid Medicaid card.

Furnish the nursing facility provider with any forms of identification necessary to utilize other health insurance coverage for any and all services.

503.2 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

A. AUTHORITY

Authority to maintain a PASRR program comes from Public Law 100-203 (OBRA 87) in Subtitle C - Nursing Home Reform Part 2 - Section 1919(b)(3)(F); Title 42, CFR (Code of Federal Regulations) section 483.100 – 483.138; an Interagency Agreement between the Division of Health Care Financing and Policy (DHCFP) - Nevada Medicaid and the Division of Mental Health and Developmental Services (MHDS); the Nevada State Plan, attachment 1.2-B, page 10; NAC 449.74425 and NRS 449.037.

The DHCFP, Nevada Medicaid, is responsible for development of policies and procedures and the oversight of all operations related to the PASRR program. DHCFP contracts with the QIO-like vendor to conduct Level I Identification screenings and PASRR Level II evaluations and determinations and to act as the mental health/mental retardation authority through a Memorandum of Understanding (MOU) with MHDS. MHDS is designated to provide and/or follow up on all specialized services. The HCQC monitors and investigates compliance with PASRR through the survey process.

B. DEFINITIONS

LEVEL I IDENTIFICATION SCREENING

A Level I Identification screening must be completed by a licensed health care professional on all applicants to a nursing facility, without exception and regardless of payment source, prior to placement in a Medicaid-certified nursing facility. The licensed health care professional completing the Level I Identification Screening form attests that the individual (or appropriate family and/or guardian) has been informed that he/she is being considered for nursing facility placement. This screening is also required for residents of a nursing facility any time a Level II is requested; such as, when a current nursing facility resident experiences a significant change in his/her physical or mental status or a prior PASRR Level II needs to be updated. The purpose of this screening is to identify any indicators of Mental Illness (MI), Mental Retardation (MR), or a Related Condition (RC) and to make referrals for PASRR Level II screenings. The Level I determination will be that the individual either has or does not have indicators of MI, MR, or RC. If there are no indicators of MI, MR, or RC, the individual is cleared through

PASRR screening for admission to a nursing facility. The QIO-like vendor will issue a determination letter to the requestor.

If there are indicators of MI, MR, or RC a determination letter is given to the requestor and the individual screened and/or their legal representative that they are being referred for a PASRR Level II screening. A PASRR Level II screening must be completed to determine nursing facility appropriateness prior to admission to a nursing facility.

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

C. EXEMPTED HOSPITAL DISCHARGE

The only exemption from a PASRR Level II screening is when a Level I Identification screening showing indicators of MI, MR, or RC identifies the applicant meets *all* the following criteria for an exempted hospital discharge:

1. An individual who 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); and

2. Who requires NF services for the condition for which he or she received care in the hospital; and

3. Whose attending physician has certified before admission to the NF that the individual is likely to require less than 30 days of nursing facility services.

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

D. PASRR LEVEL II SCREENING

When an individual has been identified with possible indicators of MI, MR or RC, a PASRR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility.

There are two types of PASRR Level II screenings. Pre-Admission Screening (PAS) refers to a PASRR Level II screening completed on an applicant for nursing facility placement. Resident Review (RR) refers to a PASRR Level II screening completed on a current resident of a nursing facility who experiences a significant change in his/her physical or

mental condition, or had previously been exempted from or was time-limited under a prior PASRR Level II. Within the Level II, there are two processes, a categorical determination or an individual evaluation and determination.

E. ADVANCED GROUP CATEGORICAL DETERMINATIONS

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

1. Convalescent Care from an acute physical illness which required hospitalization and does not meet all the criteria for an exempted hospital discharge.

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; or

   b. emergency situations requiring protective services with placement in the NF not to exceed 7 days; or

   c. respite to in-home caregivers to whom individuals with MI or MR is expected to return following a brief NF stay.

If it is determined the individual meets one of the above criteria, the QIO-like vendor's clinical reviewer will make a categorical determination. If the determination is for an advanced group categorical determination, the determination effective dates may be limited and will require an updated PASRR Level II (RR) if the individual's stay is expected to exceed the limitation date (see below).

F. PASRR LEVEL II INDIVIDUAL EVALUATION AND DETERMINATION

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

When the PASRR Level II is completed, a Summary of Findings determination letter will be provided by the QIO-like vendor to the individual screened or their legal representative, attending physician, discharging hospital or requestor, and the admitting facility (upon their request).

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

503.2A COVERAGE AND LIMITATIONS

1. COVERAGE

The QIO-like vendor will issue (verbally and in writing) a determination upon completion of the Level I and Level II (when indicated) screenings. The determination letter includes the dates the Level I or Level II screening is valid.

The QIO-like vendor may assign time limitations to categorical determinations.

2. LIMITATIONS

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

a. An individual is admitted to a nursing facility without a Level I. Medicaid reimbursement is not available until the date a Level I is completed, if there are no indications of MI, MR or RC.

b. An individual with indicators of MI, MR or RC is admitted to a nursing facility before the completion of the PASRR Level II evaluation; unless an Exempted Hospital Discharge has been approved through Level I process (see below). Medicaid reimbursement is not available until the date the Level II evaluation is completed indicating nursing facility placement is appropriate.

c. A provider who fails to obtain a completed PASRR Level II Individual Determination evaluation by day 40 of an admission under the Exempted Hospital Discharge. Medicaid reimbursement is not available until the date the PASRR II evaluation is completed indicating nursing facility placement is appropriate.

d. A provider fails to obtain a Resident Review Level II Individual Evaluation prior to the limitation date of a previously limited categorical determination. Medicaid reimbursement is not available until the PASRR II evaluation is completed indicating nursing facility placement is appropriate.

e. A provider fails to request a Nevada screening within one business day of admission when a resident is admitted to a Nevada nursing facility from out of state. No Medicaid reimbursement is available until the date the Nevada Level I and, when indicated, the Level II is completed.

f. For individuals who have been determined, through the PASRR process, to not need the services of a nursing facility.

503.2B PROVIDER RESPONSIBILITY

1. GENERAL ONGOING

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

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

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

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

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

2. LEVEL I

Prior to admission, the provider must verify the completion of a Level I Identification Screening that is valid and accurately reflects the individual's current medical and/or mental health status, and that clears the individual for nursing facility placement.

The provider may accept the verbal determination from the QIO-like vendor.

The provider must not admit an individual until a screening determination has been made and the individual has been determined appropriate for nursing facility services by the QIO-like vendor.

3. ADMISSIONS FROM OTHER STATES

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

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

4. LEVEL II

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

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

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

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

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

The provider may accept verbal determinations from the QIO-like vendor.

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

5. COORDINATION AND/OR PROVISION OF SPECIALIZED SERVICES

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

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

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

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

6. DISCHARGES

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

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

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

7. RECORD MAINTENANCE

The provider must maintain a copy of the Level I Identification screening and/or determination letter completed prior to admission, in the resident's active medical record.

In addition to the Level I completed prior to admission, the provider must maintain the most recently completed Level I Identification screening and/or determination letter in the resident's active medical record.

The provider must maintain when applicable, the PASRR Level II determination letter completed prior to admission in the resident's active medical record. In addition to the Level II completed prior to admission, the provider must retain the most current PASRR Level II (RR) determination letter in the active medical record.

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

503.2C HEARINGS

In accordance with 42 CFR 483.204 Subpart E, an individual who has been adversely affected by any PASRR determination made by the State in the context of either a PAS or a RR under Subpart C of part 483 has the right to appeal that determination.

Please reference Nevada MSM Chapter 3100, for Medicaid Recipient Hearing policy.

503.3 LEVEL OF CARE (LOC)

503.3A COVERAGE AND LIMITATIONS

A LOC screening is to be completed by a licensed health care professional on all Medicaid eligible individuals seeking nursing facility placement to determine if the individual meets nursing facility level of care criteria. The LOC assessment also assesses individuals for the possibility of qualifying for other less restrictive services, which may be community-based, or to qualify for waiver services. The nursing facility must request a new LOC determination when it appears the resident no longer meets a nursing facility standard LOC.

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

On initial and subsequent screenings, the QIO-like vendor determines whether the LOC provided or to be provided should be approved based on medical necessity. There are four possible LOC categories based on the care needs and nursing requirements for each individual as determined by the level of care assessment. These include: NF Standard, NF Ventilator Dependent, Pediatric Specialty Care I and Pediatric Specialty Care II. Each of these categories is associated with a provider specific rate for each free-standing nursing facility.

1. NF Standard encompasses the majority of recipients.

2. NF Ventilator Dependent is limited to recipients who are dependent on mechanical ventilation for a minimum of 6 out of the 24 hours per day and is an all-inclusive rate. Nursing facilities and respiratory therapists are not allowed to bill separately for ventilator management services, small volume nebulizer treatments, tracheostomy changes, etc.

3. 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 nursing facility recipients. To qualify for these rates, a nursing facility must meet certain criteria and be approved by the DHCFP staff. In addition to the Provider Qualifications listed below, the criterion for Pediatric Specialty Care I and II include:

   Pediatric Specialty Care I:

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

   Pediatric Specialty Care II:

   The patient's condition requires 25 hour access to nursing care by a registered nurse and the recipient has one or more of the following items (a-c): (a) A tracheostomy that requires mechanical ventilation a minimum of 6 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.

Treatment Procedures

a. Intermittent suctioning at least every (8) hours and mist or oxygen as needed;

b. Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy);

c. IV therapy involving:

1. Administration of continuous therapeutic agents; or

2. Hydration; or

3. Intermittent IV drug administration of more than (1) agent.

d. Peritoneal dialysis treatments requiring at least (4) exchanges every 24 hours

e. Tube utilization (nasogastric or gastrostomy; Foley, intermittent catherization; PEG, rectal tube)

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

g. Seizure precautions

h. Moderate behavior issues (including self-abuse) – describe the problem behavior, frequency and severity

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

j. Maximum assist required (quadriplegia or Hoyer lift)

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

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

The QIO-like vendor must determine the recipient meets both a NF LOC as well as a Pediatric Specialty Care LOC prior to authorization. Pediatric Specialty Care rates are approved for a maximum of six months but may be extended with an updated LOC screening and supporting documentation. If a new authorization is not obtained prior to

expiration of the previous specialty care authorization, the nursing facility will be reimbursed at the NF standard rate until such time a new pediatric specialty care LOC is determined.

Provider Qualifications for Pediatric Specialty Care Rates:

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

l. Physical facility requirements:

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

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

m. Staffing Requirements:

1. The nursing facility must employ a Registered Nurse (RN) as the Pediatric Specialty Care Unit's head nurse. The head nurse must have specialized pediatric training and at least one year's experience in pediatric nursing.

2. The nursing facility must ensure that an RN with pediatric training and experience is no duty 24 hours per day on the Pediatric Specialty Care Unit.

4. ITEMS INCLUDED IN THE PEDIATRIC SPECIALTY CARE RATE

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

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

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

condensers, in-line temperature measuring devices, and calibration and maintenance services.

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.

If a Medicaid eligible recipient is admitted to a nursing facility without a LOC screening, Medicaid reimbursement will not be available for service dates prior to the completion date of a LOC screening acknowledging the need for nursing facility services.

Periodic LOC reviews will be conducted by Medicaid staff to determine whether Medicaid recipients continue to meet a nursing facility level of care once they have resided in the nursing facility for a period of time. If a nursing facility level of care is not met, a determination letter will be sent to the recipient stating they no longer meet a nursing facility level of care and Medicaid reimbursement will end 30 days from the date of the notification letter. The facility will also be notified in writing that the recipient's discharge must be arranged within 30 days.

If the discharge planner needs further assistance, a referral can be made to the Facility Outreach and Community Integration Services (FOCIS) program. Program staff can be reached through the DHCFP District Offices.

503.3B PROVIDER RESPONSIBILITY

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

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

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

The requestor must submit a LOC screening form with the required documentation to the QIO-like vendor. A LOC determination must be received from the QIO-like vendor prior to admission for Medicaid eligible individuals.

Level of care determinations may be time limited. Reasons for time limitations may include, but are not limited to: total hip or knee replacement, compound fracture, pneumonia, recent wound care. These determinations may be limited to 90 days.

Additional documentation requirements:

1. NF Ventilator Dependent Rate: a physician's order specifying the ventilator support must accompany the screening request. Current medical records must verify that ventilator support is required for a minimum of 6 hours within a 24 hour period. The medical records must also include the date the recipient was placed on the ventilator.

2. Pediatric Specialty Care I or II: providers must complete and submit a Screening Request for Pediatric Specialty Care Services form in addition to the LOC form.

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

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

The provider must request an updated LOC determination if a recipient's condition changes significantly. For example, if a recipient who was previously determined to meet a NF Standard or Pediatric Specialty Care I later becomes ventilator dependent, the nursing facility must request a new screening determination to establish ventilator dependant 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 nursing facility must request a new determination to establish Pediatric Specialty Care I or NF Standard.

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

In the event a recipient is discharged to a community based setting and is later readmitted to the nursing facility, the nursing facility 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.

503.3C AUTHORIZATION PROCESS

The QIO-like vendor will complete LOC screenings in the following timeframes depending on the source of the screening request:

1. Acute care facility - within one business day of receipt of a screening request and the appropriate medical information.

2. Nursing facility – within three business days of receipt of a screening request and the appropriate medical information.

3. Community setting – within three business days of receipt of a screening request and the appropriate medical information.

Once the LOC determination is made by the QIO-like vendor and the individual meets nursing facility placement criteria, the requestor will be notified. Confirmation of the LOC will be sent to the requestor in writing.

503.4 NURSING FACILITY TRACKING

503.4A COVERAGE AND LIMITATIONS

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

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

This form is also used to track discharges that occur from the NF based on recommendations of the PASRR II evaluation. All discharges, regardless of pay source, that are directly related to a PASRR determination must be reported to the Medicaid office on the Nursing Facility Tracking Form. This information must be reported to CMS by Medicaid on an annual basis.

503.4B PROVIDER RESPONSIBILITY

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

1. Any admission;
2. Service level update and/or change;
3. New or retro-eligibility determinations;
4. Medicaid Managed Care disenrollment;
5. Hospice enrollment or disenrollment; or
6. Discharge or death.

If the resident becomes eligible after admission, the tracking form must be submitted upon notification of the eligibility determination. Refer to the form instructions on how to complete this form.

503.4C RECIPIENT RESPONSIBILITY

The recipient must furnish the provider with any forms of identification necessary to utilize other health insurance coverage for any and all services.

503.5 BILLING AUTHORIZATION

503.5A COVERAGE AND LIMITATIONS

Billing authorization is required to receive Medicaid reimbursement for nursing facility services. The resident must be eligible for Medicaid in order to receive reimbursement from Nevada Medicaid for services. A billing authorization will not be given for the resident whose eligibility status is pending.

Billing authorizations become invalid immediately upon any discharge from the facility, death, service level change, enrollment to Hospice coverage, or if the recipient becomes ineligible for Medicaid for more than 6 months.

503.5B PROVIDER RESPONSIBILITY

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

The facility must submit the Nursing Facility Tracking Form to the Medicaid Central Office to initiate a billing authorization.

The facility must verify that the necessary PASRR and LOC screenings are completed within appropriate time frames. Providers must monitor time-limited PASRR and LOC screenings and request an updated screening prior to the expiration date in order to extend Medicaid reimbursement.

It is the facility's responsibility to monitor the recipient's eligibility status. Month-by-month eligibility status can be verified by accessing the Eligibility Verification System (EVS), referencing the Notice of Decision (NOD) sent by the Division of Welfare and Supportive Services (DWSS) Office, or verifying information on the Medicaid card. Refer to MSM, Chapter 100 regarding eligibility information.

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

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

503.5C AUTHORIZATION PROCESS

Upon receipt of the Nursing Facility Tracking Form, verification may be made of the PASRR and LOC determinations.

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

If the resident loses Medicaid eligibility during the authorized billing time frame, the following applies: If the resident's case is reinstated or re-approved within 6 months of the beginning payment date listed on the billing authorization, the facility may resume billing if there is no change (i.e. discharge, service level change, etc.) to the existing nursing facility stay. If more than 6 months has elapsed, the facility must submit a new Nursing Facility Tracking Form to obtain a new billing authorization.

503.6 PATIENT LIABILITY (PL)

503.6A COVERAGE AND LIMITATIONS

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

503.6B PROVIDER RESPONSIBILITY

A nursing facility must notify the 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 nursing facility.

When PL is established or changes, the recipient, facility and the fiscal agent are notified of the amount and effective date. Collection of PL is the facility's responsibility. If a nursing facility receives a notice adjusting the amount of the PL and the facility has billed and received reimbursement for services, the facility must send a corrected claim to the fiscal agent to receive the appropriate adjustment within 60 days of the notice. The Surveillance and Utilization Review Section will follow-up to assure the appropriate adjustment has been completed.

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

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

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

503.7 THERAPEUTIC LEAVE OF ABSENCES

503.7A COVERAGE AND LIMITATIONS

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

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

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

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

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

503.7B PROVIDER RESPONSIBILITY

Each therapeutic leave of absence must be authorized by the attending physician's order to ensure the recipient is medically stable and capable of safely tolerating the absence. The physician's order should specify the dates the recipient will be out of the facility, authorize the facility to send necessary medications, and provide instructions for the family member/friend on how and when to administer the medications. A physician's order such as "may go out on pass" is not acceptable for this purpose. The nursing facility must provide care instructions for the responsible person who will be accompanying the recipient during their therapeutic leave of absence.

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

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

503.7C RECIPIENT RESPONSIBILITY

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

503.8 PERSONAL TRUST FUND MANAGEMENT

503.8A COVERAGE AND LIMITATIONS

A nursing facility resident has the right to manage his or her financial affairs. A nursing facility must hold, safeguard and account for a resident's personal funds upon written authorization from the resident in accordance with all applicable provisions in state and federal law.

503.8B PROVIDER RESPONSIBILITY

Nursing facilities must have a system for managing resident's funds that, at a minimum, fully complies with the requirements established by Federal law and State regulations relating to the accountability requirements related to resident personal fund management.

A nursing facility may not require residents to deposit their personal funds with the nursing facility. If a Medicaid recipient requests the facility manage their personal funds, the facility must obtain prior written authorization from the recipient.

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

A recipient's funds in excess of $50 must be maintained in an interest bearing account in a local bank insured by FDIC. Interest earned must be credited to the recipient's account.

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

Recipient's personal needs money is for the exclusive use of the recipient, as desired. The recipient's personal funds must not be used to purchase items covered by Medicaid either directly or indirectly as part of the facility's daily rate. Upon a recipient's request, specialty items not

covered by Medicaid may be purchased for the recipient. In this instance, accurate accounting records must be kept including the recipient's authorization for payment.

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

The nursing facility must notify each recipient when the amount in the recipient's personal fund account reaches $200 less than the SSI resource limit for one person.

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

PERSONAL FUND AUDITS

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

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

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

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

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

503.8C RECIPIENT RESPONSIBILITY

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

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

503.9 TRANSPORTATION

503.9A COVERAGE AND LIMITATIONS

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

503.9B PROVIDER RESPONSIBILITY

It is the responsibility of the nursing facility to provide non-emergency transportation for Medicaid recipients for all off-site medical and dental appointments and other medically necessary services. Medically necessary non-emergency transportation costs are included in the nursing facility's rate structure.

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

Refer to MSM, Chapter 1900, for transportation policies.

503.10 ROUTINE SERVICES AND SUPPLIES

503.10A COVERAGE AND LIMITATIONS

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

1. All general nursing services including: the administration of oxygen and related medications; the collection of all laboratory specimens as ordered by a physician such as blood and urine; injections; hand feeding; incontinency care; normal personal hygiene which includes bathing, skin care, hair care or nail care (excluding professional barber and beauty services), shaving, oral hygiene, enemas, etc.

2. Social work services and activity programs: nursing facility staff will provide these services as necessary in order to carry out the plan of care for the Medicaid recipients.

3. Maintenance therapy programs: facility staff will assist the Medicaid recipients as necessary under the guidelines of the recipient's restorative therapy program. Programs are intended to maintain and/or restore specific function(s).

4. Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins, bedpans, etc.

5. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually such as alcohol, applicators, cotton balls, band aids, disposable gloves, incontinency care products including disposable diapers, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, T.E.D. (antiembolism) stockings, hydrogen peroxide, OTC enemas, tests (Clinitest, Testape, Ketostix, Accu-chek), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or specialized cleansing agents, razor, shaving cream, denture adhesive, dental floss, tooth-brushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, sanitary napkins and related supplies, etc).

6. Items which are used by individual residents but which are reusable and expected to be available, such as canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, IPPB machine, electric nebulizers, other durable medical equipment, oxygen concentrators, ventilators, etc.

7. Laundry services, including personal clothing.

503.10B PROVIDER RESPONSIBILITY

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

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

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

503.11 SERVICES AND SUPPLIES NOT INCLUDED IN PER DIEM RATES

503.11A COVERAGE AND LIMITATIONS

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

Items not included in the Medicaid per diem rate include:

1. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.

2. Nutritional supplements in conjunction with tube feedings.

3. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.

4. Non-standard wheelchairs including power-operated vehicles, wheelchair seating systems, including certain pressure reducing wheelchair cushions needed for the Medicaid recipient's permanent and full time use, etc.

5. Air fluidized bed units and low air loss bed units.

6. Emergency transportation.

7. Physical, Occupational and Speech therapy services.

8. Physician services.

9. Laboratory, portable x-ray and other diagnostic services.

10. Repair of medical equipment and appliances which belong to the recipient.

503.11B PROVIDER RESPONSIBILITY

1. Non-nursing facility providers must reference the appropriate MSM for specific coverage and limitation policies related to the services and supplies not included in the nursing facility per diem. Providers must abide by the associated rules and prior authorization guidelines before providing an item or service to a recipient.

2. Provider must check for a valid Medicaid card and question the recipient/legal representative about other insurance coverage.

503.11C RECIPIENT RESPONSIBILITY

1. Furnish providers with any forms of identification necessary to utilize other health insurance coverage for any and all services and supplies.

2. Provide written authorization to the provider and nursing facility if purchasing services and supplies not covered in the per diem.

503.11D AUTHORIZATION PROCESS

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

503.12 MONTHLY FACILITY OCCUPANCY REPORT

503.12A COVERAGE AND LIMITATIONS

The purpose of occupancy reporting is to notify Nevada Medicaid's central office of the actual census of a facility on a monthly basis. The Monthly Facility Occupancy Report form is to be completed by all in-state nursing facilities statewide. Information reported is used to determine available beds (vacancies) in the state in the event of emergency situations when residents need to be relocated, to provide statistical information to the legislature and others, and for numerous statistical reports. Providers can view the statewide monthly occupancy statistics on DHCFP's website at http://www.dhcfp.nv.gov.

The Monthly Facility Occupancy Report will be posted on the DHCFP website by the 20th day of each month.

503.12B PROVIDER RESPONSIBILITIES

The facility is responsible for ensuring the census information provided on the report is accurate, complete and submitted timely. The information is based on the facility occupancy as of midnight (00:00 hour) on the first day of the month.

The facility must submit this report to Nevada Medicaid Central Office by the fifth day of the month reported. For example, the January 1st census information must be reported to the Nevada Medicaid Central Office by January 5th.

If the number of certified beds has changed, the facility must submit a copy of the certification to Nevada Medicaid.

The Monthly Facility Occupancy Report form may be accessed from DHCFP's website at http://www.dhcfp.nv.gov which includes completion and submission instructions.

503.13 DISCHARGE REQUIREMENTS

503.13A COVERAGE AND LIMITATIONS

Nevada Medicaid does not reimburse nursing facilities for the date of discharge or date of death.

503.13B PROVIDER RESPONSIBILITY

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

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

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

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

2. Obtain written consent from the recipient, his/her family and/or guardian;

3. Notify the Medicaid Central Office of the transfer by sending the Nevada Medicaid Nursing Facility Tracking form.

4. Transfer necessary medical/social/LOC/PASRR information to the receiving facility;

5. The discharging facility collects the total PL amount up to billed charges. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made and the balance of the collected PL must be transferred to the receiving nursing facility with the recipient at the time of transfer.

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

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

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

503.13C HEARINGS

Non Medicaid residents: A nursing facility resident (regardless of pay source) who receives a notice from the nursing facility of the intent to discharge may submit their appeal to the DHCFP for processing of the hearing request on this notice.

Medicaid recipients: Please reference Nevada MSM Chapter 3100, for Medicaid Recipient Hearing policy.

503.14 MEDICAID ESTATE RECOVERY

503.14A COVERAGE AND LIMITATIONS

The estate recovery mandate of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) requires states to develop programs to recoup the costs of long term care and related Medicaid services from the estates of deceased beneficiaries.

In Nevada, the Medicaid Estate Recovery (MER) Unit, located within the DHCFP, administers this program for Medicaid recipients 55 years of age and older.

503.14B PROVIDER RESPONSIBILITY

When a Medicaid recipient expires, the facility should at no time tell the personal representative that the recipient's personal trust fund is theirs to keep.

The amount of the recipient's trust fund and to whom the fund was released will be provided to the MER Unit upon request.

The facility must not use any remaining money from the recipient's personal trust fund after the recipient has expired for outstanding debts owed to the facility.

The Welfare District Office prorates patient liability for the month of death. In the event of a patient liability refund, the facility must release the refund to either the personal representative or the MER Unit.

42 CFR 483.10 requires the facility to convey the resident's personal trust fund deposited with the facility within 30 days of the death of a resident, along with a final accounting, to the individual or probate jurisdiction administering the resident's estate. If the public administrator's office does not represent the Medicaid recipient, and/or refuses to accept the personal trust fund, the fund may be sent directly to the MER Unit with a Check Release form. The Check Release form must accompany all checks mailed to the MER Unit or the checks will be returned to the facility. The Check Release Form is available from the DHCFP's website at http://dhcfp.nv.gov.

503.15 FREE-STANDING NURSING FACILITY – RUG-III CASE MIX

503.15A COVERAGE AND LIMITATIONS

The MDS/Resource Utilization Groups, Version III (RUG-III) classification system is used to classify residents and objectively determine a free-standing nursing facility's case mix index (CMI). RUG-III was developed by the CMS and is the basis for resident classification for the Medicare prospective payment system and numerous other states' Medicaid systems. Nevada uses the 34-group version that collapses the special rehabilitation category into four groups. CMS recommends this version for use with Medicaid nursing facility resident populations. CMS has also developed standard CMI based on time studies performed during the middle to late 1990s, and these indices will be the basis for calculating the average CMI, or score, for each nursing facility under Nevada's case-mix system.

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

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

503.15B PROVIDER RESPONSIBILITY

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

Comprehensive assessments, quarterly assessments, significant change assessments and annual assessments using the MDS 2.0 must be conducted in accordance with the requirements and frequency schedule found at 42 CFR section 483.20.

The provider must assure that the Resident Listing Report is accurate and submitted within the specified time limit every calendar quarter.

The provider must furnish the number of direct care staff necessary to incur direct care costs at least equal to 94% of the direct care median. This is Medicaid's rule regarding the minimum amount of direct care staff allowable and does not replace or negate the federally mandated staffing requirements which must be met by the NF in order to maintain Medicare/Medicaid certification.

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

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

503.16A COVERAGE AND LIMITATIONS

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

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

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

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

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

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

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

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

503.16B PROVIDER RESPONSIBILITY

1. The provider must possess thorough knowledge of the Resident Assessment Instrument (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 Division's website at http://www.dhcfp.nv.gov.

4. The provider must promptly provide information requested by the review team.

5. The provider must make certain the appropriate staff attends the entrance and exit meetings.

6. The provider must prepare in advance and provide to review staff at the beginning of the entrance meeting:

   a. copies of the selected MDS' (containing the attestation statement and completion signatures of staff) which review staff will use during the review and keep as a permanent part of the facility's review packet;

   b. the active medical records selected for review; and

   c. thinned/purged files and records maintained by the facility in various workbooks which contain information that supports the coding of the MDS'.

7. Facility staff responsible for the MDS must be available to Medicaid review staff during the review process.

8. The provider must analyze the error reports with the appropriate facility staff responsible for coding the MDS.

9. The provider must identify and make corrections to processes that contribute to inaccurate MDS coding. 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.

503.17 HOSPITAL-BASED NURSING FACILITY

503.17A COVERAGE AND LIMITATIONS

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

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

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

503.17B PROVIDER RESPONSIBILITY

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

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

Refer to the Provider Billing Manual for specific billing instructions.

503.18 OUT OF STATE NURSING FACILITY PLACEMENT

503.18A COVERAGE AND LIMITATIONS

Out-of-state nursing facility services may be reimbursed, if it is the general practice of Nevada Medicaid recipients living in a particular locality to customarily receive medical services from out-of-state providers (e.g., Nevada counties that border other state lines); or if a Nevada Medicaid recipient is authorized to travel to another state for approved medical services that are not available in Nevada; or when there is no available in-state nursing facility that is able to meet a particular Nevada Medicaid recipient's needs. The recipient must be eligible for Nevada Medicaid services and meet a nursing facility admission level of care. Out-of-state nursing

facilities are generally reimbursed at their own state's Medicaid rate. However, a differential "add-on rate" may be approved for a Nevada Medicaid recipient who is identified with a severe medically based behavior disorder or another medical condition for which care cannot be adequately provided in Nevada. Transportation between Nevada and an out-of-state nursing facility is a Nevada Medicaid benefit. Contact the Transportation Broker to arrange transportation services.

503.18B PROVIDER RESPONSIBILITY

1. IN-STATE PROVIDER RESPONSIBILITY

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

a. Documentation supporting that all the appropriate nursing facilities in Nevada were contacted for in-state placement and placement was denied. The documentation should include the reasons Nevada nursing facilities denied admission.

b. If the recipient was denied admission to in-state nursing facilities due to severe behavior symptoms, a current psychosocial narrative is required.

c. A PASRR screening indicating nursing facility placement is appropriate.

d. LOC screening indicating the recipient meets nursing facility placement criteria.

e. Written statement from the recipient (recipient's family/guardian) concurring with out-of-state placement, indication of who will be responsible for making health care decisions on the recipient's behalf, and that the recipient's (recipient's family/guardian) acknowledge that Medicaid benefits end with death.

f. The written statement must also include the understanding that burial and funeral arrangements must be made outside of Medicaid intervention. Documentation to show that every effort was made to purchase/obtain a burial policy if the individual does not have funeral or burial coverage.

2. OUT-OF-STATE PROVIDER RESPONSIBILITY

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

a. 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.

b. Eligibility:

Verification of Medicaid eligibility is the provider's responsibility. Eligibility should initially be verified by validating the recipient's Medicaid card. Thereafter, eligibility should be checked monthly by checking the Medicaid card, contacting the eligibility staff at the Welfare office hot line, or utilizing the EVS.

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

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

c. Reimbursement:

Out-of-state nursing facilities are generally reimbursed at their own state's Medicaid rate.

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

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

d. Billing/Payment Process:

Out-of-state nursing facilities must adhere to Medicaid's billing policies. Refer to the Provider Billing Manual for complete billing instructions.

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

Out-of-state providers must submit their claims to the Medicaid fiscal agent using the billing claim form within one year from the date of service. If eligibility is determined after the date of service, claims must be received within one year from the eligibility date of decision.

503.18C RECIPIENT RESPONSIBILITY

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

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

503.18D AUTHORIZATION PROCESS

1. IN-STATE PROVIDER

Out-of-state nursing facility admission requires approval from Nevada Medicaid with the exception of those recipients living in a particular locality (Nevada counties that border other state lines) and who customarily receive their medical services from out-of-state providers.

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

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

2. OUT-OF-STATE PROVIDER

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

504 HEARINGS

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

505 REFERENCES AND CROSS REFERENCES

505.1 Please consult other chapters of the Medicaid Service Manual which may correlate with Chapter 500, Nursing Facility Services:

Chapter 100 Medicaid Program
Chapter 200 Hospital Services
Chapter 300 Radiology Services
Chapter 600 Physician Services
Chapter 700 Rates and Cost Containment
Chapter 800 Laboratory Services
Chapter 1000 Dental
Chapter 1100 Ocular Services
Chapter 1200 Prescribed Drugs
Chapter 1300 DME, Disposable Supplies and Supplements
Chapter 1700 Therapy
Chapter 1900 Transportation
Chapter 3100 Hearings
Chapter 3300 Program Integrity
Chapter 3600 Managed Care Organization

505.2 FORMS

A. Screening forms for PASRR, LOC and Pediatric Specialty Care may be obtained from Magellan Medicaid Administration, Inc. (the QIO-like vendor) website at http://nevada.fhsc.com or by contacting the QIO-like vendor at 1-800-595-5395.

B. The following forms may be obtained from the DHCFP website at http://www.dhcfp.nv.gov or by contacting the DHCFP office at (775) 684-3676:

1. Nursing Facility Tracking Form.

2. Monthly Occupancy Report Form.

3. MER Check Release Form.

C. Information regarding the UB-92 (form CMS-1450) claims billing form may be obtained at the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

505.3 MAGELLAN MEDICAID ADMINISTRATION, INC.

Provider Relations Department
Magellan Medicaid Administration, Inc.

PO Box 30026
Reno, Nevada 89520-3026
Toll Free within Nevada (877) NEV-FHSC (638-3472)
Email: nevadamedicaid@fhsc.com

PRIOR AUTHORIZATION DEPARTMENTS

Magellan Medicaid Administration, Inc.
Nevada Medicaid and Nevada Check Up
HCM
4300 Cox Road
Glen Allen, VA 23060
(800) 525-2395

PHARMACY POINT-OF-SALE DEPARTMENT

Magellan Medicaid Administration, Inc.
Nevada Medicaid Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042
(800) 884-3238