MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 25, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
CHIEF OF DIVISION COMPLIANCE
Casey Angres (Jun 20, 2023 15:09 PDT)

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 – MEDICAID PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program are being proposed to the whole chapter.

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

Entities Financially Affected: All enrolled Nevada Medicaid provider types.

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

These changes are effective April 26, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/23	MTL 19/15; 03/19; 04/18; 06/19; 14/17; 08/17; 15/19; 04/19
MSM Chapter 100 – Medicaid Program	MSM Chapter 100 – Medicaid Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
100	**Introduction**	Added new language that the MSM has additional chapters and an Addendum. Each MSM chapter and Addendum can be found at: https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/.
100(D)		Added new Subsection D on types of National Provider Identifier (NPI) numbers.
100.1	**Authority**	Updated names of authorities. Added missing authorities.
100.2(A)(1)(b)	**Confidential Information**	Added new language on requirements of de-identified data for elements of dates.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
101.2	**Nevada Medicaid and NCU Card**	Added new language on the Nevada Medicaid app.
101.2A(2)	**Eligibility Verification and Card Use**	Note added regarding prior verification of identity and potential for recoupment.
102	**Provider Enrollment – Conditions of Participation (1)**	Updated name of section. Removed opening paragraph to Section 102.
102(A – I)		Added new language to Section 102 and all subsections to further reflect provider enrollment requirements associated with disclosures, responsibility, delegation of authority, NPI numbers, screening, provider responsibility to maintain contact information in the Provider Web Portal, and for-cause terminations. Additionally, clarification is added to CHOWs and business structure, and the requirement of providers to notify CMS when a change in ownership occurs. When applicants submit information which is false, untrue or misleading, information has been added for clarification, as well as language which further clarifies provider standards requirements for the duration of enrollment.
102.1	**Request for Enrollment, Re-Enrolment and Revalidation – Conditions of Participation (2)**	Updated name of section. Added new language to reflect enrollment requirements for initial enrollment, re-enrollment, and revalidation.
102.2	**All Providers and Applicants – Conditions of Participation (3)**	Updated name of section.
102.2(A)(3)		Added three additional High-Risk providers.
102.2(B)		Added new Subsection B to describe the responsibility of applicants to provide accurate information and consequence for failing to do so.
102.2(D)		Added new Subsection D to describe the responsibility of providers to provide accurate information for enrollment and continued enrollment.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.2(E)		Added new Subsection E to define "Convicted."
102.2(F)		Added new Subsection F to list examples of crimes and/or offenses for convictions which deem an applicant or provider ineligible for enrollment or continued enrollment. Added new #10 to list in Subsection F to include a person who holds, or previously held, five percent or more direct or indirect control or ownership which was convicted.
102.2(G)		Added new Subsection G to list examples of events and/or circumstances in which an applicant or provider is not eligible for new or ongoing participation. Added clarification to existing bullets on overpayments, exclusions, revocation/suspension. Added new bullets (#6 - #14) regarding non-cooperation with a DHCFP request, license or credential restriction, payment suspension or willful disregard of policy, returned mail, false information, non-enrolled individuals rendering services, entity or individual who help ownership or interest in an entity convicted under Medicare, Medicaid, CHIP or Title XX, or any other state or federally funded assistance program. Updated #15 requirement to disclose convictions for evaluation.
102.2(I)		Added new Subsection I for when the Fiscal Agent shall not enroll a group provider which is not structured according to licensure, and the responsibility of applicants and providers to understand the requirements of their business model and certifications and license necessary to conduct business.
102.2(K)		Added new Subsection K regarding enrollment of Out-of-State/Out-of-Catchment providers, and clarification on full enrollment versus temporary/cross-over enrollment.
102.2(L)		Added new Subsection L which require providers to report to the DHCFP circumstances which requires additional oversight from the DHCFP.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.2(O)		Added new language on failure to timely submit or failure to retain adequate documentation for services billed to Nevada Medicaid and resulting consequences.
102.3	**Enhanced Provider Screening – Conditions of Participation (4)**	Updated name of section.
102.3(B)		Added new language on risk level adjustment.
102.4	**Provisional Enrollment – Conditions of Participation (5)**	Updated name of section.
102.5	**Out-of-State Provider Participation – Conditions of Participation (6)**	Updated name of section. Added new language that out-of-state enrollments may be temporary, full enrollment, or enrollment for Medicare cross-over claims only, and all enrollments are at the discretion of DHCFP.
102.6	**Urgent/Emergent Services Outside the State of Nevada – Conditions of Participation (7)**	Updated name of section. Added new language regarding payment to urgent/emergent providers.
102.7	**Facility Disclosure – Conditions of Participation (8)**	Updated name of section.
102.8	**Provider Disclosure – Conditions of Participation (9)**	Updated name of section.
102.8(A)(9)		Added new #9 to list in Subsection A that any change in contact information must be reported within five business days.
102.9	**Disposition of Contract for Providers – Conditions of Participation (10)**	Updated name of section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
102.10	**Certification Statement – Conditions of Participation (11)**	Updated name of section.
102.10(A)		Added new language throughout Subsection A regarding certification statement, delegation of authority, disclosure of board member(s) requirement, and claims submissions.
102.12	**Contract Denial**	Added new language throughout section, including clarifying language on DHCFP's obligation, falsified information, provider's documented history of "Waste" or "Abuse," and failure to permit a site visit.
102.13	**Voluntary Termination**	Updated name of section. Added new language for when a provider can be sanctioned.
102.14	**Ordering, Prescribing, or Referring (OPR) Providers**	Added new section to define ordering, prescribing, or referring providers.
102.15	**Enrollment with Managed Care Organization (MCO) Providers**	Added new section to outline requirements for providers who want to enroll and maintain enrollment with Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), and Dental Benefits Administrator (DBA).
103(E)	**Provider Rules and Requirements**	Added new Subsection E that terminated providers have the obligation to refer recipients to other providers for ongoing services and/or care.
103.9	**Non-Discrimination and Civil Rights Compliance**	Added language to be in compliance with the Civil Rights Act.
103.9(D)		Added new language regarding limited English proficiency and vital documents.
103.9(G)		Added new language regarding community registered sign language interpreters.
103.10	**Advance Directive (AD)**	Added new language throughout the section and subsections regarding statutory requirements of Advance Directives per Nevada Revised Statute

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		(NRS) 449A Care and Rights of Patients. Removed outdated language.
103.11	**Supported Decision-Making**	Added new section regarding statutory requirements for Supported Decision-Making per NRS 162C Supported Decision-Making Act.
103.13	**Medical Record Documentation**	Added new section enumerating the specific requirements for medical record documentation.
104	**Third Party Liability (TPL) – Other Health Care Coverage**	Added new language regarding adoption/surrogacy agreements/contracts to introduction paragraph.
104(J)		Added new Subsection J to add adoption/surrogacy agreements/contracts to TPL.
104.1(G)	**Payment Limits and Exceptions**	Added new Subsection G to add new language for encounter providers and TPL.
104.1(H)		Added new language regarding payments or denial letters from Other Health Care Coverage. Removed outdated language.
104.1(I)		Added new language regarding services that are not covered under Other Health Care Coverage. Removed outdated language.
104.1(J)		Added new language regarding delays in payment from Other Health Care Coverage.
104.1(L)		Added new #4 to list in Subsection L regarding Individualized Education Program.
105.1(F)	**Medicaid Payment to Providers**	Added new language that all claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes and adhere to national coding standards. Providers must also comply with Nevada Medicaid Billing Manual and Billing Guides. Removed outdated language.
105.1(I)		Added new language regarding “incident to” billing.
105.1(N)		Added new Subsection N regarding Medicaid payments.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
105.1(O)		Added new Subsection O regarding Letters of Agreement.
105.2B	**Billing Time Frames (Stale Dates)**	Added new language regarding billing time frames and Third-Party Liability.
105.3(A)	**Billing Medicaid Recipients**	Added new Subsection A to add references and clarify Medicaid payment is payment in full; Providers may not attempt to collect additional money from recipients; Providers cannot bill recipients for covered services or remaining balances; All covered services must be billed to Nevada Medicaid.
105.3(C)		Added new language to Subsection C regarding signed written agreements.
106	**Contract Terminations**	Added new language that providers who terminate from Nevada Medicaid must assist in care coordination for the recipients they serve.
106.2(A)	**Conditions of Contract Terminations**	Added new language to Subsection A regarding immediate terminations which includes license restrictions, revocation by CMS, any licensing Board or termination/sanction by any State's Medicaid program, inactive license, and new bullets #16 - 20 to include ownership/interest in a sanctioned individual and/or entity, failure to fully cooperate with any DHCFP investigation, audit, review, existing overpayment and no repayment agreement or default on agreement, ownership/interest in a group/entity convicted of any offense in a DHHS program, and CMS or another State has terminated the individual, owner and/or group "for-cause."
106.2(B)		Added new language to Subsection B regarding advance notice of termination in instances of investigation under the rules and governance of licensure and/or returned mail.
106.3	**Sanction Periods**	Removed existing sanction language and replaced with more concise language, regarding the extension of termination and sanction actions beyond the initial group or individual termination/sanction action.
106.3(A)(4)(g)		Added new language in Subsection A to include abandonment or vulnerable persons.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
106.3(B)(2)		Added new language in Subsection B to include a sanction when a provider has failed to produce reports as requested.
106.3(B)(3)(h)		Removed #h.
106.3(C)(8-10)		Added new #8 – #10 to Subsection C to include additional Tier 3, Three Year Sanctions.
106.3(D)(4)(b)		Added new #b to Subsection D, #4 to include additional Tier 4, 12-Month Sanction with a change to the status of any license required for participation with Nevada Medicaid.
106.3(E)(2)		Added new #2 to Subsection #E to include additional Immediate Re-Application requirements and language which indicates that Nevada Medicaid is not obligated to enroll, re-enroll or re-validate providers.
106.6(A)(4-5)	**Suspension**	Added new #4 - #5 to Subsection A to include additional requirements to when a provider may be suspended from Nevada Medicaid.
108	**References**	Added new language on where to find current References online. Removed list of contact information of References as they easily become outdated.
110	**Nevada Medicaid Provider Types**	Added new language on where to find current provider types online. Removed list of provider types as they easily become outdated.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MEDICAID PROGRAM

100 INTRODUCTION

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

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

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

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

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

3. restrain the growth of health care costs; and

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

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

1. individuals;

2. groups and/or entities;

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

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

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

1. individual providers;

2. groups and/or entity providers;

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

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

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

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

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

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

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

100.1 AUTHORITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. NRS Chapter 193 – Criminality Generally.

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

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

26. NRS Chapter 199 – Crimes Against Public Justice.

27. NRS Chapter 200 – Crimes Against the Person.

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

29. NRS Chapter 232 – State Departments.

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

31. NRS Chapter 432 – Public Services for Children.

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

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

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

100.2 CONFIDENTIAL INFORMATION

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

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

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

A. Definition of Confidential Information

For the purposes of this manual, confidential information includes:

1. Protected Health Information (PHI)

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

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

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

b. the provision of health care to the individual;

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

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

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

2. Information on social and economic condition or circumstances.

3. Division/Department evaluation of personal information.

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

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

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

B. Limitations on Use and Disclosure

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

1. Establishing eligibility;

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

3. Determining third party liability;

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

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

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

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

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

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

C. Release of Information

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

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

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

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

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

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

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

D. Penalties

Penalties for inappropriate use and disclosure of confidential information are:

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

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

E. Ownership

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

101 OVERVIEW OF PROGRAMS

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

A. Medicaid

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

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

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

B. Nevada Check Up (NCU)

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

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

Section 1915(c) of the SSA permits states the option to waive certain Medicaid statutory requirements in order to offer an array of Home and Community-Based Services (HCBS) to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. Each 1915(c) Waiver is designed to provide eligible Medicaid waiver recipients access to both state plan services, as well as certain

extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes, or community settings, when appropriate.

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

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

101.1 OUT-OF-STATE SERVICES

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

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

A. needed because of a medical emergency.

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

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

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

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

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

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

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

101.2 NEVADA MEDICAID AND NCU CARD

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

101.2A ELIGIBILITY VERIFICATION AND CARD USE

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

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

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

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

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

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

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

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

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

101.2B CHILD WELFARE RECIPIENTS

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

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

101.2C RESTRICTIONS

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

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

102 PROVIDER ENROLLMENT – CONDITIONS OF PARTICIPATION (1)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. CHANGE OF OWNERSHIP (CHOW)

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

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

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

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

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

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

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

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

D. CHOW Enrollment:

1. is not guaranteed,

2. is considered a new enrollment,

3. must meet all enrollment requirements for the specified provider type,

4. must be reported within 35 days of completion.

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

4. a conviction;

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

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

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

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

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

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

E. PROHIBITED FROM ENROLLMENT CONSIDERATION

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

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

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

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

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

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

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

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

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

6. Failure to permit a site visit;

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

8. Failure to disclose current or previous state employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. on-site inspection prior to enrollment;
2. review of business records;
3. data searches; and/or
4. provisional enrollment.

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

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

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

A. The following indicates categorical risk levels for providers:

1. Limited categorical risk:

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

   b. Ambulatory surgical centers.

   c. End-stage renal disease facilities.

   d. Federally qualified health centers.

   e. Histocompatibility laboratories.

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

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

   h. Mammography screening centers.

   i. Mass immunization roster billers.

   j. Organ procurement organizations.

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

   l. Radiation therapy centers.

   m. Religious non-medical health care institutions.

   n. Rural Health Clinics.

   o. Skilled nursing facilities.

2. Moderate categorical risk:

   a. Ambulance service suppliers.

   b. Community mental health centers.

   c. Comprehensive outpatient rehabilitation facilities.

d. Hospice organizations.

e. Independent clinical laboratories.

f. Independent diagnostic testing facilities.

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

h. Portable x-ray suppliers.

i. Revalidating home health agencies.

j. Revalidating Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers.

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

3. High categorical risk:

a. Newly enrolling home health agencies.

b. Newly enrolling DMEPOS suppliers.

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

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

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

B. Applicants are responsible for the accuracy and veracity of all information and documentation submitted for enrollment consideration. Applicants are not removed from this requirement/responsibility by virtue of assigning another the authority to submit a request for enrollment on their behalf. Applicants who are found to have submitted falsified documentation, provide false information to any question on any application, or who have otherwise failed to properly and accurately disclose requested information, including any person who holds authority, control, or interest of five percent or more in any entity, shall be denied enrollment and serve a 12-month sit-out. The enrollment application is specific in its questions and does not limit the time frame for which convictions or other negative action should or should not be disclosed. See MSM Addendum for definition of "Convicted."

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

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

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

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

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

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

F. The following list, though not exhaustive, provides examples of crimes and/or offenses which indicate a provider or applicant is not eligible for new or ongoing participation:

Any conviction of the following:

1. Murder, voluntary manslaughter or mayhem;

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

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

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

5. False imprisonment, involuntary servitude or kidnapping;

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

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

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

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

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

G. The following list, though not exhaustive, provides examples of events and/or circumstances which may indicate a provider or applicant is not eligible for new or ongoing participation:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

K. The enrollment of Out-of-State/Out-of-Catchment (OOS/OOC) area providers is at the discretion of DHCFP, with the exception of Urgent/Emergent enrollment. As such, OOS/OOC enrollment or revalidation requests are reviewed for Program and recipient need. Applicants and providers are not guaranteed enrollment with Nevada Medicaid, and although full enrollment may be requested (at initial and/or revalidation), enrollment is at the discretion of DHCFP. Example: an OOS provider, fully enrolled at initial application may have, at revalidation, enrollment limited to cross-over claims only. Conversely, an OOS provider initially enrolled for cross-over claims only may be fully enrolled at revalidation, if requested, all conditions of participation are met, and full enrollment is in the best interest of the Nevada Medicaid Program and its recipients.

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

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

N. The provider is responsible for understanding and abiding by the requirements of this Chapter, the Provider Contract and the Chapter governing their provider type as stated in the Nevada MSM, along with all local, state, and federal requirements. The provider should

also be familiar with MSM Chapter 3100 – Hearings and MSM Chapter 3300— Program Integrity.

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

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

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

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

Nevada Division of Child and Family Services
Attn: Child Abuse and Neglect Records Check
4126 Technology Way, 1st Floor
Carson City, NV 89706

For additional information and authorization forms please contact:

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

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

1. conducted pre- or post-enrollment;

2. announced and/or unannounced; and/or

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

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

102.3 ENHANCED PROVIDER SCREENING – CONDITIONS OF PARTICIPATION (4)

A. CATEGORICAL RISK

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

1. Limited categorical risk:

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

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

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

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

2. Moderate categorical risk:

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

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

3. High categorical risk:

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

   b. provider consents to a criminal background check; and

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

B. RISK LEVEL ADJUSTMENT

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

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

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

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

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

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

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

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

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

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

102.4 PROVISIONAL ENROLLMENT – CONDITIONS OF PARTICIPATION (5)

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

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

owed to:

a. any State or the Federal Government;

b. Medicare;

c. Medicaid;

d. an MCO; and/or

e. a Prepaid Ambulatory Health Plan (PAHP).

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

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

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

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

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

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

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

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

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

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

4. A Change of Ownership is reported and any of the purchasing and/or new

owners/officers report any conditions noted in Section 102.

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

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

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

   a. any State or the Federal Government;

   b. Medicare;

   c. Medicaid;

   d. an MCO; and/or

   e. a PAHP

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

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

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

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

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

1. Permit site visits (announced or unannounced);

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

3. Attend provider training recommended by DHCFP;

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

and/or

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

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

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

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

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

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

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

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

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

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

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

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

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

A provider outside of the State of Nevada who furnishes authorized goods and services under the Nevada medical assistance program to eligible Nevada residents visiting another state and urgently requiring care and services shall be exempt from the full enrollment process as long as that provider

is properly licensed to provide health care services in accordance with the laws of the provider's home state and enrolled as a Medicaid provider in the provider's home state to furnish the health care services rendered. The intent of Urgent/Emergent enrollment is to pay claims to an out-of-state provider who renders services to a single Nevada Medicaid recipient for a single instance of care. Refer to the Provider Enrollment Information Booklet for enrollment instructions.

102.7 FACILITY DISCLOSURE – CONDITIONS OF PARTICIPATION (8)

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

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

A. Documents subject to disclosure include:

1. survey reports, including a statement of deficiencies;
2. official notifications of findings based on the survey;
3. written plans of correction submitted by the provider to the survey agency;
4. ownership and contract information specified below; and
5. reports of post-certification visits and summaries of uncorrected deficiencies.

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

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

1. name and address of each person with an ownership or control interest in the discloser, or in any subcontractor in which discloser has direct or indirect ownership of five percent or more;
2. whether any of the persons named is related to another as spouse, parent, child, or sibling; and
3. name of any other disclosing entity in which a person with an ownership or controlling interest in the discloser also has ownership or controlling interest.

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

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

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

102.8 PROVIDER DISCLOSURE – CONDITIONS OF PARTICIPATION (9)

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

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

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

3. conviction of any offense. Providers and/or applicants reporting convictions other than those listed in Section 102.2(B), All Providers and Applicants – Conditions of Participation (3), are not automatically precluded from enrollment. The Fiscal Agent will forward these applications or change forms to DHCFP Provider Enrollment Unit for consideration on a case-by-case basis. Providers and/or applicants must provide information, documentation, and explanation regarding each conviction;

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

5. any current open/pending court cases;

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

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

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

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

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

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

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

102.10 CERTIFICATION STATEMENT – CONDITIONS OF PARTICIPATION (11)

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

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

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

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

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

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

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

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

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

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

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

102.11 CONTRACT APPROVAL

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

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

102.12 CONTRACT DENIAL

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

A. The DHCFP will refuse to enter into a contract with an applicant for provider enrollment in the Medicaid program if the applicant:
   1. does not meet the conditions of participation as stated in this Chapter, all inclusive;

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

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

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

5. submits false or falsified information;

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

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

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

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

102.13 VOLUNTARY TERMINATION

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

102.14 ORDERING, PRESCRIBING, OR REFERRING (OPR) PROVIDERS

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

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

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

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

102.15 ENROLLMENT WITH MANAGED CARE ORGANIZATION (MCO) PROVIDERS

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

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

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

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

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

103 PROVIDER RULES AND REQUIREMENTS

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

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

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

1. referrals to other Medicaid providers are appropriate.

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

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

4. claims submitted are only for services rendered.

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

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

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

103.1 MEDICAL NECESSITY

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

1. diagnose, treat or prevent illness or disease;

2. regain functional capacity; or

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

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

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

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

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

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

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

103.2 AUTHORIZATION

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

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

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

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

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

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

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

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

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

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

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

103.3 PROVIDER REPORTING REQUIREMENTS

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

B. Within five working days, providers are required to report changes which may affect enrollment status. All changes are to be reported on the form prescribed in the online *Provider Enrollment Booklet*. Below are examples of changes effective after enrollment which shall be reported (not all inclusive):

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

103.4 CONDITIONS OF REPORTING

A. All changes, with the exception of change in ownership, must be reported in writing on the form prescribed in the online *Provider Enrollment Information Booklet* and require the

signature of the provider. If the provider is a business, the change must include the signature of the owner or administrator. Medicaid will not change any provider record without proper signatures. Annual 1099 forms reflect the information in Medicaid's records and may be incorrect if changes are not reported timely.

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

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

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

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

103.5 EMPLOYEE EDUCATION ABOUT FALSE CLAIMS

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

A. These providers are required to:

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

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

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

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

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

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

103.6 COVERAGE AND LIMITATIONS

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

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

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

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

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

4. provide documentation of employees having received the information.

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

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

103.7 SAFEGUARDING INFORMATION ON APPLICANTS AND RECIPIENTS

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

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

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

103.8 MEDICAL AND PSYCHOLOGICAL INFORMATION

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

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

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

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

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

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

103.9 NON-DISCRIMINATION AND CIVIL RIGHTS COMPLIANCE

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

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

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

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

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

1. admissions;

2. access to and provisions of services; or

3. employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

103.10 ADVANCE DIRECTIVE (AD)

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

A. Administration of Advance Directives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

103.11 SUPPORTED DECISION-MAKING

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

A. SDM aims to:

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

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

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

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

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

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

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

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

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

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

103.12 MUTUAL AGREEMENT IN PROVIDER CHOICE

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

103.13 MEDICAL RECORD DOCUMENTATION

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

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

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

D. Appropriate documentation is a necessary element of service provision. The actual rendering provider must complete and sign the documentation before they, or the billing provider (whether an individual or an organization), submits a claim to Medicaid for reimbursement. The provider who receives payment from Medicaid is required to maintain all medical record documentation.

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

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

1. Recipient’s name;

2. Date of service;

3. Place of service;

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

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

6. Procedure code or type of service provided;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

104.1 PAYMENT LIMITS AND EXCEPTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

L. Exceptions to the TPL rule are:

1. Indian/Tribal Health Services (IHS);

2. Children with Special Health Care Needs; and

3. State Victims of Crime.

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

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

104.2 SUBROGATION – COST SAVINGS PROGRAM

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

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

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

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

104.3 HEALTH INSURANCE PREMIUM PAYMENTS (HIPP)

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

105 MEDICAID BILLING AND PAYMENT

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

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

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

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

3. not dependent on the collection of the payment.

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

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

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

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

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

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

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

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

105.1 MEDICAID PAYMENTS TO PROVIDERS

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

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

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

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

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

F. All claims submitted for payment must use the appropriate and current CPT, HCPCS, and ICD codes, and the claims must adhere to national coding standards. Additionally, the provider must comply with the Nevada Medicaid Billing Manual and Billing Guidelines.

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

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

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

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

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

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

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

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

Group practices should make certain that rebilling shows the same service codes, the same physician's name, and the same Medicaid provider number. If it should be necessary to

alter the billing to show different codes or descriptors, providers are to submit an adjusted or voided claim to the Fiscal Agent through the Provider Portal.

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

O. Letters of Agreement

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

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

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

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

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

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

The RAD Unit of DHCFP is responsible for administering the provision of this section. The RAD Unit will negotiate a provider-specific reimbursement agreement within the constraints of the Medicaid State Plan and the MSM. All agreements under this section are

not final until they are fully executed by the Division's Administration. Additional and detailed information related to LOA is available in MSM Chapter 700, Section 705, LOAs or inquiries can be submitted to rates@dhcfp.nv.gov.

105.1A EXTENDED SERVICES

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

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

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

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

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

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

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

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

105.2 REIMBURSEMENT

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

105.2A LIMITATIONS

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

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

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

4. Provider Preventable Conditions

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

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

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

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

   d. Foreign object retained after surgery.

   e. Air embolism.

   f. Blood incompatibility.

   g. Surgical site infection following:

      1. Coronary artery bypass graft.

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

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

   h. Stage III and IV pressure ulcers.

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

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

k. Catheter-associated urinary tract infection.

l. Vascular catheter-associated infection.

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

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

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

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

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

105.2B BILLING TIME FRAMES (STALE DATES)

Providers must bill Medicaid for all claims within the specific time frame set by Medicaid. To be considered timely, claims must be received by the Fiscal Agent within 180 days from the date of service or the date of eligibility decision, whichever is later. For out-of-state providers or when a TPL resource exists, the timely filing period is 365 days. Any claims submitted after the stale date

will be denied for payment. Providers have the right to appeal any claim denials. This section is not related to WRAP Supplemental Payment Program. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), must refer to the respective Billing Guides for WRAP Supplemental Payment Program timely filing guidelines.

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

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

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

    b. The provider must still submit the Explanation Of Benefits (EOB) and/or documentation from the primary insurance carrier.

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

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

105.2C DISPUTED PAYMENT

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

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

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

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

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

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

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

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

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

105.3 BILLING MEDICAID RECIPIENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   b. The physician orders the discharge of the patient;

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

   d. The recipient refuses to leave.

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

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

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

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

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

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

G. Providers may bill Medicaid recipients when the recipient does not disclose Medicaid eligibility information at the time the service is provided. As a rule, all providers seek payment source information from recipients/patients before services are rendered. Any recipient not declaring their Medicaid eligibility or pending eligibility, and thus denying

the provider the right to reject that payment source, is viewed as entering into a “private patient” arrangement with the provider.

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

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

106 CONTRACT TERMINATIONS

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

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

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

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

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

106.1 TERMINATION FOR CONVENIENCE

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

106.2 CONDITIONS OF CONTRACT TERMINATIONS

A. Immediate Terminations

The DHCFP may decide to immediately terminate a provider contract if any of the following occurs, is discovered, or reported:

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

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

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

4. The provider is deceased.

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

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

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

8. The identity of the provider cannot be proven.

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

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

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

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

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

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

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

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

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

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

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

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

B. Advance Notice of Termination

An advance Notice of Intent (NOI) to terminate must be mailed no less than 20 days from the intended action date if DHCFP determines to terminate the contractual relationship.

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

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

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

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

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

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

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

7. An administrative contract termination has been performed;

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

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

106.3 SANCTION PERIODS

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

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

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

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

A. Tier 1 – Permanent Sanction

1. Provider is on the OIG exclusion list.

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

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

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

   a. Murder, voluntary manslaughter, mayhem or kidnapping;

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

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

d. False imprisonment or involuntary servitude;

e. Criminal neglect of patients per the NRS 200.495;

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

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

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

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

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

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

B. Tier 2 – 10-Year Sanction

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

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

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

a. Assault or battery;

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

c. Harassment or stalking;

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

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

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

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

C. Tier 3 – Three-Year Sanction

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

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

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

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

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

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

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

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

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

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

D. Tier 4 – 12-Month Sanction

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

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

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

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

   a. CHOW;

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

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

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

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

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

E. Immediate Re-Application

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

   a. Loss of contact;

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

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

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

106.4 PROCEDURES FOR TERMINATION AND NON-RENEWAL

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

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

A. a description of proposed action;

B. the effective date of the proposed action;

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

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

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

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

106.4A ADMINISTRATIVE CONTRACT TERMINATIONS

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

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

1. death of the provider;

2. loss of contact;

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

4. when the sole issue is a change in federal law.

106.5 MEDICAID AGENCY ACTION AFTER REVIEW, AUDIT OR INVESTIGATION

The DHCFP may initiate a corrective action plan against a provider as the result of an

investigation, audit and/or review.

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

A. U.S. DHHS;

B. U.S. Department of Justice;

C. Nevada Medicaid SUR staff;

D. MFCU;

E. Nevada Medicaid Program Integrity staff;

F. Nevada Medicaid audit staff;

G. DHCFP Audit Contractors;

H. Fiscal Agent staff;

I. ADSD staff; or

J. Other state and/or county agencies.

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

106.5A CORRECTIVE ACTIONS

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

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

   b. Seriousness of the problem(s);

   c. Number of current and past violations;

   d. Past sanctions applied; and

   e. Other available services.

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

   a. Educational contact may be used when minor errors are detected and may be in the form of a telephone call, on-site visit or a letter by DHCFP or Fiscal Agent staff.

Educational contact is made for the purpose of instructing a provider in policy compliance, correct billing procedures, program benefit limitations and to correct identified errors in billing or requests for services not covered by Medicaid.

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

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

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

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

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

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

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

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

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

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

106.6 SUSPENSION

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

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

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

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

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

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

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

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

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

106.6A PROCEDURES FOR SUSPENSION

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

1. a description of proposed action;

2. the effective date of the proposed action;

3. the length of suspension;

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

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

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

107 RE-ENROLLMENT

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

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

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

107.1 CONDITIONS OF RE-ENROLLMENT

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

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

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

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

2. Whether the state or local licensing authorities have taken any adverse action against the provider for offenses related to participation in the Medicare or Medicaid programs which was not considered in the development of the Medicaid suspension, exclusion, or termination.

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

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

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

108 REFERENCES

Vital Documents definition from HRSA:
https://www.hrsa.gov/sites/default/files/hrsa/about/organization/bureaus/ocrdi/written-translation-vital-documents.pdf

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

Nevada Division of Health Care Financing and Policy:
https://dhcfp.nv.gov/

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

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

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

Division of Welfare and Supportive Services (DWSS):
https://dwss.nv.gov/
Access Nevada - https://accessnevada.dwss.nv.gov/public/landing-page

Centers for Medicare and Medicaid Services:
https://www.cms.gov/
https://www.medicaid.gov/

109 RESERVED

110 NEVADA MEDICAID PROVIDER TYPES

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

SaveMEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 30, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES, MANAGER, HEARINGS UNIT *Casey Angres*
Casey Angres (Dec 13, 2021 08:57 PST)

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 200 – Hospital Services are being proposed to rename birth centers and obstetric centers to freestanding birthing center(s) in alignment with the passage of Assembly Bill 287 from the 81st Nevada Legislative Session. Additionally, revisions are proposed to remove two accreditation organizations, along with the Memorandum of Understanding (MOU) requirements for freestanding birthing centers as these are verified through the licensing process through Health Care Quality and Compliance (HCQC).

Entities Financially Affected: Provider Type (PT) Special Clinics (PT 17) and Birth Centers (PT 17 Specialty 169).

Financial Impact on Local Government: No financial impact.

These changes are effective January 1, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 17/21 Chapter 200 – Hospital Services	MTL 05/20, 17/15 Chapter 200 – Hospital Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
200	**Introduction**	Rename birth centers to freestanding birthing centers.
201B	**Authority**	Rename birth centers and obstetric center to freestanding birthing center(s). In addition, add a description to 42 CFR Part 440.255.
Attachment A, Policy #02-01	**Birth Centers**	Rename section from Birth Centers to Freestanding Birthing Centers. Throughout this section, rename

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		obstetric center and birth center(s) to freestanding birthing center(s). Removal of the reference to Obstetric Center as Nevada's legal term. In addition, removal of two accreditation organizations and Memorandum of Understanding (MOU) requirements.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HOSPITAL SERVICES

200 INTRODUCTION

Inpatient and outpatient hospital services are a federally mandated Medicaid benefit. A hospital is an inpatient medical facility licensed as such to provide services at an acute Level of Care (LOC) for the diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases.

Medicaid Services Manual (MSM) Chapter 200 describes the following hospital services: inpatient, swing bed, outpatient, ambulatory surgical, long-term acute care, inpatient rehabilitation specialty hospital, freestanding birthing centers, federal emergency services program including dialysis, and outpatient observation services.

The Division of Health Care Financing and Policy (DHCFP) may reimburse hospitals for providing medically necessary services, as defined in MSM Section 100 under Medical Necessity, including, but not limited to: medical/surgical/intensive care, maternity, newborn, neonatal intensive care, pediatric care, emergency care, trauma level I, inpatient rehabilitation, long-term acute care specialty, administrative skilled or intermediate days, emergency psychiatric, substance abuse treatment, and acute medical detoxification.

In Nevada, hospitals are licensed by the Bureau of Health Care Quality and Compliance (HCQC) within the Nevada Division of Public and Behavioral Health (DPBH).

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

201 AUTHORITY

A. In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation for states that elect to offer medical programs. The states must offer at least 11 basic required medical services. Two of these services are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20).

B. Other authorities include:

1. Sections 1861 (b) and (e) of the Social Security Act (Definition of Services);
2. 42 CFR Part 482 (Conditions of Participation for Hospitals);
3. 42 CFR Part 456.50 to 456.145 (Utilization Control);
4. Nevada Revised Statutes (NRS) 449 (Classification of Hospitals in Nevada);
5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers and Newborns);
6. Section 2301 of the Affordable Care Act (ACA) (Federal Requirements for Freestanding Birthing Centers);
7. NRS Chapter 449 (Hospitals, Classification of Hospitals and Freestanding Birthing Center Defined);
8. Nevada Administrative Code (NAC) Chapter 449 (Provision of Certain Special Services-Obstetric Care);
9. 42 CFR Part 440.255; "Limited services available to certain aliens";
10. NRS Chapter 422 Limited Coverage for certain aliens including dialysis for kidney failure;
11. 42 CFR 435.406 (2)(i)(ii) (permitting States an option with respect to coverage of certain qualified aliens subject to the five-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria);
12. 42 CFR 441, Subpart F (Sterilizations) and
13. 42 CFR 447.253(b)(1)(ii)(B) Other requirement.

202 RESERVED

203 INPATIENT HOSPITAL SERVICES POLICY

A. Inpatient hospital services are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that:

1. Is maintained primarily for the care and treatment of patients with disorders other than mental disease;

2. Is licensed as a hospital by an officially designated authority for state standard-setting;

3. Meets the requirements for participation in Medicare; and

4. Has in effect a Utilization Review (UR) plan, applicable to all Medicaid recipients, that meets the requirements of 42 CFR 482.30 and 42 CFR 456.50-456.145.

Inpatient hospital services do not include Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) services furnished by a hospital with a swing bed approval (42 CFR 440.10).

A hospital is an inpatient medical facility licensed as such to provide services at an acute LOC for the diagnosis, care and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an ICF for Individuals with Intellectual Disabilities (IID), regardless of name or licensure.

B. Out-of-State Acute Hospital Services

Non-emergency out-of-state acute inpatient hospital care requires prior authorization by the Quality Improvement Organization (QIO)-like vendor for Medicaid eligible recipients. Out-of-state inpatient hospital services may be authorized for specialized medical procedures not available in Nevada. The referral for out-of-state services must come from the referring/transferring Nevada physician and/or hospital. Reference MSM Chapter 100, Out-of-State Services and Out-of-State Provider Participation.

C. In-State and Out-of-State Acute Hospital Transfers

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, long-term acute care (LTAC) specialty, inpatient rehabilitation specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor must make a determination regarding the availability of such services at the referring hospital or

within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being available at the transferring facility.

It is always the receiving hospital's responsibility to confirm with the QIO-like vendor whether the transferring physician/hospital obtained authorization for a non-emergent transfer from the QIO-like vendor prior to the transfer and prior to the receiving hospital's agreeing to accept/admit the recipient.

D. Newborns and Neonatal Intensive Care Unit (NICU)

The DHCFP utilizes InterQual[1], MCG[2] and the Uniform Billing (UB) Editor[3] to define LOCs needed for each infant and revenue billing codes. These LOCs and revenue codes indicate the nursing care provided to newborn and premature infants in nursery accommodations. These revenue codes range from a healthy newborn to intensive care.

The following newborn UB revenue codes are utilized by the DHCFP to reimburse hospitals for the LOC provided to newborns for inpatient hospital stays. The LOC should be clinically evaluated on a daily basis, typically based on the resources provided to the infant. Please note that the levels identified below reference the LOC provided and not the licensure level of the facility. Licensure level of hospitals for newborn care is per Nevada Administrative Codes 442.380, 442.390, 442.401, and 442.405. LOCs are defined in the UB Editor. Levels III and IV are paid at the same rate due to the fluctuation of a newborn's health status. The revenue code of the newborns' highest LOC reached during a calendar day shall be billed by the hospital for that day. The intention of the DHCFP is to reimburse for the highest LOC per day based upon clinical documentation and review.

1. 0170 = General.

2. 0171 = Newborn – UB Level I: This level reflects routine care of apparently normal full-term or preterm neonates (considered to be newborn nursery).

3. 0172 = Newborn – UB Level II: This level reflects low birth-weight neonates who are not sick but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (considered to be continuing care).

4. 0173 = Newborn – UB Level III: This level reflects sick neonates who do not require intensive care but require six to 12 hours of nursing each day (considered to be intermediate care).

5. 0174 = Newborn – UB Level IV: This level reflects newborns who need constant nursing and continuous cardiopulmonary and other support for severely ill infants (considered to be intensive care).

The following table is a crosswalk from InterQual and MCG LOCs, to the UB Editor for LOCs and revenue codes for reimbursement. Hospitals will submit authorization requests

in the Provider Web Portal at the most appropriate InterQual or MCG LOC and UB revenue code(s) based upon the table below:

LOCs by InterQual[1], MCG[2]	**LOCs by UB Editor[3]**	**UB Revenue Codes[4] by UB Editor[3]**
Newborn Nursery	Level I	0170 / 0171
InterQual I / MCG Level I / Transitional Care	Level II	0172
InterQual II / MCG Level II	Level III	0173
InterQual III & IV / MCG Level III & IV	Level IV	0174

[1]InterQual is published by Change Healthcare. All rights reserved.
[2]MCG. All rights reserved.
[3]Uniform Billing Editor is published by Optum360[0]. All rights reserved.
[4]Correspond with National Uniform Billing Committee revenue code descriptions and guidelines by the Uniform Billing Editor published by Optum360[0].

InterQual is proprietary, nationally recognized standard utilized by Nevada Medicaid's QIO-like vendor to perform utilization management, determine medical necessity and appropriate LOC. Many hospitals in Nevada also use this same selected tool for self-monitoring. However, hospitals may also use MCG to perform the same tasks.

203.1 COVERAGE AND LIMITATIONS

A. Admission

1. Admission Criteria

The DHCFP considers the recipient admitted to the hospital when:

a. A physician provides the order for admission at the time of admission or during the hospital stay, as verified by the date and time;

b. Acute care services are rendered;

c. The recipient has been transferred to, or is awaiting transfer to, an acute care bed from the emergency department, operating room, admitting department, or other hospital services; and

d. The admission is certified by the QIO-like vendor based on pertinent supporting documentation/submitted by the provider with the admission authorization request.

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, critical access, inpatient rehabilitation, or LTAC specialty hospitals) or before authorization of payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. Reference MSM Chapter 200, Admission Medical Record Determination, Plan of Care.

2. Admission Order

Physician orders for admission must be written and signed at the time of admission or during the hospital stay. Admission orders written after discharge are not accepted. Verbal and telephone orders written by other allied personnel must be co-signed by the physician within the timeframes required by law.

The role of the QIO-like vendor is to determine whether an admission is medically necessary based on the medical record documentation, not to determine physician intent to admit.

3. Admission Date

The admission date must be reflected on the authorization as the date and time the admission order was written during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies provision of acute care services. The QIO-like vendor makes every effort to identify the documented admission date; however, it is ultimately the hospital's responsibility to provide complete and accurate admission information.

4. Planned and Transfer Admissions

For those instances in which the admission order was written (as defined above) before the recipient arrives at the hospital (planned elective admission), a signed physician order meets the requirements for admission. For transfers from other acute care hospitals, a signed physician order (as defined above) must be contained in the accepting facility's record. The admission date and time for the authorization is based on documentation most relevant and available to the admission determination contingent upon provision of acute care services and admission certification by the QIO-like vendor. Reference MSM Chapter 200, Provider Responsibilities, In-State or Out-of-State Hospital Transfers regarding provider responsibilities related to in-state and out-of-state acute hospital transfers.

5. Inpatient Admission from Observation

Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order.

6. Veterans' Hospitals

Inpatient hospital admission at a Veteran's Hospital is not a Medicaid benefit.

7. Obstetric Admissions for Early Induction of Labor (EIOL) Prior to 39 Weeks Gestation.

To be eligible for reimbursement, an obstetric hospital admission for EIOL prior to 39 weeks gestation must be prior authorized by the QIO-like vendor.

8. Obstetric Admissions for Elective Cesarean Delivery

Coverage/reimbursement of non-medically necessary obstetric admissions for elective cesarean section (e.g. performed for the convenience of the physician or recipient) is limited to the minimum federal requirement (two days) for a normal vaginal delivery and must be prior authorized.

B. Authorization Requirements

Authorization review is conducted to evaluate medical necessity, appropriateness, location of service, and compliance with the DHCFP's policy. All inpatient hospital admissions must be authorized by the QIO-like vendor for reimbursement by the DHCFP. The QIO-like vendor certifies LOC and length of stay.

Reference MSM Chapter 100, Medical Necessity regarding criteria related to medical necessity.

1. All inpatient QIO-like vendor determinations are based on pertinent medical information documented initially by the requesting physician and provided to the QIO-like vendor by a hospital with the request for admission. Pertinent information supporting the medical necessity and appropriateness of an inpatient admission must be submitted in the format and timeframes required by the QIO-like vendor as part of the authorization request. Failure of a provider to submit the required medical documentation in the format and within the timeframes specifically required by the QIO-like vendor will result in an authorization denial.

2. Authorization refers only to the determination of medical necessity and appropriateness. Authorization does not guarantee service reimbursement. Service reimbursement is also dependent upon the recipient's eligibility status and is subject to all other coverage terms and conditions of the Nevada Medicaid and NCU programs.

3. Services requiring authorization which have not been authorized by the QIO-like vendor are not covered and will not be reimbursed. An authorization request inappropriately submitted for inpatient admission after an unauthorized, planned, elective inpatient procedure or surgery is performed, will be rejected and returned without consideration. Concurrent services related to these unauthorized admissions will also be rejected and returned without consideration, unless the services are specifically related to stabilization of an emergency medical condition that develops. Once the emergency medical condition is stabilized, no additional services related to this unauthorized elective admission will be reimbursed.

4. An authorization is only valid for the dates of service authorized. If the service cannot be provided for any reason during authorized service dates (e.g. a recipient has a change of condition), the authorization becomes invalid. A new or updated authorization must be obtained for reimbursement of corresponding dates of service.

5. When available, in-state providers and facilities should be utilized. Out-of-state inpatient admission authorization determinations will be considered when appropriate services are not available in-state or when out-of-state resources are geographically and/or fiscally more appropriate than in-state resources. Reference MSM Chapter 100, Out-of-State Services.

6. Inpatient Admission Requiring Prior Authorization

   Prior authorization is authorization obtained before services are delivered. Additional inpatient days must be requested within five business days of the last day of the current/existing authorization period.

   Providers must submit pertinent clinical information and obtain prior authorization from the QIO-like vendor for the following non-emergent services:

   a. Any surgery, treatment, or invasive diagnostic testing unrelated to the reason for admission; or days associated with unauthorized surgery, treatment, or diagnostic testing.

   b. Hospital admissions for EIOL prior to 39 weeks gestation.

   c. Hospital admissions for elective/non-medically necessary cesarean sections.

   d. Antepartum admissions for the purpose of delivery when an additional elective procedure is planned (excluding tubal ligations).

   e. Dental admissions. Two prior authorizations for inpatient hospitalization for dental procedure are necessary:

      1. The Medicaid dental consultant must prior authorize the dental procedure; and

      2. The QIO-like vendor must authorize it is medically necessary for the recipient to be hospitalized for the dental procedure.

   f. An admission for a family planning procedure (e.g. a tubal ligation or vasectomy).

g. Non-emergency admissions to in-state and out-of-state facilities. An out-of-state non-emergency admission may be denied by the QIO-like vendor if the service is available in Nevada.

h. Psychiatric admissions to a free-standing psychiatric hospital IMD for recipients age 65 or older or under age 21 or to a psychiatric wing of a general acute hospital, regardless of age. Reference MSM Chapter 400 for authorization requirements.

i. All changes in LOC and/or transfer between units (e.g. medical/surgical, intensive care, obstetrics, newborn, neonatal intensive care, trauma level 1, psychiatric/detoxification, inpatient rehabilitation, administrative, and outpatient observation.) Per diem reimbursement amounts are based on the LOC authorized by the QIO-like vendor.

j. Substance abuse detoxification and treatment (inpatient) admissions. This includes transfers from detoxification to treatment within the same hospital. Reference MSM Chapter 400 for authorization requirements.

k. Swing bed admissions in a rural or critical access hospital (CAH). Reference MSM Chapter 200, Attachment A, Policy #02-03, Hospital with Swing Beds.

l. A leave of absence or therapeutic pass from an acute or inpatient rehabilitation specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference MSM 200, Leave of Absence.

m. Admission when Third Party Liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference MSM Chapter 100, Third Party Liability (TPL), Other Health Care Coverage.

n. Non-Medicare covered days within 30 days of the receipt of the Medicare Explanation of Benefits (EOB) indicating Part A Medicare benefits are exhausted. Reference MSM Chapter 100, Authorization.

o. Admissions resulting from Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening.

7. Inpatient Admission Requiring Authorization Within Five Business Days of Admission

Providers must submit pertinent clinical information and request authorization from the QIO-like vendor within five business days for the following services:

a. An emergency inpatient admission, emergency transfer to another in-state and/or out-of-state facility or unit, or emergency change in LOC. Reference MSM Chapter 400 regarding emergency psychiatric or alcohol/substance use disorder treatment admission requirements.

b. An obstetric admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or emergency cesarean delivery. After each scenario has been exceeded, the authorization must be submitted within five business days.

c. A newborn admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or elective cesarean delivery. After each scenario has been exceeded, the authorization must be submitted within five business days.

d. When delivery of a newborn occurs immediately prior to arrival at a hospital for an obstetric/newborn admission.

e. Any newborn/neonate admission or transfer to a NICU.

f. A direct inpatient admission initiated through an emergency department and/or observation status as part of one continuous episode of care (encounter) at the same facility when a physician writes an acute inpatient admission order (rollover admissions).

The following criteria applies:

1. Observation and ancillary services resulting in a direct inpatient admission provided as part of one continuous episode of care on the same calendar date and at the same facility as the inpatient admission are included in the first inpatient day per diem rate. Observation and ancillary services rendered on a calendar date preceding the rollover inpatient admission date can be billed separately.

2. Emergency department services resulting in a direct inpatient admission at the same facility and provided as part of one continuous episode of care are included in the first inpatient hospital day per diem rate, even if the emergency services are provided on the calendar date preceding the admission date.

g. Admission to hospitals without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit. Refer to MSM Chapter 400.

8. All inpatient hospital admissions must be authorized by the QIO-like vendor, except for:

   a. Medicare and Medicaid dual eligible, there is no requirement to obtain Medicaid authorization for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's authorization guidelines. Authorizations are not necessary for recipients who are eligible for Qualified Medicare Beneficiary (QMB) only since Medicaid pays only the co-pay and deductible. If Medicare benefits are exhausted (i.e. inpatient), an authorization from Medicaid's QIO-like vendor must be obtained within 30 days of the receipt of the Medicare EOB. Reference MSM 100 for authorization timeframes related to non-Medicare covered days for a dual eligible recipient.

   b. A length of stay not exceeding either three obstetric and newborn inpatient days for a vaginal delivery performed at or after 39 weeks gestation or four obstetric and newborn days for a medically necessary cesarean delivery. This does not apply to neonatal intensive care days. All NICU days must be authorized. Reference MSM 200, Inpatient Admission Requiring Authorization Within Five Business Days regarding newborn authorization requirements.

9. Utilization Review (UR) Process

   The QIO-like vendor evaluates the medical necessity, appropriateness, location of service and compliance with the DHCFP's policy related to inpatient admission requests. The QIO-like vendor reviews if services furnished or proposed to be furnished on an inpatient basis could (consistent with provision of appropriate medical care) be safely, effectively and more economically furnished on an outpatient basis, in a different type of inpatient health care facility or at a lower LOC within a general hospital. Once the QIO-like vendor is provided pertinent clinical admission information, a review of the medical information from the facility is conducted to determine the appropriate LOC and authorized time period for the length of stay.

   a. Concurrent Review

      Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period services are being provided. Initially the QIO-like vendor assigns a length of stay based on the diagnosis and condition of the recipient. For complex cases, additional days may be authorized to manage the medical condition through the concurrent review process. Additional inpatient review days must be requested within five business days of the last day of the current/existing authorization

period. If the clinical condition does not support the medical necessity or appropriateness of the setting, services are denied or reduced.

b. Retrospective Review

Retrospective review is a review of clinical information to determine whether the services will be approved after services are delivered. Retrospective review, for the purpose of this chapter, refers to cases in which eligibility is determined after services are provided. If the clinical information does not support the medical necessity or appropriateness of the setting, services are denied or reduced. The provider is notified when the QIO-like vendor's reviewer determines clinical information supports either a reduction in LOC, discharge or denial of days.

C. Leave of Absence

1. Absences from an acute hospital inpatient or rehabilitation specialty hospital are allowed:

a. In special circumstances, such as when a recipient is in the hospital on a long-term basis and needs to be absent for a few hours for a trial home visit or death of an immediate family member; or

b. Up to, but not exceeding 32 hours from an inpatient rehabilitation specialty hospital for therapeutic reasons, such as preparing for independent living.

2. Prior authorization must be obtained for a leave of absence expected to:

a. Last longer than eight hours from an acute hospital; or last longer than eight hours or involving an overnight stay from an inpatient rehabilitation specialty hospital.

3. A leave of absence from an acute hospital is not covered if a recipient does not return to the hospital by midnight of the day the leave of absence began (a reserved bed).

4. For a therapeutic leave of absence, the following information must be documented in a recipient's medical record:

a. A physician's order specifying the number of hours for the pass;

b. The medically appropriate reason for the pass prior to issuance of the pass; and

c. An evaluation of the therapeutic effectiveness of the pass when the recipient returns.

203.2 PROVIDER RESPONSIBILITIES

A. Conditions of Participation

1. To be enrolled with the DHCFP, providers must:

   a. Be in compliance with applicable licensure requirements.

   b. Be certified to participate in the Medicare program. Hospitals currently accredited by the Joint Commission or by the American Osteopathic Association (AOA) are deemed to meet all of the conditions of participation in Medicare. Centers for Medicare and Medicaid Services (CMS) makes the final determination of whether a hospital meets all Medicare criteria based on the recommendation of the state certifying agency (42 CFR Part 482).

   c. Have a Provider Contract with the DHCFP. Refer to MSM Chapter 100, Provider Enrollment.

2. Termination

   The DHCFP may terminate a provider contract for failure of a hospital to adhere to the conditions of participation, reimbursement principles, standards of licensure, or to conform to federal, state and local laws. Either party may terminate its agreement without cause at any time during the term of agreement by prior written notice to the other party.

   Loss of Medicare certification results in concomitant loss of a Medicaid contract.

   Refer to MSM Chapter 100, for termination, lockout, suspension, exclusion and non-renewal of Medicaid provider enrollment.

B. Utilization Review (UR)

Parts 456.100 through 456.145 of Section 42 CFR prescribe the requirements for a written UR plan for each hospital providing Medicaid services. The UR plan is deemed met for Medicare and Medicaid if a QIO-like vendor is conducting binding review.

CFR 482.30 provides that hospitals participating in the Medicaid program must have in effect a UR program under a QIO-like or CMS has determined the UR procedures established by the Medicaid program are superior to the procedures under the QIO-like vendor and meet the UR Plan requirements under 42 CFR 456.50 through 456.145.

C. Quality Assurance – Hospital Medical Care Evaluation Studies

The purpose of hospital medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with recipient needs and professionally recognized standards of care. (CFR 456.141 to 456.145)

As part of the conditions of participation in the Medicaid Title XIX program, a minimum of one medical care evaluation study must be in progress at any time. Additionally, one study must be completed each year. The completed study must be submitted to the QIO-like vendor at the end of each calendar year along with the study in progress topic. (A report summarizing the study topics will be submitted to Nevada Medicaid by the QIO-like vendor.)

Hospitals may design and choose their own study topic or, at the request of Medicaid, perform a topic designed by Medicaid and forward a copy of the completed study to the QIO-like vendor office within the specified time frames.

D. Civil Rights Compliance

As recipients of federal funding, hospitals must assure compliance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (including HIV, AIDS and AIDS-related conditions), the Age Discrimination Act of 1975 and the Americans with Disabilities Act (ADA) of 1990.

E. Patient Self-Determination Act (Advance Directives) Compliance

Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding for Medicare and/or Medicaid must comply with the Patient Self Determination Act (PSDA) of 1990, including Advance Directives. The DHCFP is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state advance directive requirements.

F. Form 3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form 3058 to their local Nevada Division of Welfare and Supportive Services (DWSS) District Office whenever a hospital admission, discharge or death occurs.

Failure to submit this form could result in payment delay or denial. To obtain copies of Form 3058, please contact the local DWSS.

G. Patient Rights

Pursuant to 42 CFR 482.13, a hospital must protect and promote each patient's rights. Hospitals are also required to comply with Nevada Revised Statues (NRS) 449.730 pertaining to patient's rights.

H. Claims for Denied Admissions

After having an inpatient service authorized by the QIO-like vendor, hospitals are not permitted to submit the claim to the fiscal agent as an outpatient service. The only exception to this is if an outpatient or non-inpatient related service was truly rendered prior to the inpatient admission order by the physician but the inpatient stay was denied by the QIO-like vendor (e.g., admit from ED or rollover from observation days).

I. Hospital Responsibilities for Services

Any hospital receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for the recipient's service and treatment needs. If a hospital does not have the proper or functional medical equipment or services and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing, evaluation and/or treatment, it is the transferring hospital's responsibility to fund the particular services and transportation if necessary.

J. Admission Medical Record Documentation

1. Pre-Admission Authorization
The physician (or his/her staff) must obtain prior authorization from the QIO-like vendor for all non-emergency, elective, planned hospital procedures/admissions. Lack of a prior authorization for an elective procedure or admission results in an automatic denial which cannot be appealed. Reference MSM Chapters 200 and 600.

Dental, oral and maxillofacial surgeons must also secure prior authorization from the DHCFP dental consultant to assure payment for the procedure. Reference MSM Chapter 200, Inpatient Hospital Services Policy, Coverage and Limitations, Authorization Requirements and MSM Chapters 600 and 1000 regarding covered dental benefits.

2. Physician Certification

A physician's order, written prior to or at the time of admission, is required for all inpatient admissions. If a recipient applies for assistance while in the hospital, a physician's order for inpatient admission is required before reimbursement is authorized.

A physician, physician's assistant, or advanced practice registered nurse acting within the scope of practice, as defined by state law and under the supervision of a physician, must re-certify for each applicant or recipient that inpatient services in a hospital are medically necessary. Re-certification must be made at least every 60 calendar days after the initial order. (42 CFR 456.60)

3. Plan of Care

Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the recipient's care must establish a written plan of care for each applicant or recipient. (42 CFR 456.80)
The plan of care must include:

a. Diagnoses, symptoms, complaints and complications indicating the need for admission;

b. A description of the functional level of the recipient;

c. Any orders for medications, treatments, restorative and rehabilitative services, activities, social services and diet;

d. Plans for continuing care, as appropriate; and

e. Plans for discharge, as appropriate.

K. Discharge Planning

A hospital must ensure the following requirements are met:

1. There is documented evidence that a discharge evaluation is initiated as soon as practical after admission and in a manner to prevent discharge delays for: a recipient identified as likely to suffer an adverse health consequence upon discharge if adequate discharge planning is not initiated and completed; a recipient or a person acting on the behalf of a recipient requesting a discharge evaluation; or when requested by a physician.

2. A registered nurse, social worker or other appropriately qualified personnel reviews all Medicaid admissions and develops or supervises the development of a discharge plan. The discharge plan must specify goals and resolution dates, identify needed discharge services, and be developed with input from the primary care staff, recipient and/or family, and physician as applicable.

3. Re-evaluation of a recipient's condition and needs is conducted, as necessary, during the discharge planning process and the plan must be updated with changes identified.

4. The discharge plan includes documented evidence of:

a. All attempts to discharge the recipient to an alternative appropriate setting, when applicable, and reasons and timeframes for unavoidable delays (e.g., awaiting assignment of a court-appointed guardian or for a court hearing related to out-of-state placement). Dates of service lacking documented

evidence of comprehensive discharge planning or unavoidable delay reasons and timeframes, when applicable, are not reimbursed.

b. An alternate plan when a specific discharge intervention or placement effort fails.

c. Significant contacts with the recipient, family, or legally authorized representative, when applicable.

d. A recipient's understanding of his/her condition, discharge evaluation results and discharge plan.

e. Reasonable efforts seeking alternatives to NF placement (e.g., home health services, homemaker services, placement with family, subsidized housing, meals programs, group care, etc.), when applicable.

f. NF contacts and contact results, when NF placement is required NF placement efforts need to concentrate on facilities capable of handling a recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.

g. Refusal by a recipient or recipient's family, physician, or legally responsible representative to cooperate with discharge planning efforts to either find or accept available appropriate placement. Inpatient acute or administrative days are not reimbursed effective the date of the refusal.

h. A physician's discharge order. Any readmission following a discharge is treated as a new/separate admission, even if the readmission occurs within 24 hours of the discharge.

5. Prior to NF placement, the following documents are completed and in recipient's medical record:

a. A LOC, a pre-admission screening and resident review (PASRR) Level 1 screening.

b. A PASRR Level II screening and a Summary of Findings letter, when applicable.

Refer to MSM Chapter 500 for NF screening requirements.

6. Hospitals must be in compliance with discharge planning requirements specified in 42 CFR 482.43.

7. The day of discharge is not reimbursed except when discharge/death occurs on the day of admission.

L. Financial and Statistical Data Reports

Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the DHCFP program.

All providers shall permit any representative of the single state agency to examine the records and documents necessary to determine the proper amount of payments due. These records shall include, but are not limited to, provider ownership, organization and operation; fiscal, medical and other record keeping systems; federal income tax status; asset acquisition, lease, sale or other action; franchise or management arrangements; patient service charge schedules; costs of operation; amounts of income received, by source and purpose; flow of funds and working capital; statistical and other reimbursement information.

M. Medicare/Medicaid Crossovers

Concurrent review is not conducted for Medicare/Medicaid crossover admissions unless acute days have been exhausted and/or there has been a termination of Medicare benefits and the recipient is at an acute or administrative LOC. Medicaid authorization is provided for acute and administrative days only.

A provider must:

1. Notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted.

2. Attach a copy of the Medicare EOB (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted when requesting a QIO-like vendor review.

3. Obtain prior authorization from the DHCFP's QIO-like vendor in accordance with the MSM Chapter 200, Coverage and Limitations, Authorization Requirements.

QMB claims denied by Medicare are also denied by the DHCFP.

N. Maternity/Newborn Federal Length of Stay Requirements

A provider must allow a recipient receiving maternity care or a newborn infant receiving pediatric care to remain in the hospital for no less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section delivery except when an attending physician makes a decision to discharge a mother or newborn infant prior to these timeframes.

O. Sterilization Consent Form

Providers must ensure a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure. Reference the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information for requirements related to these procedures.

1. An inpatient day during which sterilization is performed without a valid sterilization form is a non-covered service.

2. Medically necessary inpatient days within the same episode of care, not including the day of the sterilization, may be reimbursed when the sterilization consent form was not obtained. An episode of care is defined as the admission date to date of discharge. All applicable inpatient coverage rules apply.

P. In-State or Out-of-State Hospital Transfers

1. Non-Emergency Transfers

a. It is the responsibility of the transferring physician/facility to obtain prior authorization for nonemergent transfers between in-state and out-of-state facilities, prior to the transfer of the recipient and to give the authorization number to the receiving hospital.

b. A receiving hospital is responsible for verifying that the transferring hospital obtained prior authorization for a non-emergency transfer, prior to agreeing to accept or admitting the recipient and prior to the transfer.

2. Emergency Transfers

A receiving hospital is responsible for obtaining authorization for an emergency transfer within five business days of the inpatient admission.

Q. Admissions to Hospitals Without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit

1. Reference MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services.

2. Maintain and submit to the QIO-like vendor documentation demonstrating comprehensive efforts to expeditiously transfer a recipient to an appropriate alternate setting (e.g. a freestanding psychiatric hospital or a general hospital with a psychiatric unit or to an alcohol/substance abuse treatment hospital or a general hospital with a specialized alcohol/substance abuse treatment unit), upon request or when applicable.

R. Submission of Medical Documentation

1. Providers must identify and submit all pertinent (relevant and significant) supporting documentation for an inpatient admission with an authorization request and/or with a request for a QIO-like vendor reconsideration review. This information must be provided in the format required by the QIO-like vendor. In addition, any documentation specifically requested by the QIO-like vendor must be submitted within time frames specified by the QIO-like vendor. Failure to provide all pertinent medical information in the format and within time frames required by the QIO-like vendor will result in authorization denial.

S. Adverse Determination

An adverse action or determination includes, but is not limited to, a denied or reduced authorization request.

1. If a provider does not agree with the DHCFP QIO-like vendor's adverse determination, a peer-to-peer review or a reconsideration review can be requested. Reference the QIO-like vendor's/DHCFP's Billing Manual for details.

2. A provider must submit all additional pertinent documentation or information not included with the authorization request supporting services requested (e.g. documentation related to severity of illness, intensity of services, a physician's risk assessment) to the QIO-like vendor by the date of the reconsideration review. This information must be provided in the format required by the QIO-like vendor.

3. Pertinent medical information not provided to the QIO-like vendor in the required format by the reconsideration date of decision, will not be subsequently considered by the QIO-like vendor.

   a. Verbal information provided by an individual other than a recipient's attending physician must be supported by either written attestation of this information in the medical record specifically provided to the QIO-like vendor with the authorization or reconsideration review request.

   b. If a provider disagrees with the results of the QIO-like vendor's peer-to-peer and/or reconsideration review, the provider may request a fair hearing through the DHCFP, within the required timeframe. A provider must utilize internal grievance processes available through the QIO-like vendor.

T. Adherence to Requirements

To receive reimbursement for covered services, a hospital must adhere to all conditions stated in the Provider Contract, all applicable DHCFP policies related to the specific service provided, all state and federal requirements, the QIO-like vendor/DHCFP billing

requirements and current International Classification of Diseases, Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) billing guidelines.

204 ADMINISTRATIVE DAY POLICY

Administrative days are inpatient hospital days reimbursed at a lower per diem rate when a recipient's status no longer meets an acute LOC. If discharge is ordered, a recipient's medical record must contain documentation that alternative appropriate placement is not available, despite a hospital's comprehensive discharge planning efforts.

204.1 COVERAGE AND LIMITATIONS

A. COVERED SERVICES

1. The DHCFP reimburses two levels of administrative days when authorized by the QIO-like vendor in increments usually not exceeding seven calendar days per request: a skilled nursing care level (skilled administrative days) and an intermediate care level (intermediate administrative days).

2. At least one acute inpatient hospital day must immediately precede an initial request for skilled or intermediate administrative days. Reimbursement is not available for direct admission to an administrative LOC or for admission to an administrative LOC from an outpatient setting (e.g., emergency department, observation status, a physician's office, urgent care or clinic).

3. Skilled administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital or CAH as a reduction in LOC for:

   a. A recipient waiting for evaluation and/or placement in a NF/extended care facility, group home, residential treatment center (RTC) IMD, psychiatric or alcohol/substance abuse treatment hospital or unit or other treatment settings (e.g., hospice) for continuity of medical services.

   b. Delays in discharge related to durable medical equipment availability, home equipment set up, home health, or hospice service arrangements.

   c. A newborn with medical complications (not requiring acute care services) waiting for placement.

   d. A recipient requiring medical interventions not meeting acute care criteria that prevents the recipient from leaving the hospital (e.g., monitoring laboratory results, obtaining cultures, a specific treatment/workup).

   e. Preparation for a surgery unrelated to the original reason for admission that does not meet acute care criteria.

4. Intermediate administrative (intermediate care level) days are covered in an inpatient or CAH when:

   a. Services do not meet an acute LOC;

   b. The days are authorized by the QIO-like vendor; and

   c. A recipient cannot be discharged for social reasons (e.g., a stable newborn either waiting for adoption or for the mother to be discharged, a recipient waiting for medical assisted transportation, a recipient requiring evaluation after being a victim of crime).

B. NON-COVERED SERVICES

Administrative days are not covered when:

1. At least one acute inpatient hospital day did not immediately precede the initial request for administrative days.

2. The days are only for the convenience of the recipient, recipient's family or physician.

3. A recipient, a recipient's family, legally authorized representative, or physician refuse to cooperate with discharge planning efforts or refuse placement at a NF, psychiatric facility or other available alternative setting.

4. A discharge order is written, and a hospital has not provided documented evidence of a comprehensive discharge plan or an acceptable reason and timeframe for an unavoidable delay, such as awaiting a specifically identified court date for court appointed guardianship related to out-of-state NF placement.

204.2 AUTHORIZATION REQUIREMENTS

A. Prior authorization is required.

B. Retrospective authorization must be obtained when Medicaid eligibility is determined after admission to, or discharge from, an inpatient bed.

C. Administrative day policy is consistent with the inpatient prior authorization and utilization review policies.

204.3 PROVIDER RESPONSIBILITIES

A. Submit all pertinent discharge planning information to the QIO-like vendor with a prior authorization request, when applicable, and obtain authorization for administrative days within timeframes required by the QIO-like vendor.

B. Notify the QIO-like vendor when there is a reduction in LOC to administrative days.

C. Maintain documentation of appropriate, comprehensive discharge planning in recipients' medical records. This includes, but is not limited to:

1. All placement efforts, contacts and contact results;

2. Discharge planning notes from applicable social workers, case managers and/or nurses;

3. Physicians' orders and/or progress notes;

4. Modification to the discharge plan, whenever applicable; and

5. Acceptable reason and timeframes of unavoidable discharge planning delay.

205 SWING BED SERVICES POLICY

Reference Chapter 200, Attachment A, Policy #02-03, Hospital with Swing Beds.

206 OUTPATIENT HOSPITAL SERVICES POLICY

General Medical/Surgical Hospitals commonly provide several outpatient services, included but not limited to general, clinic, office, emergency department, ambulatory surgery center and observation services.

206.1 COVERAGE AND LIMITATIONS

A. Outpatient hospital services provided by hospitals are subject to the same service limitations as other outpatient service providers. Providers must refer to Medicaid/DHCFP service manuals relevant to the specific services being provided. The following is a list of some of the chapters a hospital should reference:

1. For physician, advanced practitioner of nursing, physician assistants, urgent care sites and outpatient hospital clinic visits, refer to MSM Chapter 600.

2. For radiologic services, refer to MSM Chapter 300.

3. For pharmaceutical services, refer to MSM Chapter 1200.

4. For Partial Hospitalization Program (PHP) – Policy on an outpatient alternative to an inpatient psychiatric care program with services furnished under a medical model by a hospital or Federally Qualified Health Center (FQHC). Refer to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services for PHP policy.

This is not an all-inclusive list. The MSM in its entirety needs to be reviewed.

B. Emergency Department Services

Emergency department services are defined as a case in which delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight or hearing, injury to self or bodily harm to others.

Non-emergent services provided in an emergency department are a covered service for recipients with full Medicaid eligibility. Providers are expected to follow national coding guidelines by billing at the most appropriate level for any services provided in an emergency department setting.

Laboratory and radiological services ordered during the course of emergency department services (when it is an emergency diagnosis and not a clinic diagnosis) are payable without prior payment authorization.

Charges made for stat performance of laboratory or radiological procedures ordered during a hospital's normal operating hours in the applicable department are not a DHCFP benefit.

Patients requiring mental health services while in the emergency department may receive such services if medically appropriate but must first be stabilized. Every effort must be made to transfer the patient to a psychiatric hospital or unit, accompanied by a physician's order. Authorization from the DHCFP's QIO-like vendor is also required.

C. Outpatient Observation Services

Reference Chapter 200, Attachment A, Policy #02-04, Outpatient Observation Services.

207 AMBULATORY SURGICAL CENTER SERVICES POLICY

Ambulatory Surgical Centers refers to freestanding or hospital based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients expected to return safely home within 24 hours.

By contrast, physician office (MD Office) services refers to a setting limited to use of local anesthesia, including private physician office, emergency department, urgent care centers and clinic settings.

Observation/Medical short stay refers to the "ambulatory" recipient with a coexisting medical condition or some unforeseen medical situation who may remain in a hospital environment for an extended period. This extended stay, called observation or medical short stay can be used to assure recipient stability without an inpatient admission. The recipient may occupy any hospital unit. Observation recipients may be rolled over for inpatient admission any time the patient requires acute care services. All rollovers to inpatient care require QIO-like vendor's authorization within 24 hours of the admission/rollover. Observation stays which do not rollover to inpatient status are limited to 48 hours.

207.1 COVERAGE AND LIMITATIONS

A. The DHCFP reimburses for services provided in a freestanding ambulatory surgical center or an ambulatory surgical setting within a general hospital. Some ambulatory surgical center services require QIO-like vendor authorization Reference MSM Chapter 200, Ambulatory Surgical Services Policy, Authorization Process.

B. Ambulatory surgical services are not reimbursable when:

1. The recipient's medical condition or treatment needs meet acute inpatient guidelines and standards of care.

2. The recipient requires preoperative diagnostic testing that cannot be performed in an outpatient setting.

3. The recipient requires therapeutic interventions (measures) that can only be performed in an acute hospital setting.

4. The probability of significant, rapid onset of complications is exceptionally high. Actual manifestation of such complications would require prompt intervention/measures available only in an inpatient setting.

5. Complications occur during or following an outpatient procedure that requires acute inpatient treatment and intervention.

6. Services are not reasonable and medically necessary for diagnosis or treatment of a recipient when provided for the convenience of the recipient, recipient's family or the physician.

7. Services are ordered as inpatient by the admitting physician.

8. Services can be provided in a less restrictive setting (e.g., physician office, emergency department, clinic, urgent care setting).

C. Higher Setting of Service Delivery

When any listed procedure is planned in a higher setting, the physician or his/her office staff must contact the QIO-like vendor for prior authorization of the setting. These procedures are listed in the booklet entitled "Surgical Procedures Recommended for an Ambulatory Setting (including inpatient prior authorization guidelines)."

D. Non-Covered Procedures

Reference MSM Chapter 600, Ambulatory Centers (ASC) Facility and Non-Facility Based.

E. Approval Process

The procedure approval process is designated to establish the medical necessity and appropriateness for:

1. Procedures to be performed in a higher care setting;

2. Procedures that would not routinely be covered by the DHCFP; and

3. Procedures to be performed outside Nevada.

The requesting physician must provide the QIO-like vendor with the medical documentation and justification to establish medical necessity and appropriateness.

207.2 PROVIDER RESPONSIBILITIES

Please reference MSM Chapter 200, Inpatient Hospital Services Policy, Provider Responsibilities for service provider responsibility.

207.3 AUTHORIZATION PROCESS

The provider must contact the QIO-like vendor 48 hours prior to the procedure date.

A. Provider must submit the required authorization form.

B. A copy of Medicaid card to confirm that the physician's office has verified the recipient's eligibility.

C. All supporting medical documentation the requesting physician would like considered.

D. Procedure pre-approval requests:

1. Cannot be accepted from the facility/hospital personnel.

2. Require up to two working days to process.

3. Date of Service (DOS) must be within 30 days from the Prior Authorization's date of issue.

E. Retroactive Eligible Recipients

For those recipients who applied for Medicaid eligibility after services were rendered, the QIO-like vendor must be contacted for retro eligible authorization.

The QIO-like vendor reviews the information for medical necessity, appropriateness of the procedure and compliance with Medicaid program benefits. Written notification of the review determination is sent to the physician and facility within 30 days of receipt of all required documentation.

F. Prior Authorization Is Required When:

1. A procedure indicated as "MD Office" is planned for a setting other than a physician's office, emergency department or clinic. This includes an ambulatory surgery facility, a hospital-based outpatient surgery department or inpatient treatment at an acute care hospital.

2. A procedure indicated as "Amb Surgical" is planned to be done on an inpatient basis.

3. A procedure appearing on the list is planned for a recipient who is currently being treated in an acute care hospital and the procedure is unrelated to the original reason for admission. Authorization is not required if the procedure is for treatment related to the admitting diagnosis.

4. The physician can provide compelling evidence that non-covered procedure is not cosmetic but is medically necessary.

5. The Medicaid coverage is secondary to any other private, non-Medicare insurance plans.

6. A listed procedure(s) requiring prior authorization is to be performed in conjunction with a procedure(s) exempt from authorization.

7. Any procedure is to be performed out-of-state that requires a prior authorization in-state.

8. Any procedure that is to be performed on an inpatient basis.

9. A recipient is going to be rolled over from ambulatory or observation status to an acute inpatient admission.

G. Prior Authorization is Not Required When:

1. A procedure is covered by Medicare Part B and Medicaid (QMB eligible) is only required to pay coinsurance, up to the DHCFP allowable maximum.

208 LONG TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL SERVICES POLICY

LTAC specialty hospitals meet Medicare inpatient hospital Conditions of Participation, maintain an average length of stay greater than 25 days and provide comprehensive long-term acute care to individuals with complex medical conditions and/or an acute illness, injury or exacerbation of a disease process. Most commonly, specialty or LTAC hospitals treat patients who require ventilator, wound care, or stroke-related services.

208.1 COVERAGE AND LIMITATIONS

A. COVERED SERVICES

1. The DHCFP reimburses medically necessary services meeting coverage requirements, provided in either a freestanding long-term acute care hospital or a long-term acute unit of a general hospital.

2. All of the following criteria must be met:

   a. Frequent, specialized, therapeutic interventions are required on an inpatient basis.

   b. Services are ordered and supervised by a physician or another individual authorized by State licensure law to prescribe treatment.

   c. Services include skilled nursing services, with 24-hour, on-site, registered nurse availability.

   d. Services are provided in accordance with a multidisciplinary, coordinated plan of care.

   e. Services are authorized as medically necessary by the QIO-like vendor.

B. NON-COVERED SERVICES

Services are not covered in a long-term acute care hospital when:

1. A recipient does not meet eligibility requirements;

2. The services do not meet medical necessity requirements or are only for the convenience of a recipient or a recipient's family or physician; or

3. The services are limited to only rehabilitation, coma stimulation or pain management interventions (e.g., relaxation techniques, stress management, biofeedback).

208.2 PRIOR AUTHORIZATION

A. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Reference MSM Chapter 100, Authorization.

B. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to or discharge from an LTAC specialty hospital.

C. LTAC specialty hospital's policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, Inpatient Hospital Services Policy, Coverage and Limitations, Authorization Requirements.

208.3 PROVIDER RESPONSIBILITIES

Providers must:

A. Be in compliance with provider responsibilities specified in the MSM Chapter 200, Inpatient Hospital Services Policy, Provider Responsibilities.

B. Maintain evidence of Medicare certification and state licensure as an LTAC.

209 INPATIENT REHABILITATION SPECIALTY HOSPITAL SERVICES POLICY

Inpatient rehabilitation specialty hospitals and distinct inpatient rehabilitation units in a general or CAH provide intensive, multidisciplinary, coordinated rehabilitation services (e.g., physical, occupational, speech or prosthetics/orthotics therapy) to restore optimal function following an accident or illness, (e.g., spinal cord injury, brain injury, stroke, neurologic disorders, congenital deformity, burns, amputation, major multiple trauma, fractures of the femur or hip, severe advanced osteoarthritis, active polyarticular rheumatoid arthritis, systemic vasculitis with joint inflammation, knee or hip replacement). Inpatient rehabilitation involves both retraining and relearning to achieve the maximal level of function possible, based on a recipient's abilities and disabilities.

209.1 COVERAGE AND LIMITATIONS

A. COVERED SERVICES

1. The DHCFP reimburses medically necessary, intensive, inpatient rehabilitation services meeting coverage requirements, provided in either a freestanding inpatient rehabilitation hospital or an inpatient rehabilitation unit of a general or CAH.

2. All the following criteria must be met:

   a. Services are ordered and provided under the direction of a physician with specialized training or experience in rehabilitation.

   b. Services are authorized as medically necessary by the QIO-like vendor.

   c. The inpatient admission is from an acute hospital or NF and is within one year from the initial injury or illness or most recent surgery/hospitalization as a result of the initial illness or injury.

   d. Active and ongoing therapeutic interventions from multiple therapy disciplines are required on an inpatient basis.

   e. Rehabilitative service is provided a minimum of either three hours per day, five days per week, or 15 hours within each seven-consecutive day period, beginning the date of admission.

   f. Physical and/or occupational therapy must be a component of rehabilitative services provided.

   g. Inpatient rehabilitation is only ordered when a recipient is capable of making significant, measurable, functional improvement in activities of daily living within a specified period of time.

3. A brief exception to the intensity of service requirement, during which a recipient is unable to participate in the intensive therapy program due to an unexpected clinical event (e.g., severe flu symptoms, bed rest due to signs of deep vein thrombosis, prolonged intravenous chemotherapy or blood transfusions), covered when:

   a. The exception is limited to once per admission and does not exceed three consecutive days;

   b. Comprehensive documentation of the unexpected clinical event is provided to the QIO-like vendor; and

   c. A preadmission screening, post admission physician evaluation and the plan of care support that the recipient was initially able to actively participate in the inpatient rehabilitation program.

4. In cases of brain injury, a recipient can be admitted on a trial basis lasting no longer than seven days if a comprehensive preadmission assessment supports that the recipient could reasonably be expected to benefit from an inpatient stay with an interdisciplinary team approach to the delivery of rehabilitation services. Additional days can be requested if assessments during the trial period demonstrate the recipient will benefit from inpatient rehabilitation services.

5. A leave of absence not exceeding 32 hours for a therapeutic reason (e.g., preparing for independent living) is covered when authorized by the QIO-like vendor and when the following information is documented in a recipient's medical record:

   a. A physician's order that specifies the number of hours for the leave;

   b. The medically appropriate reason for the leave; and an evaluation of the therapeutic effectiveness of the leave.

B. NON-COVERED SERVICES

Inpatient rehabilitation services are not covered when:

1. The services do not meet authorization or other policy coverage requirements (e.g., a preadmission screening demonstrates a recipient cannot participate with intensive rehabilitation services);

2. The level of rehabilitative care required can be safely and effectively rendered in an alternate, less intensive setting, such as an outpatient rehabilitation department or a SNF; or

3. Treatment goals necessitating inpatient services are achieved or further progress toward established rehabilitation goals is not occurring or is unlikely to occur.

209.2 PRIOR AUTHORIZATION

A. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Refer to MSM Chapter 100, Authorization.

B. Prior Authorization is also required for a leave of absence expected to last longer than eight hours or involving an overnight stay or a brief exception to the intensity of service rule.

C. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to, or discharge from, an inpatient rehabilitation hospital.

D. Inpatient rehabilitation hospital policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, Inpatient Hospital Services Policy, Coverage and Limitations, Authorization Requirements,

209.3 PROVIDER RESPONSIBILITIES

A. Providers must be in compliance with Provider Responsibilities specified in the MSM Chapter 200, Hospital Inpatient Services Policy, Provider Responsibilities.

B. Providers must ensure the following documentation is maintained in a recipient's medical record and submitted to the QIO-like vendor, as applicable:

1. A preadmission screen specifying the condition that caused the need for rehabilitation, the recipient's level of function, functional improvement goals and the expected frequency and duration of treatments required to accomplish these goals, any risk for clinical complications and the anticipated post discharge destination.

2. A post-admission assessment performed by a rehabilitation physician documenting a recipient's status and any discrepancies between this assessment and the preadmission screening.

3. Evidence of no less than 15 hours of therapy being provided per week, beginning with the date of admission, unless comprehensive documentation is provided to the QIO-vendor regarding an unexpected clinical event that meets the exception to intensity of service criteria.

C. Providers must ensure that the rehabilitation plan of care is:

1. Comprehensive, developed, and managed by a coordinated multidisciplinary team that includes, but is not limited to, a physician and nurse with special training or experience in the field of rehabilitation and a physical and/or occupational therapist;

2. Individualized and specify the intensity, frequency, and duration of therapies and the anticipated, quantifiable treatment goals; and

3. Modified with changes in medical or functional status, as applicable.

210 HEARINGS

Reference MSM Chapter 3100 – Hearings for the hearings process.

A. DESCRIPTION

Section 2301 of the Affordable Care Act (ACA) requires coverage of services furnished at freestanding birthing centers. A freestanding birthing center is described as a health facility that is not a hospital or physician's office, where childbirth is planned to occur away from the pregnant woman's residence. The freestanding birthing center must be in compliance with applicable state licensure and nationally recognized accreditation organization requirements for the provision of prenatal care, labor, delivery, and postpartum care. Freestanding birthing center complies with Section 2301 of the ACA freestanding birthing center requirements related to the health and safety of recipients provided services by licensed freestanding birthing centers.

B. POLICY

The DHCFP freestanding birthing center coverage and reimbursement is limited to medically necessary childbirth services which use natural childbirth procedures for labor, delivery, postpartum care, and immediate newborn care. Freestanding birthing center coverage and reimbursement are limited to women admitted to a freestanding birthing center in accordance with adequate prenatal care, prospect for a normal uncomplicated birth defined by criteria established by the American College of Obstetricians and Gynecologists and by reasonable generally accepted clinical standards for maternal and fetal health.

Refer to the Maternity Care section of MSM Chapter 600 – Physician Services, for comprehensive maternity care coverage provided by physicians and/or nurse midwives.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. Freestanding birthing center reimbursement includes childbirth services for labor, delivery, post-partum and immediate newborn care when the following pregnancy criteria are met:

1. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed freestanding birthing center protocol;

2. Completion of at least 36 weeks gestation and not more than 42 weeks gestation.

b. Freestanding birthing centers are not eligible for reimbursement if:

1. The pregnancy is high-risk.

2. There is history of major uterine wall surgery, cesarean section or other obstetrical complications which are likely to recur.

3. The recipient is discharged prior to delivery.

2. NON-COVERED SERVICES

a. Emergency treatment as a separately billed service provided by the freestanding birthing center. For emergency treatment provided in a hospital – refer to policy in MSM Chapter 200 – Hospital Services; and

b. Emergency medical transportation as a separately billed service provided by the freestanding birthing center. For policy related to emergency transportation – refer to MSM Chapter 1900 – Transportation Services.

E. PROVIDER REQUIREMENTS

Freestanding birthing centers must meet the following criteria:

1. Have a provider contract with the DHCFP. Refer to MSM Chapter 100 – Medicaid Program, Provider Enrollment.

2. Meet applicable state licensing and/or certification requirements in the state in which the center is located.

3. Licensure from Health Care Quality and Compliance (HCQC) as a freestanding birthing center.

4. Informed consent: Each recipient admitted to the freestanding birthing center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

For billing instructions and a list of covered procedure and diagnosis codes, please refer to the QIO-like vendor's Billing Manual.

A. INTRODUCTION

The Nevada State Plan provides that certain non-United States (U.S.) citizens, who otherwise meet the requirements for Title XIX eligibility, are restricted to receive only emergency service as defined by 42 CFR 440.255, titled "Limited Services Available to Certain Aliens." Provision of outpatient emergency dialysis health care services through the Federal Emergency Services (FES) Program is also deemed an emergent service for this eligibility group. The FES Program is also known as Emergency Medicaid Only (EMO).

B. DEFINITIONS

For the purpose of this chapter, the following definitions apply:

1. Federal Emergency Service (FES) Program – The DHCFP will reimburse only for the alien's care and services which are necessary for the treatment after sudden onset of an emergency condition. As defined in 42 CFR 440.255, an emergency condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

   a. Placing the FES recipient's health in serious jeopardy;

   b. Serious impairment to bodily functions; or

   c. Serious dysfunction of any bodily organ or part.

2. FES recipient – Means a qualified or non-qualified alien as described by 42 CFR 435.406(c) and 42 CFR 436.406(c) who receives services pursuant to 42 CFR 440.255.

3. Acute – Means symptoms that have arisen quickly, and which are short-lived.

4. Chronic – Means a health-related state that is not acute persisting for a long period of time or constantly recurring. The only chronic condition covered by the FES Program is ESRD.

5. End Stage Renal Disease (ESRD)/Dialysis Services – Means the method by which a dissolved substance is removed from the body of a patient by diffusion, osmosis, and convection from one fluid compartment to another fluid compartment across a semipermeable membrane (i.e., hemodialysis, peritoneal dialysis, and other miscellaneous dialysis procedures). This chronic condition is covered.

6. Stabilized – With respect to an emergency medical situation, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

C. COVERAGE AND LIMITATIONS

1. Any acute emergency medical condition that meets the definition of FES Program as identified above in the definitions described and 42 CFR 440.255.

2. Outpatient dialysis services for a FES recipient with ESRD are covered as an emergency service when the recipient's treating physician signs and completes the certification stating that in his/her

medical opinion the absence of receiving dialysis at least three times per week, would reasonably be expected to result in any one of the following:

a. Placing the FES Program recipient's health in serious jeopardy;

b. Serious impairment of bodily functions; or

c. Serious dysfunction of a bodily organ or part.

D. PRIOR AUTHORIZATION

1. Authorization requirements for all emergency services under 42 CFR 440.255 must follow authorization requirements as outlined in MSM Chapter 200.

2. Prior authorization is not required for ESRD services.

3. Refer to "Provider Requirements" Section for treating physician ESRD certification form requirements.

E. NON-COVERED SERVICES

1. FES Program – dialysis for an eligibility group not qualified under 42 CFR 435.406(2)(i)(ii).

2. Services covered prior to the coverage date of this policy.

3. Services deemed non-covered when:

a. The "FA 100 – Initial Emergency Dialysis Case Certification" form is incomplete and/or missing from the FES recipient's medical record.

b. The "FA 101 – Monthly Emergency Dialysis Case Certification" form is incomplete and/or missing from the FES recipient's medical record.

F. ESRD PROVIDER REQUIREMENTS

1. Treating physicians must complete and sign the "FA 100 – Initial Emergency Dialysis Case Certification" form and the "FA 101 – Monthly Emergency Dialysis Case Certification" form. These forms must be maintained in the FES recipient's medical record. These forms are found on the QIO-like vendor website.

2. The DHCFP may audit FES Program recipient medical records to ensure compliance with the initial and monthly requirement.

3. For billing instructions, please refer to the QIO-like vendor's Billing Manual and/or PT45 and 81 Billing Guide.

A. DESCRIPTION

A swing bed is a bed in a rural or CAH, certified as a swing bed by CMS, which can be used to provide either acute care or post-acute skilled nursing services. A recipient admitted to a swing bed for post-acute skilled nursing services following discharge from acute inpatient care, does not have to change beds or locations in a facility, unless required by the facility.

B. POLICY

This policy is specific to an acute inpatient bed that provides post-acute NF services. The DHCFP reimburses post-acute/NF swing bed days when: a recipient receiving acute inpatient hospital services for at least three consecutive calendar days (not including the day of discharge) requires post-acute, skilled nursing services seven days a week and no NF placement is available or the recipient or family refuses NF placement outside the rural area. The three-day qualifying acute inpatient stay does not have to be from the same facility as the swing bed admission. Placement in a swing bed must be on a temporary (not long-term) basis.

C. PRIOR AUTHORIZATION

Prior authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Refer to MSM Chapter 100, Authorization.

Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to or discharge from a swing bed.

Services not included in the per diem rate may require prior authorization. Reference the MSM Chapter applicable to the service type regarding authorization requirements.

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. The DHCFP covers medically necessary, post-acute, NF LOC services provided on an inpatient basis and reimbursed at a per diem rate. The per diem rate includes routine services and supplies, including a regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen and the use of equipment and facilities

b. The following services are separately reimbursed when the service meets policy requirements specific to that service:

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 eyeglasses, hearing aids, braces, prostheses, etc.

4. Customized durable medical equipment.

5. Emergency transportation.

6. Physical, occupational and speech therapy services.

7. Physician services.

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

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

2. NON-COVERED SERVICES

a. Swing bed placement when NF placement is available in the rural area where the hospital is located or in another rural or urban area acceptable to the recipient or family.

b. Swing bed days not authorized by the QIO-like vendor.

E. PROVIDER RESPONSIBILITIES

1. Ensure compliance with Provider Responsibility requirements specified in Chapter 200, Section 203.2, federal and state swing bed requirements and the DHCFP coverage and authorization requirements.

2. Utilize available NF beds prior to requesting swing bed placement, unless NF placement is outside the rural area and there is documented evidence that a recipient or family objects to placement outside the rural community.

3. Transfer a recipient to the first available NF bed.

4. Reference Chapter 500 for Pre-Admission Screening and Resident Review (PASRR) and NF LOC screening requirements prior to a recipient being transferred from a swing bed to a NF bed within the hospital or at another facility.

F. DOCUMENTATION

1. Notify and submit required documentation to the QIO-like vendor to initiate admission and concurrent review authorizations when a recipient is retro eligible.

2. Submit the following documentation to the QIO-like vendor with the initial authorization request:

a. A history and physical or acute inpatient discharge summary indicating the need for skilled nursing services;

b. A physician acute hospital discharge order and swing bed admission order;

c. NF placement efforts with documentation regarding NF bed unavailability or recipient or family refusal of NF placement outside the rural area; and any additional documentation requested by the QIO-like vendor.

3. Submit the following documentation to the QIO-like vendor with a concurrent swing bed authorization request no less frequently than monthly (when applicable):

a. Ongoing NF placement efforts and either the reasons NF bed placement is not available or recipient or family refusal of NF placement outside the rural area;

b. A monthly nursing assessment summary indicating a recipient continues to meet a skilled LOC; and

c. Any additional documentation requested by the QIO-like vendor.

A. DESCRIPTION

Outpatient observation services are physician ordered, clinically appropriate, short term hospital outpatient services including diagnostic assessment and treatments provided when a recipient's medical needs do not meet acute inpatient care guidelines. A recipient's condition is further evaluated to determine if inpatient admission is required or the recipient can be safely discharged. Outpatient observation services do not have to be provided in a designated hospital observation unit. Outpatient observation services can be provided in any area of a hospital, such as on an obstetric unit or an intermediate/progressive coronary care unit.

B. POLICY

Outpatient observation services are reimbursed when ordered by a physician or other clinician authorized by State licensure law and hospital staff bylaws to order services and at an hourly basis up to 48 continuous hours.

Medically necessary ancillary services (e.g. laboratory, radiology and other diagnostics, therapy and pharmacy services) that meet the coverage and authorization requirements of the MSM applicable to the service are separately reimbursed.

Observation and ancillary services provided at the same facility and on the same calendar date as an inpatient admission, as part of one continuous episode of care, are included in the first inpatient day, per diem rate (a rollover admission). Observation hours (not exceeding the observation 48-hour limit) and ancillary services rendered on the calendar date(s) preceding the rollover inpatient admission date are separately reimbursed.

C. PRIOR AUTHORIZATION IS NOT REQUIRED for hourly outpatient observation.

Medically necessary ancillary services may require prior authorization. Reference the MSM Chapter applicable to the service type regarding authorization requirements.

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. Observation begins the date and time specified on the physician's observation order, not when the recipient is placed in an observation bed. Observation ends when the 48-hour policy limit is reached or at the date and time the physician writes an order for either inpatient admission, transfer to another healthcare facility or discharge.

b. Observation days are covered when:

1. A recipient is clinically unstable for discharge from an outpatient setting due to either:

a. A variance from generally accepted, safe laboratory values;

b. Clinical signs and symptoms above or below normal range requiring an extension of monitoring and further evaluation;

c. An unstable presentation with vague symptoms and no definitive diagnosis; or

d. An uncertain severity of illness or condition in which a change in status requiring medical intervention is anticipated.

e. A significant adverse reaction occurs subsequent to a therapeutic service (e.g., blood or chemotherapy administration, dialysis);

f. The medically necessary services provided meet observation criteria, a provider is notified that inpatient admission is denied because it does not meet acute inpatient LOC criteria, a physician writes an order for observation status and patient rights and utilization review federal requirements are met pertaining to changing an inpatient admission to outpatient observation status.

2. NON-COVERED SERVICES

a. Observation hours exceeding the 48-hour limit.

b. Services rendered without a signed, dated physician order or documentation in the medical record that specifies the date and time observation services were initiated and discontinued.

c. Diagnostic testing or outpatient procedures prescribed for medically stable individual or services deemed by the DHCFP, the DHCFP's QIO-like vendor or other authorized agency as not medically necessary or appropriate.

d. Observation status when either a recipient's medical condition or treatment needs meet acute inpatient guidelines/standards of care or the probability of a significant, rapid onset complication is exceptionally high requiring prompt interventions available only in an inpatient setting.

e. Services that can be safely and effectively provided in a less restrictive setting (e.g., a physician's office, emergency department, clinic, urgent care setting).

f. Services limited to a therapeutic procedure (e.g., outpatient blood transfusion, intravenous fluids, chemotherapy administration, dialysis) when no other service is required or in the absence of a documented adverse reaction.

g. Services that are routine preparation prior to or monitoring after a diagnostic test, treatment, procedure or outpatient same-day surgery.

h. Services immediately preceding an inpatient admission for elective induction of labor (EIOL) prior to 39 weeks' gestation when the EIOL is not authorized as medically necessary.

i. Services provided solely for the convenience of a recipient, recipient's family or physician.

j. Services provided to an individual not eligible (concurrently or retrospectively) for Medicaid or NCU on the date of service or not covered by or performed in compliance with this or any other MSM Chapter.

3. DOCUMENTATION REQUIREMENTS

Ensure the following information is maintained in a recipient's medical record:

a. A physician's order, clearly indicating the dates and times that observation begins and ends.

b. Comprehensive documentation that supports medical necessity and describes, when applicable:

1. A significant complication or adverse reaction that requires services that would normally be included in a recovery or post-procedure period; or

2. A high probability of a significant, rapid onset complication requiring prompt interventions available in an observation setting.

c. An unstable presentation with vague symptoms and no definitive diagnosis; or

d. An uncertain severity of illness or condition in which a change in status requiring medical intervention is anticipated.

e. A significant adverse reaction occurs subsequent to a therapeutic service (e.g., blood or chemotherapy administration, dialysis);

f. The medically necessary services provided meet observation criteria, a provider is notified that inpatient admission is denied because it does not meet acute inpatient LOC criteria, a physician writes an order for observation status and patient rights and utilization review federal requirements are met pertaining to changing an inpatient admission to outpatient observation status.

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b. Services rendered without a signed, dated physician order or documentation in the medical record that specifies the date and time observation services were initiated and discontinued.

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b. Comprehensive documentation that supports medical necessity and describes, when applicable:

1. A significant complication or adverse reaction that requires services that would normally be included in a recovery or post-procedure period; or

2. A high probability of a significant, rapid onset complication requiring prompt interventions available in an observation setting.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 27, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 300 – RADIOLOGY SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 300 – Radiology Services are being proposed to remove prior authorization requirements for medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS) and Positron Emission Tomography (PET) scans.

Entities Financially Affected: Outpatient Hospitals (PT 12), Physician, M.D., Osteopath (PT 20), Advanced Practice Registered Nurse (PT 24), Radiology (PT 27) and Physician Assistant (PT 77).

Financial Impact on Local Government: Overall impact will be budget neutral.

These changes are effective September 1, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 17/19 MSM 300 – RADIOLOGY SERVICES	MTL 16/18 MSM 300 – RADIOLOGY SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
303.1A(1)	**COVERAGE AND LIMITATIONS**	Replaced Nurse Practitioner with Advanced Practice Registered Nurse.
303.1A(5)	**COVERAGE AND LIMITATIONS**	Removed prior authorization requirements for medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS) and Positron Emission Tomography (PET) scans.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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RADIOLOGY SERVICES

300 INTRODUCTION

Diagnostic testing and radiologic services are federally mandated Division of Health Care Financing and Policy (DHCFP) Medicaid and Children's Health Insurance Program (CHIP) benefits. This chapter presents policy diagnostic services provided in outpatient hospitals, diagnostic centers or mobile units.

The DHCFP reimbursement is based on the need to establish a diagnosis and to prescribe treatment. Reimbursement is also provided for progressive follow-up or staging. Diagnostic studies are rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner of Nursing (APN) and must be directly related to the presenting symptoms.

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

301 REGULATORY AUTHORITY

301.1 The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulations (CFR), Part 435 and Sections 1902 (a) (10) (A) (I) (IV) and (VI), 1902 (a) (10) (A) (ii) (XI), 1902 (a) (10) (E), 1902 (1) and (m), 1905 (p), (q) and (s), 1920, and 1925 of the Act. Title XVIII of the Social Security Act (SSA), 1862 (a) (1) (A), 411.15 et. seq. Title XVIII of the SSA, 1862 (a) (7), 405.1411-1416.

301.2 The State Legislature sets forth standards of practice for licensed professionals in the following Nevada Revised Statutes (NRS):

Chapter 454 – Poisons; Dangerous Drugs and Hypodermics (Section 454.213);

Chapter 457 – Cancer;

Chapter 630 – Physicians and Assistant;

Chapter 639 – Pharmacists and Pharmacy (Sections 639.008, 639.0095, 639.0097, 639.0105, 639.0125 and 639.0143.)

301.3 Also cited, Title XXI State Plan Attachment 1.2-B, 101.9 E (Page 7) of Title XIX State Plan.

301.4 The Food and Drug Administration (FDA), Mammography Quality Standards Act (MQSA) of 1992.

302 RESERVED

303 MEDICAID POLICY

303.1 RADIOLOGICAL STUDIES

The DHCFP medical assistance programs will reimburse for those covered services that are considered to be medically necessary for the diagnosis and treatment of a specific illness, symptom, complaint or injury or to improve the functioning of a malformed body part without prior payment authorization. The investigational use for any radiological test is not a Medicaid covered benefit

303.1A COVERAGE AND LIMITATIONS

1. A licensed physician or other licensed persons working within the scope of their practice must request radiology services (e.g., Advanced Practice Registered Nurse, Physician Assistant, Podiatrist, etc.).

2. Payment for X-rays and other radiological examinations will only be allowed for those services that are considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint or injury or to improve the functioning of a malformed body part.

3. An annual screening mammography is a covered benefit without prior authorization for women age 40 and older and/or a woman between the ages of 35-39 considered a high risk for breast cancer. High risk is defined as one or more of the following conditions:

   a. Personal history of breast cancer;

   b. Personal history of biopsy – proven beginning breast disease;

   c. A mother, sister or daughter had breast cancer; and/or

   d. A woman who has not given birth prior to age 30.

4. Diagnostic and/or treatment mammography's are not restricted to age or sex and do not require prior authorization.

5. The choice of the appropriate imaging modality or combination of imaging modalities should be determined on an individual level. Prior authorization is not required for medically necessary Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS) or Positron Emission Tomography (PET) scans and the determination of medical necessity is based on nationally recognized evidenced based clinical guidelines. Examples include but are not limited to: MCG/McKesson/Interqual Criteria. Always use other modalities or less expensive tests such as CT, ultrasound or standard X-ray, etc., when they will achieve the required results.

Use of approved modalities for investigational/experimental reasons are not a Medicaid benefit. Prior authorization will not be required for initial testing and tumor staging. Other repeated testing will require prior authorization.

6. The DHCFP medical assistance programs cover certain types of X-rays and cover skeletal films for arms, legs, pelvis, vertebral column, skull, chest and abdominal films that do not involve the contrast material and electro cardiograms furnished by a portable X-ray supplier in a residence used as a recipient's home. These services must be performed under the general supervision of a physician. All licensing conditions and health and safety conditions must be met. Coverage of portable services are defined in 42 CFR 486.

7. Documentation must be available in the clinical record to support the reasonable and necessary indications for all testing.

8. The following exception requires prior authorization:

   All non-emergency services referred and/or provided out-of-state.

9. See Billing Manual for Diagnostic Test prior authorization schedule.

303.1B PROVIDER RESPONSIBILITY

Providers are responsible for the following:

1. Verify program eligibility each month (e.g., Qualified Medicaid Beneficiary (QMB), Managed Care Organization (MCO), etc.) and comply with the program requirements. Example: A QMB only recipient never requires a Medicaid payment authorization.

2. The provider must allow, upon the request of proper representatives of the DHCFP, access to all records which pertain to Medicaid or CHIP recipients for regular review, audit or utilization review.

3. Evidence to support medical necessity for the procedures must be clearly documented in the clinical record. Duplicative testing when previous results are still pertinent is not a covered benefit.

4. The ordering physician is responsible for forwarding appropriate clinical data to the diagnostic facility.

303.1C RECIPIENT RESPONSIBILITY

The DHCFP medical assistance program recipient must:

1. present a current Medicaid card to service providers at each encounter.

2. notify providers immediately for any change in eligibility status, e.g. pending status to eligible or Fee-for-Service to managed care.

303.1D PRIOR AUTHORIZATION

Providers must submit the following documentation to substantiate a prior authorization request: the date, place and results of previous diagnostic tests performed. Fax or mail all information to the Quality Improvement Organization (QIO)-like vendor.

303.2 SCREENING MAMMOGRAPHY

Screening mammograms are radiological procedures furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and include a physician's interpretation of the results. The service must be at a minimum, a two-view exposure (that is, a cranio-caudal and medial lateral oblique view) of each breast.

The DHCFP pays for routine screening mammograms annually for women over age 40. For women aged 35-39, a baseline mammogram is allowed once during this period of time. All facilities providing mammography services are required to have a certificate issued by the FDA, assuring the mammography provider meets national quality standards in accordance with the MQSA of 1992.

303.2A COVERAGE AND LIMITATIONS

A doctor's prescription or referral is not necessary for the procedure to be covered. It is required that there be 365 days from the date of the last mammogram until the next mammogram.

303.3 ELECTRODIAGNOSTIC TESTING/NEUROPHYSIOLOGICAL STUDIES

A neurological evaluation must proceed diagnostic testing.

a. ELECTROENCEPHALOGRAM (EEG)

Routine EEG tests measure and record the electrical impulses from the cortex of the brain. A diagnosis can only be made with correlating clinical findings.

b. 24-HOUR ELECTROENCEPHALOGRAPHIC RECORDING

Intensive EEG recording (24-hours) is a safe and clinically effective method of diagnosis, classification and localization for seizure disorders and other factors precipitating individual seizures. Results can indicate which category of medication may be the most successful.

c. EEG BRAIN MAPPING

EEG brain mapping is a term commonly used for several quantitative EEG techniques. These include:

1. EEG frequency analysis;

2. topographic display;

3. statistical comparisons to a normative database; and

4. other similar computer-based calculations based on EEG or evoked potentials.

Prior authorization requests must be reviewed by a Physician Advisor highly skilled in clinical electroencephalographic testing for services which are provided by physician specialists in clinical electroencephalography. A specific correlating diagnosis has not been established.

303.3A COVERAGE AND LIMITATIONS:

EEG testing is covered when supported by sufficient information that its use was medically appropriate considering the patient's symptoms and preliminary diagnosis.

24-hour EEG recordings and EEG mapping require prior payment authorization.

303.4 ELECTROMYOGRAPHY (EMG), NERVE CONDUCTION STUDIES (NCS) DESCRIPTION:

Electromyoneurography is the combined use of electromyography (EMG) and electroneurography/NCS. These studies are done to detect neuromuscular abnormalities by measuring the nerve conduction and muscle potentials. F-wave studies assess motor nerve function along each nerve. An impulse generated at the stimulating electrode travels up the motor nerves to the motor neuron cell bodies in the spinal cord, on to the neuromuscular junction and the muscle. H-reflex studies are entirely separate from F-wave studies. H-reflex studies assess sensory and motor nerve function and their connections in the spinal cord. The EMG/NCS testing in combination with evaluating the range of motion, motor power, sensory defects and reflexes can differentiate between neuropathy and myopathy.

303.4A COVERAGE AND LIMITATIONS:

1. EMG measures the electrical activity of muscles at rest and during contractions.

2. NCS – Diagnostic nerve conduction studies include amplitude which differentiates nerve conduction studies from screening studies performed with devices which only measure latency.

3. F-wave studies are usually performed in conjunction with conventional motor nerve conductions studies of the same nerve. F-wave studies assess motor nerve function along the entire extent of each selected nerve.

4. Reflex Tests – H-reflex testing is unilateral and usually involves assessment of the tibial motor nerve and the gastrocnemius-soleus muscle complex. They are not often performed in conjunction with conventional nerve conduction studies of this nerve-muscle pair. Typically, only one or two H-reflex studies are performed on a patient during a given encounter.

5. Neuromuscular junction testing

COVERED DIAGNOSIS:

Carpal Tunnel Syndrome	Neuritis
Diabetic Neuropathy	Neuromuscular conditions
Disorders of the Peripheral Nervous System	Pain in Limb
Disturbance of Skin Sensation	Plexopathy
Fasciculation Joint Pain	Radiculopathy
Muscle Weakness	Spinal Cord Injury
Myopathy	Swelling and Cramps
Myositis	Trauma to Nerves
Nerve Root Compression	Weakness

See Billing Manual for prior authorization requirements.

303.5 EVOKED POTENTIALS (EPs):
SHORT-LATENCY SOMATOSENSORY EVOKED POTENTIAL STUDY (SSEP)
VISUAL EVOKED POTENTIAL (VEP)
AUDITORY EVOKED POTENTIALS (AEP)

DESCRIPTION: EPs are time-locked responses of the nervous system to external stimuli. Somatosensory evoked potentials (SEPs) are one type of EP, which are generated by stimulation of afferent peripheral nerve fibers elicited by electrical, tactile or other stimuli. “Short-latency” SEP (SSEP) refers to that portion of the waveform of an SEP normally occurring within a specific time

lapse variable after nerve stimulation. SEP abnormalities are not disease specific but can indicate afferent conduction impairments associated with certain disorders.

303.5A COVERAGE AND LIMITATIONS

1. The SEP study is separated into upper and lower limbs to recognize that switching from the upper to lower limbs requires an increase in work because many stimulating and recording electrodes must be moved and the patient must be stimulated many more times to perform the additional testing.

2. SEP studies performed on the trunk or head are completely separate tests from the upper and lower limb studies.

3. The visual evoked potential codes are clinical neurophysiologic studies.

4. The auditory evoked potential procedure codes can be a clinical neurophysiologic study as well as an audiology study.

COVERED DIAGNOSIS

SEP/SSEP:	VER:
Spinal Cord Lesions	Lesions of Optic Nerve/Optic Tracts
Stroke	Multiple Sclerosis (MS)
Extremity numbness and weakness	

ABR:	
Lesions in the Brain Stem including Tumor	Cerebellopontine Angle Lesions
Evaluate Hearing in Infants, Children, Adults	Infarctions
Evaluation for peripheral Hearing Loss	MS

See Billing Manual for prior authorization requirements.

303.6 MAGNETOENCEPHALOGRAPHY (MEG)
INTRAOPERATIVE NEUROPHYSIOLOGY MONITORING

DESCRIPTION: MEG is a highly refined noninvasive technique that measures the magnetic fields generated by active groups of nerve cells in the brain which would obviate the need for depth electrodes in the precise localization of epileptogenic foci. MEG Non-invasive use of MEG and MEG - EEG have been able to help focus subdural electrodes for a chronic intracranial presurgical evaluation in recipients with medically intractable epilepsy and comparison of epileptic activity with normal evoked responses may help localize epileptic zones.

Intraoperative neurophysiology/electrophysiologic monitoring of the nervous system is now widely used to help prevent complications and to identify structures during neurosurgical and other procedures. These techniques include EEG, evoked potentials, EMG and nerve conduction velocity (NCV) testing and monitoring.

303.6A COVERAGE AND LIMITATIONS:

MEG – The procedure is limited to localization of the seizure zone in medically intractable partial epilepsy for recipients being considered for surgical intervention.

Intraoperative electrophysiologic monitoring – EEG or SEP to monitor for cerebral ischemia; electrocorticography (ECoG) and SEP sensory cortex identification to define the limits of cortical resection; SEP spinal cord monitoring; Brainstem Auditory Evoke Potential (BAEP) and cranial nerve EMG monitoring during posterior fossa procedures; functional localization of cortex with direct cortical stimulation in expert hands; and EMG and compound muscle and nerve action potential measurements of various peripheral nervous system structures.

1. COVERED DIAGNOSIS:

   Partial intractable epilepsy, without mention of impairment of consciousness.

   See Billing Manual for prior authorization requirements.

2. DOCUMENTATION REQUIREMENTS

   Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization is required.

303.7 SLEEP STUDY SERVICES

303.7A SLEEP STUDY DESCRIPTION

1. According to the U.S. Department of Health and Human Services, National Institutes of Health (NIH), sleep studies are tests that measure how well someone sleeps and how the body responds to sleep problems. Sleep studies are necessary because untreated sleep disorders can raise risk for heart disease, high blood pressure, stroke and other medical conditions. Sleep disorders have also been linked to an increased risk of injury, such as falling in the elderly and automobile accidents.

   a. The following sleep study tests are covered benefits: Polysomnography (PSG) is the scientific evaluation of sleep that involves a physiologic recording of brain waves, oxygen level in blood, heart rate and breathing and eye and leg movements.

b. The multiple sleep latency test (MSLT) is performed to measure daytime sleepiness. Also known as a daytime nap study, the MSLT is the standard tool used to diagnose narcolepsy and idiopathic hypersomnia.

2. Sleep study services are performed with physician review, interpretation and report.

303.7B PRIOR AUTHORIZATION

1. The PSG and MSLT sleep study tests are limited to two services in a 12-month period without prior authorization. If the services exceed limitations, a prior authorization is required.

2. Prior authorization for MSLT includes authorization for a PSG performed on the preceding night to be valid.

3. Documentation supporting medical necessity for sleep study services must be clearly documented in the recipient's medical record and submitted when a prior authorization is requested.

303.7C COVERAGE AND LIMITATIONS

1. Sleep studies are covered services in the following settings:

a. a certified or accredited sleep disorder facility; or

b. an in-home (unattended) setting in conjunction with a comprehensive sleep evaluation by a physician board certified in sleep medicine.

2. A licensed physician or other licensed professional working within the scope of their practice must request the appropriate test.

3. The ordering provider is responsible for forwarding appropriate clinical data to the diagnostic facility.

4. The need for diagnostic testing is confirmed by medical evidence, e.g. recipient history, physician examination and other laboratory tests.

5. Reference Medicaid Services Manual (MSM) Chapter 1300, Durable Medical Equipment, for coverage and limitation guidelines for the positive airway pressure device services.

6. Polysomnography (PSM) minimum requirements include the following:

a. EEG;

b. Electro-oculography (EOG); and

c. EMG.

7. Additional parameters of sleep which may be monitored include:

a. EKG;

b. Airflow;

c. Ventilation and respiratory effort;

d. Gas exchange by oximetry, transcutaneous monitoring or end tidal gas analysis;

e. Extremity muscle activity, motor activity-movement;

f. Extended EEG monitoring;

g. Penile tumescence;

h. Gastroesophageal reflux;

i. Continuous blood pressure monitoring;

j. Snoring; and

k. Body positions, etc.

8. A PSG must be recorded and staged.

9. MSLT's are covered only when symptoms suggest a diagnosis of narcolepsy.

303.7D UNATTENDED SLEEP STUDIES

1. Portable monitoring (PM) for the diagnosis of obstructive sleep apnea (OSA) should be performed only in conjunction with a comprehensive sleep evaluation.

2. Clinical sleep evaluations following PM must be supervised and evaluated by a physician board certified in sleep medicine.

3. PM may be used as an alternative to PSG for the diagnosis of OSA in recipients with a high pretest probability to moderate to severe OSA.

4. PM should not be used for the following recipients:

   a. with significant comorbid medical conditions that may degrade the accuracy of PM, including moderate to severe pulmonary disease, neuromuscular disorders, asthma, stroke, severe hypertension or congestive heart failure.

   b. suspect of having other sleep disorders, including central sleep apnea, periodic limb movement disorder, insomnia, parasomnias, circadian rhythm disorders or narcolepsy.

5. PM should not be used for general screening of asymptomatic recipients.

6. PM may be indicated for the diagnosis of OSA in recipients for whom in-laboratory PSG is not possible by virtue of immobility, safety or critical illness.

7. At a minimum, the PM must record airflow, respiratory effort and blood oxygenation. The type of biosensors used to monitor these parameters for in-laboratory PSG are recommended for use in PM.

8. Unattended sleep studies are considered medically necessary using one of the following diagnostic techniques for recipients with symptoms suggestive of OSA when the home sleep study is used as part of a comprehensive sleep evaluation:

   a. Sleep monitoring using a Type II device, minimum of seven channels (e.g. EEG, EOG, EMG, ECG, airflow, respiratory effort, oxygen saturation);

   b. Sleep monitoring using a Type III device, minimum of four monitored channels including ventilation or airflow (at least two channels of respiratory movement or airflow), heart rate or ECG and oxygen saturation; or

   c. Sleep monitoring using a Type IV device, measuring at least three channels. Type IV devices must allow channels that allow direct calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) as the result of measuring airflow or thoracoabdominal movement.

9. An experienced sleep technician, sleep technologist or appropriately trained healthcare provider must perform the application of PM sensors or directly educate the recipient in correct application of the sensors.

10. Due to the known rate of false negative PM tests, in-laboratory PSG should be performed in cases where PM is technically inadequate or fails to establish the diagnosis of OSA in recipients with a high pretest probability.

11. If a PM test is technically inadequate or does not provide the expected result, in-laboratory PSG should be performed. Documentation supporting medical necessity for the repeat services must be clearly documented in the recipient's medical record.

303.7E NON-COVERED SLEEP STUDY SERVICES

1. Actigraphy and SleepStrip® are considered investigational/experimental and are not covered benefits.

2. Repeat studies are not covered when documentation for a repeat study does not indicate medical necessity (e.g. no new clinical documentation indicating the need for a repeat study).

303.8 RADIOPHARMACEUTICALS AND CONTRAST AGENTS

303.8A RADIOPHARMACEUTICALS AND CONTRAST AGENTS DESCRIPTION

1. According to the FDA, radiopharmaceuticals and contrast agents are used in diagnostic imaging procedures or for therapeutic purposes. Agents enhance the quality of MRI, MRA, CT scans, PET, x-ray and other modalities. Agents are also used to monitor treatment effect. Radiopharmaceuticals and contrast agents may be dispensed to the recipient in several different ways, i.e. by mouth or injection or placed into the eye or bladder. They may also be used for nuclear medicine.

303.8B COVERAGE AND LIMITATIONS

1. The DHCFP will reimburse covered, medically necessary radiopharmaceuticals and contrast agents.

304 HEARINGS

Please reference MSM, Chapter 3100, for Hearings process and policy.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 25, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
CHIEF OF DIVISION COMPLIANCE Casey Angres
Casey Angres (Aug 17, 2023 16:09 PDT)

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL AND SUBSTANCE USE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Substance Use Services are being proposed to align with "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project," remove stigmatizing and outdated language, which includes a chapter name change, and tools and services no longer allowed. For recipients ages 22-64, "Nevada's Treatment of OUDs and SUDs Transformation Project" (1115 SUD Waiver) allows for reimbursement of ASAM Levels 3.1, 3.2WM, 3.5, and 3.7WM substance use and withdrawal management services within an IMD setting through December 31, 2027.

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: These proposed changes affect all Medicaid enrolled providers delivering substance use treatment services outlined in MSM Chapter 400. Those Provider Types (PTs) include but are not limited to Hospital, Inpatient (PT 11), Psychiatric Hospital, Inpatient (PT 13), and Substance Use Agency Model (SUAM) (PT 17, Specialty 215).

Financial Impact on Local Government: Unknown at this time.

These changes are effective August 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 12/23	MTL 21/15, 01/16, 03/17, 21/17, 09/18, 17/18, 19/18, 20/18, 06/20, 10/20, 21/20, 06/22, 14/22, 04/23, 05/1
MSM 400 – Mental Health and Alcohol/Substance Use Services	MSM 400 – Mental Health and Alcohol/Substance Abuse Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 400	**Introduction**	Update language from “abuse” to “use.”
Section 401	**Authority**	Update language from “abuse” to “use.”
Section 403.5(B)	**Intensity of Needs Grid**	Update language from “abuse” to “use.”
Section 403.7	**Outpatient Alcohol and Substance Use Services Policy**	Update language from “abuse” to “use.”
Section 403.7A	**Coverage and Limitations**	Update language from “abuse” to “use.”
Section 403.8A	**Coverage and Limitations**	Update language from “detoxification” to “withdrawal management.”
Section 403.9A	**Coverage and Limitations**	Update language from “abuse” to “use.”
Section 403.9C	**Authorization Process**	Updated language from “abuse” to “use” and “detoxification” to “withdrawal management.”
Section 403.10	**Alcohol/Substance Use Withdrawal Management and Treatment Services Policy**	Updated language from “abuse” to “use” and “detoxification” to “withdrawal management.”
403.10A	**Coverage and Limitations**	Updated language from “abuse” to “use” and “detoxification” to “withdrawal management.” Added 1115 SUD Waiver explanation language. Removed duplicative language. Added clarifying language for inpatient admission documentation and removed outdated requirements. Updated Chapter reference. Removed section not applicable.
Section 403.10B	**Provider Responsibilities**	Updated language from “abuse” to “use” and “detoxification” to “withdrawal management.” Updated Chapter reference.
Section 403.10C	**Patient Responsibilities**	Added participation language.
Section 403.10D	**Authorization Process**	Updated language from “abuse” to “use” and “detoxification” to “withdrawal management.”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed outdated language. Added 1115 SUD Waiver explanation language. Removed outdated notice and liability language.
Attachment B Section B	**Substance Use Agencies Model (SUAM)**	Updated language from "abuse" to "use." Updated Chapter reference.
Attachment B Section C	**Definitions**	Updated language from "abuse" to "use."
Attachment B Section D	**Provider Requirements**	Added clarifying ASAM language. Updated language from "abuse" to "use." Removed and updated outdated policy language.
Attachment B Section F	**Documentation Requirements**	Updated Chapter references.
Attachment B Section H	**Coverage and Limitations**	Updated language from "abuse" to "use." Removed outdated screenings and updated screening names. Corrected Level 3 services. Removed outdated medications no longer used. Removed certain allowable non-covered services and services covered under the 1115 SUD Waiver.
Attachment C	**Substance Use Agency Model Level of Care Grid**	Updated language from "abuse" to "use." Removed outdated language. Added 1115 SUD Waiver explanation language. Updated language from "detoxification" to "withdrawal management."
Attachment D	**Institution for Mental Disease (IMD)**	Added 1115 SUD Waiver explanation language.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

400 INTRODUCTION

Nevada Medicaid reimburses for community-based and inpatient mental health services to both children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under State law for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functioning level. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, while in transit and/or in the recipient's home. All services must be documented as medically necessary and appropriate and must be prescribed on an individualized Treatment Plan.

Mental health rehabilitation assists individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.

Alcohol and substance use treatment and services are aimed to achieve the mental and physical restoration of alcohol and drug users. To be Medicaid reimbursable, while services may be delivered in inpatient or outpatient settings (inpatient substance use hospital, general hospital with a substance use unit, mental health clinic, or by an individual psychiatrist or psychologist), they must constitute a medical-model service delivery system.

All Medicaid policies and requirements (such as prior authorization, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000, are the same for NCU. Medicaid Services Manual (MSM) Chapter 400 specifically covers behavioral health services and for other Medicaid services coverage, limitations and provider responsibilities, the specific MSM needs to be referenced.

Nevada Medicaid's philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers and informal supports when considered appropriate per the recipient or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the recipient's needs. In the case of child recipients, providers shall deliver youth guided effective/comprehensive, evidence-based treatments and interventions, monitor child/family outcomes through utilization of Child & Family Team meetings and continuously work to improve services in order to ensure overall fidelity of recipient care. (Reference Addendum – MSM Definitions).

401 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA) authorizing varying percentages of federal financial participation (FFP) for states that elected to offer medical programs. States must offer the 11 basic required medical services. Two of these are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20). All other mental health and substance use services provided in a setting other than an inpatient or outpatient hospital are covered by Medicaid as optional services. Additionally, state Medicaid programs are required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as the result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening for children 21 years or younger, whether or not such services are covered under the state plan (Section 1905(a)).

Other authorities include:

- Section 1902(a)(20) of the SSA (State Provisions for Mental Institution Patients 65 and Older)
- Section 1905(a)(13) of the SSA (Other Diagnostic Screening, Preventative and Rehabilitative Services)
- Section 1905(h) of the SSA (Inpatient Psychiatric Services to Individuals Under Age 21)
- Section 1905(i) of the SSA (Definition of an Institution for Mental Diseases)
- Section 1905(r)(5) of the SSA (Mental Health Services for Children as it relates to EPSDT)
- Section 1947 of the SSA (Qualifying Community-Based Mobile Crisis Intervention Services)
- 42 CFR 435.1009 (2) (Definition of Institution for Mental Diseases (IMD))
- 42 CFR 435.1010 (Definitions Relating to Institutional Status)
- 42 CFR 440.160 (Inpatient Psychiatric Services to Individuals Under Age 21)
- 42 CFR 440.2(a) (Specific Definitions of Services for Inpatient vs. Outpatient)
- 42 CFR 441.150 to 441.156 (Inpatient Psychiatric Services for Individuals under age 21 in Psychiatric Facilities or Programs)
- 42 CFR, Part 482 (Conditions of Participation for Hospitals)
- 42 CFR, Part 483 (Requirements for States and Long-Term Care Facilities)

- 42 CFR, PART 435 (Eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa), 440.130 (Definitions relating to institutional status)
- 42 CFR, PART 440 (Services: General Provisions), 440.130 (Diagnostic, screening, preventive and rehabilitative services)
- CMS 2261-P, Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services)
- CMS State Medicaid Manual, Chapter 4, Section 4390 (Requirements and Limits applicable to Specific Services (IMD))
- Nevada Revised Statute (NRS), Chapter 629 (Healing Arts Generally)
- NRS 432.B (Protection of Children from Abuse and Neglect)
- NRS, Chapter 630 (Physicians, Physician Assistants and Practitioners of Respiratory Care)
- NRS Chapter 632 (Nursing)
- NRS 433.B.010 to 433.B.350 (Mental Health of Children)
- NRS 433.A.010 to 433.A.750 (Mental Health of Adults)
- NRS 433.704(2) (Mobile Crisis Teams)
- NRS 449 (Medical and other Related Facilities)
- NRS 449.01566 (Peer Support Services Defined)
- NRS 449.0915 (Endorsement of Hospital as a Crisis Stabilization Center)
- NRS 641 (Psychologists)
- NRS 641.A (Marriage and Family Therapists and Clinical Professional Counselors)
- NRS 641B (Social Workers)
- NRS 695C.194 (Provision of Health Care Services to Recipients of Medicaid or enrollees in Children's Health Insurance Program: Requirement for Health Maintenance Organizations (HMOs) to contract with hospitals with endorsements as Crisis Stabilization Centers)
- NRS 695G.320 (Provision of Health Care Services to Recipients of Medicaid or enrollees in Children's Health Insurance Program: Requirement for Managed Care Organizations

(MCOs) to contract with hospitals with endorsements as Crisis Stabilization Centers)

- Nevada State Plan, Section 4.19-A, Page 4
- Nevada Medicaid Inpatient Psychiatric and Substance Use Policy, Procedures and Requirements. The Joint Commission Restraint and Seclusion Standards for Behavioral Health.

402 RESERVED

403 POLICY

403.1 OUTPATIENT SERVICE DELIVERY MODELS

Nevada Medicaid reimburses for outpatient mental health and/or mental health rehabilitative services under the following service delivery models:

A. Behavioral Health Community Networks (BHCN)

Public or private entities that provides or contracts with an entity that provides:

1. Outpatient Mental Health (OMH) services, such as assessments, therapy, testing and medication management, including specialized services for Nevada Medicaid recipients who are experiencing symptoms relating to a covered, current International Classification of Diseases (ICD) diagnosis or who are individuals with a mental illness and residents of its mental health service area who have been discharged from inpatient treatment;

2. 24-hour per day emergency response for recipients; and

3. Screening for recipients under consideration for admission to inpatient facilities.

BHCNs are a service delivery model and are not dependent on the physical structure of a clinic. BHCNs can be reimbursed for all appropriate services covered in this chapter and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with individual Rehabilitative Mental Health (RMH) providers.

B. Independent Behavioral Health Professionals – are independently licensed in the State of Nevada as Psychiatrists, Psychologists, Advanced Practice Registered Nurses (APRN), Physician Assistants, Clinical Social Workers (LCSW), Marriage & Family Therapists (LMFT), and Licensed Clinical Professional Counselors (LCPC). These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements, expertise, and enrollment with Nevada Medicaid.

C. Behavioral Health Rehabilitative Treatment providers must meet the provider qualifications for the specific behavioral health service. Individual Rehabilitative Mental Health (RMH) providers arrange for supervision with an independently licensed Behavioral Health Professional under an agency/entity/group. enrolled with Nevada Medicaid; only an individual RMH provider enrolled as a Qualified Mental Health Professional (QMHP) and functioning as a Clinical Supervisor is not required to have an arrangement for supervision. Individual RMH providers are not directly reimbursed by

Nevada Medicaid and must contract with a BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health provider to deliver services.

403.2 PROVIDER STANDARDS

A. All providers must:

1. Provide medically necessary services;

2. Adhere to the regulations prescribed in this chapter and all applicable Division chapters;

3. Provide only those services within the scope of their practice and expertise;

4. Ensure care coordination to recipients with higher intensity of needs;

5. Comply with recipient confidentiality laws and Health Insurance Portability and Accountability Act (HIPAA);

6. Maintain required records and documentation;

7. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor;

8. Ensure client's rights; and

9. Cooperate with the Division of Health Care Financing and Policy's (DHCFP's) review process.

B. BHCN providers must also:

1. Have written policies and procedures to ensure the medical appropriateness of the services provided;

2. Operate under Clinical supervision and ensure Clinical supervisors operate within the scope of their license and expertise and have written policies and procedures to document the prescribed process;

3. Ensure access to psychiatric services, when medically appropriate, through a current written agreement, job description or similar type of binding document;

4. Utilize Clinical Supervision as prescribed in this chapter and have written policies and procedures to document the process to ensure Clinical Supervision is performed

on a regular, routine basis at least monthly and the effectiveness of the mental health treatment program is evaluated at least annually;

5. Work on behalf of recipients in their care to ensure effective care coordination within the state system of care among other community mental health providers and other agencies servicing a joint recipient;

6. Implement and maintain a Quality Assurance (QA) program which continually assesses quality measures and seeks to improve services on an ongoing basis. A QA program description must be submitted upon enrollment and updated annually on the anniversary of the BHCN enrollment month. The BHCN's QA program description and report must include the following:

   a. A list of behavioral health services and evidence-based practices that the BHCN provides to recipients.

      1. Identify the goals and objectives of the services and methods which will be used to restore recipient's highest level of functioning.

   b. An organization chart that outlines the BHCN's supervisory structure and the employees and positions within the agency. The organizational chart must identify the Clinical Supervisor(s), Direct Supervisor(s), affiliated mental health professional(s) and paraprofessionals names and National Provider Identifier (NPI) numbers for each.

   c. Document how clinical and supervisory trainings are conducted and how they support standards to ensure compliance with regulations prescribed within MSM Chapter 400. Provide a brief description of material covered, date, frequency and duration of training, location, names of employees that attended and the name of the instructor.

   d. Demonstration of effectiveness of care, access/availability of care and satisfaction of care. The BHCN must adhere to the QIO-like vendor's billing manual for further instructions concerning the required quality measures below. The following quality measures are required:

      1. Effectiveness of care:

         a. Identify the percentage of recipients demonstrating stable or improved functioning.

         b. Develop assessment tool to review treatment and/or

rehabilitation plans and report results of assessment.

2. Access and availability to care:

   a. Measure timeliness of appointment scheduling between initial contact and rendered face to face services.

3. Satisfaction of care:

   a. Conduct a recipient and/or family satisfaction survey(s) and provide results.

   b. Submit a detail grievance policy and procedure.

e. The DHCFP may require the BHCN to submit a DHCFP approved Corrective Action Plan (CAP) if the BHCN's QA report has adverse findings. The BHCN's CAP shall contain the following and must be provided within 30 days from the date of notice:

   1. The type(s) of corrective action to be taken for improvement;

   2. The goals of the corrective action;

   3. The timetable for action;

   4. The identified changes in processes, structure, internal/external education;

   5. The type of follow-up monitoring, evaluation and improvement.

f. QA Programs must be individualized to the BHCN delivery model and services provided. Duplication of QA documentation between BHCNs may be cause for rejection without review.

Failure to submit QA Program documentation or failure to meet standards of the QA Program and/or Corrective Action Plan (CAP) as required in MSM 403.B.6 within designated timeframes will result in the imposition of sanctions including, but not limited to, partial suspension and/or termination of the BHCN provider contract. Further clarification of the QA Program requirements may be found in the billing manual.

A BHCN that is accredited through the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or Council of Accreditation (COA) may substitute a copy of the documented QA program and report required for the certification in lieu of the

requirements of MSM 403.2B.6. Accreditation must be specific to a BHCN delivery model.

C. Recipient and Family Participation and Responsibilities

1. Recipients or their legal guardians and their families (when applicable) must:

a. Participate in the development and implementation of their individualized treatment plan;

b. Keep all scheduled appointments; and

c. Inform their Medicaid providers of any changes to their Medicaid eligibility.

403.2A SUPERVISION STANDARDS

1. Clinical Supervision – The documented oversight by a Clinical Supervisor to assure the mental and/or behavioral health services provided are medically necessary and clinically appropriate. Clinical Supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided, under ethical standards and professional values set forth by state licensure, certification, and best practice. Clinical Supervision is intended to be rendered on-site. Clinical Supervisors are accountable for all services delivered and must be available to consult with all clinical staff related to delivery of service, at the time the service is delivered. Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), Clinical Professional Counselors (CPC) and Qualified Mental Health Professionals (QMHP), excluding Interns, operating within the scope of their practice under state law, may function as Clinical Supervisors. Clinical Supervisors must have the specific education, experience, training, credentials and licensure to coordinate and oversee an array of mental and behavioral health services. Clinical Supervisors assume professional responsibility for the mental and/or behavioral health services provided by clinical staff, including Independent Professionals, QMHPs, and Individual RMH providers, including Qualified Mental Health Associates (QMHA) and Qualified Behavioral Aides (QBA). Clinical Supervisors can supervise other LCSWs, LMFTs, CPCs, QMHPs, QMHAs and QBAs. Clinical Supervisors may also function as Direct Supervisors.

Individual RMH providers, who are LCSWs, LMFTs, CPCs, and QMHPs, excluding Interns, may function as Clinical Supervisors over RMH services. However, Individual RMH providers, who are QMHPs, including interns, may not function as Clinical Supervisors over OMH services, such as assessments, therapy, testing and medication management. Clinical Supervisors must assure the following:

a. An up to date (within 30 days) case record is maintained on the recipient; and

b. A comprehensive mental and/or behavioral health assessment and diagnosis is accomplished prior to providing mental and/or behavioral health services (with the exception of Crisis Intervention services); and

c. A comprehensive and progressive treatment plan is developed and approved by the Clinical Supervisor and/or a Direct Supervisor, who is a QMHP, LCSW, LMFT or CPC; and

d. Goals and objectives are time specific, measurable (observable), achievable, realistic, time-limited, outcome driven, individualized, progressive and age and developmentally appropriate; and

e. The recipient and their family/legal guardian (in the case of legal minors) participate in all aspects of care planning, the recipient and their family/legal guardian (in the case of legal minors) sign the treatment plan and the recipient and their family/legal guardian (in the case of legal minors) receive a copy of the treatment plan(s); and

f. The recipient and their family/legal guardian (in the case of legal minors) acknowledge in writing that they understand their right to select a qualified provider of their choosing; and

g. Only qualified providers provide prescribed services within scope of their practice under state law; and

h. Recipients receive mental and/or behavioral health services in a safe and efficient manner.

2. Direct Supervision – Independent Professionals, QMHPs and/or QMHAs may function as Direct Supervisors within the scope of their practice. Direct Supervisors must have the practice-specific education, experience, training, credentials, and/or licensure to coordinate an array of OMH and/or RMH services. Direct Supervisors assure servicing providers provide services in compliance with the established treatment plan(s). Direct Supervision is limited to the delivery of services and does not include treatment and plan(s) modification and/or approval. If qualified, Direct Supervisors may also function as Clinical Supervisors. Direct Supervisors must document the following activities:

a. Their face-to-face and/or telephonic meetings with Clinical Supervisors.

1. These meetings must occur before treatment begins and periodically thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in a group and/or individual settings.

b. Their face-to-face and/or telephonic meetings with the servicing provider(s).

1. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in group and/or individual settings;

c. Assist the Clinical Supervisor with Treatment Plan reviews and evaluations.

403.2B DOCUMENTATION

1. Individualized Treatment Plan

a. A written individualized treatment plan, referred to as Treatment Plan, is a comprehensive, progressive, personalized plan that includes all prescribed Behavioral Health (BH) services, to include Rehabilitative Mental Health (RMH) and Outpatient Mental Health (OMH) services. A Treatment Plan is person-centered, rehabilitative and recovery oriented. The treatment plan addresses individualized goals and objectives. The objective is to reduce the duration and intensity of BH services to the least intrusive level possible while sustaining overall health. BH services are designed to improve the recipient's functional level based on achievable goals and objectives as determined in the Treatment Plan that identifies the amount and duration of services. The Treatment Plan must consist of services designed to achieve the maximum reduction of the BH services required to restore the recipient to a functional level of independence.

b. Each prescribed BH service within the Treatment Plan must meet medical necessity criteria, be clinically appropriate and must utilize evidence-based practices.

c. The prescribed services within the plan must support the recipient's restoration of functioning consistent with the individualized goals and objectives.

d. A Treatment Plan must be integrated and coordinated with other components of overall health care.

e. The person-centered treatment plan must establish strength-based goals and objectives to support the recipient's individualized rehabilitative process. The BH services are to accomplish specific, observable changes in skills and behaviors that directly relate to the recipient's individual diagnosed condition(s). BH services must be rehabilitative and meet medically necessity for all services prescribed.

2. Treatment Plan Development

a. The Treatment Plan must be developed jointly with a QMHP and:

1. The recipient or the recipient's legal representative (in the case of legal minors and when appropriate for an adult);

2. The recipient's parent, family member, guardian or legal representative with given consent from the recipient if determined necessary by the recipient;

b. All BH services requested must ensure that the goal of restoring a recipient's functional levels is consistent with the therapeutic design of the services to be provided under the Treatment Plan.

c. All requested BH services must ensure that all involved health professionals incorporate a coherent and cohesive developed treatment plan that best serves the recipient's needs.

d. Services should be developed with a goal that promotes collaboration between other health providers of the recipient, community supports including, but not limited to, community resources, friends, family or other supporters of the recipient and recipient identified stakeholders to ensure the recipient can receive care coordination and continuity of care.

e. The requested services are to be specific, measurable and relevant in meeting the goals and objectives identified in the Treatment Plan. The QMHP must identify within the Treatment Plan the scope of services to be delivered and are not duplicative or redundant of other prescribed BH services.

3. Required information contained in the Treatment Plan

a. Treatment Plans are required to include, but are not limited to, the following information:

1. Recipient's full name;

2. Recipient's Medicaid/Nevada Check Up billing number;

3. Intensity of Needs determination;

4. Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) determination;

5. Date of determination for SED or SMI;

6. The name and credentials of the provider who completed the determination.

b. Goals and Objectives of the Treatment Plan

1. The individualized treatment plan must demonstrate an improvement of the recipient's medical, behavioral, social and emotional well-being of the effectiveness of all requested BH services that are recommended in meeting the plan's stated rehabilitative goals and objectives documenting the effectiveness at each reevaluation determined by the QMHP.

c. Requested Services:

1. Services: Identify the specific behavioral health service(s) (i.e., family therapy, individual therapy, medication management, basic skills training, day treatment, etc.) to be provided;

2. Scope of Services and Duration: Identify the daily amount, service duration and therapeutic scope for each service to be provided;

3. Providers: Identify the provider or providers who are responsible for implementation of each of the plan's goals, interventions and services;

4. Rehabilitative Services: Document that the services have been determined to be rehabilitative services consistent with the regulatory definition;

5. Care Coordination: When multiple providers are involved, the plan must identify and designate a primary care coordinator. The primary care coordinator develops the care coordination plan between the identified BH services and integration of other supportive services involved with a recipient's services;

6. Strength-Based Care: Collaboratively develop a treatment plan of care involving the strengths of the recipient and family (when applicable);

7. Declined Services: If the recipient declines recommended service(s), this act must be documented within the treatment plan.

d. Discharge Plan – A Treatment Plan must include a discharge plan that identifies:

1. The planned duration of the overall services to be provided under the Treatment Plan;

2. Discharge criteria;

3. Recommended aftercare services for goals that were both achieved and not achieved during duration of the Treatment Plan;

4. Identify available agency(ies) and independent provider(s) to provide aftercare services (i.e. community-based services, community organizations, nonprofit agencies, county organization(s) and other institutions) and the purpose of each for the recipient's identified needs under the Treatment Plan to ensure the recipient has access to supportive aftercare.

4. Required Signatures and Identified Credentials

a. Signatures, along with the identified credentials, are required on all treatment plans, modifications to treatment plans and reevaluations of treatment plans include:

1. The clinical supervisor and their credentials;

2. The recipient, recipient's family or their legal representative (in the case of legal minors and when appropriate for an adult);

3. The individual QMHP and their credentials responsible for developing and prescribing the plan within the scope of their licensure.

5. Treatment Plan Reevaluation: A QMHP must evaluate and reevaluate the Treatment Plan at a minimum of every 90 days, or a shorter period as determined by the QMHP. Every reevaluated Treatment Plan must include a brief analysis that addresses the services recommended, the services actually provided pursuant to the recommendations, a determination of whether the provided services met the developed goals and objectives of those services and whether or not the recipient would continue to benefit from future services and be signed by the QMHP.

a. If it is determined that there has been no measurable restoration of functioning, a new recipient-centered treatment plan must be developed by the QMHP.

b. All recommendations and changes to the treatment goals, objectives, strategies, interventions, frequency, or duration; any change of individual providers, or any

recommendation to change individual providers; and the expected duration of the medical necessity for the recommended changes must be identified in the new plan.

c. The new treatment plan must adhere to what is identified in Sections 403.2B(1) and 403.2B(2) under Individualized Treatment Plan and Treatment Plan Development.

6. Progress Notes: Progress notes for all BH services including RMH and OMH services are the written documentation of treatment services, or services coordination provided to the recipient pursuant to the Treatment Plan, which describes the progress, or lack of progress towards the goals and objectives of the Treatment Plan.

a. All progress notes documented with the intent of submitting a billable Medicaid behavioral health service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope and duration of the service(s) provided as well as identify the provider of the service(s).

b. A Progress Note is required for each day the service was delivered, must be legible and must include the following information:

1. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated;

2. The place of service;

3. The date the service was delivered;

4. The actual beginning and ending times the service was delivered;

5. The name of the provider who delivered the service;

6. The credentials of the person who delivered the service;

7. The signature of the provider who delivered the service;

8. The goals and objectives that were discussed and provided during the time the services were provided; and

9. A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the QMHP.

c. Temporary, but clinically necessary, services do not require an alteration of the treatment plan; however, these types of services, and why they are required, must

be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

7. Discharge Summary: Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement describing the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives as documented in the Treatment Plan. The discharge summary documentation must include the reason for discharge, current intensity of needs level and recommendations for further treatment.

   a. Discharge summaries are to be completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge.

   b. In the case of a recipient's transfer to another program, a verbal summary must be given by the current health professional at the time of transition and followed with a written summary within seven calendar days of the transfer. This summary will be provided with the consent from the recipient or the recipient's legal representative.

403.3 PROVIDER QUALIFICATIONS

A. Qualified Behavioral Aide (QBA) – an individual who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by the overseeing Clinical Supervisor, to provide RMH services. These services must be provided under direct contract with a Behavioral Health Community Network (BHCN), a Behavioral Health Rehabilitative Treatment, or other behavioral health provider under which a QBA is able to deliver services. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services, delivered under the Clinical Supervision of an Independent Behavioral Health Professional who may be enrolled as a Qualified Mental Health Professional (QMHP) and the Direct Supervision of a QMHP or Qualified Mental Health Associate (QMHA); the supervising professional(s) assume(s) responsibility for their supervisees and shall maintain documentation on this supervision in accordance with MSM 403.2A Supervision Standards.

   1. QBAs must also have experience and/or training in the provision of services to individuals diagnosed with mental and/or behavioral health disorders and have the ability to:

      a. Read, write, and follow written and oral instructions; and

      b. Perform RMH services as prescribed on the rehabilitative treatment plan; and;

c. Identify emergency situations and respond appropriately; and

d. Communicate effectively with recipient and recipient's support system; and

e. Document services provided according to Chapter 400 Documentation requirements; and

f. Maintain recipient confidentiality.

2. For QBAs who will also function as Peer-to-Peer Service Specialists (hereinafter referred to as "Peer Supporters"), services are delivered under Clinical Supervision provided by an independently licensed QMHP-level mental health professional, LCSW, LMFT, or LCPC; this supervision shall be provided and documented at least monthly by the supervising professional.

a. Peer Supporter cannot be the legal guardian or spouse of the recipient.

b. The primary role of the Peer Supporter is to model skills based on lived experience to help individuals meet their rehabilitative goals.

3. Initial Competency Training

a. Before QBAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour competency training program. This training must be interactive, not solely based on self-study guides or videotapes and ensures that a QBA will be able to interact appropriately with individuals with behavioral health disorders and their support systems. This training is intended to be delivered by the agency/entity/group providing supervision over the QBA. At a minimum, this training shall include the following core competencies:

1. Case file documentation (including Chapter 400 Documentation requirements for Progress Notes); and

2. Recipient rights (including rights of parents and guardians, as appropriate); and

3. Client confidentiality pursuant to state and federal regulations (including releases of information and mandated reporting); and

4. Communication skills (verbal, non-verbal, written with children and adults); and

5. Problem solving and conflict resolution skills (including mediation, de-escalation, crisis, suicidality); and

6. Communication techniques for individuals with communication or sensory impairments (citing evidence-based practice); and

7. Understanding the components of a rehabilitation plan; and

8. Cardiopulmonary resuscitation (CPR) certification (verification with certification card is necessary to fulfill requirement). Up to two hours of initial competency training may be used for CPR certification and must be outlined in enrollment documentation.

b. Certificates of initial competency must include all of the following information:

1. Name and signature of the enrolling QBA provider who received training; and

2. Name and signature of the individual trainer who provided the training; and

3. Name and signature of responsible Clinical Supervisor for the agency/entity/group; and

4. Date of training shall not be more than 365 days prior to the requested effective date of the submitted application for enrollment; and

5. Outline of all course content as indicated by the core competencies above. NOTE: The amount of time assigned to each competency must be identified separately and must add up to at least 16 hours.

4. In-Service Training

a. QBAs require two hours of in-service training per quarter for continued enrollment. The purpose of the in-service training is to facilitate the development of specialized skills or knowledge not included in the basic training and to review or expand skills or knowledge included in the initial competency training. Consideration must be given to topics suggested by recipients. This training must include any single competency or combination of the following competencies:

1. Basic living and self-care skills – assisting recipients to regain skills to manage their daily lives, helping them to learn safe and appropriate behaviors; and/or

2. Social skills – assisting recipients to regain skills to identify and comprehend the physical, emotional, and interpersonal needs of themselves and of others, helping them to learn how to interact with others, and/or

3. Communication skills – assisting recipients to regain skills to communicate their physical, emotional, and interpersonal needs to others (expressive), helping them also learn listening skills and to identify the needs of others (receptive); and/or

4. Parental training – facilitating parent and guardian skills and abilities to maintain the recipient's Rehabilitative Mental Health (RMH) care in home and community-based settings; and/or

5. Organization and time management skills – assisting recipients to regain skills to manage and prioritize their daily activities; and/or

6. Transitional living skills – assisting recipients to regain necessary skills to establish partially-independent and fully-independent lives, as appropriate.

b. Documentation of all the completed in-service training and achieved competencies shall be maintained by the agency/entity/group providing supervision over the QBA. It is the intent that training be delivered by the agency/entity/group contracted to supervise the QBA. Training documentation must total eight hours annually. Documentation and/or certificates for in-service training are required for continued enrollment as a Medicaid provider. Documentation of competency training must include all of the following information:

1. Name and original signature of the enrolling QBA provider who received training; and

2. Name and original signature of the Clinical or Direct supervisor of the training; also must include the name and original signature of the individual who provided the training, if training is not delivered by the agency/entity/group providing supervision over the QBA; and

3. Date of training must be within 365 days prior to the requested effective date of the submitted application for continued enrollment; and

4. Outline of course content related to the competencies above.

Official transcripts for education credits earned as in-service training (individually or as part of a degree program) must be submitted with additional explanation and correspondence to outline the course content related to the core competencies above.

c. QBAs serving as Peer Supporters, must complete the Initial Competency Training and the two hours of In-Service Training per quarter. Documentation of all the completed training and achieved competencies shall be maintained by the agency/entity/group providing supervision. Peer Supporters must submit training documentation, as listed above for the QBA, for initial and continued enrollment with Nevada Medicaid. Quarterly in-service training for Peer Supporters must also include any single competency or combination of the following competencies:

1. Helping to stabilize the recipient; and/or

2. Helping the recipient access community-based mental and/or behavioral health services; and/or

3. Assisting during crisis situations and with crisis interventions; and/or

4. Providing preventative care assistance; and/or

5. Providing personal encouragement, self-advocacy, self- direction training and peer mentoring.

5. All Applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid. Applicants must submit the results of their criminal background checks to the BHCN, Behavioral Health Rehabilitative Treatment, or other applicable behavioral health entity providing supervision over the QBA. The BHCN Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request, the BHCN Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must make the criminal background request and results available to Nevada Medicaid DHCFP for review.

a. Refer to MSM Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:

1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; and

2. Any other offense determined by DHCFP to be inconsistent with the best interest of all recipients.

b. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity, upon receiving information resulting from the FBI criminal background check, or from any other source, may not continue to employ a person who has been convicted of an offense as listed above, and as cited within MSM Chapter 100.

c. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, they must immediately inform the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity in writing with the incorrect information. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity must inform DHCFP within five days of the discovery of the incorrect information; DHCFP shall give the QBA provider a reasonable amount of time, but not more than 60 days from the date of discovery, to provide corrected information before denying an application, or terminating the contract of the QBA provider pursuant to this section.

6. All applicants shall have had tuberculosis (TB) screening or testing with negative results documented or medical clearance documented, as outlined in NAC 441A.375 and the Centers for Disease Control and Prevention (CDC), prior to the initiation of service delivery. Documentation of TB screening, testing, and results shall be maintained in the provider personnel record by the BHCN, Behavioral Health Rehabilitative Treatment or other behavioral health entity. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375. For further information, contact the CDC or the Nevada TB Control Office at the Department of Health and Human Services (DHHS).

B. QMHA - an individual who meets the following documented minimum qualifications:

1. Professional licensure as a Registered Nurse (RN) issued by the Nevada State Board of Nursing; and/or

2. Official documentation of a Bachelor's degree in Human Services from an accredited college or university with additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements; or

3. Official documentation of an Associate's degree in Human Services from an accredited college or university and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated through four years of relevant professional experience by proof of past or current enrollment as a Nevada Medicaid provider delivering direct services to individuals with behavioral health disorders; or

4. Official documentation of a Bachelor's degree from an accredited college or university in a field other than Human Services and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated by four years of relevant professional experience by proof of resume.

5. A QMHA with experience and training will demonstrate the ability to:

   a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise; and

   b. Identify presenting problem(s); and

   c. Participate in treatment plan development and implementation; and

   d. Coordinate treatment; and

   e. Provide parenting skills training; and

   f. Facilitate discharge plans; and

   g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

6. A QMHA delivers services under the Clinical and Direct Supervision of a mental health provider(s) within the appropriate scope of practice; the Supervisor(s) assume(s) responsibility for their supervisees and shall maintain documentation on supervision in accordance with MSM 403.2A Supervision Standards.

7. Initial Competency Training

a. Before QMHAs can enroll as Medicaid providers, they are required to successfully complete an initial 16-hour competency training program. This training must be interactive, not solely based on self-study guides or videotapes, and ensures that a QMHA will be able to interact appropriately with individuals with behavioral health disorders and their support systems. This training is intended to be delivered by the agency/entity/group providing supervision over the QMHA. At a minimum, this training must include the following core competencies:

1. Case file documentation (including Chapter 400 Documentation requirements for Progress Notes); and

2. Recipient rights (including rights of parents and guardians, as appropriate); and

3. Client confidentiality pursuant to state and federal regulations (including releases of information and mandated reporting); and

4. Communication skills (verbal, non-verbal, written with children and adults); and

5. Problem solving and conflict resolution skills (including mediation, de-escalation, crisis, suicidality); and

6. Communication techniques for individuals with communication or sensory impairments (citing evidence-based practice); and

7. Understanding the components of a rehabilitative treatment plan; and

8. Cardiopulmonary resuscitation (CPR) certification (verification with certification card is necessary to fulfill requirement). Up to two hours of initial competency training may be used for CPR certification and must be outlined in enrollment documentation.

b. Certificates of initial competency must include all the following information:

1. Name and signature of the enrolling QMHA provider who received training; and

2. Name and signature of the individual trainer who provided the training; and

3. Name and signature of responsible Clinical Supervisor for the agency/entity/group; and

4. Date of training shall not be more than 365 days prior to the requested effective date of the submitted application for enrollment; and

5. Outline of all course content as indicated by the core competencies above. NOTE: The amount of time assigned to each competency must be identified separately and must add up to at least 16 hours.

8. In-Service Training

a. QMHAs require two hours of in-service training per quarter for continued enrollment. The purpose of the in-service training is to facilitate the development of specialized skills or knowledge not included in the basic training and to review or expand skills or knowledge included in the initial competency training. Consideration must be given to topics suggested by recipients. This training must include any single competency or combination of the following competencies:

1. Basic living and self-care skills – assisting recipients to regain skills to manage their daily lives, helping them to learn safe and appropriate behaviors; and/or

2. Social skills – assisting recipients to regain skills to identify and comprehend the physical, emotional, and interpersonal needs of themselves and of others, helping them to learn how to interact with others; and/or

3. Communication skills – assisting recipients to regain skills to communicate their physical, emotional, and interpersonal needs to others (expressive), helping them also learn listening skills and to identify the needs of others (receptive); and/or

4. Parental training – facilitating parent and guardian skills and abilities to maintain the recipient's Rehabilitative Mental Health (RMH) care in "home –" and community-based settings; and/or

5. Organization and time management skills – assisting recipients to regain skills to manage and prioritize their daily activities; and/or

6. Transitional living skills – assisting recipients to regain necessary

skills to establish partially-independent and fully-independent lives, as appropriate.

b. Documentation of all the completed training and achieved competencies shall be maintained by the agency/entity/group providing supervision over the QMHA. It is the intent that training be delivered by the agency/entity/group contracted to supervise the QMHA. Training documentation must total eight hours annually. Documentation and/or certificates for in-service training required for continued enrollment as a Medicaid provider. Certificates of competency must include all the following information:

1. Name and original signature of the enrolling QMHA provider who received training; and

2. Name and original signature of the Clinical or Direct supervisor of the training; also, must include the name and original signature of the individual who provided the training, if training is not delivered by the agency/entity/group providing supervision over the QMHA; and

3. Date of training must be within 365 days prior to the requested effective date of the submitted application for continued enrollment; and

4. Outline of course content related to the competencies above.

Official transcripts for education credits (earned separately or as part of a degree program) must be submitted with additional explanation and correspondence to outline the course content related to the core competencies above.

9. All applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid. Applicants must submit the results of their criminal background checks to the BHCN, Behavioral Health Rehabilitative Treatment, or other applicable behavioral health entity providing supervision over the QMHA. The BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request, the BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must make the criminal background request and results available to Nevada Medicaid (DHCFP) for review.

a. Refer to MSM Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:

1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; and

2. Any other offense determined by DHCFP to be inconsistent with the best interest of all recipients.

b. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity, upon receiving information resulting from the FBI criminal background check or from any other source, may not continue to employ a person who has been convicted of an offense as indicated above, and as cited within MSM Chapter 100.

c. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, they must immediately inform the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity in writing with the incorrect information. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity must inform DHCFP within five days of the discovery of the incorrect information; DHCFP shall give the QMHA provider a reasonable amount of time, but not more than 60 days from the date of discovery, to provide corrected information before denying an application or terminating the contract of the QMHA provider pursuant to this section.

10. All applicants shall have had tuberculosis (TB) screening or testing with negative results documented or medical clearance documented, as outlined in NAC 441A.375 and CDC, prior to the initiation of service delivery. Documentation of TB screening, testing, and results shall be maintained by the BHCN or Behavioral Health Rehabilitative Treatment provider personnel record. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375 For further information, contact the CDC or the Nevada TB Control Office at the Department of Health and Human Services

C. Qualified Mental Health Professional (QMHP) - An individual who meets the definition of a QMHA and also meets the following documented minimum qualifications:

1. Holds any of the following independent licensure with educational degrees:

a. Licensed Psychiatrist or Licensed Physician, M.D., Osteopath, D.O., with clinical experience in behavioral health treatment,

b. Licensed Physician's Assistant with clinical experience in behavioral health treatment.

c. Doctorate Degree in Psychology and Licensed Psychologist (Psychological Assistants, Interns, and Trainees are not able to deliver services under a psychologist enrolled as a QMHP).

d. Advanced Practice Registered Nurse (APRN) with a focus in psychiatric-mental health.

e. Independent Nurse Practitioner (NP) with a focus in psychiatric-mental health.

f. Graduate degree in Social Work and licensed as a Clinical Social Worker.

g. Graduate degree in Counseling and licensed as a Marriage & Family therapist or as a Clinical Professional Counselor.

2. Whose education and experience demonstrate the competency to identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service needs using tools required by Nevada Medicaid (including CASII, LOCUS, and service-specific assessment tools), establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise. Competency shall be supplemented by ongoing training provided through Clinical and Direct Supervision, per MSM 403.2A Supervision Standards.

3. Interns

Reimbursement for clinical Interns is based upon the rate of a QMHP, which includes the Clinical and Direct supervision of services by an independently licensed supervisor of the entity/agency/group with which the QMHP is enrolling; this supervising clinician assumes responsibility for their licensed intern supervisees and shall maintain documentation on this supervision in accordance with MSM 403.2A Supervision Standards.

Interns are excluded from functioning as a clinical supervisor.
The following interns may enroll as QMHPs:

a. Clinical Social Work Interns are licensed as Master Social Work (LMSW) post-graduate interns and meet the requirements under a program of internship pursuant to the State of Nevada Board of Examiners for Social Workers

(Nevada Administrative Code (NAC) 641B).

b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor (LCPC) Interns are licensed as Master-level Interns and meet the requirements under a program of internship pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists & Clinical Professional Counselors.

4. All applicants must have an FBI criminal background check before they can enroll with Nevada Medicaid. Applicants must submit the results of their criminal background checks to the BHCN, Behavioral Health Rehabilitative Treatment, or other applicable behavioral health entity providing supervision over the QMHP. The BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must maintain both the requests and the results of the FBI criminal background check with the applicant's personnel records. Upon request, the BHCN, Behavioral Health Rehabilitative Treatment, and/or other applicable behavioral health entity must make the criminal background request and results available to Nevada Medicaid (DHCFP) for review.

   a. Refer to MSM Chapter 100, Medicaid Program, under Conditions of Participation for all Providers. In addition, the following criteria will exclude applicants from becoming an eligible provider:

      1. Conduct or practice detrimental to the health or safety of the occupants or employees of the facility or agency; and

      2. Any other offense determined by DHCFP to be inconsistent with the best interest of all recipients.

   b. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity, upon receiving information resulting from the FBI criminal background check or from any other source, may not continue to employ a person who has been convicted of an offense as indicated above, and as cited within MSM Chapter 100.

   c. If an applicant believes that the information provided as a result of the FBI criminal background check is incorrect, they must immediately inform the BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity in writing the incorrect information. The BHCN, Behavioral Health Rehabilitative Treatment, or other behavioral health entity must inform DHCFP within five days of the discovery of the incorrect information; DHCFP shall give the QMHP provider a reasonable amount of time, but not more than 60 days from the date of discovery, to provide

corrected information before denying an application or terminating the contract of the QMHP provider pursuant to this section.

5. All applicants shall have had TB screening or testing with negative results documented or medical clearance documented, as outlined in NAC 441A.375 and the CDC, prior to the initiation of service delivery. Documentation of TB screening, testing, and results shall be maintained in the provider personnel record by the BHCN, Behavioral Health Rehabilitative Treatment or other behavioral health entity. TB screening, testing, and results must be completed for initial enrollment and thereafter as indicated by NAC 441A.375. For further information, contact the CDC or the Nevada TB Control Office at the Department of Health and Human Services.

D. Licensed Psychologists – An individual independently licensed through the Nevada Board of Psychological Examiners.

1. Psychologists licensed in Nevada through the Board of Psychological Examiners may supervise Psychological Assistants, Psychological Interns and Psychological Trainees pursuant to NRS and NAC 641. A Supervising Psychologist, as defined by NRS and NAC 641, may bill on behalf of services rendered by those they are supervising within the scope of their practice and under the guidelines outlined by the Psychological Board of Examiners. Assistants, Interns and Trainees must be linked to their designated Supervising Psychologist, appropriate to the scope of their practice, under which their services are billed to Medicaid.

2. Psychological Assistants registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

3. Psychological Interns registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

4. Psychological Trainees registered through the Nevada Board of Psychological Examiners and has a designated licensed Psychologist through the Board of Psychological Examiners may render and their supervisor may bill for their services pursuant to NRS and NAC 641.

403.4 OUTPATIENT MENTAL HEALTH (OMH) SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services,

crisis intervention, mental health therapies and therapeutic interventions (partial hospitalization and intensive outpatient), medication management and medication training/support, and case management services. For case management services, refer to MSM Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and documentation requirements.

A. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental Health Screen.

1. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.

2. Comprehensive Assessment – A comprehensive evaluation of a recipient's history and functioning which, combined with clinical judgment, is to include a covered, current ICD diagnosis and a summary of identified rehabilitative treatment needs. Health and Behavior Assessment – Used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health needs. The focus of the assessment is not on the mental health needs, but on the biopsychosocial factors important to physical health needs and treatments. The focus of the intervention is to improve the recipient's health and well-being utilizing cognitive, behavioral, social and/or psycho-physiological procedures designed to ameliorate specific disease related needs. This type of assessment is covered on an individual basis, family with the recipient present or family without the recipient present.

3. Psychiatric Diagnostic Interview – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychiatric diagnostic interview may consist of a clinical interview, a medical and mental history, a mental status examination, behavioral observations, medication evaluation and/or prescription by a licensed psychiatrist. The psychiatric diagnostic interview is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

4. Psychological Assessment – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a current ICD diagnosis and treatment recommendations.

5. Functional Assessment – Used to comprehensively evaluate the recipient's skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient's individualized treatment plan. A functional assessment is used to assess the presence of functional strengths and needs in the following domains: vocational, education, self-maintenance, managing illness and wellness, relationships and social.

   A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the individualized treatment plan. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers, shall provide advocacy for the recipient's goals and independence, supporting the recipient's participation in the meeting and affirming the recipient's dignity and rights in the service planning process.

6. Intensity of Needs Determination - A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the QMHP and/or trained QMHA. This assessment was previously known as a level of care assessment. Currently, the DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by the DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.

7. Severe Emotional Disturbance (SED) Assessment - Covered annually or if there is a significant change in functioning. The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

8. Serious Mental Illness (SMI) Assessment - Covered annually or if there is a significant change in functioning. The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

B. Neuro-Cognitive, Psychological and Mental Status Testing

1. Neuropsychological testing with interpretation and report involves assessment and evaluation of brain behavioral relationships by a neuropsychologist. The evaluation consists of qualitative and quantitative measurement that consider factors such as

the interaction of psychosocial, personality/emotional, intellectual, environmental, neurocognitive, biogenetic and neurochemical aspects of behaviors in an effort to understand more fully the relationship between physiological and psychological systems. This service requires prior authorization from the QIO-like vendor.

2. Neurobehavioral testing with interpretation and report involves the clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention, memory, visual spatial abilities, language functions and planning. This service requires prior authorization.

3. Psychological testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes.

C. Mental Health Therapies

Mental health therapy is covered for individual, group and/or family therapy with the recipient present and for family therapy without the recipient present and described as follows:

1. Family Therapy

Mental health treatment service provided to a specific recipient by a QMHP using the natural or substitute family as the means to facilitate positive family interactions among individuals. The recipient does not need to be present for family therapy services; however, the services must deal with issues relating to the constructive integration/reintegration of the recipient into the family.

2. Group Therapy

Mental health treatment service facilitated by a QMHP within their scope of licensure or practice, which utilizes the interactions of more than one individual and the focus of the group to address behavioral health needs and interpersonal relationships. The therapy must be prescribed on the treatment plan and must have measurable goals and objectives. Group therapy may focus on skill development for learning new coping skills, such as stress reduction, or changing maladaptive behavior, such as anger management. Participation in group therapy must be documented on the clinical record. Minimum group size is three and maximum therapist to participant ratio is one to ten. Group therapy can be less than three but more than one based on unforeseen circumstances such as a no-show or cancellation but cannot be billed as individual therapy. Group therapy may also include a family without the recipient present and/or multi-family groups.

3. Individual Therapy Services

Mental health treatment service provided to a specific recipient for a presenting need by an individual therapist for a specified period of time. The amount, scope and duration of individual therapy services may vary depending on the stage of the presenting mental health need, treatment program and recipient's response to the treatment approach. Individual is one recipient. Each direct one-on-one episode must be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's treatment/rehabilitative plan.

4. Neurotherapy

a. Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy as a treatment for mental health disorders. Medicaid will reimburse for medically necessary neurotherapy when administered by a licensed QMHP within the scope of their practice and expertise. A certified Biofeedback Technician may assist in the provision of biofeedback treatment; however, a QMHP must provide the associated psychotherapy. Reimbursement for biofeedback treatment provided by a Biofeedback Technician is imbedded in the QMHP rate.

b. Prior authorizations through the QIO-like vendor are required for all neurotherapy services exceeding the below identified session limits for the following covered ICD Codes:

1. Attention Deficit Disorders – 40 sessions
Current ICD Codes: F90.0, F90.8 and F90.9

2. Anxiety Disorders – 30 sessions
Current ICD Codes: F41.0 and F34.1

3. Depressive Disorders – 25 sessions
Current ICD Codes: F32.9, F33.40, F33.9, F32.3 and F33.3

4. Bipolar Disorders – 50 sessions
Current ICD Codes: F30.10, F30.9, F31.0, F31.10, F31.89, F31.30, F31.60, F31.70, F31.71, F31.72, F31.9 and F39

5. Obsessive Compulsive Disorders – 40 sessions
Current ICD Codes: F42

6. Opposition Defiant Disorders and/or Reactive Attachment Disorders – 50 sessions

Current ICD Codes: F93.8, F91.3, F94.1, F94.2, F94.9 and F98.8

7. Post-Traumatic Stress Disorders – 35 sessions
Current ICD Codes: F43.21, F43.10, F43.11 and F43.12

8. Schizophrenia Disorders – 50 sessions
Current ICD Codes: F20.89, F20.1, F20.2, F20.0, F20.81, F20.89, F20.5, F25.0, F25.1, F25.8, F25.9, F20.3 and F20.9

Prior authorization may be requested for additional services based upon medical necessity.

D. Mental Health Therapeutic Interventions

1. Partial Hospitalization Program (PHP) – A restorative program encompassing mental and behavioral health services and psychiatric treatment services designed for recipients who require a higher intensity of coordinated, comprehensive and multidisciplinary treatment for mental or substance use disorders. These services are furnished under a medical model by a hospital in an outpatient setting or by a Federally Qualified Health Center (FQHC) that assumes clinical liability and meets the criteria of a Certified Mental Health Clinic (CMHC). A hospital or an FQHC may choose to offer PHP through an enrolled SAPTA-certified clinic or an enrolled BHCN agency/entity/group, and the hospital or FQHC must enter into a contract with this provider which specifically outlines the roles and responsibilities of both parties in providing this program. The contract must be submitted to the DHCFP and reported to its fiscal agent prior to the delivery of these services to the recipient. These services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an exacerbation of a severe and persistent mental illness and/or substance use disorder. PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization. PHP is provided to individuals who are determined as Severely Emotionally Disturbed (SED) or Seriously Mentally Ill (SMI), or as medically necessary under the American Society of Addiction Medicine (ASAM) criteria.

a. Scope of Services: PHP services may include:

1. Individual Therapy

2. Group Therapy

3. Family Therapy

4. Medication Management

5. Medication Assisted Treatment

6. Drug Testing

7. Occupational Therapy

8. Behavioral Health Assessment

9. Basic Skills Training

10. Psychosocial Rehabilitation

11. Peer-to-Peer Support Services

12. Crisis Services

PHP requires around-the-clock availability of 24/7 psychiatric and psychological services. These services may not be billed separately as PHP is an all-inclusive rate.

b. Service Limitations: PHP services are direct services provided in a mental/behavioral health setting for at least three days per week and no more than five days per week; each day must include at least four hours of direct services as clinically indicated based on a patient-centered approach. If more/fewer hours and/or more/fewer days are indicated, the recipient should be reevaluated. PHP delivered through a BHCN will always require prior authorization and must be reauthorized every three weeks.

c. PHP Utilization Management: Evaluation of the patient's response to treatment interventions and progress monitoring toward treatment plan goals must include ongoing patient assessments, including intensity of needs determinations using ASAM/LOCUS/CASII at regularly scheduled intervals and whenever clinically indicated.

d. Provider Qualifications: Direct services are face-to-face interactive services led by licensed staff and components of this service can be performed by qualified, enrolled health care workers practicing within their scope under the Direct Supervision of a QMHP-level professional, including Interns. Interns can provide PHP services under Clinical Supervision. Direct Supervision requires that a licensed professional practicing within the scope of their Nevada licensure be onsite where services are rendered. Each

component of the PHP must be provided by enrolled and qualified individuals within the scope of their practice.

e. Documentation: Patient assessments must document the individual patient response to the treatment plan, progress toward goals, changes in identified goals and objective based on progress and substantiate continued stay at the current intensity/frequency of services. Resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must be evidence-based and reflect best practices recognized by professional and advocacy organizations and ensure coordination of needed services, follow-up care and recovery supports. The direct provider of each service component must complete documentation for that component. Further information on documentation standards is located within the section "Documentation" within this chapter.

f. Non-Covered Services in PHP include, but are not limited to:

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

3. Club house, recreational, vocational, after-school or mentorship program;

4. Routine supervision, monitoring or respite;

5. Participation in community-based, social-based support groups (e.g., Alcoholics Anonymous, Narcotics Anonymous);

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

2. Intensive Outpatient Program (IOP) – A comprehensive interdisciplinary program of direct mental/behavioral health services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization. IOP is provided to individuals who are determined as SED or SMI, or as medically necessary under the ASAM criteria. IOP group sizes are required to be four to 15 recipients.

a. Scope of Services: IOP may include the following direct services:

1. Individual Therapy
2. Group Therapy
3. Family Therapy
4. Medication Management
5. Medication Assisted Treatment
6. Drug Testing
7. Occupational Therapy
8. Behavioral Health Assessment
9. Basic Skills Training
10. Psychosocial Rehabilitation
11. Peer-to-Peer Support Services
12. Crisis Services

IOP requires around-the-clock availability of 24/7 psychiatric and psychological services. These services may not be billed separately as IOP is an all-inclusive rate.

b. Service Limitations: IOP services delivered in a mental/behavioral health setting are direct services provided three days per week, each day must include at least three hours and no more than six hours of direct service delivery as clinically indicated based on a patient-centered approach. If more/fewer hours and/or more/fewer days are indicated, the recipient should be reevaluated. IOP delivered through a BHCN will always require prior authorization and must be reauthorized every three weeks.

c. IOP Curriculum and Utilization Management: A curriculum and a schedule for the program delivered through a BHCN must be submitted with each prior authorization request; this information may also be provided with enrollment and the description of IOP services. The curriculum must outline the service array being delivered including evidence-based practice(s), best practice(s), program goals, schedule of program and times for service

delivery, staff delivering services, and population served in the program. IOP program recipients must receive on-going patient assessments, at regularly scheduled intervals and whenever clinically indicated, including intensity of needs determinations using ASAM/LOCUS/CASII to evaluate the recipient's response to treatment interventions and to monitor progress toward treatment plan goals. Recipient assessments must document the individual's response to the treatment plan, identify progress toward individual and program goals, reflect changes in identified goals and objectives, and substantiate continued stay at the current intensity/frequency of services. An updated treatment plan must be completed to justify a transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level.

Provider Qualifications: Direct services are face-to-face interactive services provided by qualified, enrolled providers, including both licensed staff. and other health care workers practicing within their scope under the Direct Supervision of a QMHP-level professional, including Interns. Interns can provide IOP services under Clinical Supervision. Direct Supervision requires that a licensed professional practicing within the scope of their Nevada licensure be onsite where services are rendered. Each component of the IOP must be provided by enrolled and qualified individuals within the scope of their practice.

d. Documentation: Patient assessments must document the individual patient response to the treatment plan, progress toward goals, changes in identified goals and objective based on progress and substantiate continued stay at the current intensity/frequency of services. Resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must be evidence-based and reflect best practices recognized by professional and advocacy organizations and ensure coordination of needed services, follow-up care, and recovery supports. The direct provider of each service component must complete documentation for that component. Further information on documentation standards is located within the section "Documentation" within this chapter.

e. Non-Covered services in IOP include, but are not limited to:

1. Non-evidence-based models;

2. Transportation or services delivered in transit;

3. Club house, recreational, vocational, after-school, or mentorship program;

4. Routine supervision, monitoring, or respite;

5. Participating in community based, social based support groups (i.e. Alcoholics Anonymous, Narcotics Anonymous);

6. Watching films or videos;

7. Doing assigned readings; and

8. Completing inventories or questionnaires.

3. Medication Management – A medical treatment service using psychotropic medications for the purpose of rapid symptom reduction, to maintain improvement in a chronic recurrent disorder or to prevent or reduce the chances of relapse or reoccurrence. Medication management must be provided by a psychiatrist or physician licensed to practice in the State of Nevada and may include, through consultation, the use of a physician's assistant or a certified nurse practitioner licensed to practice in the State of Nevada within their scope of practice. Medication management may be used by a physician who is prescribing pharmacologic therapy for a recipient with an organic brain syndrome or whose diagnosis is in the current ICD section of Mental, Behavioral, and Neurodevelopmental Disorders and is being managed primarily by psychotropic drugs. It may also be used for the recipient whose psychotherapy is being managed by another mental health professional and the billing physician is managing the psychotropic medication. The service includes prescribing, monitoring the effect of the medication and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive only. If the recipient received psychotherapy and drug management at the same visit, the drug management is included as part of that service by definition and medication management should not be billed in addition.

4. Medication Training and Support – This service must be provided by a professional other than a physician and is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s). To be reimbursed for this service, the provider must be enrolled as: A QMHP, a LCSW, a LMFT, or a CPC. A Registered Nurse (RN) enrolled as a QMHA may also provide this service if billed with the appropriate modifier. Medication Training and Support is a face-to-face documented review and educational session by a qualified professional, focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital

signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization. Medication Training and Support may not be billed for members who reside in ICF/IID facilities.

a. Service Limitations: Cannot exceed two units per month (30 minutes), per recipient without a prior authorization.

b. Documentation Requirements: Documentation must include a description of the intervention provided and must include:

1. If recipient was present or not;

2. Recipient's response to the medication;

3. Recipient's compliance with the medication regimen;

4. Medication benefits and side effects;

5. Vital signs, which include pulse, blood pressure and respiration; and

6. Documented within the progress notes/medication record.

c. Non-covered services in Medication Training and Support include, but are not limited to:

1. Medication Training and Support is not allowed to be billed the same day as an evaluation and management (E/M) service provided by a psychiatrist.

2. If medication management, counseling or psychotherapy is provided as an outpatient behavioral health service, and medication management is a component, Medication Training and Support may not be billed separately for the same visit by the same provider.

3. Coaching and instruction regarding recipient self-administration of medications is not reimbursable under this service.

4. Medication Training and Support may not be provided for professional caregivers.

403.5 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

A. INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of needs determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

These components include:

1. A comprehensive assessment of the recipient's level of functioning; The clinical judgment of the QMHP; and

2. A proposed treatment and/or rehabilitation plan.

B. INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved Level of Care (LOC) utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse. Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.

2. Intensity of Need for Children:

Child and Adolescent Service Intensity Instrument (CASII)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	• Significant Life Stressors and/or current ICD Codes, Z55-Z65, R45.850 and R45.821 that does not meet SED criteria (excluding dementia, intellectual disabilities and related conditions or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).

Level II Outpatient Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders that does not meet SED criteria (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).
Level III Intensive Outpatient Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SED Determination.
Levels IV Intensive Integrated Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and SED Determination.
Level V Non-secure, 24-hour Services with Psychiatric Monitoring	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires specialized treatment (e.g., sex offender treatment, etc.).
Level VI Secure, 24-hour Services with Psychiatric Management	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SED Determination; and • Requires inpatient/secured LOC.

3. Intensity of Needs for Adults:

Level of Care Utilization System for Adults (LOCUS)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders, including Z55-Z65, R45.850 and R45.821 Codes, that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).
Level II Low Intensity Community Based Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders, including Z55-Z65, R45.850 and R45.821 Codes that do not meet SMI criteria (excluding dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness).
Level III High Intensity Community Based Services (HCBS)	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Levels IV Medically Monitored Non-Residential Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Level V Medically Monitored Residential Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc.).

Level VI Medically Managed Residential Services	• Current ICD diagnosis in Mental, Behavioral and Neurodevelopmental Disorders (excluding Z55-Z65, R45.850 and R45.821 Codes, dementia, intellectual disabilities and related conditions, or a primary diagnosis of a substance use disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.

C. Utilization Management for outpatient mental health services is provided by the DHCFP QIO-like vendor as follows:

1. For BHCN, all service limitations are based upon the Intensity of Needs Grid in the definitions. The recipient must have an Intensity of Needs determination to supplement clinical judgment and to determine the appropriate service utilization. The provider must document in the case notes the level that is determined from the Intensity of Needs grid;

2. Independent psychologists are not subject to the service limitations in the Intensity of Needs Grid. The following service limitations are for psychologists:

   a. Assessments – two per calendar year, additional services require prior authorization from the QIO-like vendor; and

   b. Therapy (group, individual, family) – Up to 26 visits per calendar year are allowed without prior authorization. Additional services require prior authorization demonstrating medical necessity from the QIO-like vendor.

3. Independent psychiatrists are not subject to the service limitations in the Intensity of Needs grid. No prior authorization is required for this particular provider.

4. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents.

Child and Adolescent Service Intensity Instrument (CASII)	Intensity of Services (Per Calendar Year[1])
Levels I Basic Services: Recovery Maintenance and Health Management	• Assessment two total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy 10 total sessions; • Medication Management six total sessions

Level II Outpatient Services	• Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions
Level III Intensive Outpatient Services	All Level Two Services Plus: • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions Intensive Outpatient Program (IOP)
Levels IV Intensive Integrated Services	All Level Three Services • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • Partial Hospitalization Program (PHP)
Level V Non-secure, 24-Hour Services with Psychiatric Monitoring	All Level Four Services • Assessments: four total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions • Medication Management: eight total sessions • PHP
Level VI Secure, 24-Hour, Services with Psychiatric Management	All level Five services

A PA demonstrating medical necessity will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels.

a. Service provision is based on the calendar year beginning on January 1.

b. Sessions indicate billable codes for this service may include occurrence-based codes, time-based or a combination of both. Session = each time this service occurs regardless of the duration of the service.

5. Medicaid Behavioral Health Intensity of Needs for Adults.

Medicaid Behavioral Health Intensity of Needs for Adults. Level of Care Utilization System for Adults (LOCUS)	Intensity of Service (Per Calendar Year[1])
Levels I Basic Services - Recovery Maintenance and Health Management	• Assessment: two total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: six total sessions • Medication Management: six total sessions
Level II Low Intensity Community Based Services	• Assessment: (two assessments; does not include Mental Health Screen) • Individual, Group or Family Therapy: 12 total sessions • Medication Management: eight total sessions
Level III High Intensity Community Based Services	• Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 12 total sessions • Medication Management: 12 total sessions • IOP
Level IV Medically Monitored Non-Residential Services	• Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family Therapy: 16 total sessions • Medication Management (12 sessions) • PHP
Level V Medically Monitored Residential Services	• Assessment (two assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 18 total sessions • Medication Management (12 sessions) • PHP
Level VI Medically Managed Residential Services	All Level Five Services

A PA demonstrating medical necessity will be required and may be requested from the QIO-like vendor for additional services above the service limitations for all levels.

a. Service provision is based on the calendar year beginning on January 1.

b. Sessions indicate billable codes for this service may include occurrence-based codes, time-based or a combination of both. Session = each time this service occurs regardless of the duration of the service.

D. Non-Covered OMH Services

The following services are not covered under the OMH program for Nevada Medicaid and NCU:

1. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

2. Therapy for marital problems without a covered, current ICD diagnosis;

3. Therapy for parenting skills without a covered, current ICD diagnosis;

4. Therapy for gambling disorders without a covered, current ICD diagnosis;

5. Custodial services, including room and board;

6. Support group services other than Peer Support Services;

7. More than one provider seeing the recipient in the same therapy session;

8. Services not authorized by the QIO-like vendor if an authorization is required according to policy; and

9. Respite.

403.6 REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

1. Scope of Service: RMH services must be recommended by a QMHP within the scope of their practice under state law. RMH services are goal-oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipients to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. All RMH services must be directly and medically necessary. RMH services cannot be reimbursed on the same day as Applied Behavior Analysis (ABA) services, refer to MSM Chapter 1500.

Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a covered, current ICD diagnosis. The

assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must assure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

a. the recipient's name;

b. progress notes must reflect the date and time of day that RMS services were provided; the recipient's progress toward functional improvement and the attainment of established rehabilitation goals and objectives; the nature, content and number of RMH service units provided; the name, credential(s) and signature of the person who provided the RMH service(s). Progress notes must be completed after each session and/or daily; progress notes are not required on days when RMH services are not provided; a single progress note may include any/all the RMH services provided during that day;

c. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;

d. indications that the recipients and their families/legal guardians (in the case of legal minors) were involved in all aspects care planning;

e. indications that the recipients and their families/legal guardians (in the case of legal minors) are aware of the scope, goals, and objectives of the RMH services made available; and

f. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement that RMH services are designed to reduce the duration and intensity of care to the least intrusive level of care possible while sustaining the recipient's overall health.

2. Inclusive Services: RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR), and Crisis Intervention (CI).

3. Provider Qualifications:

a. QMHP: QMHPs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR and CI services.

b. QMHA: QMHAs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR services under the Clinical Supervision of a QMHP.

c. QBA: QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP/QMHA. QBAs may provide Peer-to-Peer Support services under the Clinical/Direct Supervision of a QMHP.

4. Therapeutic Design: RMH services are adjunct (enhancing) interventions designed to complement more intensive mental health therapies and interventions. While some rehabilitative models predominately utilize RMH services, these programs must demonstrate the comprehensiveness and clinical appropriateness of their programs prior to receiving prior authorization to provide RMH services. RMH services are time-limited services, designed to be provided over the briefest and most effective period possible. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. Also taken into consideration are other social, educational and intensive mental health obligations and activities. RMH services are planned and coordinated services.

5. Non-Covered Services: RMH services do not include (from CMS 2261-P):

a. RMH services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

b. custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training and/or other intrinsic parenting and/or care giver responsibilities;

c. maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of RMH goals and objectives, impromptu non-crisis interventions and routine daily therapeutic milieus;

d. case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage and monitoring and follow-up;

e. habilitative services;

f. services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

g. cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

h. transportation: Transporting recipients to and from medical and other appointments/services;

i. educational, vocational or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);

j. inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent;

k. room and board: Includes housing, food, non-medical transportation and other miscellaneous expenses, as defined below:

1. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs and insurance), utilities (gas, electricity, fuel, telephone and water) and housing furnishings and equipment (furniture, floor coverings, major appliances and small appliances);

2. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

3. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs and insurance;

4. Miscellaneous expenses include clothing, personal care items, entertainment and reading materials;

5. Administrative costs associated with room and board;

l. non-medical programs: Intrinsic benefits and/or administrative elements of non-medical programs, such as foster care, therapeutic foster care, child welfare, education, childcare, vocational and prevocational training, housing, parole and probation, and juvenile justice;

m. services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

n. therapy for marital problems without a covered, current ICD diagnosis;

o. therapy for parenting skills without a covered, current ICD diagnosis;

p. therapy for gambling disorders without a covered, current ICD diagnosis;

q. support group services other than Peer Support services;

r. more than one provider seeing the recipient in the same RMH intervention with the exception of CI services;

s. respite care;

t. recreational activities: Recreational activities not focused on rehabilitative outcomes;

u. personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives; and/or

v. services not authorized by the QIO-like vendor if an authorization is required according to policy.

6. Service Limitations: All RMH services require prior authorization by Medicaid's QIO-Like vendor. RMH services may be prior authorized up to 90-days.

a. Intensity of Need Levels I & II: Recipients may receive BST and/or Peer-to-Peer services provided:

1. a covered, current ICD and CASII/LOCUS Levels I or II; and clinical judgment; and

2. the overall combination does not exceed a maximum of two hours per day; and

3. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

b. Intensity of Need Level III: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

1. a covered, current ICD and CASII/LOCUS Level III; and

2. SED or SMI determination; and

3. clinical judgment; and

4. the overall combination does not exceed a maximum of four hours per day;

and

5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

c. Intensity of Need Level IV: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

1. a covered, current ICD and CASII/LOCUS Level IV; and

2. SED or SMI determination; and

3. clinical judgment; and

4. the overall combination does not exceed a maximum of six hours per day; and

5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

d. Intensity of Need Levels V & VI: Recipients may receive any combination of BST, PSR, day treatment and/or peer-to-peer services provided:

1. a covered, current ICD and CASII/LOCUS Levels V or VI; and

2. SED or SMI determination; and

3. clinical judgment; and

4. the overall combination does not exceed a maximum of eight hours per day; and

5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

e. Additional RMH Service Authorizations: Recipients may receive any combination of additional medically necessary RMH services beyond established daily maximums. Additional RMH services must be prescribed on the recipient's rehabilitation plan and must be prior authorized by Medicaid's QIO-like vendor. Additional RMH services authorizations may only be authorized for 30-day periods. These requests must include:

1. a lifetime history of the recipient's inpatient psychiatric admissions; and

2. a 90-day history of the recipient's most recent outpatient psychiatric services; and

3. progress notes for RMH services provided over the most current two-week period.

7. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period, so an interruption in services may be avoided for the recipient. In order to receive authorization for RMH services all of the following must be demonstrated in the rehabilitation plan and progress notes (if applicable).

   a. The recipient will reasonably benefit from the RMH service or services requested;

   b. The recipient meets the specific RMH service admission criteria;

   c. The recipient possesses the ability to achieve established treatment goals and objectives;

   d. The recipient and/or their family/legal guardian (in the case of legal minors) desire to continue the service;

   e. The recipient's condition and/or level of impairment does not require a more or less intensive level of service;

   f. The recipient does not require a level of structure, intensity and/or supervision beyond the scope of the RMH service or services requested; and

   g. The retention of the RMH service or services will reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall well-being.

8. Exclusion and Discharge Criteria: Prior authorization will not be given for RMH services if any of the following apply:

   a. The recipient will not reasonably benefit from the RMH service or services requested;

   b. The recipient does not continue to meet the specific RMH service admission criteria;

   c. The recipient does not possess the ability to achieve established rehabilitation goals

and objectives;

d. The recipient demonstrates changes in condition, which warrants a more or less intensive level of services;

e. The recipient and/or their family/legal guardian (in the case of legal minors) do not desire to continue the service;

f. The recipient presents a clear and imminent threat of serious harm to self and/or others (recipient presents the intent, capability and opportunity to harm themselves and others); The recipient's condition and/or level of impairment requires a more intensive level of service; and

g. The retention of the RMH service or services will not reasonably help prevent the discomposure of the recipient's mental and/or behavioral health and overall wellbeing.

403.6A RESERVED

403.6B RESERVED

403.6C BASIC SKILLS TRAINING (BST) SERVICES

1. Scope of Service: BST services are RMH interventions designed to reduce cognitive and behavioral impairments and restore recipients to their highest level of functioning. BST services are provided to recipients with age and developmentally inappropriate cognitive and behavioral skills. BST services help recipients acquire (relearn) constructive cognitive and behavioral skills through positive reinforcement, modeling, operant conditioning, and other training techniques. BST services reteach recipients a variety of life skills. BST services may include the following interventions:

a. Basic living and self-care skills: Recipients learn how to manage their daily lives, recipients learn safe and appropriate behaviors;

b. Social skills: Recipients learn how to identify and comprehend the physical, emotional and interpersonal needs of others-recipients learn how to interact with others;

c. Communication skills: Recipients learn how to communicate their physical, emotional, and interpersonal needs to others. Recipients learn how to listen and identify the needs of others;

d. Parental training: Parental training teaches the recipient's parent(s) and/or legal

guardian(s) BST techniques. The objective is to help parents continue the recipient's RMH care in home and community-based settings. Parental training must target the restoration of recipient's cognitive and behavioral mental health impairment needs. Parental training must be recipient centered;

e. Organization and time management skills: Recipients learn how to manage and prioritize their daily activities; and/or

f. Transitional living skills: Recipients learn necessary skills to begin partial-independent and/or fully independent lives.

2. Provider Qualifications:

a. QMHP: QMHPs may provide BST services. QMHA: QMHAs may provide BST services under the clinical supervision of a QMHP.

b. QBA: QBAs may provide BST services under the clinical supervision of QMHP and the direct supervision of a QMHP or QMHA.

3. Service Limitations: All BST services must be prior authorized. Up to two hours of BST services per day for the first 90 consecutive days, one hour per day for the next 90 consecutive days and anything exceeding current service limitations above 180 consecutive days would require a prior authorization meeting medical necessity. Any service limitations may be exceeded with a prior authorization demonstrating medical necessity. Services are based on a calendar year. Prior authorizations may not exceed 90-day intervals.

If a recipient has been receiving BST services for six consecutive months, the provider must validate that continued services are reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:

a. Expectation that the patient's condition will improve significantly in a reasonable and predictable period of time, or the services must be necessary for the establishment of a safe and effective rehabilitative therapeutic design required in connection with a specific disease state.

b. The amount, frequency and duration of BST must be reasonable under accepted standards of practice.

c. If the rehabilitation plan goals have not been met, the re-evaluation of the rehabilitation/treatment plan must reflect a change in the goal, objectives, services, and methods and reflect the incorporation of other medically appropriate services such as outpatient mental health services.

d. Documentation demonstrates a therapeutic benefit to the recipient by reflecting the downward titration in units of service. The reduction in services should demonstrate the reduction in symptoms/behavioral impairment.

BST services are based on the below daily maximums:

Service Limitations	Children: CASII	Adults: LOCUS
Levels I, II, III, IV, V	Maximum of two hours per day for the first 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.	Maximum of two hours per day for the first 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.
Levels I, II, III, IV, V	Maximum of one hour per day for the next 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.	Maximum of one hour per day for the next 90 days. This service limitation may be exceeded with a prior authorization demonstrating medical necessity.
Levels I, II, III, IV, V	Service limits exceeding two 90-day intervals may be overridden with a prior authorization meeting medical necessity.	Service limits exceeding two 90-day intervals may be overridden with a prior authorization meeting medical necessity.

4. Admission Criteria: The recipient and at least one parent and/or legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community-based services; and assessment documentation must indicate that the recipient has substantial impairments in any combination of the following areas:

a. Basic living and self-care skills: Recipients are experiencing age-inappropriate deficits in managing their daily lives and are engaging in unsafe and inappropriate behaviors;

b. Social skills: Recipients are experiencing inappropriate deficits in identifying and comprehending the physical, emotional and interpersonal needs of others;

c. Communication skills: Recipients are experiencing inappropriate deficits in communicating their physical, emotional and interpersonal needs to others;

d. Organization and time management skills: Recipients are experiencing inappropriate deficits managing and prioritizing their daily activities; and/or

e. Transitional living skills: Recipients lack the skills to begin partial-independent

and/or fully independent lives.

403.6D PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT (PACT)

1. A multi-disciplinary team-based approach of the direct delivering of comprehensive and flexible treatment, support and services within the community. The team must be composed of at least one QMHP and one other QMHP, QMHA or peer supporter.

2. PACT is for individuals who have the most serious and intractable symptoms of a severe mental illness and who, consequently, have the greatest difficulty with basic daily activities, keeping themselves safe, caring for their basic physical needs or maintaining a safe and affordable place to live and require interventions that have not been effectively addressed by traditional, less intensive services.

3. Services are available 24 hours a day, seven days per week. Team members may interact with a person with acute needs multiple times a day. As the individual stabilizes, contacts decrease. This team approach is facilitated by daily team meetings in which the team is briefly updated on each individual. Activities for the day are organized and team members are available to one another throughout the day to provide consultation or assistance. This close monitoring allows the team to quickly adjust the nature and intensity of services in response to individuals' changing needs. PACT is reimbursed as unbundled services.

403.6E RESERVED

403.6F PEER-TO-PEER SERVICES

1. Scope of Service: Peer-to-Peer support services are RMH interventions designed to reduce social and behavioral impairments and restore recipients to their highest level of functioning. Peer-to-Peer supporters (e.g. peer supporters) help the recipient live, work, learn and participate fully in their communities. Peer-to-Peer services must be delivered directly to recipients and must directly contribute to the restoration of recipient's diagnosis mental and/or behavioral health condition. Peer-to-Peer services may include any combination of the following:

   a. Helping stabilize the recipient;

   b. Helping the recipient access community based mental and/or behavioral health services;

   c. Assisting during crisis situations and interventions;

   d. Providing preventative care assistance; and/or

2. Providing personal encouragement, self-advocacy, self-direction training, and peer mentoring.

   Provider Qualifications: A peer supporter is a qualified individual who is currently or was previously diagnosed with a mental and/or behavioral health disorder and who possess the skills and abilities to work collaboratively with and under the clinical and direct supervision of a QMHP. The selection of the supporter is based on the best rehabilitation interest of the recipient. A peer supporter cannot be the legal guardian or spouse of the recipient. At a minimum, a peer supporter must meet the qualifications for a QBA. Peer supporters are contractually affiliated with a BHCN, independent professional (Psychologists and Psychiatrists), or individual RMH providers may provide services to any eligible Medicaid-recipient, if determined appropriate in the treatment planning process.

3. Service Limitation: All Peer-to-Peer services require prior authorization by Medicaid's QIO-like vendor. Prior authorizations may not exceed 90-day intervals. Peer-to-Peer service limits are based on the below 30-day maximums.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to II	Maximum of six hour per 90-day period	Maximum of six hour per 90-day period
Level III	Maximum of nine hour per 90-day period	Maximum of nine hours per 90-day period
Levels IV to VI	Maximum of 12 hours per 90-day period	Maximum of 12 hours per 90-day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets all of the following:

   a. The recipient would benefit from the peer supporter's understanding of the skills needed to manage their mental and/or behavioral health symptoms and for utilization of community resources;

   b. The recipient requires assistance to develop self-advocacy skills;

   c. The recipient requires peer modeling in order to take increased responsibilities for his/her own recovery; and

   d. Peer-to-Peer support services would be in the best interest of the recipient and would most likely improve recipient's mental, behavioral and overall health.

403.6G PSYCHOSOCIAL REHABILITATION (PSR) SERVICES

1. Scope of Service: PSR services are RMH interventions designed to reduce psychosocial dysfunction (i.e., interpersonal cognitive, behavioral development, etc.) and restore recipients to their highest level of functioning. PSR services target psychological functioning within a variety of social settings.

   PSR services may include any combination of the following interventions:

   a. Behavior management: Recipients learn how to manage their interpersonal, emotional, cognitive, and behavioral responses to various situations. They learn how to positively reflect anger, manage conflicts, and express their frustrations verbally. They learn the dynamic relationship between actions and consequences;

   b. Social competency: Recipients learn interpersonal-social boundaries and gain confidence in their interpersonal-social skills;

   c. Problem identification and resolution: Recipients learn problem resolution techniques and gain confidence in their problems solving skills;

   d. Effective communication: Recipients learn how to genuinely listen to others and make their personal, interpersonal, emotional and physical needs known;

   e. Moral reasoning: Recipients learn culturally relevant moral guidelines and judgment;

   f. Identity and emotional intimacy: Recipients learn personal and interpersonal acceptance. They learn healthy (appropriate) strategies to become emotionally and interpersonally intimate with others;

   g. Self-sufficiency: Recipients learn to build self-trust, self-confidence and/or self-reliance;

   h. Life goals: Recipients learn how to set and achieve observable specific, measurable, achievable, realistic, and time-limited life goals; and/or

   i. Sense of humor: Recipients develop humorous perspectives regarding life's challenges.

2. Provider Qualifications:

   a. QMHP: QMHPs may provide PSR services.

b. QMHA: QMHAs may provide PSR services under the Clinical Supervision of a QMHP.

c. QBA: QBAs may not provide PSR services.

3. Service Limitations: All PSR services require prior authorization by Medicaid's QIO-like vendor. Prior authorizations may not exceed 90-day intervals. PSR services are based on the below daily maximums.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I & II	No services authorized	No services authorized
Level III	Maximum of two hours per day	Maximum of two hours per day
Levels IV & V	Maximum of three hours per day	Maximum of three hours per day
Level VI	Maximum of four hours per day	Maximum of four hours per day

4. Admission Criteria: At least one parent or a legal guardian (in the case of legal minors) with whom the recipient is living must be willing to participate in home and community-based services; and the recipient must have substantial deficiencies in any combination of the following criteria:

a. Behavior management: Recipients are experiencing severe deficits managing their responses (viz., interpersonal, emotional, cognitive, and behavioral) to various situations. Recipients cannot age appropriately manage conflicts, positively channel anger, or express frustration verbally. They do not understand the relationship between actions and consequences;

b. Social competency: Recipients are experiencing severe deficits navigating interpersonal-social boundaries. They lack confidence in their social skills;

c. Problem identification and resolution: Recipients are experiencing severe deficits resolving personal and interpersonal problems;

d. Effective communication: Recipients need to learn how to listen to others and make their needs known to others. They cannot effectively communicate their personal, interpersonal, emotional and physical needs;

e. Moral reasoning: Recipients are experiencing severe deficits in culturally relevant

moral judgment;

f. Identity and emotional intimacy: Recipients are experiencing severe deficits with personal and interpersonal acceptance. They avoid and/or lack the ability to become emotionally and interpersonally intimate with other people;

g. Self-sufficiency: Recipients are experiencing severe deficits with self-confidence, self-esteem, and self-reliance; recipients express feelings of hopelessness and helplessness; dealing with anxiety: Recipients are experiencing severe deficits managing and accepting anxiety, they are fearful of taking culturally normal and healthy rehabilitative risks;

h. Establishing realistic life goals: Recipients are experiencing severe deficits setting and achieving realistic life goals; and/or

i. Sense of humor: Recipients are experiencing severe deficits seeing or understanding the various humorous perspectives regarding life's challenges.

403.6H CRISIS INTERVENTION (CI) SERVICES

1. Scope of Services: CI services are RMH interventions that target urgent situations where recipients are experiencing acute psychiatric and/or personal distress. The goal of CI services is to assess and stabilize situations (through brief and intense interventions) and provide appropriate mental and behavioral health service referrals. The objective of CI services is to reduce psychiatric and personal distress, restore recipients to their highest level of functioning and help prevent acute hospital admissions. CI interventions may be provided in a variety of settings, including but not limited to psychiatric emergency departments, emergency rooms, homes, foster homes, schools, homeless shelters, while in transit and telephonically. CI services do not include care coordination, case management, or targeted case management services (see MSM Chapter 2500, Targeted Case Management).

   CI services must include the following:

   a. Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization;

   b. Conduct situational risk-of-harm assessment;

   c. Follow-up and de-briefing sessions to ensure stabilization, continuity of care and identification of referral resources for ongoing community mental and/or behavioral health services.

2. Provider Qualifications: QMHPs may provide CI services. If a multidisciplinary team is used, the team must be led by a QMHP. The team leader assumes professional liability over the CI services rendered.

3. Service Limitations: Recipients may receive a maximum of four hours per day over a three-day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets any combination of the following:

   a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;

   b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);

   c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or

   d. Recipient will benefit from the stabilization, continuity of care and the referrals for ongoing community mental and/or behavioral health services.

403.6I MOBILE CRISIS RESPONSE DELIVERED BY DESIGNATED MOBILE CRISIS TEAM

On September 17, 2021, per Section 9813 of the American Rescue Plan Act (ARPA), the Nevada DHHS was awarded a state planning grant by the US Centers for Medicare & Medicaid Services (CMS) to assist in the development and implementation of qualifying community-based mobile crisis intervention services under its Medicaid state plan. In addition, Section 9813 of the ARPA established Section 1947 of the US Social Security Act (SSA), which authorizes optional state plan coverage and reimbursement for qualifying mobile crisis intervention services with a temporarily enhanced 85 percent federal medical assistance percentage (FMAP) for 12 quarters during the timeframe of April 2022 to March 2027. Section 1947 also waives standard state plan requirements for state wideness, comparability, and provider choice, in addition to providing definition for

qualifying community-based mobile crisis services.

The following policy is contingent upon State Plan Amendment (SPA) approval by CMS.

1. Scope of Services

Nevada shall ensure that Mobile Crisis Response teams respond in person at the location in the community where a crisis arises, or a location agreed upon by the family and Team within a *proposed average response time* of 30 minutes in Clark and Washoe Counties and one hour in the rest of the state. Nevada identifies these Mobile Crisis Response teams that comply with ARPA and the US SSA as DMCT.

The primary objective of this Mobile Crisis Response service is to offer "someone to come" in the crisis continuum, established through Senate Bill 390 (during the 81st Nevada Legislative Session) and subsequent legislation that formulates a comprehensive safety net of crisis services for all Nevadans. DMCTs will respond to an individual in crisis at the individual's location, 24/7/365.

While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a DMCT indicates a higher level of care is needed through an in-person response for the individual's acute/emergent episode of crisis. An assessment, including the evaluation of suicidality, is required to be delivered by a qualified and/or licensed behavioral health professional. The resulting intervention and stabilization of the crisis by the DMCT includes care coordination (through active engagement and "warm hand-off") and follow-up by providers. Care coordination is inclusive of coordinated transportation to other locations when recipients are determined to need facility-based care.

2. DMCT Access and Accessibility

a. DMCT services shall be available 24/7/365 for in-person response and ensure 24 hour/7 days per week on-call coverage and back-up availability.

b. DMCT services shall not be restricted to certain locations or days/times within the covered area. DMCTs shall:

1. Respond to wherever the recipient is in the community outside of a hospital or other facility settings.

2. Never require the individual in crisis to travel to the DMCT.

3. Respond to the preferred location based on individual in crisis and/or caregiver preference.

4. Respond with the least restrictive means possible, only involving public safety personnel when necessary.

5. DMCTs are expected to respond to dispatch through a designated call center and shall advise the designated call center of any changes to the DMCT's availability (i.e., in the event of self-dispatch to a crisis on-site).

c. DMCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers' identified catchment area and including specific populations (i.e., Tribal communities and multicultural communities, LGBTQ+, children and adolescents, aging populations, individuals with disabilities, individuals experiencing substance use, etc.).

d. For all DMCT providers, the individual served does not have to be a previous or existing client.

e. Continuity of operations and disaster plans shall comply with state standards, DHHS requirements for endorsement or credentialing, and DHCFP requirements for enrollment.

f. DMCTs shall have GPS devices linked to the designated call center(s) and a means of direct communication available at all times with all partners (including the crisis call center, Emergency Medical Services, Law Enforcement, Intensive Crisis Stabilization Service providers, and other community partners), such as a cellular phone or radio for dispatch.

g. DMCTs shall not refuse a request for dispatch unless safety considerations warrant involvement of public safety.

1. In such cases, DMCTs shall have established standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, and imminent risk of harm).

2. Policies shall appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history).

3. Ensure all interventions are offered in a clinically appropriate manner that respects the preferences of the individual in crisis and their supportive family systems while recognizing the need to maintain safety.

h. DMCTs shall accept all referrals from a designated call center and shall respond without reassessing the individual on-site only if the designated call center has completed an initial safety screen and provided the screening information to the DMCT.

i. DMCTs shall use available technology to support care coordination activities and to determine access to available post-crisis care options (e.g., through- health information technology, prior treatment information through crisis including safety plans, and psychiatric advance directive (PAD), hospital/provider bed availability, and appointment availability/scheduling).

j. DMCTs shall provide culturally and linguistically appropriate care.

k. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and ADA-compliant services (e.g., sign language interpreters, TTY lines).

l. Services to children and youth up to 18 years old shall adhere to DHHS DCFS System of Care core values and guiding principles.

m. DMCTs shall provide timely services to individuals in crisis as defined by state and federal regulations, policy, and/or guidance, including the DMCT Certification Criteria.

3. DMCT OPERATIONAL REQUIREMENTS

a. Inclusive Services

1. Screening

a. DMCTs must establish policies and protocols to ensure:

1. Consistent screening of all individuals, and

2. Documentation of all screenings and screening findings, and

3. Screenings are conducted only by QMHPs and QMHAs who have continuous access to a QMHP for consultation.

b. Selected screening tools must include use of adopted tools for evaluation of risk, violence, and suicidality.

1. Tools chosen must be nationally accepted or evidenced-based, peer-reviewed tools, and

2. Screening tools include the Columbia Suicide Screening Tool (Columbia) and other tools that meet state requirements.

2. Assessment

a. Mobile crisis teams must ensure a qualified team member (as outline in MSM 403.6I Provider Qualifications) completed a behavioral health assessment and documents the findings, when indicated.

b. Selected assessments tools must be:

1. Nationally accepted or evidenced-based, peer reviewed tools, and

2. Support evaluations necessary for an involuntary hold, when a hold is initiated.

c. Selected assessment tools may include the Collaborative Assessment & Management of Suicidality (CAMS) and other tools that meet state requirements.

d. Mobile crisis teams shall establish policies and protocols to ensure:

1. Consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances, and

2. Documentation of assessment results.

e. Crisis and Safety Plans

1. Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and

2. As part of the crisis and safety planning, DMCTs must either complete an assessment indicating individual is able stay in current placement/location or coordinate the transfer of the individual to an appropriate higher level of care.

3. Medical Records

   a. Medical records shall be kept in accordance with documentation standards set forth in MSM Chapter 100 and MSM Chapter 400, and

   b. Shared with whomever is providing the services (the follow up provider where the individual is being discharged) to support coordination of care (i.e., triggering words, specific circumstances of individual, etc.)

4. Advance Directives

   1. DMCTs shall establish protocols regarding when to consider and assist with the completion of a Psychiatric Advance Directive (PAD), in accordance with state laws and regulations, and

   2. DMCTs must follow Nevada Medicaid guidance on advance directives, as set forth in MSM 100.

5. Harm Reduction

   1. When applicable, DMCTs shall educate individuals on harm reduction practices,

   2. DMCTs shall carry harm reduction supplies, including Fentanyl test strips, and

   3. Mobile crisis teams shall carry Naloxone and have team members trained on its administration (as specified in MSM 403.6I Provider Training).

6. Family Engagement

   1. Mobile crisis teams shall establish protocols to allow family members and other collateral contacts to represent an individual in crisis, and

   2. DMCTs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM 100.

7. Coordination of Care

   a. DMCT providers shall coordinate timely follow-up services and/or referrals with providers, social supports, and other services as

needed, including but not limited to:

1. Assigned case managers

2. Primary Care Providers (PCP)

3. Existing (or referral) behavioral health providers/care teams, including mental health and substance use disorder (SUD) support, where available

4. Harm-reduction resources, where available

5. Appropriately shared information with whomever is providing the services, the follow up provider, to where the individual is being discharged – to support coordination of care (i.e., triggering words, specific circumstances to individual, etc.)

b. Discharge from episode of care

1. DMCTs shall document discharge of the individual from the crisis episode in situations where

   a. Acute/emergent presentation of the crisis is resolved

   b. Appropriate referral(s) and service engagement(s) to stabilize the crisis are completed, including transfer to a Crisis Stabilization Center (CSC) or other level of care

   c. Ongoing or existing services, supports, and linkages have been recommended and documented

   d. Services provided (in-person or via telehealth) up to 72 hours following the initial engagement with the DMCT are considered part of the crisis episode (i.e., pre-discharge)

   e. DMCTs may continue to provide bridge services and supports to the individual for up to 45 days for continued stabilization in an outpatient setting; these covered services rendered after 72 hours shall be billed to Medicaid by appropriately enrolled

providers. with the appropriate outpatient billing codes

8. Telehealth

a. Reference Chapter 3400 related to telehealth modality. The use of telehealth shall be

1. Dictated by client preference

2. Utilized to include additional member(s) of the team not on-site

3. Utilized to provide follow-up services to the individual following an initial encounter with the DMCT

4. Utilized to include highly trained members of the team, such as psychiatrists, psychiatric nurse practitioners, or others who can prescribe and/or administer medications

b. Best Practices

1. An individual in crisis is to be represented in screening/assessment, crisis planning, and follow-up by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning, especially when working with children and youth.

2. Reduce duplicative screening and assessments.

3. Access and review existing medical records/treatment information when available to support crisis intervention activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available).

4. Providers are expected to develop and maintain a strengths-based, person-centered, trauma-informed, and culturally sensitive/respectful relationship with the individual.

5. Co-creation of a safety/crisis plan, when applicable.

6. Education for the individual on harm reduction practices, when applicable.

7. Regarding Peer-to-Peer Support Services, it is the intent of policy that the DMCT include one team member who is a peer and recovery support services provider, to the greatest extent possible, as Peer Supporters will

become mandatory team service providers, certified by DHHS and enrolled with Nevada Medicaid (per SB 390), by July 1, 2026.

c. Privacy and Confidentiality Protocols

1. Policies

a. Providers shall have established/written policies in compliance with State and Federal privacy and confidentiality laws (e.g., Health Insurance Portability and Accountability Act (HIPAA)), as well as established protocols set forth in accordance with MSM Chapter 100, Chapter 400, and Chapter 3300.

2. Training

a. DMCT Clinical Supervision is responsible for the initial and ongoing training of staff on privacy and confidentiality practices and protocols.

3. Collaboration and Data Sharing

a. DMCTs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements, as well as DHHS oversight requirements.

b. Address what can and cannot be shared, especially in emergency situations.

c. Share screening and assessment information with the receiving clinical/medical provider, including crisis plans and PADs.

d. Develop and implement appropriate data-sharing agreements with partners, ensuring partners are also securing any data covered by state and federal privacy regulations.

e. Develop data sharing protocols and member information release authorizations to support collaboration practices in accordance with state and federal requirements.

f. Have formal, written, collaborative protocols, memorandums of understanding (MOU), and other agreements with community partners, as necessary:

1 Local Law Enforcement agencies

2 Emergency Medical Services (EMS) providers

3 988 crisis lines, designated crisis call centers, and dispatch centers providing service coordination among respondents

4 Medicaid Managed Care Organizations (MCO), as applicable in their catchment area.

d. Excluded Services

1. Services not eligible for reimbursement when rendered by a DMCT under Nevada Medicaid include:

a. Crisis services delivered without a screening or assessment, and/or

b. Crisis services delivered solely via telehealth without the availability of an in-person response to the individual in crisis, and/or

c. Crisis services delivered by one-member teams or one individual provider only, and/or

d. Crisis services delivered by a DMCT that is not enrolled under Provider Type and Specialty in Nevada Medicaid at the time service is rendered, and/or

e. Crisis services delivered by a Law Enforcement officer, and/or

f. Crisis services delivered within a hospital or nursing facility setting.

4. DMCT PROVIDER ELIGIBILITY REQUIREMENTS

a. DMCTs must be endorsed or certified by DHHS

b. DMCTs must be enrolled as a Nevada Medicaid provider

c. DMCTs must include at least two team members, one of which shall be able to deliver the service at the location of the individual in crisis. DMCTs must be led by a:

1. QMHP-level Independent Professional, or

2. QMHP-level Intern under Direct Supervision of a QMHP-level Independent Professional, or

3. QMHA-level paraprofessional under the Direct Supervision of a QMHP-level Independent Professional.

d. DMCT members shall fall into one of the following categories:

1. Physician

2. Physician Assistant

3. Advance Practice Registered Nurse (APRN) and Independent Nurse Practitioner (NP) with a focus in psychiatric mental health

4. Psychologist

5. LMFT, LCSW, LCPC, and qualified Post-Graduate Interns (under clinical supervision)

6. Registered Nurse and QMHA-level

7. Substance use disorder (SUD) specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), certified alcohol and drug counselor (CADCs), and/or associated interns of these specialties (under supervision)

8. Peer Supporter and Qualified Behavioral Aide (QBA)-level

e. Provider Supervision

1. All clinical supervision expectations shall align with existing requirements in Chapter 400 Supervision Standards for an outpatient behavioral health delivery model

2. All Chapter 400 Provider Eligibility Requirements shall be documented by DMCTs and made available to DHHS upon request

3. Real-time clinical consultation and supervision shall be available 24/7/365 to assist the DMCT

4. DMCTs shall have policies and procedures in place for Clinical Supervision, including a staffing plan that identifies the supervisory

structure with the employees' names and positions within the agency, and must ensure:

a. Case records are kept updated in accordance with Chapter 400 Documentation standards; and

b. Protocols are regularly updated on when and how to engage the on-call clinician in the crisis episode responded to by the DMCT; and

c. Supervisors review in-person or via telehealth the response to crisis episode with all involved QMHP-level Intern and QMHA-level staff, and shall appropriately document the time and content of that supervisory discussion; and

d. The supervisor reviews and co-signs with the rendering QMHP-level Intern and QMHA-level staff the documented screening within 24 hours or next business day; and

e. Documentation of supervisory contacts with all engaged DMCT supervisee staff, including date of supervisor review, date of observation of individual staff, log of indirect supervision contacts (e.g., paperwork reviewed), as well as date, agenda, and action plan for all conferences with supervisee staff; and

f. Each engaged QMHP-level Intern and QMHA-level staff has the documented necessary training, competencies, and skills to conduct mental health screens.

f. Provider Training

1. DMCT providers must develop a staff training and competency plan to be reviewed annually as requested by DHHS.

a. The plan will include all required trainings listed in Chapter 400 Provider Eligibility Requirements and other core competencies defined by the state.

b. The plan will outline the process for ongoing review of clinical skills and supervision of staff.

2. All engaged DMCT staff shall receive training in the following areas prior to participating in a mobile response to a crisis episode:

a. Safety/risk screening

1. Training in safety and risk screening shall include methods to:

a. Adapt to cultural and linguistic needs of individuals during the screening process; and

b. Select the appropriate screening tool; and

c. Engage with supportive family system and collateral contacts; and

d. Interpret screening tool results.

b. Stabilization and verbal de-escalation techniques shall be culturally competent, including when and how to adjust response based on the circumstances of the individual in crisis, the site of the crisis response, and the severity of the situation.

c. Harm reduction strategies for individuals with SUD should include:

1. Use of Naloxone in the field; and/or

2. How to educate individuals at risk (and their supportive family system) about Naloxone use; and/or

3. How to educate individuals about harm reduction techniques and resources.

d. Crisis/safety planning

e. Appropriate privacy and confidentiality policies and procedures

f. Use of Telehealth equipment

g. Electronic health record or other systems utilized in the provision, documentation, and/or reporting of mobile crisis services.

3. All DMCT staff shall receive training on trauma-informed care within 90 days of employment as a DMCT staff.

4. All DMCT staff shall receive annual refresher trainings on the training topics identified in this section.

5. All DMCT staff shall demonstrate competency on all post-tests, for each topic in which they have been trained.

6. Each training topic shall be covered in separate training modules dedicated to specific topics.

7. DMCTs shall maintain documentation to demonstrate satisfactory and timely completion of all required trainings.

   a. When requested by the state, DMCTs must submit training logs, training schedules, and post-test results for endorsement and certification monitoring purposes.

5. DMCT RECIPIENT ELIGIBILITY REQUIREMENTS

   a. DMCT services are available to all Medicaid eligible individuals who are: 1) outside of a hospital or other facility setting, and 2) experiencing a behavioral health crisis (including mental health and substance use disorder-related crises).

   b. Symptoms are indicative of a crisis which requires coordinated clinical response, through the implementation of intervention and stabilization services, for the safety and protection of the individual in crisis and others involved on-site (e.g., harm to self, harm to others, inability to care for oneself).

   c. Referral from a designated call center or self-referral by a DMCT.

6. AUTHORIZATION PROCESS AND CLINICAL DOCUMENTATION OF SERVICE

   a. Documentation of DMCT service by 1) a QMHP-level Independent Professional supervising and/or delivering service and 2) at least one additional team member rendering the intervention/stabilization service on-site.

   b. No prior authorization is required for the delivery of services by a DMCT, unless an outpatient service requiring prior authorization (according to service limitations) is delivered in association with but separate from the crisis episode lasting 72 hours.

   c. DMCTs shall maintain a daily log of all DMCT responses, as dispatched by a crisis call center and self-dispatched, within and outside of catchment area. Log will be made available to DHHS upon request. The log will include up to and including

      1. HIPAA compliant identifier for the individual crisis response episode, and

      2. Date of crisis response episode, and

3. Start and end time of crisis response episode (for the recipient on that day), and

4. Mechanism of response (dispatch), and

5. Name and credentials of all team members involved in response and supervising QMHP-level Independently Licensed provider.

403.6J CRISIS STABLIZATION CENTER

1. Scope of Service: Crisis stabilization is an unplanned, expedited service, to, or on behalf of, an individual to address an urgent condition requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services, which, if the condition and symptoms are not treated, present an imminent threat to the individual or others, or substantially increase the risk of the individual becoming gravely disabled.

Crisis Stabilization Centers (CSCs) are considered an emergency healthcare alternative, providing persons with an acute behavioral health problem (including co-occurring disorders) with prompt action, gentle response, and effective support in a respectful environment. CSCs are a no-wrong-door access. CSCs are a short-term, subacute care for recipients which support an individual's stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose. This model is traditionally meant to last 24 hours or less. If recipients cannot be stabilized in this period, the next step would be to refer them to an appropriate level of care at an inpatient facility. CSCs are part of a continuum of crisis services designed to stabilize and improve symptoms of distress. Recipients who can be stabilized in a CSC are anticipated to be discharged to a lower level of care.

The primary objective of the crisis stabilization service is to promptly conduct a comprehensive assessment of the individual and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the individual to a level of functioning that can be managed at a lower level of care. Active family/guardian/significant other/natural supports involvement is necessary unless contraindicated. Crisis stabilization services means behavioral health services designed to:

a. De-escalate or stabilize a behavioral health crisis, whether this is occurring concurrently with a substance use disorder; and

b. When appropriate, avoid admission of a patient to another inpatient mental health facility or hospital and connect the patient with providers of ongoing care as appropriate for the unique needs of the patient.

2. Requirements: CSCs must operate in accordance with established administrative protocols, evidenced-based protocols for providing treatment and evidence-based standards for documenting information concerning services rendered to recipients of such services in accordance with best practices for providing crisis stabilization services. Has a policy structure in place that establishes, including but not limited to:

   a. Procedures to ensure that a mental health professional is on-site 24 hours a day, seven days a week;

   b. Procedures to ensure that a licensed physician, physician assistant, or psychiatric APRN is available for consultation to direct care staff 24 hours a day, seven days a week;

   c. Procedures to ensure RNs, Licensed Practical Nurses (LPNs), social workers, community health workers, and peer support specialists (as defined per Chapter 449 of the Nevada Revised Statutes (NRS)) are available to adequately meet the needs of recipients;

   d. Procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others;

   e. Delivers crisis stabilization services:

      1. To all persons who come in the door, whether as walk-ins or drop-offs from law enforcement or a mobile crisis team.

   f. Uses a data management tool to collect and maintain data relating to admissions, discharges, diagnoses, and long-term outcomes for recipients of crisis stabilization services;

   g. Operating in accordance with best practices for the delivery of crisis stabilization services, CSCs must include:

      1. Recovery Orientation

         a. In a manner that promotes concepts that are integral to recovery for persons with behavioral health issues, including, without limitation, hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

      2. Trauma-informed care

         a. Many individuals experiencing a behavioral health crisis or

substance use disorder have experienced some sort of trauma in the past.

3. Significant use of peer staff

   a. People with lived experience who have something in common with the recipients needing help.

4. Commitment to Zero Suicide/Suicide Safer Care.

5. Strong commitments to safety for consumers/staff.

6. Collaboration with law enforcement.

3. Provider Responsibilities:

a. An endorsement as a CSC must be renewed at the same time as the license to which the endorsement applies. An application to renew an endorsement as a CSC must include, without limitation:

   1. Proof that the applicant meets the requirements per NRS 449.0915; and

   2. Proof that the hospital is a rural hospital or is accredited by the Commission on Accreditation of Rehabilitation Facilities, the Center for Improvement in Healthcare Quality, DNV GL Healthcare, the Accreditation Commission for Health Care, or the Joint Commission, or their successor organizations.

b. Medical Records: A medical record shall be maintained for each individual and shall contain, including but not limited to the following. Please also consult medical documentation requirements listed in 403.9B(2):

   1. An assessment for substance use disorder and co-occurring mental health and substance use disorder, including a statement of the circumstances under which the person was brought to the unit and the admission date and time;

   2. An evaluation by a mental health professional to include at a minimum:

      a. Mental status examination; and

      b. Assessment of risk of harm to self, others, or property.

   3. Review of the person's current crisis plan;

4. The admission diagnosis and what information the determination was based upon;

5. Coordination with the person's current treatment provider, if applicable;

6. A plan for discharge, including a plan for follow up that includes, but is not limited to:

   a. The name, address, and telephone number of the provider of follow-up services; and

   b. The follow up appointment date and time, if known.

7. The clinical record must contain a crisis stabilization plan developed collaboratively with the individual and/or guardian that includes, but is not limited to:

   a. Strategies and interventions to resolve the crisis in the least restrictive manner possible;

   b. Language that is understandable to the individual and members of the recipient's support system; and

   c. Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning.

8. If antipsychotic medications are administered, the clinical record must document:

   a. The physician’s attempt to obtain informed consent for antipsychotic medication; and

   b. The reasons why any antipsychotic medication is administered over the recipient's objection or lack of consent.

4. Admission Criteria: Accepts all patients, without regard to:

   a. Race, ethnicity, gender, socioeconomic status, sexual orientation, or place of residence of the patient;

   b. Any social conditions that affect the patient;

   c. The ability of the patient to pay; or

d. Whether the patient is admitted voluntarily to the hospital pursuant to NRS 433A.140 or admitted to the hospital under an emergency admission pursuant to NRS 433A.150;

e. Performs an initial assessment on any patient who presents at the hospital, regardless of the severity of the behavioral health issues that the patient is experiencing.

1. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health. Assessment and stabilization services will be provided by the appropriate staff. If outside services are needed, a referral that corresponds with the recipient's needs shall be made.

2. Has the equipment and personnel necessary to conduct a medical examination of a patient pursuant to NRS 433A.165.

a. Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies.

3. Considers whether each patient would be better served by another facility and transfers a patient to another facility when appropriate.

f. Crisis stabilization services that may be provided include but are not limited to:

1. Case management services, including, without limitation, such services to assist patients to obtain housing, food, primary health care, and other basic needs;

2. Services to intervene effectively when a behavioral health crisis occurs and address underlying issues that lead to repeated behavioral health crises;

3. Treatment specific to the diagnosis of a patient; and

4. Coordination of aftercare for patients, including, without limitation, at least one follow-up contact with a patient not later than 72 hours after the patient is discharged.

5. Authorization Process:

a. All recipients in a CSC may be rolled over for inpatient admission any time the patient requires acute care services.

b. When transitioning a recipient, documentation should include but is not limited to: outreach efforts to inpatient hospitals including reasons for delays in transitioning to an inpatient Level of Care, including any denial reasons and/or outreach efforts within the community to establish appropriate aftercare services and reasons for any delay in obtaining this. The CSC must make all efforts to stabilize the recipient's condition and discharge to an appropriate community setting with aftercare services or to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible.

c. Pursuant to federal law, Medicaid is payer of last resort whenever any other resources may be responsible for payment. Prior resources include but are not limited to: Medicare, labor unions, Worker's Compensation Insurance Carriers, private/group insurance, and CHAMPUS. Exceptions to this regulation are Bureau of Family Health Services, Indian Health Services (HIS), Ryan White Act, and Victims of Crime, when Medicaid is primary. Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.

403.7 OUTPATIENT ALCOHOL AND SUBSTANCE USE SERVICES POLICY

Outpatient substance use services may be provided by a QHMP within the scope of their practice under state law and expertise.

403.7A COVERAGE AND LIMITATIONS

1. Nevada Medicaid reimburses the following:

a. Outpatient alcohol/substance use treatment services within the context of services discussed in Section 403.4 of this Chapter (individual and family therapy is limited to one hour per session. Group therapy is limited to two hours per session).

b. Psychiatrist (MD) – Office and clinic visits provided by a psychiatrist are a Medicaid benefit. There are no limitations to services and prior authorization is not required.

c. Psychologist – Initial office and clinic visits for psychological evaluation and testing require a signed referral from a physician, licensed QMHP or a signed referral through a Healthy Kids (EPSDT) screening. All services (psychological evaluation, testing and subsequent individual, group and family therapies) provided by psychologists must be prior authorized using the PAR form. For children under age 21 services beyond 26 sessions per calendar year may only be provided if:

1. prior authorized by the QIO-like vendor; or

2. resulted from an EPSDT referral.

Testing services may also include an initial psychological evaluation.

d. APN – Office and clinic visits provided by an APN are a Medicaid benefit. There are no limitations to services and prior authorization is not required.

e. Psychiatric/Psychological Evaluations – This service is covered once, at the onsite of an illness or suspected illness. It may be utilized for the same recipient but only if a new episode or illness occurs after a hiatus, or admission or readmission to inpatient status due to complications of an underlying condition. Individual therapy services require prior authorization. The individual sessions are limited to a maximum of one hour per session and 26 sessions per calendar year, unless it is the result of a Healthy Kids (EPSDT) screening. When requesting the therapy, the provider needs to submit a psychological evaluation or summary with a treatment plan and requested frequency. Approval is usually given for three months at a time.

When requesting additional therapy, the provider needs to submit a progress report and include the number of attended sessions. It is the responsibility of the provider to keep track of the sessions.

f. Group Therapy Services – Group therapy services require prior authorization. These sessions are limited to a maximum of two hours. Each session counts against the 26 hours per calendar year unless there is a Healthy Kids (EPSDT) screening. Group therapy sessions may be requested on an alternate schedule with individual therapy. The provider needs to document what the recipient did, how the focus of the group applies to the diagnosis in their progress report and how the plan of therapy is being met. The provider will need to include the number of attended sessions.

g. Family Therapy Services – Family therapy services require prior authorization and are a benefit only when the recipient is present during the therapy. These sessions are limited to a maximum of one hour and count against the 26 sessions per calendar year unless there is a Healthy Kids (EPSDT) screening. Family therapy may be requested with individual therapy, but frequency must be included for each therapy. If additional therapy is requested after the initial request and approval, the provider needs to submit a progress report, number of attended sessions, and plan of treatment.

h. Individual Therapy Services – Individual therapy services require prior authorization. The sessions are limited to a maximum of one hour and to 26 sessions in a calendar year, unless it is the result of a Healthy Kids (EPSDT) screening. When requesting the therapy, the provider needs to submit a psychological

evaluation or summary with a treatment plan and requested frequency. Approval is usually given for three months at a time. When requesting additional therapy, the provider needs to submit a progress report and include the number of attended sessions. It is the responsibility of the provider to keep track of the sessions.

2. Other Covered Services

Please consult Section 403.10 of this chapter for other covered services.

3. Non-Covered Services

Please consult Section 403.5B of this chapter for all non-covered services.

4. Billing

For enrollment, prior authorization and billing instructions, please refer to the billing manual for Provider Types 11 and 13, located on the QIO-like vendor website.

403.7B PROVIDER RESPONSIBILITIES

Providers are responsible for:

1. Verifying Medicaid eligibility.

2. Submitting PARs to Medicaid's QIO-like vendor for purposes of obtaining prior authorization.

3. Appropriate billing procedures and code usage.

403.7C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide their Medicaid card to their service providers.

2. Medicaid recipients are expected to comply with the service provider’s treatment, care and service plans, including making and keeping medical appointment.

403.7D AUTHORIZATION PROCESS

Prior authorization for psychological services is secured through Medicaid's QIO-like vendor by submitting a PA with substantiating documentation which must include the diagnosis, an evaluation or problem summary denoting the severity of presenting problems, or functional disability. Specific, realistically attainable and measurable goals, and anticipated frequency and duration of treatment must be documented. Authorizations may be granted for a period of 90 days

(i.e., once per week times 12 weeks). To continue the payment process necessitates a new payment authorization request and approval, progress notes and number of sessions seen. Psychiatrist/Psychologist led group therapy counts as an office visit and meets the same limitation criteria. Reimbursement for individuals age 21 years and older are limited to 26 individual, group and/or family sessions in a calendar year for psychiatrists and psychologists.

All other specific authorization requirements are addressed earlier in this chapter in Section 403.5A, Coverage and Limitations.

403.8 RESIDENTIAL TREATMENT CENTER (RTC) SERVICES

A. RTC services are delivered in psychiatric, medical-model facilities, in- or out-of-state, that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation of Services for Families and Children (COA) and licensed as an RTC within their state. RTC services are for recipients under age 21 and must be provided before the individual reaches age 21. If the individual was receiving services in an RTC immediately before reaching age 21, these must be provided before:

1. the date the individual no longer requires the services; or

2. the date the individual reaches 22; and

3. is certified in writing to be necessary in the setting in which it will be provided.

B. The objective of RTC services is to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders, or conditions, who are no longer at or appropriate for an acute level of care, or who cannot effectively receive services in a less restrictive setting and who meet medical necessity and admission criteria for RTC services. RTCs are part of the mental health continuum of care and are an integral part of Nevada Medicaid's behavioral health system of care. Recipients who respond well to treatment in an RTC are anticipated to be discharged to a lower level of care, such as intensive home and community-based services, or to the care of a psychiatrist, psychologist or other QMHP.

All Medicaid policies and requirements for RTC's (such as prior authorization, etc.) are the same for NCU, except where noted in the NCU Manual, Chapter 1000.

C. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Accredited Residential Treatment Center (RTC)	Not Authorized

403.8A COVERAGE AND LIMITATIONS

1. Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications, quarterly RTC-sponsored family visits, psycho-educational services, and supervised work projects.

2. The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, dental, optometry, durable medical equipment, radiology, lab, and therapies (physical, speech and occupational) or formal educational services. Services that are Medicaid benefits must be billed separately by the particular service provider and may require prior authorization.

3. The QIO-like vendor may authorize all RTC stays, both Fee-for-Service and Health Maintenance Organization (HMO) (see MSM Chapter 3600) Medicaid in three-month (or less) increments. For Medicaid recipients to remain in RTCs longer than three months, the RTC must, prior to the expiration of each authorization, submit a Continuing Stay Request to the QIO-like vendor for authorization.

4. For recipients under the age of 21 in the custody of a public child welfare agency, Nevada Medicaid will reimburse for prior authorized RTC services only when the public child welfare agency has also approved the admission.

5. Criteria for Exclusion from RTC Admission

   One or more of the following criteria must be met which prohibit the recipient from benefiting rehabilitatively from RTC treatment or involve the RTC's inability to provide a necessary specialized service or program, clinical decisions will be made individually on a case-by-case basis:

   a. Psychiatric symptoms requiring acute hospitalization;

b. The following conditions which limits the recipient's ability to fully participate in RTC services and cannot be reasonably accommodated by the RTC;

1. Physical Disability;

2. Learning Capacity;

3. Traumatic Brain Injury (TBI);

4. Organic brain syndrome;

c. Pregnancy, unless the RTC can appropriately meet the needs of the adolescent, including obtaining prenatal care while in the facility. In the case of the birth of the infant while the recipient is in the RTC, planning for the infant's care is included in the discharge plan. (In such an instance the infant would be covered individually by Medicaid for medically necessary costs associated with medical care);

d. Chronic unmanageable violent behavior incompatible with RTC services which poses unacceptable and unsafe risks to other clients or staff for any reason (i.e., a danger to self, others or property);

e. Medical illness which limits the recipient's ability to fully participate in RTC services and is beyond the RTC's capacity for medical care;

f. Drug and/or alcohol withdrawal management is required as a primary treatment modality before a recipient can benefit rehabilitatively from RTC services; or

g. A diagnosis of Oppositional Defiant Disorder (ODD) and/or Conduct Disorder, alone and apart from any other covered, current ICD diagnosis.

6. RTC Therapeutic Home Passes

RTC Therapeutic Home Passes are to be utilized to facilitate a recipient's discharge back to their home or less restrictive setting. RTC recipients are allowed to utilize Therapeutic Home Passes based on individualized treatment planning needs and upon the recommendations of the RTC clinical treatment team. A total of three Therapeutic Home Passes are allowed per calendar year and Therapeutic Home Passes cannot be accumulated beyond a calendar year period. Duration per pass is no greater than 72 hours unless there is a documented medically necessary reason for a longer-term pass. The QIO-like vendor must be notified by the RTC of all therapeutic home passes at least 14 days prior to the pass being issued to the recipient. The notification form can be located on the QIO-like vendor website. All passes which exceed 72 hours must be prior authorized by the QIO-like vendor.

a. The following guidelines must be adhered to for reimbursement. Failure to follow these guidelines will result in non-payment to RTCs during the time the recipient was away on a Therapeutic Home Pass:

1. A physician's order is required for all Therapeutic Home Passes. If it is clinically appropriate for the recipient to travel alone, this must be specified in the physician's order.

2. A Therapeutic Home Pass will only occur within 90 days of the recipient's planned discharge and in coordination with their discharge plan. The recipient must have demonstrated a series of successful incremental day passes before the Therapeutic Home Pass occurs. The recipient must also be in the final phase of treatment in the RTC program.

3. Therapeutic Home Pass information which verifies days used must be documented in the recipient's case file and must include: dates for each pass, location of the pass, treatment objectives to be met by use of each pass and the total number of days used per calendar year. A copy of the physician order for each pass must also be maintained in the recipient's clinical case file.

4. The RTC must track the number of Therapeutic Home Passes used as the QIO-like vendor will not reimburse RTCs for pass days for any recipient exceeding a total of three passes per calendar year.

5. If the recipient leaves without issuance of a Therapeutic Home Pass the recipient will be considered discharged and the QIO-like vendor must be notified of the discharge and date the recipient left the facility.

6. In the event a recipient unexpectedly does not return to the RTC from a Therapeutic Home Pass or family emergency, and such an absence has been properly documented by the RTC, the RTC may utilize the day the recipient was expected to return from leave as the discharge date as long as the period does not exceed 72 hours. In the case of a family emergency or an extended pass which has been approved by the QIO-like vendor, this period cannot exceed 120 hours.

7. Any recipient who is formally discharged from an RTC and is readmitted is considered to be a new admission, regardless of the length of time away from the facility. Prior authorization and a Certificate of Need (CON) signed by a physician, is required for payment.

8. The three passes per calendar year Therapeutic Home Pass policy applies to

all RTC recipients, regardless of the recipient's custody status.

9. Therapeutic Home Passes include the day the pass begins and ends the day before the recipient returns (prior to midnight).

7. Transportation

Nevada Medicaid may reimburse the following RTC travel related services for an eligible recipient and attendant when determined to be medically necessary for:

a. initial travel to the RTC upon admission;

b. travel for an RTC Therapeutic Home Pass;

c. travel upon discharge from the RTC; and

d. travel for transfer from one RTC to another RTC or Acute Inpatient Services.

Transportation must be coordinated in accordance with Chapter 1900 of the MSM.

403.8B PROVIDER RESPONSIBILITIES

1. All RTCs must comply with the regulations in this MSM chapter and all other applicable MSM chapters.

2. Critical Events Reporting Requirements RTCs are required to notify within 48 hours:

a. The QIO-like vendor of any critical event or interaction involving any Nevada Medicaid RTC recipient. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff's investigations and physical, sexual or emotional abuse allegations.

b. The State Medicaid agency, State-designated client protection and advocacy agency and the Nevada State Bureau of Health Care Quality and Compliance (HCQC) of a resident's death, serious injury or suicide attempt for an in-state facility. If the facility is out-of-state, their own state licensing entity or appropriate departments as well as the QIO-like vendor and Nevada State Medicaid;

c. Their local Centers for Medicare and Medicaid Services (CMS) office of the death of any recipient, no later than the close of business the next business day after the resident's death per 42 CFR 483.374(c).

1. Upon notification of a critical event, Nevada Medicaid may make an adverse decision against the RTC. In the event of a death, suicide attempt,

or very serious injury (injury requiring hospitalization) of a recipient, Nevada Medicaid may make an administrative decision to impose a ban on future Medicaid-eligible admissions and/or remove recipients currently at the RTC, if they are believed to be in danger.

2. If a ban is imposed, Medicaid must receive and review HIPAA compliant documents requested from the RTC, including but not limited to, police, autopsy, state licensing, social services and internal death or serious injury reports before a decision is made to remove or continue the imposed ban or terminate the contractual relationship with the RTC.

3. RTC Regulatory and Compliance Requirements

The RTC must ensure on-going Joint Commission, COA or CARF accreditation and comply with all accreditation requirements.

4. Letter of Attestation

The RTC must comply with 42 CFR Subpart G 483.374(a) and submit a Letter of Attestation to Nevada State, by the individual having legal authority to do so (i.e., facility director, CEO, or administrator), which confirms the facility is in compliance with CMS standards governing the use of restraint and seclusion. The Letter of Attestation must be submitted at the time of enrollment as a Medicaid provider and at any time there is a change in the legal authority of the RTC. A copy of an example Letter of Attestation is available upon request from Nevada Medicaid.

5. QA/Quality Improvement

The RTC must have a QA/Quality Improvement program in place at the time of enrollment and a process to submit an annual QA report to the DHCFP upon request.

6. Quarterly Family Visits

Quarterly family visits are based on clinical appropriateness and are utilized to support person- and family- centered treatment planning. It is the responsibility of out-of-state and in-state RTCs, as part of the all-inclusive daily rate, to bring up to two family members to the facility on a quarterly basis when the family resides 200 miles or more from the RTC. This includes the RTC providing travel, lodging and meals, to the family.

For Medicaid-eligible recipients in the custody of a public child welfare agency, prior to arranging the visit, the RTC must consult with and obtain approval from the agency's clinical representative pertaining to the appropriateness of such a visit.

7. Discharge Accompaniments

RTCs must ensure the following is provided to the legal representative upon discharge of a Medicaid-eligible recipient:

a. Supply or access to current prescribed medications;

b. The recipient's Medicaid-eligibility status;

c. All pertinent medical records and post discharge plans to ensure coordination of and continuity of care.

8. Clinical Requirements

a. The RTC must have a Medical Director who has overall medical responsibility for the RTC program. The Medical Director must be a board-certified/board eligible psychiatrist with specific experience in child and adolescent psychiatry.

b. Psychiatric/Medical Services

1. Medicaid-eligible children and adolescents must receive, at a minimum, two monthly face-to-face/one-on-one sessions with a child and adolescent psychiatrist and a psychiatrist must be available 24 hours a day.

2. The RTC must provide routine medical oversight to effectively coordinate all treatment, manage medication trials and/or adjustments to minimize serious side effects and provide medical management of all psychiatric and medical issues.

c. Clinical psychotherapy (individual, group or family therapy) must be provided by a licensed QMHP. All RMH services may also be provided by a QMHP, a QMHA or a QBA within the scope of their practice under state law and expertise. Consultation by a licensed clinical psychologist must be available when determined medically necessary.

d. RTC Interns/Psychological Assistant

1. RTC providers may be reimbursed for services provided by Interns/ Psychological Assistants within the all-inclusive daily rate if they meet the requirements as prescribed in the Provider Qualifications – Outpatient Mental Health Services section of this Chapter.

2. Approved out-of-state RTC providers must comply with the

Interns/Psychological Assistants requirements in their own state.

9. Patient Rights

RTCs must protect and promote patient's rights in accordance with all applicable Federal and State regulations.

10. Federal Requirements

RTCs must comply with all Federal and State Admission Requirements. Federal regulations 42 CFR 441.151 to 441.156 address certification of need, individual plan of care, active treatment and composition of the team developing the individual plan of care.

403.8C AUTHORIZATION PROCESS

1. Admission Criteria
All RTC admissions must be prior authorized by the QIO-like vendor. RTCs must submit the following documentation to the QIO-like vendor:

a. RTC Prior Authorization Request Form which includes a comprehensive psychiatric assessment current within six months of the request for RTC admission; and

b. A CON signed by a physician which includes:

1. The current functioning of the recipient;

2. The strengths of the recipient and their family;

3. Covered, current ICD diagnosis;

4. Psychiatric hospitalization history;

5. Medical history; and

6. Current medications.

c. An initial individualized treatment plan; and

d. A proposed discharge plan.

2. The QIO-like vendor must verify the medical necessity for all RTC services and verify:

a. The level of intensity of needs for RTC services;

b. The ability for the recipient to benefit rehabilitatively from RTC services;

c. The treatment plan includes active participation by the recipient and their family (when applicable); and

d. The discharge plan is viable and includes coordinated case management services.

3. All RTCs must notify the QIO-like vendor of the transfer of a recipient to an acute psychiatric hospital or unit. If the transfer is not emergent, the hospital must receive prior authorization for the transfer. For transfers to an acute psychiatric hospital or unit, the QIO-like vendor must verify the medical necessity for acute inpatient psychiatric services and verify:

a. The Level of Intensity of Needs for acute inpatient psychiatric services;

b. The ability for the recipient to benefit rehabilitatively from acute inpatient psychiatric services;

c. Effective care coordination is in place for pre- and post-transfer service; and

d. One of the following admission criteria has been met by the recipient:

1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt within the past 30 days; or

2. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g. gun, knife or other deadly weapon); or

3. Documented aggression within the 72-hour period before admission which:

a. Resulted in harm to self, others or property;

b. Demonstrates that control cannot be maintained outside of inpatient hospitalization; and

c. Is expected to continue if no treatment is provided.

4. The RTC must request prior authorization from the QIO-like vendor to return a recipient to the RTC from acute psychiatric services. The prior authorization request must include a Discharge Summary of the acute psychiatric inpatient services.

5. Prior authorization is required prior to transferring a recipient from one RTC to another for unanticipated specialized treatment services not available at the initial RTC placement.

6. RTCs may request a retro-eligibility authorization review from the QIO-like vendor for reimbursement for an RTC patient who was not Medicaid-eligible at the time of admission and later becomes eligible for Medicaid for the period RTC services were provided.

   a. If a client becomes Medicaid eligible after admission to an RTC, the facility must submit an initial Prior Authorization request and all required information to the QIO-like vendor in accordance with MSM Chapter 100.

   b. The QIO-like vendor will process initial prior authorization requests for retro-eligible recipients in accordance with MSM Chapter 100.

7. Continuing Stay Criteria

   a. The RTC must submit a Continuing Stay Request to the QIO-like vendor prior to the expiration of the current authorization period.

   b. The QIO-like vendor will process Continuing Stay Requests for RTC services within 14 days of receipt of all required information.

   c. The RTC must notify the QIO-like vendor of all Medicaid recipient discharges within 24 hours of the discharge and provide a Discharge Summary within 30 days for a planned discharge and within 45 days of an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven calendar days of the transfer.

   d. Continued Stays Requests not authorized by the QIO-like vendor will not be reimbursed by Medicaid. The RTC must submit a request for reconsideration to the QIO-like vendor within the timelines as outlined in the QIO-like vendor's billing manual for RTC's if the continuing stay request has been denied.

8. Discharge Criteria

   The QIO-like vendor will issue a denial or partial denial for RTC services based on review of medical necessity and admission or continuing stay criteria.

   Denials may be issued for, but are not limited to:

   a. RTC services are not shown to be medically necessary;

b. The service exceeds Medicaid program limitations;

c. Level 6 of Intensity of Needs is not met, and services may be provided in a less restrictive setting;

d. Specialized RTC services are not required;

e. The legal guardian for the Medicaid recipient has requested the services be withdrawn or terminated;

f. The services are not a Medicaid benefit; and/or

g. A change in federal or state law has occurred (the Medicaid recipient is not entitled to a hearing in this case; see MSM Chapter 3100).

9. Reimbursement

RTC's all-inclusive daily rates are negotiated by the provider through the DHCFP's Rates and Cost Containment Unit. Please see MSM Chapter 700 and the Nevada Medicaid State Plan, Attachment 4.19-A, describing the methods and standards for reimbursement of Residential Treatment Centers.

403.9 INPATIENT MENTAL HEALTH SERVICES POLICY

A. Inpatient mental health services are those services delivered in freestanding psychiatric hospitals or general hospitals with a specialized psychiatric unit which include a secure, structured environment, 24-hour observation and supervision by mental health professionals and provide a multidisciplinary clinical approach to treatment.
Inpatient mental health services include treatments or interventions provided to an individual who has an acute, clinically identifiable covered, current ICD psychiatric diagnosis to ameliorate or reduce symptoms for improved functioning and return to a less restrictive setting.

B. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized

Level VI Secure, 24-Hour, Services with Psychiatric Management	Inpatient Hospitalization Authorized	Inpatient Hospitalization Authorized

403.9A COVERAGE AND LIMITATIONS

1. Admissions

a. Certification Requirement:

1. A physician must issue a written order for admission or provide a verbal order for admission, which is later countersigned by the same physician.

The order must be issued:

a. During the hospital stay;

b. At the time acute care services are rendered; or

c. The recipient has been transferred, or is awaiting transfer, to an acute care bed from an emergency department, operating room, admitting department or other hospital service.

2. The physician's order must be based on:

a. The recipient meeting Level 6 criteria on the Intensity of Needs grid and must include: The date and time of the order and the status of the recipient's admission (i.e., inpatient, observation, same day surgery, transfer from observation, etc.).

b. Admission Date and Time:

The admission date and time must be reflected on the certification as the date and time the admission order was written prior to or during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies the documentation most relevant to the admission determination contingent upon provision of acute care services.

c. Transfers and Planned Admissions:

For those instances in which a physician's admission order was issued for a planned admission and before the recipient arrives at the hospital, the order must be signed

by the physician and indicate the anticipated date of admission. A physician's order must also be issued for transfers from another acute care hospital.

Responsibilities:

1. The admission must be certified by the QIO-like vendor based on:

   a. Medical necessity;

   b. Clear evidence of a physician's admission order; and the

   c. Recipient meeting Level 6 on the intensity of needs grid.

2. The hospital must submit all required documentation including:

   a. The physician's order which is signed by a physician and reflects the admission date and time; and

   b. All other pertinent information requested by the QIO-like vendor.

d. Observation:

1. Observation status cannot exceed a maximum of 48 hours.

2. Observation begins when the physician issues an observation status order and ends when the recipient is discharged from the hospital.

3. A new admissions order must be issued and signed by a physician when a recipient is admitted to inpatient status post discharge from an observation stay. Nevada Medicaid reimburses for admissions certified by the QIO-like vendor to a:

a. Psychiatric unit of a general hospital, regardless of age; or

b. Psychiatric hospital (Institution for Mental Diseases) for recipients under age 21 or 65 or older.

For recipients under age 21 in the custody of the public child welfare agency, Nevada Medicaid reimburses for inpatient mental health services only when:

c. The child welfare agency also approves the admission/placement (this does not apply to placements at State-owned and operated facilities); and the admission is certified by the QIO-like vendor.

4. Reimbursement

   a. Nevada Medicaid reimburses for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:

      1. The admission is an emergency and is certified by the QIO-like vendor. The hospital must submit clinical documentation to the QIO-like vendor within five business days of the admission and make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit in as expeditiously as possible; or

      2. The recipient has been dually diagnosed as having both medical and mental diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

   b. Nevada Medicaid does not reimburse for services not authorized by the QIO-like vendor.

   c. If a recipient is initially admitted to a hospital for acute care and is then authorized by the QIO-like vendor to receive mental health services, the acute care is paid at the medical/surgical rate.

5. Authorized substance use services are paid at the substance use service rate.

6. Absences

   a. In special circumstances, Nevada Medicaid may allow up to an eight-hour pass from the acute hospital without denial of payment. Absences may include, but are not limited to, a trial home visit, a respite visit with parents (in the case of a child), a death in the immediate family, etc. The hospital must request prior authorization from the QIO-like vendor for an absence if the absence is expected to last longer than eight hours.

   b. There must be a physician's order that a recipient is medically appropriate to leave on pass and the therapeutic reason for the pass must be clearly documented in the chart prior to the issuance of the pass. Upon the recipient's return, the pass must be evaluated for therapeutic effect and the results clearly documented in the recipient's chart.

7. Non-Covered Services Reference Section 403.9A.

403.9B PROVIDER RESPONSIBILITIES

1. Authorization by the QIO-like vendor must be obtained prior to admission. A tentative treatment plan will be required for the QIO-like vendor's authorization. The only exception is in the event of an emergency admission, in which the recipient may be admitted, and the QIO-like vendor must be notified of the admission within five business days.

   In the event authorization is not obtained, the admission will not be authorized and/or certified by the QIO-like vendor for payment.

2. Medical Records

   A medical record shall be maintained for each recipient and shall contain the following items:

   a. An initial assessment of the recipient's clinically identifiable psychiatric disorder, which should include a chief complaint or equivalent, a history of the disorder, a statement of the circumstances which led to the request for services, a mental status examination and observations, a diagnosis or differential diagnosis and a statement of treatment goals and objectives and method of treatment.

   b. A written, individualized treatment plan (ITP) to address the problems documented during the intake evaluation. The plan shall include the frequency, modality and the goals of treatment interventions planned. It also shall include the type of personnel that will furnish the service.

   c. Dated progress notes are required for each treatment encounter to include the amount of time services were rendered, the type of service rendered, the progress of the recipient with respect to resolution of the presenting symptoms or problems, any side effects or necessary changes in treatment and the interval to the next treatment encounter.

      The provider shall make available to Nevada Medicaid or Medicaid's QIO-like vendor copies of the medical record, progress notes or summary documents which reflect the ongoing need for treatment and support any additional services requested.

      For inpatient and outpatient services, the provider is responsible to meet Healthy Kids (EPSDT) and QIO-like vendor authorization guidelines, as discussed previously in this chapter.

   d. Patient Self-Determination Act (Advance Directives) Compliance Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), and federal regulations at

42 CFR 489.100, hospitals which participate in and receive funding from Medicare and/or Medicaid must comply with The Patient Self-Determination Act (PSDA) of 1990, including Advance Directives. Specifically, the PSDA requires all Medicare and Medicaid hospital providers to do the following: Provide written information to all adult (age 18 and older) patients upon admission concerning:

1. The individual's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives (declarations and durable powers of attorney for health care decisions).

2. The written policies of the provider or organization respecting implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.

   At a minimum, a provider's or organization's statement of limitation must:

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

   b. identify the state legal authority permitting such objections (which in Nevada is NRS 449.628); and

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

e. Document in the individual's medical record whether the individual has an advance directive.

f. Not to condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

g. Ensure compliance with the requirements of state law respecting advance directives. The hospital must inform individuals any complaints concerning the advance directives requirements may be filed with the state survey and certification agency (which in Nevada is the Nevada State Health Division, HCQC).Provide education of staff concerning its policies and procedures on advance directives (at least annually).

h. Provide for community education regarding issues concerning advance directives (at least annually). At a minimum, education presented should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated

individual's control over medical treatment, and describe applicable state law concerning advance directives. A provider must be able to document and verify its community education efforts.

Nevada Medicaid is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state Advance Directive requirements.

4. QA Medical Care Evaluation Studies

The purpose of medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with patient needs and professionally recognized standards of care (42 CFR 456.141 to 456.145). As part of the conditions of participation in the Medicaid Title XIX program, a minimum of one Medical Care Evaluation Study must be in progress at any time. Additionally, one study must be completed each year. The completed study must be submitted to the QIO-like vendor at the end of each calendar year along with the study in progress topic. (A report summarizing the study topics will be submitted to Nevada Medicaid, by the QIO-like vendor). Hospitals may design and choose their own study topic, or at the request of Medicaid perform a topic designated by Medicaid and forward a copy of the completed study to the QIO-like vendor office within the specified time frames.

5. Medicaid Form NMO-3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form NMO-3058 to their local Welfare District Office whenever a hospital admission, discharge or death occurs. Failure to submit this form could result in payment delay or denial. To obtain copies of Form NMO-3058, please contact Medicaid's fiscal agent.

6. Patient Rights

Pertaining to the acute psychiatric hospital's responsibilities of protecting and promoting each patient's rights, please consult the following authorities:

a. 42 CFR 482.13.

b. NRS 449.730.

c. Joint Commission "Restraint and Seclusion Standards for Behavioral Health." Available at the following website: https:///www.jointcommission.org.

7. Non-Emergency Admissions

Non-emergency admissions for Medicaid eligible recipients must be prior authorized by

the QIO-like vendor within one business day of the admission. Physicians may call them during normal business hours. (Non-emergency admissions not prior authorized by the QIO-like vendor will not be reimbursed by Nevada Medicaid.)

8. Claims for Denied Admissions

Hospitals are not permitted, after having an inpatient service denied by the QIO-like vendor, to submit the claim to Medicaid's fiscal agent as an outpatient service. The only exception to this is if an outpatient or non-inpatient related service was truly rendered prior to the inpatient admission order by the physician but the inpatient stay was denied by the QIO-like vendor (i.e., admit from ER or rollover from observation days).

9. Hospital Responsibilities for Outside Services

Any hospital receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for that recipient service and treatment needs. If a hospital does not have the proper or functional medical equipment or services, and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing/evaluation/treatment, etc., it is the transferring hospital's responsibility, not Medicaid's, to fund the particular services and, if necessary, transportation.

10. Acute Psychiatric Admission Requirements

a. 42 CFR 441.152 addresses Certification of Need requirements.

b. 42 CFR 441.155 addresses Individual Plan of Care requirements.

c. 42 CFR 441.156 addresses the requirements of the composition of the team developing the individual plan of care.

11. Patient Liability

IMDs/freestanding psychiatric hospitals are exempt from Patient Liability (PL) requirements.

403.9C AUTHORIZATION PROCESS

The QIO-like vendor contracts with Medicaid to provide utilization and quality control review (UR) of Medicaid inpatient psychiatric hospital admissions. Within the range of the QIO-like vendors UR responsibilities are admission and length of stay criteria development, prior authorization, concurrent and retrospective review, certification and reconsideration decisions. The QIO-like vendor must approve both emergency and non-emergency inpatient psychiatric

inpatient admissions. Any hospital which alters, modifies or changes any QIO-like vendor certification in any way, will be denied payment.

1. For purposes of Medicaid mental health services, an emergency inpatient psychiatric admission to either a general hospital with a psychiatric unit or freestanding psychiatric hospital, is defined as meeting at least one of the following three criteria:

   a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 30 days; or

   b. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g., gun, knife or other deadly weapon); or

   c. Documented aggression within the 72-hour period before admission:

      1. Which resulted in harm to self, others or property;

      2. Which manifests that control cannot be maintained outside an inpatient hospitalization; and

      3. Which is expected to continue without treatment.

2. Concurrent Reviews

   For non-emergency admissions, the prior authorization request form and Certificate of Need (CON) must be submitted at least one business day prior to admission. For emergency admissions, the prior authorization request form and CON must be submitted no later than five business days following admission. Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days. If additional inpatient days are required, a provider must submit a concurrent (continuing stay) authorization request within five business days of the last day of the current/existing authorization period. The request and information submitted must identify all pertinent written medical information that supports a continued inpatient stay. The request and information submitted must be in the format and within the timeframes required by the QIO-like vendor. Failure to provide all pertinent medical information as required by the QIO-like vendor will result in authorization denial. Inpatient days not authorized by the QIO-like vendor are not covered. These concurrent review procedures also apply to inpatient substance use withdrawal management and treatment services.

   The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement, during the initial authorization period. In addition, when a recipient remains hospitalized longer than seven days the attending

physician must document the medical necessity of each additional inpatient day.

3. Nevada Medicaid will reimburse for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:

   a. The admission is an emergency admission and is certified by the QIO-like vendor (who must be contacted within five business days after the admission). The hospital must make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible; or

   b. The recipient has been dually diagnosed as having both medical and mental conditions/diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

      Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive mental health services, the acute care is paid at the medical/surgical tiered rate. The substance use services are paid at the substance use service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

4. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional authorization for physician ordered psychological evaluations and testing. The psychologist must list the "Inpatient Authorization Number" on the claim form when billing for services.

5. Prior Resources

   Pursuant to federal law, Medicaid is payer of last resort whenever any other resources may be responsible for payment. Prior resources include but are not limited to: Medicare, labor unions, Worker's Compensation Insurance carriers, private/group insurance and CHAMPUS. Exceptions to this regulation are Bureau of Family Health Services, Indian Health Services (IHS), Ryan White Act and Victims of Crime, when Medicaid is primary.

   Benefits available free of charge to recipients from other sources must be provided free of charge to Nevada Medicaid recipients.

6. Reimbursement

   Inpatient freestanding psychiatric and/or alcohol/substance use hospitals and general acute hospitals with a psychiatric and/or substance use unit are reimbursed a per diem, all-inclusive prospective daily rate determined and developed by the Nevada DHCFP's Rate Development and Cost Containment Unit. (Days certified as administrative are paid at the

all-inclusive prospective administrative day rate.)

For claims involving Medicare crossover, Medicaid payment is the lower of the Medicare deductible amount or the difference between the Medicare payment and the Medicaid per diem prospective payment. (Medicare crossover claims involving recipient's ages 21 to 64 in freestanding psychiatric hospitals are reimbursable only if the recipient is a QMB.) Also, additional Medicaid reimbursement is not made when the Medicare payment exceeds the Medicaid prospective rate. Service claims denied by Medicare are also denied by Medicaid.

403.10 INPATIENT ALCOHOL/SUBSTANCE USE WITHDRAWAL MANAGEMENT AND TREATMENT SERVICES POLICY

Inpatient substance use services are those services delivered in freestanding substance use treatment hospitals or general hospitals with a specialized substance use treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance use professionals and a structured multidisciplinary clinical approach to treatment. These hospitals provide medical withdrawal management and treatment services for individuals suffering from acute alcohol and substance use conditions.

403.10A COVERAGE AND LIMITATIONS

1. Hospital inpatient days may be considered a Medicaid benefit when withdrawal management and treatment for acute alcohol and/or other substance use necessitates the constant availability of physicians and/or medical services found in the acute hospital setting. Medicaid reimburses for admissions to substance use units of general hospitals (regardless of age), or freestanding psychiatric and substance use hospitals for recipients age 65 and older, or those under age 21. (For recipients ages 22 to 64, "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs)Transformation Project" (1115 SUD Waiver) allows for reimbursement of substance use and withdrawal management services within an IMD setting through December 31, 2027.) The QIO-like vendor must prior authorize and certify all hospital admissions for both withdrawal management and treatment services to verify appropriateness of placement and justify treatment and length of stay.

   Prior authorization is required for all Medicaid and pending Medicaid recipients, and Medicaid recipients covered through primary insurance, except Medicare Part A. If this is the case, then authorization may need to be sent through Medicare.

   Medicaid reimburses only for the following hospital alcohol/substance use withdrawal management and treatment services:

   a. Withdrawal Management

1. Medicaid reimburses for up to five hospital inpatient withdrawal management days with unlimited lifetime admission services (Medicaid covers stays beyond five days only if additional withdrawal management services are deemed medically necessary by the QIO-like vendor).

2. Results of a urine drug screen or blood alcohol test must be provided at the time of the initial request for authorization.

b. Treatment

1. Medicaid reimburses for up to 21 hospital inpatient treatment days with unlimited lifetime admissions as determined medically necessary by the physician (stays beyond 21 days are covered only if additional treatment services are deemed medically necessary by the QIO- like vendor).

2. Prior to inpatient admission, the referring or admitting physician must document discussing the following items with the recipient, including the recipient's response. This documentation must be a part of the recipient's inpatient hospital record:

a. Provider must be able to refer recipients to counseling, therapy, peer support within the substance use treatment continuum of care.

3. It is the hospital's responsibility to assist the recipient during hospitalization to assure the above-mentioned post discharge resources will be utilized. Prior to authorizing the admission, the QIO-like vendor will:

a. Verify the physician-patient communication did occur and is documented within the recipient's record; and

b. Verify appropriateness of admission, treatment, and length of stay according to ASAM Criteria.

A psychiatric screening must also be completed within 72 hours of any inpatient withdrawal management or treatment admission.

c. Absences

Please consult Section 403.9A.6 of this chapter regarding absences.

1. All Other Inpatient Services Coverage and Limitations. Please consult Section 403.9A of this chapter for all other Coverage and Limitations.

403.10B PROVIDER RESPONSIBILITIES

1. The need for hospital alcohol/substance use withdrawal management and/or treatment services must be prior authorized by the QIO-like vendor. The only exception is in the event of an emergency, where a delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight or hearing, injury to self or bodily harm to others. In this instance, the recipient may be admitted, and the QIO-like vendor must be contacted for authorization purpose within five business days of the admission.

2. Please consult MSM 200 Hospital Services and MSM 600 Physician Services for additional provider responsibilities.

403.10C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.

2. Medicaid recipients are expected to participate and comply with the service provider's treatment, care and service plans, including making and keeping medical appointments.

403.10D AUTHORIZATION PROCESS

The QIO-like vendor must certify all inpatient substance use withdrawal management and treatment admissions. Transfers to and from substance use withdrawal management /treatment services require prior authorization by the QIO-like vendor.

1. For recipients under age 21 in the custody of the public agency, Nevada Medicaid reimburses for alcohol/substance use withdrawal management and treatment services only when the following criteria are met:

   a. The admission is prior authorized and certified by the QIO-like vendor.

2. Nevada Medicaid reimburses for services for recipients admitted with an alcohol/substance use condition/diagnosis to a general hospital without a specialized alcohol/substance use unit only under one of the following conditions:

   a. The admission is an emergency and is certified by the QIO-like vendor (who must be contacted, for authorization purposes, within five business days of the admission) and the hospital, as determined by the QIO-like vendor, makes all efforts to stabilize the recipient's condition and discharge the recipient to a substance use/psychiatric hospital or general hospital with a substance use/psychiatric unit as expeditiously as possible; or

b. The recipient is dually diagnosed as having both medical and substance use conditions which warrant inpatient general hospital services, as determined by the QIO-like vendor; or

The admission is certified by the QIO-like vendor for medical withdrawal management only. Medicaid recipients between 21 and 64 years of age are covered for inpatient alcohol/substance use withdrawal management and treatment services only in a general hospital with a specialized alcohol/substance use unit. Those Medicaid recipients age 20 and under and age 65 and older are covered for inpatient substance use withdrawal management and treatment services in a freestanding psychiatric and/or alcohol/substance use hospital, as well as a general hospital with a specialized alcohol/substance use unit. (For recipients ages 22 to 64, "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs)Transformation Project" (1115 SUD Waiver) allows for reimbursement of substance use and withdrawal management services within an IMD setting through December 31, 2027.)

All transfers from withdrawal management to treatment require prior authorization. This applies to all Medicaid recipients, regardless of age.

Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive alcohol/substance use services, the acute care is paid at the appropriate medical/surgical tier rate. The alcohol/substance use services are paid at the substance use service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

3. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional PA for physician ordered psychological evaluations and testing. The psychologist must list the QIO-like vendors "Inpatient's authorization number" on the claim form when billing for services.

4. Retrospective Reviews

The QIO-like vendor authorizes only Medicaid eligible clients, not pending eligible. Should a client become Medicaid eligible while in the facility, a retrospective review must be requested by the provider to the QIO-like vendor:

a. The medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination.

b. If the information submitted is not complete, a technical denial for service will be issued.

c. The QIO-like vendor will complete the review and issue a final determination within 30 days of receipt of all requested information.

5. Reimbursement

Please consult Section 403.9C.6 of this chapter regarding reimbursement.

403.11 ADMINISTRATIVE DAYS POLICY

The primary purpose and function of administrative days is to assist hospitals, which, through no fault of their own, cannot discharge a recipient who no longer requires acute level services, due to lack of, or a delay in, an alternative appropriate setting, which includes the adequate and comprehensive documentation of discharge planning efforts. Administrative Days are reimbursed on a retrospective, not cost settlement, basis.

403.11A COVERAGE AND LIMITATIONS

Administrative days are those inpatient days which have been certified for payment by the QIO-like vendor, based on physician advisement, at the Skilled Nursing Level (SNL) or Intermediate Care Level (ICL).

1. SNL is a unique payment benefit of the Nevada Medicaid program. These reimbursement levels provide for ongoing hospital services for those recipients who do not require acute care. Discharge to a nursing facility is not required. Issuance of this level is a reflection of the hospital services required by and provided to the recipient.

   SNL days may be authorized when one or more of the following apply, or as determined by physician review:

   a. Recipient is awaiting placement, or evaluation for placement, at a nursing facility/extended care facility, group home, or other treatment setting, for continuity of medical services, e.g.:

      1. Transfers to other facilities.

      2. Rehabilitation or independent living.

      3. Hospice, etc.

   b. Recipient is to be discharged home and is awaiting home equipment set up/availability, nursing services and/or other caretaker requirements, e.g.:

      1. Home health nursing.

2. Public health nursing.

3. Durable medical equipment.

4. Family preparation.

5. Respite care.

c. Conditions which may prevent a non-acute recipient from leaving the hospital (e.g., recipient's labs must be monitored, cultures taken for staph infection or any treatment/work up that could not be safely and effectively accomplished in another setting).

1. Therapeutic foster care.

2. Day treatment.

3. Rural mental health follow-up services.

4. Set up for wrap around services.

d. Recipient has mental disabilities that prevent nursing facility placement (e.g., failed PASRR screening), and the recipient will eventually go to an institution of mental diseases.

2. ICL is a unique payment benefit of the Nevada Medicaid program, which provides reimbursement for ongoing hospital services, for those recipients who cannot be discharged due to social reasons.

ICL days are authorized when one or more of the following apply, or as determined by physician review:

a. Stable child awaiting adoption or discharge home when the mother is discharged.

b. Ready for discharge and is awaiting transportation.

c. ICL at a nursing home or alternate setting.

d. Victim of crime in need of assessment and evaluation.

3. Administrative days are denied when:

a. A recipient, recipient's family or physician refuses a Nursing Facility (NF) placement.

b. A recipient, family or physician refuses a psychiatric RTC placement, group home or psychiatric treatment center.

c. There is insufficient documentation (Monday through Friday contacts and results) in the chart reflecting adequate discharge planning.

403.11B PROVIDER RESPONSIBILITIES

Please consult Section 403.10B of this chapter for provider responsibilities.

403.11C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.

2. Medicaid recipients are expected to comply with the service provider's treatment, care and service plans, including making and keeping medical appointments.

403.11D AUTHORIZATION PROCESS

If appropriate, the QIO-like vendor certifies administrative days at either an SNL or ICL level of care.

403.12 ELECTROCONVULSIVE THERAPY (ECT)

Effective date March 1, 2004, ECT is a treatment for mental disorders, primarily depression, but also acute psychotic episodes in Schizophrenia and Bipolar Disorder. A low voltage alternating current is used to induce a generalized seizure that is monitored electrographically while under general anesthesia and muscle relaxation.

Medicaid will reimburse medically necessary ECT treatments when administered by a Board-Certified Psychiatrist in a qualified acute care general hospital, contracted acute care psychiatric hospital, or in a hospital outpatient surgery center/ambulatory surgery center. Recipients receiving outpatient ECT do not require a global treatment program provided in the inpatient setting prior to outpatient services.

Prior Authorization is required.

403.12A COVERAGE AND LIMITATIONS

ECT is generally used for treatment of affective disorders unresponsive to other forms of treatment. It has also been used in schizophrenia, primarily for acute schizophrenic episodes.

1. Prior authorization requires documentation of the following medically necessary indicators:

   a. Severe psychotic forms of affective disorders.

   b. Failure to respond to other therapies.

   c. Medical preclusion to use of drugs.

   d. Need for rapid response.

   e. Uncontrolled agitation or violence to self or others.

   f. Medically deemed for probable preferential response to ECT.

2. Recipients under 16 years of age must have all of the above indicators and:

   a. Two prior medication trials predetermined by a physician.

   b. Two concurring opinions by a Board-Certified Psychiatrist.

   c. Informed written consent by custodial parent(s)/legal guardian.

3. Covered, current ICD Codes:

   F20-F29 Schizophrenic disorders.

   F30-F33.9 Affective psychoses and depressive type psychosis and other nonorganic psychoses.

4. Covered CPT Codes:

   90870 – Electroconvulsive therapy (includes necessary monitoring); single seizure.

5. Reasons for Denial

   a. Continuing use of ECT without evidence of recipient improvement.

   b. Diagnostic codes not encompassed in the foregoing list.

6. Coding Guidelines

   a. Anesthesia administration for ECT is a payable service only if provided by a physician other than the one administering ECT.

   b. If billing is received for ECT and a visit on the same day, the latter will be denied if rendered by the physician administering ECT.

7. Documentation Requirements

Medical records should include recipient symptoms, physical findings and diagnosis to document the medical necessity of performing ECT.

404 HEARINGS

Please reference MSM Chapter 3100 – Hearings, for hearings procedures.

POLICY #4-01	DAY TREATMENT AGES 3-6	

A. DESCRIPTION

Day treatment services are interventions performed in a therapeutic milieu designed to provide evidence-based strategies to reduce emotional, cognitive, and behavioral problems. Day treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community-based settings.

B. POLICY

Day treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and Rehabilitative Mental Health (RMH) services; and
3. Provided under a Behavioral Health Community Network (BHCN) medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. Early Childhood Service Intensity Instrument (ECSII) level II or Child and Adolescent Service Intensity Instrument (CASII) score of III or higher;

b. A primary covered, current ICD diagnosis;

c. Determined Severe Emotional Disturbance (SED);

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, head start, school and/ or home placements.

Service Limitations	Ages 3-6: CASII
Levels I & II	No Services Authorized
Level III	Maximum of three hours per day
Level IV	Maximum of three hours per day
Levels V & VI	Maximum of three hours per day

2. NON-COVERED SERVICES

a. Transportation or services delivered in transit.

b. Facilities licensed as a daycare.

c. Club house, recreational, vocational, afterschool or mentorship programs.

d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

e. Routine supervision, monitoring or respite.

f. Non-evidenced based models.

g. Non milieu models.

h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement day treatment programs must be separately enrolled with the DHCFP. Program Criteria:

1. Services not to exceed three hours per day, five days per week;

2. Parental/caregiver involvement and participation in the day treatment program;

3. Ongoing participation in family counseling/therapy;

4. Minimum staff to recipient ratio is 1:3;

5. Maximum group size is six;

6. Therapeutic milieu design;

7. Services must be provided by a Qualified Mental Health Professional (QMHP) or by a Qualified Mental Health Associates (QMHA) under the Direct Supervision of an onsite QMHP;

8. Evidence based programmatic model with established curriculum and schedule;

9. Program admission, service continuation and discharge criteria; and

10. Policies and procedures specific to the day treatment program which at a minimum address the following:

a. Clinical and Direct Supervision;

b. Health Insurance Portability and Accountability Act (HIPAA) and client's rights;

c. Service provision and documentation; and

d. Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

POLICY #4-02	DAY TREATMENT AGES 7-18	

A. DESCRIPTION

Day treatment services are interventions performed in a therapeutic milieu designed to provide evidence-based strategies to reduce emotional, cognitive and behavioral problems. Day treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community-based settings.

B. POLICY

Day treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and RMH services; and
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. CASII score of III or higher;

b. A primary covered, current ICD diagnosis;

c. Determined SED;

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, school and/ or home placements.

Service Limitations	Ages 7-18: CASII
Levels I & II	No Services Authorized
Level III	Maximum of four hours per day
Level IV	Maximum of five hours per day
Levels V & VI	Maximum of six hours per day

2. NON-COVERED SERVICES

a. Transportation or services delivered in transit.

b. Facilities licensed as a daycare.

c. Club house, recreational, vocational, afterschool or mentorship programs.

d. Services provided in the home or homelike setting including campus/institution establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

e. Routine supervision, monitoring or respite.

f. Non-evidenced based models.

g. Non milieu models.

h. Programs restricted or only provided to those recipients who reside at the same location.

E. PROVIDER REQUIREMENTS

To receive reimbursement day treatment programs must be separately enrolled with the DHCFP.

1. Program Criteria:

a. Services not to exceed six hours per day, five days per week;

b. Parental/caregiver involvement and participation in the day treatment program;

c. Ongoing participation in individual therapy (not reimbursed under day treatment model);

d. Minimum staff to recipient ratio is 1:5;

e. Maximum group size is 10;

f. Therapeutic milieu design;

g. Services must be provided by a QMHP or by a QMHA under the Direct Supervision of an onsite QMHP;

h. Evidence based programmatic model with established curriculum and schedule;

i. Program admission, service continuation and discharge criteria; and

j. Policies and procedures specific to the day treatment program which at a minimum address the following:

1. Clinical and Direct Supervision;

2. HIPAA and client's rights;

3. Service provision and documentation; and

4 Admission and discharge criteria and process.

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor website.

POLICY #4-03	DAY TREATMENT AGES 19 AND OLDER	

A. DESCRIPTION

Day treatment services are RMH interventions performed in a therapeutic milieu to provide evidence-based strategies to restore and/or retain psychiatric stability, social integration skills and/or independent living competencies to function as independently as possible. Services provide recipients the opportunity to implement and expand upon what was previously learned from other mental or behavioral health therapies and interventions in a safe setting. The goal of day treatment services is to prepare recipients for reintegration back into home and community-based settings, prevent hospitalizations and ensure stability.

B. POLICY

Day treatment coverage and reimbursement is limited to medically necessary services and are covered at an hourly rate.

Day treatment services must:

1. Have goals and objective that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Must involve the recipient and family or other individuals, as appropriate, and
3. Not be contingent on the living arrangements of the recipient.

Day treatment services are:

1. Facility based, out of home services.
2. A fluid combination of all the RMH services.
3. Provided under a BHCN medical model.

C. PRIOR AUTHORIZATION IS REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate that the recipient meets all of the following criteria:

a. Must have Level of Care Utilization System for Adults (LOCUS) score of IV, V or VI;

b. A primary covered, current ICD diagnosis;

c. Determined as Serious Mental Illness (SMI);

d. Requires and benefits from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community-based environments;

e. The recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. An adequate social support system is available to provide the stability necessary for maintenance in the program; and

g. Recipient's emotional, cognitive and behavioral issues which:

1. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

2. are incapacitating, interfere with daily activities or place others in danger to the point that it causes anguish or suffering.

Service Limitations	Ages 19 and older: LOCUS
Levels I & II	No Services Authorized
Level III	No Services Authorized
Level IV	Maximum of five hours per day
Levels V & VI	Maximum of six hours per day

2. NON-COVERED SERVICES

a. Transportation or services in transit.

b. Facilities licensed as adult daycare may not provide day treatment services.

c. Recreational, mentorship or club house programs.

d. Services in a home based or home like settings, including campus/institutions that furnish in single or multiple areas, food, shelter and some treatment/services to four or more persons unrelated to the proprietor.

e. Non-evidenced based models.

f. Non milieu models.

g. Programs restricted to only those recipients residing at the same location.

E. PROVIDER REQUIREMENTS

1. Program Criteria:

a. Day Treatment services must be provided by a QMHP or by a QMHA under the Direct Supervision of an onsite QMHP;

b. Services not to exceed a maximum of six hours a day, five days a week;

c. Must involve the recipient and family or other individuals, as appropriate in the day treatment program and family counseling/therapy;

d. Minimum staff to recipient ratio is 1:5;

e. Maximum group size is 10;

f. Therapeutic milieu design;

g. Evidence based programmatic model with established curriculum and schedule;

h. Program admission, service continuation and discharge criteria in place; and

i. Policies and procedures specific to the day treatment program which as a minimum address the following:

1. Clinical and Direct Supervision;

2. HIPAA and client's rights;

3. Service provision and documentation; and

4. Admission and discharge criteria and process

Day treatment services will only be reimbursable to those programs which have been approved and enrolled to serve as Day Treatment Program service providers

For individual provider requirements see MSM Chapter 400.

For enrollment, prior authorization and billing instructions please refer to the QIO-like vendor's Billing Manual and Guidelines.

POLICY #4-04	SUBSTANCE USE AGENCIES MODEL (SUAM)	

A. DESCRIPTION/POLICY

B. SUBSTANCE USE AGENCIES MODEL (SUAM)

The DHCFP covers services for prevention and treatment for recipients who have been diagnosed or at risk of substance use disorders. The substance use policy is under the rehabilitative authority of the State Plan for behavioral health services. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

The below coverage policies are developed based upon the Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the DHHS and are best-practice guidelines for the treatment of substance use disorders.

In addition, the DHCFP utilizes American Society of Addiction Medicine (ASAM) patient placement criteria to establish guidelines for level of care placements within the substance use treatment continuum. For mental health continuum the DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients as described under Outpatient Mental Health (OMH) Services – Utilization Management in MSM Chapter 400.

The DHCFP encourages providers to utilize SAMHSA's working definition, dimensions and guiding principles of recovery from substance use disorders in their clinical decisions. The definition is continually changing due to updates in the clinical field reference https://www.samhsa.gov/ for the latest best practices. There are four major dimensions that support a life in recovery:

1. Health – Overcoming or managing one's disease(s) or symptoms;

2. Home – A stable and safe place to live;

3. Purpose – Meaningful daily activities, such as a job, school, volunteerism, family caretaking or creative endeavors, and the independence, income and resources to participate in society; and

4. Community – Relationships and social networks that provide support, friendships, love and hope.

The guiding principles of recovery are:

1. Recovery emerges from hope;

2. Recovery is person-driven;

3. Recovery occurs via many pathways;

4. Recovery is holistic;

5. Recovery is supported by peers and allies;

6. Recovery is supported through relationship and social networks; Recovery is culturally based and

7. influenced;

8. Recovery is supported by addressing trauma;

9. Recovery involves individual, family and community strengths and responsibility; and

10. Recovery is based on respect.

C. DEFINITIONS

1. Co-Occurring Capable (COC) programs – are those that "address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (The ASAM Criteria 2013, P. 416).

2. Co-Occurring Enhanced (COE) programs – have a higher level of integration of substance use and mental health treatment services. These programs are able to provide primary substance use treatment to clients and "are designed to routinely (as opposed to occasionally) deal with patients who have mental health or cognitive conditions that are more acute or associated with more serious disabilities."

   (The ASAM Criteria, 2013, P. 29) Enhanced-level service "place their primary focus on the integration of service for mental and substance use disorders in their staffing, services and program content." (The ASAM Criteria, 2013, P. 417).

3. Recovery - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

4. Substance use – as defined in DSM-V (5th Edition, Text Revision; APA 2013) is a "cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA 2013, P. 483).

5. Substance dependence – is more serious than use. This maladaptive pattern of substance use includes such features as increased tolerance for the substance, resulting in the need for ever greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems.

6. Integrated interventions – are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or integration, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques. Some examples include:

   a. Integrated screening and assessment process;

   b. Dual recovery mutual self-help meetings;

   c. Motivational enhancement interventions (individual or group) that address issues related to both mental health and substance use disorder problems;

d. Group interventions for persons with the triple diagnosis of mental disorder, substance use disorder and trauma, or which are designed to meet the needs of persons with co- occurring disorder and another shared problem such as homelessness or criminality; and

e. Combined psychopharmacological interventions, in which an individual receives medication designed to reduce cravings for substances as well as medication for a mental disorder.

Integrated interventions can be part of a single program or can be used in multiple program settings.

7. Quadrant of Care Model as developed by the National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD):

a. Category I: Less Severe mental disorder/less severe substance disorder.

b. Category II: More severe mental disorder/less severe substance disorder.

c. Category III: Less severe mental disorder/more severe substance disorder.

d. Category IV: More severe mental disorder/more severe substance disorder.

This assessment assists the provider in integrating care, defining and guiding treatment options for recipients with co-occurring disorders.

D. PROVIDER REQUIREMENTS

1. In order to be recognized and reimbursed as a Prevention and Early Intervention Level ASAM 0.5 by Division of Public and Behavioral Health (DPBH), the providers must be:

a. Recognized health care clinicians and systems by the U.S. Preventive Services Task Force (USPSTF) within their scope of practice; and

b. Certified providers under the Nevada Administrative Code (NAC) 458.103 scope of practice.

2. In order to be recognized and reimbursed as a Substance Use Treatment Clinic for ASAM Levels I-III by the DHCFP, the provider must:

a. Be Substance Abuse Prevention and Treatment Agency (SAPTA) certified from DPBH with approved ASAM levels of care; and

b. Provide Integrated Interventions; and

c. Be a Co-Occurring Capable Program; or

d. A Co-Occurring Enhanced Program.

3. In order to be recognized and reimbursed as an ASAM Level 4 – WM Medically Managed Intensive Inpatient Withdrawal Management Program by the DHCFP the provider must be Licensed by the Nevada DPBH as:

   a. An acute care general hospital with a psychiatric unit; or

   b. A free-standing psychiatric hospital.

   c. A licensed chemical dependency specialty hospital with acute care medical and nursing staff.

   d. Have Medicare certification.

E. QUALITY IMPROVEMENT

The DHCFP requires providers who are receiving funds from the DHCFP to be deemed compliant by DPBH, NRS and NAC. Qualification is based upon DPBH's Substance Abuse Prevention and Treatment Agency (SAPTA) Certification tool. The certification tool reviews the program for areas such as, but not limited to, compliance with federal and state regulations, quality improvement, applications of policies and procedures, health and safety of the recipients, clinical documentation requirements, and staff/training documentation. Non-compliance will result in the DHCFP provider termination and/or suspension without cause depending on severity of infraction.

This does not apply to Level 4 providers or physicians providing Level 0.5 services. They are governed by separate licensing boards.

F. DOCUMENTATION REQUIREMENTS

All program levels require individualized progress notes in the recipient's medical records that clearly reflect implementation of the treatment plan and the recipient's response to the therapeutic interventions for all disorders treated, as well as subsequent amendments to the plan. Treatment plan reviews are conducted at specified times as documented on the treatment plan.

1. Treatment Plan – A written individualized plan that is developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and licensed professional within the scope of their practice under state law. The treatment plan is based on a comprehensive assessment and includes:

   a. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);

   b. Documentation supporting ASAM Criteria assessment dimensions and levels of care;

   c. Specific, measurable (observable), achievable, realistic and time-limited goals and objectives;

   d. Discharge criteria specific to each goal; and for

   e. High-risk recipients accessing multiple government-affiliated and/or private agencies/

evidence of care by those involved with the recipient's care.

2. The recipient, or their legal representative, must be fully involved in the treatment planning process, choice of providers and indicate an understanding of the need for services and the elements of the treatment plan. Recipient's, family's (when appropriate) and/or representative's participation in treatment planning must be documented on the treatment plan.

3. Temporary, but clinically necessary, services do not require an alteration of the treatment plan, however, must be identified in a progress note. The note must indicate the necessity, amount scope, duration and provider of the service.

4. Progress Note – Reference section 403.2B(6).

5. Discharge Plan – Reference section 403.2B(3)(d).

6. Discharge Summary – Reference Section 403.2B(7).

7. Required signatures for treatment plan:

   a. Clinical supervisor;

   b. Recipient and their family/legal guardian (in the case of legal minors); and

   c. The individual responsible for developing the plan.

G. SUPERVISION REQUIREMENTS

Clinical Supervisor – A licensed professional operating within the scope of their practice under state law may function as clinical supervisor. Clinical supervisor must have the specific education, experience, training, credentials, and licensure to coordinate and oversee an array of services for behavioral health. The clinical supervisor will have administrative and clinical oversight of the program and must ensure that services provided are medically necessary, clinically appropriate and follow an evidence-based model recognized by the Health Division. The designated supervisor must be approved by the program operator of a SAPTA certified and funded network per NAC 458.103.

If the clinical supervisor will supervise interns, they are required to have the appropriate additional licensure needed per the Board of Examiners in addition to their professional licensure. Supervision must be within the scope of their practice and field.

H. COVERAGE AND LIMITATIONS

The DHCFP reimburses for integrated interventions in a substance use medical treatment delivery model provided by qualified Medicaid providers. Patients are assessed as meeting diagnostic criteria for substance-related disorders (including substance use disorder or substance-induced disorders) and/or mental health disorders as defined in the current International Classification of Diseases (ICD).

1. Screening – A brief systematic process to determine the possibility of a co-occurring disorder.

a. The following screens are covered within the DHCFP program. Screens must be a nationally accepted screening instrument through SAMHSA/CSAT Treatment Improvement Protocols or other Peer Supported Literature. Below is a list of recognized tools:

1. Clinical Institute Withdrawal Assessment (CIWA)
2. Modified Mini Screen (MMS)
3. Problem Behavior Inventory (PBI)
4. Substance Abuse Subtle Screening Inventory (SASSI)
5. Substance Use Disorder Diagnostic Schedule (SUDDS)
6. Recovery Attitude and Treatment Evaluator (RAATE)
7. Treatment Intervention Inventory (TII)
8. Western Personality Interview (WPI)

2. Assessment – A Comprehensive Co-occurring Assessment is an individualized examination which establishes the presence or absence of mental health and substance use disorders, determines the recipient's readiness for change, and identifies the strengths or problem areas that may affect the recipient's treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance use history, legal history, family, educational and social history and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

3. Level of Care Determination and Authorization Requirements

a. The DHCFP utilizes the ASAM Criteria, for individuals presenting with substance use disorder(s) to determine appropriate placement in a level of care. In addition, the DHCFP utilizes medical necessity as defined in MSM Chapter 100, Section 103.1. The process considers assessment and documentation of the following six dimensions:

1. Dimension 1: Acute Intoxication and/or Withdrawal Potential
2. Dimension 2: Biomedical Conditions and Complications
3. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
4. Dimension 4: Readiness to Change
5. Dimension 5: Relapse, Continued Use, or Continued Problem Potential
6. Dimension 6: Recovery/Living Environment

b. The DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients.

c. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request.

d. Reference Attachment C for authorization requirements for Substance Use Agency Model.

4. Treatment Services – The DHCFP covers the below levels based upon the ASAM patient placement criteria. Reference Attachment C for the coverage and utilization management requirements.

a. Level 0.5 Early Intervention/Prevention

b. Level 1 Outpatient Services

c. Level 2.1 Intensive Outpatient Program

d. Level 2.5 Partial Hospitalization

e. Level 3 Services provided in a Licensed ASAM Level 3 environment

f. Level 4 Medically Managed Intensive Inpatient Treatment

5. Pharmaceutical coverage – For coverage and limitations of Narcotic Withdrawal Therapy Agents (Opioid Dependent Drugs) refer to Chapter 1200 of the MSM.

6. Opioid Use Treatment

a. Provided in a Nevada licensed entity through SAPTA as an Opioid Use Disorder Treatment Program.

b. Coverage of the service:

1. Requires diagnosis of Opioid Use Disorder; and

2. Requires documentation as meeting the assessment criteria of all six dimensions of opioid treatment program in The ASAM Criteria.

c. The following service is covered for Opioid Treatment Program:

1. Medication assessment, prescribing, administering, reassessing and regulating dose levels appropriate to the individual, supervising withdrawal management from opioids, opioid use disorder treatment, overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders;

d. Opioid use disorder treatment program is required to perform:

1. Linkage with or access to psychological, medical and psychiatric consultation;

2. Linkage with or access to emergency medical and psychiatric care through affiliations with more intensive levels of care;

3. Linkage with or access to evaluation and ongoing primary medical care;

4. Ability to conduct or arrange for appropriate laboratory and toxicology tests;

a. Availability of physicians to evaluate, prescribe and monitor use of methadone and of nurses and pharmacists to dispense and administer methadone; and

b. Ability to assist in arrangements for transportation services for patients who are unable to drive safely or who lack transportation.

7. Non-Covered Services – the following services are not covered under the substance use services program for the DHCFP:

a. Services for recipients without an assessment documenting diagnostic criteria for substance-related disorder (including substance use disorder or substance-induced disorders) or mental health disorder as defined in the current ICD;

b. Services for marital problems without a covered, current ICD diagnosis;

c. Services for parenting skills without a covered, current ICD diagnosis;

d. Services for gambling disorders without a covered, current ICD diagnosis;

e. Custodial services, including room and board;

f. More than one provider seeing the recipient in the same therapy session;

g. Services not authorized by the QIO-like vendor if an authorization is required according to policy;

h. Respite;

i. Services for education;

j. Services for vocation training;

k. Habilitative services;

l. Phone consultation services; and

m. Care Coordination and treatment planning.

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention	1. Screening services recommended by the U.S. Preventive Services Task Force: a. Depression screening in adults and adolescents. b. Alcohol screening in adults, including pregnant women. c. Tobacco use, counseling, and interventions. 2. Must be direct visualization. Self-screens and over the phone are non-covered.	A. DEPRESSION SCREENING Adults: Many formal screening tools are available, including instruments designed specifically for older adults. (See Policy, Page 4) Asking two simple questions about mood and anhedonia ("Over the past two weeks, have you felt down, depressed or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?") may be as effective as using more formal instruments (2). There is little evidence to recommend one screening method over another; therefore, clinicians may choose the method most consistent with their personal preference, the patient population being served and the practice setting. All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (that is, those from the updated *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) to determine the presence or absence of specific depressive disorders, such as MDD or dysthymia. The severity of depression and comorbid psychological problems (for example, anxiety, panic attacks or substance use) should be addressed.	No prior authorization required. Limited to one screen per 90 days per disorder.

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention (Continued)		Adolescents: Instruments developed for primary care (Patient Health Questionnaire for Adolescents [PHQ-A] and the Beck Depression Inventory-Primary Care Version [BDI-PC]) have been used successfully in adolescents. There are limited data describing the accuracy of using MDD screening instruments in younger children (7-11 years of age). B. ALCOHOL SCREENING Adults/Pregnant Women: The USPSTF considers three tools as the instruments of choice for screening for alcohol misuse in the primary care setting: the Alcohol Use Disorders Identification Test (AUDIT), the abbreviated AUDIT-consumption (AUDIT-C) and single question screening (for example, the NIAAA recommends asking, "How many times in the past year have you had five [for men] or four [for women and all adults older than 65 years] or more drinks in a day?"). Of available screening tools, AUDIT is the most widely studied for detecting alcohol misuse in primary care settings; both AUDIT and the abbreviated AUDIT-C have good sensitivity and specificity for detecting the full spectrum of alcohol misuse across multiple populations.	

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Prevention			
Level 0.5 Early Intervention/ Prevention (Continued)		AUDIT comprises 10 questions and requires approximately two to five minutes to administer. AUDIT-C comprises three questions and takes one to two minutes to complete. Single-question screening also has adequate sensitivity and specificity across the alcohol-misuse spectrum and requires less than one minute to administer. C. TOBACCO Various primary care clinicians may deliver effective interventions. There is a dose-response relationship between quit rates and the intensity of counseling (that is, more or longer sessions improve quit rates). Quit rates seem to plateau after 90 minutes of total counseling contact time. Helpful components of counseling include problem-solving guidance for smokers (to help them develop a plan to quit and overcome common barriers to quitting) and the provision of social support as part of treatment. Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone "quit lines."	

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Outpatient Services			
Level 1 Outpatient Services	1. Medication management 2. 24-hour crisis intervention services face to face or telephonically available seven days per week 3. Behavioral Health/Substance Use Covered Screens 4. Comprehensive biopsychosocial assessment 5. Individual and group counseling 6. Individual, group, family psychotherapy 7. Peer Support Services	A clinic model that meets the certification requirement NAC 458.103 for alcohol and drug use programs. The entity will provide medical, psychiatric, psychological services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed.	Prior authorization is required on services after service limitations have been exceeded. Post authorization is not required for substance use only crisis intervention. Refer to MSM 400 for co-occurring and mental health crisis intervention services and limitations. Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required. Individual, group, family psychotherapy and counseling services can be utilized for up to 26 total sessions for children and adolescents and up to 18 total sessions for adults before prior authorization is required.

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Outpatient Services			
Level 2 2.1 Intensive Outpatient Treatment	An evidenced based/best practice model providing a minimum amount of skilled structured programming hours per week. During the day, before or after work setting, evening and/or weekend. Provides a milieu "real world" environment. The milieu is a combination of skilled treatment services. 1. Medical and psychiatric consultation 2. Psychopharmacological consultation 3. Medication management 4. 24-hour crisis intervention services face to face or telephonically available seven days per week 5. Comprehensive biopsychosocial assessments 6. Behavioral Health/Substance Use Covered Screens 7. Individual and group counseling 8. Individual, group, family psychotherapy 9. Self-help/recovery groups	Frequencies and intensity are appropriate to the objectives of the treatment plan. Requires a comprehensive interdisciplinary program team approach of appropriately credentialed addiction treatment professionals, including addiction – credentialed physicians who assess and treat substance-related disorders. Some staff are cross trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and interactions with substance-related disorders.	Prior authorization is required on services, except for: Behavioral Health/Substance Use Screens and 24-hour crisis intervention. Post authorization is not required for 24-hour crisis intervention.
2.5 Partial Hospitalization	1. Outpatient hospital setting. 2. All Level 2.1 services in addition need the direct access to psychiatric, medical and/or laboratory services.	Same as above, in addition psychiatric and medical management. Intensity of service required is higher than can be provided in Intensive Outpatient Treatment.	Prior authorization is required on services, except for: Behavioral Health/Substance Use Screens and 24-hour crisis intervention. Post authorization is not required for 24-hour crisis intervention.

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Outpatient Services			
Level 3 Residential 3.1-3.5	Medical, psychiatric, psychological services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. 1. 24-hour crisis intervention services face to face or telephonically available seven days per week 2. Medication management 3. Behavioral Health/Substance Use Covered Screens 4. Comprehensive biopsychosocial assessment 5. Individual and group counseling 6. Individual, group, family psychotherapy 7. Peer Support Services	A clinic model that meets the certification requirement NAC 458.103 for alcohol and drug use programs. Room and board are not a reimbursable service through DHCFP. (For recipients ages 22 to 64, "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project" (1115 SUD Waiver) allows for reimbursement of ASAM Levels 3.1, 3.2WM, 3.5, and 3.7WM substance use and withdrawal management services within an IMD setting through December 31, 2027.) The entity will provide medical, psychiatric, psychological services, which are available onsite or through consultation or referral. Medical and psychiatric consultations are available within 24 hours by telephone or in person, within a time frame appropriate to the severity and urgency of the consultation. Emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu. All other services are individually billed.	Prior authorization is required on services, after service limitations have been exceeded. Post authorization is not required for substance use only crisis intervention. Refer to MSM 400 for co-occurring and mental health crisis intervention services and limitations. Peer Support Services can be utilized for up to 18 hours/72 units annually before prior authorization is required. Individual, group, family psychotherapy and counseling services can be utilized for up to 26 total sessions for children and adolescents and up to 18 total sessions for adults before prior authorization is required. Intensity of service is dependent upon individual and presenting symptoms.

SUBSTANCE USE AGENCY MODEL LEVEL OF CARE GRID

Level of Care	Covered Services	Description of Treatment Level	Utilization Management
Withdrawal Management Services			
Inpatient Services			
Level 4 Medically Managed Intensive Inpatient and Withdrawal Management Services	Inpatient substance use services are those services delivered in freestanding substance use treatment hospitals or general hospitals with a specialized substance use treatment unit which includes a secure, structured environment, 24-hour observation and supervision by mental health substance use professionals and a structured multi-disciplinary clinical approach to treatment. These hospitals provide medical withdrawal management and treatment services for individuals suffering from acute alcohol and substance use conditions. Services provided in: 1. An acute care general hospital with a psychiatric unit, 2. A free standing psychiatric, and 3. A licensed chemical dependency specialty hospital with acute care medical and nursing staff.	Reference Section 403.10. (For recipients ages 22 to 64, "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs) Transformation Project" (1115 SUD Waiver) allows for reimbursement of substance use and withdrawal management services within an IMD setting through December 31, 2027.)	Prior Authorization required. Reference Inpatient Section 403.10.

POLICY #04-05	INSTITUTION FOR MENTAL DISEASE (IMD)	

A. DESCRIPTION

Nevada Medicaid Fee-for-Service (FFS) shall not reimburse for any services for individuals who are ages 22-64 years that are in an Institution for Mental Disease (IMD). An IMD is defined as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, and also provides for medical attention, nursing care and related services.

For recipients ages 22 to 64, "Nevada's Treatment of Opioid Use Disorders (OUDs) and Substance Use Disorders (SUDs)Transformation Project" (1115 SUD Waiver) allows for reimbursement of substance use and withdrawal management services within an IMD setting through December 31, 2027.

B. COVERAGE AND LIMITATIONS

1. Institution for Mental Disease (IMD) Exclusion - In accordance with 42 CFR 435.1009(2), Federal Financial Participation (FFP) is not available for institutionalized individuals who are individuals under the age of 65 who are patients in an institution for mental diseases (IMD) unless they are under age 22, and are receiving inpatient psychiatric services under 42 CFR 440.160, which is a psychiatric hospital or a residential treatment center for recipients under the age of 21 years. See (2e) for additional clarification.

   a. All services are excluded from Medicaid payment while a recipient is admitted to an IMD, whether the services are provided in or outside the facility.

2. In accordance with 42 CFR 435.1010: Definition of IMD means a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental disease, and also provides for medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character being that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

   a. Facilities licensed as acute care hospitals and/or nursing facilities with designated psychiatric beds ~~a~~re reviewed based upon their aggregate bed counts.

   b. The Centers for Medicare and Medicaid Services (CMS) Manual for IMD states, alcohol and other chemical dependency syndromes are classified as mental disorders, which subject them to the IMD regulations. The manual gives further guidance that services delivered by laypersons that do not constitute a medical or remedial model such as Alcoholics Anonymous do not qualify for federal matching funds. The "major factor differentiating these facilities from other chemical dependency treatment facilities are the primary reliance on lay staff." Chemically dependent patients admitted for CD treatment are counted as mentally ill under the 50% guideline.

   c. An institution for individuals with Intellectual and Developmental Disabilities is not considered an institution for mental diseases.

   d. Periods of Absence: Regulation allows for an individual to have a conditional release or convalescent leave from the IMD. During this time period the patient is not considered to be in the IMD. Services may be covered by Medicaid during this time period for emergency or other medical treatment. The periods of absence relate to the course of treatment of the

recipient's mental disorder. If the patient needs emergency or other medical treatment during this time period, these services may be covered because the patient is not considered to be in an IMD. If a patient is transferred while in the IMD for the purpose of obtaining medical treatment, it is not considered a conditional release and is not a covered service.

1. Convalescent – when a patient is sent home for a trial visit.

2. Conditional release – when a patient is released from the institution on the condition that the patient receives outpatient treatment or other comparable services.

d. Coverage of services for ages 21 up to 22 years – If a patient is receiving services immediately prior to turning age 21years, the services continue until the earlier of the date the individual no longer requires the services or the date the individual reaches 22. In this extenuating circumstance, IMD service may continue until age 22. The regulation requires that the patient must be receiving services immediately prior to age 21 and continuously up to age 22. Services cannot begin during the 21st year.

3. Guidelines for Determining if a facility is an IMD: The CMS has deferred the completion of the determination if a facility is an IMD to the DHCFP. The DHCFP utilizes the criteria as listed in the CMS Medicaid Manual for this determination. The criteria include factors such as, but not limited to:

a. Facility ownership is one single owner or governing body;

b. The Chief Medical Officer is responsible for medical staff activities in all components;

c. The Chief Executive Officer is responsible for administrative activities in all components;

d. The licensure of each component;

e. The geographic location of each facility;

f. The Condition of Participation of each component;

g. The relationship to the State Mental Health Authority;

h. The patient records; that provide evidence of psychiatric/psychological care and treatment; and

i. The current need for institutionalization for more than 50% of all the patients in the facility is resulting from mental disease, including but not limited to the bed count.

4. Medicaid may reimburse co pays and/or deductibles for Qualified Medicare Beneficiaries (QMB) while in an IMD.

(State Medicaid Manual Chapter 4, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html)

NURSING FACILITIES

500 INTRODUCTION

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

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

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.

502 RESERVED

503 POLICY

503.1 PROVIDER REQUIREMENTS

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

A. Be licensed by the Division of Public and Behavioral Health (DPBH), Bureau of Health Care Quality and Compliance (BHCQC) in accordance with the Nevada Revised Statute (NRS) and the Nevada Administrative Code (NAC).

B. Be certified by the Centers for Medicare and Medicaid Services (CMS) which assures that the NF meets the federal requirements for participation in Medicaid and Medicare per 42 Code of Federal Regulations (CFR) 483.

C. Be enrolled as an NF provider in the Nevada Medicaid program as described in Chapter 100 of the Medicaid Services Manual (MSM).

D. Accept payment in full for covered services, the amounts paid in accordance with Medicaid policy and not charge a Medicaid recipient for any services covered by Medicaid reimbursement.

E. Assure that all claims submitted to Nevada Medicaid's fiscal agent for NF services are accurate and timely.

F. Comply with all Federal and State laws, rules and regulations.

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 and NF provider contract upon notice that the NF is no longer licensed and/or certified to provide NF services.

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

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

503.2 PROGRAM PARTICIPATION

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

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

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

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

E. The facility must report their census information by midnight on the fifth day of each month. This will include the number of vacant beds in the facility which are available for resident occupancy.

F. The facility is responsible for ensuring the census information is accurate, complete and submitted timely.

G. 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.

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

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

503.3 RECIPIENT RESPONSIBILITY

The recipient, upon request, must present:

A. a valid Medicaid card; and

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

503.4 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

AUTHORITY

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

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

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

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

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

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

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

A. DEFINITIONS

LEVEL I IDENTIFICATION SCREENING

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

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

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

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

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

B. LEVEL II SCREENING

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

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

C. PASRR LEVEL II INDIVIDUAL EVALUATION AND DETERMINATION

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

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

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

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

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 of the admit date.

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

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

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

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

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

503.5 EXEMPTED HOSPITAL DISCHARGE

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

A. Is to be admitted to any NF directly from a hospital after receiving acute inpatient care at the hospital (this does not include admissions from emergency rooms, observation beds or rehabilitation units);

B. Requires NF services for the condition for which he or she received care in the hospital; and

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

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

1. ADVANCED GROUP CATEGORICAL DETERMINATION

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

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

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

c. Severity of Illness limited to: comatose, ventilator dependent, functioning at brain stem level, Chronic Obstructive Pulmonary Disease (COPD), Severe Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis (ALS) or Congestive Heart Failure (CHF). In addition to having one or more of these diagnoses, due to the severity of the illness, it is anticipated the individual is not expected to benefit from specialized services.

d. Provisional Admission for cases of:

1. Delirium where and accurate diagnosis cannot be made until the delirium clears; or

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

3. Respite to in-home caregivers to whom individuals with MI or IID is expected to return following a brief NF stay.

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

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

2. COORDINATION AND/OR PROVISION OF SPECIALIZED SERVICES

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

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

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

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

503.6 ADMISSIONS FROM OTHER STATES

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

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

503.7 DISCHARGES OR TRANSFERS

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

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

503.7A REIMBURSEMENT

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

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

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

3. A provider who fails to obtain a completed PASRR Level II screening by day 30 of an admission under the Exempted Hospital Discharge. Medicaid reimbursement is not available until the date of the PASRR II evaluation is completed indicating NF placement is appropriate.

4. A provider fails to obtain an RR Level II individual evaluation prior to the limitation date of a previously limited categorical determination. Medicaid reimbursement is not available until the PASRR II evaluation is completed indication NF placement is appropriate.

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

6. For individuals who have been determined, through the PASRR process, to not need the services of an NF.

503.7B PASRR HEARINGS

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

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

503.8 LEVEL OF CARE (LOC)

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

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

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

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

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

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

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

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

In the event a recipient is discharged to a community based setting and is later readmitted to the NF, the NF must contact the QIO-like vendor screening office to determine whether the LOC determination is still valid (based on the recipient's current condition), or if a new LOC determination is needed.

When a recipient does not meet a nursing facility LOC and an NF chooses to admit the recipient, Medicaid reimbursement will not be authorized for the NF.

On initial and subsequent screenings, the QIO-like vendor determines whether the LOC provided or to be provided should be approved based on medical necessity. There are four possible LOC categories based on the care needs and nursing requirements for each individual as determined by the LOC assessment. These include:

A. NF Standard;

B. NF Ventilator Dependent;

C. Pediatric Specialty Care I; and

D. Pediatric Specialty Care II.

Each of these categories is associated with a provider specific rate for each free-standing NF.

After an LOC has been established, the NF my also request approval the Behaviorally Complex Care Program; which also has associated rates.

NF Ventilator Dependent is limited to recipients who are dependent on mechanical ventilation for a minimum of six out of the 24 hours per day and is an all-inclusive rate. NF and respiratory therapists are not allowed to bill separately for ventilator management services, small volume nebulizer treatments, tracheostomy changes, etc.

NF Ventilator Dependent Rate: a physician's order specifying the ventilator support must accompany the screening request. Current medical records must verify that the ventilator support is required for a minimum of six hours within a 24-hour period. The medical records must also include the date the recipient was placed on the ventilator.

503.9 PEDIATRIC SPECIALTY CARE

Pediatric Specialty Care I and II are limited to recipients who are children from birth to 21 years of age who require specialized, intensive, licensed skilled nursing care beyond the scope of services provided to the majority of NF recipients.

The QIO-like vendor must determine the recipient meets both an NF LOC as well as a Pediatric Specialty Care LOC prior to authorization. Pediatric Specialty Care rates are approved for a maximum of six months but may be extended with an updated LOC screening and supporting documentation. If a new authorization is not obtained prior to expiration of the previous specialty care authorization, the NF will be reimbursed at the NF standard rate until such time a new pediatric specialty care LOC is determined.

Documentation must be submitted with request to support all treatment and services listed above. Time limited treatments may be authorized up to 90 days. Requests for extension may be granted with supporting documentation.

503.9A PEDIATRIC SPECIALTY CARE I

The patient's condition requires 24-hour access to nursing care by a Registered Nurse (RN) and the recipient has one or more of the following items (a-c): (a) A tracheostomy that requires suctioning, mist or oxygen and at least one treatment listed in the treatment procedures section below; (b) dependence on Total Parenteral Nutrition (TPN) or other Intravenous (IV) nutritional support and at least one treatment listed in the treatment procedure section below; (c) administration of at least two treatment procedures below. See Treatment Procedures below.

503.9B PEDIATRIC SPECIALTY CARE II

The patient's condition requires 24-hour access to nursing care by an RN and the recipient has one or more of the following item (a-c); 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 procedure below.

503.9C TREATMENT PROCEDURES

1. Intermittent suctioning at least every eight hours and mist or oxygen as needed;

2. Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy);

3. IV therapy involving:

    a. Administration of continuous therapeutic agents; or

    b. Hydration; or

    c. Intermittent IV drug administration of more than one agent.

4. Peritoneal dialysis treatments requiring at least four exchanges every 24 hours.

5. Tube utilization (nasogastric or gastrostomy; Foley, intermittent catherization; 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.

9. Central or Peripherally Inserted Central Catheter (PICC) line management.

10. Maximum assist required (quadriplegia or Hoyer lift).

11. Other special treatment(s) not listed above. The provider must describe in detail.

Provider Qualifications for Pediatric Specialty Care Rates:

In addition to Medicaid contractual obligations and all other provider rules contained in MSM Chapters 100 and 500, a free-standing NF must meet specified criteria to qualify for Pediatric Specialty Care rates. An on-site visit by the DHCFP staff is made to verify the NF meets the following criteria:

12. Physical facility requirements:

    a. Pediatric Specialty Care must be provided in a distinct, identifiable unit or area of the NF.

    b. The accommodating beds include contiguous rooms, wing, floor or building of the NF.

13. Staffing Requirements:

    a. The NF must employ an RN as the Pediatric Specialty Care Unit's head nurse. The head nurse must have specialized pediatric training and at least one year's experience in pediatric nursing.

    b. The NF must ensure that an RN with pediatric training and experience is on duty 24 hours per day on the Pediatric Specialty Care Unit.

503.10 BEHAVIORALLY COMPLEX CARE PROGRAM

The Behaviorally Complex Care Program (BCCP) is for those Nevada Medicaid recipients with a severe, medically-based behavior disorder. Medically-based disorders may include (not all inclusive) traumatic/acquired brain injury, dementia, Alzheimer's, Huntington's Chorea, which causes diminished capacity for judgement, or a resident, who meets the Medicaid criteria for nursing facility level of care and who has a medically-based mental health disorder or diagnosis and exhibits significant behaviors. Those facilities that request and are approved to administer the

BCCP are reimbursed with a tiered rate established with the intention of providing in-state care that addresses the recipient's needs.

NFs must demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff as documented by one or more of the following behaviors:

A. The resident engages in verbally abusive behavior where he threatens, screams or curses at others;

B. The resident presents a threat of hitting, shoving, scratching or sexually abusing other residents.

C. The resident engages in socially inappropriate and disruptive behavior by doing one of the following:

1. Makes disruptive sounds, noises and screams;

2. Engages in self-abuse acts;

3. Inappropriate sexual behavior;

4. Disrobes in public;

5. Smears or throws food or feces;

6. Hoards; and

7. Rummages through others belongings.

D. The resident refuses assistance with medication administration or activities of daily living.

Presence of elopement or wandering behavior alone, not in conjunction with aggressive or assaultive behaviors exhibiting a danger to self or others, does not qualify a recipient for the BCCP. The BCCP is not appropriate for those caring for suicidal individuals. Individuals who are suicidal should be transferred to an acute facility to ensure their safety and appropriate LOC. The BCCP may be requested while the recipient is in an acute placement if there is sufficient documentation to the support a medically based behavior disorder.

503.10A PROVIDER RESPONSIBILITY

Facilities must demonstrate competency to adequately address the individual's behavior. All behavior intervention programs must:

1. Be part of an individualized behavior modification plan;

2. Apply a precisely planned systematic application of the methods and findings of behavioral science with the intent to reduce observable negative behaviors;

3. Incorporate processes and methodologies that are the least restrictive alternative available for producing the desired outcomes;

4. Be conducted following only identification and, if feasible, remediation of environmental and social factors that likely precipitate or reinforce the inappropriate behavior;

5. Incorporate a process for identifying and reinforcing a desirable replacement behavior.

Behavior modification programs include, but are not limited to:

1. Staff training

2. Sensory Stimulation

3. Behavior Management

4. Cognitive Emotion Oriented Therapy

5. Environmental Modification

6. Clinically-Oriented Therapy

Documentation supporting the service need must be provided to the Facilities Unit in DHCFP Long Term Support Services (LTSS) by a person professionally qualified in the field of psychiatric mental health as defined in NRS 433.209 and clearly document the severe medically based behavior disorder or other medical condition prompting the approval of the BCCP.

Tiered rates have been established to cover the broad milieu of accommodations to meet patient needs. Behaviors and their frequency of occurrence will assist in establishing/requesting the appropriate Tier Level. The following is a guide for requesting:

Tier 1: Behaviors requiring a minimal amount of intervention or assistance.

Tier 2: Serious behaviors requiring moderate intervention.

Tier 3: Extreme behaviors exhibiting danger to themselves or other requiring frequent intervention.

The BCCP care level requires prior authorization. If approved, reauthorization will be required. Reauthorization timeframes are based on the approved tier. Refer to the Billing Guidelines for frequency of reauthorization. In addition, facilities are also required to report to the DHCFP, any change in recipient condition or Tier.

The requested tier will be evaluated based on the frequency and degree of the behaviors exhibited utilizing the Behaviorally Complex Care Program Evaluation Tool. The behaviors must be categorized as follows:

Always the recipient always (daily) requires intervention for behaviors.
Usually the recipient requires interventions four or more days per week.
Usually Not the recipient requires interventions, but fewer than four days a week.
Never the recipient does not have behaviors that require interventions.

Each response has a weighted value that must be supported by the medical evidence submitted. Always = 3; Usually = 2; Usually Not = 1; Never = 0 Maximum weighted value = 18

Tier I 3 to 7 points
Tier II 8 to 13 points
Tier III 14 to 18 points

Facilities may request the BCCP by submitting NMO-7079 and supporting documentation to the DHCFP. Supporting documentation may include: the face sheet, medication administration records (MAR), primary care provider progress notes, psychiatric notes and/or group therapy note, nurses notes, behavioral plan, care plan, behavior monitor logs, interdisciplinary team notes, behavior management team review and sleep logs. Absence of the listed documentation does not disqualify approval of the BCCP; the DHCFP staff in the LTSS Facilities Unit or the DHCFP QIO-like vendor will review all materials submitted to determine whether there is sufficient medical documentation and justification for the BCCP. After review, the facility and recipient will receive a Notice of Decision (NOD). The NOD may indicate that:

1. The request is approved at the tier requested;

2. The request is approved for a higher tier than requested;

3. The request is approved for a lower tier than requested; or

4. The request is denied.

Should the BCCP not be approved, the NF will receive the base rate for the applicable quarter. The BCCP care level is determined independently of any NF LOC.

503.10B HEARINGS FOR BCCP

Upon receipt of the BCCP NOD, facilities or recipients may ask the DHCFP to perform a re-review of the original request. The re-review must be based on information and/or documentation not submitted with the original request. Should the facility not agree with the re-review, a fair hearing may be requested per MSM Chapter 3100.

503.11 NURSING FACILITY TRACKING FORM

Before an NF can receive reimbursement for services rendered for a Nevada Medicaid recipient, the facility must submit a Nursing Facility Tracking form in order to receive authorization to bill. The purpose of the form is to notify the Medicaid Central Office of any admission, service level change, discharge or death for all Medicaid eligible recipients and to initiate and/or update the system with necessary information prior to billing.

A Nursing Facility Billing Authorization Letter that indicates specific billing days will be sent to the Nursing Facility. Upon receipt of the 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 guaranteed payment.

The facility must review all information of the Nursing Facility Billing Authorization Letter to verify it contains the correct information. If discrepancies are noted, contact the Medicaid office immediately to avoid delayed payment. If more than 30 days have elapsed since the tracking form submission and the facility has not received a Nursing Facility Billing Authorization Letter or been contacted by Medicaid staff, contact the Nevada Medicaid office.

The facility must submit the Nursing Facility Tracking Form to the Nevada Medicaid Central Office upon each occurrence for Medicaid eligible individuals:

a. Any admission;

b. Service level update and/or change;

c. New or retro-eligibility determinations;

d. Medicaid Managed Care disenrollment;

e. Hospice enrollment or disenrollment; or

f. Discharge or death.

If the resident becomes eligible after admission, the tracking form must be submitted upon notification of the eligibility determination.

Failure of the facility to submit the tracking form may result in payment delays or denials. This form may be accessed on the DHCFP website at http://www.dhcfp.nv.gov, which includes completion and submission instructions. The facility should retain a copy for their records.

Billing authorizations become invalid immediately upon discharge from the facility, death, service level change, enrollment to Hospice coverage or if the recipient becomes ineligible for Medicaid. Nevada Medicaid does not reimburse NFs for the date of discharge or date of death.

503.11A PROVIDER RESPONSIBILITY

The facility must determine if the recipient has other resources including other insurance coverage for any and all services and supplies

It is the facility's responsibility to verify the recipient's eligibility status monthly by accessing the Eligibility Verification System (EVS). Refer to MSM Chapter 100 regarding eligibility information.

If eligibility is determined for prior months (for service dates prior to the existing billing authorization), the facility must submit another tracking form indicating the eligibility has been determined retroactively. This will initiate another billing authorization for those service dates.

503.12 THERAPEUTIC LEAVE OF ABSENCES

503.12A COVERAGE AND LIMITATIONS

NFs will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31. Further, no portion of the unused leave days may be carried over into the next calendar year. The facility must maintain accurate leave day records on the recipient's chart, for review by Medicaid staff.

A therapeutic leave must include therapeutic or rehabilitative home and community visits with relatives and friends. Therapeutic leave also includes leave used in preparation for discharge to community living. Therapeutic leave days are considered overnight stays. Therapeutic leave does not apply when a recipient is out on pass for short periods of time for visits with family/friends, to attend church services or other social activities. Therapeutic leave does not include hospital emergency room visits or hospital stays.

The absence of a Medicaid recipient from the facility for the purpose of therapeutic leave must be authorized in writing by the recipient's attending physician and included in the recipient's plan of care.

In those instances where a Medicaid recipient resides in more than one NF within a calendar year, the receiving facility must determine the number of therapeutic leave days that have been exhausted by the sending facility within the same calendar year. A record of any leave days must be a part of the information provided to the receiving facility as part of the transfer documents.

Therapeutic leave days must be authorized by the physician for specific dates. If a recipient fails to return to the facility within the specified timeframe, Medicaid reimbursement is not available for dates beyond the physician's order.

Each therapeutic leave of absence must be authorized by the attending physician's order to ensure the recipient is medically stable and capable of safely tolerating the absence.

The physician's order should specify:

1. The dates the recipient will be out of the facility;

2. Authorize the facility to send necessary medications; and

3. Provide instructions for the family member/friend on how and when to administer the medications.

A physician's order such as "may go out on pass" is not acceptable for this purpose. The NF must provide care instructions for the responsible person who will be accompanying the recipient during their therapeutic leave of absence.

The NF must reserve and hold the same room and bed for the Medicaid recipient on a therapeutic leave. The bed may not be occupied by another individual during the period of time in which the Medicaid recipient is on such leave.

When billing for therapeutic leave of absence days, Revenue Code 183 is used on the billing claim form. See Provider Billing Manual for specific instructions.

The recipient is responsible to abide by the physician's order and to return to the facility by the date authorized by the physician's order. The recipient must contact the facility to advise them of any change in the plan regarding therapeutic leave.

503.13 PATIENT INCOME CHANGES AND PATIENT LIABILITY (PL)

503.13A COVERAGE AND LIMITATIONS

Patient Liability (PL) is determined by the Division of Welfare and Supportive Services (DWSS). The regulations at 42 CFR 435.725 require that the State (Nevada Medicaid) reduce its payment to the NF by the amount of the PL. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made. PL will also be applied to subsequent claims submitted by provider entitled to PL until monthly obligations are fulfilled.

503.13B PROVIDER RESPONSIBILITY

An NF must notify DWSS immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the NF.

DWSS is responsible for determining the amount of PL the resident is responsible for.

When PL is established or changes, the recipient, facility and the fiscal agent are notified of the amount and effective date. Collection of PL is the facility's responsibility and should be done on a monthly basis. If an NF received a notice adjusting the amount of the PL and the facility has billed and received reimbursement for services, the facility must send a corrected claim to the fiscal agent to receive the appropriate adjustment within 60 days of the notice.

No PL is to be taken during the first 20 days of a Medicare covered stay. Medicaid reimbursement will be reduced by the PL amount for all claims including Medicare co-insurance days 21-100 if applicable. PL is also applied to all other Third Party Liability (TPL) co-insurance claims.

When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by DWSS and a notice is sent regarding the PL adjustment. The NF must refund any remaining balance to the recipient or their legal representative as required.

If a Medicaid recipient is transferred during a month from any provider entitled to collect PL, the discharging provider collects the total PL amount up to billed charges. The balance of the established PL must be transferred with the recipient at the time of transfer. The transferring and receiving providers are responsible for negotiating the collection of PL.

503.14 PERSONAL TRUST FUND MANAGEMENT

503.14A COVERAGE AND LIMITATIONS

An NF resident has the right to manage his or her financial affairs. An NF may manage resident's funds upon written authorization from the resident.

503.14B MANAGING RESIDENT FUNDS

NFs must have a system for managing residents' funds that, at a minimum, fully complies with the requirements established by Federal las and State regulations.

An NF may not require residents to deposit their personal funds with the NF. The facility must obtain prior written authorization from the recipient prior to the facility assuming management from the resident.

A recipient's personal funds may not be commingled with the NF funds or with the funds of another person. A recipient's personal funds that do not exceed $50 may be maintained in a non-interest-bearing account, interest bearing account or petty cash fund. If a recipient has funds in excess of $50, these monies must be maintained in an interest-bearing account in a local bank insured by the Federal Deposit Insurance Corporation (FDIC). Interest earned must be credited to the recipient's account. The NF must notify each recipient when the amount in the recipient's personal fund account reaches $200 less than the Supplemental Security Income (SSI) resource limit for one person.

A recipient's personal needs money is for the exclusive use of the recipient, as desired. The recipient's personal funds must not be used to purchase items covered by Medicaid either directly or indirectly as part of the facility's daily rate including nursing services, dietary services, room/bed maintenance, routine personal hygiene items (hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing and basic personal laundry) or medically related services. However, should a resident request a certain brand or product type, not otherwise supplied, the recipient's personal needs money may be used to purchase those items.

Upon a recipient's request, specialty items not covered by Medicaid may be purchased for the recipient. Allowable expenditures are outlined in 42 CFR§ 483.10 but may include a personal telephone, television, personal comfort items, personal clothing, reading material, gifts purchased on behalf of the recipient, flowers and plants, and decorative items. The facility must not require a recipient (or his or her representative) to request any item or service as a condition of admission or continued stay. In addition, the facility must obtain written authorization from the recipient that

states what the charge will be. In the event the recipient is unable to sign, the NF must obtain two signatures from NF staff and accurate accounting records must be kept accounting for each purchase.

Statements regarding a recipient's financial record must be available upon request to the recipient or to the recipient's legal representative.

Within 30 days of the death of a recipient, the NF must convey the recipient's funds and a final accounting of those funds to the individual or probate jurisdiction administering the recipient's estate.

503.14C PERSONAL FUND AUDITS

The Division or its representative will periodically audit recipients' personal trust funds to assure Federal and State laws, regulations and Medicaid 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 NF must make restitution to the recipient's funds improperly handled, accounted for or dispersed.

A report of the audit findings may be sent to BHCQC and the Medicaid Fraud Control Unit (MFCU), for follow-up regarding potential deficiencies related to State or Federal regulations.

Misuse of residents' monies is subject to prosecution under the NRS.

503.14D RECIPIENT RESPONSIBILITY

The recipient has the choice to either manage their own personal funds, or to request that the facility manage their personal funds. If the recipient desires the facility to manage their personal funds, the recipient must provide the facility with written authorization to do so.

Medicaid recipients may choose to spend their personal funds on items of personal care such as professional beauty or barber services or specialty items not covered by Medicaid. In this instance, the recipient must authorize payment for the specialty items in writing.

503.15 TRANSPORTATION

503.15A COVERAGE AND LIMITATIONS

NFs are responsible for ensuring that all recipients receive appropriate medical care and related services.

It is the responsibility of the NF to provide non-emergency transportation (NET) for Medicaid recipients for all off-site medical and dental appointments and other medically necessary services after admission and prior to discharge. Medically necessary non-emergency transportation costs are included in the NF's rate structure. The NF does not have to provide NET back to the facility after a hospital admission/discharge.

When a recipient is being admitted to an out-of-state NF, the discharging facility must contact the DHCFP Out-of-State Coordinator for authorization prior to the admission.

Refer to MSM Chapter 1900 for transportation policies.

503.16 ROUTINE SERVICES AND SUPPLIES

503.16A COVERAGE AND LIMITATIONS

Routine services and supplies are included in per diem rates. Routine NF services include regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen, the use of equipment and facilities, and other routine services. Examples of routine services and supplies include, but are not limited to:

1. All general nursing services including: the administration of oxygen and related medication; the collection of all laboratory specimens as ordered by a physician such as blood and urine; injections; hand feeding; incontinency care; normal personal hygiene which includes bathing, skin care, hair care or nail care (excluding professional barber and beauty services), shaving, oral hygiene, enemas, etc.

2. Social work services and activity programs: NF staff will provide these services as necessary in order to carry out the plan of care for the Medicaid recipients.

3. Maintenance therapy programs: facility staff will assist the Medicaid recipients as necessary under the guidelines of the recipient's restorative therapy program. Programs are intended to maintain and/or restore specific function(s).

4. Items which are furnished routinely and relatively uniformly to all residents, such as gowns, linens, water pitchers, basins, bedpans, etc.

5. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually such as alcohol, applicators, cotton balls, band aids, disposable gloves, incontinency care products including disposable diapers, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, IV equipment, T.E.D. (anti-embolism) stockings, hydrogen peroxide, over the counter enemas, tests (Clinitest, Testape, Ketostix, Accu-chek), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (includes soap, moisturizing lotion, powder, shampoo, deodorant, disinfecting soaps or

specialized cleansing agents, razor, shaving cream, denture adhesive, dental floss, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, sanitary napkins and related supplies, etc.).

6. Items which are used by individual residents but which are reusable and expected to be available, such as canes, crutches, walkers, wheelchairs, Geri chairs, traction equipment, alternating pressure pad and pump, Intermittent Positive Pressure Breathing (IPPB) machine, electric nebulizers, other durable medical equipment, oxygen concentrators, ventilators, etc.

7. Laundry services, including personal clothing.

503.16B ITEMS INCLUDED IN THE PADIATRIC SPECIALTY CARE RATE

All services, durable medical equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria including, but not limited to, respiratory services, tracheostomy and related services; developmental services, nutritional services, ambulatory aids, support surfaces and bathing/toiletry services.

Oxygen, and all related equipment and supplies necessary for administration including positive and negative pressure apparatus.

This includes all oxygen therapy equipment, i.e., oxygen-conserving devices (oxymizer) and nebulizer (pulmoaide); respiratory equipment, supplies and services; respiratory therapy; tracheostomy and related services; ventilators, including humidifiers, in-line condensers, in-line temperature measuring devices, and calibration and maintenance services.

1. Feeding pumps and equipment and services necessary for tube feedings.

2. Tracheostomy speaking valves.

3. Equipment and supplies for continuous IV therapy.

4. Ambulatory assistance equipment, supplies and services, including but not limited to canes and wheelchairs.

5. Support surfaces, equipment, supplies and services, i.e., alternating pressure pads, wheelchair cushions, and gel pressure and air fluidized mattresses.

6. Bathing/toileting assistance equipment, supplies, and services, commodes, lifts.

7. Developmental services.

8. Physical, occupational and speech therapies provided within a supportive or maintenance program.

503.16C PROVIDER RESPONSIBILITY

The NF must provide routine services and supplies and not charge the Medicaid recipient or Nevada Medicaid for these services.

The NF must not charge the Medicaid recipient for any item or service not requested by the recipient.

The facility must inform the Medicaid recipient (or his/her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and the amount of the charge.

503.17 SERVICES AND SUPPLIES NOT INCLUDED IN PER DIEM RATES

503.17A COVERAGE AND LIMITATIONS

Certain services and supplies are not considered part of the NF's Medicaid per diem rate. Payment for these services and supplies may be made to non-NF providers when the criteria for coverage as outlined in the appropriate MSM is met. The provider of the service or supply may be required to obtain prior authorization. Reference MSM Chapter 1200 for Pharmacy Services and MSM Chapter 1300 for DME and Supplies.

Items not included in the Medicaid per diem rate include:

1. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.

2. Nutritional supplements in conjunction with tube feedings.

3. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.

4. Non-standard wheelchairs including power-operated vehicles, wheelchair seating systems, including certain pressure reducing wheelchair cushions needed for the Medicaid recipient's permanent and full-time use, etc.

5. Air fluidized bed units and low air loss bed units.

6. Emergency transportation.

7. Physical, Occupational and Speech therapy services.

8. Physician services.

9. Laboratory, portable x-ray and other diagnostic services.

10. Repair of medical equipment and appliances which belong to the recipient.

503.17B PROVIDER RESPONSIBILITY

1. Non-NF providers must reference the appropriate MSM for specific coverage and limitation policies related to the services and supplies not included in the NF per diem. Providers must abide by the associated rules and prior authorization guidelines before providing an item or service to a recipient.

2. Provider must check for a valid Medicaid card and question the recipient/legal representative about other insurance coverage.

503.17C RECIPIENT RESPONSIBILITY

1. Furnish providers with any forms of identification necessary to utilize other health insurance coverage for any and all services and supplies.

2. Provide written authorization to the provider and NF if purchasing services and supplies not covered in the per diem.

503.17D AUTHORIZATION PROCESS

Refer to the appropriate chapter of the MSM for the authorization processes related to specific services and supplies.

503.18 DISCHARGE REQUIREMENTS

The NF must notify the Nevada Medicaid Central Office of a Medicaid recipient's discharge or death by sending the Nursing Facility Tracking form.

The NF must provide copies of the recipient's medical record to those responsible for post-discharge care including a copy of his or her Advance Directive (AD) (declaration/living will and/or durable power of health care decision).

Facility to facility transfer: To transfer any Medicaid recipient from on facility to another, the transferring facility must:

A. Obtain the physician's written order for transfer;

B. Obtain written consent from the recipient, his/her family and/or guardian;

C. Notify the Medicaid Central Office of the transfer by sending the Nevada Medicaid Nursing Facility Tracking form;

D. Transfer necessary medical/social/LOC/PASRR information to the receiving facility;

E. The discharging facility collects the total PL amount up to billed charges. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made and the balance of the collected PL must be transferred to the receiving NF with the recipient at the time of transfer;

F. Document the transfer in the recipient's medical record.

The admitting facility must submit the NF Tracking form to the Nevada Medicaid Central Office upon admission.

If it is determined that a Medicaid recipient no longer meets a nursing facility LOC, the facility will be notified and must facilitate discharge planning and promote appropriate placement. Should the discharge planner need further assistance, a referral can be made to the FOCIS program. Program staff can be reached through the DHCFP District Offices. If an NF intends to discharge a resident, they must provide to the resident/legal representative with a 30-day written notice and include the name and address of the person to whom the resident/legal representative may appeal the discharge.

503.19 FREE-STANDING NURSING FACILITY – RUG CASE MIX

The MDS/Resource Utilization Groups (RUG) system is used to classify residents and objectively determine a free-standing NF's Case Mix Index (CMI). The RUG classification system was developed by the CMS and is the basis for resident classification for the Medicare prospective payment system and numerous other states' Medicaid systems. Nevada uses the 34-group version that collapses the special rehabilitation category into four groups. CMS recommends this version for use with Medicaid NF resident populations. CMS has also developed standard CMI indices which will be the basis for calculating the average CMI, or score, for each NF under Nevada's case-mix system.

Free-standing NFs are reimbursed according to a price-based system. Individual facility rates are developed from prices established from three separate cost centers: operating, direct health care and capital. The direct health care component utilizes each facility's CMI which is calculated four

times per year for residents in the facility on the first day of each calendar quarter (called the "picture date").

Refer to MSM Chapter 700, Rates, for detailed information regarding free-standing NF reimbursement.

503.19A PROVIDER RESPONSIBILITY

The provider must assure that each resident's assessment data is complete and accurate in accordance with federal regulations and the *CMS Resident Assessment Instrument (RAI) Users' Manual.*

Comprehensive assessments, quarterly assessments, significant change assessments and annual assessments using the MDS current version must be conducted in accordance with the requirements and frequency schedule found at 42 CFR Section 483.20.

The provider must assure that the Occupancy Report is accurate and submitted within the specified time limit every month.

503.20 FREE-STANDING NURSING FACILITY CASE MIX AND MDS VERIFICATION REVIEW DESCRIPTION

Nevada Medicaid reimburses free-standing NFs based on the facility's overall CMI identified from the MDS. RUG items are identified on the MDS and used to establish each facility's CMI. In order to validate that Medicaid reimbursement to NFs is accurate and appropriate, a periodic review of MDS coding and corresponding medical record documentation is conducted to verify the information submitted on the MDS to the national repository accurately reflects the care required by, and provided to residents.

503.20A COVERAGE AND LIMITATIONS

RNs from Medicaid District Offices conduct Case Mix and MDS Verification reviews at every free-standing Medicaid certified NF at least annually. The review consists of a comparison of medical record documentation and the coding reported on the MDS, specifically the RUG items coded with a positive response. On-site resident reviews may also be conducted to verify documentation and/or information coded on the MDS.

Facilities may be reviewed more frequently when the facility's error rate is greater than 40%, or when any significant increase in errors is identified.

Prior to the review, a sampling of residents is determined using the most recently submitted MDS data and resident listing information. The sampling is selected based on the RUG category of each resident.

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 and MDS inaccurately, which resulted in the provider being paid more monies than a correctly-coded MDS would have allowed, Medicaid may require the facility to submit a corrected MDS to the national repository. Additionally, Medicaid may recoup monies paid inappropriately.

503.20B PROVIDER RESPONSIBILITY

1. The provider must possess thorough knowledge of the RAI process including the MDS, Resident Assessment Protocols (RAPs) and Care Plans.

2. The provider must maintain current knowledge of the federal MDS Utilization Guidelines.

3. The provider must maintain current knowledge of the Nevada Medicaid Documentation Guidelines which may be obtained by accessing the DHCFP website at: http://www.dhcfp.nv.gov.

4. The provider must promptly provide information requested by the review team.

5. The provider must make certain the appropriate staff attends the entrance and exit meetings.

6. The provider must prepare in advance and provide to review staff at the beginning of the entrance meeting:

a. copies of the selected MDS' (containing the attestation statement and completion signatures of staff) which review staff will use during the review and keep as a permanent part of the facility's review packet;

b. the active medical records selected for review; and

c. thinned/purged files and records maintained by the facility in various workbooks which contain information that supports the coding of the MDS.

7. Facility staff responsible for the MDS must be available to Medicaid review staff during the review process.

8. The provider must analyze the error reports with the appropriate facility staff responsible for coding the MDS.

9. The provider must identify and make corrections to processes that contribute to inaccurate MDS coding and maintain documentation supporting the current MDS in the active medical record.

10. The provider must anticipate and prepare for more frequent reviews when the facility's error rate is 40% or higher, or when any significant increase in errors occurs.

503.21 HOSPITAL-BASED NURSING FACILITY

503.21A COVERAGE AND LIMITATIONS

All policies described in this chapter apply to hospital-based NFs with the exception of those specifically identified for free-standing NFs.

Hospital-based NFs are paid under Medicare reasonable cost-based reimbursement principles including the routine cost limitation, and the lesser of cost or charges. Payment will follow any and all applicable Medicare upper payment limitation requirements such that payments will not exceed the upper payment limitation. The routine cost limit is applied at the time of cost settlement. Each facility will receive interim payments of the lower of 1) billed charges; or 2) an interim payment percentage that is the ratio of costs to charges from the facilities most recently audited cost report.

Refer to the MSM Chapter 700, Rates, for specific details related to hospital-based NF reimbursement.

503.21B PROVIDER RESPONSIBILITY

The hospital-based NF charges for services provided to Medicaid recipients should not exceed the provider's customary charges to the general public for these services. Hospital-based NFs may bill for ancillary services in addition to room and board.

The provider must assure that each claim submitted to the Nevada Medicaid's fiscal agent for NF services is accurate and timely.

Refer to the Provider Billing Manual for specific billing instructions.

503.22 OUT-OF-STATE NURSING FACILITY PLACEMENT

To request approval for out-of-state placement, the in-state provider, such as a hospital or nursing facility, completes the questionnaire identified as Out-of-State Questionnaire and submits the following documentation to Nevada Medicaid, Out-of-State Coordinator:

a. Documentation supporting that all the appropriate NFs in Nevada were contacted for in-state placement and placement was denied. The documentation should include the reasons Nevada NFs denied admission.

b. If the recipient was denied admission to in-state NFs due to severe behavior symptoms, a current psychosocial narrative is required.

c. A PASRR screening indicating NF placement is appropriate.

d. LOC screening indicating the recipient meets NF placement criteria.

e. Written statement from the recipient (recipient's family/guardian) concurring with out-of-state placement, indication of who will be responsible for making health care decisions on the recipient's behalf, and that the recipient's (recipient's family/guardian) acknowledge that Medicaid benefits end with death.

f. The written statement must also include the understanding that burial and funeral arrangements must be made outside of Medicaid intervention. Documentation to show that every effort was made to purchase/obtain a burial policy if the individual does not have funeral or burial coverage.

1. OUT-OF-STATE NURSING FACILITY

The out-of-state NF must be enrolled as a Nevada Medicaid provider.

a. Admission/Discharge:

The out-of-state provider must adhere to Nevada Medicaid's in-state pre-admission, admission and discharge policies as described in this chapter.

b. Eligibility:

Verification of Medicaid eligibility is the provider's responsibility. Eligibility should initially be verified by validating the recipient's Medicaid card. Thereafter, eligibility should be verified monthly by utilizing EVS.

The facility is not required to submit the Nursing Facility Tracking Form until the eligibility determination is issued; however, the out-of-state provider should contact the Nevada Medicaid Central Office, Out-of-State Coordinator, when an individual is admitted with a pay source other than Nevada Medicaid, but an application for Nevada Medicaid has been submitted.

To prevent disruption of Nevada Medicaid eligibility due to a change of address by Social Security (Nevada Medicaid recipients must remain residents of Nevada), when contacting Social Security for any reason, facility staff must reiterate that the recipient is a Nevada resident who has been placed out-of-state by Nevada Medicaid.

c. Reimbursement:

Out-of-state NFs are generally reimbursed at their own state's Medicaid rate.

If a recipient has a severe medically based behavior disorder or another medical condition for which care in Nevada was not available, and 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 NFs must adhere to Medicaid's billing policies. Refer to the Provider Billing Manual and MSM Chapter 100 for complete billing

instructions.

If a differential rate is approved, a prior authorization (PA) number will be issued. The PA number must be entered on the billing claim form.

503.22A RECIPIENT RESPONSIBILITY

The recipient (recipient's family/guardian) must concur with the out-of-state placement.

The recipient (recipient's family/guardian) must provide any necessary documentation requested by DWSS to maintain Medicaid eligibility and or utilize other health insurance coverage for any and all services.

503.22B AUTHORIZATION PROCESS

1. IN-STATE PROVIDER

Out-of-state NF admission requires approval from Nevada Medicaid.

To request approval for out-of-state NF placement, the in-state provider must complete the Out-of-State Questionnaire and submit it with the necessary information to Nevada Medicaid's Central Office, Out-of-State Coordinator.

When the out-of-state placement is approved, verbal authorization will be given to the requestor and written authorization will follow. After receiving the verbal approval, the provider may contact the transportation vendor to arrange transportation.

2. OUT-OF-STATE PROVIDERS

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 (MSM) Chapter 3100 Hearings, for hearings procedures.

Nevada Supportive Documentation Guidelines
Available online at: http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing (Resources/MDS Guidelines)
Resource Utilization Group, Version III, Revised
For MDS 3.0 Assessments with an ARD on or after 10/01/2016 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
B0100 Comatose **(7-day look back)**	-Clinically Complex -Impaired Cognition (Contributes to ES count)	**Comatose:** A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g. pain). **Persistent Vegetative State:** Some comatose individuals regain wakefulness but do not display any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of coma or persistent vegetative state within the 60-day look back period.
B0700 Makes Self Understood **(7-day look back)**	-Impaired Cognition (Contributes to ES count)	Documentation that the resident is able to express or communicate requests, needs, opinions, urgent problems and to conduct social conversation, whether in speech, writing, sign language or a combination of these. Deficits in the ability to make one self-understood can include reduced voice volume and difficulty in producing sound, or difficulty in finding the right word, making sentences, writing and/or gesturing	As Evidenced By (AEB) examples describing an accurate picture of the resident within the observation period.
C0500 Summary Score (BIMS) **(7-day look back)**	-Impaired Cognition	Rules for stopping the interview before it is complete: Stop the interview after completing CO300C if: • All responses have been nonsensical, OR • There have been no verbal or written responses to any question up to this point, OR • There have been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response. If the interview is stopped, do the following: • Code dash (-) in CO400A, CO400B and CO400C. • Code 99 in the summary score in CO500. • Code 1, yes in CO600. • Complete the staff assessment for Mental Status CO700-C1000.	Document date and signature of professional clinical staff (i.e. licensed nurse or licensed social worker) conduction the interview within observation period in the medical records. The interview completion date (the date the interview was actually conducted) must be date specific if written in a quarterly, annual or summary note. The interview completion date in the medical records must match the signature date for the interview section entered at Z0400. The BIMS score coded on the MDS should match the score reported by professional clinical staff.
C0700 Short-Term Memory **(7-day look back)**	-Impaired Cognition (Contributes to ES count)	Determine the resident's short-term memory status by asking him/her to describe an event five minutes after it occurred OR to follow through on a direction given five minutes earlier. Observation should be made by staff across all shifts and departments and others with close contact with the resident. If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard "no information" code (a dash "-") to indicate that the information is not available because it could not be assessed.	If resident is coded with a memory problem (1) at C0700, a memory test must be attempted (see Steps for Assessment in C0700 section of RAI manual) and documented As Evidenced By (AEB) example within the observation period.

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MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
C1000 Cognitive Skills for Daily Decision Making **(7-day look back)**	-Impaired cognition (Contributes to ES count)	Observation should be made by staff across all shifts and departments and others with close contact with the resident. Focus on the resident's actual performance Includes choosing clothing, knowing when to go to meals, using environmental clues to organize and plan (e.g. clocks, calendars, posted event notices). In the absence of environmental cues seeks information appropriately (not repetitively) from others in order to plan their day; using awareness of one's own strengths and limitations to regulate the day's events (e.g. asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker. **Does NOT include:** Resident's decision to exercise his/her right to decline treatment or recommendations by staff.	Document the resident's actual performance in making everyday decisions about tasks or activities of daily living (ADL). Does not include financial decision making or statements relating to diagnosis (i.e. dementia). Decisions should relate to the resident's life in the facility. Documentation needs to include the observing staff member's title and AEB examples of the decisions made by the resident within the observation period. If all residents' needs are anticipated, then an AEB is required. The example needs to be specific not just a reference to the residents' safety awareness etc.
D0300 Total Severity Score (PHQ-9) **(7-day look back)**	-Clinically Complex	**Total Security Score defined:** • Sum of all frequency items (D0200 Column 2). • Total Severity Score range is 00-27. • Score >=10 resident is depressed. • Score <=10 resident is not depressed. **Total Severity Score interpreted:** • 20-27; severe depression. • 15-19; moderately severe depression. • 10-14; moderate depression • 5-9; mild depression. • 1-4; minimal depression.	Document date and signature of the professional clinical staff (i.e. licensed nurse or licensed social worker) conducting the interview within the observation period in the medical records. The interview completion date (the date the interview was actually conducted) must be date specific if written in a quarterly, annual or summary note. The interview completion date in the medical records must match the signature date for the interview section entered at Z0400. The PHQ-9 score coded on the MDS should match the score reported by professional clinical staff.
D0500A, Column 2 Staff assessment Little interest or pleasure in doing things **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's lack of interest or pleasure in doing things.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500B, Column 2 Staff assessment Feeling or appearing down, depressed or hopeless **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's feeling or appearing down, depressed or hopeless.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
D0500C, Column 2 Staff assessment Trouble falling or staying asleep, or sleeping too much **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's trouble falling or staying asleep, or sleeping too much	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500D, Column 2 Staff assessment Feeling tired or having little energy **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's feeling tired or having little energy.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500E, Column 2 Staff assessment Poor appetite or overeating **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's poor appetite or overeating.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500F, Column 2 Staff assessment Indicating that he/she feels bad about self, or is a failure, or has let self or family down. **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's indication that she/he feels bad about self, or is a failure or has let self or family down.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500G, Column 2 Staff assessment Trouble concentrating on things, such as reading the newspaper or watching TV **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's trouble concentrating on things, such as reading the newspaper or watching TV.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500H, Column 2 Staff assessment Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that she/he has been moving around a lot more than usual **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that she/he has been moving around a lot more than usual.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
D0500I, Column 2 Staff assessment States that life isn't worth living, wishes for death, or attempts to harm self **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's statements that life isn't worth living, wishes for death, or attempts to harm self.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0500J, Column 2 Staff assessment Being short tempered, easily annoyed **(14-day look back)**	-Clinically Complex	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). • Example that demonstrates resident's being short tempered, easily annoyed.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
D0600 Total Severity Score (PHQ-9-OV) **(14-day look back)**	-Clinically Complex	Total Severity Score defined: • Sum of all frequency items (D0500 Column 2) • Total Severity Score range is 00-30. • Score >=9.5 resident is depressed • Score <=9.5 resident is not depressed Total Severity Score interpreted: • 20-30; severe depression • 15-19; moderately severe depression. • 10-14; moderate depression. • 5-9; mild depression. • 1-4; minimal depression	Documentation needs to include staff interviewed (e.g. day shift nurse, activities personnel). Staff interviewed should be from a variety of shifts and staff who know the resident well. Document date and signature of the professional clinical staff (i.e. licensed nurse or licensed social worker) performing assessment within the observation period. The PHQ-9-OV score coded on the MDS should match the score reported by professional clinical staff.
E0100A Hallucinations **(7-day look back)**	-Behavior Problems	**Hallucinations defined:** • Example of a resident's perception of the presence of something that is not actually there. • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.	Document As Evidenced By (AEB) example within the observation period.
E0100B Delusions **(7-day look back)**	-Behavior Problems	**Delusions defined:** • Example of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. **Does NOT include:** • A resident's expression of a false belief when easily accepts a reasonable alternative explanation.	Document As Evidenced By (AEB) example within the observation period.
E0200A Physical behavioral symptoms *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of physical behavior symptoms directed toward others. • Hitting, kicking, pushing, scratching, abusing other sexually.	Document As Evidenced By (AEB) example within the observation period – must include frequency.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
E0200B Verbal behavioral symptoms *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of verbal behavior symptoms directed toward other. • Threatening others, screaming at other, cursing at others.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200C Other behavioral symptoms *not directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of other behavior symptoms NOT directed toward others. • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0800 Rejection of Care Presence and frequency **(7-day look back)**	-Behavior Problems	Example of the resident's rejection of care (e.g. blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goal for health and well-being. When rejection/decline of care is first identified, it is investigated to determine if the rejection/decline of care is a matter of the resident's choice. Education is provided (risks and benefits) and the resident's choice becomes part of the plan of care. On future assessments, this behavior would not be coded again in this item.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0900 Wandering – Presence and frequency **(7-day look back)**	-Behavior Problems	Example and frequency of wandering from place to place without a specified course or known direction. **Does NOT include:** • Pacing, walking for exercise or out of boredom. • Traveling via a planned course to another specific place (dining room or activity).	Document As Evidenced By (AEB) example within the observation period – must include frequency.
ADL Self-Performance **G0110A,** Bed Mobility **G0110B,** Transfers **G0110H,** Eating **G0110I,** Toilet Use **Column 1 ONLY** **(7-day look back)**	-Extensive Services -Rehabilitation -Special Care -Clinically Complex -Impaired Cognition -Behavior Problems -Reduced Physical Functions	• Documentation 24 hour/7 days within the observation period while in the facility. • Initials and dates to authenticate the services provided. • Signatures to authenticate initials of staff providing services. **ADL Keys:** For either ADL grids, or electronic data collection tools, the key for self-performance and support provided must be equivalent to the intent and definition of the MDS key. **ADLs NOT supported:** • If there is no ADL key associated with the values, the ADL values will be considered unsupported. • ADL keys with words for self-performance such as limited, extensive, etc., without the full definitions will be considered unsupported. • ADL tools that lack codes for all possible MDS coding options will be considered unsupported.	The facility must provide one source document (i.e. ADL flow sheet, nurses or staff notes) containing data reported over all shifts/departments for the 7-day observation period to support MDS coding.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
ADL Support **G0110A,** Bed Mobility **G0110B,** Transfers **G0110I,** Toilet Use **Column 2 ONLY** **(7-day look back)**	-Extensive Services -Rehabilitation -Special Care -Clinically Complex -Impaired Cognition -Behavior Problems -Reduced Physical Functions	ADL support measures the highest level of support provided by the staff over the last seven days, even if that level of support only occurred once. This is a different scale and is entirely separate from the ADL self-performance assessment.	The facility must provide one source document (i.e. ADL flow sheet, nurses or staff notes) containing data reported over all shifts/departments for the 7-day observation period to support MDS coding.
H0200C Current toileting program or trial **(7-day look back)**	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must show that the following requirements have been met: • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern. • Evidence that the program was communicated verbally and through a care plan, flow records and a written report. • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period.** • Toileting plan that is being managed during days of the 7-day look back period with some type of systematic toileting program • A specific approach that is organized, planned, documented, monitored and evaluated. **Does NOT include:** • Less than four days of a systematic toileting program. • Simply tracing continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.	"Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a program or trial. The individual resident's toileting schedule must be daily (7 days a week), available and easily accessible to all staff. No time documentation is required for this item.
H0500 Bowel toileting program **(7-day look back)**	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must show that the following requirements have been met: • Implementation of an individualized, resident-specific bowel toileting program that was based on an assessment of the resident's unique bowel pattern. • Evidence that the program was communicated verbally and through a care plan, flow records and a written report. • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period.** **Does NOT include:** • Simply tracking of bowel continence status. • Changing pads or soiled garments. • Random assistance with toileting or hygiene.	"Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The program or trial must be recorded in the individual resident record. "All residents are encouraged to use the bathroom before and after meals" is not sufficient to take credit for a program or trial. The individual resident's toileting schedule must be daily (7 day a week), available and easily accessible to all staff. No time documentation is required for this item.

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Section I: Active Diagnosis in the Last 7 Days Criteria		
***Active Diagnosis* look back period** Diagnosis that has a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.	***Documented Diagnosis* look back period** A healthcare practitioner documented diagnosis in the last 60 days that has a relationship to the resident's functional status, cognitive status, moor or behavior, medical treatments, nursing monitoring or risk of death during the 7-day look back period.	The monthly recap may be used for diagnosis if it is signed and dated by the physician, nurse practitioner, physician assistant or clinical nurse specialist within the look back period. ADL documentation cannot be used to document active treatment, as all residents receive ADL assistance.
Step 1 Identify diagnosis in the 60-day look back period. **Step 2** Determine diagnosis status: active or inactive in the 7-day look back period.		

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
I2000 Pneumonia **(60-7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count)	Inflammation of the lungs; most commonly of bacterial or viral origin. An active physician diagnosis must be present in the medical record. **Does NOT include:** • A hospital discharge note referencing pneumonia during a hospitalization.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of pneumonia within the observation period is required. Documentation of **current (within 7-day look back period)** treatment of diagnosis must be present in the medical record. X-ray report signed by radiologist may be used to confirm diagnosis.
I2100 Septicemia **(60-7-day look back)**	-Clinically Complex (Contributes to ES count)	Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted provided the physician has documented the septicemia diagnosis in the resident's clinical record. Urosepsis is not considered for MDS review verification. **Does NOT include:** • A hospital discharge note referencing septicemia during hospitalization.	Physician, nurse practitioner, physician assistant or clinical nurse specialist documentation of specific diagnosis of septicemia within the observation period is required. Documentation of **current (within 7-day look back period)** treatment of diagnosis must be present in the medical record.
I2900 Diabetes Mellitus **(60-7-day look back)**	-Clinically Complex (Contributes to ES count)	An active physician documented diagnosis must be present in the medical record.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. May include diet controlled diabetes.
I4300 Aphasia **(60-7-day look back)**	-Special Care (Contributes to ES count)	A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e. speaking, writing) or understanding spoken or written language. Includes aphasia due to CVA.	Diagnosis can be accepted from the monthly order recap it the recap is signed and dated by the healthcare practitioner within the observation period and the documentation of active treatment involved which would indicate the resident does have aphasia.
I4400 Cerebral Palsy **(60-7-day look back)**	-Special Care (Contributes to ES count)	Paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.

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I4900 Hemiplegia/ Hemiparesis **(60-7-day look back)**	-Clinically Complex (Contributes to ES count)	Hemiplegia/hemiparesis: Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism or tumor.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated. Right or left sided weakness or CVA will not be accepted for this item.
I5100 Quadriplegia **(60-7-day look back)**	-Special Care (Contributes to ES count)	Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.)	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
I5200 Multiple Sclerosis (MS) **(60-7-day look back)**	-Special Care (Contributes to ES count	Chronic disease affecting the central nervous system with remissions and relapses of weakness, paresthesia, speech and visual disturbances.	Diagnosis can be accepted from the monthly order recap if the recap is signed and dated by the healthcare practitioner within the observation period and the diagnosis is being treated.
JI550A Fever **(7-day look back)**	-Special Care (Contributes to ES count)	The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. • Fever of 2.4 degrees above the baseline. • A baseline temperature established prior to the observation period. • A temperature of 100.4 on admission is a fever.	Documentation of specific occurrences of fever in the observation period. A baseline temperature must be established and documented prior to the observation period for comparison.
JI550B Vomiting **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of regurgitation of stomach contents, may be caused by many factors (e.g. drug toxicity, infection, psychogenic).	Documentation of vomiting in the observation period including description of vomitus (type and amount).
JI550C Dehydrated **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count)	Documentation does require two or more of the three dehydration indicators. **Does include:** • Usually takes in less than 1500cc of fluid daily. One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc. • Fluid loss that exceeds intake daily. **Does NOT include:** • A hospital discharge note referencing dehydration during hospitalization unless two of the three dehydration indicators are present and documented. • A diagnosis of dehydration.	Documentation of signs of dehydration in the observation period.

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JI550D Internal Bleeding **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of frank or occult blood. • Black, tarry stools. • Vomiting "coffee grounds." • Hematuria. • Hemoptysis • Severe epistaxis (nosebleed) requires packing. **Does NOT include:** • Nosebleeds that are easily controlled, menses or UA with a small amount of red blood cells.	Documentation of specific occurrences on internal bleeding in the observation period including description.
K0300 Weight Loss **(30- and 180-day look back)**	-Special Care (Contributes to ES count)	Documentation that compares the resident's weight in the current observation period with his/her weight at two snapshots in time. • Weight loss of 5% a point closest to 30 days preceding current observation period. • Weight loss of 10% at a point closest to 180 days preceding current observation period. Mathematically round weights prior to completing the weight loss calculation. Physician prescribed weight loss regimen is a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie restricted diet or other weight loss diets and exercise. Also includes planned dieresis for weight loss. It is important that weight loss is intentional.	Must have a documented weight within the current observation period (within 30 days of ARD) for comparison. Documentation, including dates with weights and prescribed diet if applicable are required.
K0510A either as not a resident (1) or as a resident (2) Parenteral/IV Feeding	-Extensive Services -ADL Score	Documentation of IV administration (while a resident or while not a resident) for nutrition or hydration. **Does include:** • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently. • IV at KVO (keep vein open). • IV fluids contained in IV Piggybacks. • Hypodermoclysis and sub-Q ports in hydration therapy. • IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. **The following items are NOT to be coded in K0510A:** • IV medications – **Code these when appropriate in O0100H, IV Medications.** • IV fluids used to reconstitute and/or dilute medications for IV administration.	Documentation of parenteral/IV administration during the observation period which may include medicine administration records (MARs) and treatment records. For fluids given while not a resident, facility records are required with amounts administered.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		• IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • IV fluids administered during chemotherapy or dialysis	
K0510B either 1 or 2 Feeding Tube **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	Documentation of any type of feeding tube for nutrition and hydration while a resident or while not a resident. • Documentation of any type of tube that can deliver food/nutritional substance directly into the GI system **Does include:** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes.	Presence of the feeding tube is sufficient to code this item.
K0710A Calorie intake through parenteral or tube feeding **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	Documentation must support the proportion of all calories actually received for nutrition or hydration through parenteral or tube feeding. **For residents receiving PO nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include:** • Total calories from parenteral route. • Total calories from tube feeding route. • Calculation used to find percentage of calories consumed by artificial routes.	Dietary notes can be used to support MDS coding.
K0710B Average Fluid Intake Intake by IV or tube feeding **(7-day look back)**	-Special Care -Clinically Complex (Contributes to ES count) -ADL Score	Documentation must support average fluid intake per day by IV and/or tube feeding. This is calculated by reviewing the intake records, adding the total amount of fluid received each day by IV and/or tube feedings only. Divide the week's total fluid intake by the number of days in the observation period. This will provide the average fluid intake per day.	Dietary notes may be used to support MDS coding. Documentation to include evidence of the average fluid intake per day by IV or tube feeding during the entire seven days' observation period. Refers to the actual amount of fluid the resident received by these modes (not the amount ordered).
M0300A **No. of Stage 1** **M0300B1** **No. of Stage 2** **M0300C1** **No. of Stage 3**	-Special Care (Contributes to ES count)	Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed. • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured. • Description of the ulcer including the stage. **Does NOT include:** • Reverse staging. • Pressure ulcers that are healed before the look back period (these are coded at M0900).	Documentation must indicate the number of pressure ulcers on any part of the body observed during the observation period. Pressure ulcer staging must be clearly defined by description and/or measurement in order to support MDS coding during the observation period Documentation must include date, clinician signature, and credentials.

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M0300D1 **No. of Stage 4** **M0300F1** **No. of unstageable** **(7-day look back)**		• Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured.	
M1030 No. of Venous/Arterial Ulcers **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Venous Ulcers: Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus above the inner or outer ankle, or on the lower calf area of the leg. Arterial Ulcers: Ulcers caused by peripheral artery disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.	Documentation must indicate the number of venous or arterial ulcers observed during the observation period. Documentation must include date, clinician signature and credentials.
M1040A Infection of the foot **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of signs and symptoms of infection of the foot. **Does include:** • Cellulitis. • Purulent drainage. **Does NOT include:** • Ankle problems. • Pressure ulcers coded in M0300-M0900.	Documentation of signs and symptoms of infection of the foot must be present in the medical record to support the MDS coding. Documentation to include description and location of the infection. Documentation must include date, clinician signature and credentials.
M1040B Diabetic foot ulcer **M1040C** Other open lesion on the foot **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of signs and symptoms of foot ulcer or lesions. • Description of foot ulcer and/or open lesions such as location and appearance. **Does NOT include:** • Pressure ulcers coded in M0300-M0900. • Pressure ulcers that occur on residents with diabetes mellitus.	Documentation of sign and symptoms of foot ulcer or other lesion on the foot must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature and credentials.
M1040D Open lesions other than ulcers, rashes, cuts **(7-day look back)**	-Special Care (Contributes to ES count)	**Does include:** • Skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. • Description of the open lesion such as location and appearance • Documentation in the care plan. **Does NOT include:** • Pressure ulcers coded in M0300-M0900. • Skin tears, cuts, abrasions.	Documentation of signs and symptoms of open lesion other than ulcers, rashes or cuts must be present in the medical record to support the MDS coding. Documentation must include date, clinician signature and credentials. RAI manual examples are not all inclusive, other lesions will be considered for inclusion in this item (i.e. shingles lesions or weeping wounds).
M1040E Surgical Wounds	-Special Care (Contributes to ES count)	**Does include:** • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage site on any part of the body.	Documentation of a surgical wound must be present in the medical record to support the MDS coding during the observation period.

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(7-day look back)		• Pressure ulcers that are surgically repaired with grafts and flap procedures. • Description of the surgical wound such as location and appearance. **Does NOT include:** • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure. • PICC sites, central line sites, IV sites • Pressure ulcers that have been surgically debrided.	Cannot be coded after the site is healed even though cleansing and a dressing may still be applied (example healed stoma or G-tube site). Documentation must include date, clinician signature and credentials.
M1040F Burns **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation to include a description of the appearance of the second or third-degree burns. **Does include:** • Second or third-degree burns only; may be in any stage of healing. • Skin and tissue injury caused by heat or chemicals. **Does not include:** • First-degree burns (changes in skin color only).	Documentation of signs and symptoms of second and third-degree burns must be present in the medical record to support MDS coding during the observation period. Documentation must include date, clinician signature and credentials.
M1200A Pressure Relieving Device/Chair **M1200B** Pressure Relieving Device/Bed **(7-day look back)**	-Special Care (Contributes to ES count)	Equipment aimed at relieving pressure away from areas of high risk. **Does include:** • Foam, air, water, gel or other cushioning. • Pressure relieving, reducing, redistributing devices. **Does NOT include:** • Egg crate cushions of any type. • Doughnut or ring devices.	Documentation and/or description of pressure relieving, reducing or redistributing devices in the medical record to support MDS coding during the observation period. Each device must be documented separately (e.g. "Pressure relieving for chair/bed" will not be accepted). Use of the device must be noted in the medical record at least on time during the observation period. Additionally, the term "pressure relieving," "pressure reducing" or "pressure redistributing" needs to be verifiable through manufacture documentation and available upon request by the review team.
M1200C Turning/repositioning program	-Special Care (Contributes to ES count)	The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. reposition on side, pillows between knees), and frequency (e.g. every two hours). Progress notes, assessments and other documentation (as directed by facility policy), should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.	"Program" is defined as a specific approach that is organized, planned, documented, monitored and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. The goals of the program must be measurable and must occur a minimum of seven days per week.

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(7-day look back)			Evaluation by a licensed nurse during the observation period is required: Co-signing by the nurse will not be accepted. Documentation must be specific if the program is for maintenance or improvement and must include a description of the resident's response to the program within the observation period. Does not include: "Standard of Care Statement," (i.e. two hour turning).
M1200D Nutrition/hydration intervention to manage skin problems **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of dietary intervention(s) to prevent or treat specific skin conditions. • Description of specific skin condition. **Does include:** • Vitamins and/or supplements.	Nutrition and/or hydration interventions for the purpose of preventing or treating specific skin conditions (i.e. wound healing) ONLY. The MAR's must note that the medication, vitamin or supplement is for treatment of a skin condition to support MDS coding of this item.
M1200E Pressure Ulcer Care **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation to include any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at each Stage (M0300 A-G). **Does include:** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT). • Hydrotherapy.	Documentation of pressure ulcer treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.
M1200F Surgical Wound Care **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation to include any intervention for treating or protecting any type of surgical wound. **Does include:** • Topical cleaning. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. **Does NOT include:** • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer. • The observation of the surgical wound.	Documentation of surgical wound treatment must include intervention, date and clinician signature with credentials in the medical record to support MDS coding.

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M1200G Application of non-surgical dressings; other than to the feet **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. **Does include:** • Dressing application even once. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydro active particles. **Does NOT include:** • Dressing application to the ankle. • Dressing for pressure ulcer on the foot.	Documentation of application of non-surgical dressing to body part other than the feet must include dressing type, date and clinician signature with credentials in the medical record to support MDS coding.
M1200H Application of ointments/medications other than to the feet **(7-day look back)**	-Special Care (Contributes to ES count)	Documentation of application of ointment/medications **(used to treat or prevent a skin condition)** other than to the feet. **Does include:** • Topical creams. • Powders. • Liquid sealants.	Documentation of application of ointment/medication used to treat or prevent a skin condition other than to the feet must include product, date and clinician signature with credentials in the medical record to support MDS coding.
M1200I Application of dressings (feet) **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation of dressing changes to the feet (with or without topical medication). • Interventions to treat any foot wound or ulcer other than a pressure ulcer.	Documentation of intervention to treat any foot wound or ulcer other than a pressure ulcer must include treatment, date and clinician signature with credentials in the medical record to support MDS coding.
N0300 Injections **(7-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation includes the number of days that the resident received any medication, antigen, vaccine, etc., by subcutaneous, intramuscular or intradermal injection while resident is in facility. **Does include:** • Subcutaneous pumps, only the number of days that the resident actually required a subcutaneous injection to restart the pump. • Insulin injections.	Documentation of number of days injections given must include clinician signature and credentials in the medical record to support MDS coding. Source document for this item may include MAR and/or Diabetic administration flow sheet.
O100A, either as not a resident (1) or as a resident (2) Chemotherapy **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation to include the administration of any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment.	Documentation of chemotherapy administration, including MAR, while a resident or while not a resident must include date, clinician signature and credentials. Administration Record from the treating facility is required with date, clinician's signature/credentials in the medical record to support MDS coding.

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O0100B, either as not a resident (1) or as a resident (2) Radiation **(14-day look back)**	-Special Care (Contributes to ES count)	**Does include:** • Intermittent radiation therapy. • Radiation administered via radiation implant. • A nurse's note that resident went out for radiation treatment will be sufficient if there is a corresponding physician order.	Administration Record from the treating facility is required with date and clinician's signature/credentials in the medical record to support MDS coding.
O0100C, either as not a resident (1) or as a resident (2) Oxygen Therapy **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include the administration of oxygen. • The administration of oxygen continuously or intermittently via mask, cannula, etc. • Code when used in BiPAP/CPAP **Does NOT include:** • Hyperbaric oxygen for wound therapy.	Documentation of oxygen therapy while a resident or while not a resident with liter flow with date and signature/credentials of clinician/staff in the medical record to support MDS coding.
O0100D, either as not a resident (1) or as a resident (2) Suctioning **(14-day look back)**	-Extensive Services	Documentation of **ONLY** nasopharyngeal or tracheal suctioning. • Nasopharyngeal suctioning. • Tracheal suctioning. **Does NOT require:** • Oral suctioning.	Documentation of suctioning while a resident or while not a resident with signature/credentials of clinician in the medical record to support MDS coding.
O0100E, either as not a resident (1) or as a resident (2) Tracheostomy Care **(14-day look back)**	Extensive Services	Documentation of tracheostomy and/or cannula cleansing. **Does include:** • Changing a disposable cannula.	Documentation of treatment while a resident or while not a resident with signature/credentials of clinician in the medical record to support MDS coding.
O0100F, either as not a resident (1) or as a resident (2) Ventilator or Respirator	-Extensive Services	Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support devices. **Does include:** • Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days. **Does NOT include:** • CPAP or BiPAP in this field.	Documentation of ventilator use while a resident or while not a resident with the date and signature/credentials of clinician in the medical record to support MDS coding.
O0100H, either as not a resident (1) or as a resident (2) IV Medication	-Extensive Services	Documentation of IV medication by push, epidural pump or drip administration through a central or peripheral port. **Does include:** • Any drug or biological (contrast material). • Epidural, intrathecal and Baclofen pumps. • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids. **Does NOT include:** • Saline or heparin flush to keep a heparin lock patent, or IV fluids without medications. • Subcutaneous pumps.	Documentation of IV medication administration must include signature/credentials of clinician in the medical record to support MDS coding.

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(14-day look back)		• IV medications administered only during chemotherapy of dialysis.	
O0100I, either as not a resident (1) or as a resident (2) Transfusions **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include transfusions of blood or any blood products administered directly into the blood stream. **Does NOT include:** • Transfusions administered during dialysis or Chemotherapy.	Documentation must include product infused and signature/ credentials of clinician in the medical record to support the MDS coding.
O0100J, either as not a resident (1) or as a resident (2) Dialysis **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. **Does include:** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). **Does NOT include:** • IV, IV medication and blood transfusion during dialysis.	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. Administration Record from the treating facility is required with date and clinician's signature/credentials in the medical record to support MDS coding.
O0400A, 1, 2 & 3 **O0400B, 1, 2 & 3** **O0400C, 1, 2 & 3** Therapy minutes	-Rehabilitation **Individual therapy** -Treatment of one resident at a time **Concurrent therapy** -Treatment of two residents at the same time in line-of-sight for Part A only. Residents may not be treated concurrently for Part B – instead report under Group therapy. **Group therapy** -Treatment of two or four residents at the same time – Part A only. -Treatment of two or more residents at the same time – Part B only.	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. • Only therapy provided while a resident in the facility. • Skilled therapy ONLY. • Physician order, treatment plan and assessment. • Actual therapy minutes ONLY. • Time provided for each therapy must be documented separately. **Does include:** • Subsequent reevaluations. • Set-up time. • Co-treatment when minutes are split between disciplines and do not exceed the total time. • Therapy treatment inside or outside the facility. **Does NOT include:** **Therapy services not medically reasonable and necessary.** • Therapy provided prior to admission. • Initial evaluation. • Conversion of units to minutes. • Rounding to the nearest 5th minute. • Therapy services that are not medically reasonable and necessary. • Therapy provided as restorative nursing.	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical chart on a daily basis to support the total number of minutes of direct therapy provided. Includes: • Only therapy provided while a resident in the facility. • Skilled therapy ONLY. • Therapy that is physician ordered, treatment planned and assessed. • Actual therapy minutes ONLY. • Time provided for each therapy must be documented separately. **Accepted documentation for therapy minutes can only be the computer-generated therapy log/grid that is submitted for billing to CMS.**

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(7-day look back)		• Services provided by aides. • Services provided by a speech-language pathology assistant.	
O0400A4 **O0400B4** **O0400C4** Therapy days **(7-day look back)**	-Rehabilitation	Documentation of direct therapy days with associated initials/ signature(s) to be cited in the medical chart on a daily basis to support the total number of days of direct therapy provided. • Treatment for 15 minutes or more during the day. **Does NOT include:** • Treatment for less than 15 minutes during the day.	Documentation includes number of days and signature/ credentials of clinician in medical record to support MDS coding. **Accepted documentation for therapy minutes can only be the computer-generated therapy log/grid that is submitted for billing to CMS.**
O0400D, 2 Respiratory Therapy days **(7-day look back)**	-Special Care (Contributes to ES count)	**A day of therapy is defined as 15 minutes or more of treatment in a 24-hour period.** **Does include:** • Subsequent reevaluation time. • Set-up time. **Does NOT include:** • Therapy provided prior to admission. • Time spent on documentation or initial evaluation. • Conversion of units to minutes. • Rounding to the nearest 5th minute. • Therapy services that are not medically necessary. Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse.	Documentation of therapy days with associated initials/signature(s) to be cited in the medical record on a daily basis to support MDS coding. • Only therapy provided while a resident in the facility. • Therapy must be physician ordered, treatment planned, and assessed. Oxygen on its own is not a respiratory therapy.
O500A-J Restorative Nursing Programs	-Rehabilitation -Impaired Cognition -Behavior Problems -Reduced Physical Functions	Documentation must include the five criteria to meet the definition of a restorative nursing program: • Measurable objectives and interventions must be documented in the care plan and in the medical record. • Evidence of periodic evaluation by a licensed nurse must be present in the resident's medical record. Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period. • Staff must be trained in the proper techniques to promote resident involvement in the activity. • Restorative nursing program activity must be supervised by an RN or LPN. No more than four residents per supervising staff personnel.	"Program is defined as a specific approach that is organized, planned, documented, monitored and evaluated by a licensed nurse (not co-signed) and provided during the observation period based on an assessment of the resident's needs. Evaluation must include statement if program should be continued, discontinued or changed. All components must be present to support MDS coding. Program validation must include initials/signature(s) on a daily basis to support the total days and minutes of nursing restorative programs provided. Evaluation by a licensed nurse is required within the observation period.

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
(7-day look back)		****When residents are part of a group, provide documentation to identify the group, program, minutes and initials of person providing program.** **Does NOT require:** Physician orders.	Includes: • Days for which 15 or more minutes of restorative nursing was provided within a 24-hour period for a minimum of six days. • Time provided for each restorative program must be documented separately. MDS review staff may ask to review the training records of the facilities restorative program staff. When residents are part of a group, provide documentation to identify the number of residents in the group and how many staff members are assisting. At least one staff member must be a Restorative Nursing Assistant (RNA) or licensed staff person.
O0600 Physician examination **(14-day look back)**	-Clinically Complex (Contributes to ES count)	Documentation must include evidence of an exam by the physician or other authorized practitioners. **Record the number of days that a physician progress note reflects that a physician examined the resident (or since admission if less than 14 days ago).** **Does include:** • Partial or full exam in facility or in physician's office. **Does NOT include:** • Exams conducted prior to admission or readmission. • Exams conducted during an ER visit or hospital observation stay. • Exam by a Medicine Man.	Document the number of days a physician or other authorized practitioner examined the resident. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners or clinical nurse specialists working in collaboration with the physician.
O0700 Physician orders **(14-day look back)**	-Clinically Complex (Contributes to ES count)	**Does include:** • Written, telephone, fax or consultation orders for new or altered treatment. • Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. **Does NOT include:** • Standard admission orders, return admission orders, renewal orders or clarifying orders without changes. • Activation of a PRN order already on file. • Monthly Medicare certification. • Orders written by a pharmacist. • Orders for transfer of care to another physician.	Document the number of days a physician or other authorized practitioner changed the resident's orders. Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners or clinical nurse specialists working in collaboration with the physician. Does not include sliding scale dose change based on guidelines already ordered.

Review Procedures

Supporting Documentation Related to the MDS/Case Mix Documentation Review:

a. Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction within the observation period.

b. A quarterly, annual or summary note will not substitute for documentation which is date specific to the to the observation period.

c. Improper or illegible corrections will not be accepted for the MDS case mix documentation review.

d. All documentation, including corrections, must be part of the original legal medical record.

e. Any and all MDS coding and interpretation questions shall be referred to the local State RAI Coordinator.

f. Late entry documentation more than 72 hours from the ARD will not be accepted.

Signature Date at Z0400:

a. Interview items (BIMS and PHQ-9) must be conducted during the observation periods stated in the RAI Manual and the signature date entered at Z0400 must be prior to or on the ARD.

b. The signature date for these interview items entered at Z0400 must match the date the interview was actually conducted in the medical records. If these dates do not match, facility will not receive credits for these interview items due to conflicting documentation.

c. In the rare situation that interview items were collected (completed) by two people or by the same person but on different dates, (e.g. half of the interview questions were conducted on the next day), each person must enter the signature date at Z0400 and indicate specific interview questions conducted (e.g. D0200 2.A through D; D0200 2.E through I and D0300) in sections.

d. The definition of “date collected” and “date completed” date information was collected and coding decision were made. They are one, the same date. This is not the same as the data entry date.

Electronic Health Records (EHR)

a. The facility must grant access to requested medical records in a read-only or other secure format.

b. The facility is responsible for ensuring data backup and security measures are in place.

c. Access to HER must not impede the review process.

d. Medicaid recipients must have their PASRR and LOC in the active EHR.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 31, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES Casey Angres (Feb 13, 2023 11:00 PST)
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter–600 are being proposed to include up to two additional reimbursable doula visits to encourage doulas to navigate recipients to prenatal/antepartum and/or oral health care during pregnancy.

Entities Financially Affected: Special Clinics (PT 17), Physicians (PT 20), Dentists (PT 22) Advanced Practice Registered Nurses (PT 24), Nurse Midwives (PT 74), Physician Assistants (PT 77), and Doulas (PT 90).

Financial Impact on Local Government: An estimated increase in annual aggregate expenditure.

SFY 2024: $11,946
SFY 2025: $11,656.

These changes are effective February 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 01/23 MSM 600 – Physician Services	MTL 08/22 MSM 600 – Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.4E(2)(c)(3)	**Doula Services**	Added doulas may receive reimbursement for one additional doula visit if the recipient has received two prenatal/antepartum visits.
603.4E(2)(c)(4)	**Doula Services**	Added doulas may receive reimbursement for one additional doula visit if the recipient has received any dental service during the prenatal/antepartum period.

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PHYSICIAN SERVICES

DIVISION OF HEALTH CARE FINANCING AND POLICY

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600 INTRODUCTION

The Nevada Medicaid Program is dependent upon the participation and cooperation of Nevada providers and other licensed professionals who provide health care to Medicaid recipients. Licensed professionals providing services within the scope of their license are recognized by Nevada as independently contracted Medicaid providers. The policy in this chapter is specific to the following identified health care professionals:

A. Advanced Practice Registered Nurse APRN;

B. Certified Registered Nurse Anesthetists (CRNA);

C. Chiropractors (DC);

D. Nurse Midwives (NM);

E. Emergency Medical Technicians, Advanced Emergency Medical Technicians, and Paramedics with community paramedicine endorsement;

F. Physicians (M.D. and D.O. including those in a teaching hospital);

G. Physician Assistants (PA/PA-C);

1. Physician Assistants who are employed at a Military Treatment Facility (MTF) and who possess a National Commission on Certification Physician Assistants (NCCPA) certification are considered to be allowable Nevada Medicaid providers. With the NCCPA certification, physician assistants employed at a MTF will not be required to be licensed in the state of practice.

H. Podiatrists (DPM); and

I. Registered Dietitians.

To enroll as a provider for the Division of Health Care Financing and Policy (DHCFP) in the Nevada Medicaid Program, the above listed licensed professionals working within their scope of practice must be authorized by the licensing authority of their profession to practice in the state where the service is performed at the time the state services are provided. Specific service exclusions will be noted in policy.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Services Manual, Chapter 1000.

The DHCFP encourages integrated interventions as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). Please reference Medicaid Services Manual (MSM) Chapter 400, Mental Health and Alcohol and Substance Abuse Services for specific policy.

Disclaimer: The term "Provider" used throughout this chapter is an all-inclusive description relative to the above identified providers working within their respective scope of practice and does not equate one professional to another. It serves only to make the document more reader friendly. A "Primary Care Provider" (PCP) is considered to be a Physician (M.D/D.O.), Advance Practice Registered Nurse (APRN), or Physician Assistant (PA) with a specialty in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or nurse midwifery.

601 AUTHORITY

A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (42 CFR) Part 440, Subparts A and B; and Sections 1929 (a), 1902 (e), 1905 (a), 1905 (p), 1915, 1920, and 1925 of the Social Security Act.

B. Regulations for services furnished by supervising physicians in teaching settings are found in 42 CFR Part 415; Subpart D. Key portion is defined in [Reg. 415.172(a)].

C. The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

1. Section 330 of the Public Health Service (PHS) Act;
2. NRS Chapter 634 – Chiropractic Physicians and Chiropractors' Assistants;
3. NRS Chapter 629 – Healing Arts Generally;
4. NRS Chapter 632 – Nursing;
5. NRS Chapter 630 – Physicians, Physician Assistants, Medical Assistants, Perfusionists and Practitioners of Respiratory Care;
6. NRS Chapter 633 - Osteopathic Medicine;
7. NRS Chapter 635 – Podiatric Physicians and Podiatry Hygienists;
8. NRS Chapter 640E – Registered Dietitians
9. NRS Chapter 450B – Emergency Medical Services;
10. NRS Chapter 449 – Medical Facilities and Other Related Entities;
11. Section 1861 of the Social Security Act;
12. Section 1905 of the Social Security Act;
13. Section 1461 of the Omnibus Budget Reconciliation Act of 1990;
14. Department of Defense 6025.13-R – Military Health System Clinical Quality Assurance Program Regulation;
15. Air Force Instruction 44-119 – Medical Quality Operations.

602 RESERVED

603 PROVIDERS AND LICENSED PROFESSIONAL POLICY

603.1 PROVIDER'S ROLE IN RENDERING SERVICES

603.1A COVERAGE AND LIMITATIONS

1. Nevada Medicaid reimburses for covered medical services that are reasonable and medically necessary, ordered or performed by a physician or under the supervision of a physician, APRN or other licensed health care provider listed in Section 601 – Authority, and that are within the scope of practice of their license as defined by state law. Providers shall follow current national guidelines, recommendations, and standards of care. The provider must:

    a. Examine the recipient;

    b. Make a diagnosis;

    c. Establish a plan of care; and

    d. Document these tasks in the appropriate medical records for the recipient before submitting claims for services rendered. Documentation is subject to review by a state authority or contracted entity.

2. Services must be performed by the provider or by a licensed professional working under the personal supervision of the provider.

    a. The following are examples of services that are considered part of the billable visit when it is provided under the direct and professional supervision of the provider:

        1. An injection of medication;

        2. Diagnostic test like an electrocardiogram (ECG);

        3. Blood pressure taken and recorded;

        4. Dressing changes; and

        5. Topical application of fluoride.

    b. Providers or their designee may not bill Medicaid for services provided by, including and not limited to, any of the following professionals below. All providers must enroll into their designated provider type and bill for the services they provided. Nevada Medicaid will neither accept nor reimburse for professional billing of services or supplies rendered by anyone other than the provider under whose name and provider number the claim is submitted. Refer to MSM Chapter

100, Medicaid Payments to Providers, for additional information regarding incident-to billing.

1. Another Provider;
2. Psychologist;
3. Medical Resident (unless teaching physician);
4. Therapist, including Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (SP), Respiratory Therapist (RT);
5. Counselor/Social Worker;
6. Advanced Practice Registered Nurse (APRN) (other than diagnostic tests done in the office which must be reviewed by the physician);
7. Physician Assistants (PA/PA-C);
8. Certified Registered Nurse Anesthetist (CRNA);
9. Pharmacist;
10. Nurse Midwife (NM);
11. Emergency Medical Technician, Advanced Emergency Medical Technician, and Paramedic with community paramedicine endorsement; or
12. Any other provider that has a designated Nevada Medicaid provider type.

3. Teaching Physicians

Medicaid covers teaching physician services when they participate in the recipient's care. The teaching physician directs no more than four residents at any given time and is in such proximity as to constitute immediate availability. The teaching physician's documentation must show that he or she either performed the service or was physically present while the resident performed the key and critical portions of the service. Documentation must also show participation of the teaching physician in the management of the recipient and medical necessity for the service. When choosing the appropriate procedure code to bill, consideration is based on the time and level of complexity of the teaching physician, not the resident's involvement or time.

Nevada Medicaid follows Medicare coverage guidelines for Teaching Physicians, Interns, and Residents including the exceptions as outlined by Medicare's policy.

4. Out-of-State Providers

   a. If a prior authorization is required for a specific outpatient or inpatient service in-state, then a prior authorization is also required for an out-of-state outpatient or inpatient service by the Nevada Medicaid Quality Improvement Organization (QIO)-like vendor. Conversely, if a prior authorization is not required for a service in-state (i.e. office visit, consultation), then a prior authorization is not required for the same service out-of-state. Refer to MSM Chapter 1900, Transportation Services, for out-of-state transportation policy. The QIO-like vendor's determination will consider the availability of the services within the State. If the recipient is being referred out-of-state by a Nevada provider, the Nevada provider is required to obtain the prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.

   b. When in-state medical care is unavailable for Nevada recipients residing near state borders (catchment areas) the contiguous out-of-state provider/clinic is considered the Primary Care Provider (PCP). All in-state benefits and/or limitations apply.

   c. All servicing providers must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. See MSM Chapter 100, Medicaid Program.

5. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

   The EPSDT program provides preventive health care to recipients under the age of 21 years old who are eligible for medical assistance. The purpose of the EPSDT program is the prevention of health problems through early detection, diagnosis, and treatment. The required screening components for an EPSDT examination are to be completed according to the time frames on a periodicity schedule that was adopted by the American Academy of Pediatrics and the DHCFP. See MSM Chapter 1500, Healthy Kids Program.

6. Federal Emergency Services Program (also known as Emergency Medicaid Only)

   Professional services provided to an alien/non-citizen may be covered if the condition meets the definition provided in Section 1903(v)(1-3) of the SSA, 42 CFR 440.255 and NRS 422.065. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for policy details.

603.2 PROVIDER OFFICE SERVICES

Covered services are those medically necessary services when the provider either examines the patient in person or is able to visualize some aspect of the recipient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of X-rays, electrocardiogram (ECG) and electroencephalogram (EEG) tapes, tissue samples, etc.

Telehealth services are also covered by Nevada Medicaid. See MSM Chapter 3400, Telehealth Services for the complete coverage and limitations for Telehealth.

A. Consultation Services

A consultation is a type of evaluation and management service provided by a provider and requested by another provider or appropriate source, to either recommend care for a specific condition or problem or determine whether to accept responsibility for ongoing management of the patient's entire care. A consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for consult may be made by a provider or other appropriate source and documented in the patient's medical record by either the consulting or requesting provider or appropriate source. The consultant's opinion and any services that are ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting provider or appropriate source. When a consultant follows up on a patient on a regular basis or assumes an aspect of care on an ongoing basis, the consultant becomes a manager or co-manager of care and submits claims using the appropriate hospital or office codes.

1. When the same consultant sees the same patient during subsequent admissions, the provider is expected to bill the lower-level codes based on the medical records.

2. A confirmatory consultation initiated by a patient and/or their family without a provider request is a covered benefit. Usually, requested second opinions concerning the need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) third opinion will be covered if the first two opinions disagree.

B. New and Established Patients

1. The following visits are used to report evaluation and management services provided in the provider's office or in an outpatient or other ambulatory facility:

   a. Minimal to low level visits - Most patients should not require more than nine office or other outpatient visits at this level by the same provider or by providers of the same or similar specialties in a three-month period. No prior authorization is required.

   b. Moderate visits - Generally, most patients should not require more than 12 office or other outpatient visits at this level by the same provider or by providers of the same or similar specialties in a 12-month calendar year. No prior authorization is required.

c. High severity visits – Generally, most patients should not require more than two office or other outpatient visits at this level by the same provider or by providers of the same or similar specialties in a 12-month period. Any exception to the limit requires prior authorization.

2. Documentation in the patient's medical record must support the level of service and/or the medical acuity which requires more frequent visits and the resultant coding. Documentation must be submitted to Medicaid upon request. A review of requested reports may result in payment denial and a further review by Medicaid's Surveillance and Utilization Review (SUR) Unit.

3. Medicaid does not reimburse providers for telephone calls between providers and patients (including those in which the provider gives advice or instructions to or on behalf of a patient) except documented psychiatric treatment in crisis intervention (e.g. threatened suicide).

4. New patient procedure codes are not payable for services previously provided by the same provider or another provider of the same group practice and same specialty, within the past three years.

5. Some of the procedures or services listed in the Current Procedural Terminology (CPT) code book are commonly carried out as an integral component of a total service or procedure and have been identified by the inclusion of the term "separate procedure". Do not report a designated "separate procedure" in addition to the code for the total procedure or service of which it is considered an integral component. A designated "separate procedure" can be reported if it is carried out independently or is considered to be unrelated or distinct from other procedures/services provided at the same time.

6. Physical therapy administered by a Physical Therapist (PT) on staff or under contract in the provider's office requires a prior authorization before rendering service.

   If the provider bills for physical therapy, the provider, not the PT, must have provided the service.

   A provider may bill an office visit in addition to physical therapy, on the same day in the following circumstances:

   a. A new patient examination which results in physical therapy on the same day;

   b. An established patient with a new problem or diagnosis; and/or

   c. An established patient with an unrelated problem or diagnosis.

Reference MSM Chapter 1700, Therapy for physical therapy coverage and limitations.

7. Provider administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200, Prescribed Drugs for coverage and limitations.

8. Medication-Assisted Treatment (MAT) services provided by a physician, APRN, physician assistant, or nurse midwife with a DATA 2000 waiver are available for recipients who meet medical necessity with an opioid use disorder. Refer to MSM Chapter 3800, Medication-Assisted Treatment for coverage and limitations.

9. Qualifying Clinical Trials (QCTs) policy, refer to Attachment A, Policy #6-01.

10. Non-Covered Provider Services

    a. Temporomandibular Joint (TMJ) related services (see MSM Chapter 1000, Dental).

C. Referrals

When a prior authorization is required for either in-state or out-of-state services, the referring provider is responsible for obtaining a prior authorization from the QIO-like vendor. If out-of-state services are medically necessary, the recipient must go to the nearest out-of-state provider for services not provided in-state. It is also the responsibility of the referring provider to obtain the authorization for a recipient to be transferred from one facility to another, either in-state or out-of-state.

D. Hospice

Adult recipients enrolled in hospice have waived their rights to Medicaid payments for any Medicaid services related to the terminal illness and related conditions for which hospice was elected. Providers should contact the designated hospice provider to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200, Hospice for coverage and limitations.

E. Home Health Agency (HHA)

HHA services provide periodic nursing care along with skilled and non-skilled services under the direction of a qualified provider. The provider is responsible for writing the orders and participating in the development of the plan of care. Reference MSM Chapter 1400, Home Health Agency for coverage and limitations.

F. Laboratory

Reference MSM Chapter 800, Laboratory Services for coverage and limitations for laboratory services.

G. Diagnostic Testing

Reference MSM Chapter 300, Radiology Services for coverage and limitations for diagnostic services.

H. Vaccinations

Vaccinations are a covered benefit for Nevada Medicaid recipients as a preventative health services benefit.

1. Childhood vaccinations: All childhood vaccinations, per the latest recommendations of the Advisory Committee on Immunization Practices (ACIP), are covered without prior authorization under the Healthy Kids Program for children under the age of 21 years old. Refer to MSM Chapter 1500, Healthy Kids Program, for more information on childhood vaccinations.

2. Adult vaccinations: All adult vaccinations, per the latest recommendations of the ACIP, are covered without prior authorization for those 21 years of age or older. Refer to MSM Chapter 1200, Prescribed Drugs, for more information on adult vaccinations.

I. Ordering, Prescribing, and Referring (OPR) Providers

OPR providers do not bill Nevada Medicaid for services rendered, but may order, prescribe, or refer services/supplies for Medicaid recipients.

603.2A AUTHORIZATION PROCESS

Certain provider services require prior authorization. There is no prior authorization requirement for allergy testing, allergy injections or for medically necessary minor office procedures unless specifically noted in this chapter. Contact the QIO-like vendor for prior authorization information.

603.3 FAMILY PLANNING SERVICES

State and federal regulations grant the right for eligible Medicaid recipients of either sex of child-bearing age to receive family planning services provided by any participating clinics, physician, physician assistant, APRN, nurse midwife, or pharmacy.

Females, who are enrolled for pregnancy-related services only, are covered for all forms of family planning, including tubal ligation and birth control implantation up to 60 days post-partum including the entire month in which the 60th day falls.
Abortions (surgical or medical) and/or hysterectomies are not included in Family Planning Services. These procedures are a Medicaid benefit for certain therapeutic medical diagnoses.

Family Planning Services and supplies are for the primary purpose to prevent and/or space pregnancies. Providers shall follow current national guidelines, recommendations, and standards of care, including but not limited to, American College of Obstetricians and Gynecologists (ACOG) and/or U.S. Preventive Services Task Force (USPSTF).

A. Prior authorization is not required for:

1. Provider services.

2. Physical examination.

3. Pap smears.

4. FDA approved birth control drugs and delivery devices/methods, including but not limited to the following:

a. Intrauterine contraceptive device (IUD);

Note: When a woman has an IUD inserted, she may no longer be eligible for Medicaid when it is time to remove the device. There is no process for Medicaid reimbursement when the recipient is not Medicaid-eligible.

b. Birth control pills;

c. Diaphragm/cervical cap;

d. Contraceptive foam and/or jelly;

e. Condoms;

f. Implanted contraception capsules/devices;

Note: When a woman has a contraceptive implant inserted, she may no longer be eligible for Medicaid when it is time to remove the implant. There is no process for Medicaid reimbursement when the recipient is not Medicaid-eligible.

g. Contraceptive injections;

Note: If contraceptive injections are administered in the providers office, the provider may bill for the drug itself with a National Drug Code (NDC) and the intramuscular administration CPT code. Refer to MSM Chapter 1200, Prescribed Drugs for Outpatient Pharmaceuticals.

h. Vaginal contraceptive suppositories;

i. Contraceptive dermal patch;

j. Contraceptive ring and/or other birth control methods.

5. Vasectomy or tubal ligation (age 21 years or over). In accordance with federal regulations, the recipient must fill out a sterilization consent form at least 30 days prior to the procedure. The provider is required to send the consent form to the fiscal agent with the initial claim. See the QIO-like vendor website to access the FA-56 Sterilization Consent Form which is also the HHS-687 form.

B. Medicaid has removed all barriers to family planning counseling/education provided by qualified providers (e.g. Physicians, Physician Assistants, APRN, Nurse Midwife, Rural Health Clinics, Federally Qualified Health Centers, Indian Health Programs, etc.). The provider must provide adequate counseling and information to each recipient when they are choosing a birth control method. If appropriate, the counseling should include the information that the recipient must pay for the removal of any implants when the removal is performed after Medicaid eligibility ends.

C. Family planning education is considered a form of counseling intended to encourage children and youth to become comfortable discussing issues such as sexuality, birth control and prevention of sexually transmitted disease. It is directed at early intervention and prevention of teen pregnancy. Family planning services may be provided to any eligible recipient of childbearing age (including minors who may be considered sexually active).

D. Insertion of Long-Acting Reversible Contraceptives (LARC) immediately following delivery is a covered benefit for eligible recipients. LARC insertion is a covered benefit post discharge as medically necessary.

E. Family Planning Services are not covered for those recipients, regardless of eligibility, whose age or physical condition precludes reproduction.

F. A pelvic exam or pap smear is not required for self-administered birth control.

603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, labor and delivery, and postpartum care provided by a physician, physician assistant, APRN, and/or a nurse midwife. Maternity care services can be provided in the home, office, hospital, or freestanding birthing center settings. All maternity care providers are allowed to provide services within all settings that are allowed per their scope of practice and licensure.

Provider shall follow current national guidelines, recommendations, and standards of care for maternity care services, including but not limited to, USPSTF, ACOG, Society of Maternal-Fetal Medicine, and the American College of Nurse Midwives.

Per NRS 449.0155 "Freestanding Birthing Center" means a facility that is not part of a hospital and provides services for normal, uncomplicated births. Nevada Administrative Code (NAC) regulations for Freestanding Birthing Centers are located in NAC 449.6113 – 449.61178. Please also refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-01, Freestanding Birthing Centers.

For women who are eligible for pregnancy-related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the entire month in which the 60th day falls. She is eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21 years old, and eligible for pregnancy only, are not entitled to EPSDT services.

It is the responsibility of the treating provider to employ a care coordination mechanism to facilitate the identification and treatment of high-risk pregnancies. "High-Risk" is defined as a probability of an adverse outcome to the woman and/or her baby greater than the average occurrence in the general population. Home and freestanding birthing center births and corresponding pregnancy services are appropriate for recipients with low-risk pregnancies, intended vaginal delivery, and no reasonably foreseeable expectation of complication. Recipients that are eligible for Freestanding Birthing Center services is outlined in NAC 449.61134. If assessments suggest the likelihood of complications that could make the delivery high-risk, then services will be reimbursed when provided by a provider in the hospital setting.

For those females enrolled in a managed care program, the Managed Care Organization (MCO) physicians are responsible for making referrals for early intervention and case management activities on behalf of those women. Communication and coordination between the MCO physicians, service physicians, and MCO staff is critical to promoting optimal birth outcomes.

603.4A STAGES OF MATERNITY CARE

1. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery totaling approximately 13 routine visits. Any other visits or services within this time period for non-routine maternity care should be coded separately. Non-emergency antepartum care is not a covered benefit for non-U.S. citizens/aliens who have not lawfully been admitted for permanent residence in the United States or permanently residing in the United States under the color of the law. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for allowable services to non-U.S. citizens.

2. Labor and delivery services include home delivery, admission to the hospital, or freestanding birthing center, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without an episiotomy/operative delivery (vacuum or forceps)), or cesarean delivery in hospital setting. Medical problems complicating labor and delivery management may require additional resources and should be billed utilizing the CPT codes in the Medicine and Evaluation and Management Services sections in addition to codes for maternity care.

   a. In accordance with standard regulations, vaginal deliveries with a hospital stay of three days or less and cesarean-section deliveries with a hospital stay of four days or less do not require prior authorization. Reference MSM Chapter 200, Hospital Services for inpatient coverage and limitations.

   b. Non-Medically Elective Deliveries

      1. Reimbursement for Avoidable Cesarean Section

         To make certain that cesarean sections are being performed only in cases of medical necessity, Nevada Medicaid will reimburse providers for performing cesarean sections only in instances that are medically necessary and not for the convenience of the provider or patient. Elective cesarean sections must be prior authorized and will be reimbursed at the vaginal delivery rate.

      2. Early Induction of Labor (EIOL)

         Research shows that early elective induction (<39 weeks gestation) has no medical benefit and may be associated with risks to both the mother and infant. Based upon these recommendations, Nevada Medicaid will require prior authorization for hospital admissions for EIOL prior to 39 weeks to determine medical necessity.

         Nevada Medicaid encourages providers to review the "Early Elective Deliveries Toolkit" compiled by the March of Dimes, the California Maternity Quality Care Collaborative, and the California Department of Public Health, Maternal, Child and Adolescent Health Division at http://www.cmqcc.org/resources-tool-kits/toolkits/early-elective-deliveries-toolkit. The aim of the toolkit is to offer guidance and support to providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

      3. Progesterone therapy to prevent preterm birth.

Preterm birth is determined when a baby is born prior to 37 weeks of pregnancy. Women who have a history of preterm birth are at greater risk of future preterm births. Progesterone therapy is a hormone therapy designed to prevent the onset of preterm birth.

Nevada Medicaid covers services related to the prevention of preterm birth. Progesterone therapies are initiated between 16 and 20 weeks of pregnancy, with weekly injections until 37 weeks.

Please see PT 20, 24, 74, and 77 Billing Guides for specific coverage and limitations.

c. Provider responsibilities for the initial newborn examination and subsequent care until discharge includes the following:

1. The initial physical examination done in the home, freestanding birthing center, or hospital delivery room is a rapid screening for life threatening anomalies that may require immediate billable attention.

2. Complete physical examination is done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized. This examination is billable.

3. Brief examinations should be performed daily until discharge. On day of discharge, provider may bill either the brief examination or discharge day code, not both.

4. Routine circumcision of a newborn male is a Medicaid benefit for males up to one year of age. For males older than one year of age, a prior authorization is required to support medical necessity.

5. If a newborn is discharged from a hospital or freestanding birthing center less than 24 hours after delivery, Medicaid will reimburse newborn follow-up visits in the provider's office or recipient's home up to four days post-delivery. This is also allowable for all home births.

6. All newborns must receive a hearing screen in accordance with NRS 442.540 and corresponding NAC 442.850. This testing and interpretation are included in the facility per diem rate. Hearing screening is not required if parent or legal guardian objects in writing. If a baby is born in the home setting, the nurse midwife may not have the necessary equipment to conduct the hearing screen. Therefore, a referral can be made to a hearing specialist.

7. All newborns must receive a newborn screening blood analysis in accordance with NRS 442.008 and corresponding NAC 442.020 – 442.050.

This testing is included in the facility per diem rate. Newborn screening is not required if parent or legal guardian objects in writing.

3. Postpartum care includes hospital, office visits, and home visits following vaginal or cesarean section delivery. Women, who are eligible for Medicaid on the last day of their pregnancy, remain eligible for all pregnancy related and postpartum medical assistance including family planning education and services for 60 days immediately following the last day of pregnancy, including the entire month in which the 60th day falls. Pregnancy related only eligible women are not covered for any Medicaid benefits not directly related to their pregnancy.

4. Reimbursement: If a provider provides all or part of the antepartum and/or postpartum care but does not perform delivery due to termination of the pregnancy or referral to another provider, then reimbursement is based upon the antepartum and postpartum care CPT codes. A global payment will be paid to the delivering provider, when the pregnant woman has been seen seven or more times by the delivering provider. If the provider has seen the pregnant woman less than seven times with or without delivery, the provider will be paid according to the Fee-for-Service (FFS) visit schedule using the appropriate CPT codes. For MCO exceptions to the global payment please refer to MSM Chapter 3600, Managed Care Organization. Please refer to MSM Chapter 700, Rates and Supplemental Reimbursement for more information.

603.4B FETAL NON-STRESS TESTING

1. Fetal Non-Stress testing (NST) is a means of fetal surveillance for most conditions that place the fetus at high risk for placental insufficiency. Providers shall follow current national guidelines, recommendations, and standards of care for the indications, techniques, and timing of the appropriate antepartum fetal surveillance methods and management guidelines.

2. Home uterine activity monitoring service may be ordered for a recipient who has a current diagnosis of pre-term labor and a history of pre-term labor/delivery with previous pregnancies. Reference MSM Chapter 1300, Durable Medical Equipment (DME) for coverage and limitation guidelines.

603.4C MATERNAL/FETAL ULTRASOUND STUDIES

Obstetrical ultrasound of a pregnant uterus is a covered benefit of Nevada Medicaid when it is determined to be medically necessary for the woman and/or the fetus.

Per CPT guidelines, an obstetrical ultrasound includes determination of the number of gestational sacs and fetuses, gestational sac/fetal structure, qualitative assessment of amniotic fluid volume/gestational sac shape, and examination of the maternal uterus and adnexa. The patient's record must clearly identify all high-risk factors and ultrasound findings.

1. Coverage and Limitations

A first trimester ultrasound may be covered to confirm viability of the pregnancy, to rule out multiple births and better define the Estimated Date of Confinement (EDC).

One second trimester or third trimester ultrasound per pregnancy with detailed anatomic examination is considered medically necessary to evaluate the fetus for fetal anatomic abnormalities. Refer to most current ACOG guidance for a list of qualified indications.

An initial screening ultrasound due to late entry prenatal care is a covered benefit. The use of a second ultrasound in the third trimester for screening purposes is not covered. Subsequent ultrasounds, including biophysical profiles should clearly identify the findings from the previous abnormal scan and explain the high-risk situation which makes repeated scans medically necessary. The patient's record must clearly identify all high-risk factors and ultrasound findings.

It is policy to perform ultrasound with detailed fetal anatomic study only on those pregnancies identified as being at risk for structural defects (e.g. advanced maternal age, prior anomalous fetus, medication exposure, diabetes, etc.).

a. Ultrasound coverage includes, but is not limited to:

1. Suspected abnormality in pregnancy, such as:

a. Suspected ectopic pregnancy;

b. Suspected hydatiform mole;

c. Threatened or missed abortion;

d. Congenital malformation, fetal or maternal;

e. Polyhydramnios;

f. Oligohydramnios;

g. Placenta previa;

h. Abruptio placenta; or

i. Vaginal bleeding.

2. Medical conditions threatening the fetus and/or delivery, such as:

a. Suspected abnormal presentation;

b. Suspected multiple gestation;

c. Significant difference between the size of the uterus and the expected size based on EDC (> 3 cm);

d. Elevated maternal serum alpha-fetoprotein;

e. Suspected fetal death;

f. Suspected anatomical abnormality of uterus;

g. Maternal risk factors, such as family history of congenital anomalies or chronic systemic disease (hypertension, diabetes, sickle cell disease, anti-phospholipid syndrome, poorly controlled hyperthyroidism, Hemoglobinopathies, cyanotic heart disease, systemic lupus erythematosus) or substance abuse;

h. Suspected macrosomia; or

i. Intrauterine Growth Retardation-IUGR ($\leq 15^{th}$ percentile of the combined biometrical parameters-biparietal diameter, head circumference, abdominal circumference, head/abdominal circumference ration, length of femur and length of humerus, and estimated fetal weight).

3. Confirmation of the EDC when clinical history and exam are uncertain. In general, a single ultrasound performed between 14 and 24 weeks is sufficient for this purpose.

4. Diagnosis of "decreased fetal movement" (accompanied by other clinical data, i.e. abnormal kick counts).

5. Follow up ultrasounds which may be considered medically necessary if the study will be used to alter or confirm a treatment plan.

b. Non-coverage – Ultrasound is not covered when it fails to meet the medical necessity criteria listed above or for the reasons listed below:

1. When the initial screening ultrasound (regardless of trimester) is within normal limits or without a significant second diagnosis.

2. When used solely to determine the sex of the neonate, or to provide the mother with a picture of the baby.

2. Provider Responsibility

For repeat evaluations, documentation should include, at a minimum:

a. Documentation of the indication for the study (abnormality or high-risk factors);

b. Crown-rump length (CRL);

c. Biparietal diameter (BPD);

d. Femur length (FL);

e. Abdominal circumference (AC);

f. Re-evaluation of organ system;

g. Placental location;

h. Number of fetuses (embryos);

i. Amniotic fluid volume assessment (qualitative or quantitative)

1. Oligohydramnios; or

2. Polyhydramnios.

j. Intrauterine growth restriction (IUGR).

For a list of maternal/fetal ultrasound codes, please refer to the PT 20, 24, 74, and 77 Billing Guides.

NOTE: The use of the diagnosis of "Supervision of High-Risk Pregnancy" or "Unspecified Complications of Pregnancy" without identifying the specific high risk or complication will result in non-payment.

603.4D PRENATAL SCREENING AND DIAGNOSTIC TESTING

Nevada Medicaid covers current national guidelines, recommendations, and standards of care for prenatal screening and diagnostic testing.

1. Screening includes:

a. First trimester and second trimester screenings. This does not include coverage of cell-free fetal DNA screening.

2. Diagnostic testing includes obtaining specimens through amniocentesis and chorionic villus sampling (CVS) to conduct diagnostic testing such as:

a. Karyotype chromosomal testing, fluorescence in situ hybridization (FISH) testing, and chromosomal microarray analysis.

3. Comprehensive patient pretest and post-test genetic counseling from a provider regarding the benefits, limitations, and results of chromosome screening and testing is essential. Nevada Medicaid does not reimburse for genetic counselors but does reimburse for providers that are physicians (M.D./D.O.), physician assistants, APRNs, or nurse midwives.

4. All prenatal chromosomal screening and diagnostic testing should not be ordered without informed consent, which should include discussion of the potential to identify findings of uncertain significance, nonpaternity, consanguinity, and adult-onset disease.

603.4E DOULA SERVICES

A Doula is a non-medical trained professional who provides education, emotional and physical support during pregnancy, labor/delivery, and postpartum period. Doulas may provide services within the home, office, hospital, or freestanding birthing center settings.

1. DOULA PROVIDER QUALIFICATIONS

Certification as a Doula must be obtained through the Nevada Certification Board.

2. COVERAGE AND LIMITATIONS

Doula services may be provided upon the confirmation of pregnancy. Doulas should encourage recipients to receive prenatal/antepartum and postpartum care.

a. Covered Services:

1. Emotional support, including bereavement support.

2. Physical comfort measures during peripartum (i.e., labor and delivery).

3. Facilitates access to resources to improve health and birth-related outcomes.

4. Advocacy in informed decision-making (i.e., patient rights for consent and refusal).

5. Evidence-based education and guidance, including but not limited to, the following:

a. General health practices, including but not limited to, reproductive health.

b. Child birthing options.

c. Newborn health and behavior, including but not limited to, feeding (i.e., bottle feeding), sleep habits, establishing routines, and pediatric care.

d. Infant care, including but not limited to, soothing, coping skills, and bathing.

e. Family dynamics, including but not limited to, sibling education and transition.

f. Breastfeeding, chestfeeding, lactation support, and providing related resources.

b. Non-Covered Services:

1. Travel time and mileage.

2. Services rendered requiring medical or clinical licensure.

c. Service Limitations:

Doula services for the same recipient and pregnancy are limited to a maximum of the following:

1. Four visits during the prenatal/antepartum and/or postpartum period (up to 90 days postpartum).

2. One visit at the time of labor and delivery.

3. If two prenatal/antepartum visits have occurred with a licensed physician, nurse midwife, APRN, or physician assistant, doulas may receive reimbursement for one additional visit. Doulas are encouraged to navigate recipients to prenatal/antepartum and postpartum care.

a. Certification for Additional Doula Services form must be completed by the healthcare professional's office who rendered the prenatal/antepartum services or the recipients' primary obstetrics provider and must be attached to the claim for reimbursement of the additional doula service. Refer to the FA-111 Nevada Medicaid Certification for Additional Doula Services form on the QIO-like vendor website.

4. If a recipient receives any dental service during the prenatal/antepartum period, the doula may receive one additional visit. Doulas are encouraged to navigate recipients to access oral health services which are expanded for adults during pregnancy.

   a. Certification for Additional Doula Services form must be completed by the oral health provider's office who rendered the dental services and must be attached to the claim for reimbursement of the Additional Doula Service. Refer to the FA-111 Nevada Medicaid Certification for Additional Doula Services form on the QIO-like vendor website.

d. Prior authorization is not required.

e. For a list of covered procedure codes please refer to the Doula Services Billing Guide (PT 90).

603.4F ABORTION/TERMINATION OF PREGNANCY

1. Reimbursement is available for an induced abortion to save the life of the mother, only when a provider has attached a signed certification to the claim that on the basis of his/her professional judgment, and supported by adequate documentation, the life of the mother would be endangered if the fetus were carried to term. Refer to the QIO-like vendor website to access the abortion certification form. Providers may use the FA-57 Certification Statement for Abortion to Save the Life of the Mother form or substitute any form that includes the required information.

2. Reimbursement is available for induced abortion services resulting from a sexual assault (rape) or incest. A copy of the appropriate declaration statement must be attached to the claim. Refer to the QIO-like vendor website to access the abortion declaration forms. Providers may use the FA-54 Abortion Declaration (Rape) form or the FA-55 Abortion Declaration (Incest) form or substitute any form that includes the required information. The Nevada mandatory reporting laws related to child abuse and neglect must be followed for all recipients under the age of 18 years old and providers are still required to report the incident to Child Protective Services (CPS) through the Division of Child and Family Services (DCFS) or, in some localities, through County Child Welfare Services.

3. Reimbursement is available for the treatment of incomplete, missed, or septic abortions under the criteria of medical necessity. The claim should support the procedure with sufficient medical information and by diagnosis. No certification or prior authorization is required.

   NOTE: Any abortion that involves inpatient hospitalization requires a prior authorization from the QIO-like vendor. See MSM Chapter 200, Hospital Services, Authorization Requirements for further information.

603.5 HYSTERECTOMY

According to federal regulations, a hysterectomy is not a family planning (sterilization) procedure. Hysterectomies performed solely for the purpose of rendering a female incapable of reproducing are not covered by Medicaid. All hysterectomy certifications must have an original signature of the physician certifying the forms. Refer to the FA-50 Nevada Medicaid Hysterectomy Acknowledgement Form on the QIO-like vendor website. A stamp or initial by billing staff is not acceptable. Payment is available for hysterectomies as follows:

1. Medically Necessary – A medically necessary hysterectomy may be covered only when the physician securing the authorization to perform the hysterectomy has informed the recipient or her representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the recipient permanently incapable of reproducing, and the recipient or her representative has signed a written FA-50 Hysterectomy Acknowledgement Form.

2. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the FA-50 Nevada Medicaid Hysterectomy Acknowledgement Form is also required. Therefore, it is advisable to inform the recipient or her authorized representative prior to the exploratory surgery or biopsy.

3. Emergency – The physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The completed FA-50 Nevada Medicaid Hysterectomy Acknowledgment Form must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, and anesthesiologist). The physician must include a description of the nature of the emergency and this certification must be dated after the emergency. The recipient does not have to sign this form. An example of this situation would be when the recipient is admitted to the hospital through the emergency room for immediate medical care and the recipient is unable to understand and respond to information pertaining to the Hysterectomy Acknowledgement Form due to the emergency nature of the admission.

4. Sterility – The physician who performs the hysterectomy certifies in writing that the recipient was already sterile at the time of the hysterectomy and needs to include a statement regarding the cause of the sterility. The completed FA-50 Nevada Medicaid Hysterectomy Acknowledgment Form, which is also the federal HHS-687 form, must be attached to each claim form related to the hysterectomy. The recipient does not have to sign the form. (For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.)

5. Hysterectomies Performed During a Period of Retroactive Eligibility – Reimbursement is available for hysterectomies performed during periods of retroactive eligibility. In order

for payment to be made in these cases, the physician must submit a written statement certifying one of the following conditions was met:

a. He or she informed the woman before the operation the procedure would make her sterile. In this case, the recipient and the physician must sign the written statement; or,

b. The woman met one of the exceptions provided in the physician's statement. In this case, no recipient signature is required. Claims submitted for hysterectomies require the authorization number for the inpatient admission. The authorization process will ensure the above requirements were met. Payment is not available for any hysterectomy performed for the purpose of sterilization or which is not medically necessary.

603.6 GYNECOLOGIC EXAM

Nevada Medicaid reimburses providers for preventative gynecological examinations. The examination may include a breast exam, pelvic exam, sexually transmitted disease screening, and tissue collection if needed (also known as Pap Smear). Pelvic exams and pap smears should not be required for self-administered birth control. Providers shall follow current national guidelines, recommendations, and standards of care, including but not limited to, ACOG and/or USPSTF.

603.7 CHIROPRACTIC SERVICES POLICY

Medicaid will pay for a chiropractic manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuro-musculoskeletal condition for which manipulation is the appropriate treatment.

Services are limited to Medicaid eligible children under 21 years of age.

A. Prior authorization is not required for:

Four or less chiropractic office visits (emergent or non-emergent) for children under 21 years of age in a rolling 365 days. The visits must be as a direct result of an EPSDT screening examination, diagnosing acute spinal subluxation.

B. Prior authorization is required for:

Chiropractic visits for children under 21 years of age whose treatment exceeds the four visits. The provider must contact the Nevada Medicaid QIO-like vendor for prior authorization.

603.8 PODIATRY

Podiatry services are rendered by a podiatrist. Podiatrists are medical specialists who diagnose, treat and care for: injury, disease or other medical conditions affecting the foot, ankle, and structure of the leg. Podiatrists perform surgical procedures and prescribe corrective devices, medications, and physical therapy.

A. Prior Authorization and Limitations

1. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination or a surgical procedure must be billed using the appropriate Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS) code. Medicaid will pay for the orthotic in addition to the office visit.

2. Radiology Service

a. Radiology services are covered when deemed medically necessary; refer to MSM Chapter 300, Radiology Services for services and prior authorization requirements.

3. Laboratory Services

a. Laboratory services are covered when deemed medically necessary; refer to MSM Chapter 800, Laboratory Services for services and prior authorization requirements.

4. Prescription Drugs

a. Prescription drugs are covered when deemed medically necessary; refer to MSM Chapter 1200, Prescribed Drugs for services and prior authorization requirements.

5. Telehealth Services

a. Telehealth services are covered when deemed medically necessary; refer to MSM Chapter 3400, Telehealth Services for services and prior authorization requirements.

B. Covered Services

1. Evaluation and Management Services

a. Evaluations, examinations, consultations, treatments, health supervision.

b. Office visits, home visits, hospital visits, emergency room visits, nursing home visits.

2. Surgical Procedures

a. Multiple surgeries.

b. Mycotic procedures.

c. Casting/strapping/taping.

1. These procedures are covered when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains and open wounds (related to podiatrist's scope of practice) and require prior authorization.

3. Infection and Inflammation Services

a. Trimming of nails, cutting or removal of corns and calluses are allowed if either infection or inflammation is present.

C. Non-Covered Services

1. Preventive care including the cleaning and soaking of feet and the application of creams to insure skin tone.

2. Routine foot care in the absence of infection or inflammation. Routine foot care includes the trimming of nails, cutting or removal of corns and calluses.

a. Preventive care and routine foot care can be provided by Outpatient Hospitals, APRN, physician, or physician assistant.

603.9 PROVIDER SERVICES PROVIDED IN RURAL HEALTH CLINICS

Rural Health Clinic (RHC)

Medicaid covered outpatient services provided in RHCs are reimbursed at an all-inclusive per recipient per encounter rate. Regardless of the number or types of providers seen, only one encounter is reimbursable per day.

A. This all-inclusive rate includes any one or more of the following services provided by a Licensed Qualified Health Professional and/or certified provider.

1. Licensed Qualified Health Professionals approved to furnish services included in the outpatient encounter are:

a. Physician (MD/DO);

b. Dentist;

c. Advance Practice Registered Nurse (APRN);

d. Physician Assistant (PA/PA-C);

e. Certified Registered Nurse Anesthetist (CRNA);

f. Nurse Midwife (NM);

g. Psychologist;

h. Licensed Clinical Social Worker (LCSW);

i. Registered Dental Hygienist (RDH);

j. Podiatrist (DPM);

k. Radiology;

l. Optometrist (OD);

m. Optician;

n. Clinical Laboratory Services;

o. Licensed Marriage and Family Therapist (LMFT);

p. Licensed Pharmacist; and

q. Registered Dietitian (RD).

2. Certified providers approved to furnish services included in the outpatient encounter are:

a. Community Health Workers (CHW); and

b. Doulas.

B. Encounter codes are used for primary care services provided by the RHCs in the following areas:

1. Core visits include the following:

a. Medical and dental office visits, patient hospital visits, injections and oral contraceptives;

b. Women's annual preventive gynecological examinations; and

c. Colorectal screenings.

2. Home visits; or

3. Family planning education.

a. Up to two times a calendar year the RHC may bill for additional reimbursement along with the encounter rate.

C. For billing instructions for RHC, please refer to PT 17 Special Clinics Billing Guide.

603.10 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and Certified Registered Nurse Anesthetists (CRNAs) are based on the CMS base units.

A. Each service is assigned a base unit which reflects the complexity of the service and includes work provided before and after reportable anesthesia time. The base units also cover usual preoperative and post-operative visits, administering fluids and blood that are part of the anesthesia care, and monitoring procedures.

B. Time for anesthesia procedures begins when the anesthesiologist/CRNA begins to prepare the recipient for the induction of anesthesia and ends when the anesthesiologist/CRNA is no longer in personal attendance, and the recipient is placed under postoperative supervision.

C. All anesthesia services are reported by use of the anesthesia CPT codes. Nevada Medicaid does not reimburse separately for physical status modifiers or qualifying circumstances.

D. Using the CPT/ASA codes, providers must indicate on the claim the following:

1. Type of surgery;

2. Length of time;

3. Diagnosis;

4. Report general anesthesia and continuous epidural analgesia for obstetrical deliveries using the appropriate CPT codes; and

5. Unusual forms of monitoring and/or special circumstances rendered by the anesthesiologist/CRNA are billed separately using the appropriate CPT code. Special circumstances include but are not limited to nasotracheal/bronchial catheter aspiration, intra-arterial, central venous and Swan-Ganz lines, transesophageal echocardiography, and ventilation assistance.

603.11 PROVIDER SERVICES IN OUTPATIENT SETTING

A. Outpatient hospital-based clinic services include non-emergency care provided in the emergency room, outpatient therapy department/burn center, observation area, and any established outpatient clinic sites. Visits should be coded using the appropriate Evaluation/Management (E/M) CPT code (e.g. office visit/observation/etc.). Do not use emergency visit codes.

Services requiring prior authorization include the following:

1. Hyperbaric Oxygen Therapy for chronic conditions (reference Attachment A, Policy #6-03 for Coverage and Criteria);

2. Bariatric surgery for Morbid Obesity (reference Attachment A, Policy #6-07 for Coverage and Criteria);

3. Cochlear implants (See MSM Chapter 2000, Audiology Services);

4. Diabetes training exceeding 10 hours (reference Attachment A, Policy #6-10 for Coverage and Criteria);

5. Vagus nerve stimulation (reference Attachment A, Policy #6-06 for Coverage and Criteria); and

6. Services requiring authorization per Ambulatory Surgical Center (ASC) list.

B. Emergency Department Policy

Nevada Medicaid uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services are defined as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the recipient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious function of any bodily organ or part.” The threat to life or health of the recipient necessitates the use of the most accessible hospital or facility available that is equipped to

furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

1. Prior authorization will not be required for admission to a hospital as a result of a direct, same day admission from a provider's office and/or the emergency department. The requirement to meet acute care criteria is dependent upon the QIO-like vendor's determination. The QIO-like vendor will continue to review and perform the retrospective review for these admissions based upon approved criteria. Prior authorization is still required for all other inpatient admissions. See MSM Chapter 200, Hospital Services for additional information regarding emergency admissions and retrospective reviews.

2. Direct physical attendance by a physician is required in emergency situations. The visit will not be considered an emergency unless the physician's entries into the record include his or her signature, the diagnosis, and documentation that he or she examined the recipient. Attendance of a physician assistant does not substitute for the attendance of a physician in an emergency situation.

3. Physician's telephone or standing orders, or both, without direct physical attendance does not support emergency treatment.

4. Reimbursement for physician–directed emergency care and/or advanced life support rendered by a physician located in a hospital emergency or critical care department, engaged in two-way voice communication with the ambulance or rescue personnel outside the hospital is not covered by Medicaid.

5. Services deemed non-emergency and not reimbursable at the emergency room level of payment are:

    a. Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition;

    b. Refusal to comply with currently ordered procedures or treatments;

    c. The recipient had previously been treated for the same condition without worsening signs or symptoms of the condition;

    d. Scheduled visit to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion;

    e. Visits made to receive a "tetanus" vaccination in the absence of other emergency conditions;

f. The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition;

g. Medical clearance/screenings for psychological or temporary detention ordered admissions; and

h. Diagnostic x-ray, diagnostic laboratory, and other diagnostic tests provided as a hospital outpatient service are limited to physician ordered tests considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body member. For coverage and limitations, reference MSM Chapter 300 for Radiology and Diagnostic Services and MSM Chapter 800 for Laboratory Services.

C. Therapy Services (OT, PT, RT, ST)

Occupational, Physical, Respiratory and Speech Therapy services provided in the hospital outpatient setting are subject to the same prior authorization and therapy limitations found in the MSM Chapter 1700, Therapy.

D. Observation Services Provided by The Physician

1. Observation services are provided by the hospital and supervising physician to recipients held but not admitted into an acute hospital bed for observation. Consistent with federal Medicare regulations, Nevada Medicaid reimburses hospital "observation status" for a period up to, but no more than 48 hours.

2. Observation services are conducted by the hospital to evaluate a recipient's condition or to assess the need for inpatient admission. It is not necessary that the recipient be located in a designated observation area such as a separate unit in the hospital, or in the emergency department in order for the physician to bill using the observation care CPT codes, but the recipient's observation status must be clear.

3. If observation status reaches 48 hours, the physician must make a decision to:

a. Send the recipient home;

b. Obtain authorization from the QIO-like vendor to admit into the acute hospital; or

c. Keep the recipient on observation status with the understanding neither the physician nor the hospital will be reimbursed for any services beyond the 48 hours.

4. The physician must write an order for observation status, and/or an observation stay that will rollover to an inpatient admission status.

   See MSM Chapter 200, Hospital Services for policy specific to the facility's responsibility for a recipient in "observation status."

E. End Stage Renal Disease (ESRD) Outpatient Hospital/Free-Standing Facilities. The term "end-stage renal disease" means the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

1. Treatment of ESRD in a physician-based (i.e. hospital outpatient) or independently operated ESRD facility certified by Medicare is a Medicaid covered benefit. Medicaid is secondary coverage to Medicare for ESRD treatment except in rare cases when the recipient is not eligible for Medicare benefits. In those cases, private insurance and/or Medicaid is the primary coverage.

2. ESRD Services, including hemodialysis, peritoneal dialysis and other miscellaneous dialysis procedures are Medicaid covered benefits without prior authorization.

3. If an established recipient in Nevada requires out-of-state transportation for ESRD services, the physician or the facility must initiate contact and make financial arrangements with the out-of-state facility before submitting a prior authorization request to the non-emergency transportation (NET) broker. The request must include dates of service and the negotiated rate. (This rate cannot exceed Medicare's reimbursement for that facility) Refer to MSM Chapter 1900, Transportation Services for requirements of non-emergency transportation.

4. Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are covered services for hemodialysis and Continuous Ambulatory Peritoneal Dialysis (CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.

5. Reference Attachment A, Policy #6-09 for ESRD Coverage.

F. Ambulatory Surgical Centers (ASC) Facility and Non-Facility Based

Surgical procedures provided in an ambulatory surgical facility refers to freestanding or hospital-based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical

procedures on recipients who do not generally require extended lengths of stay or extensive recovery or convalescent time.

Outpatient surgical procedures designated as acceptable to be performed in a provider's office/outpatient clinic, ambulatory surgery center or outpatient hospital facility are listed on the QIO-like vendor's website. For questions regarding authorization, the provider should contact the QIO-like vendor.

1. Prior authorization is not required when:

    a. Procedures listed are to be done in the suggested setting or a setting which is a lower level than suggested;

    b. Procedures are part of the emergency/clinic visit.

2. Prior authorization is required from the QIO-like vendor when:

    a. Procedures are performed in a higher-level facility than it is listed in the ASC surgical list (e.g., done in an ASC but listed for the office);

    b. Procedures on the list are designated for prior authorization;

    c. Designated podiatry procedures; and

    d. The service is an out-of-state service and requires a prior authorization if that same service was performed in-state.

3. Surgical procedures deemed experimental, not well established, or not approved by Medicare or Medicaid are not covered and will not be reimbursed for payment. Below is a list of definitive non-covered services.

    a. Cosmetic Surgery: The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the recipient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or the improvement of a malformed body member, to restore or improve function, which coincidentally services some cosmetic purpose. Examples of procedures which do not meet the exception to the exclusion are facelift/wrinkle removal (rhytidectomy), nose hump correction, moon-face, etc.;

    b. Fabric wrapping of abdominal aneurysm;

    c. Intestinal bypass surgery for treatment of obesity;

d. Transvenous (catheter) pulmonary embolectomy;

e. Extracranial-Intracranial (EC-IC) Arterial bypass when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries;

f. Breast reconstruction for cosmetic reasons, however breast reconstruction following removal of a breast for any medical reason may be covered;

g. Stereotactic cingulotomy as a means of psychosurgery to modify or alter disturbances of behavior, thought content, or mood that are not responsive to other conventional modes of therapy, or for which no organic pathological cause can be demonstrated by established methods;

h. Radial keratotomy and keratoplasty to treat refractive defects. Keratoplasty that treats specific lesions of the cornea is not considered cosmetic and may be covered;

i. Implants not approved by the FDA; Partial ventriculectomy, also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery;

j. Gastric balloon for the treatment of obesity;

k. Cochleostomy with neurovascular transplant for Meniere's Disease; and

l. Surgical procedures to control obesity other than bariatric for morbid obesity with significant comorbidities. See Attachment A, Policy #6-07 for policy limitations.

603.12 SERVICES IN THE ACUTE HOSPITAL SETTING

A. Admissions to acute care hospitals both in and out-of-state are limited to those authorized by Medicaid's QIO-like vendor as medically necessary and meeting Medicaid benefit criteria. Refer to MSM Chapter 200, Hospital Services for authorization requirements.

B. Physicians may admit without prior approval only as outlined in MSM Chapter 200, Hospital Services, Authorization Requirements.

C. All other hospital admissions both in-state and out-of-state must be prior authorized by the QIO-like vendor. Payment will not be made to the facility or to the admitting physician, attending physician, consulting physician, anesthesiologist, or primary/assisting surgeon if the authorization is denied by the QIO-like vendor.

D. Attending physicians are responsible for ordering and obtaining prior authorization for all transfers from the acute hospital to all other facilities.

E. Physicians may admit recipients to psychiatric and/or substance abuse units of general hospitals (regardless of age), or freestanding psychiatric and substance abuse hospitals for recipients 65 years of age and older or those under the age of 21 years old. All admissions must be prior authorized by the QIO-like vendor with the exception of a psychiatric emergency. Refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services for coverage and limitations.

F. Inpatient Hospital Care

1. Routine Inpatient Hospital Care is limited to reimbursement for one visit per day (same physician or physicians in the same group practice) except when extra care is documented as necessary for an emergency situation (e.g., a sudden serious deterioration of the recipient's condition).

2. The global surgical package includes the following when provided by the physician who performs the surgery, whether in the office setting, out-patient or in-patient:

   a. Preoperative visits up to two days before the surgery;

   b. Intraoperative services that are normally a usual and necessary part of a surgical procedure;

   c. Services provided by the surgeon within the Medicare recommended global period of the surgery that do not require a return trip to the operating room; and follow-up visits related to the recovery from the surgery which are provided during this time by the surgeon, and

   d. Post-surgical pain management.

3. The surgeon's initial evaluation or consultation is considered a separate service from the surgery and is paid as a separate service, even if the decision, based on the evaluation, is not to perform the surgery. If the decision to perform a major surgery (surgical procedures with a 90-day global period) is made on the day of or the day prior to the surgery, separate payment is allowed for the visit on which the decision is made, however supporting documentation may be requested. If post payment audits indicate documentation is insufficient to support the claim, payment will be adjusted accordingly.

4. If a recipient develops complications following surgery that requires the recipient to be returned to the operating room for any reason for care determined to be medically necessary, these services are paid separately from the global surgery amount. Complications that require additional medical or surgical services but do

not require a return trip to the operating room are included in the global surgery amount.

5. Payment may be made for services by the surgeons that are unrelated to the diagnosis for which the surgery was performed during the post-operative period. Supportive documentation may be requested. Services provided by the surgeon for treating the underlying condition and for a subsequent course of treatment that is not part of the normal recovery from the surgery are also paid separately. Full payment for the procedure is allowed for situations when distinctly separate but related procedures are performed during the global period of another surgery in which the recipient is admitted to the hospital for treatment, discharged, and then readmitted for further treatment.

6. Payment for physician services related to patient-controlled analgesia is included in the surgeon's global payment. The global surgical payment will be reduced if post-payment audits indicate that a surgeon's recipients routinely receive pain management services from an anesthesiologist. For a list of covered codes, please refer to the billing manual.

7. For information on payment for assistant surgeons, please refer to the billing manual.

8. There is no post-operative period for endoscopies performed through an existing body orifice. Endoscopic surgical procedures that require an incision for insertion of a scope will be covered under the appropriate major or minor surgical policy which will include a post-operative period according to the Medicare recommended global period.

9. For some dermatology services, the CPT descriptors contain language, such as "additional lesion", to indicate that multiple surgical procedures have been performed. The multiple procedure rules do not apply because the RVU's for these codes have been adjusted to reflect the multiple nature of the procedure. These services are paid according to the unit. If dermatologic procedures are billed with other procedures, the multiple surgery rules apply. For further information, please refer to the billing manual.

10. Critical Care

    Critical Care, the direct delivery of medical care by a physician or physicians for a critically ill or critically injured recipient to treat a single or multiple vital organ system failure and/or to prevent further-life threatening deterioration of the recipient's conditions, is reimbursed by Medicaid. Reimbursement without documentation is limited to a critical illness or injury which acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-

threatening deterioration in the recipient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system functions. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology, critical care may be provided in life threatening situations when these elements are not present.

a. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the recipient, provided that the recipient's condition continues to require the level of physician attention described above. Providing medical care to a critically ill, injured, or post-operative recipient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

b. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

c. Services for a recipient who is not critically ill but happen to be in a critical care unit, are reported using other appropriate evaluation/management (E/M) codes.

d. According to CPT, the following services are included in reporting critical care when performed during the critical period by the physicians providing critical care: the interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) gastric intubation, temporary transcutaneous pacing, ventilatory management and vascular access procedures. Any services performed which are not listed above should be reported separately.

e. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient.

11. Neonatal and Pediatric Critical Care

a. Neonatal and Pediatric Critical Care CPT codes are used to report services provided by a single physician directing the care of a critically ill neonate/infant. The same definitions for critical care services apply for the adult, child, and neonate. The neonatal and pediatric critical care codes are

global 24-hour codes (billed once per day) and are not reported as hourly services consistent with CPT coding instructions.

b. Neonatal critical care codes are used for neonates (28 days of age or less) and pediatric critical care codes are used for the critically ill infant or young child age 29 days through 71 months of age, admitted to an intensive or critical care unit. These codes will be applicable as long as the child qualifies for critical care services during the hospital stay.

c. If the physician is present for the delivery and newborn resuscitation is required, the appropriate E&M code can be used in addition to the critical care codes.

d. Care rendered under the pediatric critical care codes includes management, monitoring, and treatment of the recipient including respiratory, enteral and parenteral nutritional maintenance, metabolic and hematologic maintenance, pharmacologic control of the circulatory system, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

e. In addition to critical services for adults, the pediatric and neonatal critical care codes also include the following procedures:

1. peripheral vessel catheterization;

2. other arterial catheters;

3. umbilical venous catheters;

4. central vessel catheters;

5. vascular access procedures;

6. vascular punctures;

7. umbilical arterial catheters;

8. endotracheal intubation;

9. ventilator management;

10. bedside pulmonary function testing;

11. surfactant administration;

12. continuous positive airway pressure (CPAP);

13. monitoring or interpretation of blood gases or oxygen saturation;

14. transfusion of blood components;

15. oral or nasogastric tube placement;

16. suprapubic bladder aspiration;

17. bladder catheterization; and

18. lumbar puncture.

Any services performed which are not listed above, may be reported separately.

f. Initial and Continuing Intensive Care Services are reported for the child who is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, or for services provided by a physician directing the continuing intensive care of the Low Birth Weight (LBW) (1500-2500 grams) present body weight infant, or normal (2501-5000 grams) present body weight newborn who does not meet the definition of critically ill, but continues to require intensive observation, frequent interventions, and other intensive care services.

603.13 PROVIDER'S SERVICES IN NURSING FACILITIES

A. Provider services provided in a Nursing Facility (NF) are a covered benefit when the service is medically necessary. Provider visits must be conducted in accordance with federal requirements for licensed facilities. Reference MSM Chapter 500, Nursing Facilities for coverage and limitations.

B. When the recipient is admitted to the NF in the course of an encounter in another site of service (e.g., hospital ER, provider's office), all E/M services provided by that provider in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. Admission documentation and the admitting orders/plan of care should include the services related to the admission he/she provided in the other service sites.

C. Hospital discharge or observation discharge services performed on the same date of NF admission or readmission may be reported separately. For a recipient discharged from inpatient status on the same date of nursing facility admission or readmission, the hospital

discharge services should be reported as appropriate. For a recipient discharged from observation status on the same date of NF admission or readmission, the observation care discharge services should be reported with the appropriate CPT code.

603.14 PROVIDER'S SERVICES IN OTHER MEDICAL FACILITIES

A. Intermediate Care Facility for Individuals with Intellectual Disabilities) ICF/IID

A provider must certify the need for ICF/IID care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/IID, before the Nevada Medicaid Office authorizes payment.) The certification must refer to the need for the ICF/IID level of care, be signed and dated by the provider and be incorporated into the resident's record as the first order in the provider's orders.

Recertification by a physician or an APRN for the continuing need for ICF/IID care is required within 365 days of the last certification. In no instance is recertification acceptable after the expiration of the previous certification. For further information regarding ICF/IID refer to MSM Chapter 1600, Intermediate Care for Individuals with Intellectual Disabilities.

B. Residential Treatment Center (RTC)

Physician services, except psychiatrists are not included in the all-inclusive facility rate for RTCs. Please reference MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services.

604 COMMUNITY PARAMEDICINE SERVICES

Nevada Medicaid reimburses for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services fill patient care gaps in a local health care system and prevent duplication of services while improving the healthcare experience for the recipient. Prevention of unnecessary ambulance responses, emergency room visits, and hospital admissions and readmissions can result in cost reductions for the DHCFP.

604.1 COMMUNITY PARAMEDICINE PROVIDER QUALIFICATIONS

A. The following Nevada-licensed providers may provide community paramedicine services for Nevada Medicaid recipients:

1. Emergency Medical Technician (EMT);

2. Advanced Emergency Medical Technician (AEMT); or

3. Paramedic.

B. Required endorsement:

1. Community paramedicine endorsement from the Nevada Division of Public and Behavioral Health, Office of Emergency Medical Services; or

2. Community paramedicine endorsement from the Southern Nevada Health District's Board of Health.

C. Must be enrolled as a Nevada Medicaid provider and employed by a permitted Emergency Medical System (EMS) agency.

D. Must possess a scope of service agreement, based upon the provider's skills, with the Medical Director of the EMS agency under which they are employed.

1. The Medical Director of the EMS agency providing community paramedicine services must be enrolled as a Nevada Medicaid Provider.

604.2 COVERAGE AND LIMITATIONS

Community paramedicine services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed EMS agency medical director and coordinated with a primary care provider (PCP). The plan of care is to be developed after an appropriate assessment and does not have to be in place before community paramedicine services are started but must be developed while the recipient is receiving community paramedicine services. If a recipient does not have a PCP, the plan of care must include establishing a medical home with a PCP. It is

expected that all health care providers delivering care to community paramedicine recipients coordinate the patient's care to avoid duplication of services to the recipient.

A. The following services can be provided within a community paramedicine provider's scope of practice as part of a community paramedicine visit when requested in plan of care:

1. Evaluation/health assessment;
2. Chronic disease prevention, monitoring and education;
3. Medication compliance;
4. Vaccinations.
5. Laboratory specimen collection and point of care lab tests;
6. Hospital discharge follow-up care;
7. Minor medical procedures and treatments within their scope of practice as approved by the EMS agency's medical director;
8. A home safety assessment; and
9. Telehealth originating site.

B. Non-covered services:

1. Travel time;
2. Mileage;
3. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital;
4. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code;
5. Duplicated services;
6. Personal Care Services; and
7. Mental and behavioral health/crisis intervention.

C. For a list of covered procedure and diagnosis codes, please refer to the PT 32, Specialty 249 Billing Guide.

D. Prior authorization is not required for community paramedicine services.

605 COMMUNITY HEALTH WORKER SERVICES

Community Health Workers (CHW) are trained public health educators improving health care delivery requiring integrated and coordinated services across the continuum of health. CHWs provide recipients culturally and linguistically appropriate health education to better understand their condition, responsibilities, and health care options. CHW services must be related to disease prevention and chronic disease management that follow current national guidelines, recommendations, and standards of care, including but not limited to, the United States Preventive Services Task Force (USPSTF) A and B recommended screenings. CHWs may provide services to recipients (individually or in a group) within the home, clinical setting, or other community settings.

605.1 COMMUNITY HEALTH WORKER PROVIDER QUALIFICATIONS

A. Certification as a CHW must be obtained through the Nevada Certification Board.

B. Must be supervised by a Nevada Medicaid enrolled physician, physician assistant (PA) or advanced practice registered nurse (APRN).

605.2 COVERAGE AND LIMITATIONS

A. Covered services:

1. Guidance in attaining health care services.

2. Identify recipient needs and provide education from preventive health services to chronic disease self-management.

3. Information on health and community resources, including making referrals to appropriate health care services.

4. Connect recipients to preventive health services or community services to improve health outcomes.

5. Provide education, including but not limited to, medication adherence, tobacco cessation, and nutrition.

6. Promote health literacy, including oral health.

B. Non-covered services:

1. Delegate the CHW to perform or render services that require licensure.

2. Transport a recipient to an appointment.

3. Make appointments not already included within the CHW visit/service (i.e. receptionist duties or front desk support).

4. Deliver appointment reminders.

5. Employment support, including but not limited to, resume building, interview skills.

6. Coordinate and participate in community outreach events not related to individual or group Medicaid recipients.

7. Case management.

8. Accompanying a recipient to an appointment.

9. Provide child-care while the recipient has an appointment.

10. Application assistance for social service programs.

11. Mental health/alcohol and substance abuse services, including peer support services.

C. Service Limitations:

1. CHW services are not reimbursable when services are provided under the supervision of a physician, PA or APRN billing under Behavioral Health Outpatient Treatment PT 14, Behavioral Health Rehabilitative Treatment PT 82, or Special Clinics PT 17, Specialty 215 Substance Abuse Agency Model.

2. Services provided by a CHW are limited to four units (30 minutes per unit) in a 24-hour period, not to exceed 24 units per calendar month per recipient.

3. When providing services in a group setting, the number of participants must be at a minimum of two and a maximum of eight.

D. Prior authorization is not required.

E. For a list of covered procedure codes please refer to the Community Health Worker PT 89 Billing Guide.

606 ORGAN TRANSPLANT SERVICES

606.1 COVERAGE AND LIMITATIONS

Organ transplantation and associated fees are a limited benefit for Nevada Medicaid recipients. Non-Citizens/Aliens are not eligible for organ transplants. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for eligible emergency conditions.

A. The following organ transplants, when deemed the principal form of treatment are covered:

1. Bone Marrow/Stem Cell – allogeneic and autologous;

a. Non-covered conditions for bone marrow/stem cell:

1. Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma;

2. Autologous stem cell transplantation is not covered as treatment for acute leukemia not in remission, chronic granulocytic leukemia, solid tumors (other than neuroblastoma) and tandem transplantation for recipients with multiple myeloma;

2. Corneal – allograft/homograft;

3. Kidney – allotransplantation/autotransplantation; and

4. Liver – transplantation for children (under 21 years old) with extrahepatic biliary atresia or for children or adults with any other form of end-stage liver disease. Coverage is not provided with a malignancy extending beyond the margins of the liver or those with persistent viremia.

B. Prior authorization is required for bone marrow, corneal, kidney, and liver transplants from Medicaid's contracted QIO-like vendor.

1. A transplant procedure shall only be approved upon a determination that it is a medically necessary treatment by showing that:

a. The procedure is not experimental and/or investigational based on Title 42, CFR, Chapter IV (Centers for Medicare & Medicaid) and Title 21, CFR, Chapter I FDA;

b. The procedure meets appropriate Medicare criteria;

c. The procedure is generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is proposed, or there is authoritative evidence that attests to the proposed procedures safety and effectiveness; and

d. If the authorization request is for chemotherapy to be used as a preparatory therapy for transplants, an approval does not guarantee authorization for any harvesting or transplant that may be part of the treatment regimen.

2. A separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out-of-state.

607 PREVENTIVE HEALTH SERVICES

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a patient's current or possible future health care risks through assessments, lab work and other diagnostic studies. The U.S. Preventive Services Task Force (USPSTF) is an independent volunteer panel of national experts in prevention and evidence-based medicine authorized by the U.S. Congress. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. Each recommendation has a letter grade (an A, B, C, D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service.

607.1 COVERED SERVICES

Nevada Medicaid reimburses for preventive health services for men, women and children as recommended by the USPSTF A and B recommendations. For the most current list of reimbursable preventive services, please see the USPSTF A and B recommendations located at https://www.uspreventiveservicestaskforce.org/.

Family planning related preventive health services as recommended by the USPSTF are a covered benefit.

607.2 NON-COVERED SERVICES

Preventive health services not cataloged or that do not have a current status as either an A or B recommendation by the USPSTF are not covered.

607.3 PRIOR AUTHORIZATIONS

Prior authorizations are not required for preventive health services that coincide with the USPSTF A and B recommendations.

607.4 BILLING REQUIREMENTS

Most preventive health services may be performed as part of an office visit, hospital visit or global fee and may not be billed separately. Please see the Preventive Services Billing Guide or the USPSTF website.

608 GENDER REASSIGNMENT SERVICES

Transgender Services include treatment for gender dysphoria (GD), formerly known as gender identity disorder (GID). Treatment of GD is a Nevada Medicaid covered benefit, including both hormonal and surgical modalities, and psychotherapy, based on medical necessity. Genital reconstruction surgery (GRS) describes a number of surgical procedure options for the treatment of GD.

According to the World Professional Association for Transgender Health (WPATH), the organization that promotes the standards of health care for transsexual, transgender and gender nonconforming individuals, through the articulation of Standards of Care, gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).

608.1 COVERAGE AND LIMITATIONS

A. Hormone Therapy

1. Hormone therapy is covered for treatment of GD based on medical necessity; refer to MSM Chapter 1200, Prescribed Drugs, for services and prior authorization requirements.

B. Genital Reconstruction Surgery

1. Genital reconstruction surgery is covered for recipients that are sufficiently physically fit and meet eligibility criteria under Nevada and federal laws.

2. Prior authorization is required for all genital reconstruction surgery procedures.

3. To qualify for surgery, the recipient must be 18 years of age or older.

4. Male-to-Female (MTF) recipient, surgical procedures may include:

   a. breast/chest surgery; mammoplasty

   b. genital surgery; orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy

5. Female-to-Male (FTM) recipient, surgical procedures may include:

   a. breast/chest surgery; mastectomy

   b. genital surgery; hysterectomy/salpingo-oophorectomy, phalloplasty, vaginectomy, vulvectomy, scrotoplasty

6. Augmentation mammoplasty for MTF recipients is a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy.

7. All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization. Refer to MSM Chapter 600, Section 603.4B for information regarding sterilization services.

8. Refer to the Documentation Requirements section below for additional criteria.

C. Mental Health Services

1. Mental health services are covered for treatment of GD based on medical necessity; refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services for services and prior authorization requirements.

D. Non-Covered Services

1. Payment will not be made for the following services and procedures:

a. cryopreservation, storage and thawing of reproductive tissue, and all related services and costs;

b. reversal of genital and/or breast surgery;

c. reversal of surgery to revise secondary sex characteristics;

d. reversal of any procedure resulting in sterilization;

e. cosmetic surgery and procedures including:

1. neck tightening or removal of redundant skin;

2. breast, brow, face or forehead lifts;

3. chondrolaryngoplasty (commonly known as tracheal shave);

4. electrolysis;

5. facial bone reconstruction, reduction or sculpturing, including jaw shortening and rhinoplasty;

6. calf, cheek, chin, nose or pectoral implants;

7. collagen injections;

8. drugs to promote hair growth or loss;

9. hair transplantation;

10. lip reduction or enhancement;

11. liposuction;

12. thyroid chondroplasty; and

13. voice therapy, voice lessons or voice modification surgery.

E. Documentation Requirements

1. The recipient must have:

a. persistent and well-documented case of GD;

b. capacity to make a fully informed decision and give consent for treatment. According to the American Medical Association (AMA) Journal of Ethics, in health care, informed consent refers to the process whereby the patient and the health care practitioner engage in a dialogue about a proposed medical treatment's nature, consequences, harms, benefits, risks and alternatives. Informed consent is a fundamental principle of health care.

c. comprehensive mental health evaluation provided in accordance with WPATH standards of care; and

d. prior to beginning stages of surgery, obtained authentic letters from two qualified licensed mental health professionals who have independently assessed the recipient and are referring the recipient for surgery. The two letters must be authenticated and signed by:

1. A licensed qualified mental health care professional working within the scope of their license who have independently assessed the recipient;

a. one with whom the recipient has an established ongoing relationship; and

b. one who only has an evaluative role with the recipient.

2. Together, the letters must establish the recipient have:
   a. a persistent and well-documented case of GD;

   b. received hormone therapy appropriate to the recipient's gender goals, which shall be for a minimum of 12 months in the case of a recipient seeking genital reconstruction surgery, unless such therapy is medically contraindicated, or the recipient is otherwise unable to take hormones;

   c. lived for 12 months in a gender role congruent with the recipient's gender identity without reversion to the original gender, and has received mental health counseling, as deemed medically necessary during that time; and

   d. significant medical or mental health concerns reasonably well-controlled; and capacity to make a fully informed decision and consent to the treatment.

3. When a recipient has previously had one or more initial surgical procedures outlined in this chapter, the recipient is not required to provide referral letters to continue additional surgical procedures, at discretion of the surgeon. The surgeon must ensure this is clearly documented in the recipient's medical record.

2. Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization is required.

609 MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy (MNT) is nutritional diagnostic, therapy and counseling services for the purpose of management of nutrition related chronic disease states. MNT involves the assessment of an individual's overall nutritional status followed by an individualized course of nutritional intervention treatment to prevent or treat medical illness. MNT is provided by a licensed and Registered Dietitian (RD) working in a coordinated, multidisciplinary team effort with the Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN) referred to as provider throughout this policy and takes into account a person's food intake, physical activity, and course of any medical therapy including medication and other treatments, individual preferences, and other factors. This level of instruction includes individualized dietary assessment that is above basic nutrition counseling.

Nevada Medicaid considers medical nutrition therapy medically necessary for diabetes, obesity, heart disease and hypertension where dietary adjustment has a therapeutic role, when it is prescribed by a provider and furnished by a RD. The only providers that should submit claims for medical nutrition therapy are RDs. Other qualified health care professionals may provide medical nutrition therapy; however, they must submit a claim for evaluation and management services.

609.1 POLICY

Medicaid will reimburse for MNT services rendered to Medicaid eligible individuals in accordance with the Nevada Medicaid coverage authority. MNT services must be medically necessary to address nutrition related behaviors that contribute to diabetes, obesity, heart disease and hypertension. Services must be rendered according to the written orders of the Physician, PA or an APRN. The treatment regimen must be designed and approved by an RD.

All services must be documented as medically necessary and be prescribed on an individualized treatment plan.

609.2 COVERAGE AND LIMITATIONS

A. MNT is initiated from a referral from a provider that can refer and includes information on labs, medications and other diagnoses. MNT includes:

1. A comprehensive nutritional and lifestyle assessment determining nutritional diagnosis.

2. Planning and implementing a nutritional intervention and counseling using evidence-based nutrition practice guidelines to achieve nutritional goals and desired health outcomes.

3. Monitoring and evaluating an individual's progress over subsequent visits with a RD.

B. Coverage of services includes:

1. Initial nutrition and lifestyle assessment.

2. One-on-one or group nutrition counseling.

3. Follow-up intervention visits to monitor progress in managing diet.

4. Reassessments as necessary during the 12-rolling month episode of care to assure compliance with the dietary plan.

5. Four hours maximum in the first year.

   a. Additional hours are permitted if treating provider determines a change in medical condition, diagnosis or treatment regimen requires a change in MNT.

   b. Additional hours beyond the maximum four hours in the first year require prior authorization.

   c. Documentation should support the patient's diagnosis of the specific condition, along with the referral from the provider managing the patient's condition.

   d. The documentation should also include a comprehensive plan of care, individualized assessment and education plan with outcome evaluations for each session, as well as referring provider feedback.

   e. There should be specific goals, evaluations and outcome measures for each session documented within the patient's records.

6. Two hours maximum per 12 rolling month period in subsequent years.

7. Services may be provided in a group setting. The same service limitations apply in the group setting.

C. MNT is not to be confused with Diabetic Outpatient Self-Management Training (DSMT)

1. Nevada Medicaid considers DSMT and MNT complementary services. This means Medicaid will cover both DSMT and MNT without decreasing either benefit as long as the referring provider determines that both are medically necessary.

2. See MSM Chapter 600, Attachment A, Policy #6-10 for DSMT coverage.

D. MNT is only covered for the management of diabetes, obesity, heart disease and hypertension-related conditions.

E. MNT may be provided through Telehealth services. See MSM Chapter 3400 for the Telehealth policy.

609.3 PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is required when recipients require additional or repeat training sessions beyond the permitted maximum number of hours of treatment. This can occur if there is a change of diagnosis, medical condition or treatment regimen related to a nutritionally related disease state.

609.4 PROVIDER QUALIFICATIONS

In order to be recognized and reimbursed as an MNT provider, the provider must meet the following requirements:

A. Licensed and RD under the qualifications of NRS 640E.150. An RD is an individual who has earned a bachelor's degree or higher education from an accredited college or university in human nutrition, nutrition education or equivalent education, has completed training and holds a license from the Nevada State Board of Health.

609.5 PROVIDER RESPONSIBILITY

A. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit, or utilization review.

B. The provider will ensure services are consistent with applicable professional standards and guidelines relating to the practice of MNT as well as state Medicaid laws and regulations and state licensure laws and regulations.

C. The provider will ensure caseload size is within the professional standards and guidelines related to the practice of MNT.

610 LICENSED PHARMACIST SERVICES

A licensed pharmacist is a health care professional licensed to engage in pharmacy duties including dispensing prescription drugs, monitoring drug interactions, and counseling patients regarding the effects and proper usage of drugs and dietary supplements. Billable services are specified within Section 610.2.

610.1 LICENSED PHARMACIST QUALIFICATIONS

Licensed pharmacist qualifications are defined per NRS 639.015 as a person whose name has been entered in the registry of pharmacists by the Nevada State Board of Pharmacy (BOP) and to whom a valid certificate or certificate by endorsement as a registered pharmacist or valid renewal thereof has been issued.

610.2 COVERAGE AND LIMITATIONS

A. Nevada Medicaid reimburses pharmacists for the following services:

1. The dispensing of self-administered hormonal contraceptive based on the protocols established by the BOP regardless of whether a patient has obtained a prescription from a practitioner.

2. The prescribing, dispensing and administration of drugs to prevent the acquisition of HIV and ordering and conducting certain HIV laboratory tests based on protocols established by the BOP.

B. Nevada Medicaid does not reimburse separately for services listed in Section 610.2(A) when provided in an inpatient or outpatient hospital, emergency department, or inpatient psychiatric facility of service.

C. Prior authorization is not required.

D. For a list of covered procedure codes please refer to the PT 91 - Licensed Pharmacist Billing Guide at https://www.medicaid.nv.gov/providers/rx/PDL.aspx.

611 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM) Chapter 3100 for hearings procedures.

POLICY #6-01	QUALIFYING CLINICAL TRIALS	EFFECTIVE DOS 1/1/22

A. DESCRIPTION

The "Consolidated Appropriations Act (CAA), 2021" amended Section 1905(a) of the Social Security Act (SSA) (42 U.S.C. 1396d) which includes new requirements to promote access to clinical trials by allowing Medicaid recipients coverage of routine patient costs for items and services furnished in connection with participation in Qualifying Clinical Trials (QCTs). This mandate also includes amendments to Sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory.

Pursuant to Sections 1905(a)(30) and 1905(gg)(1) of the Act, routine patient costs must be covered for a recipient participating in a QCT, including any item or service within the Nevada Medicaid State Plan, waiver, or demonstration project under Section 1115 of the Act provided to prevent, diagnose, monitor, or treat complications resulting from participation in the QCT.

For purpose of Section 1905(a)(30) of the Act, a QCT is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

1. To meet the statutory definition, the QCT must also be one or more of the following:

    a. A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:

        1. The National Institutes of Health (NIH);

        2. The Centers for Disease Control and Prevention (CDC);

        3. The Agency for Health Care Research and Quality (AHRQ);

        4. The Centers for Medicare and Medicaid Services (CMS);

        5. A cooperative group or center of any of the entities described above, the Department of Defense, or the Department of Veterans Affairs; or

        6. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

    b. A QCT, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Department of Health and Human Services (DHHS) Secretary, determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

        1. The Department of Energy;

        2. The Department of Veterans Affairs; or

        3. The Department of Defense.

c. A QCT that is conducted pursuant to an investigational new drug exemption under Section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under Section 351(a)(3) of the Public Health Service Act; or

d. A clinical trial that is a drug trial exempt from being required to have one of the exemptions listed under Item c. above.

B. PRIOR AUTHORIZATION

Prior Authorization is not required for participation in the QCT; however, if a routine patient cost/service or item requires a prior authorization or exceeds the service limitations, a prior authorization may be required. Please refer to the respective policies for prior authorization requirements.

For medically necessary services requiring a prior authorization, the appropriate QIO-like vendor must review and complete the request within 72 business hours.

C. COVERAGE AND LIMITATIONS

1. For a recipient participating in a QCT, coverage shall:

a. Be made without regard to the geographic location or network affiliation of the health care provider treating the recipient or the principal investigator of the QCT.

b. Be based on attestation regarding the appropriateness of the QCT by the health care provider and principal investigator.

c. Not require submission of the protocols of the QCT or any other documentation that may be proprietary or determined by the DHHS Secretary to be burdensome to provide.

2. The following items and services are not covered under the new mandatory benefit as described under Section 1905(gg) of the Act:

a. An investigational item or service that is the subject of the QCT and is not otherwise covered outside of the clinical trial under the State Plan, waiver, or demonstration project.

b. Routine patient cost does not include any item or service that is provided to the recipient solely to satisfy data collection and analysis for the QCT that is not used in the direct clinical management of the recipient and is not otherwise covered under the State Plan, waiver, or demonstration project.

NOTE: For policy regarding pharmaceutical clinical studies, please refer to MSM Chapter 1200 – Prescribed Drugs.

D. MEDICAID ATTESTATION FORM

1. The QCT principal investigator and the recipient's healthcare provider must complete the Medicaid Attestation Form on the Appropriateness of the QCT (FA-110). This form is available at the appropriate QIO-like vendor website at

https://www.medicaid.nv.gov/providers/forms/forms.aspx. This Medicaid Attestation Form must be submitted to the appropriate QIO-like vendor.

POLICY #6-02	WOUND MANAGEMENT	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-01

A. DESCRIPTION

A wound is defined as impaired tissue integrity that may involve the epidermis, dermis, and subcutaneous tissue, and may extend down to the underlying fascia and supporting structures. The wound may be aseptic or infected.

B. POLICY

Wound care is a Nevada Medicaid covered benefit for recipients who have a viable healing process.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. The patient's medical record must include a comprehensive wound history that includes date of onset, location, depth and dimension, exudate characteristics, circulatory, neuropathy, and nutritional assessments, current management and previous treatment regime. The provider must culture all infected wounds prior to initiating systemic antibiotics, per Center for Disease Control guidelines. Photographs are necessary to establish a baseline and to document the progress of the wound, as are weekly measurements. Providers are expected to educate recipients about the disease process, how to manage their own wound care and the importance of complying with the treatment plan. This education should be documented in the recipient's medical record.

2. The use of supplies during wound care treatment is considered part of the treatment. Do not bill separately.

3. Burn Care

    a. Burn care provided in the outpatient hospital setting will follow wound care guidelines with the exception of requiring a prior authorization.

    b. All diagnosis codes must be coded to the highest level of specificity.

E. COVERED CPT CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-03	OUTPATIENT HOSPITAL BASED HYPERBARIC OXYGEN THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-03

A. DESCRIPTION

Hyperbaric Oxygen Therapy (HBOT) is therapy in which a recipient breathes 100% oxygen intermittently while the pressure of the treatment chamber is increased to a point higher than sea level pressure (i.e.,>1 atm abs.). Breathing 100% oxygen at 1 atm of pressure or exposing isolated parts of the body does not constitute HBOT; the recipient must receive the oxygen by inhalation within a pressurized chamber.

B. POLICY

1. This Nevada Medicaid benefit is covered in an outpatient hospital, with limitations, for chronic conditions. Payment will be made where HBOT is clinically practical. HBOT is not to be a replacement for other standard successful therapeutic measures. Treatment of acute conditions, e.g., acute carbon monoxide intoxication, decompression illnesses, cyanide poisoning, and air or gas embolism may be provided in an outpatient hospital.

2. PRIOR AUTHORIZATION IS REQUIRED for chronic conditions (see billing manual)

3. PRIOR AUTHORIZATION IS NOT REQUIRED for acute conditions (see billing manual)

4. Documentation supporting the reasonableness and necessity of the procedure must be in the recipient's medical record including recipient's risk factors and submitted with the PA when required.

C. COVERAGE AND LIMITATIONS

1. Wound Therapy

Approval will be restricted to requests documenting that the wound has not responded to conventional treatments as outlined in the WOUND MANAGEMENT POLICY (6-02) and initiated by a provider. Attach a copy of the provider's order to the request for treatment. Maximum numbers of treatments authorized on consecutive days are 45. Therapy is conducted once or twice daily for a maximum of two hours each treatment.

2. HBOT must be provided and attended by an HBOT physician. Reimbursement will be limited to therapy provided in a chamber (including the one-person unit). No payment will be made for topical HBOT, or for other than the covered diagnosis.

3. Diabetic wounds of the lower extremities in patients who meet the following three criteria:

   a. Patient has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;

   b. Patient has wound classified as Wagner grade III or higher; and

   c. Patient has failed an adequate course of standard wound therapy.

D. COVERED DIAGNOSIS CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

A. DESCRIPTION/POLICY

FDA approved Intrathecal Baclofen (ITB) Therapy is a Nevada Medicaid covered benefit for recipients with severe spasticity of spinal cord origin, [(e.g. Multiple Sclerosis (MS), Spinal Cord Injury (SCI)], or spasticity of cerebral origin, [e.g., Cerebral Palsy (CP), and Brain Injury (BI)], who are unresponsive to oral Baclofen therapy or who have Intolerable Central Nervous System (CNS) side effects.

B. PRIOR AUTHORIZATION IS REQUIRED

C. COVERAGE AND LIMITATIONS

1. Coverage of treatment will be restricted to recipients with the following indicators:

   a. Spasticity due to spinal cord origin or spasticity of cerebral origin. If spasticity is result of BI, the injury must have occurred over one year prior to be considered for ITB therapy;

   b. Severe spasticity (as defined by a score of three or more on the Ashworth Scale) in the extremities for a duration of six months or longer;

   c. Recipients with increased tone that significantly interferes with movement and/or care;

   d. Spasm score of two or more; documentation to include pre and post testing of strength, degree of muscle tone, and frequency of spasm (Spasm Scale not applicable to CP recipients as spasms are not a frequent symptom in these recipients);

   e. Recipient is four years or older and has sufficient body mass to support the infusion pump;

   f. Documented six-weeks or more of failed oral antispasmodic drug therapy at the maximum dose. Recipient is refractory to oral Baclofen, or has intolerable side effects;

   g. Recipient has adequate cerebrospinal fluid flow as determined by myelogram or other studies;

   h. Recipient has no known allergy to Baclofen;

   i. Documentation of a favorable response to a trial dose of ITB prior to pump implantation. If recipient requires a second and/or third trial dose of ITB, documentation needs to include videotape of the recipient's arm and leg range of motion to assess spasticity and muscle tone before and after increased test doses of ITB. Recipients who do not respond to a dose consistent with baclofen screening trial protocols are not candidates for an implanted pump for chronic infusion therapy. Recipient must be free of infection at the time of the trial dose;

   j. Recipient, family, and physicians should agree on treatment goals. Recipient, family and caregivers should be motivated to achieve the treatment goals and be committed to meet the follow-up care requirements;

   k. Recipient must be free of systemic infection and/or infection at the implantation site at the time of surgery;

2. Benefit coverage includes up to three trial doses of ITB, surgical implantation of the device and follow-up provider office visits for dose adjustments and pump refills.

3. Documentation in the recipient's medical record should include what the expected functional outcomes and improvements in quality of life are for the recipient post procedure, e.g., increased independence, ease of caretaking activities, decreased pain, increased ADL's and improved communication. Also, document why the recipient is not a candidate for Botox injections.

4. Reimbursement for recipients with low muscle tone (often described as floppy muscles), chorea (uncontrollable, small jerky types of movements of toes and fingers) or athetosis (involuntary movements of face, arms or trunk) are not a Nevada Medicaid benefit.

D. COVERED CODES

For a list of covered procedure and diagnostic codes, please see the billing manual.

POLICY #6-05	RESERVED FOR FUTURE USE	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06

RESERVED FOR FUTURE USE

POLICY #6-06	VAGUS NERVE STIMULATOR (VNS)	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06

A. DESCRIPTION

Vagus Nerve Stimulation (VNS) is a method for treating recipients with refractory epilepsy who are not candidates for intracranial surgery and/or continue to be refractory following epilepsy surgery. The programmable NeuroCybernetic Prosthesis (NCP) is surgically implanted in the upper left chest with the leads tunneled to the vagus nerve in the left neck. An external magnet is provided to activate the generator and deliver additional impulses when needed. The external magnet may also be used to inhibit the NCP generator in the event of a malfunction.

B. POLICY

The Vagus Nerve Stimulator (VNS) is a covered Nevada Medicaid benefit. The benefit includes diagnostic EEG, surgical procedure, device and medically necessary follow-up office visits for analysis and reprogramming.

C. PRIOR AUTHORIZATION IS REQUIRED

Documentation supporting the medical necessity of the procedure must be in the recipient's medical record and submitted with the prior authorization when required.

D. COVERAGE AND LIMITATIONS

1. Implantation of VNS is used as an adjunctive therapy in reducing the frequency of seizures in adults and children over age six who have seizures which are refractory to Antiepileptic Drugs (AED). It is also indicated in recipients for whom surgery is not an option, or in whom prior surgery has failed.

2. Coverage is restricted to those recipients with the following indicators:

   a. Diagnosis of intractable epilepsy;

   b. Failed antiepileptic drug (AED) therapy tried for two to four months. The medical record should indicate changes/alterations in medications prescribed for the treatment of the recipient's condition. Documentation to include maintaining a constant therapeutic dose of AED as evidenced by laboratory results per manufacturer's recommendations;

   c. Have six or more medically intractable seizures per month;

   d. Have no other independent diagnosis that could explain why seizures are failing to respond to treatment;

   e. A recipient whose epileptologist/neurologist has recommended VNS implantation;

   f. A surgeon experienced with implantation of the VNS;

   g. The VNS will be managed by a physician familiar with the settings and protocols for use of the device;

   h. Recipients from three to six years of age must have all of the above indicators;

i. Be the result of a Healthy Kids Screening (EPSDT) referral for treatment; and

j. Be supported by peer review literature, and a written recommendation for VNS implantation and use from two Board Certified Pediatric Neurologists (other than the treating neurologist(s).

3. Reasons for non-coverage include, but are not limited to the following diagnoses/conditions: status epilepticus, progressive or unstable neurologic or systemic disorders, severe mental retardation, drug abuse, gastritis, gastric/duodenal ulcers, status post bilateral or left cervical vagotomy, unstable medical condition, pregnancy, use of investigational AED's, bradycardia, hypersecretion of gastric acid and/or a seizure disorder etiology more appropriately treated by other means (i.e., operation).

E. COVERED CODES

For a list of covered procedure and diagnosis codes, please see the billing manual.

POLICY #6-07	BARIATRIC SURGERY FOR MORBID OBESITY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-08

A. DESCRIPTION/POLICY

1. Bariatric Surgery is a covered Nevada Medicaid benefit reserved for recipients with severe and resistant morbid obesity in whom efforts at medically supervised weight reduction therapy have failed and who are disabled from the complications of obesity. Morbid obesity is defined by Nevada Medicaid as those recipients whose Body Mass Index (BMI) is 35 or greater, and who have significant disabling comorbidity conditions which are the result of the obesity or are aggravated by the obesity. Assessment of obesity includes BMI, waist circumference, and recipient risk factors, including family history.

2. This benefit includes the initial work-up, the surgical procedure and routine post-surgical follow-up care. The surgical procedure is indicated for recipients between the ages of 21 and 55 years with morbid obesity. (Potential candidates older than age 55 will be reviewed on a case by case basis.)

B. PRIOR AUTHORIZATION IS REQUIRED

Documentation supporting the reasonableness and necessity of bariatric surgery must be in the recipient's record and submitted with the PA.

C. COVERAGE AND LIMITATIONS

1. Coverage is restricted to recipients with the following indicators:

   a. BMI of 35 or greater;

   b. Waist circumference of more than 40 inches in men, and more than 35 inches in women;

   c. Obesity related comorbidities that are disabling;

   d. Strong desire for substantial weight loss;

   e. Well-informed and motivated;

   f. Committed to a lifestyle change; and

   g. Negative history of significant psychopathology that contraindicates this surgical procedure.

2. Documentation supporting the reasonableness and necessity of the surgery must be in the medical record and should include evidence of participation in a medically supervised weight loss program for a minimum of three months prior to the surgery. There must also be documentation of weight loss therapy participation including recipient efforts at dietary therapy, physical activity, behavior therapy, pharmacotherapy, combined therapy or any other medically supervised therapy.

3. No coverage will be provided for pregnant women, women less than six months postpartum, or women who plan to conceive in a time frame less than 18 to 24 months post gastric bypass surgery.

D. COVERED CODES

For a list of covered procedure codes, please see the billing manual.

E. REFERENCES:

1. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/mm5013.pdf

2. http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf

POLICY #6-08	HYALGAN AND SYNVISC INJECTIONS	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-09

A. DESCRIPTION

Hyalgan and Synvisc are injectable drugs that are used to treat osteoarthritis of the knee. These solutions act like an "oil" to cushion and lubricate the knee joint. Hyalgan is injected directly into the osteoarthritic knee for a single course of treatment. Injections are administered one week apart for a total of five injections. Synvisc is administered as a total of three intra-articular injections into the knee joint during a three-week period. Each course of treatment must be performed by a qualified physician.

B. POLICY

1. Hyalgan and Synvisc injectables are a covered Nevada Medicaid benefit for the treatment of pain due to osteoarthritis of the knee. Diagnosis must be supported by radiological evidence.

2. Repeat treatment is not reimbursable, as it is not medically indicated, if the first course of treatment is not beneficial to the recipient.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. Hyalgan and Synvisc are indicated for recipients who do not obtain adequate relief from simple pain medication and/or from exercise and physical therapy.

2. An Evaluation & Management (E&M) service will not be covered during subsequent visits for injections unless there is a separately identifiable problem.

A. DESCRIPTION

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are a covered service for hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.

B. PRIOR AUTHORIZATION IS NOT REQUIRED

C. COVERAGE AND LIMITATIONS

1. A provider's service furnished to dialysis recipients who are treated as outpatients, are divided into two major categories: direct recipient care and administrative.

2. Provider's evaluation and management-type services, "unrelated" to the dialysis procedure (not provided during a dialysis treatment) may be billed in addition to the dialysis procedure.

3. Provider's providing evaluation and management-type services "related" to the dialysis procedure same day dialysis is performed, or during a dialysis treatment) are billed as included in the dialysis procedure. Service units' equal number of treatments.

4. Criteria for instituting IDPN/IPN:

   a. Three-month average predialysis serum albumin level of <3.4 mg/dl.

   b. Three-month average predialysis serum creatine of <8.0 mg/dl.

   c. Three-month average predialysis serum pre-albumin level of <25 mg/dl.

   d. Weight loss of 7.5% of usual body weight over three months.

   e. A clinical exam consistent with moderate to severe malnutrition.

   f. A dietary history of reduced food intake (protein <0.8 g/kg/day; calories <25 cal/kg/day).

   g. Failed attempts at dietary and oral supplementation.

   h. Eternal tube feeding contraindicted.

   i. Gastrointestinal diagnosis, supported by GI consult, GI medications (Prilosec, Reglan, Imodium, etc.).

5. Criteria for discontinuing IDPN/IPN:

   a. Three-month average predialysis serum albumin level of >3.8 mg/dl.

   b. Three-month average predialysis serum creatine of >10 mg/dl.

c. Three-month average predialysis serum pre-albumin level of >28 mg/dl.

d. A clinical exam consistent with improved nutritional status.

e. A dietary history of increased food intake (protein 1.0 g/kg/day; calories 30 cal/kg/day).

f. Absence of active inflammation or other serious condition characterized by high albumin turnover.

g. No improvement with IDPN/IPN treatment after six months.

h. Complications or intolerance associated with IDPN/IPN treatment.

6. No coverage will be provided for situations involving temporary impairments (less than 90 days). No coverage will be provided if recipients are noncompliant with the plan of treatment.

A. DESCRIPTION

1. Nevada Medicaid defines DSMT as the development of a specific treatment plan for Type I and Type II diabetics to include blood glucose self-monitoring, diet and exercise planning, and motivates recipients to use the skills for self-management.

2. Reimbursement will follow Medicare guidelines for initial recipient and group training sessions. For information regarding blood glucose monitors and diabetic supplies see MSM Chapter 1300, DME Disposable Supplies and Supplements.

3. Services must be furnished by certified programs which meet the National Diabetes Advisory Board (NDAB) standards and hold an Education Recognition Program (ERP) certificate from the American Diabetes Association and/or the American Association of Diabetic Educators. Program instructors should include at least a nurse educator and dietician with recent didactic and training in diabetes clinical and educational issues. Certification as a diabetes educator by the National Board of Diabetes Educators is required.

B. PRIOR AUTHORIZATION IS REQUIRED

When recipients require additional or repeat training sessions that exceed ten hours of training.

C. COVERAGE AND LIMITATIONS

1. The provider managing the recipient's diabetic condition certifies the comprehensive plan of care to provide the recipient with the necessary skills and knowledge in the management of their condition, and to ensure therapy compliance. The program must be capable of offering, based on target population need, instruction in the following content areas:

   a. Diabetes review;

   b. Stress and psychological adjustment;

   c. Family involvement and social support;

   d. Medications;

   e. Monitoring blood glucose and interpretation of results;

   f. Relationships between nutrition, exercise and activity, medication and glucose levels;

   g. Prevention, detection and treatment of both acute and chronic diabetic complications, including instruction related to care of feet, skin and teeth;

   h. Behavioral change strategies, goal setting, risk factor reduction and problem solving;

   i. Benefits, risks and management options for improvement of glucose control;

   j. Preconception care, pregnancy and gestational diabetes; and

k. Utilization of health care systems and community resources.

2. Indications for repeat training Prior Authorization is required for recipients whose diabetes is poorly controlled include:

a. Hemoglobin A 1 c blood levels of 8.5 or greater;

b. Four or more serious symptomatic hypoglycemic episodes in a two-month period;

c. Two or more hospitalizations for uncontrolled diabetes in a six-month period;

d. Any ketoacidosis or hyperosmolar state;

e. Pregnancy in a previously diagnosed diabetic; or

f. Diabetics beginning initial insulin therapy.

3. No coverage will be provided for initial training which exceeds ten hours, or for repeat training, without a prior authorization.

D. COVERED CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-11	BOTULINUM TOXIN	EFFECTIVE DATE 12/18/04 RE-ISSUE/UPDATE 01/29/20

A. DESCRIPTION

Botulinum Toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries and multiple sclerosis. The injections may also reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow better range of motion, to permit better physical therapy and/or provide adequate perineal hygiene.

B. PRIOR AUTHORIZATION

Prior authorization is required for Botulinum Toxin. Please reference MSM Chapter 1200, Prescribed Drugs for prior authorization criteria.

POLICY #6-12	RESERVED FOR FUTURE USE	

RESERVED FOR FUTURE USE

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 30, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 700 – RATES AND SUPPLEMENTAL REIMBURSEMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 700 – Rates and Cost Containment are being proposed to update and clarify the information. The title of the Chapter is being changed from "Rates and Cost Containment" to "Rates and Supplemental Reimbursement." Section 705 – Letters of Agreement is being added.

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. Global changes were made in reference to the Medicaid State Plan in order that it be consistent throughout the chapter.

Entities Financially Affected: All provider types are affected by the proposed changes.

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective May 1, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 10/19 MSM Ch 700 – Rates and Supplemental Reimbursement	MTL 21/13, 16/12, 19/09, 26/07 MSM Ch 700 – Rates and Supplemental Reimbursement

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
700(D)	**INTRODUCTION**	Revising language from "mentally retarded" to "Individuals with Intellectual Disabilities (ICF/IID)."
703.2(A)	**FEE TO INCREASE**	Changing the language from "non-Medicare" patients to "all" patients. Adding new language after that to read:

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	QUALITY OF NURSING CARE	"during the preceding month listed by the type of insurance coverage for each patient day,…"
703.2(B)(1)		Changing the percent from 5.5% to 6.0% as that is the current federal limit the program is operating under.
703.2(B)(2)		Clarifying the reference by changing … "patients by the rate in 2.a" to "patients by the rate in 703.2(B)(1)."
703.2(B)(3)		Adding clarifying language when the January report is due as this differs from other months.
703.3(B)(1)	**COST REPORTS**	Revising language from "Mentally Retarded (ICF/MR)" to "ICF/IID."
703.3(C)(2)		Clarifying the reference by changing "any amounts due under 3.a" to "any amounts due under 703.3(A)."
704	**MEDICAID RATE(S) APPEAL**	Revising language referencing the Nevada Medicaid State Plan. Clarifying "Appeals" to "Rate appeals." Adding language to indicate "provider-specific rates." Changing "procedures" to "the methodologies" and clarifying "cannot be appealed and the policies outlined in MSM 704 would not apply." Adding information clarifying who may or may not file appeals.
704(G)(10)		Adding 10. to the list that reads: "That the basis for relief is fiscally acceptable under current and/or future budget authority."
704(I)		Removing "The decision on the appeal shall set forth Findings of Fact and Conclusions of Law" and adding "The DHCFP will contact the person designated in 704(F)(1) to provide an explanation of the decision and allow an opportunity to reconcile the dispute."
704 (J)		Clarifying the reference by changing "to the person designated in 704.2.a" … to "to the person designated in 704(F)(1)."
704(K)		Revising the language to read: "The Administrator's decision is considered final."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
705	**LETTERS OF AGREEMENT**	This section is being added and provides information related to Letters of Agreement (LOA) for out-of-state providers.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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RATES AND SUPPLEMENTAL REIMBURSEMENT

700 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) establishes the methods and standards for provider reimbursements for Medicaid services in accordance with the Code of Federal Regulations (CFR), Title 42, Part 447 and in consultation with providers and a public hearings process. The methods and standards for rate determinations are described in Nevada's approved State Plan under Title XIX of the Social Security Act (i.e. the Medicaid State Plan).

Providers should consult the Medicaid State Plan, Section 4.19 – Payment for Services, for methods and standards for reimbursement. The following is a brief summary of the detail attachments to Section 4.19:

A. Attachment 4.19-A describes methods and standards for reimbursing inpatient hospitals, residential treatment centers, Indian Health Service and Tribal 638 Health Facilities.

B. Attachment 4.19-B describes the methods and standards for reimbursing medical services provided by licensed professionals in various settings and those items ancillary to licensed medical services, such as laboratory and x-ray, pharmaceuticals, dentures, prosthetic devices, eyeglasses, medical supplies, appliances and equipment and transportation.

C. Attachment 4.19-C describes the methods and standards for reimbursing reserved beds in various institutions excluding acute care facilities.

D. Attachment 4.19-D describes the methods and standards for long-term care facilities including hospital-based and freestanding nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and swing beds in hospitals.

701 AUTHORITY

701.1 FEE TO INCREASE QUALITY OF NURSING CARE

Nevada Revised Statute (NRS) 442.3755 to NRS 422.379

701.2 COST REPORTS

CFR, Title 42, Part 413-Principles of Reasonable Cost Reimbursement, Section 413.24

A. Title XIX of the Social Security Act (SSA), Medicaid State Plan, Attachment 4.19-D, Page 6, Section C.

701.3 MEDICAID RATE(S) APPEAL

The authority for provider rate(s) appeals exists under the CFR (CFR, Title 42, Chapter IV, Part 447 – Payments for Services, Section 447.253(e) – Other requirements). This section states, "The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates."

702 ELIGIBILITY RULES FOR SUPPLEMENTAL PAYMENT PROGRAMS

702.1 RULES OF PARTICIPATION FOR INPATIENT UPPER PAYMENT LIMIT (UPL) FOR PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT PROGRAM

Attachment 4.19-A, Section XV, Part B of the Medicaid State Plan authorizes Medicaid supplemental payments to certain private hospitals affiliated with Nevada units of government through a Low Income and Needy Care Collaboration Agreement. Participation in the program must be consistent with federal approval of the State Plan.

In order to be eligible to provide the non-federal share of these Medicaid supplemental payments, *a unit of government* must execute a certification that it will comply with the program limitations adopted by the DHCFP in its Nevada Medicaid Supplemental Payment Program Conditions of Participation (CoP). Each unit of government must execute this certification on a form promulgated by the DHCFP. Each unit of government's participation must be consistent with federal approval of the State Plan.

In order to be eligible to receive Medicaid supplemental payments under this section of the Medicaid State Plan, *a hospital* must execute a certification that it will comply with the program limitations adopted by the DHCFP in its Nevada Medicaid Supplemental Payment Program CoP. Each hospital must execute this certification on a form promulgated by the DHCFP. Each private hospital's participation must be consistent with federal approval of the State Plan.

The State Plan, CoP, certification forms and other participation requirements are available to the public at the DHCFP's office and on the website at: https://dhcfp.nv.gov/hcfpdata.htm.

In order to be consistent with CFR Title 42, Chapter IV, Part 447, Subpart C, Section 447.272, the DHCFP:

A. Prohibits any cash or in-kind transfers from the private hospitals to the governmental entity that have a direct or indirect relationship to Medicaid payments;

B. Does not allow a governmental entity to condition the amount it funds the Medicaid program on a specified or required minimum amount of low income and needy care;

C. Does not allow a governmental entity to assign any of its contractual or statutory obligations to a private hospital receiving payments under State Plan Amendment (SPA) 10-002C;

D. Does not allow the governmental entity to recoup funds from a hospital that has not adequately performed under the Low Income and Needy Care Collaboration Agreement;

E. Prohibits each private hospital from returning any of the supplemental payments it receives under SPA 10-002C to the governmental entity that provides the non-federal share of the payments; and

F. Prohibits each governmental entity from receiving any portion of the supplemental Medicaid payments made to the private hospitals under SPA 10-002.

703 POLICY

703.1 INPATIENT HOSPITAL SERVICES

Inpatient hospital services, which have been authorized for payment at the acute level by a Quality Improvement Organization (QIO-like vendor), as specified in the contract between the QIO-like vendor and the DHCFP, are reimbursed by all-inclusive, prospective per diem rates by type of admission/service. The all-inclusive prospective rates cover routine and ancillary services furnished by the hospital, including direct patient care for professional services furnished to inpatients by hospital-staffed physicians and practitioners. For specific rate methods and standards for inpatient hospital services, refer to the State Plan, Section 4.19, Attachment A.

703.2 FEE TO INCREASE QUALITY OF NURSING CARE

The DHCFP established the following policy to assess and collect fees to increase the quality of nursing care. NRS 422.3775 states: *"Each nursing facility that is licensed in this State shall pay a fee assessed by the Division to increase the quality of nursing care in this State."*

A. Reporting Requirements:

Each nursing facility shall file with the DHCFP each month a report setting forth the total number of days of care it provided to all patients during the preceding month listed by the type of insurance coverage for each patient day, the total gross revenue it earned as compensation for services provided to patients during the preceding month, and any other information required by the Division.

B. Payment of Fee:

1. The DHCFP shall annually establish a rate per non-Medicare patient day that is equivalent to 6.0%, or a percentage not to exceed any limitation provided under federal law or regulation, of the total annual accrual basis gross revenue for services provided to patients of all nursing facilities licensed in this state.

2. The DHCFP shall calculate the fee owed by each nursing facility by multiplying the total number of days of care provided to non-Medicare patients by the rate in 703.2(B)(1).

3. The monthly report and fee assessed pursuant to this section are due 30 days after the end of the month for which the fee was assessed. The January report is due not later than the last day of February.

C. Failure to Pay or Late Payment of Fee:

1. The DHCFP may assess a penalty of one percent of the fee for each day a fee is past due up to 10 days. The DHCFP may assess interest at the rate of 1.5% of the fee per month or fraction thereof for any past due fee. In the event a facility has not submitted the required monthly report, the DHCFP may estimate the fee due for purposes of assessing penalties and interest.

2. The DHCFP may withhold past due fees, penalties and interest from a facility's Medicaid claims payments until such past due amounts are paid in full.

703.3 COST REPORTS

The DHCFP established the following policy to collect Medicare/Medicaid cost reports. (A Medicare/Medicaid Cost Report is the standard Medicare Cost Report with the required Medicaid sections completed.)

The DHCFP adopts Medicare deadlines for the Medicare/Medicaid cost reports. These requirements are found in the CFR (CFR, Title 42, Part 413 – Principles of Reasonable Cost Reimbursement, Section 413.24). This section states, *"Due dates for cost reports. (i) Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period."*

The authority to collect Medicaid Cost Reports exists under Title XIX of the SSA, Medicaid State Plan, Attachment 4.19. Cost and other statistical information within the cost report must be reported in compliance with allowable and non-allowable cost definitions contained in the Medicare/Medicaid provider reimbursement manual (commonly referred to as Centers for Medicare and Medicaid Services (CMS) Publication 15).

A. Hospital Cost Reporting Requirements:

Hospital (including hospital-based nursing facility) annual Medicare/Medicaid cost reports are to be filed with the Medicaid program (DHCFP) following the cost report filing deadlines adopted in 42 CFR 413.24. If a facility requests an extension from the Medicare program, they must also request an extension from the DHCFP. Extension requests approved by Medicare will automatically be approved by the DHCFP, once the DHCFP receives evidence of Medicare approval from the facility.

B. Free-Standing Cost Reporting Requirements:

1. Free-standing nursing facilities and ICF/IID must complete and file an annual Medicare/Medicaid cost report with the DHCFP.

2. Cost reports are to be received by the DHCFP by the last day of the third month

following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame, a request for a 30-day extension can be requested from the DHCFP prior to the original cost report due date. Reasonable extension requests will be granted.

3. Minimum Direct Care Staffing Requirement: In the event that a nursing facility does not incur direct care cost at least equal to 94% of the direct care median, the DHCFP will have the option to recoup, from future payments to that provider, an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing. Any penalties collected shall accrue to the State General Fund and shall be used to offset Medicaid expenses.

C. Failure to File or Late Filing of Cost Reports

1. Facilities failing to file a Medicare/Medicaid cost report in accordance with these provisions may have their Medicaid payments suspended or be required to pay back to the Medicaid program all payments received during the fiscal year period for which they were to provide a cost report. Facilities may also be subject to an administrative fine of up to $500 per day for each day the required cost reports are delinquent.

2. The DHCFP may withhold any amounts due under 703.3(A) (above) from a facility's Medicaid claims payments until such amounts are paid in full.

704 MEDICAID RATE(S) APPEAL

The following appeal procedure applies to reimbursement rates paid to providers for providing services under the Medicaid State Plan to Medicaid recipients enrolled in the Fee-for-Service Medicaid program. Rate appeals are limited to individual providers requesting review of a provider-specific rate. For example, a provider who is reimbursed under a negotiated rate or by cost pursuant to the State Plan may seek review through the process outlined in Medicaid Services Manual (MSM) Chapter 704.

The rate appeal process may not be used to request a rate increase for general rates. General rates are determined by methodologies set forth in the State Plan and are not eligible for review through the process outlined in MSM Chapter 704.

In addition to the above, appeals may not be filed by the following:

A. Providers who are reimbursed under the Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS Publication 15;

B. Providers who are reimbursed under the Prospective Payment System (PPS) established by cost-based reporting as required by the SSA §1902(a)(15) (42 United States Code (USC) §1396a(a)(15)) and S.S.A. §1902(bb) (42 USC §1396a(bb));

C. Indian Health Services who are reimbursed in accordance with the most recent Federal Register Notice; and

D. Government providers who undergo a cost reconciliation or cost settlement reimbursement.

E. Appeals must be submitted in writing to the address below and clearly marked as a Rate appeal.

To ensure receipt of the appeal, certified mail or other commonly accepted delivery methods which clearly show the date of receipt are encouraged.

Appeal address: Administrator DHCFP, 1100 E. William Street, Suite 101, Carson City, Nevada 89701.

F. The appeal must contain the following information:

1. The name, address and telephone number of the person who has authority to act on behalf of the provider/appellant;

2. The specific rate(s) to be reviewed;

3. The basis upon which the provider believes relief should be granted including supporting documentation:

   a. Claims documentation showing costs for Medicaid services not fully compensated by Medicaid payments is necessary, but not sufficient to form a basis for relief.

   b. The documentation should show that payments received from Medicaid for the appealed rate fail to compensate for costs attributable to providing services to Medicaid patients as well as for the rates in aggregate for the provider.

   c. The documentation must show how the specific circumstances of services provided to Medicaid recipients relative to other like-providers result in higher costs not adequately or appropriately considered in the development of the existing rate(s).

4. The relief requested, including the methodology used to develop the relief requested.

   Actual costs from the most recent prior year(s), or costs from part of the current year, may be used in developing the methodology for the relief request, so long as it is not a cost reimbursement methodology; and

5. Any other information the provider believes to be relevant to the review.

G. The Administrator, or their designee, may consider the following factors in deciding whether to grant rate relief:

1. Whether there are circumstances related to the appellant when compared to other providers that cause the appellant to have higher Medicaid costs in the rate category reviewed;

2. Whether the circumstances relating to the provider are adequately considered in the rate-setting methodology set forth in the State Plan;

3. The extent to which comparable health care services are available and accessible for all people in the geographic area served by the appellant/provider;

4. Whether Medicaid payments are sufficient to meet Medicaid costs in the appealed rate(s);

5. The total Medicaid payments to the provider and all Medicaid payments for the appealed rate(s): In the case of hospitals, this includes total Medicaid costs to the hospital for inpatient care and the hospital's Medicaid costs for the appealed rate(s);

6. Audit review information, if any;

7. Information and data used to set the existing or appealed rate;

8. Such other information or documentation as the Administrator, or their designee, deems relevant; and

9. That the basis for relief results in uncompensated Medicaid costs to the provider, both in the appealed rate(s) and in aggregate Medicaid payments under the State Plan; and

10. That the basis for relief is fiscally acceptable under current and/or future budget authority.

H. The Administrator, or their designee, shall review the appeal and supporting documentation and issue a written decision within 90 calendar days of receipt of a properly submitted appeal. The Administrator, or their designee, may request any additional information from the provider, including independent verification by an unrelated third party of the provider's claims. If the Administrator, or their designee, requests additional information or verification, the period in which the Administrator, or their designee, must issue a decision is extended to 90 calendar days from the receipt of the requested information.

I. The DHCFP will contact the person designated in 704(F)(1) to provide an explanation of the decision and allow an opportunity to reconcile the dispute.

J. The decision will be sent in writing by certified mail, return receipt requested, to the person designated in 704(F)(1).

K. The Administrator's decision is considered final.

705 LETTERS OF AGREEMENT

Pursuant to the conditions and limitations prescribed in the Medicaid State Plan, the DHCFP may negotiate reimbursement rates for out-of-state providers to serve Nevada Medicaid recipients. The services of these providers are often necessary to ensure access to services for Medicaid and Nevada Check Up recipients that may not otherwise be available from in-state providers or in those instances where a recipient is in need of emergency care while outside of the State of Nevada.

705.1 SCOPE AND RESPONSIBILITY

The following procedure will be used for all out-of-state providers requesting a provider-specific rate. These procedures do not apply to external professional services billed outside of an inpatient or outpatient facility setting.

These procedures are applicable primarily to out-of-state inpatient and outpatient acute, psychiatric and specialty hospital services and other services associated with such treatment, including transportation and physician services.

The Rate Analysis and Development (RAD) unit of the DHCFP is responsible for administering the provision of this section. All agreements under this section are not final until they are fully executed by the Division's Administration.

705.2 PROCEDURES

A. Before an agreement under this section can be finalized, a provider must be enrolled as a current Nevada Medicaid provider. The provider must submit a list of their current active Nevada Medicaid provider numbers for which the agreement will apply.

B. If the service requires a prior authorization (PA), providers must present the PA number when requesting a Letter of Agreement (LOA). Information regarding PAs may be found in the MSM Chapter 100 – Medicaid Program.

C. The RAD unit will negotiate a provider-specific reimbursement agreement within the constraints of the Medicaid State Plan and the MSM. A percentage of usual and customary billed charges is the most common methodology, but other methods may be acceptable.

1. Negotiations will be conducted with the purpose of ensuring both fiscal responsibility and restraint, as well as providing access to services for Nevada Medicaid recipients.

D. Agreements may be for a single recipient or an individual provider. They are for all services rendered by the out-of-state provider. Methodologies may vary by type of service.

E. All agreements must have a reimbursement effective and expiration date. This allows for periodic review and updates of the methodology. In the event an agreement expires without renewal, the provider will be reimbursed on the same basis as in-state providers for the same service(s).

1. If a PA is not required, the effective date for the LOA is the time of the request. If a PA is required, the effective date for the LOA will be the authorized effective date on the PA issued by the fiscal intermediary for Nevada Medicaid. A retroactive LOA will only be provided if the service occurred over a weekend, or for emergencies, and must be approved by the DHCFP Administrator.

F. All agreements must be consistent with the capabilities of the Medicaid Management Information System (MMIS), which is used for processing billing claims.

G. The LOA template, as approved by the DHCFP, will be used to confirm the reimbursement agreement with the provider. The LOA may only be executed using the template approved by the DHCFP. Reproduced templates will not be accepted.

H. Copies of the fully executed agreement will be sent to the provider, the fiscal intermediary and the appropriate DHCFP Chiefs.

I. When submitting claims, the provider must include a copy of the LOA to ensure reimbursement will be at the provider-specific rate.

705.3 PERIODIC REVIEW

Agreements may be reviewed by the DHCFP as necessary to ensure compliance with Nevada Medicaid policy.

At any time, the out-of-state provider may request a review of the provider-specific rate for the LOA.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 26, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE/*Lynne Foster/*

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 800 – LABORATORY SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 800 – are proposed to update language, definitions and limitations for drug screening and testing. Presumptive drug screens are limited to one per day with a maximum of 20 tests per 12-rolling months. Only three definitive drug screens are permitted per recipient per 12-rolling months. Should more than three be needed, a prior authorization is required.

Entities Financially Affected: Hospital, Outpatient (Provider Type (PT) 12), Special Clinics (PT 17), Physician/Osteopath (PT 20), Certified Registered Nurse Practitioner, Nurse (PT 24), Laboratory – Pathology/Clinic (PT 43), School Based Services (PT 60), Nurse Midwife (PT 74), and Physician's Assistant (PT 77).

Financial Impact on Local Government: Unknown at this time.

These changes are effective August 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 11/18 MSM Chapter 800 – Laboratory Services	MTL 15/14 MSM Chapter 800 – Laboratory Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
803.1A.1.p.1	**Coverage and limitations**	Added language to clarify the requirements of the presence of a drug or drug class for when to conduct a drug screen.
803.1.A.1.p.3	**Coverage and limitations**	Added language to clarify structures of screening of drugs including presumptive and definitive. This includes the maximum number of 20 presumptive and the

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		maximum number of three definitive drugs screens that can be performed in a 12-month rolling period.
803.1.A.1.p.4	**Coverage and limitations**	Added language that standing orders for presumptive drug screens may be utilized.
803.1.A.1.p.5	**Coverage and limitations**	Added language that procedure codes should only be reported with a quantity of one per episode of care.
803.1.A.1.p.6	**Coverage and limitations**	Added language that testing for the same drug with a blood and urine specimen simultaneously is not covered.
803.1.A.1.p.7	**Coverage and limitations**	Added language that drugs screens not meeting medical necessity are not covered.
803.1.A.1.p.8	**Coverage and limitations**	Added language that routine drug screens are not covered unless used in conjunction with an extended course of treatment for substance abuse disorders.
803.1.A.1.p.9	**Coverage and limitations**	Added language that drug confirmation tests are not eligible to be separately reported under any procedure code, unlisted or otherwise.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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LABORATORY SERVICES

ATTACHMENT A

800 LABORATORY SERVICES

INTRODUCTION

All providers participating in the Medicaid Program must deliver services in accordance with the rules and regulations of the Medicaid Program.

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.

801 AUTHORITY

The Centers for Medicare and Medicaid Services (CMS) mandate that necessary and essential laboratory services be available for all Nevada Medicaid recipients. Laboratory services for children are provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program per the Social Security Act (SSA) of 1905 (a)(3)(1)(B)(iv)(r)(5). The Nevada EPSDT program provides children with services additional to those available to adult recipients.

Laboratory services are available through the Medicaid Program according to the:

Code of Federal Regulations (CFR):

- 42 CFR 493 Laboratory Requirements
- 42 CFR 410.32 Diagnostic X-Ray and Laboratory Tests
- 42 CFR 440.30 Other Laboratory and X-Ray Services
- 42 CFR 441.17 Laboratory Services

Nevada Revised Statute (NRS) Chapter 652 (Medical Laboratories)

Medicaid State Plan Attachment 1.2-B, 101.9.C and Attachment 4.19-B.3.

Other authorities regarding laboratory services available through the Medicaid Program include:

Social Security Act:

- Section 1902(a)(9)(C) (State Plans for Medical Assistance)
- Section 1905(a)(3), Section 1905(r)(1)(B)(iv) and Section 1905(r)(5) (EPSDT, Provision of Laboratory Services)

42 CFR 482.27 (Conditions of Participation for Hospitals, Laboratory Services)

NRS:

- NRS 442.600- 442.660 (Serologic or rapid test Human Immunodeficiency Virus (HIV))
- NRS 442.010 (Serologic testing for syphilis in the first and third trimester of pregnancy)

802 RESERVED

803 POLICY

803.1 Nevada Medicaid and NCU reimburse for medically necessary, diagnosis related, covered laboratory services provided to all eligible recipients.

Nevada Medicaid and NCU provide outpatient clinical laboratory services through one or more independent clinical laboratories, physician office laboratories, clinics and hospital-based laboratories.

803.1A COVERAGE AND LIMITATIONS

1. Covered Services:

   a. Except for specific laboratory tests identified under non-covered services, the Division of Health Care Financing and Policy (DHCFP) reimburses organ or disease oriented panels, therapeutic drug assays, evocative/suppression testing, clinical pathology consultations, urinalysis, chemistry, hematology and coagulation, immunology, tissue typing, transfusion medicine, microbiology, cytopathology, cytogenic, surgical pathology, total transcutaneous bilirubin and tests specified under, “Other Procedures” in the most recent version of Current Procedural Terminology (CPT). Reference the Nevada Medicaid and NCU billing guidelines for Provider Type 43, Laboratory, Pathology/Clinical, for covered CPT codes.

   b. Follow-up testing performed by either the discharging hospital laboratory and/or the newborn’s physician for newborns discharged with a hyperbilirubinemia diagnosis.

   c. Ova and parasite testing for medically appropriate diagnosis.

   d. An arterial blood drawing fee for Arterial Blood Gases (ABG) performed by physicians and/or respiratory therapists.

   e. Specialized or unique testing which cannot be performed within the State and catchment area laboratories referred to a reference laboratory. Reference Section 803.1C.2 regarding prior authorization requirements.

   f. Genotype and Phenotype assay testing for recipients:

      1. With an acute (new or recent) HIV diagnosis upon entry into HIV care and/or prior to the initiation of antiretroviral therapy;

      2. Presenting with documented virologic failure after initiation of antiretroviral therapy; or

3. Demonstrating documented suboptimal suppression of viral load after initiation of antiretroviral therapy.

g. One venipuncture specimen collection fee per patient, per date of service, specifically when the specimen is sent directly from a physician's office laboratory or clinic to an independent clinical laboratory for testing.

h. Laboratory tests associated with the EPSDT (Healthy Kids Program) screening examination referenced in Medicaid Services Manual (MSM) Chapter 1500. The associated costs of the hematocrit and urine "dip stick" with the exception of metabolic screening (e.g. Phenylketonuria (PKU)) and sickle cell screening fees, are included as part of the fee for EPSDT.

i. Metabolic screening (e.g. PKU) tests are referred to the Nevada State Public Health Laboratory.

j. Sickle cell screens are referred to an independent clinical laboratory.

k. Serological or rapid-test HIV testing during the first and/or third trimester of pregnancy or during childbirth performed in accordance with NRS 442.600 – 442.660.

l. An HIV rapid test for newborns (including infants in foster care) when the mother has not been tested for HIV prior to or during the delivery or if the mother's HIV status is unknown postpartum.

m. Serologic testing for syphilis in the first and third trimester of pregnancy in accordance with NRS 442.010.

n. Semen analysis, motility and count following a vasectomy procedure, not including Huhner test, is limited to the CPT code that is specified in the DHCFP's/Quality Improvement Organization (QIO)-like vendor billing manual.

o. HIV tropism testing, not meeting criteria specified in Section 803.1A.2.m.

p. Drug Screening and Testing

1. Drugs or drug classes for which screening is performed should only reflect those likely to be present based on the recipient's medical history, current clinical presentation or risk potential for abuse and diversion.

2. Each drug or drug class being tested for must be indicated by the referring physician in a written order and reflected in the patient's medical record.

This information must be patient-specific and accurately reflect the need for each test and must include the specific drugs being screened including recipient diagnosis.

3. Current coding for testing of drugs relies on a structure of screening (known as presumptive screening) and may be followed by quantitative measurements (known as definitive testing) that identifies the specific drug or drugs and quantity in the recipient.

   a. Only one presumptive test performed by direct observation or instrument assisted direct observation or instrument chemistry analyzers may be billed per recipient per day within a maximum of 20 presumptive test per 12-rolling months.

      1. If the recipient should require more than 20 presumptive tests per 12-rolling month, a prior authorization is required.

   b. Only three definitive drug tests are permitted per recipient per 12-rolling months.

      1. If the recipient requires more than three definitive tests per 12-rolling month, a prior authorization is required, meeting medical necessity.

      2. Definitive testing is only covered to confirm an unexpected result or identify drugs or metabolites that cannot be detected on a presumptive drug screen.

      3. Definitive testing should be based on the recipient's presentation and history and only include what is needed for safe pain management.

4. Standing orders for presumptive drug screens may be utilized, but must be individualized for each member, signed and dated by the treating practitioner and updated every 30 days. Standing orders are not permitted for definitive drug screens.

5. Procedure codes should be reported with a quantity of one per episode of care, regardless of the number of collection/testing items used, the number of procedures and/or the drug classes screened.

6. Testing for the same drug with a blood and urine specimen simultaneously is not covered.

7. Drug screening for pre-employment or employment purposes, medicolegal and/or court ordered that do not meet medical necessity and/or drug screenings for participation in school or military are not covered.

8. Routine drug screening is not covered unless used in conjunction with an extended course of treatment for substance use disorders. Specific intervals, at which recipient test should be performed, based on their individual needs, must be documented in the member's medical record with their treatment plan.

9. Drug confirmation tests are not eligible to be separately reported under any procedure code, unlisted or otherwise.

2. Non-Covered Services

Laboratory tests listed in the most recent, annually updated CPT publication which are not benefits include:

a. Post mortem examination codes.

b. Reproductive medicine procedures, except as indicated in Section 803.1.A.1.m.

c. Handling/conveyance fees (e.g. urine, stool cultures, pap smears).

d. Medicaid and NCU Managed Care recipients (laboratory tests are the sole responsibility of the managed care provider).

e. Those services deemed inappropriate to a probable diagnosis are not covered. Services deemed inappropriate will be reviewed for possible recoupments.

f. All unlisted laboratory codes except for the unlisted microbiology code used to bill phenotype assay tropism testing only.

g. Routine venipuncture by a provider testing the laboratory specimen or referring the laboratory specimen to an affiliate laboratory.

h. Collection of a capillary blood specimen (e.g. finger, heel or ear stick) when it is part of or integral to the test procedure (e.g. a bleeding or clotting time).

i. Physician services related to deviation from standard blood banking procedures (e.g. use of outdated blood or Rh incompatible units).

j. Microdissection by laser capture.

k. Caffeine halothane contracture test.

l. Routine use (e.g. serial testing) of genotype and/or phenotype testing in individuals without virologic failure or suboptimal viral response or with viral loads maintained at an undetectable level on a current medication regime.

m. HIV tropism test:

1. Subsequent to a prior mixed or dual tropism test result; or

2. Testing performed more than twice in a recipient's lifetime.

n. Blood typing for paternity testing.

o. Gene expression profiling, except when it is

™, as defined in Policy Attachment #08-02.

p. Molecular testing except for BRCA1/BRCA2 testing services for:

1. Individuals without a personal history of breast and/or ovarian cancers, considered to be high risk as defined in Policy Attachment #08-01 or as otherwise defined by the US Preventive Services Task Force;

2. Women with a personal history of breast and/or ovarian cancer with a personal history of breast cancer as defined in Policy Attachment #08-01 or as otherwise defined by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines; or

3. Men with a personal history of breast cancer as defined in Policy Attachment #08-01 or as otherwise defined by the NCCN Clinical Practice Guidelines.

803.1B PROVIDER RESPONSIBILITY

Providers must:

1. Verify recipients Medicaid eligibility and program benefit. Medicaid Fee-for-Service (FFS) will not reimburse for laboratory procedures performed for Medicaid or NCU recipients in managed care. Managed care plans may have their own authorization requirements. See MSM Chapter 3600.

2. Have appropriate state licensure or registration from the state where the laboratory is located, as applicable.

3. Have current and appropriate CLIA certification for the level of laboratory tests performed.

4. Except in the case of provision of emergency laboratory services, have a valid Provider Contract with the Nevada DHCFP and Nevada Medicaid enrollment number or be an affiliate of an in-state laboratory that has a valid Medicaid enrollment number.

   An out-of-state laboratory providing covered, emergency medical laboratory services to a Medicaid or NCU recipient is exempt from the enrollment process for these services as long as the provider is enrolled as a Medicaid provider and is licensed to provide the laboratory service in the provider's home state.

5. Be in compliance with all applicable federal, state and local laboratory requirements.

6. Be in compliance with all Nevada MSM policies.

7. Be in compliance with claim and billing requirements specified in MSM Chapter 100, the QIO-like vendor/Medicaid and NCU billing manual, and the most recent version of the CPT and the Healthcare Common Procedure Coding System manuals.

8. Include on all claims the highest level of code specificity in accordance with the most current International Classification of Diseases, Clinical Modification manual related to the laboratory test performed. If a diagnosis or narrative diagnosis is not submitted by the prescribing practitioner, a laboratory must request this information from the physician/ practitioner who ordered the service.

9. Specify the current CLIA number of the laboratory performing the test on all claims, except when billing for CLIA exempt tests.

10. Only bill for laboratory services that the laboratory is currently licensed/registered and certified to perform.

11. Ensure each recipient's laboratory record contains the following information:

    a. Identification number of the specimen;

    b. Name or any other means of confidentially identifying the person from whom the specimen was taken;

    c. Name of the prescriber and, if applicable, the referring laboratory that submitted the specimen;

d. Date the specimen was collected by the prescriber or laboratory;

e. Date the specimen was received in the laboratory;

f. Condition of unsatisfactory specimens when received (e.g. broken, leaked, hemolyzed or turbid);

g. Test performed;

h. Date the test was performed;

i. Results of the test and the date of reporting; and

j. Name and address of the laboratory where any specimen is referred, if applicable.

12. Ensure that there is a written report on file for laboratory and pathology services that have a professional component requiring physician interpretation, whether or not "with interpretation and report" is stated in the code description of the service provided.

13. Maintain a quality-control program and make results of proficiency testing programs available to Nevada Medicaid or the QIO-like vendor upon request.

803.1C PRIOR AUTHORIZATION

The ordering physician must obtain prior authorization for the following services, except for Medicare/Medicaid dual eligible recipients who are still eligible for Medicare benefits:

1. Genotype and phenotype assay testing for recipients with chronic HIV infection prior to initiation of highly active antiretroviral therapy.

2. Laboratory tests referred by a physician office laboratory directly to an out of state laboratory.

804 HEARINGS

Reference Nevada MSM Chapters 100 and 3100 for the Medicaid Hearings and Grievance process.

DESCRIPTION

POLICY

BRCA1/BRCA2 testing services for individuals without a personal history of breast and/or ovarian cancer should be provided to high risk individuals as defined below or as otherwise defined by the US Preventive Services Task Force (USPSTF).

BRCA1/BRCA2 testing services for women with a personal history of breast and/or ovarian cancer and for men with a personal history of breast cancer should be provided as defined below or as otherwise defined by the NCCN Clinical Practice Guidelines.

Genetic counseling must precede genetic testing for hereditary cancer.

If the mutation in the family is known, only the test for that mutation is covered. For example, if a mutation for BRCA1 has been identified in a family, a single site mutation analysis for that mutation is covered, while a full sequence BRCA1 and BRCA2 analyses is not. An exception to this can be considered if a Certified Genetic Counselor presents sufficient justifiable need.

PRIOR AUTHORIZATION: YES ☒ NO ☐

COVERAGE AND LIMITATIONS:

1. For individuals without diagnosis of breast or ovarian cancer:

    a. Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 years or younger;

    b. A combination of three or more first- or second-degree relatives with breast cancer regardless of age at diagnosis;

    c. A combination of both breast and ovarian cancer among first- or second-degree relatives;

    d. A first-degree with bilateral breast cancer;

e. A combination of two or more first- or second-degree relatives with ovarian cancer, regardless of age at diagnosis;

f. A first or second-degree relative with both breast and ovarian cancer at any age;

g. History of breast cancer in a male relative; or

h. For women of Ashkenazi Jewish descent, any first-degree relative (or two second-degree relatives on the same side of the family) with breast or ovarian cancer.

2. A family history of breast or ovarian cancer that includes a relative with a known deleterious BRCA mutation; or

3. A personal history of breast cancer plus one or more of the following:

a. Diagnosed at age ≤ 45 years;

b. Diagnosed at age ≤ 50 years with ≥ 1 close blood relative with breast cancer diagnosed at any age or with a limited family history;

c. Two breast primaries when first breast cancer occurred at age ≤ 50 years;

d. Diagnosed at age ≤ 60 years with a triple negative breast cancer;

e. Diagnosed at age ≤ 50 years with a limited family history;

f. Diagnosed at any age, with ≥ 1 close blood relative with breast cancer diagnosed ≤ 50 years;

g. Diagnosed at any age with ≥ 2 close blood relatives with breast cancer at any age;

h. Diagnosed at any age with ≥ 1 close blood relative with epithelial ovarian cancer;

i. Diagnosed at any age with ≥ 2 close blood relatives with pancreatic cancer or aggressive prostate cancer (Gleason Score ≥ 7) at any age;

j. Close male blood relative with breast cancer; or

k. For an individual of ethnicity associated with higher mutation frequency (e.g. Ashkenazi Jewish) no additional family history may be required.

4. Personal history of epithelial ovarian cancer; or

5. Personal history of male breast cancer; or

6. Personal history of pancreatic cancer or aggressive prostate cancer (Gleason Score ≥ 7) at any age with ≥ 2 close blood relatives with breast and/or ovarian and/or pancreatic cancer or aggressive prostate cancer (Gleason Score ≥ 7) at any age.

REFERENCES:

1. The NCCN Clinical Practice Guidelines in Oncology Breast Cancer (Version 3.2013). 2013 National Comprehensive Cancer Network, Inc. Available at: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp. Accessed August 20, 2013.

2. US Preventive Services Task Force. Genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility recommendation statement. Available at: http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/brca-related-cancer-risk-assessment-genetic-counseling-and-genetic-testing. Accessed August 10, 2016.

DESCRIPTION

™ predicts the 10-year risk of distant recurrence and the likelihood of chemotherapy benefit in women with ER-positive, HER2-negative, early stage invasive breast cancer. The application of gene expression profiling using Onco*type* DX™ is employed to identify patients who are predicted to obtain the most therapeutic benefit from adjuvant Tamoxifen and may not require adjuvant chemotherapy. The Onco*type* DX™ uses reverse transcription polymerase chain reaction (RT-PCR) to determine the expression of a panel of 21 genes isolated from formalin-fixed, paraffin-embedded tissue (FPET).

POLICY

™

PRIOR AUTHORIZATION: YES ☒ NO ☐

COVERAGE AND LIMITATIONS:

™

1.

2.

a.

b.

c.

d.

e.

3.

4.

5.

a.

Frequency is limited to once in a lifetime.

1.

REFERENCES

CMS local coverage determination (LCD) Gene expression profiling panel for use in the management of breast cancer treatment available at:

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33586&ver=6&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=81519&bc=gAAAABAAAAAAAA%3d%3d&

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 27, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE /Lynne Foster/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 900 – PRIVATE DUTY NURSING

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 900 – Private Duty Nursing (PDN) are being proposed to ensure compliance with federal requirements. Language restricting the provision of services solely to the recipient's place of residence has been removed. Language now allows PDN to be provided in the recipient's home or any setting where normal life activities occur. Medical necessity for the PDN program was clarified and language was updated accordingly for clarity and readability. Service limitations and prior authorization (PA) requirements for all PDN services have also been added. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. The timeframe for ongoing authorizations was changed. The chapter now requires ongoing authorizations be submitted at least 10 days prior to the end of the authorization period, versus 15 days, to align with Chapter 1400 – Home Health Agencies ongoing authorization timeframe.

PDN definitions have been moved to the MSM Addendum. MSM Addendum Sections C and I are being proposed to revise language regarding the definition of Concurrent Care and add language regarding the definition of Immediate Relative.

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: Providers of skilled nursing services in the community setting, including, but not limited to Home Health Agencies and Private Duty Nursing (Provider Type (PT) 29).

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective December 28, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 21/18 MSM Chapter 900 – Private Duty Nursing	MTL 10/03, 22/07, 22/08 MSM Chapter 900 – Private Duty Nursing

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
900	**INTRODUCTION**	Language was updated and/or reworded for improved readability and clarity.
901	**AUTHORITY**	Added new language "any setting where normal life activities occur." to align with federal requirements.
902	**DEFINITIONS**	Deleted this section. Added reference to MSM Addendum.
903.1	**POLICY STATEMENT**	Clarified language for PDN program. Added language to define "continuous," "complex" and "substantial." Added new language, PDN is not intended for 24-hour care.
903.1A(1)	**PROGRAM ELIGIBILTY CRITERIA**	Deleted Subsection (b) regarding "legally responsible adult providing care" and clarified language in Subsection (c) to align with federal requirements.
903.1A(2)	**COVERED SERVICES**	"Tracheotomy" was replaced with "tracheostomy" for accurate medical terminology. Replaced "to remain at home" with "prevent institutionalization." Language was updated and/or reworded for improved readability and clarity.
903.1A(3)	**MEDICAL CRITERIA**	Section renamed "MEDICAL NECESSITY." Deleted Skilled Nursing Need Categories within section. Examples of "skilled nursing interventions" updated for accurate medical terminology. Defined "BID" as twice per day for clarity. Added language for "Non-invasive" ventilation. "Decision Guide" section deleted. Language was updated and/or reworded for improved readability and clarity.
903.1A(4)	**NON-COVERED SERVICES**	Added new language regarding "non-skilled interventions which are custodial in nature" and included examples. New "Legally Responsible Individual (LRI)" was added to align with other MSM policy definitions. Language was updated and/or reworded for improved readability and clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
903.1B	**PROVIDER RESPONSIBILITIES**	Language added to state provider compliance with all Chapter 900 language, MSM Chapter 100 and any and all state and federal regulations. Added Social Security Act reference. Added new language "any setting where normal life activities occur." to align with federal requirements. "Termination of Services" section updated for clarity and readability regarding "Immediate Termination" and "Advanced Termination" of services. Throughout the section "patient" is replaced with "recipient" where appropriate and language was updated or reworded for clarity.
903.1C	**RECIPIENT RESONPNSIBILITIES**	Language was updated and/or reworded for improved readability and clarity.
903.1D	**AUTHORIZATION PROCESS AND REIMBURSEMENTS**	Section renamed "AUTHORIZATION PROCESS." Clarifying language added for authorized hours for recipients with new tracheostomy. Service hours may be increased to 84 hours per week. Clarifying language added for authorized hours for recipients with a new ventilator. Service hours may be increased to 112 hours per week for an eight week interval. Language added to section for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, reference to MSM Chapter 1500 for authorization process. Third Party Liability language deleted as it is duplicative to previous section earlier in Chapter. Section 903.1D(d) deleted, as holiday hour reimbursement is no longer applicable. Durable Medical Equipment changed to Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS), reference to MSM Chapter 1300 for DMEPOS policy and provider billing guide for clarity added. Section 903.1D(e) "REIMBURSEMENT" moved to end section of the chapter and renumbered. Ongoing authorization timeline changed from 15 days to 10 days for consistency with processing timeframes. Clarifying language added to "RETRO AUTHORIZATIONS" regarding services provided while Prior Authorization (PA) requests are "pending."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Ongoing authorization language clarified. Language added to authorization process and ongoing authorizations PDN acuity grid must be completed. PDN acuity grid is used to determine if PDN services are medically necessary and to authorize the number of hours required. For ongoing authorization of hours for recipients with a new tracheostomy or ventilator, clinical documentation must be submitted.
903.2A	**COVERAGE AND LIMIATIONS**	Section renamed to "24 HOUR CARE COVERAGE AND LIMITATIONS" for clarity.
903.2B	**PROVIDER RESPONSILBITIES**	Section renamed to "24 HOUR CARE PROVIDER RESPONSIBLITIES" for clarity.
903.2C	**RECIPIENT RESPONSIBILITES**	Section renamed to "24 HOUR CARE RECIPIENT RESPONSIBLITIES" for clarity.
903.2D	**AUTHORIZATION PROCESS**	Section renamed to "24 HOUR CARE AUTHORIZATION PROCESS" for clarity.
903.3	**CONCURRENT CARE**	"Multiple" replaced with "up to three" for more concise definition.
903.3A	**PROVIDER RESPONSIBILITIES**	Section renamed to "CONCURRENT CARE PROVIDER RESPONSIBILITIES" for clarity.
903.4	**OUT-OF-STATE SERVICES**	Language added to section Out-of-State Services in which a PA is required by the QIO-like vendor.
903.4A	**COVERAGE AND LIMITATIONS**	Section renamed to "OUT-OF-STATE COVERAGE AND LIMITATIONS." Language added regarding service limitation of 30 days and ongoing authorizations after the initial out-of-state authorization period must be prior authorized by the QIO-like vendor. Language from MSM 100 added to section to define locality for clarity.
903.4B	**PROVIDER RESPONSIBILITIES**	Section renamed to "OUT-OF STATE PROVIDER RESPONSIBLITIES" for clarity.
903.4C	**RECIPIENT RESPONSBILITIES**	Section renamed to "RECIPIENT RESPONSIBLITIES FOR OUT-OF-STATE SERVICES" for clarity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
903.5A	**COVERAGE AND LIMITATIONS**	Section renamed to "CRISIS OVERRIDE COVERAGE AND LIMITATIONS" for clarity.
903.5B	**PROVIDER RESPONSIBLITIES**	Section renamed to "CRISIS OVERRIDE PROVIDER RESPONSIBLITIES" for clarity. Reference to previous chapter section corrected.
904	**RATES AND REIMBURSEMENT**	Previously in Section 903.1(e), now a new stand-alone section which refers to billing guide and reimbursement code table for specific billing codes and reimbursements.
905	**HEARINGS**	Manual section renumbered.
906	**REFERENCES AND CROSS REFERENCES**	Section deleted.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

PRIVATE DUTY NURSING

900 INTRODUCTION PRIVATE DUTY NURSING

Private duty nursing (PDN) is an optional benefit offered under the Nevada Medicaid State Plan. PDN provides more individual and continuous care than is available from a visiting nurse for recipients who meet specified criteria and require more than four continuous hours of skilled nursing (SN) care per day. The intent of private duty nursing is to assist recipients with complex direct skilled nursing care, to develop caregiver competencies through training and education and to optimize recipient health status and outcomes. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial, complex and continuous SN care to prevent institutionalization.

PDN services may be provided, within program limitations, to a recipient in his/her home or in settings outside the home wherever normal life activities take place. Services are authorized based on medical necessity, program criteria, utilization control measures and the availability of the state resources to meet recipient needs.

All Medicaid policies and requirements are the same for Nevada Check Up, except for areas where Medicaid and Nevada Check Up policies differ as documented in Medicaid Services Manual (MSM) Chapter 3700.

901 AUTHORITY

Social Security Act (SSA) Sections 1814(a)(2)(c), 1835(a)(2)(a) and 1905(a)(8).

42 CFR 440.80 PDN services.

PDN services mean nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided:

A. By a registered nurse or a licensed practical nurse;

B. Under the direction of the recipient's physician; and

C. At the State's option, to a recipient in one or more of the following locations:

1. In the recipient's home or any setting where normal life activities occur;

2. A hospital; or

3. A nursing facility

Nevada Medicaid has opted to provide PDN in the recipient's home or any setting where normal life activities take place.

902 DEFINITIONS

Program definitions can be found in the MSM Addendum.

903 POLICY

903.1 POLICY STATEMENT

The PDN benefit reimburses medically necessary and appropriate hourly nursing services by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN. PDN services are not intended to provide 24-hour care. PDN may be authorized for recipients needing both a medical device to compensate for the loss of a vital body function and substantial, complex and continuous skilled nursing care to prevent institutionalization.

For purposes of the chapter, "Continuous" means nursing assessments requiring skilled interventions to be performed at least every two to three hours during the Medicaid-covered PDN shift. The recipient's medical condition(s) and necessary skilled interventions must justify a shift of at least four continuous hours. "Complex" means multifaceted needs requiring SN interventions. Observation in the event an intervention is required is not considered complex skilled nursing and shall not be covered as medically necessary PDN services. "Substantial" means there is a need for interrelated nursing assessments and interventions. Interventions that do not require assessment or judgment by a licensed nurse are not considered substantial.

Service hours are determined based on medical necessity and are not related to diagnoses of mental illness (MI) or intellectual disability (ID).

903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

a. The recipient has ongoing Medicaid eligibility for services;

b. The services have been determined to meet the medical criteria for private duty nursing; and

c. The service can be safely provided in the home or setting where normal life activities take place.

2. COVERED SERVICES

a. PDN service may be authorized for recipients who need more continuous SN care than can be provided in an intermittent skilled nurse visit through a home health agency and whose care exceeds the scope of service that can be provided by a home health aide or personal care attendant (PCA).

b. PDN services may be approved for up to 84 hours per week for new tracheostomy recipients for the initial eight-week authorization the period immediately following

discharge from the hospital.

c. PDN services may be approved for up to 112 hours per week for new ventilator dependent recipients for the initial eight-week authorization period immediately following discharge from the hospital.

d. PDN services may be approved for recipients who are chronically ill who require extensive SN care to prevent institutionalization.

3. MEDICAL NECESSITY

PDN is considered medically necessary when a recipient requires the services of a licensed RN or an LPN under the supervision of an RN to perform SN interventions to maintain or improve the recipient's health status. SN refers to assessments, judgments, intervention and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the recipient's care and the frequency of SN interventions. Services must be provided under the direction of a physician and according to a signed plan of care.

Different SN intervention refers to distinct tasks that affect different body systems and require separate SN knowledge. For example, care for a tracheostomy and care for total parenteral nutrition (TPN) would be considered two different SN tasks. Related SN interventions are tasks that are an intrinsic component of the SN task. For example, suctioning is an integral part of tracheostomy care and would be considered one SN task.

a. Some examples of typical "SN interventions" include, but are not limited to, the following:

1. Ventilator care.

2. Tracheostomy with related suctioning and dressing changes.

3. Non-invasive ventilation (NIV), i.e. CPAP or BiPAP, may be considered SN interventions in the management of both acute and chronic respiratory failure for recipients who are clinically unstable, and when the NIV is new. Or within 60 days of the start of CPAP or BiPAP, and stability with use is not yet established. Once NIV has been established for 60 days, if recipient is clinically stable, then NIV is no longer considered a skilled nursing intervention. CPAP or BiPAP for indications other than acute and chronic respiratory failure is not considered a skilled nursing intervention.

4. TPN.

5. Peritoneal dialysis.

6. Enteral feedings, and administration of medication, are considered a SN task when associated with complex medical problems or with medical fragility of the recipient.

7. Complex medication administration – six or more prescription medications on different frequency schedules or four or more medications requiring close monitoring of dosage and side effects.

8. Continuous oxygen administration, with a pulse oximeter and a documented need for observation and adjustments in the rate of oxygen administration.

9. Multiple sterile complex dressing change required at least twice per day. The dressing change must be separate from other SN interventions such as changing a tracheostomy site dressing when associated with tracheostomy care.

Additional skilled interventions not listed here may be considered in determining the intensity of SN needed.

4. NON-COVERED SERVICES

The following services are not covered benefits under the PDN program and are therefore not reimbursable:

a. Services provided to recipients that are ineligible for Medicaid.

b. Non-skilled nursing interventions which are custodial in nature. Some examples of typical "non-skilled nursing interventions" include, but are not limited to, the following:

1. Administration of nebulized medications

2. Application and removal of orthotic braces

3. Application of chest vest and use of cough assist device(s)

While a PDN may perform such tasks, there must be an additional need for interventions that do require the assessment and/or judgment of a licensed nurse.

c. Services provided by a legally responsible individual (LRI) or immediate family member. No reimbursement is made for services provided by an immediate relative or LRI.

d. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a nursing facility for the mentally ill (NF/MI) or intermediate care facility for the Individuals with Intellectual Disabilities (ICF/IID) or at institution for the treatment of mental health or chemical addiction.

e. Services rendered at school sites responsible for providing "school-based health service" pursuant to IDEA 34 Code of Federal Regulations (CFR)§300.24.

f. Services provided to someone other than the intended recipient.

g. Services that Nevada Medicaid determines could reasonably be performed by the recipient.

h. Services provided without authorization.

i. Services that are not on the approved plan of care (POC).

j. Service requests that exceed program limits.

k. Respite care.

l. Companion Care, baby-sitting, supervision or social visitation.

m. Homemaker services.

n. Medical Social Services (MSS).

o. Duplicative services, such as personal care services (PCS) that are provided during private duty nursing hours.

p. Travel time to and from the recipient's residence.

q. Transportation of the recipient by the private duty nurse.

903.1B PROVIDER RESPONSIBILITIES

The provider shall furnish qualified RNs and/or LPNs, under the supervision of a registered nurse to assist eligible Medicaid recipients with complex skilled nursing tasks as identified in the physician's written POC. Services are to be provided as specified in this Chapter and must meet

the conditions of participation as stated in MSM Chapter 100. The provider must comply with all local, state and federal regulations, and applicable statutes, including but not limited to Federal Law Section 1905(a)(8) of the SSA.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare certified Home Health Agency (HHA), licensed and authorized by State and Federal Laws to provide health care in the home.

2. MEDICAID ELIGIBILITY

The provider must verify, each month, continued Medicaid eligibility for each recipient. This can be accomplished by viewing the recipient's Medicaid Identification card, contacting the eligibility staff at the welfare office hot line or utilizing the electronic verification system (EVS). Verification of Medicaid eligibility is the sole responsibility of the provider agency.

3. PHYSICIAN ORDER AND PLAN OF CARE

The provider must provide PDN services initiated by a physician's order and designated in the POC which is documented on a CMS 485. The POC is a written set of medical orders signed by the physician which certify the specific HHA services that will be provided, the frequency of the services and the projected time frame necessary to provide such services. The POC is reviewed by the physician every 60 days. A new POC is required when there is a change in the recipient's condition, change in orders following hospitalization and/or change in the ordering physician.

4. PRIOR AUTHORIZATION

The provider must obtain prior authorization for all PDN services prior to the start of care. Refer to the authorization process 903.1D.

5. THIRD PARTY LIABILITY (TPL)

The provider must determine, on admission, the primary payor source. If Medicaid is not the primary payor, the provider must bill the third-party payor before billing Medicaid. The provider must also inform the recipient orally and in writing of the following:

a. The extent to which payment may be expected from third-party payors; and

b. The charges for services that will not be covered by third-party payors; and

c. The charges that the recipient may have to pay.

6. PLACE OF SERVICE

The provider must provide PDN service in the recipient's place of residence or in any setting where normal life activities take place. School sites are excluded as a matter of special education law (IDEA 34 CFR§300.24).

7. CASE INITIATION

A referral from physicians, discharge planners or recipient triggers the process for PDN hours.

The provider should make an initial visit to the recipient's home or to the hospital to complete an evaluation to determine if the recipient is appropriate for PDN hours and if they can accept the case. During this visit the provider must:

a. Complete a nursing assessment, using a CMS Outcome and Assessment Information Set (OASIS) form for recipients age 21 or older or age-appropriate evaluation;

b. Complete a Nevada Medicaid PDN prior authorization (PA) form and physician's POC using the CMS 485 Form; and

c. Establish the safety of the recipient during the provision of services.

If the provider determines the recipient is not appropriate for PDN services or they cannot accept the case, the provider must contact the Nevada Medicaid District Office Care Coordinator and inform them of the reason the service cannot be delivered.

If the provider is able to initiate service, all required documents should be submitted to the Quality Improvement Organization (QIO)-like vendor.

8. CONFIDENTIALITY

The provider must ensure the confidentiality of recipient records and other information, such as the health, social, domestic and financial circumstances learned in providing services to recipients.

The provider shall not release information related to recipients without written consent from the recipient or the recipient's legal representative, except as required by law.

Providers meeting the definition of a "covered entity" as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 CFR 160) must

comply with the applicable Privacy Regulations contained in 45 CFR 160, 162 and 164 for recipient health information.

9. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers are in compliance with all laws relating to incidences of abuse, neglect or exploitation.

a. CHILD ABUSE

State law requires that certain persons employed in certain capacities must make a report to a child protective services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reason to suspect a child has been abused or neglected.

For minors under the age of 18, the Division of Child and Family Services or the appropriate county agency accepts reports of suspected abuse.

Refer to Nevada Revised Statutes (NRS) 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adults aged 60 and over, the Aging and Disability Service Division accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

For all other individuals, contact social services and/or law enforcement agencies.

10. RECIPIENT RIGHTS

The governing body of the provider agency has an obligation to protect and promote the exercise of the recipient rights. A recipient has the right to exercise his/her rights as a recipient of the provider. A recipient's family or guardian may exercise a recipient's rights when a recipient has been judged incompetent. The recipient has the right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each recipient and family with a written copy of the bill of rights. A signed, dated copy of the recipient's bill of rights will be included in the patient's medical record. Refer to recipient rights later in this chapter.

11. ADVANCE DIRECTIVES

The provider must provide the recipient or parent/legal guardian with information regarding their rights to make decisions about their health care, including the right to execute a living will or grant a power of attorney to another individual, per 42 CFR 489.102, Patient Self Determination Act (Advance Directives).

HHA's must also:

a. Provide written information to the recipient(s) at the onset of service concerning an individual's right under Nevada state law, NRS 449, to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives;

b. Inform recipients about the agency's policy on implementing Advance Directives.

c. Document in the individual's medical record whether or not the individual has executed an Advance Directive.

d. Ensure compliance with the requirements of NRS 449 regarding Advance Directives at agencies of the provider or organization.

e. Provide (individually or with others) education to staff and the community on issues concerning Advance Directives.

f. Not discriminate against a recipient based on whether he or she has executed an Advance Directive.

12. NON-DISCRIMINATION

The provider must act in accordance with federal rules and regulations and may not discriminate unlawfully against recipients based on race, color, national origin, sex, religion, age, disability or handicap (including AIDS or AIDS-related conditions).

13. COMPLAINT RESOLUTION

The provider must respond to all complaints in a reasonable and prompt manner. The provider must perform recipient/provider problem solving and complaint resolution.

a. The provider must maintain records that identify the complaint, the date received and the outcome.

b. The provider must submit documentation regarding the complaint to Nevada Medicaid Central Office (NMCO) immediately upon request.

14. TERMINATION OF SERVICES

a. IMMEDIATE TERMINATION

The provider may terminate PDN services immediately for the following reasons:

1. The recipient or other persons in the household subjects the skilled nurse to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations or threats of physical harm.

2. The recipient is ineligible for Medicaid.

3. The recipient requests termination of services.

4. The place of service is considered unsafe for the provision of PDN services;

5. The recipient is admitted to an acute hospital setting or other institutional setting.

b. ADVANCE NOTICE TERMINATION

The provider must provide at least five calendar days advance written notice to recipients when PDN services are terminated for the following reasons:

1. The recipient or caregiver refuses to comply with the physician's POC.

2. The recipient or caregiver is non-cooperative in the establishment or delivery of services.

3. The recipient no longer meets the criteria for PDN services.

4. The recipient refuses service of a skilled nurse based solely or partly on the race, religion, sex, marital status, color, age, disability or national origin.

5. The provider is no longer able to provide services as authorized (i.e. no qualified staff).

Note: A provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's PDN program. The recipient may choose another provider.

Note: The nurse provider must comply with Nevada Administrative Code (NAC) 632 (the Nurse Practice Act) regarding patient abandonment.

c. NOTIFICATION REQUIREMENTS

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The QIO-like vendor should be notified by telephone within two working days. The provider should submit written documentation within five working days.

The provider will send a written notice which advises the QIO-like vendor of an effective date of the action of the termination of service, the basis for the action and intervention/resolution attempted prior to terminating services.

15. RECORDS

The provider must maintain medical records which fully disclose the extent and nature of the service provided to the recipient and which supports fees or payments made. Medical and financial records and all other records provided must be maintained for an interval of not less than six years. Following HIPAA Privacy Regulations contained in 45 CFR 160 and 164, the provider must make records available upon request to the Division.

903.1C RECIPIENT'S RESPONSIBILITIES

The recipient or personal representative shall:

1. Provide the HHA with a valid Medicaid card at the start of service and each month thereafter.

2. Provide the HHA with accurate and current medical information, including diagnosis, attending physician, medication regime, etc.

3. Notify the HHA of all third-party insurance information, including the name of other third-party insurance, such as Medicare, TRICARE, Workman's Compensation or any changes in insurance coverage.

4. Inform the HHA of any other home care benefit that he/she is receiving through state plan services, such as PCS, intermittent HHA skilled nursing or therapy services. Services provided through another agency or program such as respite, case management or participation in a Waiver program should also be identified.

5. Have a primary LRI, who accepts responsibility for the individual's health, safety and welfare. The LRI must be responsible for the majority of daily care in a 24-hour interval.

6. Have an identified alternate LRI or a backup plan to be utilized if the primary LRI and/or the provider are unable to provide services. The PDN nurse provider is not an alternate caregiver with legal authority.

7. Have written emergency plans in place. The caregiver/parent should inform the provider of an alternate caregiver and/or with a plan that indicates his/her wishes if the responsible caregiver became ill or disabled and is unavailable to provide care for any other.

8. Cooperate in establishing the need for and the delivery of services.

9. Have necessary backup utilities and communication systems available for technology dependent recipients.

10. Comply with the delivery of services as outlined in the POC.

11. Sign the PDN visit forms to document the hours and the services that were provided.

12. Notify the provider when scheduled visits cannot be kept or services are no longer required.

13. Notify the provider of unusual occurrences of complaints regarding the delivery of services and of dissatisfaction with specific staff.

14. Give the provider agency a copy of an Advance Directive, if applicable.

15. Not request the provider agency staff to work more hours than authorized or to change the days/hours approved.

16. Not request the provider agency staff to provide care to non-recipients or to provide service not on the POC (babysitting, housekeeping tasks, etc.).

17. Not subject the provider or Division staff to physical and/or verbal abuse, sexual harassment, exposure to the use of illegal substances, illegal situations or threats of physical harm.

18. Not refuse service of a provider based solely or partly on the provider's race, religion, sex, marital status, color, age, disability and/or national origin.

RECIPIENT RIGHTS

Every Medicaid recipient, their LRI, legal guardian or authorized representative is entitled to receive a statement of "Recipient Rights" from their provider. The recipient should review and sign this document. The recipient's rights should include the following:

1. A recipient has the right to courteous and respectful treatment, privacy and freedom from abuse and neglect.

2. A recipient has the right to be free from discrimination because of race, religion, sex, marital status, color, age, disability, national origin, sexual orientation and/or diagnosis.

3. A recipient has the right to have his property treated with respect.

4. A recipient has the right to confidentiality regarding information about his/her health, social and financial circumstances and about what takes place in his home.

5. A recipient has the right to access information in his own record upon written request.

6. A recipient has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so.

7. The recipient has the right to be informed of the provider's right to refuse admission to, or discharge any recipient whose environment, refusal of treatment or other factors prevent the HHA from providing safe care.

8. The recipient has the right to be informed of all services offered by the agency prior to or upon admission to the agency.

9. The recipient has the right to be informed of his condition in order to make decisions regarding his home health care.

10. The recipient has the right to be advised, in advance, of the services that will be provided and frequency of such services.

11. The recipient has the right to be advised, in advance, of any change in the plan of care before the change is made.

12. The recipient has the right to participate in the development of the plan of care, treatment and discharge planning.

13. The recipient has the right to refuse services or treatment.

14. The recipient has the right to request a Fair Hearing when disagreeing with Nevada Medicaid's action to deny, terminate, reduce or suspend service.

903.1D AUTHORIZATION PROCESS

1. PRIOR AUTHORIZATION

PDN services must be prior authorized by the Nevada Medicaid QIO-like vendor, except for mileage and initial assessments. The provider must submit all required PDN PA forms to the QIO-like vendor.

The QIO-like vendor will review the request and supporting documentation for medical necessity. The PDN PA form and supporting documentation will be used to determine medical necessity and to qualify and quantify the appropriate number of PDN hours. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. The QIO-like vendor will issue an authorization number for the approved PDN service hours. Service hours cannot be initiated until the QIO-like vendor has issued an authorization number. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. The PDN acuity grid is used to determine if PDN services are medically necessary and to authorize the number of hours required. The PDN acuity grid must be completed in its entirety, including all signatures. Incomplete or unsigned forms will result in PA denial. All forms and documentation must be submitted together. Failure to complete all sections of PDN acuity grid or failure to provide all medical documentation to support the prior authorization request may result in the number of PDN hours not being appropriately authorized.

New tracheostomy recipients may receive up to 84 hours per week, for the initial eight-week authorization period immediately following discharge from the hospital.

New ventilator dependent recipients up to 112 hours per week, for the initial eight-week authorization period immediately following discharge from the hospital.

A Medicaid recipient under 21 years of age may be eligible for additional authorized PDN hours under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Refer to MSM Chapter 1500 Healthy Kids Program for EPSDT authorization process.

If a recipient does not meet medical necessity criteria for PDN, the PA will be denied. If the request is for more hours than can be authorized according to program criteria, a Notice of Decision (NOD) will be issued by the QIO-like vendor.

PDN services requested for a recipient enrolled in a Managed Care Organization (MCO) must be prior authorized by the MCO. The MCO has sole responsibility for all decisions related to the PDN service for MCO recipients.

a. INITIAL EVALUATION VISIT

The initial evaluation visit does not require a PA from Nevada Medicaid or their QIO-like vendor. During the visit the skilled nurse evaluator must complete a nursing assessment using an OASIS or age appropriate tool. The nurse must complete a Nevada Medicaid PDN PA form.

b. DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies require a PA request at the time of request for HHA services and are to be listed on the Home Health Prior Authorization Form. Wound care supplies will be authorized for the HHA for an initial ten-day period only. Supplies will be authorized only for the specific procedure or treatment requested. Refer to MSM Chapter 1300 regarding Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) policy and the provider billing guide.

c. MILEAGE

Actual mileage is reimbursed one way from the HHA/PDN office to the recipient's residence. Actual mileage should be listed on the PA request form to establish a baseline for reimbursement.

2. ONGOING AUTHORIZATIONS

Requests for continuing PDN services must be submitted to the QIO-like vendor at a minimum of 10 working days but no more than 30 days prior to the expiration date of the existing authorization. The completed request must be submitted to the QIO-like vendor along with a current nurse assessment and PDN assessment form. The QIO-like vendor will review for appropriate number of hours based on program criteria and program limitations. Hours authorized will be the number of hours that are medically necessary to support the skilled interventions required. Hours may be reduced after the initial authorization period based on a comprehensive review of the clinical documentation. The PDN acuity grid is used to determine if PDN services are medically necessary and to authorize the number of hours required. The PDN acuity grid must be completed in its entirety, including all signatures. Incomplete or unsigned forms will result in prior authorization denial. All forms and documentation must be submitted together. Failure to complete all sections of PDN acuity grid or failure to provide all medical documentation to support the PA request may result in the number of PDN hours not being appropriately authorized.

An ongoing authorization request for 84 hours per week, after the initial eight-week authorization period immediately following discharge from the hospital for a new

tracheostomy, must include clinical documentation to support the continued need for 84 hours. If such clinical documentation is not included in the request, hours may be reduced.

An ongoing authorization request for 112 hours per week, after the initial eight-week authorization period immediately following discharge from the hospital for a new ventilator, must include clinical documentation to support the continued need for 112 hours. If such clinical documentation is not included in the request, hours may be reduced.

If a recipient does not meet medical necessity criteria for PDN, the PA will be denied. If the request is for more hours than can be authorized according to program criteria, a Notice of Decision (NOD) will be issued by the QIO-like vendor.

PDN services may be authorized for a maximum of six months.

3. ADDITIONAL AUTHORIZATIONS

a. School Break

During "planned breaks" of at least five consecutive school days (e.g. track break, summer vacation), additional hours may be authorized within program limitations. A separate authorization request should be submitted for the specific number of hours requested beyond those already authorized.

b. Change in Condition/Situation

A new authorization must be requested when the recipient has a change of condition or situation that requires either a reduction in PDN hours or an increase in PDN hours. A completed prior authorization request (PAR) must be submitted to the QIO-like vendor along with documentation supporting medical necessity and program criteria.

4. RETRO AUTHORIZATIONS

a. A request for authorization of services provided to pending recipients may be made retroactively, once Medicaid eligibility has been established. Medicaid may authorize services retroactively for covered services within limitations of program criteria. The PAR must include the date of determination of eligibility. Please note, if the PA request is pending and services are provided, the provider is assuming responsibility for PDN costs if the PA request is denied. A PA only approves existence of medical necessity, not recipient eligibility.

903.2 24-HOUR CARE

In the event an LRI is absent due to a medical need of the LRI, parent/guardian or authorized representative, a Medicaid recipient under 21 years of age may be eligible to receive 24-hour care at home through an EPSDT referral. Twenty-four-hour care must be prior authorized.

903.2A 24-HOUR COVERAGE AND LIMITATIONS

1. Twenty-four-hour care is limited to five days per calendar year;

2. No other legally responsible adult or caregiver is available to provide care;

3. Twenty-four-hour day care is medically necessary and placement in a facility would be detrimental to the recipient's health;

903.2B 24-HOUR PROVIDER RESPONSIBILITIES

1. The provider is responsible for requesting documentation that the primary caregiver or family member is absent due to a medical need.

2. The provider must submit an EPSDT screening by a physician provider that the 24-hour care is medically necessary and placement in a facility is detrimental to the recipient's health.

3. The provider needs to secure an authorization for disclosure from the LRI, parent/guardian or authorized representative to provide documentation of absence due to a medical need. Such information will be released to Nevada Medicaid or their designee for determination of eligibility for this benefit.

All other policies found in Section 903.1B, Provider Responsibilities, of this chapter shall apply.

903.2C 24-HOUR CARE RECIPIENT RESPONSIBILITIES

1. The LRI must provide supporting documentation of the absence of the primary caregiver due to medical need.

2. The LRI must pursue the availability of alternate caregivers to provide care during the interval before requesting 24-hour care.

3. All other policies found in Section 903.1C, Recipient Responsibilities, of this chapter shall apply.

903.2D 24-HOUR CARE AUTHORIZATION PROCESS

1. The provider may request a verbal authorization of the QIO-like vendor if the need for such service was unanticipated. A written request, along with supporting information should be submitted as soon as possible thereafter, but no later than three working days after the verbal request.

2. The provider agency must submit a PAR along with the EPSDT screening referral and supporting documentation of the absence of a primary caregiver to the QIO-like vendor prior to the provision of 24-hour coverage, if the need for such service was anticipated.

903.3 CONCURRENT CARE

Concurrent care allows for the provision of PDN service by a single nurse to more than one recipient simultaneously. A single nurse may provide care for up to three recipients if care can be provided safely. Concurrent care allows for authorized nursing hours to be collectively used for the multiple recipients. Concurrent care allows for optimum utilization of limited skilled nurse resources while providing safe skilled nursing care to Nevada Medicaid recipients. Concurrent care must be prior authorized.

903.3A CONCURRENT CARE PROVIDER RESPONSIBILITIES

1. The provider shall evaluate and determine the safety of settings for the provision of concurrent care.

2. The provider shall adjust requests for PDN hours when concurrent care is provided.

All policies found in Section 903.1 of this chapter shall apply.

903.4 OUT-OF-STATE SERVICES

PDN services are allowed out-of-state for Medicaid recipients absent from the state per (42 CFR 431.52). A PA is required for out-of-state services by the QIO-like vendor. Payment for services furnished in another state are reimbursed to the same extent that Nevada would pay for service provided within Nevada's boundaries. Out-of-state PDN services are reimbursed at the rural rate.

903.4A OUT-OF-STATE COVERAGE AND LIMITATIONS

In addition to the policies described in Section 903.1A of this chapter, the following apply for out-of-state. The authorization timeframe for out-of-state services is limited to no more than a 30-day interval. For ongoing authorizations after the initial 30-day period the out-of-state provider must contact the QIO-like vendor.

Out-of-state services may be authorized when:

1. There is a medical emergency and the recipient's health would be endangered if he were required to return to the State of Nevada to obtain medical services;

2. The recipient travels to another state because the Division finds the required medical services are not available in Nevada;

3. The Division determines that it is general practice for recipients in a particular locality to use medical services in another state (e.g., Nevada counties that border other State lines);

   a. Nevada residents living near state lines or borders may be geographically closer to out-of-state providers than in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what the Division of Health Care Financing and Policy (DHCFP) refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation. Refer to the MSM 100 billing manual for catchment areas.

   b. The same services that are covered within the state of Nevada are available for payment for any qualified provider, in the catchment area, who is or will be enrolled with the plan.

   c. Nevada Medicaid does not pay for medical services rendered by health care providers outside the United States.

4. The recipient is on personal business. Nevada Medicaid may reimburse for these services; however, they will be limited to service hours currently authorized.

903.4B OUT-OF-STATE PROVIDER RESPONSIBILITIES

1. The out-of-state provider must contact provider enrollment at the Nevada Medicaid Central Office (NMCO) to become enrolled as a Nevada Medicaid HHA provider.

2. The out-of-state provider must comply with all provisions identified in Section 903.1B.

903.4C RECIPIENT RESPONSIBILITIES FOR OUT-OF-STATE SERVICES

1. The recipient or their personal representative should contact HHA providers in the geographic out-of-state region in which they wish service to be provided, to determine the availability of Nevada Medicaid PDN service providers.

2. The recipient should notify the out-of-state provider who is not a Nevada Medicaid provider who is interested in becoming a provider to contact provider enrollment at NMCO.

The recipient must comply with all the provisions identified in Section 903.1C of this chapter.

903.5 CRISIS OVERRIDE

The PDN benefit allows, in rare circumstances, a short-term increase of nursing hours beyond standard limits in a crisis. A crisis is one that is generally unpredictable and puts the patient at risk of institutionalization without the provision of additional hours.

903.5A CRISIS OVERRIDE COVERAGE AND LIMITATIONS

1. Additional services may be covered up to 20% above program limits.

2. Additional services are limited to one, 60-day interval in a three-year period (calendar years).

903.5B CRISIS OVERRIDE PROVIDER RESPONSIBILITIES

The provider must contact the QIO-like vendor with information regarding the crisis situation and need for additional hours.

All other policies as discussed in Section 903.1B.

904 RATES AND REIMBURSEMENT

Refer to the provider billing guide for instructions and the reimbursement code table for specific billing codes.

905 HEARINGS

Please reference Nevada MSM Chapter 3100 for the Medicaid Hearing process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 23, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER
/Jessica Kemmerer/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1000 – DENTAL

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1000 – Dental are being proposed to update the American Dental Association's (ADA) Dental Claim Form required for all prior authorization requests, claims, adjustments, and voids. Currently, the ADA 2012 version is required. The Division of Health Care Financing and Policy (DHCFP) proposes to allow the continued use of the ADA Dental Claim Form version 2012 and allow newer versions of this form. Additionally, the DHCFP is proposing to remove a duplication of congenitally missing teeth, listed as part of the Medically Necessary Orthodontic Automatic Qualifying Conditions.

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: This proposed change affects all Medicaid enrolled Provider Type (PT 22) – Dentists, all specialties.

Financial Impact on Local Government: None.

These changes are effective February 24, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 05/21 MSM Chapter 1000 – Dental	MTL 14/20 MSM Chapter 1000 – Dental

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8(A)(2)(a)	**Orthodontics Coverage and Limitations**	Removed duplicate medically necessary orthodontic automatic qualifying condition "a. Congenitally missing teeth (excluding third molars) of at least one tooth per quadrant."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1003.8(D)(1)	**Authorization Process**	Removed duplicate medically necessary orthodontic automatic qualifying condition "a. Congenitally missing teeth (excluding third molars) of at least one tooth per quadrant."
1005.2	**Forms**	Clarified 2012 or newer version of ADA dental claim form required is for all prior authorization requests, claims, adjustments, and voids.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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DENTAL

1000 DENTAL

INTRODUCTION

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. Dental services provided shall maintain a high standard of quality and shall be provided within the coverage and limitation guidelines outlined in this Chapter and the Quality Improvement Organization-Like (QIO-Like) Vendor's Billing Guide. All Medicaid policies and requirements are the same for Nevada Check Up members, unless otherwise specified in the Nevada Check Up Manual Chapter 1000.

Dentists, dental hygienists, public health endorsed dental hygienists and dental therapists participating in Nevada Medicaid shall provide services in accordance with the rules and regulations of the Nevada Medicaid program. Dental care provided in the Nevada Medicaid program must meet prevailing professional standards for the community-at-large. Any dental provider who undertakes dental treatment as covered by Nevada Medicaid must be qualified by training and experience in accordance with the Nevada State Board of Dental Examiners rules and regulations.

All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association (ADA). All dental services, including without limitation, examinations, radiographs, restorative and surgical treatment, as well as record keeping are to be provided in accordance with current ADA guidelines and the ADA Code of Ethics, and are to be coded according to the definitions and descriptions in the current ADA Code on Dental Procedures and Nomenclature (CDT Code) manual. All dental services must conform to the statutes, regulations and rules governing the practice of dentistry in the state in which the treatment takes place.

Nevada Medicaid provides dental services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. For Medicaid-eligible adults age 21 years and older, dental services are an optional service as identified in this chapter and the Billing Guide documents located at www.medicaid.nv.gov in Provider Type (PT) 22 Dentist.

Individuals under Age 21

Through the EPSDT benefits, individuals under the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease and maintenance of dental health. The EPSDT program assures children receive the full range of necessary dental services, including orthodontia when medically necessary and pre-approved by the Nevada Medicaid QIO-like vendor.

Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) reflects prior authorization requirements, covered CDT codes and service limitations. Prior authorization

(PA) is not required for most services covered under EPSDT, except when seeking medically necessary services that are outside of what is covered in the benefit schedule. For example, a PA request needs to be submitted for a child who needs cleanings every three months rather than the six months allowed by current service limitations.

The EPSDT screening provider may refer children for dental services. However, such a referral is not necessary if the parent otherwise elects to contact a Medicaid dental provider. The local Medicaid District Office can direct the parent/guardian to local dental providers.

Individuals age 21 and older

Dental services for Medicaid-eligible adults who qualify for full Medicaid benefits receive emergency extractions, palliative care and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations as detailed in Section 1003.5 of this chapter.

Pregnancy Related Services

Nevada Medicaid offers expanded dental services in addition to the adult dental services covered for Medicaid-eligible pregnant women. These expanded pregnancy related services require a PA. In order to reduce the risk of premature birth due to periodontal disease, pregnant women will be allowed dental prophylaxes, fluoride varnish and certain periodontal and restorative services during pregnancy. Refer to Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) for covered CDT codes, services limitations and PA requirements. Providers are expected to refer to the American Dental Association for current clinical recommendations, guidelines and contraindications for treatment of pregnant women, including the use of silver diamine fluoride. Medical providers and/or Managed Care Organizations should provide a dental referral when it is discovered that a recipient is pregnant. Dental providers should attach a copy of the referral or provide a statement of pregnancy in the comment section of the ADA claim form for any PA requests for pregnancy related dental services. Pregnancy related dental services are discontinued on the date of delivery or termination of pregnancy, except services that were authorized but not completed prior to the end of the pregnancy. An approved PA request for pregnancy related dental services will be authorized from the date the request was received through the expected delivery date, unless a shorter timeframe is requested by the provider. Services authorized are honored through the time authorized on the prior authorization request, regardless of whether the services have been started or not. Example: a pregnant woman is authorized for one prophylaxis for the period of April 1st through September 30th. She gives birth on August 1st. The woman has until September 30th to receive her prophylaxis.

1001 AUTHORITY

Nevada Revised Statute (NRS) 631 – Dentistry and Dental Hygiene.

The State Plan of Nevada describes the amount, duration and scope of dental care and services provided to the categorically needy in Attachments 3.1-A 10 and 3.1-A 12b.

The Centers for Medicare and Medicaid Services (CMS) state that necessary and essential dental services are mandatory for all eligible Medicaid children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under the Social Security Act (SSA) 1905(r)(3). The Nevada EPSDT program provides children with services that are in addition to those available to adult recipients as cited in the Code of Federal Regulations (CFR) Title 42 Section 441.56.

1002 RESERVED

1003 NEVADA MEDICAID POLICY

Dentists, public health endorsed dental hygienists and dental therapists enrolled with Nevada Medicaid are able to bill for services provided to Medicaid eligible recipients.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov in PT 22 Dentist Billing Guide for a list of CDT codes detailing prior authorization requirements and service limitations.

1003.1 DIAGNOSTIC AND PREVENTIVE SERVICES (D0100 – D1999)

The branch of dentistry used to identify and prevent dental disorders and disease.

The United States Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. Nevada Medicaid lists these recommendations in Medicaid Services Manual (MSM) Chapter 600, Attachment A.

The USPSTF recommends application of fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption, and oral fluoride supplementation starting at six months of age for children whose water supply is fluoride deficient.

Nevada Medicaid promotes oral health by providing coverage for routine, periodic oral examinations and preventive treatment, fluoride treatment and sealant application for children, in accordance with the recommendations of the American Dental Association (ADA) and the American Academy of Pediatric Dentists (AAPD) for the prevention of tooth decay and the promotion of good oral health. Medicaid's coverage for preventive services, for children, is guided by the recommendations of the ADA and AAPD. Periodic dental examinations and routine preventive treatment should begin with eruption of the first tooth and before the first birthday, and should continue every six months or as recommended by the dentist. The examination includes assessment of pathology and injuries, growth and development and caries risk assessment. Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention and non-nutritive oral habits should be included.

Nevada Medicaid authorizes payment of diagnostic and preventive dental services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Coverage is limited to EPSDT for persons less than 21 years of age. Coverage for persons over 21 years of age is limited to diagnostic services needed for emergency extractions or palliative care.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.2 RESTORATIVE DENTISTRY SERVICES (D2000 – D2999)

The branch of dentistry used to restore the integrity of the teeth through the use of fillings or crowns.

Nevada Medicaid authorizes payment of restorative dentistry for qualified recipients.

A. COVERAGE AND LIMITATIONS

Restorative services are covered under EPSDT for persons less than 21 years of age.

For recipients age 21 years and older, with a PA, Nevada Medicaid reimburses for certain fillings and crowns on teeth that are an abutment (anchor) tooth for that partial denture. The ADA defines an abutment tooth as "a tooth used as a support for a prosthesis" (i.e. partial denture). Nevada Medicaid also reimburses for palliative treatment for persons 21 years of age and older. Pregnancy related services and coverage are listed in the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) found in the QIO-like vendor's web portal at www.medicaid.nv.gov.

Fillings are limited to the use of amalgam or tooth colored restorations.

Tooth preparation, acid etching, all adhesives (including bonding agents) liners and bases, polishing and curing and occlusal adjustment of either the restored tooth or the opposing tooth, is part of the amalgam restoration and must be included in the fee for the restoration. If pins are used, they should be reported under the appropriate code.

Tooth colored restorations refers to a broad category of materials including, but not limited to, self-curing composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the resin based composite restoration. If pins are used, they should be reported under the appropriate code.

The ADA defines an Indirect Pulp Cap as a nearly exposed pulp that is covered with a protective dressing to protect the pulp from additional injury and to promote healing. If the pulp is exposed and the provider attempts to cover it in the hopes of avoiding further injury to the nerve, that would be a Direct Pulp Cap (D3110). Placing a protective covering under a deep filling to help avoid sensitivity or pulpal irritation is not a billable service and is included in the restoration as a "liner."

Crowns are limited to stainless steel and composite resin repairs.

Reference the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.3 ENDODONTIC SERVICES (D3000 – D3999)

The branch of dentistry specializing in disease or injury that affects the root tips or nerves in the teeth through the use of root canals.

Nevada Medicaid authorizes payment of endodontics for qualified recipients.

A. COVERAGE AND LIMITATIONS

Restorative services are covered under EPSDT for persons less than 21 years of age.

Reference the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov.

1003.4 PERIODONTIC SERVICES (D4000 – D4999)

The branch of dentistry used to treat and prevent disease affecting supporting bones, ligaments and gums of the teeth.

Nevada Medicaid authorizes payment of periodontics for qualified recipients.

A. COVERAGE AND LIMITATIONS

1. Periodontic services are covered under EPSDT for persons less than 21 years of age. Periodontal services for persons less than 21 years of age are limited to either four quadrants of scaling and root planing every two years with a maximum of four periodontal maintenance treatments annually or a maximum of two dental prophylaxis treatments annually.

2. Medicaid carefully monitors for the appropriate use of the codes for periodontal scaling and root planing. These codes are generally limited to recipients who are at least 14 years old. Providers' in-office records must verify x-rays, periodontal charting and diagnoses documenting the need for these procedures.

3. Periodontal scaling and root planing for pregnant recipients is a covered service that requires a PA. Due to the risk of pregnancy gingivitis, Medicaid will cover a second cleaning during pregnancy as well as 100% coverage of the treatment of inflamed gums around wisdom teeth during pregnancy. Medical providers and/or Managed Care Organizations should provide a dental referral when a recipient becomes pregnant. Dental providers should attach a copy of the referral or provide

a statement of pregnancy in the comment section of the ADA claim form to any PA requests for pregnancy related dental services. Pregnancy related dental services are discontinued on the date of delivery or termination of pregnancy, except for services that were authorized but not completed prior to the end of the pregnancy.

4. Palliative treatment is covered for persons 21 years of age and older.

Medicaid also monitors for the appropriate use of the code for full mouth debridement. This code is typically reserved for severe cases in which the licensed dental provider is unable to complete an oral evaluation because the tooth surfaces are covered by thick deposits of plaque and calculus. The full mouth debridement involves gross removal of the prominent plaque and calculus deposits, making it possible for a licensed dental provider to inspect the oral cavity for signs of decay, infection or gum disease. CDT Code D4355 is a preliminary treatment that should be completed before the exam and should not occur on the same day.

Reference the Nevada Medicaid Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.5 PROSTHODONTICS SERVICES (D5000 – D6999)

The branch of dentistry used to replace missing teeth or restore oral structure through the use of partials, dentures, etc.

Nevada Medicaid provides payment benefits of certain prosthodontics for qualified recipients. Emergency prosthetic repair refers to dental prosthetics that are rendered completely unserviceable. Loose dentures or dentures with broken/missing teeth do not meet the intent of the definition unless irritation is present and sufficiently documented. The dentist's in-office records must substantiate the emergency for the purposes of Medicaid post-payment utilization review and control.

A. COVERAGE AND LIMITATIONS

1. Partial dentures and full dentures may be provided when medically necessary to prevent the progression of weight loss and promote adequate mastication. Medicaid limits reimbursement of services to one new full or partial denture per five years. Given reasonable care and maintenance, prostheses should last five years. Education given by the dentist on the proper care of the prostheses is expected and included in the purchase of any prosthetic service.

2. Medicaid will pay for necessary emergency x-rays required to diagnose Medicaid covered removable prostheses. No PA is necessary for the initial comprehensive examination and x-rays. The dentist's office records must substantiate the recipient's medical necessity (e.g., x-ray evidence, reported significant loss of

weight, sore and bleeding gums, painful mastication, etc.). Payment for the examination and x-rays may be withdrawn if post-payment reviews of in-office records do not substantiate the medical necessity. Payment for dentures or partials includes any adjustments or relines necessary for six months after the date of delivery.

3. A person qualifies for a partial denture if four or more teeth in sequence are missing unilaterally, or four or more teeth are missing that would cause the person to have difficulty with mastication.

   A benefit when replacing permanent teeth is due to a lack of posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:

   a. five posterior permanent teeth are missing, (excluding 3rd molars); or

   b. all four 1st and 2nd permanent molars are missing; or

   c. the 1st and 2nd permanent molars and a premolar are missing on the same side.

   Third molars are not considered in the qualification for dentures. Teeth anterior to the third molars (including second molars) are considered in qualification for dentures. For example, a partial would be appropriate for someone missing teeth numbers 2, 3, 4 and 5 because these are four missing teeth in sequence. A partial would be appropriate for someone missing teeth numbers 18, 19, 20 and 28 or 29 because the person would be expected to have difficulty with mastication. A partial would not be appropriate for someone missing teeth numbers 19, 20 and 31 because there are not enough teeth missing for significant difficulty with mastication.

4. Third molars are not replaceable as missing teeth nor are they considered in the qualification for payment of partial dentures. Second molars are replaceable as missing teeth with missing posteriors in the same quadrant as explained in the above examples. A flipper may be used as a temporary replacement for employment purposes when an anterior tooth is extracted. For healing purposes, a flipper may be used temporarily when the partial for an anterior tooth will not be available for greater than three months.

5. A person may also qualify for a partial when missing any one of the six upper or lower anterior teeth (6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26 or 27) when necessary for employment. A supportive written Division of Welfare and Supportive Services (DWSS), New Employees of Nevada (NEON) report meets the employment verification requirement. The NEON report must be maintained in the recipient's dental record for retrospective review.

6. Requests to override the 5-year limitation on full and partial dentures will require a PA and will only be considered for the following exceptional circumstances:

   a. Dentures were stolen (requires a copy of the police report). Also under consideration is if the theft is a repeatedly occurring event. The recipient must exercise reasonable care in maintaining the denture.

   b. Dentures were lost in a house fire (requires a copy of the fire report or other notification documenting the fire such as a newspaper article).

   c. Dentures were lost in a natural disaster (requires a copy of documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or any other documentation indicating that the recipient's residence was in the area affected by the natural disaster).

   d. Dentures no longer fit due to a significant medical condition. Requires documentation regarding the supporting medical condition, such as a letter from the recipient's physician/surgeon supporting the medical need, and a letter from the dentist stating that the existing denture cannot be made functional by adjusting or relining it and that new dentures will be functional. Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

   e. Dentures could not be made functional by the issuing dentist. Requires a letter from the recipient's new dentist and the recipient. The dentist stating that the existing denture cannot be made functional by adjusting or relining it, the medical necessity for the new denture and that the new denture will be functional. The recipient stating that they returned to the issuing dentist requesting the denture be made functional and the issuing dentist was unable to comply (see Section 1003.5.8). Providers and recipients cannot expect to receive approval for replacement prosthesis without adequate justification and documentation.

   Process to request an override based on the above exceptional circumstances requires PA. The provider must submit the following in the PA request:

   f. A properly completed ADA claim form clearly marked "Request for Denture Override".

   g. Copies of current radiographs when requesting an override for a partial denture to a full denture.

   h. Any supporting documentation listed in this section, as applicable.

   i. A cover letter that clearly describes the circumstances of the case.

j. These requests must be submitted electronically through Medicaid's QIO-like vendor's web portal.

7. Medicaid will pay for a maximum of one emergency denture reline and/or adjustment not more often than once every six months, with a maximum of six relines or adjustments every five years, beginning six months after the date of partial/denture purchase Denture/partial relines and adjustments required within the first six months are considered prepaid with Medicaid's payment for the prosthetic. No prior approval is required for relines or adjustments. The provider's in-office records must substantially document the medical emergency need. Dentists should search the recipient's service history in the provider portal or call or write to the fiscal agent to ensure the reline is not being done within six months of the date of the last reline or new denture purchase. A claim submitted for a reline or adjustment sooner than six months since the last payment for a reline or adjustment will deny for payment. Post payment review will be done to assure that medical necessity of the service has been substantially documented.

8. If the recipient is unable to wear the denture, the recipient must schedule an appointment with the issuing dentist to have the denture/partial made functional. Factors which would cause the denture to not be functional would include improper fit, sore or bleeding gums and painful mastication. If the issuing dentist is unable to make the denture functional, resulting in the recipient requiring services from another dentist, a full or partial recoupment of payment may occur less the cost of the laboratory services. When the issuing dentist receives a recoupment notice the dentist must provide a copy of the invoice detailing the laboratory charges so that it may be deducted from the recoupment amount. The requirements in Section 1003.6 are applicable if a dentist requests a new denture within a five year period.

B. PROVIDER RESPONSIBILITY

1. New dentures or partials (or their replacements every five years) must be evaluated for medical necessity. Medicaid will pay for one comprehensive examination per 36 rolling months (Code D0150) in connection with new dentures or denture replacements only. Dentists may bill the comprehensive examination charge at the time of the comprehensive exam. Dentists may bill up to two additional exams (D0140) for subsequent denture appointments. The claim for the prosthetic should not be submitted to Nevada Medicaid prior to the delivery date.

2. Keep diagnosable, panoramic or full mouth x-rays as part of the dentist's record for all removable prosthetics. The x-rays and dentists office notes must substantiate all missing teeth.

3. The recipient must sign and date a delivery receipt to verify that the dentures/partials were received and are accepted and/or acceptable. The date of the

signature on the delivery receipt must be the date the dentures/partials were received by the recipient. The delivery receipt must include the recipient's name, quantity, detailed description of the time(s) delivered and the date and time of delivery and be maintained in the recipient's dental record. The delivery receipt is a required attachment when submitting the claim for reimbursement through the QIO-like vendor's web portal. Claims cannot be submitted prior to the date of delivery.

C. AUTHORIZATION REQUIREMENTS

1. PA is required for partials and/or full dentures for all recipients residing in Nursing Facilities or receiving Hospice services. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

2. Requests for partials and/or full dentures for all recipients residing in Nursing facilities or receiving Hospice services must explain the significance of the medical need. PA requests must include:

   a. One letter each from the recipient's primary care physician and dentist documenting the recipient's medical need for the service in considering his/her total medical condition.

   b. The below information must be included in the prior authorization request. The information can be contained within the letter signed by the attending physician, in a separate letter from the facility's social worker or other appropriate staff, included as documentation from chart notes, etc., or provided in a combination. Include:

      1. Current weight compared to the previous year (to determine whether there has been fluctuation); and

      2. Type of diet; and

      3. Diagnosis; and

      4. Mental status relating to the recipient's ability to understand the use and care of the partials and/or full dentures. If the recipient is unable to care for the dentures, include details on who will care for them. Any other factors relating to conditions that hinder effective functioning, including but not limited to, impaired mastication, muscular dysfunction, ability to swallow and reason for poor nutrition. When documenting reason for poor nutrition, specify whether this is related to dental structures or related to the recipient's

physical or medical condition, and whether the poor nutrition will be improved with dentures.

3. No PA is required for partials and/or full dentures for all other recipients. Post payment review will be completed at the discretion of the DHCFP with recoupment of payment for any partials or full dentures not meeting the above policy for qualification of coverage.

1003.6 DENTURE IDENTIFICATION EMBEDDING

Nevada Medicaid provides payment of denture identification embedding for qualified recipients.

A. COVERAGE AND LIMITATIONS

Any removable prosthetic appliance paid for by the Nevada Medicaid program must have permanent identification labeling embedded in it as defined in NRS 631.375. All artificial teeth, dentures or other removable dental appliances, at the time they are manufactured or sent to a laboratory for repair, must be identified with the name or social security number of the owner by:

1. Embedding the name or number in the material of the appliance;

2. Adding the name or number with an adhesive; or

3. Making the appliance in any manner consistent with advances in technology and approved by the Board.

B. PROVIDER RESPONSIBILITY

Medicaid requires embedding of the recipient's first initial, last name or the last four digits of the social security number for complete dentures, partial dentures with acrylic saddles and when relining unmarked appliances. In cases of insufficient room, you may reduce the person's name and identifiers to the first and second initials or the last four digits of the social security number.

Code D5899 and descriptor "ID Embedding" must be completed by delivery unless the prosthetics already show such markings and the provider so states.

C. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not require PA for ID embedding.

1003.7 ORAL AND MAXILLOFACIAL SURGERY (D7000 – D7999)

The branch of dentistry using surgery to treat disorders/diseases of the mouth.

Nevada Medicaid authorizes payment of oral surgery for qualified recipients.

A. COVERAGE AND LIMITATIONS

1. Services are covered under EPSDT for persons less than 21 years of age. For pregnant women and persons 21 years of age and older, services are covered as emergency care or palliative treatment.

2. Tooth extraction coverage is limited to cases involving symptomatic teeth with clinical symptoms and/or signs of pathology, including acute or chronic pain, inflammation, infection or peri-radicular radiographic evidence of defect.

3. Elective tooth extractions are not covered by Medicaid. “Elective Tooth Extraction” is the extraction of asymptomatic teeth, that is, teeth without symptoms and/or signs of pathology. It includes the extraction of other asymptomatic teeth without clinical evidence of pathology, including third molars (tooth numbers 1, 16, 17 and 32). The exception is extractions that are deemed medically necessary as part of a prior authorized orthodontic treatment plan.

B. AUTHORIZATION REQUIREMENTS

No PA is necessary for most oral and maxillofacial surgery services under EPSDT and for persons 21 years of age and older if the service is considered an emergency extraction or palliative care.

Reference Nevada Medicaid’s Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor’s web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.8 ORTHODONTICS (D8000 – D8999)

The branch of dentistry used to correct malocclusions (the "bite") of the mouth and restore it to proper alignment and function.

Nevada Medicaid authorizes payment for orthodontics for qualified recipients under 21 years of age when certain conditions are met that confirm medical necessity.

Diagnostic Code D0350 is considered to be an “Orthodontia” service only code when required for Orthodontia treatment prior authorization. Nevada Medicaid reimburses for D0350 to Orthodontists only, unless prior authorization is received through EPSDT.

A. COVERAGE AND LIMITATIONS

1. Nevada Medicaid excludes orthodontic work, except that which is authorized by Medicaid's QIO-like vendor as medically necessary Nevada Medicaid has adopted the automatic qualifying conditions list developed by the American Association of Orthodontists' (AAO) Committee on Medically Necessary Orthodontic Care. If a recipient under age 21 does not meet the criteria for any of the AAO's automatic qualifying conditions, but the orthodontist finds there is a medical need for orthodontic work as defined under Section 1003.8.D.2, services can be requested under EPSDT.

2. Medically Necessary Orthodontic Automatic Qualifying Conditions are deemed medically necessary and are qualified for reimbursement when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused by trauma or a severe malocclusion or cranio-facial disharmony that include, but are not limited to:

   a. Overjet equal to or greater than 9 millimeters.

   b. Reverse overjet equal to or greater than 3.5 millimeters.

   c. Anterior and/or posterior crossbite of three or more teeth per arch.

   d. Lateral or anterior open bite equal to or greater than 2 millimeters; of four or more teeth per arch.

   e. Impinging overbite with evidence of occlusal contact into the opposing soft tissue.

   f. Impactions where eruption is impeded but extraction is not indicated (excluding third molars).

   g. Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology.

   h. Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant.

   i. Crowding or spacing of 10 millimeters or more, in either the maxillary or mandibular arch (excluding third molars).

   Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating medical need as defined in Section 1003.8(D)(2).

3. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

   a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

   b. missed no more than 30 percent of any scheduled appointments, for any reason on all Client Treatment History forms submitted.

   c. The referring provider must provide the applicable dental appointment history and not submit more than two years of dental appointment history.

   When a recipient is unable to attend dental appointments for any reason, the treatment plan could be jeopardized or caused to extend beyond the anticipated time to complete the treatment, for which the Orthodontist is not reimbursed.

4. Orthodontia treatment is limited to once per a recipient's lifetime for limited transitional treatment (Dental Codes D8010, D8020 and D8040), and once per lifetime for comprehensive orthodontic treatment (Dental Codes D8080 and D8090). If treatment is discontinued for any reason, including the recipient's non-compliance, Medicaid will not authorize a second orthodontia treatment.

5. Medicaid reimburses for orthodontia services only to those providers enrolled with Nevada Medicaid with the orthodontia specialty (PT 22 with Specialty Code 079).

B. PROVIDER RESPONSIBILITY

1. Only Dentists with a specialty of Orthodontia: PT 22 with the Specialty Code 079 will be reimbursed for orthodontic services. Payment for orthodontia covers the length of treatment.

2. A copy of the Client Treatment History form must be completed by the recipient's treating general or pediatric dentist and is to be in the orthodontic PA request. The treating orthodontist must complete a new Client Treatment History form when requesting a PA for a second phase of orthodontic treatment.

3. Medicaid shall deny any orthodontic prior authorization requests when the attached Client Treatment History form report does not show the recipient has a good history of keeping dental appointments. "Good history "is defined as: missing no more than 30 % of scheduled appointments for any reason within a 24 month period or not complying with dental care treatment plans, as evidenced by active carious lesions, acute gingivitis, acute periodontitis, poor oral hygiene or other unresolved dental factors that could result in poor orthodontic case success.

4. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

   a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

   b. missed no more than 30% of any scheduled appointments, for any reason on all Client Treatment History forms submitted.

   c. The referring provider must provide the applicable dental appointment history and not submit more than two years of dental appointment history.

   When a recipient is unable to attend dental appointments for any reason, the treatment plan could be jeopardized, or could cause the treatment plan to extend beyond the anticipated time to complete the treatment, for which the Orthodontist is not reimbursed.

5. Coordination with Ancillary Dentists: The orthodontist and any ancillary dentists must coordinate with each other to assure Medicaid will pay for the ancillary dental services. For example, the orthodontist's proposed treatment plan should show he/she will be referring the child for extractions or other services. The ancillary dentist need not obtain separate approval for his/her services.

   a. Additionally, the treating orthodontist must coordinate with the recipient's general dentist, or provide in their own orthodontic practice, routine cleanings and examinations according to the AAPD periodicity schedule.

6. A recipient may select a new Orthodontist if the recipient becomes dissatisfied with the original Orthodontist or must geographically move before completion of the treatment plan. When a recipient changes providers during active treatment, the provider must comply with the following:

   a. Acceptance of reimbursement by the Orthodontist is considered their agreement to prorate and forward any unused portion of the reimbursement to a Nevada Medicaid contracted Orthodontist, selected by the recipient, to complete the treatment.

   b. The originating provider must not release Medicaid funds to anyone other than another Medicaid orthodontic provider who agrees to use the funds to complete the approved treatment plan. No additional funds will be allocated or approved to the new Orthodontist for the completion of the treatment. Without such an agreement, the originating provider must return the unused fund (see Section 8 below) to the Medicaid fiscal agent at the address listed in Section 1005.1 of this chapter.

c. Medicaid payment for orthodontic services includes the removal of any banding and providing retainers at no additional cost to the recipient. The Orthodontist accepts this responsibility as part of providing Medicaid services.

7. Circumstances in which an Orthodontist may discontinue treatment:

a. Due to the recipients' poor oral hygiene compliance, when identified and documented by the Orthodontist; and/or

b. The recipient fails to contact the Orthodontist's office within a four-month period; and/or

c. The recipient has not kept at least one appointment within a six-month period.

8. When treatment is discontinued due to any of the reasons listed above, the provider must refund any unused portion of the reimbursement to the Medicaid Fiscal Agent (address listed in Section 1005.1 of this chapter). The provider must contact the Fiscal Agent to request a balance of the remaining funds which should be refunded. The refund amount will be based on the approved treatment plan, the services already rendered and the residual amount that will be refunded to the Fiscal Agent. Any refunded unused funds are not available to be used for further or future orthodontic treatment for that recipient.

9. The Orthodontist may not bill the recipient or Medicaid for additional charges on broken bands, or other necessary services, even if the recipient's poor compliance or carelessness caused the need for additional services.

10. Providers must maintain a detailed, comprehensive, legible dental record of all orthodontia treatment and care. Legible electronic dental records are acceptable.

C. RECIPIENT'S RESPONSIBILITIES

1. Prior to the Orthodontist requesting a PA for Orthodontic services, the following criteria must be met:

a. the recipient must have received dental services by a referring dentist on at least two occasions, on separate days; and

b. missed no more than 30% of any scheduled appointments, for any reason.

c. The recipient's referring provider must provide the applicable dental appointment history and not submit more than two years of dental appointment history.

2. The recipient is responsible for maintaining good oral hygiene on a regular basis, as instructed by the Orthodontist and/or dentist, to maintain the orthodontia treatment plan or orthodontic appliances received.

3. The recipient is responsible to attend all scheduled and follow-up appointments as scheduled as part of the treatment plan.

4. The recipient is responsible for contacting the Orthodontic provider immediately when they are going to miss any scheduled appointments, change providers, or when they have a change in their eligibility status, or when they are moving out of the area.

D. AUTHORIZATION PROCESS

1. Requests for orthodontic treatment must be prior authorized. The PA request must include a completed Orthodontic Medical Necessity (OMN) form. To qualify for authorization, the form must explain the significance of at least one of the following Medically Necessary Orthodontic Automatic Qualifying Conditions, in the OMN form (form found at www.medicaid.nv.gov) or medical need under an EPSDT "Healthy Kids" exception. Clinical documentation must be submitted that substantiates and validates the condition(s) with diagnostic panoramic radiographs, diagnostic photos or photographs of diagnostic models with the automatic qualifying condition.

   Medically necessary Orthodontics are deemed necessary and qualified when it is part of a case involving treatment of cranio-facial anomalies, malocclusions caused as a result of trauma or a severe malocclusion or cranio-facial disharmony that includes, but not limited to:

   a. Overjet equal to or greater than 9 millimeters.

   b. Reverse overjet equal to or greater than 3.5 millimeters.

   c. Anterior and/or posterior crossbite of three or more teeth per arch.

   d. Lateral or anterior open bite equal to or greater than 2 millimeters; of four or more teeth per arch.

   e. Impinging overbite with evidence of occlusal contact into the opposing soft tissue.

   f. Impactions where eruption is impeded but extraction is not indicated (excluding third molars).

g. Jaws and/or dentition which are profoundly affected by a congenital or developmental disorder (craniofacial anomalies), trauma or pathology.

h. Two or more congenitally missing teeth (excluding third molars) of at least one tooth per quadrant.

i. Crowding or spacing of 10 millimeters or more, in either the maxillary or mandibular arch (excluding third molars).

Note: For conditions not listed above, providers may request orthodontic treatment under the EPSDT "Healthy Kids Exception" by demonstrating "Medical Need."

2. The automatic qualifying conditions specified by the AAO have been determined to be medically necessary. Requests for orthodontia under an ESPDT exception must demonstrate a functional impairment indicative of medical necessity. The PA request must explain the significance of one or more of the following considerations of "medical need."

a. Functional factors relating to conditions that hinder effective functioning, including, but not limited to, impaired mastication and muscular dysfunction.

b. Factors related to the degree of deformity and malformation which produce a psychological need for the procedure. The PA request must include documentation from a Qualified Mental Health Practitioner (QMHP) acting within the scope of their practice that verifies the psychological need; the documentation must be based on objective evidence and reviewed by the QIO-like vendor.

c. The recipient's overall medical need for the service in light of his/her total medical condition. For example, an orthodontia need which might be slight in an otherwise healthy child may become quite severe for a child suffering from complicating ailments such as cerebral palsy or epilepsy. A functional impairment must be demonstrated.

d. The medical appropriateness of an orthodontic treatment plan as opposed to other available dental treatment. Appropriate consideration may be given, for example, to a child's inability to understand and follow a treatment plan where failure to follow the plan would result in medical complications of the child's condition.

Medicaid does not authorize orthodontic treatment based on the possibility of risk of a future condition, ease of hygiene or aesthetic improvement.

3. PA requests must be submitted on an American Dental Association (ADA) claim form.

   The following documents are required to be attached with the prior authorization request to the QIO-like vendor:

   a. Orthodontic Medical Necessity (OMN) Form.

   b. Client Treatment History Form.

   c. A copy of the oral examination record(s), including diagnostic photographs or photos of diagnostic models demonstrating measurements and a copy of a panoramic x-ray. Diagnostic photographs and/or photographs of diagnostic models and panoramic x-rays must be of sufficient quality to confirm the diagnosis and must include any other documentation or measurements as required in the Orthodontic Medical Necessity Form, to confirm the diagnosis.

   d. The provider must submit the appropriate level of documentation to support the diagnosis. Providers are encouraged to use the recommendations for diagnostic records encompassed in the most current edition of the American Association of Orthodontists "Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics" which includes the recommendations for the use of panoramic radiographs, cephalometric radiographs and Intraoral and Extraoral photographs to confirm a diagnosis.

   e. If the request is submitted under one of the AAO automatic qualifiers, include a treatment plan, principal diagnosis and any significant associated diagnoses, and prognosis.

      If the request is submitted as an EPSDT exception, include the following:

      1. Principal diagnosis and any significant associated diagnoses.

      2. Prognosis.

      3. Date of onset of the illness or condition and etiology if known.

      4. Clinical significance or functional impairment caused by the illness or condition.

      5. Specific services to be rendered by each discipline and anticipated time for achievement of treatment goals.

6. Therapeutic goals to be achieved by each discipline and anticipated time for achievement of the therapeutic goals.

7. A description of previous services that were provided to address the illness/condition and the result of the prior care.

8. Treatment plan.

f. Any other documentation that may be required to substantiate the prior authorization decision.

The Orthodontic Medical Necessity Form and the Client Treatment History Form are located on the QIO-like vendor's web portal at www.medicaid.nv.gov.

4. Medicaid's QIO-like vendor will accept PA requests ONLY from those providers with a specialty in Orthodontia (PT 22 with Specialty Code 079).

a. Orthodontists must use one of the codes for "limited" or "comprehensive" orthodontic treatment for claims and PA requests.

b. Medicaid will deny an extension of orthodontic treatment if the results are poor or the recipient has failed to keep appointments or comply with treatment.

c. PA requests submitted must show all proposed orthodontic procedures and list the following at a minimum: initial banding, months of treatment including retention treatments and any retainers. Medicaid expects the provider to render unlisted but necessary treatment components at no additional charge. The provider's usual and customary charge must show for each service. Stating a total fee for all services is not acceptable.

d. The QIO-like vendor may require the Orthodontists to shorten their treatment plan after reviewing the submitted PA materials and documentation.

5. The QIO-like vendor inputs the disposition for the requested orthodontic service directly into the current system. No forms are submitted for signature for indication of approved reimbursement amount. The fiscal agent does not return denied orthodontic requests to providers.

6. When the provider completes the initial banding, he/she must enter the date of service and the usual and customary charges amount on the claim form and return it to the fiscal agent. The fiscal agent will make payment for the total specified on the approved treatment plan.

E. OUT – OF STATE ORTHODONTIA

Nevada Medicaid will not pay for the continuation of orthodontic treatment if the recipient started their treatment with an out-of-state provider. Nevada Medicaid will pay for the removal of the orthodontic appliance(s) under EPSDT. The new, Nevada orthodontist can then submit a PA request following the NV Medicaid criteria detailed in Section 1003.8(D).

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.9 ADJUNCTIVE GENERAL SERVICES (D9000 – D9999)

The branch of dentistry for unclassified treatment including palliative care and anesthesia.

Nevada Medicaid authorizes payment of adjunctive general services for qualified recipients under 21 years of age and for emergency care, palliative care and anesthesia for persons 21 years of age and older.

A. COVERAGE AND LIMITATIONS

Services are covered under EPSDT for persons less than 21 years of age; palliative care is covered for persons 21 years of age and older.
For dental codes related to General or IV anesthesia, the provider must show the actual beginning and end times in the recipient's dental record. Anesthesia time begins when the provider administering the anesthetic agent initiates the appropriate anesthesia and monitoring protocol and ends when the provider is no longer in constant attendance (i.e., when the recipient can be safely placed under postoperative supervision).

B. AUTHORIZATION REQUIREMENTS
No PA is necessary for most services under EPSDT. Persons 21 years of age and older require PA unless the service is for emergency extractions or palliative care.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.10 PERSONS 21 YEARS OF AGE AND OLDER

Nevada Medicaid authorizes payment for qualified persons 21 years of age and older for partials, dentures, emergency extractions and palliative care only.

A. COVERAGE AND LIMITATIONS

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

B. PROVIDER RESPONSIBILITY

1. Providers must keep all substantiating x-rays on file for a minimum of six years following the date of service. Providers must keep the x-rays, related charting and other case documentation easily available to Medicaid reviewers during this period.

2. The Medicaid program considers emergency extractions a program benefit without prior or post approval. This includes the use of in-office sedation or anesthesia. The program does not cover extractions for cosmetic purposes. Dentists need not routinely submit substantiating x-rays to the Medicaid fiscal agent. However, Medicaid will periodically request copies of x-rays substantiating third molar extractions (teeth 1, 16, 17 and 32 for adults and children) related to tissue impaction, partial and full bony and surgical versus simple extractions. The dentists on-file x-rays must reveal sufficient bone and root complications for difficult surgical removal procedures.

3. For treatment necessary to avoid life-threatening health complications, providers perform services necessary to prevent life-threatening deterioration of a person's physical health without PA even though the services do not immediately qualify as Medicaid covered emergency services. The dentist must certify the services were medically necessary due to health complicating conditions such as HIV, AIDS, cancer, bone marrow transplantation or post kidney transplant. The dentist's certification must be part of a note explaining why the treatment was necessary to avoid life-threatening problems. For example, the dentist may explain successful cancer treatment or organ transplantation depended on extractions or treatment of caries to protect the recipient's compromised immune system from the stress of oral infection.

C. AUTHORIZATION REQUIREMENTS

No authorization is needed if the service is for emergency extraction or palliative care. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.11 SERVICES NOT COVERED BY MEDICAID

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not cover the following services:

1. Cosmetic services.

2. Routine and preventive dental care, such as periodic prophylaxis, sealants, silver diamine fluoride application, restoration of incipient or minor decay, treatment of sensitivity to hot and cold or other minor pain is not covered for persons 21 years of age and older. (Prophylaxes and restorative dental services under pregnancy related services require PA and are reviewed on an individual basis).

3. Crowns are not allowed for persons 21 years of age and older, except where required on an anchor or abutment tooth for a partial denture. Gold crowns are not a covered benefit for any age.

4. For persons 21 years of age and older, Temporal Mandibular Disease (TMD) services are not covered by Nevada Medicaid except for adult emergency services.

5. No show appointments or charges for missed appointments are not allowed.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

1003.12 PHARMACY SERVICES

Nevada Medicaid authorizes payment of pharmacy services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Fluoride supplements are covered only for recipients less than 21 years old.

B. PROVIDER RESPONSIBILITY

At this time, PA is not required for preventative medicaments like fluoride supplements when prescribed by a dentist; however, it is recommended that prescribers check current policy for any changes made.

The recipient must present the prescription with a Nevada Medicaid card to a Medicaid participating pharmacy provider. Providers must verify eligibility prior to service.

C. AUTHORIZATION PROCESS

These guidelines do not change any Medicaid policy regarding non-covered medications or medications which always require PA.

The Nevada Medicaid Preferred Drug List (PDL), PA requirements and quantity limits are available on the www.medicaid.nv.gov website.

Refer to the pharmacy policy located in MSM Chapter 1200 Prescribed Drugs.

1003.13 RESIDENTS OF INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Nevada Medicaid authorizes payment for Medicaid covered services provided in an ICF/IID to full Medicaid-eligible recipients.

All dental services provided to recipients in an ICF/IID are administered under the same policy coverage and limitations provided throughout this dental chapter. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

A. COVERAGE AND LIMITATIONS

Under Federal regulations (CFR 483.460(e-h), the ICF/IID is required to provide or make arrangements for comprehensive dental diagnostic and treatment services for their residents.

B. PROVIDER RESPONSIBILITY

For dental services beyond the Medicaid covered benefit, the dentist must establish a relationship with the ICF/IID facility staff to assure verification of the recipient's ICF/IID residency, and payment source for dental services prior to service.

1003.14 PROVIDERS OUTSIDE NEVADA

Nevada Medicaid authorizes payment for out-of-state providers under Medicaid guidelines.

A. COVERAGE AND LIMITATIONS

Out-of-state providers are subject to the coverage and limitations of dental services under Nevada Medicaid.

B. PROVIDER RESPONSIBILITY

Out-of-state providers are subject to all Medicaid rules and guidelines.

C. AUTHORIZATION REQUIREMENTS

Out-of-state providers must use the same PA process as in-state dental providers.

1003.15 PAYMENT OF NON-COVERED SERVICES

A. COVERAGE AND LIMITATIONS

Nevada Medicaid does not authorize payment for non-covered services.

B. PROVIDER RESPONSIBILITY

Dental providers must inform the recipient of his/her financial responsibility before rendering any uncovered service. Consider this done when the recipient or a responsible designee signs a written document acknowledging acceptance of financial responsibility for each specific itemized service. The signed document must state, "I understand Medicaid will not cover the above itemized service cost(s). I agree to pay for the services."

If Medicaid covers a procedure, the provider cannot charge the recipient for the balance after Medicaid's payment. Also, providers cannot charge Medicaid for one covered service and provide a different service. For example, since Medicaid does not cover restorations or prosthetics made of gold, Medicaid's payment on a covered restoration or prosthesis cannot be used to offset one made of gold. The recipient would need to pay the complete charge for the gold restoration or prosthesis, or the recipient must accept the Medicaid benefit service only.

C. RECIPIENT RESPONSIBILITY

Services exceeding program limitations are not considered Medicaid benefits. These services are the financial responsibility of the recipient. For persons less than 21 years of age, medically necessary services that are outside of what is covered in the benefit schedule can be requested with a PA as an EPSDT exception. For example, a PA request needs to be submitted for a child who needs cleanings every three months rather than the six months allowed by current service limitations.

D. AUTHORIZATION REQUIREMENTS

Nevada Medicaid does not authorize payment for non-covered services.

1003.16 SERVICES PROVIDED IN NURSING FACILITIES

Nevada Medicaid authorizes payment for services provided in nursing facilities to qualified recipients eligible with full Medicaid benefits.

A. COVERAGE AND LIMITATIONS

All dental services provided to recipients in a nursing facility are administered under the same policy coverage and limitations provided throughout this Dental Chapter.

B. PROVIDER RESPONSIBILITY

Medicaid advises dentists to confirm the recipient's eligibility through the Eligibility Verification System (EVS) for the month the service will be provided and retain a copy prior to service. Medicaid advises dentists to develop procedures with nursing facility staff to screen for ineligible recipients. Medicaid recommends dentists become users of EVS by making arrangements with Medicaid's QIO-like vendor.

C. NURSING FACILITY RESPONSIBILITY

Nursing facility staff must screen for Medicaid eligibility.

D. AUTHORIZATION REQUIREMENTS

PA is required for partials and/or full dentures for all recipients residing in nursing facilities or receiving Hospice services. See Section 1003.5.C.

1003.17 HOSPITAL/SURGICAL CENTERS

A. COVERAGE AND LIMITATIONS

Nevada Medicaid authorizes payment for certain dental services in hospital or surgical centers for qualified recipients with PA unless it is an emergency.

B. AUTHORIZATION REQUIREMENTS

1. Inpatient Hospital Setting: Prior authorization for inpatient hospitalization for a dental procedure is necessary for Medicaid reimbursement.

   a. If PA is required for the dental procedure (CDT code), the dental consultant must obtain prior authorization. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

   b. PA must be obtained from Medicaid's QIO-like vendor or the Managed Care Organization (MCO) to certify the necessity for the recipient to be hospitalized for the performance of the inpatient dental procedure. The certification must be done before or on the date of the admission.

      The provider must write, "Hospital Admission" at the top of the Examination and Treatment Plan box of the claim form.

2. Outpatient/Surgical Center Setting: Prior authorization for dental procedures performed in an outpatient/surgical center setting may require prior authorization.

   a. For Medicaid recipients of all ages: If PA is required for the dental procedure (CDT code), the dentist rendering the service must obtain prior authorization. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

   b. For Medicaid recipients ages five and below, prior authorization is required for the outpatient facility. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason, including medical necessity, that the recipient is unable to have the services completed in the office.

   c. For Medicaid recipients ages 6 to 20, specific authorization is not required for the anesthesiologist and/or outpatient facility. Procedures done as outpatient services for recipients less than 21 years of age in a hospital or surgical center must be identified. The provider must write "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

   d. For Medicaid recipients 21 years of age and older, the outpatient facility services must be prior authorized. The authorization request must include a narrative signed by the provider with the clinical rationale for the dental procedure to be completed in an outpatient setting. The narrative must detail the clinical reason that the recipient is unable to have the services completed in the office.

   e. All dentists providing surgical center services to Medicaid recipients must retain in-office copies of x-rays, intra-oral preoperative photographs (when necessary) and documentation necessary to substantiate service need. The substantiating evidence must be retained and remain readily available for no less than six years. Medicaid holds the provider responsible for assuring the evidence is sufficient for the Medicaid agency's post utilization review/control purposes.

   f. In situations where the dentist believes his treatment plan to have weak support from x-rays, intra-oral photographs, etc., the dentist should submit the evidence with a request for PA. Without PA, Medicaid will reclaim payment for the services if post service review findings do not support the dentist's treatment plan and medical necessity.

g. Medicaid does not reimburse providers for travel and hospital call related costs for services done in an outpatient surgical center.

1003.18 MAXILLOFACIAL SURGERY AND OTHER PHYSICIAN SERVICES

Nevada Medicaid authorizes payment for maxillofacial surgery and other physician services for qualified recipients.

A. COVERAGE AND LIMITATIONS

Temporomandibular Disorders (TMDs) encompasses a variety of conditions. For recipients less than 21 years of age, TMD services may be provided by a dentist or medical doctor under EPSDT. Coverage for the medical management of TMD related disease for recipients will be limited to appropriate current TMD related diagnosis codes.

Adult dental services continue to be restricted to palliative treatment, emergency extractions and dentures/partials.

Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the PT 22 Billing Guide) document located in the QIO-like vendor's web portal at www.medicaid.nv.gov for a list of covered CDT codes, prior authorization requirements and service limitations.

B. PROVIDER RESPONSIBILITY

Program utilization control requires that each type of provider (dentist, physician, pharmacist, etc.) be delineated with the use of a specific PT number. For example, dentists are a PT 22 while physicians are a PT 20. Providers also have the option to choose a specialty type. For example, a PT 22 can choose a specialty type of Maxillofacial Surgery (Specialty 170) or Oral Surgery (Specialty 080). All dental related services must be billed/requested with the most appropriate dental code found on the QIO-like vendor's web portal at www.medicaid.nv.gov. For certain oral and maxillofacial surgery procedures, when an appropriate dental code is not available, a CPT Code may be used if Medicaid allows the code to be billed by a PT 22, Specialty 080 and/or 170. Providers are encouraged to check the www.medicaid.nv.gov website or contact the QIO-like vendor to confirm ability to bill for specific CPT codes.

The CPT Code for fluoride varnish application which can be administered by PT 17, 20, 24 and 77 should be billed on a CMS 1500 form using the most appropriate and available ICD diagnosis code.

C. AUTHORIZATION REQUIREMENTS

See B. Provider Responsibility.

1003.19 CONDITIONS FOR PARTICIPATION

All dental providers must have a current license issued by the Nevada State Board of Dental Examiners to practice dentistry. Dental specialists must be dental specialties that are recognized and approved by the American Dental Association and the Nevada State Board of Dental Examiners and be enrolled as a Nevada Medicaid provider. Out of state dentists must meet the licensing requirements of the state in which they practice and be enrolled as a Nevada Medicaid provider.

Dental services may also be performed in a clinic setting as long as the care is furnished by or under the direction of a dentist. The clinic must have a dental administrator and all professional staff, dentists, hygienists, public endorsed hygienists, dental therapists, etc. must have a current Nevada license and/or certification from the appropriate state licensing board.

1003.20 IMPROPER BILLING PRACTICE

Providers must bill only for the dates when services were actually provided, in accordance with this MSM Chapter and the PT 22 Billing Guide.

Any provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include but are not limited to:

A. Submitting claims for unauthorized procedures or treatments.

B. Submitting claims for services not provided.

C. Submitting false or exaggerated claim of the level of functional impairment or medical necessity to secure approval for treatment and reimbursement.

D. Submitting claims for treatment or procedures without documentation to support the claims.

E. Submitting claims for unnecessary procedures or treatments that are in excess of amount, scope and duration necessary to reasonably achieve its purpose.

F. Submitting claims for dental services provided by unqualified personnel.

Any Dental provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupment in accordance with MSM Chapter 3300 – Program Integrity. All Medicaid overpayments are subject to recoupment.

Any such action taken against a dental provider by the DHCFP has no bearing on any criminal liability of the provider.

1004 HEARINGS

Please reference Nevada MSM Chapter 3100 for the Medicaid Hearing process.

1005 REFERENCES AND CROSS REFERENCES/FORMS

Other sources which may impact the provision of Dental services include, but are not limited to the following:

Chapter 100: Medicaid Program
Chapter 200: Hospital Services
Chapter 300: Radiology Services
Chapter 500: Nursing Facilities
Chapter 600: Physician Services
Chapter 1200: Prescribed Drugs
Chapter 1500: Healthy Kids Program (EPSDT)
Chapter 1600: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Chapter 2100: Home and Community-Based Services Waiver for Individuals with Intellectual Disabilities
Chapter 3100: Hearings
Chapter 3300: Program Integrity

1005.1 CONTACTS

A. Nevada Medicaid Provider Enrollment
Division of Health Care Financing and Policy
1100 East William Street
Carson City, NV 89701
(775) 684-3705
https://dhcfp.nv.gov

B. DXC Technology
Customer Services Center
(For claim inquiries and general information)
(877) 638-3472
www.medicaid.nv.gov

C. Prior Authorization for Dental
(800) 525-2395 (Phone)

1005.2 FORMS

A. The ADA Dental Claim Form 2012 or newer version is required for all prior authorization requests, claims, adjustments and voids.

1005.3 DENTAL PERIODICITY SCHEDULE

The recommended periodicity schedule can be found at http://www.aapd.org/.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 26, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL LYNNE

FROM: FOSTER, CHIEF OF DIVISION COMPLIANCE /Lynn Foster/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES CHAPTER 1100, OCULAR SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1100 – Ocular Services are being proposed to add new language clarifying ocular prosthetic services.

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: Optometrist (Provider Type (PT) 25) and Durable Medical Equipment (PT 33).

Financial Impact on Local Government: None.

These changes are effective July 27, 2017.

MATERIAL TRANSMITTED	**MATERIAL SUPERSEDED**
MTL 17/17 OCULAR SERVICES	MTL 24/15 OCULAR SERVICES

Manual Section	**Section Title**	**Background and Explanation of Policy Changes, Clarifications and Updates**
1103.1A(5)	**Ocular Prosthetic Services**	Add new language clarifying ocular prosthetic services.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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OCULAR SERVICES

1100 INTRODUCTION

The Nevada Medicaid Ocular program reimburses for medically necessary ocular services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Support Services at Nevada Medicaid.

Ocular services are an optional benefit within the Nevada Medicaid Program.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of areas where Medicaid and NCU policies differ. For further clarification, please refer to the NCU Manual, Chapter 1000.

1101 AUTHORITY

The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulation (CFR) Part 440.200, and Sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Social Security Act (SSA). CFR 440.225 and 441.30. Nevada State Plan Section 3.1, Pages 19, 216 and 27.

The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- Physicians: NRS Chapter 630.375
- Optometry: NRS Chapter 636
- Dispensing Opticians: NRS Chapter 637

1102 RESERVED

1103 POLICY

1103.1 OCULAR SERVICES

1103.1A COVERAGE AND LIMITATIONS

Medicaid will reimburse for routine comprehensive ophthalmological examinations and/or refractive examinations of the eyes and glasses with a prescription for and provision of corrective eyeglasses to eligible Medicaid recipients of all ages once every 12 months. Any exceptions require prior authorizations.

1. HEALTHY KIDS (EPSDT)

   a. Nevada Medicaid provides for vision screenings as referred by any appropriate health, developmental or educational professional after a Healthy Kids Screening Exam. Optometrists and ophthalmologists may perform such exams without prior authorization upon request or identification of medical need. "Medical Need" may be identified as any ophthalmological examination performed to diagnose, treat or follow any ophthalmological condition that has been identified during the Healthy Kids examination.

   b. Glasses may be provided at any interval without prior authorization for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) recipients, as long as there is a change in refractive status from the most recent exam, or for broken or lost glasses. Physician records must reflect this change and the records must be available for review for the time mandated by the federal government. Recipients enrolled in a Managed Care plan are mandated to access Healthy Kids EPSDT ocular services through their Managed Care provider.

2. EXAMINATIONS

   a. Refractive examinations performed by an optometrist or ophthalmologist are covered for Medicaid recipients of all ages once every 12 months. Any exceptions require prior authorization.

   b. Ocular examinations performed by an optometrist for medical conditions within the scope of their license do not require a prior authorization.

   c. Ocular examinations performed by an ophthalmologist for medical conditions do not require prior authorization and are considered a regular physician visit. Current limitations are based on medical necessity.

d. Following cataract surgery, if the recipient is Medicare eligible and requires eyeglasses, the provider must bill Medicare first and attach the Medicare Explanation of Benefits (EOB) to the claim for co-insurance and deductible.

3. LENSES

Lenses are covered for recipients of all ages. No prior authorization is needed for recipients under 21. For recipients over 21, a prior authorization is required if the 12-month limitation is exceeded.

a. COVERED

The following are covered for Nevada Medicaid recipients of all ages as noted:

1. A change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within the 12-month limitation;

2. Lens material may be tempered glass tillyer grade or equivalent or standard plastic, at recipient's option;

3. Ultra-lightweight plastics, e.g., Lite Style and polycarbonate-style, are covered when they are medically necessary to avoid very heavy glasses which would hurt the bridge of the nose. The acceptable means for avoiding severe imbalance of the weight of the glasses are up to $\pm$7 diopters in children;

4. Polycarbonate lenses are covered under EPSDT when medically necessary;

5. Safety lenses when the recipient has vision in only one eye;

6. A single plano or balance lens is handled as if it were a corrective lens and so called "half glasses" are handled as if they were standard size corrective lenses;

7. Slab-off lenses, Prisms, Aspheric, Lenticular lenses;

8. "Executive" bifocals may be covered for children with: esotropia, and esophoria, accommodation, oculomotor dysfunction such as tracking and saccadic problems. Prior authorization is not required when using one of the above medical diagnoses;

9. Filters: PLS 40 filters when prescribed for patients with the following diagnoses: macular degeneration, retinitis pigmentosa, rod/cone dystrophy or

achromastopia. In all these cases, the best uncorrected vision must test better than 20/200;

10. UV filters when prescribed following cataract surgery;

11. Bifocals and trifocals are reimbursable for a combination of any of the conditions at near or far point, including but not limited to: estropia, esophoria, cataracts, glaucoma, accommodative dysfunctions, nystogmus, stigmatism, myopia, presbyopia;

12. Double segment lenses required for employment which must be prior authorized;

13. Therapeutic contact lenses when prescribed for treatment of a medical condition;

14. Tints are covered when medically necessary;

15. Low vision aides such as telescopic lenses, magnifying glasses, bioptic systems and special inserts in regular lenses which must be prior authorized;

16. Scratch-proof coatings for plastic lenses are covered for EPSDT recipients.

b. NON-COVERED

The following are not covered:

1. Sunglasses and cosmetic lenses.

2. Contact lenses are disallowed UNLESS their use is:

   a. The only means to bring vision to the minimum criteria required to avoid legal blindness; or

   b. Medically indicated following cataract surgery; or

   c. The necessary means for avoiding very heavy glasses which would hurt the bridge of the nose (e.g., where the correction is 9+ diopters in each eye). The necessary means for avoiding severe imbalance of the weight of glasses is where one eye is corrected to 9+ diopters and the other eye is 3+; or

   d. Required when the recipient has a diagnosis of Keratoconus.

3. Replacement of lenses, unless the patient has a significant change in refractive status.

4. Blended and progressive multi-focal lenses, “transitional lenses.”

5. Faceted lenses.

6. “Additional” Cost of an Extended Repair Replacement (ERR) warranty.

4. FRAMES

a. COVERED

1. Existing frames must be used whenever possible. If new frames are necessary, they may be metal or plastic, at the patient's option, up to Medicaid’s allowable cost.

2. Providers must stock a variety of frames to enable the recipient to choose a frame at no cost to them, if they so choose.

b. NON-COVERED

The following are not covered:

1. Frames with ornamentation.

2. Eyeglass frames which attach to or act as a holder for hearing aid(s).

5. OCULAR PROSTHETIC SERVICES

a. Ocular prosthesis is covered when medically necessary, allowing one per eye, per 60 months (five years).

b. Ocular prosthesis requires prior authorization. Please reference Medicaid Services Manual (MSM) Chapter 1300, Durable Medical Equipment (DME), for prior authorization guidelines.

c. A physician or optometrist must submit a referral for an ocular prosthesis, and the referral must be maintained in the recipient’s medical record.

d. Necessity for the procedure must include:

1. explanation of medical necessity for the prosthetic eye;

2. prior prosthetic eye history, if applicable; and

3. description and justification other than a pre-cast prosthesis.

e. For replacement of a prosthetic eye or sclera cover shell, one of the following justifications must be included:

1. accommodation for changes resulting from orbital development;

2. as necessary to prevent a significant disability;

3. when prior prosthesis was lost or destroyed due to circumstances beyond the recipient's control; or

4. when the prior prosthesis can no longer be rehabilitated.

f. Polishing/resurfacing of an ocular prosthesis is covered once each 12 months, per eye without prior authorization. If medical necessity exceeds limitations, a prior authorization is required.

g. If there is one paid claim historically for the same eye, right or left, medical necessity for a second claim within the 60-month period must include one of the following conditions:

1. socket growth or contracture;

2. lagophthalmos;

3. ptosis;

4. lower lid laxity;

5. entropion;

6. ectropion;

7. implant exposure; or

8. other conditions that can be improved or minimized with appropriate prosthetic modification.

h. Fabrication and fitting of an ocular conformer must include:

1. a written prescription by a physician or optometrist, and the prescription must be retained in the recipient's medical record;

2. medical necessity for the recipient; and

3. documentation of post-surgical use to prevent closure and/or adhesions between the orbit and eyelid during the healing process.

i. The recipient is responsible for general care and maintenance of the eye socket and prosthesis, as directed by the provider.

6. VISION THERAPY

Vision therapy is a covered Medicaid benefit and must be prior authorized by the QIO-like vendor.

1103.1B PROVIDER RESPONSIBILITY

1. Providers must confirm the recipient's eligibility by reviewing the current Medicaid card before providing services, or access eligibility via the Electronic Verification of Eligibility (EVE) system.

2. It is the provider's responsibility to ask the recipient if there is additional visual coverage through third party payers.

1103.1C RECIPIENT RESPONSIBILITY

Services requested by the recipient but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid, such as eyeglass extras. Prior to service, the recipient must be informed in writing and agree in writing he/she will be responsible for payment.

1. The recipient is responsible for presenting a valid Medicaid card to the examiner and/or optician.

2. The recipient is responsible for presenting any form or identification necessary to utilize other health insurance coverage.

3. If the recipient selects a frame with a wholesale cost greater than the Medicaid allowable, they will be responsible for the additional amount. The recipient's agreement to make payment must be in writing. A copy of the agreement must be retained in the recipient's chart. The Nevada Medicaid Surveillance and Utilization Review Unit (SUR) conducts a regular review of claims history to monitor this.

4. If the recipient selects a lens option not covered by Medicaid, he/she is then responsible for payment only of the non-covered options. Medicaid pays the lens cost minus the cost of options. Non-covered options must be listed separately on the invoice. Claims will be returned to providers for correction.

5. If the recipient chooses an ERR warranty which is not covered by Medicaid's payment, he/she is responsible for warranty payment.

6. The recipient is responsible for making and keeping appointments with the doctor.

7. The recipient is responsible for contacting the provider of the eyeglasses (if different from the examiner) for fitting and delivery.

8. The recipient is responsible for picking up the eyeglasses and returning for any necessary adjustments within the time allotted for such adjustments. (Medicaid will not pay for office visits for adjustments. The provider is expected to make reasonable adjustments and repair, without charge).

9. UNCLAIMED EYEGLASSES

   The recipient has 15 days to claim eyeglasses reimbursed by Nevada Medicaid. If after 15 days, the item is still held by the provider:

   a. The provider shall notify the appropriate district office.

   b. The caseworker attempts to contact the recipient and make arrangements to claim the eyeglasses.

      If the caseworker is unable to contact the recipient or the recipient refuses to claim the eyeglasses, the worker advises the Nevada Medicaid Office (NMO) and notifies the provider the item will not be picked up, NMO then notifies Utilization Control for a possible restriction of the recipient's medical services.

   c. Following notification the item will remain unclaimed, provider may submit a bill in the normal fashion to the Nevada Medicaid fiscal agent.

1104 HEARINGS

Please reference MSM Chapter 3100, for Medicaid Recipient Hearings process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 30, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres* Casey Angres (Jul 13, 2023 19:49 PDT)
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200 – Prescribed Drugs are being proposed to add new prior authorization criteria for Physician-Administered Drugs (PADs). The proposed changes include addition of new PAD-specific prior authorization criteria for Libtayo® (cemiplimab-rwlc), Ocrevus® (ocrelizumab), Opdivo® (nivolumab), Tecentriq® (atezolizumab) within the Anti-PD-1 Monoclonal Antibodies Section; addition of new PAD-specific prior authorization criteria for Eylea® (aflibercept), Lucentis®; Byooviz™; Cimerli™(ranibizumab), Susvimo® (ranibizumab) within the Anti-Angiogenic Opthalmic Agent Section; addition of new PAD-specific prior authorization criteria for SCIG (immune globulin): Hizentra®, Gammagard Liquid®, Gamunex®-C, Gammaked®, HyQvia®, Cuvitru®, Cutaquig®, Xembify® within the Immunoglobulins Section; addition of new PAD-specific prior authorization criteria for Pemetrexed within the Antimetabolites Section; addition of new PAD-specific prior authorization criteria for Perjeta® (pertuzumab), Herceptin®; Ogivri®; Kanjinti™; Trazimera™; Herzuma™; Ontruzant® (Trastuzumab); Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk) within the HER2 Inhibitor Section; addition of new PAD-specific prior authorization criteria for Rituxan®, Truxima®, Ruxience™, Riabni™ (Rituximab), Rituxan Hycela® (rituximab and hyaluronidase human) within the CD20 Monoclonal Antibodies Section; addition of new PAD-specific prior authorization criteria for Soliris® (eculizumab), Ultomiris® (ravulizumab-cwyz) within the Selective Immunosuppressants Section; addition of new PAD-specific prior authorization criteria for Yervoy® (ipilimumab) within the Anti-CLTA-4 Monoclonal Antibodies Section.

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.

These changes are effective June 5, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL N/A MSM Chapter 1200 - Prescribed Drugs	MTL N/A MSM Chapter 1200 - Prescribed Drugs

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix B Section B	**Anti-PD-1 Monoclonal Antibodies**	Created new section for PAD prior authorization criteria and quantity limits for Libtayo® (cemiplimab-rwlc), Ocrevus® (ocrelizumab), Opdivo® (nivolumab), Tecentriq® (atezolizumab).
Appendix B Section H	**Anti-Angiogenic Opthalmic Agent**	Created new section for PAD prior authorization criteria and quantity limits for Eylea® (aflibercept), Lucentis®; Byooviz™; Cimerli™ (ranibizumab), Susvimo® (ranibizumab).
Appendix B Section I	**Immunoglobulins**	Created new section for PAD prior authorization criteria and quantity limits for SCIG (immune globulin): Hizentra®, Gammagard Liquid®, Gamunex®-C, Gammaked®, HyQvia®, Cuvitru®, Cutaquig®, Xembify®.
Appendix B Section N	**Antimetabolites**	Created new section for PAD prior authorization criteria and quantity limits for Pemetrexed. Deleted Section for Libtayo®.and placed it under Anti-PD-1 Monoclonal Antibodies Section.
Appendix B Section O	**HER2 Inhibitors**	Created new section for PAD prior authorization criteria and quantity limits for Perjeta® (pertuzumab), Herceptin®; Ogivri®; Kanjinti™; Trazimera™; Herzuma®; Ontruzant® (trastuzumab); Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk).
Appendix B Section P	**CD20 Monoclonal Antibodies**	Created new section for PAD prior authorization criteria and quantity limits for Rituxan®, Truxima®, Ruxience™, Riabni™ (rituximab) and Rituxan Hycela® (rituximab and hyaluronidase human).
Appendix B Section Q	**Selective Immunosuppressants**	Created new section for PAD prior authorization criteria and quantity limits for Soliris® (eculizumab), Ultomiris® (ravulizumab-cwvz).
Appendix B Section R	**Anti-CLTA-4 Monoclonal Antibodies**	Created new section for PAD prior authorization criteria and quantity limits for Yervoy® (ipilimumab).
Appendix B Section S	**Miscellaneous Antineoplastics**	Created new section for PAD prior authorization criteria and quantity limits for Zynlonta® (loncastuximab tesirine-lpyl).

DIVISION OF HEALTH CARE FINANCING AND POLICY

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PRESCRIBED DRUGS

1200 INTRODUCTION

The Nevada Medicaid Pharmacy Services program pays for medically necessary prescription services for eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions hereinafter specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Services.

This Chapter describes covered services, service limitations and general reimbursement methodology.

This manual obsoletes all previous policy and procedure manuals, bulletins and policy news.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

1201 AUTHORITY

A. The Code of Federal Regulations (CFR), Title 42, Public Health, Chapter IV, Center for Medicare and Medicaid Services (CMS), Subchapter C Medical Assistance Programs, Parts 430 through 456, states prescription drug coverage is an optional service under Title XIX.

B. The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates additional preventive health care services for infants, children and young adults (newborn through age 20) eligible for Medicaid. These mandates provide that children and adolescents under age 21 receive follow-up services for a medically necessary condition discovered in a screening examination, Early Preventative Screening and Diagnostic Testing (EPSDT), see Medicaid Services Manual (MSM) Chapter 1500; this includes prescription services.

C. CFR Title 42 and Section 1927 of the Social Security Act (SSA), require states to provide for a Drug Utilization Review (DUR) program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical results SSA, Title 19, (g)(1)(A)).

D. Section 1927 of the SSA allows a state to require a prior authorization on any covered outpatient drug, providing the prior authorization program complies with the requirements outlined in the act.

The SSA requires the establishment of a DUR board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of program beneficiaries.

E. Chapter 422 of Nevada Revised Statute (NRS) amended by AB 384 to require the Department of Health and Human Services (DHHS) to:

1. develop a list of preferred prescription drugs;

2. manage prescription drug use through the use of prior authorization and step therapy; and

3. create the Pharmacy and Therapeutics Committee.

F. U.S. Troop Readiness, Veteran's Health Care, Katrina Recovery and Iraq Accountability Appropriations Act 2007, Section 7002(b) of the act requires Medicaid outpatient drugs (defined in Section 1927(k)(2) of the SAA) will be reimbursable only if non-electronic written prescriptions are executed on a tamper-resistant prescription pad.

G. The Deficit Reduction Act of 2005 requires Fee-for-Service (FFS) State Medicaid programs to capture and report National Drug Codes (NDC) for outpatient drugs in order for the state to receive federal financial participation.

1202 RESERVED

1203 POLICY

The Division of Health Care Financing and Policy (DHCFP), Nevada Medicaid, reimburses pharmacies and practitioners for legend (prescription) and non-legend (over the counter) pharmaceuticals dispensed or administered to Medicaid recipients. All prescribers must have a license as a healthcare practitioner, such as a physician, podiatrist, osteopath, dentist, Advanced Practice Registered Nurse (APRN), physician's assistant, etc., keeping within the scope of their practice. The DHCFP requires that pharmaceuticals are written, dispensed and prescribed in accordance with the Nevada State Board of Pharmacy regulations and enforcement.

1203.1 COVERAGE AND LIMITATIONS

A. Covered drugs are subject to prior authorization and/or quantity limits and the following:

1. Section 1927(d)(1)(B)(i) of the SSA allows Medicaid to restrict coverage for an outpatient drug if the prescribed drug is not for a medically accepted indication. Section 1927(k)(6) defines a medically accepted indication as any use for a covered outpatient drug, which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia:

   a. American Hospital Formulary Service Drug Information;

   b. United States Pharmacopeia;

   c. DRUGDEX Information System; or

   d. Peer-reviewed medical literature.

2. Pharmaceuticals must be manufactured by companies participating in the Federal Medicaid Drug Rebate Program.

3. Medicaid is mandated by federal statute to require all written (non-electronic) prescriptions for all outpatient drugs for Medicaid recipients to be on tamper-resistant prescription pads. This requirement does not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. Refer to MSM Addendum for more information on tamper-resistant prescription pads.

4. The Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Silver State Scripts Board (formerly known as the Pharmacy and Therapeutics (P&T) Committee). Reference Medicaid Operations Manual (MOM) Chapter 200 for the Silver State Scripts Board bylaws. Pharmaceuticals not on the PDL, but within drug classes reviewed by the Silver State Scripts Board, require prior

authorization, unless exempt under NRS or federal law or excluded through recommendations of the Silver State Scripts Board or excluded by the DHCFP.

a. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan or by NRS are covered without a Standard Preferred Drug List Exception prior authorization until, or if, the Silver State Scripts Board adds the drug class to the PDL and reviews the product or evidence.

b. New Food and Drug Administration (FDA) approved drugs, or existing pharmaceutical products within reviewed PDL drug classes, for which there is new clinical evidence supporting its inclusion on the PDL and are not excluded under state plan or by NRS, are covered with an approved Standard Preferred Drug List Exception prior authorization until the Silver State Scripts Board can review the new evidence or drug.

c. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.

d. If the Silver State Scripts Board determines that there are no significant differences between drugs within specific classes based on clinical efficacy, safety, and outcomes for patients, the DHCFP or its Quality Improvement Organization (QIO)-like vendor, may consider cost in determining which drugs are selected for inclusion on the PDL.

B. Standard Preferred Drug List Exception Criteria

Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.

1. Coverage and Limitations

a. Allergy to all preferred medications within the same class;

b. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;

c. History of unacceptable/toxic side effects to all preferred medications within the same class;

d. Therapeutic failure of two preferred medications within the same class;

e. If there are not two preferred medications within the same class, therapeutic failure only needs to occur on the one preferred medication;

f. An indication which is unique to a non-preferred agent, and is supported by

peer-reviewed literature or a FDA-approved indication;

g. Psychotropic, Antidepressant Medication – Continuity of Care;

Recipients discharged from an institution on non-preferred psychotropic and/or non-preferred anti-depressant medication(s), their drugs will continue to be covered by Medicaid for up to six months to allow the recipient time to establish outpatient mental health services;

h. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications, the recipient demonstrated therapeutic failure on one preferred agent.

2. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms/aspx

C. Excluded

The DHCFP will not reimburse for the following pharmaceuticals:

1. Agents used for weight loss.

2. Agents used to promote fertility.

3. Agents used for cosmetic purposes or hair growth.

4. Yohimbine.

5. Drug Efficacy Study Implementation (DESI) list "Less than Effective Drugs": In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is identical, related or similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

This includes pharmaceuticals designated "ineffective" or "less than effective" (including identical, related or similar drugs) by the FDA as to substance or diagnosis for which prescribed.

6. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

7. Agents used for impotence/erectile dysfunction.

D. Refills

A refill is a prescription subject to the limitations below:

1. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) Chapter 639.

2. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. If a prescription is for a 34-day supply, a consistent refill would be filled in 30 days; an inconsistent refill date would be filled in 20 days from the original fill. Lost medications: Nevada Medicaid does not pay for replacement of lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the medication. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications only. See "Maintenance Medications" section for more information on maintenance medications.

E. Early Refills

1. Nevada Medicaid only pays for up to a 34-day supply of medications (100-day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the non-controlled substance prescription, and 90% of the controlled substance prescription, is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

2. In areas for which an emergency or disaster has been declared, Medicaid will waive the requirement for 80% of a non-controlled substance prescription to be used before paying for refills. Prescriptions for non-controlled substances will be covered up to 30 days after the declaration or until the end of the emergency or disaster, whichever is later.

3. In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill. This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

4. Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

F. Maintenance Medications

1. Exceptions to the 34-day supply of medications are allowed for maintenance medications.

2. Maintenance medications are required to be filled in three-month (100-day) supplies.

3. A one-time initial fill of less than three months will be allowed for the first fill to assure tolerability and compliance.

4. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

5. The following drug categories are considered maintenance medications and are required to be filled in three-month (100-day) supplies:

   a. Antianginals;

   b. Antiarrhythmics;

   c. Antidiabetics;

   d. Antihypertensives;

   e. Cardiac Glycosides;

   f. Diuretics;

   g. Estrogens; and

   h. Progesterone.

6. Contraceptive drugs are considered maintenance medication. Contraceptive drugs that are approved by the FDA are covered up to a 12-month supply.

   a. This includes a drug for contraception or its therapeutic equivalent; insertion of a device for contraception; removal of such a device that was inserted while the insured was covered by the same policy of health insurance; education and counseling relating to contraception; management of side effects relating to contraception; and voluntary sterilization for women.

   b. Up to three months of contraception may be dispensed immediately, and up to nine months of contraception may be dispensed at the subsequent visit.

c. For a refill following the initial dispensing of a contraceptive drug, the provider may dispense up to a 12-month supply or any amount that covers the remainder rolling year.

d. If a prescription for a contraceptive drug is less than a one-year period, the provider must dispense the contraceptive in accordance with the quantity specified in the prescription order.

7. Anticonvulsants and thyroid preparations are considered maintenance medications, but are not required to be filled in a three-month (100-day) supply.

8. Medications administered in a skilled nursing facility or physician's office are exempt from the three-month (100-day) supply requirement.

9. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)

G. Emergency supply of medication

1. In an emergency situation, dispensing of up to a 96-hour supply of covered outpatient drugs that require prior authorization will be allowed.

2. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization.

3. The physician must indicate the diagnosis on the prescription (preferably with an International Classification of Disease (ICD) code) to support the use of the emergency policy.

4. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor to obtain a verbal verification number.

5. An approved prior authorization (if required) will be necessary to get additional medication.

H. Nevada Check Up (NCU)

All coverage and limitation policies and rules, including any prior authorization requirements, outlined in this chapter apply to NCU recipients as well as Nevada Medicaid FFS recipients. There are NO exceptions.

I. Vaccines

Nevada Medicaid recognizes the importance of preventative health care through vaccines and immunizations. Unless otherwise stated in this chapter, vaccines are covered without prior authorization. Reference Appendix A of this chapter.

1. Childhood vaccines: All childhood vaccines are covered without prior authorization under the Healthy Kids Program. Refer to MSM Chapter 1500, Healthy Kids Program for more information on childhood vaccines.

2. Adult vaccines: Adult vaccines such as tetanus, flu vaccine and pneumococcal vaccine are covered without prior authorization. For a list of covered adult vaccines, please reference the Physician's Fee Schedule at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

3. Human Papillomavirus (HPV) Vaccine: The 9-valent HPV vaccine (for both males and females) is covered for Medicaid eligible recipients ages nine years through 45 years, based on the US FDA approved indications. These may be accessed by following the link: https://www.fda.gov/vaccines-blood-biologics/vaccines/gardasil. The HPV vaccines are available through the State Division of Public and Behavioral Health (DPBH) as part of the Vaccines for Children (VFC) program for eligible females and males age nine through 18 years. Please refer to MSM Chapter 1500 for more information on the VFC program.

4. Pharmacies may administer childhood and adult vaccines/immunizations.

   a. Pharmacies must adhere to all Nevada State Board of Pharmacy (BOP) regulations regarding vaccine/immunization administration including certification to administer as documented in NAC Chapter 639.

   b. Pharmacies must receive childhood vaccinations through the VFC Program. The DHCFP or Nevada Medicaid and NCU do not reimburse for vaccines included in the VFC Program.

   c. Covered vaccinations not included in the VFC Program will be reimbursable per the Nevada Medicaid and NCU Pharmacy Manual.

   d. If the pharmacist administers the vaccinations, the dispensing fee will not be reimbursed. An administration fee is paid instead.

J. Pharmacist Submitted Prior Authorizations

1. The DHCFP will allow pharmacists to submit a prior authorization if:

   a. The requesting pharmacist has access to the recipient's medical records.

K. Dispensing Practitioners:

1. Must have a current Certificate of Registration through the Nevada State Board of Pharmacy. Refer to NRS 639.070 and NAC 639.390; and

2. Must be enrolled with Nevada Medicaid provider enrollment as a Provider Type (PT) 28; and

3. Dispensing practitioners' offices must be located in the State of Nevada; and

4. All prior authorization criteria and quantity limitations apply to dispensing practitioner claims; and

5. Only PT 28 can be reimbursed for a dispensing fee; and

6. All claims must be submitted in the National Council for Prescription Drug Programs (NCPDP) format through Medicaid's Point of Sale (POS) system; and

7. All dispensing practitioners must be compliant with all applicable BOP statutes and regulations.

1203.1A PROVIDER RESPONSIBILITY

1. The pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required.

a. The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.

b. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.

2. Utilization Control

a. Prospective (Concurrent) Drug Utilization Review (Pro-DUR)

Pro-DUR functions will be carried out via the POS Systems.

1. Pro-DUR edits apply to POS claims.

2. Long Term Care (LTC) claims are subject to all Pro-DUR edits that apply to retail.

3. Providers may submit override codes using the (NCPDP) standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.

4. No long term override codes are issued, codes must be entered each time errors occur. Reference the Nevada Medicaid and NCU Pharmacy Manual for more information on the current Pro-DUR edits and override procedures.

5. All drugs are subject to quantity limitations. Refer to the Nevada Medicaid and NCU Pharmacy Manual for established quantity limits.

b. Retro Drug Utilization Review (DUR)

Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.

c. Drug Utilization Review (DUR)

Nevada Medicaid policy and federal law allows the state appointed DUR Board to conduct review of the information compiled about individual clients and providers and allows the DUR Board to educate Medicaid providers about the changes in drug therapeutics. Educational programs may include information such as drug interactions between medications that physicians have prescribed for the clients and medications they are prescribing that are unnecessarily expensive. In this case, educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid clients.

d. Eligibility

Please refer to MSM Chapter 100 for information on Medicaid eligibility, eligibility verification and the Eligibility Verification System (EVS).

e. Pharmacy Lock-In Program

The Pharmacy Lock-In Program is intended to prevent recipients from obtaining excessive quantities of controlled substances through multiple visits to physicians, clinics, and pharmacies. When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, or the DHCFP has determined that the recipient requires close medical management, the recipient may be “locked-in” to a specific pharmacy. This means that Medicaid will only pay for controlled substance prescriptions at a single pharmacy.

1. Pharmacy Lock-In Criteria.

a. The DHCFP conducts a comprehensive clinical review to determine whether a recipient should be “locked-in” to a single pharmacy using the following criteria:

1. The recipient has filled ten or more controlled substance prescriptions in the past 60-day period (includes controlled substance pharmaceuticals given in the emergency room); and

2. One of the following:

   a. The recipient has utilized more than one pharmacy in the past 60-day period; or

   b. The recipient has utilized more than three physicians in the past 60-day period; or

   c. The recipient has utilized the emergency room(s) for receiving controlled substances; or

   d. The recipient has been diagnosed with a drug dependency related condition; or

   e. The dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or the recipient has other noted drug seeking behaviors.

b. Recipients who are locked-in to one pharmacy are issued a written Notice of Decision (NOD) 15 days prior to the implementation of the pharmacy restriction. The NOD includes the individual's right to request a fair hearing within 90 days if he/she disagrees with the findings and/or the DHCFP's action.

c. The DHCFP assigns the pharmacy most frequently used by the recipient for access of controlled substance prescriptions. Recipients may change their locked-in pharmacy by contacting their Medicaid District Office.

d. Upon implementation of pharmacy lock-in, the POS system will not allow another pharmacy to bill for controlled substance prescriptions, and a message will be given at the time of service to notify the pharmacy that the recipient is locked-in. Any non-controlled substance prescriptions can be filled at any pharmacy.

2. Duration of Lock-In Status.

   a. Initially, a recipient remains in lock-in status for period lasting 36 months. Utilizing the pharmacy lock-in criteria, the DHCFP

conducts a clinical review not less than a month prior the 36-month mark to determine whether the recipient will remain or may be removed from lock-in status.

1. A recipient may be placed on a second lock-in period lasting 108 months, if determined by the DHCFP that the recipient is continuing to obtain excessive and/or inappropriate controlled substance prescription or requires additional close medical management or monitoring. Recipients placed on a second lock-in period are re-evaluated at every 108-month period to determine whether lock-in status still appropriate or may be removed from lock-in status.

2. A written NOD is issued by the DHCFP 15 days prior the effective date of continuation or removal of the pharmacy restriction. The NOD includes the individual's right to request a fair hearing within 90 days if he/she disagrees with the findings and/or the DHCFP action.

b. Recipients in lock-in status who are transitioning from a Nevada Medicaid contracted Managed Care Organization (MCO) will start a new initial 36-month lock-in period.

3. Pharmacy Lock-In Exemption

a. Some circumstances allow a recipient to receive medications from a pharmacy other than their assigned locked-in pharmacy. A Pharmacy may call the Technical Call Center to request an override if:

1. The locked-in pharmacy is out of stock.

2. The locked-in pharmacy is closed.

3. The recipient is out of town and cannot access the locked-in pharmacy.

3. Generic Substitution

Per NRS Chapter 639, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

a. is less expensive than the drug prescribed by brand name;

b. is biologically equivalent to the drug prescribed by brand name;

c. has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and

d. is of the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

4. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies that a specific brand of medication is medically necessary for a particular patient.

The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure for certification must comply with the following:

a. The certification must be in the physician's own handwriting.

b. Certification must be written directly on the prescription blank.

c. The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions "Dispense as written" must be noted. Not acceptable: A printed box on the prescription blank checked by the prescriber to indicate "brand necessary" or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.

d. A prior authorization is required to override genetic substitution.

e. Certification is not required if a generic is not manufactured.

f. A fax copy/verbal order may be taken by the pharmacist from the physician, but the pharmacy must obtain an original printed copy and keep on file.

1203.1B SERVICE DELIVERY MODEL

For the rate and reimbursement methodology see MSM Chapter 700, Rates. For POS claims refer to the Pharmacy Manual, and for Medicaid Management Information System (MMIS) claims refer to the Nevada Medicaid and NCU Billing Manual (Billing Manual).

1. Institutional settings

   a. Medical/Surgical, Specialty, Psychiatric Hospitals and free-standing inpatient hospice facilities – All pharmacy services are included in the daily per diem rate for inpatient services, which are billed through MMIS.

   b. Long Term Care (LTC)

      1. Nursing Facilities (NF) – Legend (prescription) pharmaceutical services are excluded from the daily per diem facility rate. This includes compound prescriptions and Total Parenteral Nutrition (TPN) solution and additives. Legend pharmaceuticals are billed separately directly by a licensed pharmacy through POS.

         Non-legend (over the counter) pharmaceuticals are not separately reimbursable by the DHCFP.

      2. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – Legend and non-legend pharmaceuticals are excluded from the facility rate. Pharmaceuticals are billed directly by a licensed pharmacy through POS.

      3. Hospice services in NFs, all drugs related to the documented terminal illness and palliative, symptom relief are to be covered by the hospice and will not be reimbursed by the DHCFP. Refer to MSM Chapter 3200, Hospice, for more information.

2. Outpatient Pharmaceuticals

   a. Covered outpatient drugs (COD(s)) are reimbursed separately from medical services, in the following settings, in accordance with Section 1927 of the SSA.

      1. Retail pharmacies (billed through POS).

      2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics (billed through POS).

         a. Disposable supplies are billed separately with a 33 Provider Type number (billed through MMIS).

         b. Refer to the Nevada Medicaid and Check Up Pharmacy Billing Manual.

3. COD(s) administered in an outpatient setting, such as a physician's office (NVPAD).

    a. COD(s) are billed utilizing the appropriate National Drug Code (NDC) and NDC quantity (billed through MMIS).

    b. The administration of the drug is billed using the appropriate Current Procedural Terminology (CPT) code (billed through MMIS).

4. Hospital based outpatient clinics.

    a. COD(s) are billed utilizing the appropriate NDC and NDC quantity (billed through MMIS).

    b. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

5. End Stage Renal Disease (ESRD) Facilities.

    a. Any COD(s) not included in the Prospective Payment System (PPS) Rate are billed using the appropriate NDC and NDC quantity.

    b. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

    c. COD(s) included in the PPS Rate as documented in the CMS Manual System, Publication # 100-04, Medicare Claims Processing, Transmittal 2134 will deny if billed separately.

6. Emergency Rooms.

    a. COD(s) are billed utilizing the appropriate NDC and NDC quantity (billed through MMIS).

b. CODs are not reimbursed separately, in the following settings, in accordance with 1927(k)(2) of the SSA.

1. Ambulatory Surgical Centers (ASC). COD(s) are included in the facility rate. COD(s) may not be billed separately.

2. Outpatient facilities/clinics/Federally Qualified Health Centers (FQHCs) that are paid per encounter, cannot be reimbursed separately for CODs when drugs are included in their encounter rate.

3. Outpatient hospice reimbursement for CODs related to the documented terminal illness and palliative, symptom relief, are to be covered by the hospice and will not be reimbursed by the DHCFP. Refer to MSM Chapter 3200, Hospice, for more information.

3. Disposable Medical Supplies

Please refer to MSM Chapter 1300, Durable Medical Equipment (DME), for instructions on billing and any applicable limitations for these items.

4. Unit Dose (Repackage and Re-Stock) Repackage
Nevada Medicaid provides reimbursement incentives for LTC providers who repackage non-unit dose pharmaceuticals; An additional $0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit dose products are not covered for this policy.

This incentive is available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the QIO-like Vendor Pharmacy Department to enroll in this incentive program.

In accordance with the CMS, State Medicaid Director Letter (SMDL) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State BOP. In addition, NFs must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of the medication.

5. Coordination of Benefits (COB)

On-line COB (cost avoidance) is part of the Nevada Medicaid POS system.

a. If Nevada Medicaid is the recipient's secondary carrier, claims for COB will be accepted.

b. Nevada Medicaid is always the payer of last resort.

c. Other coverage will be identified by the presence of other carrier information on the recipient eligibility file.

d. If the recipient shows other coverage, the claim will be denied. The POS system will return a unique client-identified carrier code identifying the other carrier, the recipient's policy number and the carrier name in the additional message filed. It is possible that a recipient may have more than one active other carrier; in that case, the returned code will be from the first carrier, subsequent codes will be returned until fully exhausted. Providers will be required to submit this code OTHER PAYER ID (#340-7C) field as part of the override process.

e. Even if "no other insurance" is indicated on the eligibility file, the claim will be processed as a Third Party Liability (TPL) claim if the pharmacy submits.

f. If other insurance is indicated on the eligibility file, the claim will be processed as a TPL regardless of what TPL codes the pharmacy submits.

g. In all cases, the Nevada Medicaid "allowed amount" will be used when calculating payment. In some cases, this may result in a "0" payment, when the insurance carrier pays more than the Medicaid "allowable amount."

h. In order to facilitate the TPL/COB process, Nevada Medicaid will allow providers to override "days supply limits" and/or "Drug Requires prior authorization" conditions by entering a value of "5" (exemption from prescription limits) in the PA/MC CODE field (NCPCP #416DG) if there are no prior authorization requirements on these drugs from the primary insurer.

6. Pharmacy Billing Process

a. NCPDP Standard Billing Units

Nevada Medicaid reimburses for outpatient pharmaceuticals according to NCPDP "Billing Unit Standard Format" guidelines. The standard provides for the billing of pharmaceuticals in one of three billing units for all drug products. These units are "each," "milliliter (ml)," and "gram (g)." The following guidelines are to be used when billing Nevada Medicaid for pharmaceuticals:

Tablets, Capsules, Suppositories, Pre-filled Syringes: must be billed by "each" or by "mls." For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.

Liquids, Liquid Orals, Suspensions, Solutions, Opthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guiafenesin is dispensed, the quantity entered will be 560.

PLEASE NOTE:

Ounces must be converted to ml (1 ounce = 30ml).
Liters must be converted to ml (1L = 1000ml).
Ointments, Bulk Powders: must be billed by grams. For example, if a two ounce tube of oxiconazole nitrate is dispensed, the quantity entered will be 60.

PLEASE NOTE:

Ounces must be converted to grams (1 ounce = 30g, ½ ounce = 15g). Oral Contraceptives/Therapy packs: must be billed per "each" tablet dispensed, not the

number of packages. For example, Ortho Tri-Cyclen is a 28-day dial pack, the quantity entered will be 28.

Transdermal Patches/Powder Packets: must be billed per "each" patch/packet dispensed, regardless of whether they are pre-packaged in a box or come in individual pouches/packets. For example, Catapress-TTS comes in a box of four patches. If two of these boxes are dispensed, the quantity entered will be eight.

Inhalers and Aerosols: must be billed as either grams or ml, as specified by the manufacturer on the labeling. For example a 90mcg(microgram)/inh Albuterol Inhaler has a total of 17gm in the canister. If one of these is dispensed, 17 will be quantity entered.

Topical Products: must be billed as either grams or ml, as specified by the manufacturer on the labeling.

PLEASE NOTE: Ounces must be converted to grams or ml.

1 ounce = 30ml
1 ounce = 30g

Reconstitutables (oral, otic, ophthalmic): must be billed per ml that are/will be in the bottle after reconstitution according to the manufacturer's instructions.

Liquid Injectables (vials, ampoules): must be billed by milliliters (ml). For example, if a 10ml vial of Novolin 70/30 is dispensed, the quantity entered will be 10.

Powdered Injectables (vials): must be billed by "each" vial given per dose. For example if the recipient receives Ampicillin 1g every six hours for one week, the quantity entered will be 1, as only one vial is used per dose (assuming a 1gm vial is used), and the number of doses entered will be 28 (four per day x seven days).

PLEASE NOTE: If the product is supplied with a diluent, the quantity entered is only the number of powdered vials dispensed, the diluent is not factored in.

Intravenous Solutions: must be billed in ml administered per dose. For example, if a recipient receives 250ml of Normal Saline four times per day, the quantity entered will be 250, as that is the quantity per dose.

Blood Derived Products: products may vary in potency from batch to batch. Anithemophilic products must be billed as the number of antihemophilic units dispensed (each). Prolastin must similarly be billed as the number of milligrams dispensed (each).

Kits: defined as products with at least two different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single NDC. Kits are intended to be dispensed as a unit and should be billed as a unit of each kit dispensed (each).

For further information, refer to the NCPDP Billing Unit Standard Format Official Release.

b. Provider Numbers

The state National Association of Boards of Pharmacy (NABP) provider number is to be used and entered when billing online using the POS system or when using the UCF.

7. State Maximum Allowable Cost (SMAC)

a. SMAC is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the DHCFP or QIO-like vendor.

1. The DHCFP or QIO-like vendor will perform ongoing market analysis to monitor pricing patterns and product availability.

2. The DHCFP or QIO-like vendor will perform monthly updates of the drugs subject to the SMAC.

3. All drugs subject to the SMAC and updates will be posted on the following website: http://www.medicaid.nv.gov/providers/rx/MACinfo.aspx

b. Providers may appeal the current SMAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.

1. The pharmacy must contact the QIO-like vendor technical call center to initiate the appeal.

2. Information needed to make a decision will include the NDC number, manufacturer, drug name, strength and price paid. A faxed copy of the actual invoice for the drug may be requested.

3. Inquiries not resolved by the technical call center are forwarded to the QIO-like vendor's SMAC Coordinator for investigation and resolution.

4. If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to:

   a. Adjust SMAC pricing for the particular claim being appealed; and

   b. Make changes to the SMAC pricing file.

5. Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

1203.1C PRIOR AUTHORIZATION PROCEDURES

1. Prior authorization requests may be done via phone, fax or via the internet. A facsimile signature stamp is acceptable on faxed prior authorization requests.

2. Prior authorization requests must be submitted on the appropriate Prior Authorization Request form. Pharmacy prior authorization forms can be found at the following web site: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

3. LTC drug claims are subject to prior authorization requirements.

4. The QIO-like vendor will process the prior authorization request within 24 hours of receipt.

   a. The requesting practitioner will be advised of the prior authorization status (approval, denial, pending further information) within 24 hours of the receipt.

   b. For prior authorization requests in which the QIO-like vendor has pended the request for further information, the prior authorization will deny if the practitioner does not respond to a request for further information within three working days.

5. An approved prior authorization will be entered in the POS system prior to the dispensing of the medication. There may be situations in which an authorization request is considered after the fact (e.g. retroactive eligibility).

6. The Nevada Medicaid QIO-like vendor will send all Notice of Decision denial of service letters. Reference MSM Chapter 3100 for the information on hearings.

7. Refer to the Nevada Medicaid and Check Up Pharmacy Billing Manual for more information.

1203.2 INTRAVENOUS (IV) THERAPY

For specific instructions related to billing via the POS system, refer to the Nevada Medicaid Check-Up Pharmacy Billing Manual.

A. Billing Guidelines

IV therapy is billed through the pharmacy POS system using the multi-ingredient functionality. Drug coverage edits and prior authorization edits will be processed at the individual ingredient level.

B. Long Term Care (LTC)

1. For recipients in LTC, a daily dispensing fee of $10.17 will be applied to IV therapy claims. This dispensing fee will be multiplied by the number of days the therapy was provided

a. Non-Billable Items

IV hydration therapy of standard fluids without additives (e.g., antibiotics, potassium and heparin) and supplies associated with IV therapy, enteral nutrition and TPN administration are included in Nevada Medicaid's LTC/NF rate and may not be billed as a separate charge.

b. Billable Items

IV Drugs/TPN for recipients in LTC facilities may be billed as a separate charge. Refer to MSM Chapter 500, Nursing Facilities, for further information.

1204 HEARINGS

Please reference MSM Chapter 3100 for the Medicaid Hearings process.

W

X

Z

All drugs in Appendix A may be subject to Quantity Limitations.
Check the Nevada Medicaid and Nevada Check Up Pharmacy Manual for a listing of the exact Quantity Limitation.

1. DRUGS REQUIRING A PRIOR AUTHORIZATION AND/OR QUANTITY LIMITATION

A. Proton Pump Inhibitors (PPIs)

Therapeutic Class: Proton Pump Inhibitors
Last Reviewed by the DUR Board: April 30, 2020

PPIs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

a. The recipient is not exceeding once daily dosing (quantity limit of one unit/day).

b. Requests for PPIs exceeding once daily dosing must meet one of the following:

1. The recipient has failed an appropriate duration of once daily dosing; or

2. The recipient has a diagnosis of a hypersecretory condition (e.g., Zollinger-Ellison Syndrome), esophagitis, Barrett's esophagitis, reflux esophagitis or treatment of an ulcer caused by H.Pylori

c. Prior Authorization Guidelines

1. Prior authorization approval will be for up to 12 months.

2. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

B. Pyrukynd® (mitapivat)

Therapeutic Drug Class: Pyruvate Kinase Activators
Last Reviewed by DUR Board: October 20, 2022

Pyrukynd® (mitapivat) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity.

1. Approval will be given if the following criteria are met and documented:

    a. Recipient is at least 18 years of age; and

    b. Recipient has a confirmed diagnosis of pyruvate kinase deficiency (PKD) as defined by the documented presence of at least two variant alleles in the PKLR gene, of which at least one was a missense variant; and

    c. Recipient is not homozygous for the c.1436G>A (p.R479H) variant; and

    d. Recipient does not have two non-missense variants (without the presence of another missense variant) in the PKLR gene; and

    e. Recipient has a baseline serum hemoglobin level less than 10g/dL or required more than six transfusions in the prior year; and

    f. Other causes of hemolytic anemia have been ruled out (e.g., immune hemolysis, other enzyme deficiencies, vitamin/mineral deficiencies); and

    g. Recipient does not have moderate or severe hepatic impairment; and

    h. Prescriber will advise patients currently on hormonal contraceptives to use an alternative non-hormonal contraceptive method or add a barrier method of contraception during treatment; and

    i. Quantity limit is 60 tablets/30 day (max dose 100mg/day).

2. Recertification Request:

    a. Recipient must continue to meet the above criteria; and

    b. Recipient has shown a beneficial response to therapy compared to pre-treatment baseline in one or more of the following:

        1. Hemoglobin (Hb) response (defined as a greater than or equal to 1.5g/dL increase in Hb level without transfusion over a four week or longer time period; or

2. Transfusion reduction response (defined as a greater than or equal to 33% reduction in the number of red blood cell [RBC] units transfused compared to historical transfusion burden); or

3. Recipient had an increase in Hb and/or decrease in transfusion requirement, to a lesser extent than the above, and also had an improvement in the signs and symptoms (e.g., fatigue, jaundice, shortness of breath) and/or markers of hemolysis (e.g., indirect bilirubin, reticulocyte count, LDH, haptoglobin).

c. Recertification will be approved for six months.

3. Prior authorization guidelines:

a. Prior authorization will be approved for six months.

C. Agents Used for the Treatment of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Therapeutic Class: ADD/ADHD Agents
Last Reviewed by the DUR Board: April 25, 2019

Agents for the treatment of ADD/ADHD are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria is met and documented:

a. General Criteria (Children and Adults)

1. A diagnosis of ADD/ADHD or other FDA approved diagnosis.

2. Only one long-acting stimulant (amphetamine and methylphenidate products) may be used at a time.

3. A 30-day transitional overlap in therapy will be allowed.

4. Other treatable causes of ADD/ADHD have been ruled out.

b. ADD/ADHD Criteria (Children up to age 18 years)

1. The recipient is at least three years of age (short-acting stimulants) or at least six years of age (long-acting stimulants, long-acting alpha agonists, atomoxetine).

An initial evaluation or regular examination has been done within the past 12 months with the treating prescriber.

2. Exception Criteria

a. Prescriptions for ADD/ADHD medications do not require prior authorization for children five years of age, up to 18 years of age, if the following criteria are met and documented:

1. The recipient is at least five years of age for short acting stimulants or at least six years of age for long-acting stimulants, long acting alpha agonists, atomoxetine);

2. The medication is prescribed by a psychiatrist; and

3. An ICD code for ADD with or without hyperactivity is documented on the prescription and transmitted on the claim.

3. Prior Authorization Guidelines

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

D. Growth Hormones
Therapeutic Class: Growth Hormone

Last Reviewed by the DUR Board: July 28, 2022

Growth Hormones are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Approval will be given if the following criteria are met and documented:

1. Children (with open epiphyses and with remaining growth potential) must meet all the following:

a. The recipient has had an evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for growth hormone therapy; and

b. The recipient has had an evaluation ruling out all other causes for short stature; and

c. The recipient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids, or gonadotropic hormones.

The recipient must then meet one of the following:

1. The recipient has a diagnosis of Noonan Syndrome, Prader-Willi Syndrome or Turner Syndrome and their height is at least two standard deviations below the mean or below the fifth percentile for the patient's age and gender and the bone age is less than 16 years for male recipients or less than 14 years for female recipients; or

2. The recipient has a diagnosis of Prader-Willi Syndrome; or

3. The recipient has a diagnosis of Turner Syndrome, is female and has a bone age of less than 14 years; or

4. The recipient has a diagnosis of chronic renal insufficiency (<75 mL/minute), and their height is at least two standard deviations below the mean or below the third percentile for the recipient's age and gender; or

5. The recipient has a diagnosis of being small for gestational age, the recipient is two years of age or older, and the height is at least two standard deviations below the mean or below the third percentile for the recipient's age and gender; or

6. The recipient is a newborn infant with evidence of hypoglycemia, and has low growth hormone level (<20 ng/mL), low for age insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3 (no stimulation test required for infants); or

7. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation), and their height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender and their bone age is less than 16 years for male or less than 14 years for female.

   And recipient must meet one of the following:

   a. The recipient has failed two growth hormone stimulation tests (<10 ng/mL); or

   b. The recipient has failed one growth hormone stimulation test (<10 ng/mL) and one IGF-1 or IGFBP-3 test; or

   c. The recipient has failed one growth hormone stimulation test (<10 ng/mL) or IGF-1 or IGFBP-3 test and they have deficiencies in three or more pituitary axes (e.g., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotropic hormone (ACTH) or antidiuretic hormone (ADH)).

2. Adults (with closed epiphyses, and no remaining growth potential) must meet all the following:

   a. The recipient is being evaluated by an endocrinologist; and

   b. The recipient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids, or gonadotropic hormones; and

   c. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to

structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation); and
The recipient must then meet one of the following:

1. The recipient has failed two growth hormone stimulation tests (<5 ng/mL); or

2. The recipient has failed one growth hormone stimulation test (<5 ng/mL) and one IGF-1 or IGFBP-3 test; or

3. The recipient has failed one growth hormone stimulation test (<5 ng/mL) or IGFBP-3 test and has deficiencies in three or more pituitary axes (i.e., TSH, LH, FSH, ACTH, ADH), and has severe clinical manifestations of growth hormone deficiency as evident by alterations in body composition (e.g., decreased lean body mass, increased body fat), cardiovascular function (e.g., reduced cardiac output, lipid abnormalities) or bone mineral density.

3. Continued authorization will be given for recipients (up to age 21, with remaining growth potential) who meet all the following:

   a. The recipient has a diagnosis of chronic renal insufficiency, growth hormone deficiency, hypothalamic pituitary disease, newborn infant with evidence of hypoglycemia, Noonan Syndrome, Prader-Willi Syndrome, small for gestational age or Turner Syndrome; and

   b. The recipient's epiphyses are open; and

   c. The recipient's growth rate on treatment is at least 2.5 cm/year; and

   d. The recipient does not have evidence of an expanding lesion or tumor formation; and

   e. The recipient has not undergone a renal transplant.

4. Continued authorization will be given for recipients (age 21 years and older, with closed epiphyses and no remaining growth potential) who meet all the following:

   a. The recipient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease; and

   b. There is documentation of improvement in clinical manifestations associated with growth hormone deficiency

5. Prior Authorization Guidelines

a. Initial prior authorization will be for six months.

b. Recertification approval will be for 12 months.

b. Serostim® (somatropin)

1. Approval will be given if the following criteria are met and documented:

a. The recipient has a diagnosis of Human Immune Deficiency Virus (HIV) with wasting or cachexia; and

b. The medication is indicated to increase lean body mass, body weight and physical endurance; and

c. The recipient is receiving and is compliant with antiretroviral therapy; and

d. The recipient has experienced an involuntary weight loss of >10% pre-illness baseline or they have a body mass index of <20 kg/m^2; and

e. The recipient has experienced an adverse event, allergy, or inadequate response to megestrol acetate, or the recipient has a contraindication to treatment with this agent; and

f. The recipient has experienced an adverse event, allergy, or inadequate response to an anabolic steroid (e.g., testosterone, oxandrolone, nandrolone) or the recipient has a contraindication to treatment with these agents.

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 12 weeks.

c. Zorbtive® (somatropin)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient has a diagnosis of short bowel syndrome; and

b. The recipient is age 18 years or older; and

c. The medication is being prescribed by or following a consultation with a gastroenterologist; and

d. The recipient is receiving specialized nutritional support (e.g., high carbohydrate, low-fat diets via enteral or parenteral nutrition).

2. Prior Authorization Guidelines

a. Initial authorization will be approved for six months.

b. Recertification request will be approved for 12 months.

d. Somavert® (pegvisomant)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient has a diagnosis of acromegaly; and

b. The recipient is 18 years age or older; and

c. One of the following:

1. The recipient has an inadequate response to one of the following:

a. Surgery; or

b. Radiation Therapy; or

c. Dopamine agonist (e.g. bromocriptine, cabergoline) therapy; or

2. The recipient is not a candidate for all the following:

a. Surgery; and

b. Radiation Therapy; and

c. Dopamine agonist (e.g. bromocriptine, cabergoline) therapy; and

d. The recipient has tried and failed, a contraindication, or intolerance to generic octreotide (a somatostatin analogue); and

e. The medication is prescribed by or in consultation with an endocrinologist.

2. Recertification Criteria:

a. The recipient must meet the following:

1. The recipient must have a documented positive clinical response to Somavert® therapy (e.g. biochemical control; decrease or normalization of IGF-1 levels).

3. Prior Authorization Guidelines:

a. Initial authorization will be approved for 12 weeks.

b. Recertification approval will be approved for 12 months.

e. Skytrofa® (Lonapegsomatropin-tcgd)

1. Approval will be given if the following criteria are met and documented:

a. Recipient is one year or age or older; and

b. Recipient's weight is greater than 11.5kg; and

c. Recipient has growth failure secondary to growth hormone deficiency (GHD); and

d. Recipient has short stature as defined by height that is greater than or equal to two standard deviations below the mean for chronological age; and

1. Recipient has hypothalamic-pituitary defects (e.g., major congenital malformation, tumor, or irradiation) and a deficiency of greater than or equal to one additional pituitary hormone; or

2. Recipient had an inadequate response to growth hormone (GH) provocation tests on two separate stimulation tests as defined as a serum peak GH concentration less than 10 ng/mL; and

e. Other causes of growth failure must be ruled out (e.g., malnutrition, hypothyroidism, hypercortisolism).

2. Recertification Criteria:

a. Recipient must continue to meet the initial criteria; and

b. Recipient has shown a beneficial response compared to pre-treatment baseline (with lonapegsomatropin-tcgd or somatropin [if used as switch maintenance]) as evidenced by greater than or equal to one of the following:

1. Improvement in height; or

2. Improvement in growth velocity.

3. Prior Authorization Guidelines:

   a. Prior authorization approval will be given for 12 months.

E. Over-the-Counter (OTC) Drugs

Last Reviewed by the DUR Board: N/A

OTC drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   a. OTC drugs must be FDA approved and manufactured by pharmaceutical companies participating in the Federal Medicaid Drug Rebate Program.

   b. OTC drugs are limited to two prescription requests for medications within the same therapeutic class.

   c. Nevada Medicaid will reimburse up to the OTC Maximum Allowable Cost (MAC) listed in the OTC MAC table. Refer to the Nevada Medicaid Nevada Check Up Pharmacy Manual for details.

   d. Insulin and diabetic supplies are exempt from any prior authorization and OTC MAC limits.

2. Prior Authorization Guidelines:

   a. Prior Authorization is required for more than two prescriptions within the same therapeutic class. Determinations are based on medical necessity and may require additional information.

   b. Approval will be for a one-month time limit.

F. Transdermal Fentanyl

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by the DUR Board: April 25, 2019

Transdermal fentanyl, a narcotic agonist analgesic, is indicated in the management of chronic pain in patients requiring continuous opioid analgesia for pain that cannot be managed by lesser means such as acetaminophen-opioid combinations, non-steroidal analgesics or PRN dosing with short-acting opioids. Transdermal fentanyl is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Because serious or life-threatening hypoventilation could occur, fentanyl transdermal is contraindicated in management of acute or postoperative pain, mild or intermittent pain responsive to PRN or non-opioid therapy or in doses exceeding 25 mcg/hr at the initiation of opioid therapy. Therefore, patients must meet the following criteria in order to gain prior authorization approval:

a. Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteriodal analgesics or PRN dosing with short-acting opioid.

b. Patient requires continuous opioid administration.

c. Prescribers are required to check the Nevada State BOPs Prescription Monitoring Program (PMP) prior to prescribing narcotic analgesics. Refer to the PMP website at http://bop.nv.gov/links/PMP/.

d. If transitioning from another opioid, daily morphine equivalent doses are used to calculate the appropriate fentanyl patch dose.

1. Morphine 60-134 mg/day PO; initial Transdermal Fentanyl dose 25 mcg/hr.

2. Morphine 135-224 mg/day PO; initial Transdermal Fentanyl dose 50 mcg/hr.

3. Morphine 225-314 mg/day PO; initial Transdermal Fentanyl dose 75 mcg/hr.

4. Morphine 315-404 mg/day PO; initial Transdermal Fentanyl dose 100 mcg/hr.

5. Morphine 405-494 mg/day PO; initial Transdermal Fentanyl dose 125 mcg/hr.

6. Morphine 495-584 mg/day PO; initial Transdermal Fentanyl dose 150 mcg/hr.

7. Morphine 585-674 mg/day PO; initial Transdermal Fentanyl dose 175 mcg/hr.

8. Morphine 675-764 mg/day PO; initial Transdermal Fentanyl dose 200 mcg/hr.

9. Morphine 765-854 mg/day PO; initial Transdermal Fentanyl dose 225 mcg/hr.

10. Morphine 855-944 mg/day PO; initial Transdermal Fentanyl dose 250 mcg/hr.

11. Morphine 945-1034 mg/day PO; initial Transdermal Fentanyl dose 275 mcg/hr.

12. Morphine 1035-1124 mg/day PO; initial Transdermal Fentanyl dose 300 mcg/hr.

2. Prior Authorization Guidelines

a. Prior authorization approval will be given for 12 months.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

G. Immediate-Release Fentanyl Products

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by the DUR Board: July 28, 2022

Immediate-Release Fentanyl Products are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Approval will be given if the following criteria are met and documented:

1. Subsys® (fentanyl sublingual spray), Onsolis® (fentanyl citrate buccal film), Fentora® (fentanyl citrate buccal tablet), Lazanda® (fentanyl citrate nasal spray), Abstral® (fentanyl citrate sublingual tablet) and Actiq® (fentanyl citrate transmucosal lozenge):

2. The recipient must meet all the following:

a. The recipient is 18 years of age or older or the recipient is greater than 16 years of age if requesting fentanyl citrate transmucosal lozenge (Actiq®); and

b. The recipient has pain resulting from a malignancy; and

c. The recipient is already receiving and is tolerant to opioid therapy; and

d. The recipient is intolerant of at least one of the following immediate-release opioids: hydrocodone, hydromorphone, morphine, or oxycodone.

b. Recertification Criteria:

1. Documentation of disease improvement and/or stabilization.

c. Prior Authorization Guidelines:

1. Prior authorization approval will be for six months.

H. Hematopoietic/Hematinic Agents

Therapeutic Class: Erythropoiesis Stimulating Agents (ESAs)
Last Reviewed by the DUR Board: January 19, 2023

This policy applies in all settings with the exception of inpatient facilities. Hematopoietics and Hematinics are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   a. The recipient has been evaluated for adequate iron stores; and

   b. Recent laboratory results are required for prior authorization, i.e. serum hemoglobin, within seven days of prior authorization request; and

   c. Recipients must meet one of the following criteria for coverage:

      1. Achieve and maintain hemoglobin levels in one of the following conditions:

         a. Treatment of anemia secondary to myelosuppressive anticancer chemotherapy, Hb levels should not exceed 10 g/dL.

         b. Treatment of anemia related to zidovudine therapy in HIV-infected patients. Hb levels should not exceed 12 g/dL.

         c. Treatment of anemia secondary to ESRD. Hb levels should not exceed 11 g/dL if on dialysis or 10 g/dL if not on dialysis.

   d. Epoetin alfa (Epogen®) is indicated to reduce the need for allogenic transfusions in surgery patients when a significant blood loss is anticipated. It may be used to achieve and maintain hemoglobin levels within the range of 10 to 13 gm/dl. Darbepoetin Alfa (Aranesp®) has adequate iron stores as demonstrated by serum ferritin greater than or equal to 100 ng/mL (mcg/L) and transferrin saturation (TSAT) greater than or equal to 20% (measured within the previous three months for renewal).

2. Non-Covered Indications

   a. Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding or bone marrow fibrosis.

   b. Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) or erythroid cancers.

   c. Anemia of cancer not related to cancer treatment.

   d. Any anemia associated only with radiotherapy.

e. Prophylactic use to prevent chemotherapy-induced anemia.

f. Prophylactic use to reduce tumor hypoxia.

g. Patients with erythropoietin-type resistance due to neutralizing antibodies.

h. Anemia due to cancer treatment if patients have uncontrolled hypertension.

3. Recertification Request

a. Coverage can be renewed based upon the following criteria:

1. Recipient continues to meet universal and other indication-specific relevant criteria identified in section III; and

2. Previous dose was administered within the past 60 days; and

3. Disease response with treatment as defined by improvement in anemia compared to pretreatment baseline; and

4. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: pure red cell aplasia severe allergic reactions (anaphylaxis, angioedema, bronchospasm, etc.), severe cardiovascular events (stroke, myocardial infarction, congestive heart failure, thromboembolism, etc.), uncontrolled hypertension, seizures, increased risk of tumor progression/recurrence in recipients with cancer, severe cutaneous reactions (erythema multiforme, Stevens-Johnson Syndrome [SJS]/Toxic Epidermal Necrolysis [TEN], etc.), etc.; and

b. Anemia Due to Myelodysplastic Syndrome (MDS):

1. Hemoglobin (Hb) less than 12 g/dL and/or Hematocrit (Hct) less than 36%.

c. Anemia Due to Myeloproliferative Neoplasms (MPN) – Myelofibrosis:

1. Hemoglobin (Hb) less than 10 g/dL and/or Hematocrit (Hct) less than 30%.

d. Anemia Due to Chemotherapy Treatment:

1. Refer to Section III for criteria.

e. Anemia Due to Chronic Kidney Disease (Non-Dialysis Patients):

1. Pediatric patients: Hemoglobin (Hb) less than 12 g/dL and/or Hematocrit (Hct) less than 36%.

2. Adult patients: Hemoglobin (Hb) less than 11 g/dL and/or Hematocrit (Hct) less than 33%.

4. Prior Authorization Guidelines

a. Prior approval will be given for a one month period.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

I. Anti-Fungal Agents

Therapeutic Class: Antifungal Agents
Last Reviewed by the DUR: October 20, 2022

Anti-Fungal Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Topical Agents (Jublia® (efinaconazole), Kerydin® (tavaborole))

   a. Approval will be given if the following criteria are met and documented:

      1. Diagnosis of onychomycosis; and

      2. At least one of the following:

         a. The recipient is experiencing pain which limits normal activity; or

         b. The recipient has diabetes; or

         c. The recipient has significant peripheral vascular compromise; or

         d. The recipient's disease associated with immunosuppression; or

         e. The recipient's disease is iatrogenically induced; and

            1. An inadequate response (to an appropriate length or therapy), and adverse reaction, a contraindication to use, or a clinical reason either oral terbinafine or itraconazole cannot be used; and

            2. The recipient must have an adverse reaction or have a contraindication to ciclopirox 8% solution.

2. Oral Agents (Sporanox®, Lamisil®)

   a. Approval will be given if the following criteria are met and documented:

      1. An adequate response (to an appropriate length of therapy), an adverse reaction, a contraindication to use, or a clinical reason either oral terbinafine or itraconazole cannot be used; and

      2. The recipient must have had an adverse reaction or have a contraindication to ciclopirox 8% solution.

   b. Prior Authorization Guidelines

      1. Prior authorization will be approved for 48 weeks.

3. Brexafemme® (ibrexafungerp)

   a. Approval will be given if all the following criteria is met and documented:

      1. Recipient is postmenarchal female 12 years of age or older; and

      2. Diagnosis of vulvovaginal candidiasis (VVC); and

      3. Females of reproductive potential must have negative pregnancy test; and

      4. Recipient must have an adequate trial and failure, contraindication, resistance, or intolerance of at least single dose 150mg oral fluconazole.

      5. Quantity Limit is four tablets.

   b. Recertification Request:

      1. Coverage is not renewable.

   c. Prior Authorization Guidelines:

      1. Prior Authorization will be for one day.

4. Vivjoa® (oteseconazole)

   a. Approval will be given if all the following criteria are met and documented:

      1. Recipient has a diagnosis of recurrent vulvoginal candidiasis with greater than or equal to three episodes of vulvovaginal candidiasis (VVC) in a 12-month period; and

      2. Recipient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy); and

      3. Recipient must not have hypersensitivity to any component of the product; and

      4. Recipient is not pregnant; and

      5. Recipient is not lactating; and

      6. Recipient has tried and failed or has contraindication or intolerance to maintenance antifungal therapy with oral fluconazole for six months; and

      7. Quantity limit is 18 tablets per treatment course.

b. Recertification Request:

1. Coverage is not renewable.

c. Prior Authorization Guidelines:

1. Prior Authorization will be for 12 weeks.

J. Benlysta® (belimumab)

Therapeutic Class: Benlysta® (belimumab)
Last Reviewed by the DUR Board: January 25, 2018

Benlysta® (belimumab) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Initial request:

1. The recipient has a diagnosis of active Systemic Lupus Erythematosus (SLE); and

2. The recipient must be 18 years of age or older; and

3. Documentation confirms that the recipient is autoantibody positive (i.e., anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA)); and

4. The recipient is currently receiving at least one standard of care treatment for active SLE that includes one or more of the following agents (unless all agents are contraindicated): antimalarials (e.g., Plaquenil (hydroxychloroquine)), corticosteroids (e.g., prednisone), glucocorticoids, or immunosuppressants (e.g., methotrexate, Imuran (azathioprine), mycophenolate); and

5. The medication is prescribed by or in consultation with a rheumatologist; and

6. The recipient must not have active CNS Lupus; and

7. The recipient must not currently be receiving treatment for a chronic infection; and

8. The recipient must not have evidence of severe renal disease.

b. Recertification Request (the recipient must meet all the following criteria):

1. Authorization for continued use shall be reviewed at least every six months when the following criteria are met:

a. Documentation of positive clinical response to Benlysta® therapy.

2. Prior Authorization Guidelines

a. Prior authorization approvals will be for:

1. Initial request: six months.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

K. Spinal Muscular Atrophy (SMA) Agents

Therapeutic Class: Spinal Muscular Atrophy Agents
Last Reviewed by the DUR Board: July 28, 2022

SMA agents are subject to prior authorization and quantity limitatons based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid Check Up Pharmacy Manual for specific quantity limits.

1. Evrysdi® (risdiplam)

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient has a diagnosis of SMA type I, II, or III; and

      2. Both the following:

         a. Recipient has mutation or deletion of genes in chromosome 5q resulting in one of the following:

            1. Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13); or

            2. Compound heterozygous mutation (e.g., deletion of survival motor neuron 1 (SMN1) exon 7 [allele 1] and mutation of SMN1 [allele 2]); and

         b. Recipient has at least two copies of SMN2; and

      3. Recipient is not dependent on invasive ventilation or tracheostomy and non-invasive ventilation beyond use for naps and nighttime sleep; and

      4. At least one of the following exams (based on the recipient's age and motor ability) have been conducted to establish baseline motor ability:

         NOTE: Baseline assessments for patients less than two months of age requesting risdiplam proactively are not necessary to not delay access to initial therapy in recently diagnosed infants. Initial assessments shortly post-therapy can serve as baseline with respect to efficacy reauthorization assessment.

         a. Hammersmith Infant Neurological Exam (HINE) (infant to early childhood); or

         b. Hammersmith Functional Motor Scale Expanded (HFMSE); or

         c. Upper Limb Module (ULM) Test (Non ambulatory); or

d. Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND); or

e. Motor Function Measure 32 (MFM-32) Scale; and

5. The medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA; and

6. Recipient is not to receive concomitant chronic SMN modifying therapy for the treatment of SMA (e.g. Spinraza®); and

7. One of the following:

a. Recipient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma®); or

b. Recipient has previously received gene therapy for the treatment of SMA (e.g. Zolgesma®) and the provider attest that there has been an inadequate response to gene therapy (e.g. sustained decrease in at least one motor test score over a period of six months).

b. Recertification Request (recipient must meet all criteria):

1. The recipient has documentation of positive clinical response to therapy from pretreatment baseline status as demonstrated by the most recent results from one of the following exams:

a. One of the following HINE-2 milestones:

1. Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick; or

2. Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp; or

3. Recipient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement); or

4. The recipient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk); or

b. One of the following HFMSE milestones:

1. Improvement or maintenance of a previous improvement of at least a 3-point increase in score from pretreatment baseline; or

2. Recipient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk); or

c. One of the following ULM test milestones:

1. Improvement or maintenance of a previous improvement of at least a 2-point increase in score from pretreatment baseline; or

2. Recipient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk); or

d. One of the following CHOP INTEND milestones:

1. Improvement or maintenance of a previous improvement of at least a 4-point increase in score from pretreatment baseline; or

2. Recipient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk); or

e. One of the following MFM-32 milestones:

1. Improvement or maintenance of a previous improvement of at least a 3-point increase in score from pretreatment baseline; or

2. Recipient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk); and

2. Recipient remains not be dependent on invasive ventilation or tracheostomy and use of non-invasive ventilation beyond use for naps and nighttime sleep; and

3. The medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA; and

4. Recipient is not to receive concomitant chronic SMN modifying therapy for the treatment of SMA (e.g. Spinraza®); and

5. One of the following:

a. Recipient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma®); or

b. Recipient has previously received gene therapy for the treatment of SMA (e.g. Zolgesma®) and the provider attest that there has been an inadequate response to gene therapy (e.g. sustained decrease in at least one motor test score over a period of six months).

c. Prior Authorization Guidelines:

1. Initial authorization will be approved for 12 months.

2. Recertification request will be approved for 12 months.

2. Spinraza® (nusinersen)

a. Approval will be given if the following criteria are met and documented:

1. Initial request:

a. The recipient has a diagnosis of SMA, and

b. The medication is prescribed by or in consultation with a neurologist who has experience treating SMA.

2. Recertification Request (the recipient must meet all the following criteria):

a. The recipient has been on therapy for less than 12 months; and

b. The recipient is maintaining neurological status; and

c. The recipient is tolerating therapy; and

d. The medication is prescribed by or in consultation with a neurologist who has experience treating SMA, or all the following:

1. The recipient has been on therapy for 12 months or more; and

2. The recipient has experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients); and

3. The recipient is maintaining neurological status; and

4. The recipient is tolerating therapy; and

3. Prior Authorization Guidelines

a. Initial request will be approved for 12 months.

b. Recertification request will be approved for 12 months.

3. Zolgensma® (onasemnogene abeparvovec-xioi)

a. Approval will be given if the following criteria are met and documented:

1. The recipient must be two years of age or younger; and

a. The recipient must have the mutation or deletion of genes in chromosome 5q in one of the following: homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13); or

b. Compound heterozygous mutation of SMN1 gene (e.g., deletion of SMN1, exon 7 [allele 1] and mutation of SMN1 [allele 2]); and

1. The recipient has a diagnosis of SMA confirmed by a neurologist with expertise in the diagnosis of SMA; or

2. The recipient has a diagnosis of SMA based on the results of SMA newborn screening with three copies or less of SMN 2; and

c. The recipient is not dependent on either invasive ventilation or tracheostomy or use of non-invasive ventilation beyond use of naps and nighttime sleep; and

d. Submission of medical records (e.g., chart notes, laboratory values) documenting the recipient's anti-AAV9 antibody titers are less than or equal to 1:50; and

e. The recipient is not to receive concomitant SMN modifying therapy (e.g. Spinraza®); and

f. The medication is prescribed by a neurologist with expertise in the diagnosis of SMA; and

g. The recipient has never received Zolgensma® treatment in their lifetime.

b. Prior Authorization Guidelines

1. Prior authorization approval is limited to once in a lifetime.

L. Immunomodulator Drugs

Therapeutic Class: Immunomodulators
Last Reviewed by the DUR Board: October 20, 2022

Actemra® (tocilizumab)	Ilaris® (canakinumab)	Remicade® (infliximab)
Amevive® (alefacept)	Ilumya® (tildrakizumab)	Renflexis® (infliximab)
Arcalyst® (rilonacept)	Inflectra® (infliximab)	Siliq® (brodalumab)
Cimzia® (certolizumab pegol)	Kevzara® (sarilumab)	Simponi® (golimumab)
Consentyx® (secukinumab)	Kineret® (ankinra)	Simponi® ARIA™ (golimumab)
Enbrel® (etanercept)	Olumiant® (baricitinib)	Skyrizi® (risankizumab-rzaa)
Entyvio® (vedolizumab)	Orencia® (abatacept)	Stelara® (ustekinumab)
Humira® (adalimumab)	Otezla® (apremilast)	Taltz® (ixekizumab)
Xeljanz® (tofacitinib)		

Immunomodulator Drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. For all recipients:

      1. The recipient has had a negative tuberculin test; and

      2. The recipient does not have an active infection or a history of recurring infections; and

      3. The approval will not be given for the use of more than one biologic at a time (combination therapy); and

      4. The requested medication is being prescribed for an FDA-approved indication or the prescriber has provided clinical justification for off-label usage; and

      5. Each request meets the appropriate diagnosis-specific criteria (b-j).

   b. Rheumatoid Arthritis (RA):

      1. The recipient has a diagnosis of moderately to severely active RA; and

      2. The recipient is 18 years of age or older; and

      3. The recipient has had a rheumatology consultation, including the date of the visit; and one of the following:

         a. The recipient has had RA for less than six months (early RA) and has high disease activity; and an inadequate or adverse reaction to a disease modifying antirheumatic drug (DMARD) (methotrexate,

hydroxychloroquine, leflunomide, minocycline and sulfasalazine); or

b. The recipient has had RA for greater than or equal to six months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine); or

c. The recipient has had RA for greater than or equal to six months (intermediate or long-term disease duration) and has high disease activity.

c. Psoriatic Arthritis:

1. The recipient has a diagnosis of moderate or severe psoriatic arthritis; and

2. The recipient is 18 years of age or older; and

3. The recipient has had a rheumatology consultation including the date of the visit or a dermatology consultation including the date of the visit; and

4. The recipient had an inadequate response or a contraindication to treatment with any one nonsteroidal anti-inflammatory (NSAID) or to any one of the following DMARDs: methotrexate, leflunomide, cyclosporine or sulfasalazine.

d. Ankylosing Spondylitis:

1. The recipient has a diagnosis of ankylosing spondylitis; and

2. The recipient is 18 years or older; and

3. The recipient has had an inadequate response to NSAIDs; and

e. Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis:

1. The recipient has a diagnosis of moderately or severely active juvenile RA or juvenile idiopathic arthritis; and

2. The recipient is at an appropriate age, based on the requested agent, and:

a. Abatacept: Six years of age or older.

b. Adalimumab, canakinumab, etanercept, tocilizumab: Two years of age or older.

3. And the recipient has at least five swollen joints; and

4. The recipient has three or more joints with limitation of motion and pain, tenderness or both; and

5. The recipient has had an inadequate response to one DMARD.

f. Plaque Psoriasis:

1. The recipient has a diagnosis of chronic, moderate to severe plaque psoriasis; and

2. The recipient is 18 years of age of older; and

3. The agent is prescribed by a dermatologist; and

4. The recipient has failed to adequately respond to a topical agent; and

5. The recipient has failed to adequately respond to at least one oral treatment.

g. Crohn's Disease:

1. The recipient has a diagnosis of moderate to severe Crohn's Disease; and

2. The recipient is at an appropriate age, based on the requested agent:

a. Adalimumab, infliximab: Six years of age or older.

b. All others: 18 years of age or older.

1. And the recipient has failed to adequately respond to conventional therapy (e.g. sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide); or

2. The recipient has fistulizing Crohn's Disease.

h. Ulcerative Colitis (UC):

1. The recipient has a diagnosis of moderate to severe UC; and

2. The recipient is at an appropriate age, based on the requested agent:

a. Infliximab: Six years of age or older.

b. Humira: five years of age or older.

c. All others: 18 years of age or older.

1. And the recipient has failed to adequately respond to one or more of the following standard therapies:

a. Corticosteroids;

b. 5-aminosalicylic acid agents;

c. Immunosuppressants; and/or

d. Thiopurines.

4. Zeposia® (ozanimod) for diagnosis of UC

a. Approval will be given if all the following criteria are met and documented:

1. Prescribed by or in consultation with a gastroenterologist; and

2. Recipient has a diagnosis of moderately to severely active UC; and

3. Inadequate response after a 90-day trial of one of the following conventional therapies:

a. 6-mercaptopurine

b. Aminosalicylates (e.g., mesalamine, balsalazide, olsalazine)

c. Sulfasalzine

d. Azathioprine

e. Corticosteroids (e.g., budesonide, high dose steroids 40-60mg of prednisone daily); and

4. Recipient has tried and failed two preferred immunomodulator therapies indicated for moderately to severely active UC.

i. Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflammatory Syndromes (FCAS) or Muckle-Wells Syndrome (MWS):

1. The recipient has a diagnosis of FCAS or MWS; and

2. The recipient is at an appropriate age, based on the requested agent:

a. Canakinumab: Four years of age or older.

b. Rilonacept: 12 years of age or older.

j. Cryopyrin-Associated Periodic Syndromes (CAPS): Neonatal-Onset Multisystem Inflammatory Disease (NOMID):

1. The recipient has a diagnosis of NOMID.

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 12 months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

M. Topical Immunomodulators

Therapeutic Class: Topical Immunomodulators
Last Reviewed by the DUR Board: July 28, 2022

Topical Immunomodulators drugs are a subject to prior authorization and quantity limitations and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

    a. Authorization will be given if the following criteria are met and documented:

        1. Patient has a documented diagnosis of Atopic Dermatitis:

            a. Elidel® for mild to moderate, for ages greater than or equal to two years.

            b. Eucrisa® for mild to moderate, for ages greater than or equal to three months.

            c. Protopic® 0.03%; moderate to severe, for ages greater than or equal to two years.

            d. Protopic® 0.1%; moderate to severe, for ages greater than or equal to 16 years.

        2. The agent is not for chronic use.

        3. Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.

        4. Not recommended for use in immunocompromised patients.

2. Opzelura® (ruxolitinib)

    a. Approval will be given if all the following criteria is met and documented:

        1. The patient has a documented diagnosis of mild to moderate Atopic Dermatitis; and

        2. Recipient is 12 years of age or older; and

        3. The medication will not be used chronically; and

        4. Recipient is not immunocompromised; and

5. Recipient has had a trial and failure, contraindication, or intolerance to two or more of the following classes:

    a. Prescription topical corticosteroids.

    b. Topical calcineurin inhibitor (e.g., Elidel® (pimecrolims) or Protopic (tacrolimus)).

    c. Topical phosphodiesterase-4 inhibitor (e.g., Eucrisa® (crisaborole)).

b. Recertification Request:

    1. Recipient must have disease improvement and/or stabilization.

c. Prior Authorization Guidelines

    1. Prior authorization will be approved within 12 months.

N. Psychotropic Medications for Children and Adolescents

Therapeutic Class: Psychotropic Agents
Last Reviewed by the DUR Board: July 23, 2020

Psychotropic medications for children and adolescents are subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for billing information.

Authorization will be given if the following criteria are met and documented.

1. Coverage and Limitations

The DHCFP requires prior authorization approval for children and adolescents for the psychotropic therapeutic classes below and medication combinations considered to be polypharmacy. The DHCFP has adopted the following practice standards to strengthen treatment outcomes for our children and adolescents.

a. The psychotropic therapeutic classes subject to this policy are:

1. Antipsychotics

2. Antidepressants

3. Mood Stabilizers (including lithium and anticonvulsants used for behavioral health indications.)

4. Sedative hypnotics

5. Antianxiety agents

b. For all children under 18 years of age, the following must be documented in the medical record for authorization.

1. For psychotropic medications in this age group, when possible, be prescribed by or in consultation with a child psychiatrist.

2. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy.

3. Physician and/or prescriber monitoring is required while the recipient is utilizing any psychotropic medication.

a. For recipients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), medical documentation must support a monthly or more frequent visit with the physician and/or prescriber. If the recipient was discharged from

an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber.

b. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.

c. Polypharmacy: Each psychotropic medication prescribed must be independently treating a specific symptom and/or diagnosis.

1. Polypharmacy (intra-class) is defined as more than one drug within the same therapeutic class within a 60-day time period.

a. Prior authorization approval is required for two or more drugs in the same therapeutic class within a 60-day period.

2. Polypharmacy (inter-class) is defined as more than one drug across different therapeutic classes within a 60-day time period.

a. Prior authorization approval is required for four or more drugs across all psychotropic therapeutic classes listed in this policy within a 60-day time period.

3. Approval for polypharmacy may be given in situations where the requested medication(s) will be used for cross tapering and situations where the recipient will be discontinuing the previously prescribed agent. A 30-day cross-taper will be allowed.

4. Approval for polypharmacy may be given for a medication to augment the effect of another psychotropic medication as long as the purpose of the polypharmacy is clearly documented in the recipient's medical record and each agent is supported by individual authorizations.

5. The recipient must have a trial of each individual medication alone. The reasons for an inadequate response must be documented in the medical record.

6. For intra-class and inter-class polypharmacy, all psychotropic medications must be utilized for a medically accepted indication as established by the FDA, and/or peer reviewed literature.

7. Polypharmacy rules will be bypassed for antidepressants, antipsychotics, anticonvulsants, and mood stabilizers, if the medication is prescribed by a board-certified child psychiatrist.

d. For children under six years of age, in addition to the Coverage and Limitation requirements, all psychotropic medications require a prior authorization approval

and must be utilized for a medically accepted indication as established by the FDA and/or peer-reviewed literature.

e. Continuity of Care. In an effort to improve recipient safety and quality of care:

1. For recipients under 18 years of age, who have been discharged from an institutional facility, they will be allowed to remain on their discharge medication regimen for up to six months to allow the recipient time to establish outpatient mental health services. The initial prior authorization after discharge must document the name of the discharge institution and the date of discharge.

2. For all other recipients under the age of 18, a six month prior authorization will be granted to cover current medication(s) when it is documented that the recipient has been started and stabilized. This will allow the recipient time to establish services if necessary and to transition to medication(s) per Nevada Medicaid policy.

2. Exceptions to Criteria for Anticonvulsants and ADD/ADHD Medications:

a. Treatment for seizure disorders with anticonvulsants are not subject to this policy. The ICD Codes for Epilepsy and/or Convulsions will bypass the prior authorization requirement at the pharmacy POS if the correct ICD Code is written on the prescription and transmitted on the claim. Or the prior authorization requirement will be overridden for anticonvulsant medications when the prescriber has a provider Specialty Code of 126, neurology or 135, pediatric neurology, in the POS system.

b. The current policy for treatment of ADD/ADHD is to be followed. Refer to this Chapter's Appendix A.

3. Prior Authorization Guidelines

a. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

O. Lidoderm 5% Patches®

Therapeutic Class: Topical, Local Anesthetics
Last Reviewed by the DUR Board: October 17, 2019

1. Coverage and Limitations

Topical Lidoderm Patches® are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

Authorization will be given if one of the following criteria are met and documented:

a. If an ICD code for herpes zoster is documented on the prescription; or

b. Completion of a prior authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

P. Respirator and Allergy Biologics

Therapeutic Class: Respirator and Allergy Biologics
Last Reviewed by the DUR Board: January 19, 2023

Respirator and Allergy Biologics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Xolair® (Omalizumab)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient will not use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies; and

b. All the following criteria must be met and documented for a diagnosis of moderate to severe persistent asthma:

1. The recipient must be six years of age or older; and

2. The recipient must have a history of a positive skin test or Radioallergosorbent (RAST) test to a perennial aeroallergen; and

3. The prescriber must be either a pulmonologist or allergist/ immunologist; and

4. The recipient must have had an inadequate response, adverse reaction, or contraindication to inhaled, corticosteroids; and

5. The recipient must have had an inadequate response, adverse reaction, or contraindication to a leukotriene receptor antagonist; and

6. The recipient must have had a pretreatment serum total Immunoglobulin E (IgE) level between 30 IU/mL and 700 IU/mL; and

7. The recipient's current weight must be recorded; and

8. The requested dose is appropriate for the recipient’s pre-treatment serum IgE and body weight (see Table 1).

2. All the following criteria must be met and documented for diagnosis of chronic idiopathic urticaria (CIU):

   a. The recipient is 12 years of age or older; and

   b. The recipient must have had an inadequate response, adverse reaction, or contraindication to two different oral second-generation antihistamines; and

   c. The recipient must have had an inadequate response, adverse reaction, or contraindication to an oral second-generation antihistamine in combination with a leukotriene receptor antagonist; and

   d. The prescriber must be either an allergist/immunologist, dermatologist or a rheumatologist or there is documentation in the recipient's medical record that a consultation was done by an allergist/immunologist, dermatologist or a rheumatologist regarding the diagnosis and treatment recommendations; and

   e. One of the following:

      1. The request is for initiation of therapy and the dose will be 150 mg every four weeks; or

      2. The request is for initiation of therapy and the dose will be 300 mg every four weeks, and clinical rationale for starting therapy at 300 mg every four weeks has been provided (pharmacy review required); or

      3. The request is for continuation of therapy and the dose will be 150mg or 300mg every four weeks

3. All the following criteria must be met for diagnosis of Nasal Polyps (NP) and all the following:

   a. The recipient is 18 years of age or older; and

   b. The prescriber must be one of the following, or there is documentation in the recipient's medical record that a consultation regarding diagnosis and treatment recommendations was done by one of the following:

      1. Allergist/Immunologist; or

      2. Dermatologist; or

      3. Rheumatologist; and

c. The recipient must have had an inadequate response, adverse reaction, or contraindication to at least 2 months of therapy with an intranasal corticosteroid and had inadequate response; and

d. One of the following:

1. The recipient will continue intranasal corticosteroid treatment along with omalizumab therapy; or

2. The prescriber has provided valid medical rationale for not continuing intranasal corticosteroid treatment along with omalizumab therapy; or

3. The request is for continuation of therapy and there is documentation of a positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS; 0-8 scale], improvement in nasal congestion/obstruction score [NCS; 0-3 scale]

4. Prior Authorization Guidelines:

a. Prior authorization approval will be for 12 months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Table 1: Dosing for Xolair® (omalizumab)*

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	>60-70	>70-90	>90-150
≥30-100	150 mg	150 mg	150 mg	300 mg
>100-200	300 mg	300 mg	300 mg	225 mg
>200-300	300 mg	225 mg	225 mg	300 mg
>300-400	225 mg	225 mg	300 mg	
>400-500	300 mg	300 mg	375 mg	
>500-600	300 mg	375 mg		
>600-700	375 mg	DO NOT DOSE		
Every 2 Weeks Dosing				
Every 4 Weeks Dosing				

b. Nucala® (mepolizumab), Cinqair® (reslizumab)

1. All the following criteria must be met and documented:

a. The recipient will not use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies; and

b. The recipient must have a diagnosis of severe eosinophilic-phenotype asthma; and

c. The recipient must be of FDA indicated appropriate age:

1. Mepolizumab: six years of age or older;

2. Reslizumab: 18 years of age or older; and

d. The prescriber must be either a pulmonologist or allergist/ immunologist; and

e. The recipient must be uncontrolled on current therapy including high dose corticosteroid and/or on a secondary asthma inhaler; and

f. There is documentation of the recipient's vaccination status; and

g. The requested dose is appropriate:

1. Mepolizumab: 100 mg subcutaneously every four weeks.

2. Reslizumab: 3 mg/kg via intravenous infusion of 20 to 50 minutes every four weeks.

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 12 months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

c. Nucala® (mepolizumab) for the treatment of severe asthma

1. Approval will be given if all the following criteria are met and documented:

a. The recipient must have a diagnosis of severe asthma; and

b. The asthma is an eosinophilic phenotype as defined by one of the following:

1. Baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter; or

2. Peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months; and

c. One of the following:

1. The recipient has had at least one or more asthma exacerbations requiring systemic corticosteroid within the past 12 months; or

2. The recipient has had prior intubation for an asthma exacerbation; or

3. The recipient has had prior asthma-related hospitalization within the past 12-months; and

d. The recipient is currently being treated with one of the following (unless there is a contraindication or intolerance to these medications)

1. Both the following:

a. High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day); and

b. Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline); or

2. One maximally dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); and

e. The recipient age is greater than or equal to six years; and

f. The medication must be prescribed by or in consultation with one of the following:

1. Pulmonologist; or

2. Allergist/Immunologist

2. Recertification request (the recipient must meet all the criteria)

a. Documentation of positive clinical response to therapy (e.g. reduction in exacerbations, improvement in forced expiratory volume in one second [FEV1], decreased use of rescue medications); and

b. The recipient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

1. Both the following:

a. ICS; and

b. Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline); or

2. A combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); and

c. The medication must be prescribed by or in consultation with one of the following:

1. Pulmonologist; or

2. Allergist/Immunologist

3. Prior Authorization Guidelines:

a. Initial authorization will be approved for six months.

b. Recertification will be approved for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

d. Nucala® (mepolizumab) for the treatment of Eosinophilic Granulomatosis with Polyangiitis (EGPA)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient must have a diagnosis of EGPA; and

b. The recipient's disease has relapsed or is refractory to standard of care therapy (i.e. corticosteroid treatment with or without immunosuppressive therapy); and

c. The recipient is currently receiving corticosteroid therapy; and

d. The medication must be prescribed or in consultation with one of the following:

1. Pulmonologist; or

2. Rheumatologist; or

3. Allergist/Immunologist.

2. Recertification Requests (the recipient must meet the following criteria)

a. Documentation of positive clinical response to therapy (e.g. increase in remission time).

3. Prior Authorization Guidelines:

a. Initial authorization will be approved for 12 months.

b. Recertification request will be approved 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

e. Nucala® (mepolizumab) for treatment of Hypereosinophilic Syndrome (HES)

1. Approval will be given if the following criteria are met and documented:

a. Recipient is greater than or equal to 12 years old; and

b. Recipient has a diagnosis of uncontrolled HES for greater than or equal to six months defined by both of the following:

1. History of greater than or equal to two flares over the past 12 months; and

2. Baseline (pre-treatment) blood eosinophil count greater than or equal to 1,000 cells/mL; and

c. No identifiable non-hematologic secondary cause of the HES; and

d. Recipient does not have FIP1L1-PDGFRa kinase-positive HES; and

e. Recipient is currently received a stable dose of background HES therapy (e.g., episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and

f. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

2. Recertification Request:

a. Documentation of positive clinical criteria response to therapy (e.g., decreased number of flares, improved fatigue, reduced corticosteroids requirements, and decreased eosinophil levels).

b. Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

3. Prior Authorization Guidelines:

a. Initial prior authorization will be given for 12 months.

b. Recertification will be given for 12 months.

f. Nucala® (mepolizumab) for treatment of Chronic Rhinosinusitis with Nasal Polyps

1. Approval will be given if the following criteria are met and documented:

a. Recipient is greater than or equal to 18 years old.

b. Recipient has a diagnosis of Chronic Rhinosinusitis with Nasal Polyps (CRSwNP); and

c. Unless contraindicated, the recipient has had an inadequate response to at least two months of treatment with an intranasal corticosteroid (initial approval only); and

d. Mepolizumab will be used as add-on medication to maintenance therapy (e.g. intranasal corticosteroid, saline nasal irrigations, systemic corticosteroids, antibiotics).

2. Recertification Request:

a. Recipient continues to meet above criteria; and

b. Documentation of positive clinical response to Nucala® (mepolizumab).

3. Prior Authorization Guidelines:

a. Initial prior authorization will be given for 12 months.

b. Recertification approval will be given for 12 months.

e. Fasenra® (benralizumab)

1. All the following criteria must be met and documented:

a. The recipient must be 12 years of age or older; and

b. The recipient will not use the requested antiasthmatic monoclonal antibody in combination with other antiasthamtic monoclonal antibodies; and

c. The recipient must have a diagnosis of severe eosinophilic phenotype asthma; and

d. One of the following:

1. Patient has had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months; or

2. Any prior intubation for an asthma exacerbation; or

3. Prior asthma-related hospitalization within the past 12 months.

e. Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

1. Both a high-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline); or

2. One maximally dosed combination ICS/LABA product (e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)).

f. Prescribed by or in consultation with one of the following:

1. Pulmonologist; or

2. Allergy/Immunology specialist.

2. Recertification Request: Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. There is documentation of a positive clinical response (e.g., reduction in exacerbation).

b. Recipient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

1. Both an ICS (5,E) and an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline); or

2. A combination ICS/LABA product (e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)).

c. Prescribed by or in consultation with one of the following:

1. Pulmonologist; or

2. Allergy/Immunology specialist.

3. Prior Authorization Guidelines:

a. Initial prior authorization will be for 12 months.

b. Recertification request will be for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

f. Dupixent® (dupilumab)

1. Approval will be given if the following criteria are met and documented:

a. The recipient has a diagnosis moderate of severe atopic dermatitis and all the following:

1. The medication is prescribed by or in consultation with a dermatologist or allergist/immunologist or an otolaryngologist; and

2. One of the following:

a. Trial and failure contraindication or intolerance to one medium to high potency topical corticosteroid (e.g. betamethasone, triamcinolone); or

b. Trial and failure or intolerance to one of the following, unless the recipient is not a candidate for therapy (e.g. immunocompromised):

1. Elidel® (pimecromulus) topical cream; or

2. Tacrolimus topical ointment; or

b. Diagnosis of moderate to severe asthma and all the following:

1. Recipient is six years of age or older; and

2. One of the following:

a. The recipient is currently dependent on oral corticosteroids for the treatment of asthma:

1. One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months.

2. Any prior intubation for an asthma exacerbation.

3. Prior asthma-related hospitalization within the past 12 months; or

b. All the following:

1. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter; and

2. The recipient has one of the following:

a. One or more asthma exacerbations requiring systematic corticosteroid within the past 12 months.

b. Any prior intubation for an asthma exacerbation.

c. Prior asthma-related hospitalization within the past 12 months; and

3. Recipient is currently being treated with one of the following (or there is a contraindication or intolerance to all these medications):

a. Both a high-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline); or

b. One maximally dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol],

Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]); and

4. Prescribed by or in consultation with a Pulmonologist or allergy/immunology specialist; or

3. Recertification Request:

a. Diagnosis of moderate to severe atopic dermatitis or severe eosinophilic asthma or oral corticosteroid-dependent asthma and all of the following:

1. Documentation of positive clinical response to Dupixent® therapy.

2. Recertification Criteria for severe eosinophilic asthma or oral corticosteroid-dependent asthma:

a. Both an ICS and asthma controller medication (e.g., leukotriene, receptor agonist, long-acting beta-2 agonist (LABA), theophylline); or

b. One maximally dosed combination ICS/LABA product combination ICS/LABA product (e.g., Advair (fluticasone, Propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budenoside/formoterol)

3. Prescribed by or in consultation with an allergist/immunologist/otolaryngologist/ENTs.

c. Diagnosis of Chronic Rhinosinusitis with Nasal Polyps

1. Approval will be given if the following criteria are met and documented:

a. Recipient is at least 18 years of age or older

b. Unless contraindicated, the recipient has had an inadequate response to two months of treatment with an intranasal corticosteroid (e.g., fluticasone,

mometasone) [Document drug(s), dose, duration, and date of trial]; and

c. The medication will not be used in combination with another agent for CRSwNP; and

d. Prescribed by or in consultation with an allergist/immunologist/otolaryngologists/ENTs.

2. Recertification Request:

a. Documentation of positive clinical response to Dupixent® therapy; and

b. Prescribed by or in consultation with an allergist/immunologist/otolaryngologists/ENTs

c. Medication will not be used in combination with another agent for CRSwNP.

d. Diagnosis of Eosinophilic Esophagitis (EoE)

1. Approval will be given if the following criteria are met and documented:

a. Recipient is greater than or equal to 12 years old; and

b. Recipient weighs greater than or equal to 40 kg; and

c. Prescribed by or in consultation with an allergist or gastroenterologist; and

d. Recipient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor.

2. Recertification Request:

a. Documentation of positive clinical response to Dupixent® therapy; and

b. Prescribed by or in consultation with an allergist or gastroenterologist.

3. Prior Authorization Guidelines:

a. Prior authorization will be approved for 12 months.

b. Recertification requests will be approved for 12 months.

e. Diagnosis of Prurigo Nodularis (PN)

1. Approval will be given if the following criteria are met and documented:

a. Recipient is greater than or equal to 18 years old; and

b. Prescribed by or in consultation with a dermatologist, allergist, or immunologist.

2. Recertification Request:

a. Documentation of positive clinical response to Dupixent® therapy; and

b. Prescribed by or in consultation with a dermatologist, allergist, or immunologist.

3. Prior Authorization Guidelines:

a. Prior authorization will be approved for 12 months.

b. Recertification requests will be approved for 12 months.

Q. Long-Acting Narcotics

Therapeutic Class: Analgesics, Narcotic
Last Reviewed by DUR Board: April 28, 2016

Long-Acting Narcotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

The current criteria for the use of fentanyl transdermal patches (Appendix A, (F.)) or oxycodone/acetaminophen ER tablets (Appendix A, (XX.)) is to be met.

For all other long-acting narcotics requests that exceed the quantity limit, the following criteria must be met and documented:

a. The recipient has a diagnosis of terminal cancer; or

b. All the following criteria must be met:

1. The recipient is 18 years of age or older; and

2. The requested agent will be used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment; and

3. There is documentation in the recipient's medical record that alternative agents (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated or would be otherwise inadequate to provide sufficient management of pain.

2. Prior Authorization Guidelines

a. The prior authorization approval will be for three months.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

R. Toradol® (ketorolac tromethamine) tablets

Therapeutic Class: Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
Last Reviewed by the DUR Board: April 30, 2020

Toradal® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Ketorolac is indicated for the short-term (up to five days) management of moderately severe acute pain that requires analgesia at the opioid level. It is not indicated for minor or chronic painful conditions. The following criteria must be met:

   a. Oral treatment must be indicated only as continuation therapy to IV/IM therapy; and

   b. Oral treatment must not to exceed five days; and

   c. Oral treatment must not exceed 40 mg/day.

2. Prior Authorization Guidelines

   a. Initial request will be approved for up to five days.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

S. Anti-Migraine Medications

Therapeutic Class: Serotonin 5-HT1 receptor agonists (triptans)
Last Reviewed by the DUR Board: July 25, 2019

Therapeutic Class: Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications
Last Reviewed by the DUR Board: January 27, 2022

Therapeutic Class: Ergot Derivatives
Last Reviewed by the DUR Board: July 28, 2022

Serotonin 5-HT1 receptor agonists commonly referred to as "triptans", CGRP Receptor Inhibitor medications and Ergot Derivatives or anti-migraine medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Serotonin 5-HT1 Receptor Agonists (triptans)

   a. An approved prior authorization is required for any prescription exceeding the quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

      1. The recipient's current medication history documents the use of prophylactic medications for migraine headache, or the medical provider agrees to initiate such therapy which includes beta-blockers, tricyclic antidepressants, anticonvulsants, Selective Serotonin Reuptake Inhibitors (SSRIs) and/or calcium channel blockers; or

      2. The medical provider is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required monthly.

         a. Recipient's current medication history must NOT have Monoamine Oxidase (MAO) Inhibitors present for approval of Imitrex® (sumatriptan), Maxalt® (rizatriptan) or Zomig® (zolmitriptan).

         b. Recipients whose current medication history indicates the use of propranolol will NOT be granted prior authorization of Maxalt® (rizatriptan) 10mg tablet or 10mg orally disintegrating tablet.

         c. Prior authorization will NOT be given to patients with ischemic heart disease.

   b. Prior Authorization Guidelines:

      1. Approval for exceeding the quantity limits on triptans will be provided for a two-month period.

2. The prior authorization must be initiated by the prescriber. The approved prior authorization must be available if requested.

2. Calcitonin Gene-Related Peptide (CGRP) Receptor Inhibitor Medications

a. CGRP General Criteria

1. Approval will be given if the following criteria are met and documented:

a. The recipient must have one of the following:

1. Both the following:

a. The recipient has a diagnosis of episodic migraines; and

b. The recipient has four to 14 migraine days per month, but not more than 14 headache days per month: or (for Nurtec® requests, the recipient does not have more than 18 headache days per month); or

2. All the following:

a. The recipient has a diagnosis of chronic migraines; and

b. The recipient has greater than or equal to 15 headache days per month, of which at least eight must be migraine days for at least three months; and

c. The recipient has been considered for medication overuse headache (MOH) and potentially offending medication(s) have been discontinued; and

b. The recipient is 18 years of age or older; and

c. The recipient has a documented history of failure (after at least a two-month trial) or an intolerance/contraindication to at least one medication from two of the following categories:

1. Evail (amitriptyline) or Effexor (venlafaxine)

2. Depakote/Depakote ER (divalproex) or Topamax (topiramate)

3. One of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metroprolol; and

d. The medication will not be used in combination with any other CGRP Inhibitor.

2. Recertification Request:

a. The recipient must have a documented positive response to CGRP therapy, demonstrated by a reduction in headache frequency and/or intensity; and

b. The recipient has had a decrease in use of acute migraine medications (e.g., NSAIDs, triptans) since the start of CGRP therapy; and

c. For chronic migraine only: The recipient continues to be monitored for MOH.

3. Prior Authorization Guidelines:

a. Initial request will be approved for six months.

b. Recertification request will be approved for 12 months.

b. CGRPs for Acute Migraines:

1. Ubrelvy® (ubrogepant), Nurtec® ODT (rimegepant).

a. Approval will be given if all the following criteria are met and documented:

1. Recipient must have a diagnosis of acute migraine with or without aura; and

2. Recipient is 18 years of age or older; and

3. The prescribed dose will not exceed two doses per migraine and treating no more than eight migraine episodes per 30 days; and

4. The recipient has had at least one trial and failure of a triptan agent; and

5. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

b. Recertification Request:

1. The recipient must have a documented positive response to the CGRP therapy; and

2. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

c. Prior Authorization Guidelines:

1. Initial request will be approved for six months.

2. Recertification request will be approved for 12 months.

2. CGRPs for Episodic Cluster Headache

a. Emgality® (galcanezumab-gnlm)

1. Approval will be given if all the following criteria are met and documented

a. The recipient has a diagnosis of episodic cluster headache; and

b. The recipient has experienced at least two cluster periods lasting from seven days to 365 days, separated by pain-free periods lasting at least three months.

c. The recipient is 18 years of age or older.

d. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

e. The medication will not be used in combination with any other CGRP inhibitor.

2. Recertification Request:

a. The recipient has documented positive response to Emgality® therapy, demonstrated by a reduction in headache frequency and/or intensity; and

b. The medication must be prescribed by or in consultation with either a Neurologist or a Pain Specialist.

3. Prior Authorization Guidelines:

a. Initial request will be approved for three months.

b. Recertification request will be approved for 12 months.

3. CGRP's Antagonists for Episodic Migraines

a. Nurtec® ODT (rimegepant).

1. Approval will be given if all criteria are met and documented:

a. The recipient is 18 years of age or older; and

b. The recipient has a documented diagnosis of episodic migraines, having 4-18 migraine days per month but not more than 18 headache days per month; and

c. Two of the following:

1. The recipient has a documented history of failure (after at least a two-month trial) or intolerance to Elavil® (amitriptyline) or Effexor® (venlafaxine); or has a contraindication to both Elavil® (amitriptyline) and Effexor ® (venlafaxine); or

2. The recipient has a documented history of failure (after at least a two-month trial) or intolerance to Depakote/Depakote ER (divalproex) or Topamax (topiramate); or has a contraindication to both Depakote/Depakote ER (divalproex) and Topamax (topiramate); or

3. The recipient has a history of failure (after at least a two-month trial) or intolerance to one of the following beta blockers:

a. Atenolol; or

b. Propranolol; or

c. Nadolol; or

d. Timolol; or

e. Metroprolol; and

d. Medication will not be used in combination with any other CGRP inhibitor.

2. Prior Authorization Guidelines:

a. Initial request will be approved for six months.

b. Recertification requests will be approved for 12 months.

4. Ergot Derivatives

a. Brand D.H.E. 45 (dihydroergotamine mesylate) injection, Generic dihydroergotamine mesylate injection, Brand Migranal nasal spray, or Generic dihydroergotamine mesylate nasal spray or Trudhesa®.

1. Approval will be given if all criterias are met and documented:

a. The recipient has a diagnosis of headahces with or without aura; and

b. The medication will be used for the acute treatment of migraine; and

c. The recipient is 18 years of age or older; and

d. One of the following:

1. The recipient has tried and failed or has intolerance to two triptants (e.g., eletriptan, rizatriptan, sumatriptan); or

2. The recipient has contraindication to all triptans; and

e. The medication is prescribed by or in consultation with either a Neurologist, a Pain Specialist, or a Headache Specialist; and

f. If the recipient has more than four headache days per month, they must meet at least one of the following:

1. The recipient is currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications; or

2. The recipient is currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a

contraindication or intolerance to these medications; or

3. The recipient is currently being treated with a beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol) unless there is a contraindication or intolerance to these medications; and

2. Recertification Request:

a. The recipient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea); and

b. The medication is prescribed by or in consultation with either a Neurologist, a Pain Specialist, or a Headache Specialist.

3. Prior Authorization Guidelines:

a. Initial request will be approved for three months.

b. Recertification requests will be approved for 12 months.

b. Brand D.H.E. 45 injection or Generic dihydroergotamine mesylate injection

1. Approval will be given if all criterias are met and documented:

a. The recipient has a diagnosis of cluster headache; and

b. The recipient is 18 years of age or older; and

c. The recipient has had a trial and failure, contraindication, or intolerance to sumatriptain injection; and

d. The medication is prescribed by or in consultation with either a Neurologist, a Pain Specialist, or a Headache Specialist.

2. Recertification Request:

   a. The recipient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity; and

   b. The medication is prescribed by or in consultation with either a Neurologist, a Pain Specialist, or a Headache Specialist.

3. Prior Authorization Guidelines:

   a. Initial authorization will be approved for three months.

   b. Recertification requests will be approved for three months.

T. Tobacco Cessation Products

Therapeutic Class: Tobacco Cessation Agents
Last Reviewed by the DUR Board: April 30, 2020

Smoking cessation products, including patches, gums, lozenges and inhalers (based on the recipients' route of choice), are subject to quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board.

Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

U. Short-Acting Bronchodilators

Therapeutic Class: Beta Adrenergic Agents
Last Reviewed by the DUR Board: January 24, 2019

Short-Acting Bronchodilators are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. This criteria applies to, but is not limited to, the following list:

Proventil® HFA	ProAir® HFA	ProAir RespiClick®
Ventolin® HFA	Albuterol Nebulizer	Nebulizer Solution

a. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

1. Quantity Limits:

a. Albuterol Metered Dose Inhalers (MDI): two units per month.

b. Albuterol Nebulizer Solution: three bottles of 20ml each or 125 nebulizer units per month.

2. In order to exceed the quantity limit, a recipient must meet all of the following:

a. The recipient must have a diagnosis of asthma; and

b. The recipient has been assessed for causes of asthma and external triggers have been removed or reduced where possible.

3. For recipients 18 years of age or younger the following criteria must be met:

a. The recipient has a diagnosis of asthma; and

b. The recipient requires an additional inhaler unit for school or equivalent program.

b. Prior Authorization Guidelines

1. Prior authorization approval will be for 12 months.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

2. Xopenex®

a. Coverage and Limitations
Authorization will be given if the following criteria are met and documented:

1. Authorization only for recipients experiencing side effects on one other beta-adrenergic agent of any formulation.

2. Authorization for patients whose cardiovascular status is considered to be in severe deteriorating condition.

b. Prior Authorization Guidelines

Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

V. Anti-Insomnia Agents (Sedative Hypnotics)

Therapeutic Class: Anxiolytics, Sedatives and Hypnotics
Last Reviewed by the DUR Board: September 3, 2015

See Section N of this Appendix for criteria for Sedatives and Hypnotics when prescribed for a psychotropic indication.

Sedatives Hypnotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented.

   a. An FDA approved ICD diagnosis code, such as insomnia, is documented on the prescription and transmitted on the claim; or

   b. A PA with an FDA approved diagnosis, such as insomnia, is submitted.

2. Prior Authorization Guidelines

   a. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms/aspx

W. Doxepin Topical

Therapeutic Class: Other Topical Anti-Pruiritics
Last Reviewed by DUR Board: October 22, 2020

Doxepin Topical is subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for billing information.

1. Authorization will be given if the following criteria are met and documented:

   a. The recipient has a documented diagnosis of pruritus with atopic dermatitis or lichen simplex chronicus; and

   b. The recipient is 18 years of age or older; and

   c. Treatment must not exceed eight days.

2. Prior Authorization Guidelines:

   a. Prior Authorization approval will be given for eight days.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

X. Antiemetics

Therapeutic Class: Antiemetics, (Serotonin Receptor Antagonists (5 HT3 Antiemetics))
Last Reviewed by the DUR Board: October 28, 2010
Therapeutic Class: Antiemetic (Cannabinoid Antiemetics)
Last Reviewed by DUR Board: October 18, 2018

Antiemetics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

An approved prior authorization is required for any prescription exceeding the quantity limits. Approval for additional medication beyond these limits will be considered only under the following circumstances:

Serotonin Receptor Antagonists (5 HT3 Antiemetics)

1. Coverage and Limitations

   a. The recipient has failed on chemotherapy-related antiemetic therapy at lower doses; or

   b. The recipient is receiving chemotherapy treatments more often than once a week; or

   c. The recipient has a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) associated nausea and vomiting; or

   d. The recipient has a diagnosis of hyperemesis gravidarum and has failed at least one other antiemetic therapy or all other available therapies are medically contraindicated.

2. Prior Authorization Guidelines

   A prior authorization to override the quantity limits to allow for a 30-day fill for these drugs may be effective for up to six months.

Cannabinoid Antiemetics

1. Coverage and Limitations

   Approval will be given if all the following criteria are met and documented:

   a. Nabilone

      1. The recipient has a diagnosis of chemotherapy-induced nausea and/or vomiting; and

2. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one serotonin receptor antagonist; and

3. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent; and

4. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient.

b. Dronabinol

1. The recipient has a diagnosis of chemotherapy-induced nausea and/or vomiting; and

a. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one serotonin receptor antagonist; and

b. The recipient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent; and

c. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient; or

2. The recipient has been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) and has anorexia associated with weight loss; and the recipient has experienced an inadequate response, adverse event or has a contraindication to megestrol (Megace®); and

a. The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the recipient.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

Y. Synagis® (palivizumaub)

Therapeutic Class: Antiviral Monoclonal Antibodies
Last Reviewed by the DUR Board: January 22, 2015

Synagis® (palivizumab) injections are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

For consideration outside these guidelines, a prior authorization may also be submitted with supporting medical necessity documentation.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Recipients younger than 12 months of age at the start of Respiratory Syncytial Virus (RSV) season, must meet one of the following criteria:

1. The recipient was born at 28 weeks, six days of gestation or earlier; or

2. The recipient has a diagnosis of chronic lung disease (CLD) of prematurity; or

3. The recipient has hemodynamically significant congenital heart disease; or

4. The recipient has congenital abnormalities of the airways or neuromuscular disease; or

5. The recipient has a diagnosis of cystic fibrosis; and

a. The recipient has clinical evidence of CLD and/or nutritional compromise.

b. Recipients younger than two years of age at the start of RSV season must meet one of the following criteria:

1. The recipient has a diagnosis of CLD of prematurity; and

a. The recipient has required medical therapy (e.g., bronchodilator, diuretics, oxygen, coritcosteroids) within six months to the start of RSV season; or

2. The recipient has had a cardiac transplant; or

3. The recipient is severely immunocompromised (solid organ or hematopoietic stem cell transplant, chemotherapy, or other conditions) during the RSV season; or

4. The recipient has had a cardiopulmonary bypass and continues to require prophylaxis after surgery or at the conclusion of extracorporeal membrane oxygenation; or

5. The recipient has a diagnosis of cystic fibrosis; and

a. The recipient has had manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persists when stable) or weight for length less than the tenth percentile.

2. Prior Authorization Guidelines

a. Prior authorization approval will be up to five doses per RSV season for recipients meeting criteria.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Z. Opioids, Opioid Containing Cough Preparations, Opioids Prescribed to Under Age 18

Therapeutic Class: Opioids, Last reviewed by the DUR Board: July 26, 2018
Opioid Containing Cough Preparations Last reviewed by the DUR Board: July 26, 2018
Opioids Prescribed to Under Age 18: Last Reviewed by the DUR Board: October 18, 2018

Opioids, Opioid Containing Cough Preparations and Opioids Prescribed to Under Age 18 are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

Opioids

1. Coverage and Limitations

   a. Opioids will be covered without prior authorization:

      1. For initial prescriptions of seven days or less; and

      2. For a total of 13 seven-day prescriptions in any rolling 12-month period; and

      3. For prescriptions of 60 mg morphine equivalents or less per day.

   b. Recipients currently on chronic opioid medications will not be subject to the seven-day requirement for an opioid(s) they have been receiving in the past 45 days.

   c. Prior Authorization Criteria: To exceed the number of seven-day prescriptions, or to exceed the seven-day limit, or to exceed the 60 mg morphine equivalents or less per day:

      1. All of the following criteria must be met and documented:

         a. The recipient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber; and

         b. Pain cannot be controlled through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants, anti-seizure medications, physical therapy, etc.); and

         c. The lowest effective dose is being requested; and

         d. A pain contract is on file.

   d. Exceptions to this policy:

      1. Recipients with cancer/malignancy related pain; or

2. Recipients who are post-surgery with an anticipated prolonged recovery (greater than three months); or

3. Recipients receiving palliative care; or

4. Recipients residing in a long-term care facility; or

5. Recipients receiving treatment for HIV/AIDS; or

6. Prescriptions written by or in consultation with a pain specialist.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

3. CDC Guidance:

a. http://www.cdc.gov/drugoverdose/prescribing/guideline.html.

4. Opioid Containing Cough Preparations

a. The recipient must be 18 years of age or older.

b. Prior authorization approval will be for six months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

d. For references purposes, codeine and tramadol for children prior authorization criteria can also be found within this chapter in Section TTT.

5. Opioids Prescribed to Under Age 18

a. Short Acting Opioids will be covered without PA for:

1. Initial prescription of three days or less; and

2. A total of 13 three-day prescriptions in any rolling 12-month period; and

3. Prescriptions of 60 morphine milligram equivalents (MME) or less per day.

b. Recipients currently on chronic opioid medications will not be subject to the three-day requirement for an opioid(s) they have been receiving in the past 45 days.

c. To exceed the number of three-day prescriptions, or to exceed the three-day limit, or to exceed the 60 MME or less per day:

1. All of the following criteria must be met and documented:

a. The recipient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber; and

b. Pain cannot be controlled through the use of non-opioid therapy (acetaminophen, NSAIDs, antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.); and

c. The lowest effective dose is being prescribed; and

d. A pain contract is on file.

d. Exceptions:

1. Recipients with cancer/malignancy related pain, recipients who are post-surgery with an anticipated prolonged recovery (greater than three months), recipients residing in a long-term care facility, recipients receiving treatment for HIV/AIDS, hospice, palliative care or end-of-life care.

2. Prescriptions written by or in consultation with a pain specialist.

e. Prior Authorization Guidelines

1. Prior authorization approval will be for three months.

f. Prescribing Guidance:

1. CDC Guidance: https://www.cdc.gov/drugoverdose/prescribing/guideline.html

2. HHS Opioids and Adolescents: https://www.hhs.gov/ash/oah/adolescent-development/substance-use/drugs/opioids/index.html

AA. Savella® (milnacipran)

Therapeutic Class: Fibromyalgia Agents: Serotonin-Norepinephrine Reuptake Inhibitor
Last Reviewed by DUR Board: July 23, 2020

Savella® (milnacipran) is subject to prior authorization.

1. Approval will be given if all of the following criteria are met and documented:

    a. The recipient has a diagnosis of Fibromyalgia:

        1. If an ICD code for Myalgia and Myositis unspecified is documented on the prescription; or

        2. Completion of a prior authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

2. Prior Authorization Guidelines:

    a. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

BB. Substance Abuse Agents

Therapeutic Class: Narcotic Withdrawal Therapy Agents
Last Reviewed by the DUR Board: July 23, 2020

Buprenorphine/Naloxone and Buprenorphine are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Buprenorphine/Naloxone and Buprenorphine

1. Approval will be given if all of the following criteria are met and documented:

a. Prior authorization approval will be required for all prescriptions over 24 mg.

b. Requires diagnosis of opioid dependence.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for 12 months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

b. Lucemyra™ (lofexidine)

1. Approval will be given if all of the following criteria are met and documented:

a. The recipient has a diagnosis of opioid withdrawal with symptoms due to abrupt opioid discontinuation; and

b. The requested quantity must not exceed 2.88 mg/day for up to 14 days.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for 14 days.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

c. Vivitrol® (naltrexone)

1. Coverage and Limitations Approval will be given if the following criteria are met and documented:

a. The drug is being used for an FDA approved indication; and

b. The drug must be delivered directly to the prescriber's office; and

c. The drug is only to be administered once per month; and

d. Routine urine screening and monitoring is recommended.

2. Prior Authorization Guidelines

a. Prior authorization approvals will be for six months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

CC. Multiple Sclerosis (MS) Agents

Therapeutic Class: Agents for the treatment of Neuromuscular Transmission Disorder
Last Reviewed by the DUR Board: January 19, 2023

MS Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

    a. The recipient has a diagnosis of MS.

2. Ampyra® (dalfampridine)

    a. Approval will be given if all the following criteria are met and documented:

        1. The recipient must have a diagnosis of MS; and

        2. The medication is being used to improve the recipient's walking speed; and

        3. The medication is being prescribed by or in consultation with a neurologist; and

        4. The recipient is ambulatory and has an EDSS score between 2.5 and 6.5; and

        5. The recipient does not have moderate to severe renal dysfunction (CrCL less than 50 ml/min); and

        6. The recipient does not have a history of seizures; and

        7. The recipient is not currently pregnant or attempting to conceive.

    b. Prior Authorization Guidelines

        1. Initial prior authorization approval will be for three months.

        2. Request for continuation of therapy will be approved for one year.

3. Relapsing Forms of MS Agents:

    a. Approval will be given if all the following criteria are met and documented:

        1. The recipient must have a diagnosis of a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses).

b. Lemtrada® (alemtuzumab)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient must have a diagnosis of a relapsing form of MS; and one of the following:

1. Both the following:

a. The recipient has not been previously treated with alemtuzumab; and

b. The recipient has had failure after a trial of at least four weeks; a contraindication, or intolerance to two of the following disease-modifying therapies for MS:

1. Aubagio® (teriflunomide)

2. Avonex® (interferon beta-1a)

3. Betaseron® (interferon beta-1b)

4. Copaxone/Glatopa® (glatiramer acetate)

5. Extavia® (interferon beta-1b)

6. Gilenya® (fingolimod)

7. Mavenclad® (cladrivine)

8. Mayzent® (siponimod)

9. Ocrevus® (ocrelizumab)

10. Plegridy® (peginterferon beta-1a)

11. Rebif® (interferon beta-1a)

12. Tecfidera® (dimethyl fumarate)

13. Tysabri® (natalizumab); or

14. Zinbryta® (daclizumab)

c. Both the following:

a. The recipient has previously received treatment with alemtuzumab; and

b. The recipient has had at least 12 months elapsed or will have elapsed since the most recent treatment course with alemtuzumab; and

2. The medication will not be used in combination with another disease-modifying therapy for MS.

2. Prior Authorization Guidelines

a. Initial authorization approval will be for 12 months.

b. Recertification approval will be for 12 months.

c. Mavenclad® (cladribine)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient must have a diagnosis of a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses); and one of the following:

1. Both the following:

a. The recipient has not been previously treated with cladribine; and

b. The recipient has had failure after a trial of at least four weeks; contraindication, or intolerance to two of the following disease-modifying therapies for MS:

1. Aubagio® (teriflunomide)

2. Avonex® (interferon beta-1a)

3. Betaseron® (interferon beta-1b)

4. Copaxone®/Glatopa® (glatiramer acetate)

5. Extavia (interferon beta-1b)

6. Gilenya® (fingolimod)

7. Lemtrada® (alemtuzumab)

8. Mayzent® (siponimod)

9. Ocrevus® (ocrelizumab)

10. Plegridy® (peginterferon beta-1a)

11. Rebif® (interferon beta-1a)

12. Tecfidera® (dimethyl fumarate)

13. Tysabri® (natalizumab); or

14. Zinbryta® (daclizumab)

2. Both the following:

a. The recipient has previously received treatment with cladribine; and

b. The recipient has not already received the FDA-recommended lifetime limit of two treatment courses (or four treatment cycles total) of cladribine; and

b. The medication will not be used in combination with another disease-modifying therapy for MS.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one month.

d. Ocrevus® (ocrelizumab)

1. Approval will be given if all the following criteria are met and documented:

a. Recipient is at least 18 years of age (unless otherwise specified); and

b. Recipient has been screened for the presence of Hepatitis B virus (HBV) prior to initiating treatment and does not have active disease (i.e., positive HBsAg and anti-HBV tests); and

c. Recipient has had baseline serum immunoglobulins assessed; and

2. Universal Criteria

a. Recipient will not receive live or live-attenuated vaccines while on therapy or within four weeks prior to initiation of treatment; and

b. Recipient does not have an active infection; and

3. Multiple Sclerosis

a. Recipient must have a confirmed diagnosis of multiple sclerosis (MS) as documented by laboratory report (i.e., MRI); and

b. Must be used as single agent therapy; and

1. Recipient has a diagnosis of relapsing form of MS [i.e., relapsing-remitting MS (RRMS), active secondary progressive disease (SPMS), or clinically isolated syndrome (CIS)]; or

2. Recipient has a diagnosis of primary progressive MS (PPMS); and

a. Recipient is less than 65 years; and

b. Recipient has an expanded disability status scale (EDSS) score of less than or equal to 6.5.

2. Recertification Request (the recipient must meet all criteria):

a. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

b. Recipient has not received a dose of ocrelizumab within the past five months; and

c. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion reactions, severe infections, progressive multifocal leukoencephalopathy malignancy, hypogammaglobulinemia, immune-mediated colitis, etc.; and

d. Continuous monitoring of response to therapy indicates a beneficial response [manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate (ARR), development of new/worsening T2 hyperintensities, or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale (EDSS), timed 25-foot walk (T25-FW), 9-hole peg test (9-HPT)].

1. Inadequate response, in those who have been adherent and receiving therapy for sufficient time to realize the full treatment effect, is defined as greater than or equal to one relapse, greater than or equal to two unequivocally new MRI-detected lesions, or increased disability on examination over a one-year period.

e. PPMS

1. Recipient continues to ambulatory, defined as an EDSS score of less than 7.5.

3. Prior Authorization Guidelines

a. Initial prior authorization approval will be 12 months.

b. Recertification approval will be for 12 months.

e. Zeposia® (ozanimod)

1. Approval will be given if all the following criteria is met and documented:

a. The recipient has a documented diagnosis of a relapsing form of MS (e.g., relapsing-remitting MS, secondary-progressive MS with relapses); and

b. One of the following:

1. The agent is used for continuation of therapy; or

2. The recipient has had failure after a trial of at least four weeks, contraindication, or intolerance to at least two of the following disease-modifying therapies for MS:
a. Avonex® (interferon beta-1a)

b. Betaseron® (interferon beta-1b)

c. Copaxone®/Glatopa® (glatiramer acetate)

d. Tecfidera® (dimethyl fumarate); and

c. The medication is prescribed by or in consultation with a neurologist.

2. Recertification Criteria (the recipient must meet all criteria):

a. The recipient has documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression); and
b. The medication is prescribed by or in consultation with a neurologist.

3. Prior Authorization Guidelines:

a. Prior authorization approval will be for 12 months.

b. Recertification approval will be for 12 months.

f. Ponvory® (ponesimod)

1. Approval will be given if all the following criteria are met and documented:

a. Recipient has a diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting disease [RRMS]; active secondary progressive MS [SPMS]+, or clinically isolated syndrome [CIS]); and

b. Recipient will NOT be initiating therapy after previous treatment with alemtuzumab; and

c. Ponesimod will be prescribed by, or in consultation with, neurologist; and

d. One of the following:

1. The agent is used for continuation of therapy; or

2. The recipient has had failure after a trial of at least four weeks, contraindication, or intolerance to at least two of the following disease-modifying therapies for MS;

a. Avonex® (interferon beta-1a); or
b. Betaserone® (interferon beta-1b); or

c. Copaxone®/Glatopa® (glatiramer acetate); or

d. Tysabri® (natalizumab); or

e. Tefidera® (dimethyl fumarate); or

f. Aubagio® (teriflunomide); or

g. Gilenya® (fingolimod)

2. Recertification Request:

a. The recipient has documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression); and

b. Ponesimod will be prescribed by, or in consultation with, neurologist.

3. Prior Authorization Guidelines:

a. Prior authorization approval will be given for 12 months.

4. Primary Progressive Forms of Multiple Sclerosis (PPMS) Agents:

a. Ocrevus® (ocrelizumab)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient must have a diagnosis of PPMS; and

b. The medication must not be used in combination with another disease-modifying therapy for MS; and

c. The medication must not be used in combination with another B-cell targeted therapy (e.g., Rituxan® (rituximab), Benlysta® (belimumab), Arzerra® (ofatumumab)); and

d. The medication must not be used in combination with another lymphocyte trafficking blocker (e.g., Lemtrada® (alemtuzumab), mitoxantrone).

2. Recertification Request (the recipient must meet all criteria):

a. Documentation of a positive clinical response to Ocrevus® therapy; and
b. The medication must not be used in combination with another disease-modifying therapy for MS; and

3. The medication must not be used in combination with another B-cell target therapy (e.g., Rituxan® (rituximab), Benlysta (belimumab), Arzerra (ofatumumab)); and

a. The medication must not be used with another lymphocyte trafficking blocker (e.g., Lemtrada® (alemtuzumab), mitoxantrone).

4. Prior Authorization Guidelines

a. Prior authorization approval will be for 12 months.

b. Recertification approval will be for 12 months.

DD. Hormones and Hormone Modifiers

Therapeutic Class: Androgenic Agents
Last Reviewed by the DUR Board: October 20, 2022

1. Topical Androgens

a. Approval will be given if all the following criteria are met and documented:

1. Recipient is male; and

2. The medication is used for FDA-approved indication:

a. Primary (congenital or acquired); or

b. Secondary (congenital or acquired) hypogonadism; and

3. Recipient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used; and

4. Recipient does not have breast or prostate cancer, a palpable prostate nodule or induration, prostate-specific antigen greater than 4 ng/ml or severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) greater than 19; and

5. Recipient does not have a hematocrit greater than 50%; and

6. Recipient does not have untreated severe obstructive sleep apnea; and

7. Recipient does not have uncontrolled or poorly controlled heart failure.

b. Diagnosis of Gender Dysphoria:

1. Approval will be given if the following criteria are met and documented:

a. Recipient is using the hormones to change their physical characteristics; and

b. Recipient is a female-to-male transsexual.

2. Xyosted™ (testosterone enanthate)

a. Approval will be given if the following criteria are met and documented:

1. Diagnosis of Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 E29.1); and

2. The recipient is male at birth; and

3. One of the following:

a. Two pre-treatment serum total testosterone levels less than 300 ng/dL (< 10.4 nmol/L) or less than the reference range for the lab; or both of the following:

1. Recipient has a condition that may cause altered sex hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV, liver disorder, diabetes, obesity); and

2. One pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (<0.17 nmol/L) or less than the reference range for the lab; or

b. Recipient has a history of one of the following: bilateral orchiectomy, panhypopituitarism or a genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome).

b. Diagnosis of Gender Dysphoria

1. Approval will be given if the following criteria are met and documented:

a. Recipient is using the hormones to changes in their physical Characteristics; and

b. Recipient is a female-to-male transsexual

c. Prior Authorization Guidelines:

1. Prior authorization approval with a diagnosis of hypogonadism will be given for one year.

2. Prior authorization approval with a diagnosis of gender dysphoria will be given for six months for recipients new to testosterone therapy; or

a. Prior authorization approval will be given to recipients continuing testosterone therapy without a current authorization on file for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Oral Testosterone Products

a. Hypogonadism:

1. Approval will be given if the following criteria are met and documented:

   a. The recipient is greater than 18 years of age; and

   b. Recipient is male; and

   c. Recipient has a diagnosis of primary hypogonadism or hypogonadotropic hypogonadism (congenital or acquired); and

   d. Recipient has history of failure, contraindication, or intolerance to both testosterone cypionate and testosterone enanthate injection; and

   e. Recipient has signs/symptoms consistent with hypogonadism (e.g., low libido, decreased morning erections, loss of body hair, low bone mineral density, gynecomastia, small testes); and

   f. Recipient does not have "age-related hypogonadism' or another hypogonadal condition not associated with structural or genetic etiologies; and

   g. Recipient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used (initial approval only); and

   h. Recipient is only receiving one androgen or anabolic agent; and

   i. Recipient does not have current or history of breast cancer; and

   j. Recipient does not have a hematocrit greater than 50%; and

   k. Recipient does not have uncontrolled hypertension or heart failure; and

   l. Recipient does not have uncontrolled obstructive sleep apnea; and

   m. Medication is prescribed by or in consultation with an endocrinologist or urologist.

b. Diagnosis of Gender Dysphoria:

   1. Approval will be given if the following criteria are met and documented:

      a. Recipient is using the hormones to change their physical characteristics; and

      b. Recipient is a female-to-male transsexual.

c. Recertification Request:

1. Recipient must continue to meet above criteria; and

2. Recipient must have disease improvement and/or stabilization.

d. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 months.

EE. Colchicine (Colcrys®)

Therapeutic Class: Antigout Agents
Last Reviewed by the DUR Board: January 28, 2016

Colchicine (Colcrys®) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Colchicine Tablets

1. The recipient has a diagnosis of acute gout (does not require prophylaxis) and the recipient must meet all of the following:

a. The recipient is 16 years of age or older; and

b. The recipient has had an inadequate response, adverse reaction or contraindication to an NSAID (indomethacin, naproxen, ibuprofen, sulindac or ketoprofen); and

c. The recipient has had an inadequate response, adverse reaction or contraindication to a corticosteroid (oral or intra-articular).

2. For prophylaxis of chronic gout:

a. The recipient is 16 years of age or older and must meet one of the following:

1. There is documentation that the recipient will be treated with colchicine in combination with allopurinol, Uloric® (febuxostat) or probenecid; or

2. There is documentation that the recipient will be treated with colchicine monotherapy and the recipient must meet all of the following:

a. The recipient has had an inadequate response to allopurinol at a dose of 600 mg/day for at least two weeks or had an adverse reaction or contraindication to allopurinol; and

b. The recipient has had an inadequate response to Uloric® (febuxostat) at a dose of 80 mg/day for at least two weeks or has had an adverse reaction or contraindication to Uloric® (febuxostat).

3. For Familial Mediterranean Fever (FMF):

   a. The recipient is four years of age or older.

4. Requests exceeding the quantity limit may be approved for colchicine tablets if all of the following are met and documented:

   a. The recipient is 12 years of age or older; and

   b. The recipient has a diagnosis of FMF; and

   c. The recipient's dose is ≤ 2.4 mg daily (120 tablets/30 days); and

   d. Medical necessity must be provided and documented in the recipient's medical record that the recipient had an inadequate response to 1.8 mg daily (90 tablets/30 days).

b. Colchicine Capsules

1. For Prophylaxis of chronic gout:

   a. The recipient is 18 years of age or older and the recipient must meet one of the following:

      1. There is documentation that the recipient will be treated with colchicine in combination with allopurinol, Uloric® (febuxostat) or probenecid; or

      2. There is documentation that the recipient will be treated with colchicine monotherapy, and the recipient must meet all of the following:

         a. The recipient has had an inadequate response to allopurinol at a dose of 600 mg/day for at least two weeks or had an adverse reaction or contraindication to allopurinol; and

         b. The recipient has had an inadequate response to Uloric® (febuxostat) at a dose of 80 mg/day for at least two weeks or has had an adverse reaction or contraindication to Uloric® (febuxostat).2. Prior Authorization Guidelines

c. Prior authorization approval will be given based on diagnosis.

1. For FMF and chronic gout: one year.

2. For acute gout: two months.

d. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

FF. Thrombin Inhibitors

Therapeutic Class: Thrombin Inhibitors
Last Reviewed by the DUR Board: January 22, 2015

Thrombin Inhibitors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. A diagnosis code associated with the FDA approved indication(s) is documented on the prescription and transmitted on the claim; and

b. There are no contraindications to prescribing this medication; or

c. An approved Prior Authorization documenting the recipient meeting all of the criteria above (1.) (a. and b.).

2. Prior Authorization Guidelines

a. Prior authorization approval will be for up to one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

GG. Antihemophilia Agents

Therapeutic Class: Antihemophilia Agents
Last Reviewed by the DUR Board: July 26, 2018

Antihemophilia Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. The medication being prescribed must be for an FDA approved indication; or

b. One of the following:

1. The diagnosis is supported as a use of American Hospital Formulary Service Drug Information (AHFS DI); or

2. The diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table); or

3. Both of the following:

a. Diagnosis is listed in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of III or Class Indeterminant (see DRUGDEX Strength of Recommendation table); and

b. Efficacy is rated as “effective” or “evidence favors efficacy” (see DRUGDEX Efficacy Rating and Prior Authorization Approval Status table); or

4. Diagnosis is supported in any other section of DRUGDEX; or

5. The use is supported by clinical research in two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal; and

a. One of the following:

1. The dosage quantity/duration of the medication is reasonably safe and effective based on information contained in the FDA approved labeling, peer-reviewed

medical literature or accepted standards of medical practice; or

2. The dosage/quantity/duration of the medication is reasonably safe and effective based on one of the following compendia:

   a. AHFS Compendium;

   b. Thomson Reuters (Healthcare) Micromedex/ DRUGDEX (not Drug Points) Compendium;

   c. Elsevier Gold Standard's Clinical Pharmacology Compendium;

   d. National Comprehensive Cancer Network Drugs and Biologics Compendium; and

c. The dispensing provider will monitor the amount of product a recipient has left to avoid over-stock; and

d. The prescriber is a specialist in treating hemophilia; and

e. A new prior authorization will be required for any dose adjustment in excess of 5% (increase or decrease).

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for 12 months.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

HH. Anti-Hepatitis Agents

Therapeutic Class: Anti-Hepatitis Agents
Last Reviewed by the DUR Board: April 22, 2021

Anti-Hepatitis Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Epclusa® (sofosbuvir and velpatasvir)

   a. Approval will be given if all the following criteria are met and documented:

      1. The recipient is not receiving Epclusa® (sofosbuvir and velpatasvir) in combination with another HCV direct acting antiviral agent (e.g., Sovaldi®, Olysio®); and

      2. The medication must be prescribed by or in consultation with one of the following:

         a. Hepatologist

         b. Gastroenterologist

         c. Infectious Disease Specialist

         d. HIV Specialist (certified through the American Academy of HIV Medicine)

   b. Genotype 1, 2, 3, 4, 5 or 6, without decompensated liver disease

      1. The recipient has a documented diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

      2. The recipient must not have decompensated liver disease; and

      3. Epclusa® must be used alone; and

      4. The request is FDA approved for recipient weight and age; and

      5. Prior authorization approval will be for 12 weeks.

   c. Genotype 1, 2, 3, 4, 5 or 6 with decompensated liver disease

      1. The recipient has a documented diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has decompensated liver disease; and

3. Epclusa® is being used in combination with Ribavirin; and

4. The request is FDA approved for recipient weight and age; and

5. Prior authorization approval will be for 24 weeks.

d. Genotype 1, 2, 3, 4, 5 or 6 Ribavirin intolerance/ineligible or prior Sovaldi® (sofosbuvir) or NS5A-based treatment failure.

1. The recipient has a documented diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has decompensated liver disease; and

a. One of the following:

1. The recipient is Ribavirin intolerant or ineligible; or

2. Both of the following:

a. The recipient has had prior failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) to Sovaldi® or NS5A-based treatment; and

b. Epclusa® is used in combination with Ribavirin®.

3. Prior authorization approval will be for 24 weeks.

2. Harvoni® (ledipasvir/sofosbuvir)

a. Approval will be given if the following criteria are met and documented:

1. The recipient is not receiving Harvoni® in combination with another HCV direct acting antiviral agent (e.g., Sovaldi®, Olysio®); and

2. The medication must be prescribed by or in consultation with one of the following:

a. Hepatologist

b. Gastroenterologist

c. Infectious Disease Specialist

d. HIV Specialist (certified through the American Academy of HIV Medicine)

b. Genotype 1, treatment naïve, without cirrhosis and pre-treatment HCV RNA is less than six million IU/mL

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

a. The recipient does not have cirrhosis; and

b. The recipient is treatment naïve; and

c. Medical records documenting pre-treatment HCV RNA less than six million IU/mL must be submitted; and

d. Prior authorization approval will be for eight weeks.

c. Genotype 1, treatment naïve, without cirrhosis and pre-treatment HCV RNA is greater than or equal to six million IU/mL

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient does not have cirrhosis; and

3. The recipient is treatment naïve; and

4. Medical records documenting pre-treatment HCV RNA greater than or equal to six million IU/mL must be submitted; and

5. Prior authorization approval will be for 12 weeks.

d. Genotype 1, treatment naïve with compensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. Submission of medical records (e.g., chart notes, laboratory values) documenting that the recipient has cirrhosis; and

3. The recipient is treatment naïve; and

4. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

5. Prior authorization approval will be for 12 weeks.

e. Genotype 1, treatment experienced without cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient does not have cirrhosis; and

3. One of the following:

a. The recipient has experienced treatment failure with a previous treatment regimen that included peginterferon plus Ribavirin or an HCV protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) plus peginterferon plus Ribavirin; or

b. Both of the following:

1. The recipient has experienced treatment failure with a previous treatment regimen that included Sovaldi® (sofosbuvir) except in combination with Olysio® (simeprevir); and

2. The medication is used in combination with Ribavirin.

4. Prior authorization approval will be for 12 weeks.

f. Genotype 1, Ribavirin eligible, treatment experienced and with compensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. Submission of medical records (e.g., chart notes, laboratory values) documenting that the recipient has cirrhosis; and

3. The recipient has experienced treatment failure with a previous treatment regimen that included peginterferon plus Ribavirin or an HCV protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) plus peginterferon plus Ribavirin; and

4. The medication is used in combination with Ribavirin; and

5. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

6. Prior authorization approval will be for 12 weeks.

g. Genotype 1, Ribavirin ineligible, treatment experienced and with compensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. Submission of medical records (e.g., chart notes, laboratory values) documenting that the recipient has cirrhosis; and

3. The recipient has experienced treatment failure with a previous treatment regimen that included peginterferon plus Ribavirin or an HCV protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) plus peginterferon plus Ribavirin; and

4. The recipient is Ribavirin ineligible; and

5. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

6. Prior authorization approval will be for 24 weeks.

h. Genotype 1, 4, 5 or 6, decompensated cirrhosis or post-liver transplant

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. One of the following:

a. Submission of medical records (e.g., chart notes, laboratory values) documenting that the recipient has decompensated cirrhosis (e.g., Child-Pugh class B or C); or

b. Both of the following:

1. The recipient is a liver transplant recipient; and

2. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

3. The medication is used in combination with Ribavirin; and

4. Prior authorization approval will be for 12 weeks.

i. Genotype 1,4, 5, or 6, decompensated cirrhosis, Ribavirin ineligible or prior failure of Sovaldi® or NS5A based regimen

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. Submission of medical records (e.g., chart notes, laboratory values) documenting that the recipient has decompensated cirrhosis (e.g., Child-Pugh class B or C); and

3. One of the following:

   a. The recipient is Ribavirin ineligible; or

   b. Both of the following:

      1. The recipient has experienced treatment failure with a previous treatment regimen that included Sovaldi® (sofosbuvir) or an NS5A inhibitor (e.g., Daklinza® (daclatasvir)); and

      2. The medication is used in combination with Ribavirin; and

4. Prior authorization approval will be for 24 weeks.

j. Genotype 4, treatment naïve or treatment experienced (peginterferon plus Ribavirin)

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 4 (submission of medical records e.g., chart notes, laboratory values); and

2. One of the following:

   a. The recipient is treatment naïve; or

   b. One of the following:

      1. The recipient has experienced failure with a previous treatment regimen that included peginterferon plus Ribavirin and is without cirrhosis; or

      2. Both of the following:

         a. The recipient has experienced failure with a previous treatment regimen that included peginterferon plus Ribavirin and has compensated cirrhosis (Child-Pugh class A); and

         b. The medication is used in combination with Ribavirin.

3. Prior authorization approval will be for 12 weeks.

k. Genotype 5 or 6, treatment naïve or treatment experienced (peginterferon plus Ribavirin)

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. One of the following:

a. The recipient is treatment naïve; or

b. The recipient has experienced failure with a previous treatment regimen that included peginterferon plus Ribavirin; and

3. Prior authorization approval will be for 12 weeks.

3. Mavyret® (glecaprevir/pibrentasvir)

a. Approval will be given if the following criteria are met and documented:

1. The recipient is not receiving Mavyret® in combination with another HCV direct acting antiviral agent (e.g., Harvoni® (ledipasvir/sofosbuvir), Zepatier® (elbasvir/grazoprevir)); and

2. The medication must be prescribed by or in consultation with one of the following:

a. Hepatologist

b. Gastroenterologist

c. Infectious Disease Specialist

d. HIV Specialist (certified through the American Academy of HIV Medicine)

b. Genotype 1, 2, 3, 4, 5 or 6, treatment naïve without cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient is treatment naïve; and

3. The recipient is without cirrhosis; and

4. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

5. Prior authorization approval will be for 12 weeks.

c. Genotype 1, 2, 3, 4, 5 or 6, treatment naïve with compensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient is treatment naïve; and

3. The recipient has compensated cirrhosis (Child-Pugh class A); and

4. Prior authorization approval will be for eight weeks.

d. Genotype 1, treatment experienced (prior failure to an NS3/4A protease inhibitor), without decompensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has experienced failure with a previous treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)); and

3. The recipient has had no previous treatment experience with a treatment regimen that included an NS5A inhibitor (e.g., Daklinza® (daclatasvir)); and

4. The recipient is without decompensated cirrhosis (Child-Pugh class B or C); and

5. Prior authorization approval will be for 12 weeks.

e. Genotype 1, treatment experienced (prior failure to an NS5A inhibitor), without decompensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has experienced failure with a previous treatment regimen that included an NS5A inhibitor (e.g., Daklinza® (daclatasvir)); and

3. The recipient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)); and

4. The recipient is without decompensated cirrhosis (Child-Pugh class B or C); and

5. Prior authorization approval will be for 16 weeks.

f. Genotype 3, treatment experienced (interferon or Sovaldi® based regimen), without decompensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 3 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has experienced failure with a previous treatment regimen that included interferon, peginterferon, Ribavirin, and/or Sovaldi® (sofosbuvir); and

3. The recipient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (e.g., Daklinza® (daclatasvir)); and

4. The recipient is without decompensated cirrhosis (Child-Pugh class B or C); and

5. Prior authorization approval will be for 16 weeks.

g. Genotype 1, 2, 4, 5 or 6, treatment experienced (interferon or Sovaldi® based regimen), without cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 2, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has experienced failure with a previous treatment regimen that included interferon, peginterferon, Ribavirin, and/or Sovaldi® (sofosbuvir); and

3. The recipient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (e.g., Daklinza® (daclatasvir)); and

4. The recipient is without cirrhosis; and

5. Prior authorization approval will be for eight weeks.

h. Genotype 1, 2, 4, 5 or 6, treatment experienced (interferon or Sovaldi® based regimen), with compensated cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 2, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has experienced failure with a previous treatment regimen that included interferon, peginterferon, Ribavirin, and/or Sovaldi® (sofosbuvir); and

3. The recipient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (e.g., Daklinza® (daclatasvir)); and

4. The recipient has compensated cirrhosis (e.g., Child-Pugh class A); and

5. Prior authorization approval will be for 12 weeks.

4. Sovaldi® (sofosbuvir)

a. Approval will be given if the following criteria are met and documented:

1. The medication must be prescribed by or in consultation with one of the following:

a. Hepatologist

b. Gastroenterologist

c. Infectious Disease Specialist

d. HIV Specialist (certified through the American Academy of HIV Medicine)

b. Genotype 1 or 4, without decompensated liver disease

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 or 4 (submission of medical records e.g., chart notes, laboratory values); and

2. The medication is used in combination with peginterferon alfa and Ribavirin; and

3. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

4. The recipient has not experienced failure with a previous treatment regimen that includes Sovaldi®; and

5. Prior authorization approval will be for 12 weeks.

c. Genotype 3, without decompensated liver disease

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 3 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient must be 18 years of age or older; or

3. Both of the following:

a. The recipient has a documented diagnosis of chronic hepatitis C virus (HCV) genotype 3 (submission of medical records e.g., chart notes, laboratory values); and

b. The recipient is 12 to 17 years of age; or both of the following:

1. The recipient weighs at least 35 kg; and

2. The recipient is less than 12 years of age; and

4. The medication is used in combination with Ribavirin; and

5. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

6. The recipient has not experienced failure with a previous treatment regimen that includes Sovaldi®; and

7. Prior authorization approval will be for 24 weeks.

d. Genotype 2, without decompensated liver disease

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 2 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient must be 18 years of age or older; or

3. Both of the following:

a. The recipient has a documented diagnosis of chronic hepatitis C genotype 2 (submission of medical records e.g., chart notes, laboratory values); and

b. The recipient is 12 to 17 years of age; or both of the following:

1. The recipient weighs at least 35 kg; and

2. The recipient is less than 12 years of age; and

4. The medication is used in combination with Ribavirin; and

5. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

6. The recipient has not experienced failure with a previous treatment regimen that includes Sovaldi®; and

7. Prior authorization approval will be for 12 weeks.

e. Genotype 1, without cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The medication is used in combination with Olysio® (simeprevir); and

3. The recipient is without cirrhosis; and

4. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

5. The recipient has not experienced failure with a previous treatment regimen that includes Olysio® or other HCV NS3/4A protease inhibitors (e.g., Incivek® (telaprevir), Victrelis® (boceprevir)); and

6. Prior authorization approval will be for 12 weeks.

f. Genotype 1, with cirrhosis

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The medication is used in combination with Olysio® (simeprevir); and

3. The recipient has cirrhosis; and

4. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

5. The recipient has not experienced failure with a previous treatment regimen that includes Olysio® or other HCV NS3/4A protease inhibitors (e.g., Incivek® (telaprevir), Victrelis® (boceprevir)); and

6. Prior authorization approval will be for 12 weeks.

g. Genotype 1

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1 (submission of medical records e.g., chart notes, laboratory values); and

2. The medication is used in combination with Daklinza® (daclatasvir); and

3. The recipient has not experienced failure with a previous HCV NS5A treatment regimen (e.g., Daklinza® (daclatasvir)); and

4. One of the following:

a. The recipient is without decompensated cirrhosis and is not a liver transplant recipient; or

b. Both of the following:

1. The recipient has decompensated cirrhosis and/or is a liver transplant recipient; and

2. The medication is used in combination with Ribavirin.

5. Prior authorization approval will be for 12 weeks.

h. Genotype 3

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 3 (submission of medical records e.g., chart notes, laboratory values); and

2. The medication is used in combination with Daklinza® (daclatasvir); and

3. The recipient has not experienced failure with a previous HCV NS5A treatment regimen (e.g., Daklinza® (daclatasvir)); and

4. One of the following:

a. The recipient is without cirrhosis and is not a liver transplant recipient; or

b. Both of the following:

1. The recipient has cirrhosis (compensated or decompensated) and/or is a liver transplant recipient; and

2. The medication is used in combination with Ribavirin.

5. Prior authorization approval will be for 12 weeks.

5. Viekira Pak® (ombitasvir, paritaprevir, ritonavir tablets, dasabuvir tablets)

a. Genotype 1a or Mixed Genotype 1 Infection without Cirrhosis and without Liver Transplant

1. Approval will be given if all criteria are met and documented:

a. Submission of medical records (e.g., chart notes, laboratory values) documenting the recipient's diagnosis of chronic hepatitis C genotype 1a or mixed genotype 1 infection; and

b. The recipient is without cirrhosis; and

c. The medication is used in combination with ribavirin; and

d. The recipient is without decompensated liver disease (e.g., Child-Pugh Class B or C); and

e. The medication is prescribed by or in consultation with one of the following:

1. Hepatologist

2. Gastroenterologist

3. Infectious disease specialist

4. HIV specialist certified through the American Academy of HIV Medicine; and

f. The recipient has not experienced failure with a previous treatment regimen that includes a HCVNS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (Daklinza® (daclatasvir).

2. Prior Authorization Guidelines:

a. Prior authorization will be for 12 weeks.

b. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

b. Genotype 1a or Mixed Genotype Infection with Cirrhosis and without Liver Transplant

1. Approval will be given if all criteria are met and documented:

a. Submission of medical records (e.g., chart notes, laboratory values) documenting the recipient's diagnosis of chronic hepatitis C genotype 1a or mixed genotype 1 infection; and

b. Submission of medical records (e.g., chart notes, laboratory values) documenting the recipient has cirrhosis; and

c. The medication is being used in combination with ribavirin; and

d. The recipient is without decompensated liver disease (e.g., Child-Pugh Class B or C); and

e. The medication is prescribed by or in consultation with one of the following:

1. Hematologist

2. Gastroenterologist

3. Infectious Disease Specialist

4. HIV Specialist Certified through the Academy of HIV Medicine; and

f. The recipient has not experienced failure with a previous treatment regimen that includes a HCVNS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (Daklinza® (daclatasvir)); and

g. The recipient is not receiving Viekira® in combination with another HCV direct acting antiviral agent (e.g., Harvoni® (ledipasvir/sofosbuvir), Sovaldi® (sofosbuvir).

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 24 weeks.

b. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

c. Genotype 1b without Liver Transplant

1. Approval will be given if all criteria are met and documented:

a. Submission of medical records (e.g., chart notes, laboratory values) documenting the recipient's diagnosis of chronic hepatitis C genotype 1b; and

b. The recipient is without decompensated liver disease (e.g., Child-Pugh Class B or C); and

c. The medication is prescribed by or in consultation with one of the following:

1. Hepatologist

2. Gastroenterologist

3. Infectious Disease Specialist

4. HIV Specialist Certified through the Academy of HIV Medicine; and

d. The recipient has not experienced failure with a previous treatment regimen that includes a HCVNS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (Daklinza® (daclatasvir)); and

e. The recipient is not receiving Viekira® in combination with another HCV direct acting antiviral agent (e.g., Harvoni® (ledipasvir/sofosbuvir), Sovaldi® (sofosbuvir).

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 12 weeks.

b. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

d. Genotype 1 (Regardless of Sub genotype) – Liver Transplant Recipient

1. Approval will be given if all criteria are met and documented:

a. Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C genotype 1; and

b. Documentation confirming the recipient is a liver transplant recipient; and

c. Submission of medical records (e.g., chart notes or laboratory values) documenting the recipient's normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2); and

d. The medication is used in combination with ribavirin; and

e. Prescribed by or in consultation with one of the following:

1. Hepatologist

2. Gastroenterologist

3. infectious disease specialist

4. HIV specialist certified through the American Academy of HIV Medicine; and

f. The recipient has not experienced failure with a previous treatment regimen that includes a HCVNS3/4A protease inhibitor (e.g., Incivek® (telaprevir), Olysio® (simeprevir), Victrelis® (boceprevir)) or an NS5A inhibitor (Daklinza® (daclatasvir)); and

g. The recipient is not receiving Viekira® in combination with another HCV direct acting antiviral agent (e.g., Harvoni® (ledipasvir/sofosbuvir), Sovaldi® (sofosbuvir).

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 24 weeks.

b. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

6. Vosevi® (sofosbuvir/velpatasvir/voxilaprevir)

a. Approval will be given if all criteria are met and documented:

1. The recipient is without decompensated liver disease (e.g., Child-Pugh class B or C); and

2. The recipient is not receiving Vosevi® in combination with another HCV direct acting antiviral agent (e.g., Harvoni® (ledipasvir), Zepatier® (elbasvir/grazoprevir)); and

3. The medication must be prescribed by or in consultation with one of the following:

a. Hepatologist

b. Gastroenterologist

c. Infectious Disease Specialist

d. HIV Specialist (certified through the American Academy of HIV Medicine)

b. Genotype 1, 2, 3, 4, 5 or 6; without decompensated cirrhosis, prior relapse to NS5A based regimen

1. Approval will be given if all criteria are met and documented:

   a. The recipient has a documented diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5 or 6 (submission of medical records e.g., chart notes, laboratory values); and

   b. The recipient is a previous relapse to an NS5A based regimen (e.g., Daklinza® (daclatasvir), Epclusa® (ledipasvir/sofosbuvir), Mavyret® (glecaprevir/pibrentasvir), Technivie® (ombitasvir/ paritaprevir/ ritonavir), Viekira® (ombitasvir/ paritaprevir/ ritonavir/dasabuvir), Zepatier® (elbasvir/grazoprevir); and

   c. Submission of medical records (e.g., chart notes or laboratory values) documenting normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2); and

2. Prior Authorization Guidelines:

   1. Prior authorization approval will be for 12 weeks.

3. Genotype 1a, without decompensated cirrhosis, prior relapse to sofosbuvir based regimen without an NS5A inhibitor

   a. Approval will be given if all criteria are met and documented:

      1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1a (submission of medical records e.g., chart notes, laboratory values); and

      2. The recipient is a previous relapser to a sofosbuvir based regimen without an NS5A inhibitor; and

   b. Prior Authorization Guidelines:

      1. Prior authorization approval will be for 12 weeks.

      2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

4. Genotype 3, without decompensated cirrhosis, prior relapse to sofosbuvir based regimen without an NS5A inhibitor

   a. Approval will be given if all criteria are met and documented:

      1. The recipient has a documented diagnosis of chronic hepatitis C genotype 3 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient is a previous relapser to a sofosbuvir based regimen without an NS5A inhibitor; and

b. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 weeks.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

7. Zepatier® (elbasvir/grazoprevir)

a. Approval will be given if all criteria are met and documented:

1. The recipient does not have moderate to severe hepatic impairment (e.g., Child-Pugh class B or C); and

2. The recipient is not receiving Zepatier® in combination with another HCV direct acting antiviral agent (e.g., Sovaldi® (sofosbuvir), Olysio® (simeprevir)); and

3. The medication must be prescribed by or in consultation with one of the following:

a. Hepatologist

b. Gastroenterologist

c. Infectious Disease Specialist

d. HIV Specialist (certified through the American Academy of HIV Medicine)

b. Genotype 1a, treatment naïve, or PegIFN/RBV experienced, or PegIFN/RBV/protease inhibitor experienced, without NS5A polymorphisms

1. Approval will be given if all criterias are met and documented:

a. The recipient has a documented diagnosis of chronic hepatitis C genotype 1a (submission of medical records e.g., chart notes, laboratory values); and

b. One of the following:

1. The recipient is treatment naïve; or

2. The recipient has had prior failure to peginterferon alfa plus Ribavirin treatment; or

3. The recipient has had prior failure to treatment with peginterferon alfa plus Ribavirin plus an HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir or telaprevir); and

c. Both of the following:

1. The recipient has been tested for the presence of NS5A resistance associated polymorphisms; and

2. The recipient has baseline NS5A resistance associated polymorphisms (e.g., polymorphisms at amino acid positions 28, 30, 31, or 93); and

d. The medication is used in combination with Ribavirin; and

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 16 weeks.

b. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Genotype 1b, treatment naïve, or PegIFN/RBV experienced, or PegIFN/RBV/protease inhibitor experienced

a. Approval will be given if all criteria are met and documented:

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 1b (submission of medical records e.g., chart notes, laboratory values); and

2. One of the following:

a. The recipient is treatment naïve; or

b. The recipient has had prior failure to peginterferon alfa plus Ribavirin treatment; or

c. Both of the following:

1. The recipient has had prior failure to treatment with peginterferon alfa plus Ribavirin plus an HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir or telaprevir); and
2. The medication is used in combination with Ribavirin; and

b. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 weeks.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

4. Genotype 4, treatment naïve

a. Approval will be given if all criteria are met and documented:

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 4 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient is treatment naïve; and

b. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 weeks.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

5. Genotype 4, PegIFN/RBV experienced

a. Approval will be given if all criteria are met and documented:

1. The recipient has a documented diagnosis of chronic hepatitis C genotype 4 (submission of medical records e.g., chart notes, laboratory values); and

2. The recipient has had prior failure to peginterferon alfa plus Ribavirin; and

3. The medication is used in combination with Ribavirin; and

b. Prior Authorization Guidelines:

1. Prior authorization approval will be for 16 weeks.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

II. Daliresp® (roflumilast)

Therapeutic Class: Phosphodiesterase-4 Inhibitors.
Last Reviewed by the DUR Board: October 17, 2019

Daliresp® (roflumilast) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. The recipient has experienced an inadequate response, adverse event or has a contraindication to a long-acting anticholinergic agent;

b. The recipient has experienced an inadequate response, adverse event or has a contraindication to a long-acting beta (β) agonist;

c. The recipient has experienced an inadequate response, adverse event or has a contraindication to an inhaled corticosteroid;

d. The recipient has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD); and

e. The recipient has a history of COPD exacerbations.

2. Contraindication

a. Daliresp (roflumilast) may not be approved for a recipient with a diagnosis of moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment.

3. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

JJ. Hereditary Angioedema Agents

Therapeutic Class: Hereditary Angioedema Agents
Last Reviewed by DUR Board: April 22, 2021

Hereditary Angioedema (HAE) agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Cinryze® (C1 esterase inhibitor), Haegarda® (C1 estarase inhibitor), Orladeyo® (berotralstat) or Takhzyro® (ianadelumab-flyo)

   a. Approval will be given if all the following criteria are met and documented:

      1. The recipient has a diagnosis of HAE; and

      2. The recipient's diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:

         a. C1-INh antigenic level below the lower limit of normal; or

         b. C1-INh functional level below the lower limit of normal; and

            1. The medication is being prescribed by or in consultation with an allergist or immunologist.

      3. The medication is being used as prophylaxis against attacks; and

   b. Prior Authorization Guidelines:

      1. Prior authorization approval will be approved for 12 months.

      2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

2. Cinryze® (C1 esterase inhibitor) *, Firazyr® (icatibant), Ruconest® (C1 esterase inhibitor)

   Note: * off label use

   4. Approval will be given if all the following criteria are met and documented:

      1. The recipient has a diagnosis of HAE; and

      2. The recipient's diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:

         a. C1-INh antigenic level below the lower limit of normal; or

b. C1-INh functional level below the lower limit of normal; and

3. The medication is being used for the treatment of acute HAE attacks; and

4. The medication is not used in combination with other approved treatment for acute HAE attacks; and

5. The medication is prescribed by or in consultation with an allergist or immunologist.

b. Prior Authorization Guidelines:

1. Prior authorization approval will be approved for 12 months.

2. Prior authorization forms are available https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

3. Kalbitor® (ecallantide)

a. Approval will be given if all the following criteria are met and documented:

1. The recipient has a diagnosis of HAE; and

2. The recipient's diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:

a. C1-INh antigenic level below the lower limit of normal; or

b. C1-INh functional level below the lower limit of normal; and

3. The medication is being used for the treatment of acute HAE attacks; and

4. The recipient is 12 years of age or older; and

5. The medication is not used in combination with other approved treatments for acute HAE attacks; and

6. The medication is prescribed by or in consultation with an allergist or immunologist.

b. Prior Authorization Guidelines:

1. Prior authorization approval will be approved for 12 months.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

4. Berinert® (C1 esterase inhibitor)

a. Approval will be given if all the following criteria are met and documented:

1. The recipient has a diagnosis HAE; and

2. The recipient's diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by one of the following:

a. C1-INh antigenic level below the lower limit of normal; or

b. C1-INh functional level below the lower limit of normal; and

3. The medication is not used in combination with other approved treatments for acute HAE attacks; and

4. The medication is being prescribed by or in consultation with an allergist or immunologist; and

5. The medication is being used to treat acute HAEattacks and

6. One of the following:

a. The recipient has trial and failure, contraindication, or intolerance to Ruconest®; or

b. The recipient is 12 year of age or younger and there is documentation that the recipient has history of laryngeal attacks.

b. Prior Authorization Guidelines:

1. Prior authorization approval will be approved for 12 months.

2. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

KK. Incretin Mimetics

Therapeutic Class: Incretin Mimetics
Last Reviewed by the DUR Board: January 26, 2017
Previously reviewed by the DUR Board: July 26, 2012

Incretin Mimetics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   a. An ICD code for Type 2 Diabetes Mellitus is documented on the prescription and transmitted on the claim; or

   b. A prior authorization documenting a diagnosis of Type 2 Diabetes Mellitus has been submitted.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

LL. Cystic Fibrosis Agents

Therapeutic Class: Cystic Fibrosis Agents
Last Reviewed by the DUR Board: January 27, 2022

Cystic Fibrosis (CF) Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given for a single agent concomitantly if the following criteria are met and documented:

   a. Kalydeco® (ivacaftor)

      1. Approval will be given if the following criteria are met and documented:

         a. The recipient is age appropriate according to the FDA-approved package labeling; and

         b. The recipient has a diagnosis of CF; and

         c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the gene mutations listed in the FDA-approved package insert; and

         d. The medication is prescribed by or in consultation with a pulmonologist or a specialist affiliated with a CF care center.

      2. Recertification Request (the recipient must meet all the following criteria)

         a. Documentation of a positive clinical response to Kalydeco® therapy.

      3. Prior Authorization Guidelines:

         a. Initial request will be approved for 12 months.

         b. Recertification request will be for 12 months.

         c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

   b. Orkambi® (lumacaftor/ivacaftor)

      1. Approval will be given if the following criteria are met and documented:

         a. The recipient has a diagnosis of CF; and

b. The recipient is age appropriate according to the FDA-approved package labeling; and

c. The recipient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene; and

d. The requested dose is two tablets every 12 hours; or

e. The requested dose is one tablet every 12 hours in the presence of severe hepatic impairment.

2. Prior Authorization Guidelines:

a. Prior authorization approvals will be for one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

c. Symdeko® (tezacaftor/ivacaftor)

1. Approval will be given if the following criteria are met and documented:

a. Initial Request:

1. The recipient is age appropriate according to the FDA-approved package labeling; and

2. The recipient has a documented diagnosis of CF; and

3. The medication must be prescribed by or in consultation either a Pulmonolist or a specialist associated with a CF care center.

4. One of the following:

a. The recipient is homozygous for the F508del mutation as detected by an FDA cleared CF mutation test or Clinical Laboratory Improvement Amendments (CLIA) approved facility; or

b. The recipient has one of the FDA approved package insert listed mutations on at least one allele in the (CFTR) gene as detected by FDA cleared CF mutation test or CLIA approved facility.

b. Recertification Request (the recipient must meet the following criteria):

1. Documentation of a positive clinical response to Symdeko® (tezacaftor/ivacaftor) therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations).

2. Prior Authorization Guidelines:

a. Initial request will be approved for 12 months.

b. Recertification request will be approved for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

d. Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor)

1. Approval will be given if the following criteria are met and documented:

a. The recipient is age appropriate according to the FDA-approved package labeling; and

b. The recipient has a documented diagnosis of CF; and

c. The recipient has at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data as detected by an FDA cleared CF mutation test, or a test performed at a CLIA approved facility; and

d. The medication is prescribed by or in consultation with either a Pulmonologist or a specialist affiliated with a CF care center.

2. Recertification Request:

a. The recipient must have documentation of a positive clinical response to Trikafta® therapy (e.g. improvement in lung function [percent predicted forced expiratory volume in one second {PPFEV1}] or decreased number of pulmonary exacerbations)

3. Prior Authorization Guidelines:

a. Initial request will be approved for 12 months.

b. Recertification request will be approved for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

MM. Gimoti® (metoclopramide)

Therapeutic Class: Gastrointestinal Prokinetic Agents
Last Reviewed by the DUR Board: October 26, 2021
Gastrointestinal Prokinetic Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if all the following criteria are met and documented:

    a. The recipient has a diagnosis of acute diabetic gastroparesis; and

    b. The recipient is 18 years of age or older; and

    c. The recipient does not have any of the following:

        1. History of signs or symptoms of tardive dyskinesia (TD); or

        2. History of a dystonic reaction to metoclopramide; or

        3. Known or suspected circumstances where stimulation of gastrointestinal (GI) motility could be dangerous (e.g., GI hemorrhage, mechanical obstruction, or perforation); or

        4. Known or suspected pheochromocytoma or other catecholamine-releasing paraganglioma; or

        5. Diagnosis of epilepsy or any other seizure disorder; or

        6. Hypersensitivity to metoclopramide (e.g., angioedema, bronchospasm); or

        7. Moderate or severe renal impairment (creatinine clearance [CrCl] < 60 mL/minute); or

        8. Moderate or severe hepatic impairment (Child-Pugh B or C); and

    d. One of the following:

        1. The recipient has had an adequate (e.g., 2-4 week) trial and failure of oral (e.g., tablet, solution, orally disintegrating tablet) or injectable (e.g., intramuscular) metoclopramide; or

        2. The recipient is NOT a candidate for oral metoclopramide (e.g., demonstrated or documented erratic absorption of oral medications)

2. Recertification Request:

    a. Recipient continues to meet all initial authorization criteria; and

b. At least 2 weeks have passed (i.e., drug holiday) since completion of a previous course or metoclopramide treatment of any dosage form; and

c. Recipient demonstrated improvement in signs and symptoms of diabetic gastroparesis (e.g., nausea, vomiting, early satiety, postprandial fullness, bloating, upper abdominal pain); and

d. Prescriber attestation that the patient is being monitored for extrapyramidal symptoms (e.g., tardive dyskinesia, dystonia) or other serious adverse events (e.g., suicidal ideation, fluid retention)

3. Prior Authorization Guidelines:

a. Prior Authorization approval will be for two months

b. Recertification requests will be approved for two months

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

NN. Platelet Inhibitors

Therapeutic Class: Platelet Inhibitors
Last Reviewed by the DUR Board: April 22, 2021

Platelet Inhibitors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Authorization will be given if the following criteria are met and documented:

   a. Brilinta® (ticagrelor)

      1. The recipient has a diagnosis of Acute Coronary Syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction); and

      2. The recipient does not have an active pathological bleed or history of intracranial hemorrhage; and

      3. The recipient will be receiving concomitant treatment with aspirin in a dose of less than 100 mg/daily; and

      4. One of the following:

         a. The recipient has been started and stabilized on the requested medication; or

         b. The recipient has experienced an adverse event with or has an allergy or contraindication to clopidogrel; or

         c. Another clinically appropriate rationale is provided for why clopidogrel cannot be used.

   b. Effient® (prasugrel)

      1. The recipient has a diagnosis of ACS (unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction); and

      2. The recipient does not have an active pathological bleed or history of transient ischemic attack or cerebral vascular accident (CVA); and

      3. The recipient will be receiving concomitant treatment with aspirin in a dose of less than 100 mg/daily; and

      4. The recipient has a history of percutaneous coronary intervention; and

5. One of the following:

   a. The recipient has been started and stabilized on the requested medication; or

   b. The recipient has experienced an adverse event with or has an allergy or contraindication to clopidogrel; or

   c. Another clinically appropriate rationale is provided for why clopidogrel cannot be used.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for 12 months.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

OO. Osteoporosis Agents

Therapeutic Class: Bone Resorption Inhibitors (Osteoporosis Agents)
Last Reviewed by DUR Board: January 19, 2023

Osteoporosis agents are subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board.

1. Coverage and Limitations

a. Evenity® (romosozumab-aqqg)

1. Approval will be given if all criteria are met and documented:

a. The recipient has a diagnosis of postmenopausal osteoporosis or osteopenia; and

b. One of the following:

1. Both the following:

a. The recipient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site); and

b. One of the following:

1. The recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm; or

2. The recipient has documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]); or

c. Both the following:

1. The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site); and

2. One of the following:

a. The recipient has a documented history of low-trauma fracture of the

hip, spine, proximal humerus, pelvis, or distal forearm; or

b. Both the following:

1. The recipient has a documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]); and

2. One of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

a. The recipient has a major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions.

b. The recipient has a hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions; and

c. The recipient has a documented trial and failure, contraindication, or intolerance to one of the following:

1. Forteo® (teriparatide)

2. Tymlos® (abaoparatide); and

d. Treatment duration of Evenity® (romosozumab-aqqg) has not exceeded a total of 12 months during the recipient's lifetime.

2. Prior Authorization Guidelines:

a. Prior authorization approval will be given for 12 months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

b. Prolia® (denosumab)

1. Criteria for Physician Administered Drugs (PAD)

a. Approval will be given if the following criteria are met and documented:

1. Recipient must be supplementing with 1,000 mg of calcium and at least 400 IU of vitamin D daily; and

2. Recipient must not have hypocalcemia; and

3. Coverage is provided in the following conditions:

a. Recipient is at least 18 years of age; and

b. Recipient must be at a high risk for fracture; and

c. Pregnancy ruled out prior to starting therapy in women of childbearing potential; and

2. For bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer.

a. Approval will be given if all criteria is met and documented:

1. The recipient has a diagnosis of nonmetastatic prostate cancer; and

2. The recipient is undergoing androgen deprivation therapy with one of the following:

a. Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar® (triptorelin), Vantas (histrelin), and Zoladex® (goserelin)]; or

b. Bilateral orchiectomy (i.e., surgical castration); and

3. One of the following:

a. The recipient is 70 years of age or older; or

b. Both the following:

1. The recipient is less than 70 years of age; and

a. One of the following:

1. BMD scan T-score is less than -1.0 (1.0 standard deviation or greater below the mean for young adults); or

2. Documented history of one of the following resulting from minimal trauma:

a. Vertebral compression fracture

b. Fracture of the hip

c. Fracture of the distal radius

d. Fracture of the pelvis

e. Fracture of the proximal numerous; and

b. Recertification Request (the recipient must meet all criteria):

1. The recipient is undergoing androgen depravation therapy with one of the following:

a. Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar® (triptorelin), Vantas® (histrelin), and Zoladex® (goserelin)]; or

b. Bilateral orchiectomy (i.e., surgical castration); and

2. The recipient has no evidence of metastases; and

3. Documentation that the recipient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.)

c. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 months.

2. Recertification approval will be for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer.

a. Approval will be given if all criteria is met and documented:

1. The recipient has a diagnosis of breast cancer; and

2. The recipient is receiving adjuvant aromatase inhibitor therapy (e.g., Arimidex® [anastrozole], Aromasin® [exemestane], Femara® [letrozole]); and

3. One of the following:

a. The recipient's BMD scan T-score is less than -1.0 (1.0 standard deviation or greater below the mean for young adults); or

b. Documented history of one of the following resulting from minimal trauma:

1. Vertebral compression fracture

2. Fracture of the hip

3. Fracture of the distal radius

4. Fracture of the pelvis

5. Fracture of the proximal humerous; and

4. The recipient has a documented trial and failure, intolerance, or contraindication to one bisphosphonate (e.g. alendronate)

b. Recertification Request (recipient must meet all criteria):

1. The recipient is receiving adjuvant aromatase inhibitor therapy (e.g., Arimidex® [anastrozole], Aromasin® [exemestane], Femara® [letrozole]); and

2. Documentation that the recipient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.)

c. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 months.

2. Recertification approval will be for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

4. For Postmenopausal Osteoporosis or Osteopenia

a. Criteria for Physician Administered Drugs (PAD)

1. Approval will be given if the following criteria are met and documented:

a. Recipient must be a woman; and

b. Recipient has a documented diagnosis of osteoporosis indicated by one or more of the following:

1. Hip/femur DXA (femoral neck or total hip) or lumbar spine T-score less than or equal to negative two and a half and/or forearm DXA at the 33% (one-third) radius site; or

2. T-score less than or equal to negative one or low bone mass and a history of fragility fracture to the hip or spine; or

3. T-score between negative one and negative two and a half with a FRAX 10-year probability for major fracture greater than or equal to 20% or hip fracture greater than or equal to 3%; and

c. Documented treatment failure or ineffective response to a minimum (12) month trial on previous therapy with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid; or

d. Recipient has a documented contraindication or intolerance to both oral bisphosphonates and intravenous (IV) bisphosphonates such as alendronate, risedronate, ibandronate, or zoledronic acid.

b. Recertification Request:

1. Documentation that indicates the recipient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.) without significant adverse effects.

c. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 months.

2. Recertification approval will be for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

5. Glucocorticoid-Induced Osteoporosis

a. Criteria for Physician Administered Drugs (PAD):

1. Approval will be given if all criteria are met and documented:

a. Recipient will be initiating or is continuing systemic glucocorticoid therapy at a daily dosage equivalent to greater than or equal to 7.5 mg of prednisone and is expected to remain on glucocorticoid therapy for at least six months; and

b. Documented treatment failure or ineffective response to a minimum (12) month trial on previous therapy with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid; or

c. Recipient has a documented contraindication or intolerance to both oral bisphosphonates and intravenous (IV) bisphosphonates such as alendronate, risedronate, ibandronate, or zoledronic acid.

6. Osteoporosis treatment and prevention in prostate cancer patients

a. Criteria for Physician Administered Drugs (PAD)

1. Approval will be given if the following criteria are met and documented:

a. Documented Hip DXA (femoral neck or total hip) or lumbar spine T-score less than or equal to negative one (or recipient meets the diagnostic criteria for osteoporosis above); and

b. Recipient must be receiving androgen deprivation therapy for non-metastatic prostate cancer

7. Osteoporosis treatment and prevention in breast cancer patients

a. Criteria for Physician Administered Drugs (PAD)

1. Approval will be given if the following criteria are met and documented:

a. Recipient must be receiving adjuvant aromatase inhibitor therapy for breast cancer.

b. Recertification Request:

1. Documentation that the recipient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, improved biochemical markers, etc.) without significant adverse effects.

c. Prior Authorization Guidelines:

1. Prior authorization approval will be for 12 months.

2. Recertification request will be approved for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

c. Forteo® (teriparatide)

1. For Postmenopausal Osteoporosis or Osteopenia, or Men with Primary or Hypogonadal Osteoporosis or Osteopenia at High Risk for Fracture

a. Approval will be given if all criteria are met and documented:

1. The recipient has a diagnosis of postmenopausal osteoporosis or osteopenia, or primary or hypogonadal osteoporosis or osteopenia; and

2. One of the following:

a. Both the following:

1. The recipient has a BMD T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site); and

2. One of the following

a. The recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm; or

b. Documented trial and failure, contraindication intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]); or

b. Both the following:

1. The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site); and

2. One of the following:

a. Recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm; or

b. Both the following:

1. Recipient has a documented trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]); and

2. One of the following FRAX 10-year probabilities:

a. Major osteoporotic fracture at 20% or more in the U.S., or

the country-specific threshold in other countries or regions; or

b. Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions; and

3. Recipient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos® [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime.

2. For Glucocorticoid-Induced Osteoporosis at High Risk for Fracture

a. Approval will be given if all criteria are met and documented:

1. The recipient has a diagnosis of glucocorticoid-induced osteoporosis; and

2. The recipient has documented history of prednisone or its equivalent at a dose greater than or equal to 5 mg/day for greater than or equal to three months; and

3. One of the following:

a. BMD T-score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site); or

b. The recipient has one of the following FRAX 10-year probabilities:

1. Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions; or

2. Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions; or

c. The recipient has documented history of one of the following fractures resulting from minimal trauma:

1. Vertebral compression fracture

2. Fracture of the hip

3. Fracture of the distal radius

4. Fracture of the pelvis

5. Fracture of the proximal humerous; and

4. Documented trial and failure, contraindication, or intolerance to one bisphosphonate (e.g., alendronate); and

5. The recipient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos® [abaloparatide]) has not exceed a total of 24 months during the patient's lifetime.

3. Prior Authorization Guidelines:

a. Prior authorization approval will be for 24 months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

d. Tymlos® (abaloparatide)

1. Approval will be given if all criteria are met and documented:

a. The recipient has a diagnosis of postmenopausal osteoporosis or osteopenia; and

b. One of the following:

1. Both the following:

a. BMD T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site); and

b. One of the following:

1. Documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm; or

2. Documented trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]); or

2. Both the following:

a. Recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site); and

b. One of the following:

1. Recipient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm; or

2. Both the following:

a. Documented trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]); and

b. The recipient has one of the following FRAX 10-year probabilities:

1. Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions; or

2. Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions; and

c. Recipient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos® [abaloparatide]) has not exceeded a total of 24 months during their lifetime.

2. Prior Authorization Guidelines:

a. Prior authorization approval will be for 24 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

PP. Gonadotropin Releasing Hormone Receptor (GnRH) Antagonist and Combinations

Therapeutic Class: GnRH Antagonist and Combinations
Last Reviewed by DUR Board: October 22, 2020

GnRH Antagonist and Combinations are subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board.

1. Orilissa® (elagolix)

   a. Approval will be given if all criteria are met and documented:

      1. The recipient has a diagnosis of moderate to severe pain associated with endometriosis; and

      2. One of the following:

         a. The recipient has documented history of inadequate pain control response following a trial of at least three months or the recipient has documented history of intolerance or contraindication:

            1. Danazol; or

            2. Combination (estrogen/progesterone) oral contraceptive; or

            3. Progestins; or

         b. The recipient has had surgical ablation to prevent occurrence.

      3. For Orilissa® 200 mg request only, the treatment will not exceed six months.

   b. Recertification Request (All criteria must be met and documented):

      1. The recipient has documented improvement in pain associated with endometriosis improvement in dysmenorrhea and non-menstrual pelvic pain); and

      2. Treatment duration has not exceeded a total of 24 months; and

      3. The request is for Orilissa® 150 mg.

   c. Prior Authorization Guidelines:

      1. Prior authorization approval will be for six months.

      2. Recertification approval will be for six months.

      3. Prior Authorization forms are available at:

https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

2. Oriahnn® (elagolix, estradiol, and norethindrone)

a. Approval will be given if all criteria is met and documented:

1. The recipient has a diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids); and

2. One of the following:

a. The recipient has documented history of inadequate pain control response following a trial of at least three months or the recipient has documented history of intolerance or contraindication:

1. Danazol; or

2. Combination (estrogen/progesterone) oral contraceptive; or

3. Progestins; or

b. The recipient has had surgical ablation to prevent occurrence.

b. Recertification Request:

1. The recipient has documented improvement in menstrual bleeding; and

2. Treatment duration will not exceed a total of 24 months.

c. Prior Authorization Guidelines:

1. Prior authorization approval will be for six months.

2. Recertification approval will be for six months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

QQ. Spravato™ (esketamine)

Therapeutic Class: Miscellaneous Anti-Depressant
Last Reviewed by the DUR Board: July 25, 2019

Spravato™ (esketamine) is subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   a. Initial approval will be given if the following criteria are met and documented:

      1. The recipient is 18 years of age or older; and

      2. Recipient must have a diagnosis of treatment resistant depression as evidence of failure of two antidepressants; and

      3. Medication must be administered under the direct supervision of a healthcare provider with post-administration observation; and

      4. Treatment must be in conjunction with an oral antidepressant; and

      5. The medication must be prescribed by or in consultation with a psychiatrist; and

      6. The recipient must not have an aneurism or AV (arteriovenous**)** malformation.

   b. Approval will not be given for recipients who are currently pregnant or lactating and breastfeeding.

2. Recertification Request:

   a. In addition to the prior authorization criteria listed above (initial approval), the recipient must also have a positive clinical response to the medication treatment.

3. Prior Authorization Guidelines

   a. Initial prior authorization approval will be given for four weeks.

   b. Recertification authorization approval will be given for six months.

   c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

RR. Omontys® (peginesatide)

Therapeutic Class: Erythropoiesis Stimulating Agent (ESA)
Last Reviewed by DUR Board: October 25, 2012

Omontys® (peginesatide) is subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis of anemia secondary to chronic kidney disease;

   b. The recipient must be over 18 years of age;

   c. The recipient is receiving dialysis;

   d. Other causes for anemia have been evaluated and ruled out (e.g., iron, vitamin B12 or folate deficiencies);

   e. The recipient's hemoglobin level is <10 g/dL, (laboratory values from the previous 14 days must accompany the request); and

   f. The target hemoglobin level will not exceed 11 g/dL.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for one month.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

SS. Colony Stimulating Factors (POS Claims Only)

Therapeutic Class: Colony Stimulating Factors
Last Reviewed by the DUR Board: January 19, 2023

Colony Stimulating Factors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The requested agent is being used for an FDA-approved indication.

b. The requests for a diagnosis of nonmyeloid malignancy must meet one of the following criteria:

1. The recipient is receiving myelosuppressive anticancer drugs that are associated with a febrile neuropenia risk of ≥ 20%; or

2. The recipient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age > 65 years, absolute neutrophil count (ANC) < 100 cells/μL or the expected duration of neutropenia is > 10 days); or

3. The recipient has experienced a prior episode of febrile neutropenia and the requested drug will be used as secondary prophylaxis.

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one month.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

TT. Auvi-Q® (epinephrine injection device)

Therapeutic Class: Anaphylaxis-Self Injectable Epinephrine
Last Reviewed by the DUR Board: January 23, 2014

Auvi-Q® (Epinephrine Injection Device) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. The recipient or recipient's caregiver is unable to read or comprehend written directions.

2. Prior Authorization Guidelines

   a. Initial prior authorization approval will be for one year.

   b. Recertification approval will be for one year.

   c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

UU. Aduhelm® (aducanumab-avwa)

Therapeutic Class: Alzheimer's Disease Agents
Last Reviewed by DUR Board: October 26, 2021

Aduhelm® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

    a. Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

        1. Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, one the following;

            a. Diagnosis of mild cognitive impairment due to Alzheimer's disease; or

            b. Diagnosis of probable Alzheimer's disease dementia; and

        2. All of the following:

            a. Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4; and

            b. Repeatable Battery for the Assessment of Neuropsychological (RBANS) score less than or equal to 85; and

            c. Mini-Mental State Examination score of 24-30; or

            d. Montreal Cognitive Assessment (MoCA) of 17 or above; and

    b. Documentation of beta-amyloid protein disposition, as evidenced by one of the following:

        1. Positive amyloid positron emission tomography (PET) scan; or

        2. Both of the following:

            a. Attestation that the patient does not have access to amyloid PET scanning; and

            b. Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., AB42 level, AB42:AB40 ratio); and

c. All of the following:

1. Recipient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less); and

2. Recipient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment; and

3. Recipient had no history of relevant brain hemorrhage, bleeding disorder, and cerebrovascular abnormalities in last six months; and

d. A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment to rule out other causes (e.g., stroke, small vessel disease, tumor); and

e. Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting; and

f. The medication is prescribed by a neurologist, geriatrician, or geriatric psychiatrist, or other expert in the disease state.

2. Recertification Request:

a. Approval will be given if the following criteria are met and documented:

1. Submission of medical records (e.g., chart notes, laboratory values) documenting recipientis benefitting from therapy as defined by both of the following:

a. Based on the NIA-AA criteria, one of the following:

1. Recipient continues to have a diagnosis of mild cognitive impairment due to Alzheimer's disease; or

2. Recipient continues to have a diagnosis of probable disease dementia; and

b. All of the following;

1. CDR-G score of 0.5 of CDR-SB score of 0.5-4; and

2. RBANS score less than or equal to 85; and

3. Mini-Mental State Examination score of 24-30; and

2. Recipient has a follow-up brain MRI has been completed after the initiation of therapy to show one of the following:

    a. Both of the following:

        1. Less than ten new incident microhemorrhages; and

        2. Two or less focal areas of superficial siderosis; or

    b. If ten or more new incident microhemorrhages or greater than two focal areas of superficial siderosis are present then both of the following:

        1. Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances); and

        2. Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H); and

        3. The medication is prescribed by a neurologist, geriatrician, or geriatric psychiatrist.

3. Prior Authorization Guidelines

    a. Prior Authorization approval will be for six months.

    b. Recertification requests will be approved for six months.

    c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

VV. Medications for the Treatment of Acne

Therapeutic Class: Acne Agents
Last Reviewed by the DUR Board: July 24, 2014

Acne agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

No prior authorization necessary for recipients up to 21 years of age.

Approval will be given if the following criteria are met and documented:

a. The recipient is age 21 years of age or older; and

b. The recipient has a diagnosis of moderate to severe acne (Grade III or higher).

2. Prior Authorization Guidelines

a. Prior authorization approval will be for one year.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

WW. Functional Gastrointestinal Disorder Agents

Therapeutic Class: Chronic Idiopathic Constipation (CIC) Agents, Irritable-Bowel Syndrome Agents, Opioid-Induced Constipation Agents
Last Reviewed by the DUR Board: January 23, 2020

Functional Gastrointestinal Disorder Agents are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Chronic Idiopathic Constipation (CIC) Agents

   a. Approval will be given if all the following criteria are met and documented:

      1. The requested drug must be FDA approved for the recipient's age; and

      2. Must have a diagnosis of CIC; and

      3. Recipient has trial and failure, contraindication or intolerance to either lactulose or polyethylene glycol (Miralax); and

      4. Recipient has trial and failure, contraindication or intolerance to at least one stimulant laxative, such as sessosides (Ex-lax, Senokot), bisacodyl (Dulcolax) or cascara sagrada; and

      5. The maximum allowable dose for CIC indication are as follows:

         a. Linzess® (linaclotide): 145 mcg, once daily

         b. Amitiza® (lubiprostone): 24 mcg, twice daily

         c. Motegrity® (prucalopride): 2mg, once daily

         d. Trulance® (plecanatide): 2mg, once daily

   b. Prior Authorization Guidelines

      1. Prior authorization approval will be for one year.

      2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

2. Irritable-Bowel Syndrome Agents

   a. Coverage and Limitations

      1. Approval will be given if the following criteria are met and documented:

         a. The recipient is 18 years of age or older; and

b. The requested agent is being prescribed based on FDA approved guidelines; and

1. For requests for a diagnosis of Irritable-Bowel Syndrome with Constipation (IBS-C):

a. For requests for Amitiza® (lubiprostone), the recipient must be female.

b. The requested dose is appropriate based on indication and age.

1. Linzess® (linaclotide): 290 µg daily.

2. Amitiza® (lubiprostone): 16 µg daily.

3. Trulance® (plecanatide): 3 µg daily.

2. For requests for a diagnosis of Irritable-Bowel Syndrome with Diarrhea (IBS-D):

a. The medication is being prescribed by or in consultation with a gastroenterologist; and

b. The requested dose is appropriate based on indication and age.

1. Lotronex® (alosetron): 0.5 mg twice daily or 1 mg twice daily.

2. Viberzi® (eluxadoline): 75 mg twice daily or 100 mg twice daily.

3. Xifaxan® (rifaximin): 550 mg three times a day for 14 days.

b. Prior Authorization Guidelines

1. Prior authorization approval will be given for an appropriate length of therapy based on the requested agent and diagnosis, not to exceed one year.

2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

c. Zelnorm® (tegaserod)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient has a diagnosis of IBS-C; and

b. The recipient is female; and

c. The recipient is less than 65 years of age; and

d. The recipient has had trial and failure, contraindication, or intolerance to one of the following:

1. Lactulose; or

2. Polyethylene glycol.

2. Reauthorization Request (the recipient must meet all criteria):

a. Documentation of positive clinical response to Zelnorm® therapy.

3. Prior Authorization Guidelines

a. Initial prior authorization approval will be for six weeks.

b. Recertification approval will be 12 months.

c. Prior authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Opioid-Induced Constipation Agents

a. Approval will be given if all the following criteria are met and documented:

1. The recipient is 18 years of age or older; and

2. The requested medication is being used for an FDA approved indication; and

3. The recipient must meet the following criteria:

a. There is documentation in the recipient's medical record of an inadequate response, adverse reaction or contraindication to one agent from three of the four traditional laxative drug classes:

1. Bulk forming laxatives;

2. Osmotic laxatives;

3. Saline laxatives;

4. Stimulant laxatives.

4. And, requests for methylnaltrexone bromide that exceed the quantity limit must meet all the following criteria:

   a. The recipient has opioid-induced constipation in advanced illness, is receiving palliative care, and is not enrolled in DHCFP's hospice program; and

   b. The requested dose is 0.15 mg/kg; and

   c. The recipient's current weight is >114 kg.

b. Prior Authorization Guidelines

   1. Prior authorization approval will be for one year.

   2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

XX. Xartemis® XR (oxycodone and acetaminophen)

Therapeutic Class: Opioid Analgesic
Last Reviewed by the DUR Board: January 22, 2015

Xartemis® XR (oxycodone and acetaminophen) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The recipient is 18 years or older; and

b. A diagnosis code of Acute Pain is documented on the prescription and transmitted on the claim; or

c. An approved prior authorization documenting the recipient meeting the following criteria:

1. The recipient is 18 years or older; and

2. A diagnosis code of Acute Pain is documented on the Prior Authorization form.

2. Prior Authorization Guidelines

a. More than two fills of a quantity of 60 each, within six months requires an approved prior authorization documenting the reason to exceed the prescribing limit.

b. Prior authorization approval will be for six months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

YY. GnRH Analogs

Therapeutic Class: GnRH Analogs
Last Reviewed by the DUR Board: April 26, 2018

GnRH Analogs are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. This prior authorization criteria only applies to recipients who are under 18 years of age. Approval of Lupron® (leuprolide) will be given if all the following criteria, per individual diagnosis, are met and documented:

1. The recipient has a diagnosis of idiopathic or neurogenic central precocious puberty (CPP), and

a. The requested dose and frequency is based on FDA-approved guidelines; and

b. The medication is being prescribed by or in consultation with a pediatric endocrinologist; and

c. There is an onset of secondary sex characteristics before age eight years (females) or nine years (males); and

d. The recipient is currently less than 11 years of age (females) or 12 years of age (males).

2. The recipient has a diagnosis of gender dysphoria, formerly known as gender identity disorder; and

a. The medication is being prescribed for suppression of puberty; and

b. The provider indicates a demonstrable knowledge what gonadotropins medically can and cannot do and their social benefits and risks; and

c. One of the following:

1. A documented real-life experience (living as the other gender) for at least three months prior to the administration of gonadotropin; or

2. A period of psychotherapy for a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

d. The member must meet the definition of gender dysphoria (see definition below):

1. Gender Disphoria:

a. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

b. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

c. The disturbance is not concurrent with a physical intersex condition.

d. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

e. The transsexual identity has been present persistently for at least two years.

f. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

3. The recipient has a diagnosis of endometriosis, and

a. The requested dose and frequency is based on FDA-approved guidelines; and

b. The recipient has had an inadequate response, adverse reaction or contraindication to an NSAID; and

c. The recipient has had an inadequate response, adverse reaction or contraindication to a hormonal contraceptive.

4. The recipient has a diagnosis of uterine leiomyomata (fibroids), and

a. The requested dose and frequency is based on FDA-approved guidelines; and

b. The recipient is symptomatic; and

c. Documentation has been submitted of the anticipated surgery date (or notation that surgery is planned once the fibroids shrink) or clinical rational why surgical intervention is not required.

5. The recipient has a diagnosis of prostate cancer, and

   a. The requested dose and frequency is based on FDA-approved guidelines.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be given for an appropriate length of therapy based on the diagnosis, unless the prescriber indicates a shorter duration of approval.

      1. CPP: One year, or until the member reaches the age of 11 years (female) or 12 years (male).

      2. Endometriosis: One year.

      3. Uterine Leiomyomata (fibroids): One month or until the time of the documented surgery (maximum of three months).

      4. Prostate Cancer: One year.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

ZZ. Human Immunodeficiency Virus (HIV) Agents
Therapeutic Drug Class: HIV Agents
Last Reviewed by the DUR Board: April 28, 2022

HIV agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Cabenuva® (cabotegravir, rilpivirine) and Vocabria® (cabotegravir).

      1. All of the following:

         a. Diagnosis of HIV-1 infection; and

         b. Recipient is currently virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable, uninterrupted antiretroviral regimen for at least 6 months; and

         c. Recipient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine; and

         d. Prescribed by or in consultation with a clinician with HIV expertise; and

         e. Will not be used concurrently with other ART medications; or

      2. The agent is used for continuation of prior therapy.

   b. Prior Authorization Guidelines:

      1. Prior authorization approval will be given in 12 months.

AAA. Narcolepsy Agents

Therapeutic Class: Narcolepsy Agents (non-stimulants)
Last Reviewed by the DUR Board: October 20, 2022

Narcolepsy Agents are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Provigil® (modafinil) and Nuvigil® (armodafinil)

    a. Approval will be given if the following criteria are met and documented:

        1. The recipient has a diagnosis of narcolepsy; or

            a. Obstructive Sleep Apnea (OSA); or

            b. Excessive sleepiness associated with shift work disorder.

    b. For treatment of OSA:

        1. Approval will be given if all the following criteria are met and documented:

            a. The recipient must have a diagnosis of OSA defined by one of the following:

                1. The recipient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study unless the prescriber provides justification confirming that a sleep study would not be feasible; or

                2. Both the following:

                    a. Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); and

                    b. One of the following signs/symptoms are present:

                        1. Daytime sleepiness; or

                        2. Nonrestorative sleep; or

                        3. Fatigue; or

                        4. Insomnia; or

5. Waking up with breath holding, gasping, or choking; or

6. Habitual snoring noted by a bed partner or other observer; or

7. Observed apnea; and

c. Both the following:

1. The recipient has used a standard treatment(s) for the underlying obstruction for one month or longer (e.g., CPAP, BiPAP); and

2. The recipient is fully compliant with ongoing treatment(s) for the underlying airway obstruction; and

c. Recertification Request:

1. Documentation of positive clinical response to therapy.

2. For OSA: The recipient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction. (e.g., CPAP, BiPAP).

d. Prior Authorization Guidelines:

1. Prior authorization approval will be given for 12 months.

2. Xyrem® (sodium oxybate)

a. The recipient has tried and failed on Provigil® (modafinil) or Nuvigil® (armodafinil); and/or

b. The recipient has a diagnosis of narcolepsy with cataplexy; and

c. The drug was prescribed by or in consultation with a neurologist or sleep specialist.

d. Prior Authorization Guidelines

1. Prior authorization approvals will be for 12 months.

3. Sunosi® (solriamfetol)

a. For treatment of Narcolepsy

1. Approval will be given if all the following criteria are met and documented:

   a. The recipient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); and

   b. The recipient has had trial and failure, contraindication, or intolerance to both of the following:

      1. modafinil; and

      2. armodafinil.

2. Recertification Request:

   a. Documentation of positive clinical response to Sunosi® therapy.

3. Prior Authorization Guidelines:

   a. Initial request will be approved for 12 months.

   b. Recertification request will be approved for 12 months.

b. For treatment of OSA

   1. Approval will be given if all the following criteria are met and documented:

      a. The recipient must have a diagnosis of OSA defined by one of the following:

         1. The recipient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); or

         2. Both the following:

            a. Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); and

            b. One of the following signs/symptoms are present:

               1. Daytime sleepiness; or

               2. Nonrestorative sleep; or

               3. Fatigue; or

4. Insomnia; or

5. Waking up with breath holding, gasping, or choking; or

6. Habitual snoring noted by a bed partner or other observer; or

7. Observed apnea; and

c. Both the following:

1. The recipient has used a standard treatment(s) for the underlying obstruction for one month or longer (e.g., CPAP, BiPAP); and

2. The recipient is fully compliant with ongoing treatment(s) for the underlying airway obstruction; and

d. The recipient has had a trial and failure, contraindication, or intolerance to both of the following:

1. Modafinil; and

2. Armodafinil.

2. Recertification Request (recipient must meet all the criteria)

a. Documentation of positive clinical response to therapy; and

b. The recipient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction. (e.g., CPAP, BiPAP)

3. Prior Authorization Guidelines

a. Initial request will be approved for six months.

b. Recertification request will be approved for six months.

3. Wakix® (pitolisant)

a. Approval will be given if all the following criteria are met and documented:

1. The recipient has a documented diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); and

2. The recipient is 18 years of age and older.

b. Recertification Requests:

1. The recipient must have documentation of positive clinical response to Wakix® therapy.

c. Prior Authorization Guidelines:

1. Initial request will be approved for six months.

2. Recertification request will be approved for 12 months.

4. Xywav® (calcium, magnesium, potassium, and sodium oxybates)

a. Narcolepsy with Cataplexy (Narcolepsy Type 1).

1. Approval will be given if the following criteria are met and documented:

a. The recipient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); and

b. The recipient has present symptoms of cataplexy; and

c. The recipient has symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep); and

d. The medication is prescribed by or in consultation with either a Neurologist, a Psychiatrist, or a Sleep Medicine Specialist.

2. Recertification Request:

a. The recipient has documentation demonstrating a reduction in the frequency of cataplexy attacks associate with therapy; or

b. The recipient has documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.

3. Prior Authorization Guidelines:

a. Initial request will be approved for six months.

b. Recertification request will be approved for 12 months.

b. Narcolepsy without Cataplexy (Narcolepsy Type 2)

1. Approval will be given if all the following criteria are met and documented:

a. The recipient has diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible); and

b. The recipient symptoms of cataplexy are absent; and

c. The recipient has symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep); and

d. The recipient has trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to generic modafinil or generic armodafinil and Sunosi®; and

e. One of the following:

1. The recipient has trial and failure, contraindication, or intolerance to an amphetamine (e.g., amphetamine, dextroamphetamine) or methylphenidate-based stimulant; or

2. The recipient has history of or potential for substance use disorder; and

f. The medication is prescribed by or in consultation with either a Neurologist, a Psychiatrist, or a Sleep Medicine Specialist.

2. Recertification Request:

a. The recipient has documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.

3. Prior Authorization Guidelines:

a. Initial request will be approved for six months.

b. Recertification request will be approved for 12 months.

BBB. Vimovo® (naproxen/esomeprazole magnesium), Duexis® (ibuprofen/famotidine)

Therapeutic Class: Nonsteroidal Anti-inflammatory Drug/Anti-ulcer Agent Combinations
Last Reviewed by the DUR Board: April 23, 2015

Vimovo® (naproxen/esomeprazole magnesium), Duexis® (ibuprofen/famotidine) are subject to prior authorizations and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The drug is being used for an FDA approved indication; and

b. The recipient's medical records documents one of the following risk factors for developing a NSAID-related ulcer:

1. Previous history of a major gastrointestinal bleed, perforation or obstruction; or

2. Previous history of a peptic ulcer, hemorrhagic gastritis, hemorrhagic gastropathy or erosive esophagitis; or

3. Concomitant therapy for an anticoagulant or antiplatelet agent (including aspirin) or chronic oral corticosteroids; or

4. The recipient has had gastric bypass surgery (Roux-en-Y gastric bypass); and

c. The recipient is intolerant to a COX-2 inhibitor or has had a gastric or duodenal ulcer while taking a COX-2 inhibitor; and

d. The recipient has experienced an NSAID-associated ulcer in the past while taking a single-entity proton pump inhibitor (PPI) or prostaglandin agent concomitantly with an NSAID or the recipient is intolerant to both PPIs and prostaglandin agents; and

e. The recipient's medical records document an inadequate response or adverse reaction with concurrent therapy of an equivalent dose of the individual components.

2. Prior Authorization Guidelines

a. Prior authorization approvals will be for one year.

b. Prior Authorization forms available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

CCC. Rayos® (prednisone delayed-release)

Therapeutic Class: Corticosteroid, Systemic
Last Reviewed by the DUR Board: April 23, 2015

Rayos® (prednisone delayed-release) is subject to prior authorizations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board.

1. Coverage and Limitations

   Approval will be given if all of the following criteria are met and documented:

   a. The requested drug is being used for a FDA approved indication; and

   b. The recipient's medical records document an inadequate response or adverse reaction to generic prednisone immediate–release tablets.

2. Prior Authorization Guidelines

   a. Prior authorization approvals will be:

      1. Initial therapy: three months.

      2. Recertification: one year.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

DDD. Corlanor® (ivabradine)

Therapeutic Class: Cardiovascular Agent
Last Reviewed by the DUR Board: September 3, 2015

Corlanor® (ivabradine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. A diagnosis of chronic heart failure; and

b. A left ventricular ejection fraction (LVEF) $\leq$ 35%; and

c. A resting heart rate $\geq$ 70 bpm; and

d. The recipient is $\geq$ 18 years of age; and

e. The prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted regarding the diagnosis and treatment recommendations; and

f. The recipient is in a normal sinus rhythm; and

g. The recipient is on a maximally tolerated dose of a beta-blocker or the recipient has a contraindication to beta-blocker use.

2. Prior Authorization Guidelines

a. The extent of prior authorization approvals will be based on the appropriate use for the individual agents.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

EEE. Anti-lipidemic Agents – PCSK9 Inhibitors

Therapeutic Class: Antilipemic Agent, PCSK9 Inhibitors
Last Reviewed by the DUR Board: July 23, 2020

Anti-lipidemic Agents – PCSK9 Inhibitors are subject to prior authorization and quantity limitation based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if all the following criteria are met and document:

    a. Initial Request:

        1. The recipient has an FDA-approved diagnosis; and

        2. The requested medication was prescribed by or in consultation with a cardiologist or lipid specialist; and

        3. The requested medication will be used as an adjunct to a low-fat diet and exercise; and

        4. For the treatment of homozygous familial hypercholesterolemia:

            a. With alirocumab (Praluent®)

                1. The recipient is 18 years of age or older; or

            b. With evolocumab (Repatha®)

                1. The recipient is 13 years of age or older.

        5. And the recipient must meet one of the following (a, b, c, or d):

            a. The recipient has had an inadequate response to high intensity statin therapy defined as all of the following:

                1. The recipient has received therapy with atorvastatin $\geq$ 40 mg or rosuvastatin $\geq$ 20 mg for at least the past three months; and

                2. The recipient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past two weeks or the recipient has a contraindication to ezetimibe therapy; and

                3. The LDL-C after therapy for at least the past three months was $\geq$ 100 mg/dL (HeFH) for $\geq$ 70 mg/dL (clinical atherosclerotic cardiovascular disease); and

4. The statin therapy will be continued with PCSK-9 therapy.

b. Or, the recipient has had an inadequate response to moderate intensity statin therapy defined as all of the following:

1. The recipient has an intolerance or contraindication to high intensity statin therapy; and

2. The recipient has received therapy with:

a. atorvastatin 10 to 20 mg; or

b. rosuvastatin 5 to 10 mg; or

c. simvastatin > 20 mg; or

d. pravastatin >40 mg; or

e. lovastatin 40 mg; or

f. fluvastatin XL 80 mg; or

g. fluvastatin 40 mg twice daily; or

h. pitavastatin > 2 mg

for at least the past three months; and

3. The recipient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past two weeks or the recipient has a contraindication to ezetimibe therapy; and

4. The LDL-C after therapy for at least the past three months was $\geq$ 100 mg/dL (HeFH) or $\geq$ 70 mg/dL (clinical atherosclerotic cardiovascular disease); and

5. Statin therapy will be continued with PCSK-9 therapy.

c. Or the recipient experienced an adverse reaction to at least two statins, the statins and adverse reactions must be documented in the recipient's medical record.

d. Or the recipient has a labeled contraindication to all statins, the contraindication is documented in the recipient's medical record.

2. Recertification Request (The recipient must meet all criteria (a-d))

a. The recipient has been adherent with PCSK-9 inhibitor therapy; and

b. The recipient has been adherent with statin therapy, or the recipient has a labeled contraindication to statin therapy; and

c. The recipient is continuing a low-fat diet and exercise regimen; and

d. The recipient has achieved a reduction in LDL-C level.

3. Prior Authorization Guidelines

a. Initial authorization will be approved for six months.

b. Recertification approval will be approved for 12 months.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

FFF. Long-Acting Injectable (LAI) Antipsychotics

Therapeutic Class: Second Generation (Atypical) Antipsychotic
Last Reviewed by the DUR Board: July 28, 2022

LAI antipsychotic drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. General for all LAIs:

   a. Treatment-naïve patients require documentation confirming tolerance to the oral formulation prior to transitioning to the LAI.

2. Invega Trinza® (paliperidone palmitate)

   a. Approval will be given if the following criteria are met and documented.

      1. The recipient has a diagnosis of schizophrenia; and

      2. The recipient has been stabilized on once-monthly paliperidone palmitate injection (Invega Sustenna®) for at least four months with the two most recent doses of the once-monthly injection being the same strength; and

      3. The recipient is 18 years of age or older; and

      4. The requested dose is one injection every three months.

   b. Prior Authorization Guidelines

      1. Prior authorization approvals will be for 12 months.

3. Invega Hafyera® (paliperidone palmitate)

   a. Approval will be given if the following criteria are met and documented.

      1. The recipient has a diagnosis of schizophrenia; and

      2. The recipient has been stabilized on once-monthly paliperidone palmitate extended-release (PP1M) injectable suspension (Invega Sustenna®) for at least four months, the two most recent doses of the once-monthly injection being the same strength or one dose of three-month IM paliperidone (Invega Trinza®); and

      3. Patient is 18 years of age or older; and

      4. The requested dose is one injection every six months.

b. Recertification Requests:

1. Documentation confirming a positive response from therapy.

c. Prior Authorization Guidelines:

1. Prior authorization approvals will be for 12 months.

GGG. Medications for Recipients on Hospice

Last Reviewed by the DUR Board: January 27, 2017
Previously reviewed: January 28, 2016

Medications for recipients on hospice are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   a. For recipients 21 years of age or older:

      1. The prescriber has verified the recipient is enrolled in the hospice program; and

      2. The requested medication is not being used to treat or manage symptoms of the terminal hospice diagnosis; and

      3. The requested medication is not being used for palliative care; and

      4. The requested medication is unrelated to the terminal hospice diagnosis and is medically necessary to treat the recipient; and

      5. The requested medication is not providing a curative or long-term prophylactic therapy.

   b. For recipients 20 years of age or younger:

      1. The prescriber has verified the recipient is enrolled in a hospice program; and

      2. The requested medication is not being used to treat or manage symptoms of the terminal hospice diagnosis; and

      3. The requested medication is not being used for palliative care.

      4. Medically necessary curative medications for this age group are covered by the DHCFP pursuant to Sections 1905(o)(1) and 2110(a)(23) of the SSA.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for three months.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

HHH. Ileal Bile Acid Transporter (IBAT) Inhibitor (D7F))

Therapeutic Drug Class: Ileal bile acid transporter (IBAT) inhibitor (D7F)
Last Reviewed by the DUR Board: July 28, 2022

Ileal bile acid transporter (IBAT) inhibitor (D7F) drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Bylvay® (odevixibat)

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient is three months of age or older; and

      2. Recipient is diagnosed with progressive familial intrahepatic cholestasis (PFIC) type 1 or type 2, confirmed by a genetic test; and

      3. Recipient has elevated serum bile acid concentration; and

      4. Recipient experiences persistent moderate to severe pruritus; and

      5. Recipient does not have any of the following:

         a. Positive test for the ABCB11 gene variant that predicts complete absence of the bile salt export pump (BSEP) protein; and

         b. Prior heaptic decompensation event; and

         c. Another concomitant liver disease; and

         d. An international normalized ratio (INR) greater than 1.4; and

         e. Significant portal hypertension; and

         f. An alanine aminotransferase (ALT) or total bilirubin (TB) level more than 10 times the upper limit of normal (ULN); and

         g. Medical history or ongoing chronic diarrhea; and

         h. Decompensated cirrhosis; and

         i. Significant portal hypertension; and

      6. Bylvay® is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist).

b. Recertification Request:

1. Recipient has experienced a reduction in serum bile acids from baseline; and

2. Recipient must continue to meet above criteria, except for the initial serum bile acid approval criteria; and

3. Recipient must experience improvement in pruritus; and

4. Recipient has not experienced any treatment-restricting adverse effects (e.g., persistent diarrhea; persistent fat-soluble vitamin deficiency despite vitamin A,D,E,K supplementation; elevated liver function tests [alanine aminotransferase (ALT), total bilirubin (TB), direct bilirubin (DB)]); and

5. Recipient has not developed decompensated cirrhosis; and

6. Recipient has not developed significant portal hypertension

c. Prior Authorization Guidelines:

1. Prior authorization approval will be given for 12 months

2. Livmarli® (maralixibat)

a. Approval will be given if all the following criteria are met and documented:

1. Recipient is one year of age or older; and

2. Recipient is diagnosed with Alagille syndrome; and

3. Recipient experiences persistent moderate to severe pruritus; and

4. Recipient does not have any of the following:

a. Chronic diarrhea requiring ongoing intravenous fluid or nutritional intervention; and

b. Prior hepatic decompensation event; and

c. Significant portal hypertension; and

d. Decompensated cirrhosis; and

e. Another concomitant liver disease; and

5. Maralixibat is prescribed by or in consultation with a specialist (e.g.,gastroenterologist, hepatologist, dermatologist); and

6. Patient has failed an adequate trial, or is intolerant to, or has a contraindication to at least one pruritus treatment (e.g., ursodeoxycholic acid [ursodiol], cholestyramine, rifampin, naloxone, naltrexone, antihistamine).

b. Recertification Request:

1. Recipient has experienced a reduction in serum bile acids from baseline; and

2. Recipient must continue to meet the above criteria, except for the initial serum bile acid approval criteria; and

3. Recipient must experience improvement in pruritus; and

4. Recipient has not experienced any treatment-restricting adverse effects (e.g., persistent diarrhea; persistent fat-soluble vitamin deficiency despite Vitamin A, D, E, K supplementation; elevated liver function tests [alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin (TB), direct bilirubin (DB)]); and

5. Recipient has not developed decompensated cirrhosis; and

6. Recipient has not developed significant portal hypertension.

c. Prior Authorization Guidelines:

1. Prior Authorization approval will be given for six months.

2. Recertification will be given for 12 months.

III. Hetlioz® (tasimelteon)

Therapeutic Class: Sedative Hypnotic
Last Reviewed by the DUR Board: April 28, 2022

Hetlioz® (tasimelteon) is subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

2. Coverage and Limitations

a. For treatment of Non-24-Hour Sleep-Wake Disorder (Non-24).

1. Approval will be given if all following criteria are met and documented:

a. The recipient has a diagnosis of Non-24 disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome); and

b. The medication is being prescribed by or in consultation with a sleep specialist; and

c. The recipient had an adverse reaction, contraindication, or an inadequate response (after at least three months of therapy) to a therapeutic dose of melatonin.

2. Recertification Request:

a. Documentation of positive clinical response to therapy.

3. Prior Authorization Guidelines:

a. Initial prior authorization will be approved for six months.

b. Recertification will be approved for 12 months.

b. For the treatment for nighttime sleep disturbances in Smith-Magenis Syndrome (SMS).

1. Approval will be given if all criteria are met and documented:

a. The recipient has a diagnosis of SMS; and

b. The recipient is at least 16 years of age and older (3 through 15 years of age for LQ suspension); and

c. The recipient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking); and

d. Prescribed by a neurologist or a specialist in sleep disorder; and

e. The recipient had an adverse reaction, contraindication, or an inadequate response (after at least three months of therapy) to a therapeutic dose of melatonin.

2. Recertification Request:

a. Documentation of positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality).

3. Prior Authorization Guidelines:

a. Initial Prior Authorization will be approved after six months.

b. Recertification will be approved after 12 months.

JJJ. Entresto® (sacubitril/valsartan)

Therapeutic Class: Angiotension II Receptor Blocker
Last Reviewed by the DUR Board: October 26, 2021

Entresto® (sacubitril/valsartan) is subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis of chronic heart failure NYHA Class II to IV; and

   b. The recipient has reduced left ventricular ejection fraction (LVEF); and

   c. The recipient is one year of age or older; and

   d. The prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted; and

   e. The recipient has had a trial of an angiotensin converting enzyme (ACE) or an angiotensin receptor blocker (ARB) for at least four weeks prior to the initiation of therapy; and

   f. The recipient will not concurrently receive an ACE inhibitor; and

   g. The recipient is on an individualized dose of a beta blocker, or the recipient has a contraindication to beta blocker use; and

   h. Entresto® will be given twice daily with a maximum dose of 97/103 mg.

2. Prior Authorization Guidelines:

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

KKK. Neurokinin-1 Antagonists and Combinations

Therapeutic Class: Neurokinin-1 Antagonists and Combinations
Last Reviewed by the DUR Board: April 28, 2016

Neurokinin-1 antagonists and combinations are subject to prior authorization and quantity limits based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

For requests to exceed the quantity limits approval will be given if all the following criteria are met and documented:

a. The requested medication is being used for an FDA-approved indication; and

b. The requested medication is being prescribed by an oncologist or in consultation with an oncologist; and

c. The recipient must meet one of the following criteria:

1. The recipient is 18 years of age or older; or

2. The recipient is 12 years of age or older, the requested medication is aprepitant (Emend®) and the recipient is diagnosed with nausea and vomiting caused by chemotherapy; and

d. It is medical necessity for the recipient to exceed the quantity limit (e.g., duration of chemotherapy cycle).

2. Prior Authorization Guidelines

a. Prior authorization approval will be for six months.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

LLL. Voquenza® Dual Pak® (vonoprazan and amoxicillin), Voquenza® Triple Pak® (vonoprazan, amoxicillin, and clarithromycin)

Therapeutic Drug Class: Qualified Infection Disease Product
Last Reviewed by DUR Board: October 20, 2022

Voquenza® Dual Pak® (vonoprazan and amoxicillin), Voquenza® Triple Pak® (vonoprazan, amoxicillin, and clarithromycin) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

    a. Recipient is 18 years or age or older; and

    b. Recipient has a confirmed diagnosis of Helicobacter pylori (H. pylori) infection; and

    c. Recipient must not have hypersensitivity or cross-hypersensitivity to any component or drug class of the product (e.g., penicillins, cephalosporings, macrolides); and

    d. Treatment will not be used concurrently with rilpivrine-containing products; and

    e. For vonoprazan/amoxicillin/clarithromycin requests (Voquenza® Triple Pak®), the patient does not have a history or hepatic dysfunction or cholestatic jaundice associated with prior use of clarithromycin; and

    f. For vonoprazan/amoxicillin/clarithromycin (Voquenza® Triple Pak®), the patient does not have ventricular cardiac arrythmia, prolongation of the QT interval, or proarrhythmic condition (e.g., uncorrected hypokalemia or hypomagnesemia); and

    g. Recipient must have an adequate trial and failure of, or relevant medical reason for not using, proton pump inhibitor-based H.pylori treatment regimen; and

    h. Baseline renal and hepatic function laboratory tests have been obtained; and

    i. Quantity limit of 14-day supply.

2. Recertification Request:

    a. Coverage is not renewable.

3. Prior Authorization Guidelines:

    a. Prior Authorization will be given for 14 days.

MMM. Duchenne Muscular Dystrophy (DMD) Agents

Therapeutic Class: Duchenne Muscular Dystrophy (DMD) Agents
Last Reviewed by the DUR Board: January 27, 2022

DMD agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Exondys 51® (eteplirsen)

   a. Approval will be given if all the following criteria are met and documented:

      1. Initial request:

         a. The recipient has a diagnosis of Duchenne muscular dystrophy (DMD); and

         b. There is documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping; and

         c. The medication is prescribed by or in consultation with a neurologist who has experience treating children; and

         d. The prescribed dose does not exceed 30 milligrams per kilogram of body weight once weekly.

      2. Recertification Request (the recipient must meet all the following criteria).

         a. The recipient has been on therapy for less than 12 months; and

         b. The recipient has experienced clinically significant benefit; and

         c. The recipient is tolerating therapy; and

         d. The prescribed dose will not exceed 30 milligrams per kilogram of body weight once weekly; and

         e. The medication is prescribed by or in consultation with a neurologist who has experience treating children, or all the following:

            1. The recipient has been on therapy for 12 months or more; and

            2. The recipient has experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients); and

            3. The recipient has experienced clinically significant benefit; and

4. The recipient is tolerating therapy; and

5. The prescribed dose will not exceed 30 milligrams per kilogram of body weight once weekly; and

6. The medication is prescribed by or in consultation with a neurologist who has experience treating children.

b. Prior Authorization Guidelines

1. Initial authorization will be approved for six months.

2. Recertification request will be approved for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

2. Emflaza® (deflazacort)

a. Approval will be given if all the following criteria are met and documented:

1. Initial request:

a. The recipient must have a diagnosis of (DMD); and

b. The recipient must be five years of age or older; and

c. The recipient must have received genetic testing for a mutation of the dystrophin gene, and one of the following:

1. Documentation of a confirmed mutation of the dystrophin gene; or

2. Muscle biopsy confirming an absence of dystrophin protein; and

d. The medication must be prescribed by or in consultation with a neurologist who has experience treating children; and

e. The recipient has had at least a three-month trial and failure of prednisone (prednisolone or equivalent dose) or a documented intolerance to prednisone (prednisolone or equivalent dose) given at a dose of 0.75 mg/kg/day or 10 mg/kg/week; and

The dose will not exceed 0.9 milligrams per kilogram of body weight once daily.

b. Recertification request (the recipient must meet all the following criteria):

1. Documentation of positive clinical response to Emflaza® therapy (e.g., improvement or preservation of muscle strength); and

2. The dose will not exceed 0.9 milligrams per kilogram of body weight once daily.

c. Prior Authorization Guidelines:

1. Initial prior authorization approval will be approved for 12 months.

2. Recertification request will be approved for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

3. Vyondys 53® (golodirsen)

a. Approval will be given if all the following criteria are met and documented:

1. Submission of medical records (e.g. chart notes, laboratory values) documenting the following:

a. The recipient has a diagnosis of DMD; and

b. Documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping; and

2. The medication is prescribed by or in consultation with a neurologist who has experience treating children; and

3. The dose will not exceed 30 milligrams per kilogram of body weight infused once weekly.

b. Recertification request (recipient must meet all criteria):

1. One of the following:

a. All the following:

1. The recipient has been on therapy for less than 12 months; and

2. The recipient is tolerating therapy; and

3. Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly; and

4. The medication is prescribed by or in consultation with a neurologist who has experience treating children; or

b. All the following:

1. The recipient has been on therapy for 12 months or more; and

2. Recipient experienced a benefit from therapy (e.g. disease amelioration compared to untreated patients); and

3. Recipient is tolerating therapy; and

4. Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly; and

5. The medication is prescribed by or in consultation with a neurologist who has experience in treating children.

c. Prior Authorization Guidelines:

1. Initial authorization will be approved for six months.

2. Recertification request will be approved for 12 months.

3. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

4. Viltepso® (viltolarsen)

a. Approval will be given if all the following criteria are met and documented:

1. Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

a. The recipient has a diagnosis of DMD; and

b. The recipient has documentation of a confirmed mutation of the dystrophin gene amenable to exon 53 skipping; and

2. The medication is prescribed by or in consultation with a Neurologist who has experience treating children; and

3. Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly.

b. Recertification request (recipient must meet all criteria):

1. One of the following:

   a. All of the following:

      1. The recipient has been on therapy for less than 12 months; and

      2. The recipient is tolerating therapy; and

      3. Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly; and

      4. The medication is prescribed by or in consultation with a Neurologist who has experience treating children; or

   b. All of the following:

      1. The recipient has been on therapy for 12 months or more; and

      2. The recipient has experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients); and

      3. The recipient is tolerating therapy; and

      4. Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly; and

      5. The medication is prescribed by or in consultation with a Neurologist who has experience treating children.

   c. Prior Authorization Guidelines:

      1. Initial authorization will be approved for six months.

      2. Recertification request will be approved for 12 months.

      3. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

5. Amondys 45® (casimersen)

   a. Approval will be given if all the following criteria are met and documented:

      1. Submission of medical records (e.g., chart notes, laboratory values) documenting both of the following:

         a. Diagnosis of Dystrophy (DMD); and

b. Documentation of a confirmed mutation of the dystrophin gene amenable to exon 45 to exon 45 skipping; and

2. Prescribed by or in consultation with a neurologist who has experience treating children; and

3. Dose will not exceed 30 milligrams per kilograms of body weight infused once weekly.

b. Recertification request (recipient must meet all criteria):

1. Recipient is tolerating therapy; and

2. Dose will not exceed 30 milligrams per kilogram of body weight infused weekly; and

3. The medication is prescribed by or in consultation with a neurologist who has experience treating children.

c. Prior Authorization Guidelines:

1. Prior authorization will be approved for six months.

2. Recertification request will be approved for 12 months.

3. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

NNN. Qutenza® (capsaicin)

Therapeutic Class: Topical Neuropathic Pain Agents
Last Reviewed by the DUR Board: January 27, 2022

Qutenza® (capsaicin) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if all the following criteria is met and documented:

   a. The recipient has a diagnosis of neuropathic pain associated with postherpetic neuralgia; or

   b. The recipient has a diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet; and

   c. The recipient has history of failure or intolerance to over-the-counter capsaicin.

2. Recertification Request (recipient must meet all criteria):

   a. At least three months have transpired since the last Qutenza® application/administration; and

   b. The recipient experienced pain relief with a prior course of therapy; and

   c. The recipient is experiencing a return of neuropathic pain.

3. Prior Authorization Guidelines:

   a. Initial authorization will be approved for three months.

   b. Recertification request will be approved for three months.

   c. The Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

OOO. Movement Disorder Agents

Therapeutic Class: Movement Disorder Agents
Last Reviewed by the DUR Board: April 28, 2022

Movement Disorder Agents are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Austedo® (deutetrabenazine)

   a. For treatment of Chorea Associated with Huntington's Disease.

      1. Approval will be given if all the following criteria are met and documented:

         a. The recipient must have a diagnosis of chorea associated with Huntington's disease; and

         b. The recipient must be 18 years of age or older; and

         c. The medication is prescribed by or in consultation with a neurologist; and

      2. Recertification criteria:

         a. Documentation of positive clinical response to therapy.

      3. Prior Authorization Guidelines

         a. Initial prior authorization approval will be for 12 months.

         b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

   b. For the treatment of Tardive Dyskinesia (TD).

      1. Approval will be given if all the following criteria are met and documented:

         a. The recipient must have a confirmed diagnosis of TD; and

         b. The recipient must be 18 years of age or older; and

         c. The medication is prescribed by or in consultation with a neurologist or psychiatrist; and

         d. One of the following:

            1. Persistent symptoms of TD despite a trial dose reduction, tapering or discontinuation of the offending medication; or

2. The recipient is not a candidate for trial dose reduction, tapering or discontinuation of the offending medication.

2. Recertification request:

a. Documentation of positive clinical response to therapy

3. Prior Authorization Guidelines

a. Initial prior authorization approval will be for three months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

2. Ingrezza® (valbenazine)

a. Approval will be given if the following criteria are met and documented:

2. Initial request:

a. The recipient must have a diagnosis of severe tardive dyskinesia (TD);

b. The recipient must be 18 years of age or older; and

c. The drug must be prescribed by or in consultation with a neurologist or psychiatrist; and

d. One of the following:

1. The recipient must have persistent symptoms of TD despite a trial of dose reduction, tapering or discontinuation of the offending medication; or

2. The recipient must not be a candidate for a trial of dose reduction, tapering or discontinuation of the offending medication.

b. Recertification Request:

1. Documentation of positive clinical response to therapy.

c. Prior Authorization Guidelines:

1. Initial authorization will be approved for three months.

2. Recertification will be approved for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

PPP. Brineura® (cerliponase alfa)

Therapeutic Class: Brineura® (cerliponase alfa)
Last Reviewed by the DUR Board: October 19, 2017

Brineura® (cerliponase alfa) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if all the following criteria are met and documented:

a. Initial request:

1. The recipient must have a diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis Type 2 (CLN2) also known as tripeptidyl peptidase 1 (TPP1) deficiency; and

2. The diagnosis must be confirmed by TPP1 enzyme detected by a dried blood spot test and CLN2 genotype analysis; and

3. The recipient must be three years of age or older; and

4. The drug must be prescribed by or in consultation with a neurologist with expertise in the diagnosis of CLN2; and

5. The drug must be administered by, or under the direction of, a physician knowledgeable in intraventricular administration; and

6. The recipient must not have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections); and

7. The recipient must not have a ventriculoperitoneal shunt.

b. Recertification request (the recipient must meet all of the following criteria):

1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

a. The recipient must not have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections); and

b. The recipient must not have a ventriculoperitoneal shunt; and

c. Documentation of positive clinical response to Brineura®, (e.g., improvement in walking or crawling, or no evidence of disease progression).

c. Prior Authorization Guidelines

1. Initial prior authorization approval will be for four months.

2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

QQQ. Vuity® (pilocarpine) 1.25% Ophthalmic Solution

Therapeutic Class: Ophthalmic Agents, Intraocular Pressure (IOP)-Modifying

Last Reviewed by the DUR Board: April 28, 2022

Vuity® (pilocarpine) 1.25% Ophthalmic Solution is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis of presbyopia; and

   b. The medication prescribed by or in consultation with an ophthalmologist or optometrist; and

   c. The recipient is unable to use corrective lenses (e.g., eyeglasses or contact lenses) confirmed by medical records (e.g., chart notes); and

   d. Vuity will not be prescribed concurrently with any ophthalmic pilocarpine formulations.

2. Recertification Request:

   a. Documentation or positive clinical response to therapy (e.g., improvement in near vision in low light conditions without loss of distance vision); and

   b. Prescribed by or in consultation with an ophthalmologist or optometrist.

3. Prior Authorization Guidelines:

   a. Initial authorization will be approved for one month.

   b. Recertification will be approved for six months.

   c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

RRR. Livtencity® (maribravir)

Therapeutic Drug Class: Antivirals
Last Reviewed by DUR Board: October 20, 2022

Livencity® (maribravir) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

    a. Recipient is greater than or equal to 12 years of age; and

    b. Recipient must weigh greater than 35 kilograms (kg); and

    c. Recipient of a hematopoietic stem cell or solid organ transplant; and

    d. Recipient has documented cytomegalovirus (CMV) infection in whole blood or plasma (screening value greater than or equal to 2,730 IU/mL in whole blood or greater than or equal to 910 IU/mL in plasma) in two consecutive assessments separated by greater than or equal to one day; and

    e. Recipient has current CMV infection that is refractory (documented failure to achieve greater than 1 log10 decrease in CMV deoxyribonucleic acid [DNA] level in whole blood or plasma after greater than or equal to 14 days treatment) to anti-CMV treatment agents (ganciclovir, valganciclovir, cidofovir, or foscarnet), even with documented genetic mutations associated with resistance; and

    f. Maribravir will not be coadministered with ganciclovir or valganciclovir; and

    g. Recipient will be monitored for clinically important drug interactions that could results in decreased therapeutic effect of maribravir.

2. Recertification Request:

    a. Recipient must continue to meet the above criteria; and

    b. Recipient must have disease improvement and/or stabilization or improvement in the slope of decline (greater than 1 log10 decrease in CMV DNA level in whole blood or plasma after 14 days or longer treatment); and

    c. Recipient has not experienced any treatment-restricting adverse effects (e.g., dysgeusia, diarrhea, nausea, and recurrence of underlying disease); and

    d. Recipient is not a non-responder (resistant) to maribravir.

3. Prior Authorization Guidelines:

    a. Prior authorization will be approved for six months

SSS. Anti-Parkinson's Agents

Therapeutic Class: Anti-Parkinson's Agents
Last Reviewed by the DUR Board: October 20, 2022

Anti-Parkinson's Agents is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Xadago® (safinamide)

   a. Approval will be given if all the following criteria are met and documented:

      1. The recipient must have a diagnosis of Parkinson's disease: and

      2. The recipient must be five years of age or older; and

      3. Documented continued Levodopa and/or other dopaminergic treatments; and

      4. Recipient reports greater than 1.5 hours per day "off" episodes ("off" episodes refer to "end-of-dose wearing off" and unpredictable "on/off" episodes); and

      5. Recipient must not also be taking any of the following drugs: other MAOIs or other drugs that are potent inhibitors of MAOI (e.g., linezolid), opioid drugs (e.g., tramadol, meperidine, and related derivatives), selective norepinephrine reuptake inhibitors (SNRIs), tri- or tetra-cyclic or triazolopyridine antidepressants (TCAs), cyclobenzaprine, methylphenidate, amphetamine and their derivatives, St. John's wort or dextromethorphan; and

      6. The recipient must not have severe hepatic impairment (e.g., Child-Pugh C).

   b. Recertification Request:

      1. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

         a. Documentation of positive clinical response to Xadago® therapy; and

         b. Documented continued Levodopa and/or other dopaminergic treatments.

   c. Prior Authorization Guidelines:

      1. Initial prior authorization approval will be for three months.

2. Kynmobi® (apomorphine)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is 18 years of age or older; and

2. Recipient has a documented diagnosis of Parkinson's disease (PD); and

3. Recipient is experiencing "off" episodes of PD at least two hours per day on average; and

4. Recipient is on a stable levodopa-based therapy; and

5. Recipients will not be on a concomitant 5HT3 antagonists (e.g., ondansetron, granisetron, dolansetron, palonosetron, alosetron); and

6. Recipient will be prescribed a non-5HT3 antagonist antiemetic (e.g., trimethobenzamide) for initial therapy; and

7. Recipient does not have a major psychotic disorder.

b. Recertification Request:

1. Recipient must continue to meet the initial criteria above; and

2. Recipient has demonstrated a beneficial response to therapy (e.g., decrease in frequency and duration from baseline in motor fluctuations ["off episodes]); and

3. Recipient is absent of unacceptable toxicity from the drug (e.g., nausea or vomiting, oral mucosal irritation or stomatitis, decreased impulse control, syncope or hypotension, hallucinations or psychotic-like behavior, QTc prolongation, fibrotic complications, priapism, retinal atrophy or degeneration, excessive daytime sleepiness including falling asleep during activities that require active participation).

c. Prior Authorization Guidelines:

1. Prior authorization will be approved for 12 months.

TTT. Codeine and Tramadol for Children

Therapeutic Class: Opioid Analgesic
Last Reviewed by the DUR Board: October 19, 2017

Codeine, codeine with acetaminophen and tramadol, tramadol with acetaminophen are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

a. Codeine, codeine with acetaminophen

1. All of the following criteria must be met:

a. The recipient must be 12 years of age or older; and

b. The lowest effective dose for the shortest period of time is being requested; and

c. The recipient must not be obese (BMI > 30 kg/m^2), have obstructive sleep apnea, or severe lung disease; and

d. The recipient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy.

b. Tramadol, tramadol with acetaminophen

1. All of the following criteria must be met:

a. The recipient must be 12 years of age or older; and

b. The lowest effective dose for the shortest period of time is being requested; and

c. The recipient must not be obese (BMI > 30 kg/m^2), have obstructive sleep apnea, or severe lung disease; and

d. The recipient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy; and

e. The prescribed dose does not exceed 200mg/day and does not exceed a five-day supply.

2. Tramadol Extended Release (ER) will not be approved for children under 18 years of age and will reject at point of sale.

c. Prior Authorization Guidelines

1. Codeine, codeine with acetaminophen

a. Prior authorization approval will be given for the lowest effective dose for the shortest period of time requested.

1. Prior authorization will be given for a one-month time period.

2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

2. Tramadol, tramadol with acetaminophen

a. Prior authorization approval will be given for the lowest effective dose for the shortest period of time requested.

b. Prior authorization will be given for a one-month time period.

c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

UUU. High Dollar Claim

Last Reviewed by the DUR Board: April 26, 2018

A High Dollar Claim is defined as a single point-of-sale claim that exceeds $10,000. A High Dollar Claim is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits. If other prior authorization criteria exists, it will supersede this criteria.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. One of the following:

1. The medication is being prescribed for a Food and Drug Administration (FDA) approved indication; or

2. One of the following:

a. Diagnosis is supported as a use of American Society of Health-System Pharmacists Drug Information (AHFS DI); or

b. Diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation and carries a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table); or

3. Both of the following:

a. Diagnosis is listed in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation and carries a Strength of Recommendation rating of III or Class Indeterminant (see DRUGDEX Strength of Recommendation table); and

b. Efficacy is rated as “Effective” or “Evidence Favors Efficacy” (see DRUGDEX Efficacy Rating and Prior Authorization Approval Status table); or

4. Diagnosis is supported in any other section in DRUGDEX; or

5. The use is supported by clinical research in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

b. And one of the following:

1. The dosage/quantity/duration of the medication is reasonably safe and effective based on information contained in the FDA approved labeling, peer-reviewed medical literature or accepted standards of medical practice; or

2. The dosage/quantity/duration of the medication is reasonably safe and effective based on one of the following compendia:

a. American Hospital Formulary Service (AHFS) Compendium.

b. Thomson Reuters (Healthcare) Micromedex/DRUGDEX (not Drug Points) Compendium.

c. Elsevier Gold Standard Clinical Pharmacology Compendium.

d. National Comprehensive Cancer Network Drugs and Biologics Compendium.

c. Excluded:

1. Hemostatic coagulation factors used for the treatment of hemophilia are excluded from this criteria.

d. Prior Authorization Guidelines

1. Prior authorization approval will be for 12 months.

2. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

VVV. Cuvrior® (trientine tetrahydrochloride)

Therapeutic Drug Class: Copper Chelator
Last Reviewed by DUR Board: October 20, 2022

Cuvrior® (trientine tetrahydrochloride) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given once the following criteria are met and documented:

   a. Recipient is 18 years of age or older; and

   b. Recipient has Wilson's disease (defined by a prior or current Leipzig score of greater than or equal to four); and

   c. Recipient is being treated with penicillamine for greater than or equal to one year at a stable dose and regimen for greater than or equal to four months, and recipient is tolerating penicillamine and adequately controlled (e.g., serum non-ceruloplasmin copper [NCC] level between greater than or equal to 25 and less than or equal to 150 mcg/L or 24-hour urinary copper excretion [UCE] of between levels greater than or equal to 100 and less than or equal to 900 mcg/24 hours); and

   d. Penicillamine will be discontinued before initiating Cuvrior; and

   e. Recipient will not concurrently use another formulation of trientine (e.g., Syprine, generics); and

   f. Prescribed by or in consultation with a hepatologist or neurologist; and

   g. Quantity limit is 300 tablets/30 days (max daily dose 3,000mg).

2. Recertification Request:

   a. Recipient must continue to meet the above criteria; and

   b. Recipient has evidence of effectiveness of therapy (e.g., as assessed by serum NCC level between greater than or equal to 25 and less than or equal to 150 mcg/L or 24-hour UCE levels greater than or equal to 100 and less than or equal to 900 mcg/24 hours); and

   c. Recipient does not exhibit clinical manifestations of advancement of Wilson's disease from baseline (e.g., jaundice, edema, ascites, esophageal varices, liver failure, central nervous system symptoms); and

   d. Recipient has not experienced any treatment-restricting adverse effects (e.g., hypersensitivity reactions, copper deficiency, iron deficiency).

3. Prior Authorization Guidelines:

   a. Prior authorization will be approved for six months.

WWW. Botulinum Toxin

Therapeutic Class: Neurotoxic Protein
Last reviewed by the DUR Board: July 26, 2018

Botulinum toxins are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Policy

   Botulinum toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries and multiple sclerosis. The injections may reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow improved range of motion, to permit better physical therapy and provide adequate perineal hygiene.

2. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. It is expected that physicians be familiar with and experienced in the use of botulinum toxin products and utilize FDA-approved product labeling, compendia and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each recipient condition. A complete list of covered indications can be found within the "Provider Type 20, 24 and 77 Billing Guide" applicable to botulinum toxins.

   b. Documentation must be provided that the recipient has been unresponsive to conventional methods of treatment (e.g., medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions); and

   c. If maximum dose is reached and positive clinical response is not established, treatment must be discontinued; and

   d. Documentation of medical necessity is required for treatment more frequent than every 90 days; and

   e. Coverage will be approved for one injection per site. A site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face or neck.

   f. Coverage will not be provided for injections given for cosmetic or for investigational purposes.

3. Recertification Request (the recipient must meet all the following criteria):

a. Authorization for continued use shall be reviewed at least every 12 months when the following criteria are met:

1. Documentation of a positive clinical response to Botulinum Toxin therapy.

4. Prior Authorization Guidelines

a. Prior authorization approval will be for six months.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

XXX. Compounded Medications

Last Reviewed by the DUR Board: January 24, 2019

Compounded medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. Each active ingredient in the compounded medication is FDA-approved or national compendia supported for the condition being treated; and

b. The therapeutic amounts and combinations are supported by national compendia or peer-reviewed literature for the condition being treated in the requested route of delivery; and

c. If any prescription ingredients require prior authorization and/or step therapy, all drug specific criteria must also be met; and

d. The compounded medication must not be used for cosmetic purpose; and

e. The compounded medication must not include any ingredient that has been withdrawn or removed from the market due to safety reasons (drugs withdrawn from the market due to safety or effectiveness); and

f. The recipient has tried and failed therapy or had an intolerance to at least two FDA-approved, commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless one of the following criteria are met:

1. The recipient has a contraindication to commercially available products; or

2. One or no other therapeutic alternatives are commercially available; or

3. Compound medication is prepared in a different dosage form for a recipient who is unable to take the commercially available formulation (mixing or reconstituting commercially available products based on the manufacturer's instructions or the product's approved labeling does not meet this criteria); or

4. The recipient has an allergy or sensitivity to inactive ingredients (e.g., dyes, preservatives, sugars, etc.) that are found in commercially available products.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for six months unless the provider requests for a shorter length of therapy.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

YYY. Antibiotics

Last Reviewed by the DUR Board: July 26, 2018

Antibiotic medications are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

The outpatient antibiotic class criteria apply to the following:

Third Generation Cephalosporins	**Fluoroquinolones**	**Oxazolidinones**
cefixime	ciprofloxacin	tedizolid
cefdinir	levofloxacin	linezolid
cefpodoxime	delafloxacin	
ceftibuten	moxifloxacin	
cefdotoren	ofloxacin	

If applicable, reference current Infectious Disease Society of America (IDSA) (or equivalent organization) guidelines to support the use of the following:

1. Coverage and Limitations for Third Generation Cephalosporins and Fluoroquinolones

   Approval will be given if the following criteria are met and documented:

   a. Culture and sensitivity-proven susceptibilities and resistance to other agents suggest the requested drug is necessary.

2. Coverage and Limitations for Oxazolidinones

   a. Sivextro® (tedizolid)

      Approval will be given if the following criteria are met and documented:

      1. Recipient has diagnosis of Acute Bacterial Skin and Skin Structure Infection; and

      2. Infection is caused by methicillin-resistant *Staphylococcus aureus* (MRSA); and

      3. Recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to:

trimethoprim/sulfamethoxazole (TMP/SMX), doxycycline, vancomycin, daptomycin, telavancin, clindamycin); or

4. Recipient started treatment with intravenous antibiotic(s) in the hospital and requires continued outpatient therapy.

b. Zyvox® (linezolid)

Approval will be given if the following criteria are met and documented:

1. Recipient has a diagnosis of vancomycin-resistant *enterococcus* (VRE) *faecium* infection or diagnosis of MRSA infection; and

2. Recipient has had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: TMP/SMX, doxycycline, vancomycin, tetracycline, clindamycin); or

3. Recipient started treatment with intravenous antibiotic(s) in the hospital and requires continued outpatient therapy.

3. Exception Criteria (applies to antibiotic medications)

a. Prescribed by an infectious disease specialist or by an emergency department provider; or

b. Ceftriaxone prescribed as first line treatment for gonorrhea, pelvic inflammatory disease, epididymo-orchitis and as an alternative to benzylpenicillin to treat meningitis for those with a severe penicillin allergy; or

c. If cefixime is prescribed for gonococcal infection where ceftriaxone is unavailable; or

d. The recipient resides in one of the following:

1. Acute Care

2. Long-term Acute Care (LTAC)

3. Skilled Nursing Facility (SNF)

4. Prior Authorization Guidelines

a. Prior authorization approval will be for a single course.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

5. References

a. CDC Antibiotic Prescribing and Use in Doctor's Offices: https://www.cdc.gov/antibiotic-use/community/for-hcp/outpatient-hcp/index.html

b. CDC Improving Prescribing: https://www.cdc.gov/antibiotic-use/community/improving-prescribing/index.html

c. IDSA Guidelines: https://www.idsociety.org/practice-guidelines/#/score/DESC/0/+/

ZZZ. Oral Oncology Agents

Therapeutic Class: Oral Oncology Agents
Last Reviewed by the DUR Board: January 24, 2019

Oral oncology agents are subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations (this criteria only applies if other product-specific criteria is not available in MSM Chapter 1200 – Prescribed Drugs)

   Approval will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis that is indicated in the FDA approved package insert or listed in nationally recognized compendia, for the determination of medically accepted indications; and

   b. If the oral oncology medication is not indicated as a first line agent, either in the FDA approved package insert or nationally recognized compendia, then documentation of previous therapies tried and failed is required; and

   c. The medication is prescribed by or in consultation with an oncologist or hematologist; and

   d. The recipient does not have any contraindications to the requested oral oncology medication; and

   e. The requested quantity and dosing regimen falls within the manufacturer's published dosing guidelines or nationally recognized compendia and is appropriate for the recipient's age; and

   f. The medication must be used in combination with other chemotherapeutic or adjuvant agents according to the FDA approved prescribing information; and

   g. One of the following:

      1. If an FDA-approved companion diagnostic test for the requested agent exists, then documentation that the test was performed to confirm the diagnosis is required; or

      2. If a test with adequate ability to confirm a disease mutation exists, then documentation that the test was performed to confirm the diagnosis is required.

2. Recertification Request

   a. Documentation of a positive clinical response to the oral oncology treatment.

3. Prior Authorization Guidelines

   a. Prior authorization approval will be for 12 months.

   b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

AAAA. Pulmonary Arterial Hypertension Agents

Therapeutic Class: Pulmonary Arterial Hypertension Agents
Reviewed by the DUR Board: January 24, 2019

Pulmonary arterial hypertension (PAH) agents are subject to prior authorization based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

a. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The recipient has a documented diagnosis of pulmonary arterial hypertension; or

b. The recipient has one of the following ICD-10 diagnosis codes submitted on the pharmacy claim:

ICD-10	Description
127.20	Pulmonary Hypertension, Unspecified
127.21	Secondary Pulmonary Arterial Hypertension
127.22	Pulmonary Hypertension Due to Left Heart Disease
127.23	Pulmonary Hypertension Due to Lung Diseases and Hypoxia
127.9	Pulmonary Heart Disease, Unspecified

2. Prior Authorization Guidelines

a. Prior authorization approval will be for 12 months.

b. Prior Authorization forms are available at:
https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

BBBB. Anticonvulsants

Therapeutic Class: Anticonvulsants
Last Reviewed by the DUR Board: April 22, 2021

Anticonvulsants are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Cannabinoid

   a. Epidiolex® (cannabidiol)

      1. Approval will be given if the following criteria are met and documented:

         a. The recipient has a diagnosis of Lennox-Gastaut syndrome, Dravet Syndrome or Tuberous Sclerosis Complex (TSC); and

         b. The recipient is one years of age or older; and

         c. A recent serum transaminase (ALT and AST) and total bilirubin level has been obtained and is within normal limits; and

         d. The drug is prescribed by or in consultation with a neurologist; and

         e. The total dose does not exceed 20 mg/kg/day (10mg/kg twice daily); and

         f. The medication will be used as adjunctive therapy (the recipient has been taking one or more antiepileptic drugs and has chart notes confirming the presence of at least four convulsive seizures per month).

      2. Recertification Request

         a. Documentation of a positive clinical response to Epidiolex® therapy; and

         b. Serum transaminase (ALT and AST) and total bilirubin level has been re-checked per package insert.

      3. Prior Authorization Guidelines

         a. Initial prior authorization will be for three months.

         b. Recertification approval will be for 12 months.

         c. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx

4. For anticonvulsant criteria for children and adolescents, refer to Section N, titled Psychotropic Medications for Children and Adolescents.

2. Nayzilam® (midazolam)

a. Approval will be given if the following criteria are met and documented:

1. The recipient has a diagnosis of acute intermittent seizures; and

2. The recipient is at least 12 years of age; and

3. The medication is prescribed by or in consultation with a Neurologist; and

4. The dose must not exceed two sprays per seizure cluster, no more than one episode every three days and treat no more than five episodes per month.

b. Recertification Request

1. Documentation of positive clinical response to Nayzilam® therapy.

c. Prior Authorization Guidelines

1. Initial prior authorization will be for six months.

2. Recertification approval will be for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Valtoco® (diazepam)

a. Approval will be given if all the following criteria are met and documented:

1. The recipient has a diagnosis of epilepsy; and

2. The recipient is six years and older; and

3. The medication is prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern; and

4. The medication is prescribed by or in consultation with a neurologist; and

5. The quantity must not exceed five episodes per month.

b. Prior Authorization Guidelines:

1. Documentation of positive clinical response to Valtoco® therapy.

c. Prior Authorization Guidelines:

1. Initial authorization will be approved for six months.

2. Recertification approval will be approved for 12 months.

3. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

4. Fintepla® (fenfluramine)

a. Approval will be given if all the following criteria are met and documented:

1. The recipient has a documented diagnosis of seizures associated with Dravet Syndrome; and

2. The recipient is two years of age or older; and

3. The medication is prescribed by or in consultation with a neurologist.

b. Recertification Request:

1. The recipient has documentation of positive clinical response to Fintepla® therapy.

c. Prior Authorization Guidelines:

1. Initial authorization will be for 12 months.

2. Recertification approval will be for 12 months.

3. Prior authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

CCCC. Amvuttra® (vutrisiran)

Therapeutic Drug Class: Amyloidosis-Agents Transthyretin (TTR) Suppression (P9B)
Last Reviewed by DUR Board: October 20, 2022

Amvuttra® (vutrisiran) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity.

1. Approval will be given if the following criteria are met and documented:

    a. Recipient is greater than or equal to 18 years of age; and

    b. Recipient will receive supplementation with vitamin A as the recommended daily allowance during vutrisiran therapy; and

    c. Vutrisiran must not be used in combination with other transthyretin (TTR) reducing agents (e.g., inotersen [Tegsedi®], tafamidis [Vyndamax®, Vyndaqel®], patisiran [Onpattro®]); and

    d. Recipient has a definitive diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis/FAP (familial amyloidotic polyneuropathy) as documented by amyloid deposition on tissue biopsy and identification of a pathogenic TTR variant using molecular genetic testing; and

    e. Polyneuropathy is demonstrated by greater than or equal to two of the following criteria:

        1. Subjective patient symptoms are suggestive of neuropathy; or

        2. Abnormal nerve conduction studies are consistent with polyneuropathy; or

        3. Abnormal neurological examination is suggestive of neuropathy; and

    f. Recipient’s peripheral neuropathy is attributed to hATTR/FAP and other causes of neuropathy have been excluded; and

    g. Baseline strength/weakness has been documented using an objective clinical measuring tool (e.g., Medical Research Council [MRC] muscle strength); and

    h. Recipient has not had an orthotopic liver transplant (OLT); and

    i. Quantity limit is one syringe every three months.

2. Recertification Request:

    a. Recipient continues to meet the above criteria; and

b. Recipient is absent of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: ocular symptoms related to hypovitaminosis A, etc.; and

c. Recipient has experienced disease response compared to pre-treatment baseline as evidenced by stabilization or improvement in greater than or equal to one of the following:

1. Signs and symptoms of neuropathy; or

2. MRC muscle strength.

d. Recertification will be approved for six months.

3. Prior Authorization Guidelines:

a. Prior authorization will be approved for six months.

DDDD. Oxervate® (cenegermin-bkbj)

Therpeutic Drug Class: Ophthalmic Human Nerve Growth Factor (Q25)
Last Reviewed by DUR Board: October 20, 2022

Oxervate® (cenegermin-bkbj) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity.

1. Approval will be given if the following criteria are met and documented:

    a. Recipient must be greater than or equal to two years of age; and

    b. Recipient must have a diagnosis of moderate to severe (stage two or stage three) neurotrophic keratitis (NK); and

    c. Prescribed by or in consultation with an ophthalmologist; and

    d. Prescriber attestation that patient or caregiver has been counseled on proper administration technique; and

    e. Quantity Limit of eight kits per affected eye per lifetime.

2. Renewal Criteria:

    a. Coverage not renewable.

3. Prior Authorization Guidelines:

    a. Prior authorization will be approved for eight weeks.

EEEE. Penicillamine

Therapeutic Class: Antirheumatics
Last reviewed by DUR Board: January 19, 2023

Penicillamine is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Wilson's Disease

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient has diagnosis of Wilson's Disease; and

      2. Medication prescribed by or in consultation with gastroenterologist, hepatologist, rheumatologist, or liver transplant physician.

   b. Recertification Request:

      1. Recipient continues to meet above criteria; and

      2. Recipient has demonstrated positive clinical response to therapy.

   c. Prior Authorization Guidelines:

      1. Initial approval will be given for 12 months.

      2. Recertification approval will be given for 12 months.

2. Cystinuria

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient has diagnosis of Cystinuria; and

      2. Recipient has a history of failure, contraindication, or intolerance to conservative treatment measures (e.g., use of urinary alkalinization such as potassium citrate, high fluid intake, sodium, and protein restriction) [initial criteria only]; and

      3. Medication is prescribed by or in consultation with nephrologist or urologist.

   b. Recertification Request:

      1. Recipient continues to meet above criteria; and

2. Recipient has demonstrated positive clinical response to therapy.

c. Prior Authorization Guidelines:

1. Initial approval will be given for 12 months.

2. Recertification will be approved for 12 months.

3. Rheumatoid Arthritis

b. Approval will be given if the following criteria are met and documented:

1. Recipient has diagnosis of severe, active rheumatoid arthritis; and

2. Recipient has contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of at least one non-biologic DMARD (such as methotrexate, leflunomide, or azathioprine) [initial criteria only].

3. Medication is prescribed by or in consultation with a rheumatologist.

b. Recertification Request:

1. Recipient continues to meet above criteria; and

2. Recipient has demonstrated positive clinical response to therapy.

c. Prior Authorization Guidelines:

1. Initial approval will be given for 12 months.

2. Recertification will be approved for 12 months.

FFFF. Rayaldee® (calcifediol)

Therapeutic Class: Vitamins
Last reviewed by DUR Board: January 19, 2023

Rayaldee® (calcifediol) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Rayaldee® (calcifediol)

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient is greater than or equal to 18 years of age; and

      2. Recipient has a diagnosis of secondary hyperparathyroidism (HPT); and

      3. Recipient has both of the following:

         a. serum total 25-hydroxyvitamin D level less than 30 ng/mL; and

         c. serum corrected total calcium below 9.8 mg/d; and

      4. Recipient has Chronic Kidney Disease (CKD) Stage 3 or 4

      5. Recipient does not have CKD Stage 5 or end stage renal disease on dialysis

      6. Recipient has a history of failure, contraindication, or intolerance to adequate trial of all of the following:

         a. Calcitriol

         b. Doxercalciferol

         d. Paricalcitol

      7. Medication is prescribed by or in consultation with nephrologist or endocrinologist.

   b. Recertification Request:

      1. Recipient has demonstrated positive response to treatment as defined by increase in serum total 25-hydroxyvitamin D level and/or decrease in intact parathyroid hormone (iPTH).

      2. Medication is prescribed by or in consultation with nephrologist or endocrinologist.

5. Prior Authorization Guidelines:

1. Initial approval will be given for six months.

2. Recertification will be approved for six months.

GGGG. Relyvrio® (sodium phenylbutyrate/taurursodiol)

Therapeutic Class: Amyotrophic Lateral Sclerosis (ALS)
Last reviewed by DUR Board: January 19, 2023

Relvyrio® (sodium phenylbutyrate/taurusodiol) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Relyvrio® (sodium phenylbutyrate/taurusodiol)

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient is greater than or equal to 18 years of age; and

      2. Recipient has a diagnosis of amyotrophic lateral sclerosis (ALS) based on validated criteria (e.g., revised El Escorial criteria, Awaji criteria, Gold Coast criteria); and

      3. Recipient must have an adequate trial of riluzole for greater than or equal to eight weeks or contraindication to therapy; and

      3. Physician has assessed baseline disease severity utilizing an objective measure/tool (e.g., Amyotrophic Lateral Sclerosis Functional Rating Scale-Revised (ALSFRS-R); and

      4. Recipient does not require permanent assisted ventilation; and

      5. Therapy prescribed by or in consultation with neurologist; and

   b. Recertification Request:

      1. Recipient must continue to meet the above criteria; and

      2. Recipient must have disease stabilization or improvement in the slope of decline as demonstrated on an objective measure/tool (e.g., ALSFRS-R); and

      3. Recipient has not experienced any unacceptable toxicity from treatment (e.g., worsening hypertension or heart failure).

   a. Prior Authorization Guidelines:

      1. Initial approval will be given for six months.

      2. Recertification will be approved for six months.

Z

2. MEDICATIONS WITH GENDER/AGE EDITS

A. Prenatal Vitamins

1. Payable only for female recipients.

2. Exemption to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.

B. Oral/Topical Contraceptives

1. Payable only for female recipients.

2. Exemption to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.

C. Gender Edits

1. Hormones

a. Estrogen – payable only for female recipients.

b. Progestins – payable only for female recipients.

c. Estrogen and Androgen Combinations – payable only for female recipients.

d. Estrogen and Progestin Combinations – payable only for female recipients.

e. Contraceptive Hormones – payable only for female recipients.

f. Testosterone – payable only for male recipients.

g. Androgen Hormone Inhibitor – payable only for male recipients.

2. Exception to the above gender edits:

A diagnosis of Gender Dysphoria (formerly known as Gender Identity Disorder) will bypass the gender edit if the appropriate ICD code is documented on the prescription and transmitted on the claim.

D. Vitamins with Fluoride

1. Payable only for recipients up to age 21 years.

3. ANTIRETROVIRALS

Antiretrovirals for the treatment of HIV/AIDS are a covered benefit for Nevada Medicaid recipients. FDA approved antiretrovirals whose manufacturers participate in the federal Drug Rebate Program and are not DESI drugs, are covered.

4. DIABETIC SUPPLY PROGRAM

Diabetic Supplies are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

Prior authorization is required for preferred and non-preferred diabetic products (including insulin delivery system and Continuous Glucose Monitor [CGM] receivers and readers).

Preferred diabetic product information is found at:
https://www.medicaid.nv.gov/providers/rx/diabeticsupplies.aspx

Preferred (including sensors and transmitters) and nonpreferred (including tubing, reservoirs for pumps and transmitters and sensors for CGM's) diabetic supplies do not require a prior authorization. These items require a documented diagnosis of diabetes mellitus type I (DM1) or gestational diabetes and recipients must meet all age restrictions stated on the manufacturer's label.

Pharmacy benefit allows a 100-day supply for insulin system and CGM supplies.

A. Preferred Insulin Delivery System

1. Approval will be given if the following criteria are met and documented:

a. Recipient must have a documented diagnosis of Diabetes Mellitus Type I or Gestational Diabetes; and

b. The product must be prescribed by or in consultation with an endocrinologist; and

c. The recipient must meet all age restrictions stated in the manufacturer's label; and

d. The recipient must have been compliant on their current antidiabetic regimen for at least the last six months and this regimen must include multiple day injections of insulin (requiring at least three injections per day); and

e. One of the following:

1. Documented history of recurring hypoglycemia; or

2. Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL, or

3. Prior use of an insulin pump with documented frequency of glucose self-testing of at least four times per day in the month immediately prior to the request.

2. Prior Authorization Guidelines

a. Initial prior authorization approval will be for one year.

b. Prior Authorization forms are available at: https://www.medicaid.nv.gov/providers/rx/rxforms.aspx.

3. Recertification Request

a. Recertification of prior authorization approval will be given if the recipient has documented positive clinical response to the product (including current HbA1C).

b. Recertification prior authorization approval will be for one year.

B. Non-Preferred Insulin Delivery System

1. Approval will be given if the following criteria are met and documented:

a. In addition to meeting the "Preferred Insulin Delivery System" criteria, the recipient must also meet the following:

1. The recipient must have been trained to use the non-preferred product; and

2. The recipient must have benefited from use of the non-preferred product; and

3. The recipient must have one of the following reasons/special circumstances:

4. Recipient has had an allergic reaction to a preferred product or related supply; or

5. Recipient has a visual impairment which requires the use of a non-preferred product; or

6. Recipient has medical necessity justification (e.g. mental or physical limitation) which requires them to stay on their current product.

C. Preferred Continuous Glucose Monitors (CGMs)

1. Approval will be given if the following criteria are met and documented:

a. Recipient must have a documented diagnosis of Diabetes Mellitus Type I or Gestational Diabetes; and

b. Recipient must meet all age restrictions stated in the manufacturer's label; and

c. Recipient must have been compliant on their current antidiabetic regimen for at least the last six months and this regimen must include multiple daily injections of insulin (requiring at least three injections per day); and

d. One of the following:

1. Documented history of recurring hypoglycemia; or

2. Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL; or

3. Recipient is currently using insulin pump therapy while continuing to need frequent dosage adjustments or experiencing recurring episodes of severe hypoglycemia (50 mg/dL).

2. Prior Authorization Guidelines

a. Initial prior authorization approval will be for one year.

b. Prior Authorization forms are available at: https/www.medicaid.nv.gov/providers/rx/rxforms.aspx

D. Non-Preferred Continuous Glucose Monitor (CGM)

1. Approval will be given if the following criteria are met and documented:

a. In addition to meeting the Preferred CGM criteria, the recipient must also meet the following:

1. Recipient has had an allergic reaction to a preferred product or related supply; or

2. Recipient has a visual impairment which requires the use of a non-preferred product; or

3. Recipient has medical necessity justification (e.g. mental or physical limitation) which requires them to stay on their current product; or

4. The recipient must have been trained to use the non-preferred product; and

5. The recipient must have benefited from use of the non-preferred product.

E. Test Strips and Lancets

a. Pharmacy Services billing information including Billing Manual and Quantity Limits is available at: https://www.medicaid.nv.gov/providers/rx/billinginfo.aspx

*Blood Glucose monitors with special features (e.g. voice synthesizers) require a prior authorization. For special blood glucose monitors, a diagnosis and a statement from the physician documenting the impairment is required with a prior authorization.

5. PHYSICIAN ADMINISTERED DRUGS (PADs) REQUIRING PRIOR AUTHORIZATION AND/OR QUANTITY LIMITATIONS

A. Abraxane® (paclitaxel protein-bound particles)

Therapeutic Class: Taxane Chemotherapy
Last Reviewed by the DUR Board: N/A

Physician Administered Drugs (PAD) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

a. Recipient is at least 18 years of age; and

b. Breast Cancer

1. Recipient failed on combination chemotherapy for metastatic disease or relapsed within six months of adjuvant therapy; and

a. Previous chemotherapy included an anthracycline unless clinically contraindicated; or

2. Recipient has recurrent unresectable (local or regional) or metastatic (Stage IV [M1]) disease or inflammatory breast cancer with no response to preoperative systemic therapy; and

a. Used a single agent or in combination with carboplatin in recipient with high tumor burden, rapidly progressing disease, and visceral crisis; and

b. Disease is HER2-negative; and

1. Disease is hormone receptor-negative; or

2. Disease is hormone receptor-positive, and recipient is refractory to endocrine therapy or has a visceral crisis; or

c. Used as third line or greater therapy in combination with trastuzumab for disease that is HER2-positive; or

d. Used in combination with pembrolizumab for PD-L1 positive triple-negative disease; or

3. May be substituted for paclitaxel or docetaxel if the recipient has experienced hypersensitivity reactions despite premedication, or the patient has contraindication to standard hypersensitivity premedication.

c. Non-Small Cell Lung Cancer (NSCLC)

1. Used as first-line therapy for locally advanced or metastatic disease, in combination with carboplatin, in patients who are not candidates for curative surgery or radiation therapy; or

2. May be substituted for paclitaxel or docetaxel if the recipient has experienced hypersensitivity reactions despite premedication or the recipient has contraindications to standard hypersensitivity premedication; or

3. Used for recurrent, advanced, metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence or disseminated disease), or mediastinal lymph node recurrence with prior radiation therapy; and

a. Used as first-line therapy; and

1. Used in combination with carboplatin and pembrolizumab (for squamous cell histology) or atezolizumab (for non-squamous histology); and

a. Used in recipients with tumors that have negative actionable molecular biomarkers; and

b. Used in recipients with PS 0-1 who are positive for one of the following molecular mutations: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2); or

2. Used in combination with carboplatin in recipients with contraindications to PD-1 or PD-L1 inhibitors (PS score of 0-2) or as a single agent (PS score of 2); and

a. Used in recipients with tumors that have negative actionable molecular biomarkers and PD-L1 greater than or equal to one percent; or

b. Used in recipients with tumors that have negative actionable molecular biomarkers and PD-L1 less than one percent; or

c. Used in recipients who are positive for one of the following molecular mutations: EFGR exon 20, KRAS G12C, BRAD V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2); or

b. Used as subsequent therapy; and

1. Used as a single agent (if not previously given) in recipients with a PS 0-2; and

a. Used for first progression after initial systemic therapy; or

b. Used in combination with carboplatin and pembrolizumab (for squamous cell histology) or atezolizumab (for non-squamous histology) in recipients with PS score of 0-1; and

1. Used in recipients who are positive for one the following molecular mutations: BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, or RET rearrangement; or

2. Used in recipients who are positive for one of the following molecular mutations and have received prior targeted therapy for those aberrations: EGFR exon 19 deletion or L858R tumors, EGFR S768I, L861Q, and/or G719X positive tumors, ALK rearrangement, or ROS1 rearrangement; or

c. Used in combination with carboplatin in recipients with contraindications to PD-1 or PD-L1 inhibitors (PS score of 0-2) or as a single agent (PS score of 2); and

1. Used in recipients who are positive for one of the following molecular mutations: BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, or RET rearrangement; or

2. Used in recipients who are positive for one of the following molecular mutations and have received prior targeted therapy for those aberrations: EGFR exon 19 deletion or

L858R tumors, EGFR S7681, L861Q, and/or G719X positive tumors, ALK rearrangement, or ROS1 rearrangement; or

3. Used in recipients with PD-L1 expression-positive (greater than or equal to one percent) tumors that are negative for actionable molecular biomarkers with prior PD-1/PD-L1 inhibitor therapy but no prior platinum-doublet chemotherapy.

d. Ovarian Cancer (Epithelial Ovarian/Fallopian Tube/Primary Peritoneal)

1. Recipient has recurrent or persistent disease; and

2. Recipient is not experiencing an immediate biochemical relapse (i.e., rising CA-125 without radiographic evidence of disease); and

a. Used a single agent; and

1. Recipient has platinum-resistant disease; and

a. Used for progression on primary, maintenance, or recurrence therapy; or

b. Used for stable or persistence disease if not currently on maintenance therapy; or

c. Used for relapse disease less than six months after complete remission from prior chemotherapy; or

2. Recipient has platinum-sensitive disease; and

a. Used for radiographic and/or clinical relapse greater than or equal to six months after complete remission from prior chemotherapy; or

b. Used in combination with carboplatin for platinum-sensitive disease with confirmed taxane hypersensitivity; and

1. Used for relapse greater than or equal to six months after complete remission from prior chemotherapy; or

3. Recipient has recurrent low-grade serous carcinoma; and

a. Used as a single agent for platinum-sensitive or platinum-resistant disease; or

b. Used in combination with carboplatin for platinum-sensitive disease with confirmed taxane hypersensitivity; or

4. May be substituted for paclitaxel if the recipient has experienced hypersensitivity reactions despite premedication or the recipient has contraindications to standard hypersensitivity premedication.

e. Pancreatic Adenocarcinoma

1. Used in combination with gemcitabine; and

a. Recipient has locally advanced or metastatic disease; and

1. Used as first-line therapy; or

2. Used an induction therapy followed by chemoradiation (locally advanced disease only); or

3. Used as subsequent therapy after progression with a fluoropyrimide-based therapy; or

4. Used as continuation (subsequent) therapy if no disease progression after first-line therapy (locally advanced disease only); or

5. Used as continuation (maintenance) therapy if acceptable tolerance and no disease progression after at least 4-6 months of first-line therapy (metastatic disease only); or

b. Recipient has recurrent disease in the pancreatic operative bed or metastatic disease, post-resection; and

1. Used greater than or equal to six months after completion of primary therapy; or

2. Used less than six months from completion of primary therapy with a fluoropyrimidine-based regimen; or

c. Used as neoadjuvant therapy; and

1. Recipient has resectable disease with high-risk features (i.e., markedly elevated CA 19-9, large primary tumors, large regional lymph nodes, excessive weight loss, extreme pain); or

2. Recipient has biopsy positive borderline resectable disease; or

2. Used in combination with gemcitabine and cisplatin; and

a. Recipient has metastatic disease; and

b. Recipient has ECOG PS 0-1; and

1. Used as first-line therapy; or

2. Used as continuation (maintenance) therapy if acceptable tolerance and no disease progression after at least 4-6 months of first-line therapy.

f. Cutaneous Melanoma

1. Used as a single agent or in combination with carboplatin for metastatic or unresectable disease; and

a. Used as subsequent therapy for disease progression; or

b. Used after maximum clinical benefit from BRAF targeted therapy (e.g., dabrafenib/trametinib, vemurafenib/cobimetinib, encorafenib/binimetinib, etc.).

g. Uveal Melanoma

1. Used as a single agent for distant metastatic disease

h. Endometrial Carcinoma (Uterine Neoplasms)

1. Used as a single agent therapy; and

2. Recipient has tried paclitaxel and treatment paclitaxel was not tolerated due to a documented hypersensitivity reaction, despite use of recommended premedication, or there is a documented medical contraindication to recommended premedication; and

a. Recipient has endometroid adenocarcinoma; and

1. Used a primary treatment of disease not suitable for primary surgery; and

a. Recipient has suspected or gross cervical involvement (excluding recipients using a chemotherapy alone); or

b. Recipient has locoregional extrauterine disease; or

c. Recipient has distant metastases; or

2. Recipient has carcinosarcoma, clear cell carcinoma, serous carcinoma, or un-/de-differentiated carcinoma; and

a. Used for locoregional recurrence or disseminated metastases; or

b. Used as additional treatment of metastatic disease that is suitable for primary surgery; or

c. Used as primary treatment of metastatic disease that is not for primary surgery.

i. Hepatobiliary Adenocarcinoma (Intrahepatic /Extrahepatic Cholangiocarcinoma, Gallbladder)

1. Used in combination with gemcitabine for unresectable or metastatic disease; and

a. Used as a primary treatment; or

b. Used as a subsequent treatment for progression on or after systemic therapy.

j. Small Bowel Adenocarcinoma

1. Recipient has advanced or metastatic disease; and

2. Used as single agent or in combination with gemcitabine; and

a. Used as subsequent therapy; or

b. Recipient has had prior adjuvant oxaliplatin exposure, or a contraindication to oxaliplatin; and

1. Used as initial therapy; or

2. Used as subsequent therapy in recipient who previously received initial therapy with nivolumab with or without ipilimumab, pembrolizumab, or dostarlimab-gxly.

k. Kaposi Sarcoma

1. Used as subsequent therapy; and

a. Used as a single agent for patients that do not have HIV; or

b. Used in combination with antiretroviral therapy (ART) for recipients with HIV; and

2. Recipient has relapsed/refractory advanced cutaneous, oral, visceral, or nodal disease; and

3. Disease has progressed on or not responded to first-line systemic therapy; and

4. Disease has progressed on alternative first-line systemic therapy.

l. Ampullary Adenocarcinoma

1. Used in combination with gemcitabine; and

2. Recipient has pancreatobiliary and mixed type disease; and

a. Used as neoadjuvant therapy for localized disease in high-risk recipients (i.e., imaging findings, markedly elevated CA 19-9, markedly elevated carcinoembryonic antigen [CEA], large primary tumors, large regional lymph nodes, excessive weight loss, extreme pain); or

b. Used as first-line therapy for unresectable localized or metastatic disease; or

c. Used as subsequent therapy for disease progression.

2. Dosing Limits

a. Quantity Limit (max daily dose) [NDC Unit]:

1. Abraxane® 100 mg powder for injection single dose vial: 9 vials per 21-day supply

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Kaposi Sarcoma

1. 300 billable units per 28 days

b. All other indications

1. 900 billable units per 21 days

3. Recertification Request:

a. Recipient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in Section III; and

b. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

c. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe myelosuppression (e.g., severe neutropenia [absolute neutrophil count less than 1,500 cell/mm3] or thrombocytopenia), sensory neuropathy, sepsis, pneumonitis, severe hypersensitivity reactions (including anaphylactic reactions), etc.

4. PA Guidelines:

a. Initial approval will be given for six months.

b. Recertification will be given for six months.

B. Anti-PD-1 Monoclonal Antibodies

Therapeutic Class: Anti-PD-1 Monoclonal Antibodies
Last Reviewed by the DUR Board: N/A

Anti-PD-1 Monoclonal Antibodies are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Bavencio® (avelumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age, unless otherwise indicated; and

2. Universal Criteria

a. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)-directed therapy (e.g., nivolumab, pembrolizumab, dostarlimab, atezolizumab, durvalumab, cemiplimab, nivolumab/relatlimab-rmbw, etc.), unless otherwise specified; and

3. Merkel Cell Carcinoma (MCC)

a. Recipient is at least 12 years of age; and

b. Used as single-agent therapy; and

c. Recipient has metastatic or recurrent disseminated disease.

4. Urothelial Carcinoma (Bladder Cancer)

a. Used as single-agent therapy; and

1. Recipient has one of the following diagnoses:

a. Locally advanced or metastatic urothelial carcinoma

b. Muscle invasive bladder cancer with local recurrence or persistent disease in a preserved bladder

c. Metastatic or local bladder cancer recurrence post cystectomy

d. Metastatic upper genitourinary (GU) tract tumors

e. Metastatic urothelial carcinoma of the prostate

f. Recurrent or metastatic primary carcinoma of the urethra (excluding recurrence of stage T3-4 disease or palpable inguinal lymph nodes); and

2. Used for disease that progressed during or following platinum-containing chemotherapy; or

3. Used as second-line treatment after chemotherapy other than a platinum; or

b. Used for first-line maintenance treatment; and

1. Recipient has locally advanced or metastatic urothelial carcinoma (inclusive of bladder, upper GU tract, urethra, and/or prostate cancer); and

2. Recipient has not progressed with first-line platinum-containing chemotherapy.

4. Renal Cell Carcinoma (RCC)

a. Used in combination with axitinib; and

b. Used as first-line therapy; and

c. Used for the treatment of advanced, relapsed, or stage IV disease and clear cell histology.

5. Gestational Trophoblastic Neoplasia

a. Used a single-agent therapy for multiagent chemotherapy-resistant disease; and

1. Recipient has intermediate placental site trophoblastic tumor (PSTT) or epithelioid trophoblastic tumor (ETT); and

a. Recipient has recurrent or progressive disease; and

b. Recipient was previously treatment with a platinum-based regimen; or

2. Recipient has high-risk disease (i.e., prognostic score greater than or equal to seven or FIGO stage IV disease).

6. Endometrial Carcinoma (Uterine Neoplasms)

a. Used as single-agent therapy; and

b. Recipient has recurrent or metastatic disease; and

c. Used as second-line treatment for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) tumors.

b. Dosing Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Bavencio 200 mg/10mL single dose vial: 4 vials per 14 days

2. Max Units (per dose and over time) [HCPCS Unit]:

a. 80 billable units (800 mg) every 14 days (all indications)

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe or life-threatening infusion-related reactions, hepatotoxicity, severe and fatal immune-mediated adverse reactions (e.g., pneumonitis, hepatitis, colitis, endocrinopathies, nephritis with renal dysfunction, dermatitis/dermatologic adverse reactions, etc.), major adverse cardiovascular events (MACE) when used in combination with axitinib, complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc.

d. PA Guidelines:

1. Initial approval will be given for 6 months.

2. Recertification will be given for 6 months.

2. Imfinzi® (durvalumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age; and

2. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)- directed therapy (e.g., nivolumab, pembrolizumab,

atezolizumab, avelumab, cemiplimab, dostarlimab, nivolumab/relatlimab-rmbw, etc.) unless otherwise specified; and

3. Non-Small Cell Lung Cancer (NSCLC)

   a. Recipient has a performance status (PS) of 0-1; and

      1. Used as a single agent; and

         a. Used as consolidation therapy: and

         b. Recipient has unresectable stage II-III disease; and

         c. Disease has not progressed after definitive chemoradiation; or

      2. Used in combination with tremelimuab-actl and platinum-based chemotherapy; and

         a. Used as first-line therapy for metastatic disease; and

         b. Recipient had no EGFR mutations or ALK genomic tumor aberrations.

4. Small Cell Lung Cancer (SCLC)

   a. Recipient has extensive stage disease (ES-SCLC); and

      1. Used as first-line therapy in combination with etoposide and either carboplatin or cisplatin; or

      2. Used as single-agent maintenance therapy after initial therapy with etoposide and either carboplatin or cisplatin.

5. Hepatobiliary Cancers

   a. Recipient has hepatocellular carcinoma (HCC); and

      1. Used a first-line therapy as a single agent; and

         a. Recipient has unresectable disease and is not a transplant candidate; or

         b. Recipient has liver-confirmed disease that is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease; or

         c. Recipient has metastatic disease or extensive liver tumor burden; or

2. Used as first-line therapy in combination with tremelimumab-actl; and

a. Recipient has unresectable disease; and

b. Recipient has Child-Pugh Class A hepatic impairment (i.e., excludes class B and C impairments); and

1. Recipient has intermediate disease (i.e., multinodular, PS 0) and is not eligible for locoregional therapy; or

2. Recipient has advanced disease (i.e., portal invasion, regional lymph node metastasis, distant metastasis, PS 1-2); or

b. Recipient has biliary tract cancer (e.g., gallbladder cancer or intra-/extra- hepatic cholangiocarcinoma); and

1. Used in combination with cisplatin and gemcitabine; and

a. Used as primary treatment for unresectable, locally advanced, or metastatic disease; or

b. Used for recurrent disease greater than six months after surgery with curative intent and greater than six months after completion of adjuvant therapy.

b. Dosage Limits

1. Quantity Limits (max daily dose) [NDC Unit]:

a. Imfinzi 120 mg/2.4 mL single dose vial: four vials per 14 days

b. Imfinzi 500 mg/10 mL single dose vial: two vials per 14 days

2. Max Units (per dose and over time) [HCPCS Unit]:

a. NSCLC: 112 billable units (1,120 mg) every 14 days

b. SCLC: 150 billable units (1,500 mg) every 21 days x six disease, then 150 billable units (1,500 mg) every 28 days

c. Biliary Tract Cancer: 150 billable units (1,500 mg) every 21 days x eight doses, then 150 billable units (1,500 mg) every 28 days

d. Hepatocellular Carcinoma: 150 billable units (1,500 mg) every 28 days

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe or life-threatening infusion-related reactions, immune-mediated adverse reactions (e.g., pneumonitis, hepatitis, colitis, endocrinopathies, nephritis with renal dysfunction, dermatology reactions, pancreatitis, etc.), complications of allogeneic hematopoietic stem cell transplantation (HCST), etc.; and

4. NSCLC (single-agent use)

a. Recipient has not exceeded a maximum of 12 months of therapy

5. Hepatobiliary Cancers

a. Cases for recipients with HCC who use treatment as part of STRIDE and experience disease progression but who are clinically stable and still deriving clinical benefit will be reviewed on a case-by-basis.

6. Continuation Maintenance Therapy for SCLC

a. Refer to Section III for criteria.

d. PA Guidelines:

1. Initial approval for Non-Small Cell Lung Cancer (single agent use) will be given for six months.

2. Recertification for Non-Small Cell Lung Cancer (single agent use) will be given for 12 months.

3. Initial approval for Non-Small Cell Lung Cancer (use in combination with tremelimumab-act] and platinum-based chemotherapy, Small Cell Lung Cancer and Hepatobiliary Cancers will be given for six months.

4. Recertification for Non-Small Cell Lung Cancer (used in combination with tremelimumab-act] and platinum-based chemotherapy, Small Cell Lung Cancer and Hepatobiliary Cancers will be for six months.

3. Libtayo® (cemiplimab-rwlc)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)-directed therapy (e.g., avelumab, pembrolizumab, atezolizumab, durvalumab, nivolumab, dostarlimab, nivolumab/relatlimab-rmbw, etc.), unless otherwise specified; and

3. Cutaneous Squamous Cell Carcinoma (cSCC)

a. Recipient has metastatic disease, locally advanced disease, unresectable disease, inoperable or incompletely resected regional disease, new regional disease, or local or regional recurrence; and

b. Used as a single agent; and

c. Recipient is not a candidate for curative surgery or curative radiation therapy.

4. Basal Cell Carcinoma

a. Recipient has previously been treated with a hedgehog pathway inhibitor (HHI) (e.g., vismodegib, sondegib, etc.)

b. Used as a single agent; and

1. Recipient has locally advanced disease; or

2. Recipient has local recurrence and is not a candidate for curative surgery or curative radiation therapy; or

3. Recipient has nodal, regional, or metastatic disease.

5. Non-Small Cell Lung Cancer (NSCLC)

a. Recipient has tumors that are negative for actionable molecular biomarkers; and

1. Used as first-line therapy in combination with platinum-based chemotherapy; and

a. Recipient has locally advanced disease and is not a candidate for surgical resection or definitive chemoradiation; or

b. Recipient has metastatic disease; or

2. Used for recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease with no evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy; and

a. Recipient has tumors with high PD-L1 expression (Tumor Proportion Score [TPS] greater than or equal to 50%) as determined by an FDA-approved or CLIA compliant test; and

b. Used as a single agent; and

1. Used as first-line therapy; or

2. Used as continuation maintenance therapy in recipients who achieved a tumor response or stable disease after first-line therapy with cemiplimab-rwlc.

b. Dosage Limits

1. Quantity Limits (max daily dose) [NDC Unit]:

a. Libtayo® 350 mg/seven mL single-dose vial: one vial per 21 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. 350 billable units (350 mg) every 21 days.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion-related reactions, severe and fatal immune-mediated adverse reactions (e.g., pneumonitis, colitis, hepatitis, endocrinopathies, nephritis with renal dysfunction, dermatologic adverse

reactions, etc.), complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc; and

3. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

d. Prior Authorization Guidelines

1. Initial approval will be given for six months.

2. Recertification will be given for six months.

4. Ocrevus® (ocrelizumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age (unless otherwise specified); and

2. Recipient has been screened for the presence of Hepatitis B virus (HBV) prior to initiating treatment and does not have active disease (i.e., positive HBsAg and anti-HBV tests); and

3. Recipient has had baseline serum immunoglobulins assessed; and

4. Universal Criteria

a. Recipient will not receive live or live-attenuated vaccines while on therapy or within four weeks prior to initiation of treatment; and

b. Recipient does not have an active infection; and

5. Multiple Sclerosis

a. Recipient must have a confirmed diagnosis of multiple sclerosis (MS) as documented by laboratory report (i.e., MRI); and

b. Must be used as single agent therapy; and

1. Recipient has diagnosis of relapsing form of MS [i.e., relapsing-remitting MS (RRMS), active secondary progressive disease (SPMS), or clinically isolated syndrome (CIS); or

2. Recipient has a diagnosis of primary progressive MS (PPMS); and

a. Recipient is less than 65 years; and

b. Recipient has an expanded disability status scale (EDSS) score of less than or equal to six and a half.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Ocrevus® 300mg single-dose vial: two vials in first two weeks, then two vials per six months.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Initial Dose

1. 300 billable units (300 mg) on day one and day 15.

b. Subsequent Dose

1. 600 billable units (300 mg) every six months.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Recipient has not received a dose of ocrelizumab within the past five months; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion reactions, severe infections, progressive multifocal leukoencephalopathy malignancy, hypoegammaglobulinemia, immune-mediated colitis, etc.; and

4. Continuous monitoring of response to therapy indicates a beneficial response [manifestations of MS disease activity include, but are not limited to, an increase in annualized relapse rate (ARR), development of new/worsening T2 hypertensities or enhancing lesions on brain/spinal MRI, and progression of sustained impairment as evidenced by expanded disability status scale (EDSS), timed 25-foot walk (T25-FW), nine-hole peg test (nine-HPT].

a. Inadequate response, in those who have been adherent and receiving therapy for sufficient time to realize the full treatment effect, is defined as greater than or equal to one relapse, greater than or equal to two unequivocally new MRI-detected lesions, or increased disability on examination over a one-year period.

5. PPMS

a. Recipient continues to be ambulatory, defined as an EDSS score of less than seven and a half.

d. Prior Authorization Guidelines

1. Initial approval will be given for six months.

2. Recertification will be given for six months.

5. Opdivo® (nivolumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age (unless otherwise specified); and

2. Universal Criteria

a. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)-directed therapy (e.g., cemiplimab, avelumab, pembrolizumab, atezolizumab, durvalumab, dostarlimab, nivolumab/relatlimab-rmbw, etc.), unless otherwise specified; and

3. Ampullary Adenocarcinoma

a. Recipient's disease is microsattelite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

b. Used in combination with ipilimumab; and

1. Used as first-line therapy for unresectable or metastatic intestinal type disease; or

2. Used as subsequent therapy for disease progression.

4. Anal Carcinoma

a. Recipient has metastatic squamous cell disease; and

b. Used as a single agent for subsequent therapy.

5. Urothelial Carcinoma (Bladder Cancer)

a. Used as a single agent; and

1. Used for disease that progressed during or following platinum-containing chemotherapy as a second-line treatment after chemotherapy other than a platinum; and

a. Recipient has one of the following diagnoses:

1. Locally advanced or metastatic urothelial carcinoma

2. Muscle invasive bladder cancer with local recurrence or persistent disease in a preserved bladder

3. Metastatic or local bladder cancer recurrence post-cystectomy

4. Recurrent or metastatic primary carcinoma of the urethra; and

a. Recipient does not have recurrence of stage T3-4 disease or palpable inguinal lymph nodes

5. Metastatic upper genitourinary (GU) tract tumors

6. Metastatic urothelial carcinoma of the prostate; or

2. Used as adjuvant therapy; and

a. Recipient has urothelial carcinoma of the bladder, bulbar urethra, prostate with stromal invasion, ureter, or renal pelvis; and

b. Recipient underwent radical surgical resection or atriall cystectomy; and

c. Recipient is at high risk for disease recurrence.

6. Bone Cancers

a. Recipient has one of the following: Ewing sarcoma, chondrosarcoma (excluding mesenchymal chondrosarcoma), osteosarcoma, or chordoma; and

b. Recipient has tumor mutation burden-high (TMB-H) tumors [greater than or equal to 10 mutations/megabase (mut/Mb)] as determined by an FDA-approved or CLIA-compliant test; and

c. Used in combination with ipilimumab; and

d. Recipient has unresectable or metastatic disease that progressed following prior treatment; and

e. Recipient has no satisfactory alternative treatment options.

7. Adult Central Nervous System (CNS) Cancers

a. Used in one of the following treatment settings:

1. Used as initial treatment in recipients with small asymptomatic brain metastases

2. Used for relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options

3. Recipient has recurrent limited brain metastases

4. Used for recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options; and

b. Used as a single-agent or in combination with ipilimumab for the treatment of brain metastases in recipients with BRAF non-specific melanoma; or

c. Used as a single-agent for the treatment of brain metastases in recipients with PD-L1 positive non-small cell lung cancer (NSCLC).

8. Pediatric Central Nervous System (CNS) Cancers

a. Recipient is less than or equal to 18 years of age; and

b. Recipient has hypermutated diffuse high-grade glioma; and

1. Used for recurrent or progressive disease as a single agent (excluding oligodendroglioma, IDH-mutant and 1p/19q co-deleted or astrocytoma IDH-mutant); or

2. Used as adjuvant therapy (excluding diffuse midline glioma, H3 K27-altered or pontine location); and

a. Recipient is less than three years of age and used as a single agent; or

b. Recipient is greater than or equal to three years of age and used following standard brain radiation therapy (RT) with or without concurrent temozolomide.

9. Cervical Cancer

a. Used as subsequent therapy as a single agent; and

b. Recipient has persistent, recurrent, or metastatic disease; and

c. Tumor expressed PD-L1 (e.g., CPS greater than or equal to one) as determined by an FDA-approved or CLIA-compliant test.

10. Colorectal Cancer

a. Recipient is at least 12 years of age; and

b. Recipient's disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

c. Used as a single agent or in combination with ipilimumab; and

1. Used as subsequent therapy for advanced or metastatic disease that progressed following treatment with one of the following:

a. Fluoropyrimidine-, oxaliplatin-, and/or irinotecan-based chemotherapy

b. Non-intensive therapy in recipients with an improvement in functional status; or

2. Used as primary treatment; and

a. Used as neoadjuvant therapy for clinical T4b colon cancer; or

b. Used as neoadjuvant therapy for resectable liver and/or lung metastases; or

c. Used if resection is contraindicated following neoadjuvant therapy for advanced, locally unresectable, or medically inoperable rectal cancer; or

d. Used for unresectable (or medically inoperable) or metastatic disease.

11. Appendiceal Adenocarcinoma – Colon Cancer

a. Recipients' disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

b. Used as a single agent or in combination with ipilimumab; and

1. Used as subsequent therapy for advanced or metastatic disease that progressed following previous oxaliplatin-irinotecan- and/or fluoropyrimidine-based therapy; or

2. Used as initial therapy for advanced or metastatic disease.

12. Esophageal Cancer and Esophagogastric/Gastroesophageal Junction Cancers

a. Used as first-line therapy; and

1. Recipient has esophageal squamous cell carcinoma (ESCC); and

a. Recipient is not a surgical candidate or has unresectable advanced, recurrent, or metastatic disease; and

1. Used in combination with ipilimumab; or

2. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy; or

b. Recipient has adenocarcinoma; and

1. Recipient is not a surgical candidate or has unresectable, advanced, recurrent, or metastatic disease; and

2. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy; or

b. Used as subsequent therapy; and

1. Recipient has esophageal squamous cell carcinoma (ESCC); and

2. Recipient is not a surgical candidate or has unresectable advanced, recurrent, or metastatic disease; and

3. Used as a single agent; or

c. Used as adjuvant treatment of completely resected disease; and

1. Used as a single agent in recipient with residual disease following neoadjuvant chemoradiotherapy (CRT).

13. Gestational Trophoblastic Neoplasia

a. Used as single-agent therapy for multiagent chemotherapy-resistant disease; and

1. Recipient has intermediate placental site trophoblastic tumor (PSTT) or epithelioid trophoblastic tumor (ETT); and

a. Recipient has recurrent or progressive disease; and

b. Recipient has previously treated with a platinum-based regimen; or

2. Recipient has high risk disease (i.e., greater than or equal to seven Prognostic score or stage IV disease).

14. Gastric Cancer

a. Recipient is not a surgical candidate or has unresectable, advanced, recurrent, or metastatic disease; and

1. Used as first-line therapy in combination with fluoropyrimidine – and platinum containing chemotherapy.

15. Squamous Cell Carcinoma of the Head and Neck (SCCHN)

a. Recipient has Cancer of the Nasopharynx; and

1. Used in combination with cisplatin and gemcitabine for oligometastatic or metastatic disease; or

b. Recipient has Very Advanced Head and Neck Cancer; and

1. Recipient has nasopharyngeal cancer; and

a. Used in combination with cisplatin and gemcitabine for recipients with performance status 0-1; and

b. Used for one of the following:

1. Unresectable locoregional recurrence with prior radiation therapy (RT)

2. Unresectable second primary with prior RT

3. Unresectable persistent disease with prior RT

4. Recurrent/persistent disease with distant metastases; or

2. Recipient has non-nasopharyngeal cancer; and

a. Used as a single agent; and

b. Recipient has unresectable, recurrent, persistent, or metastatic disease; and

c. Disease has progressed on or after platinum-containing chemotherapy.

16. Hepatocellular Carcinoma (HCC)

a. Used in combination with ipilimumab; and

b. Used as subsequent therapy for progressive disease; and

c. Recipient has Child-Pugh Class A hepatic impairment; and

1. Recipient was previously treated with sorafenib; or

2. Recipient has unresectable disease and is not a transplant candidate; or

3. Recipient has liver-confined disease that is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic-disease; or

4. Recipient has metastatic disease or extensive liver tumor burden.

17. Adult Classical Hodgkin Lymphoma (cHL)

a. Used as a single agent; and

1. Recipient has relapsed or progressive disease after autologous hematopoietic stem cell transplantation (HSCT) and brentuximab vedotin; or

2. Used for disease that is refractory to at least three prior lines of therapy or as palliative therapy in recipient greater than 60 years of age; and

a. Recipient has relapsed or progressive disease after autologous HSCT; or

b. Recipient has relapsed or refractory disease and is transplant-ineligible based on comorbidities or failure or second-line chemotherapy; or

c. Recipient is post-allogeneic stem-cell transplant; or

b. Used in combination with brentuximab vedotin or ICE (ifosfamide, carboplatin, etoposide); and

1. Used as subsequent therapy (if not previously used) for relapse or refractory disease; and

a. Recipient has relapsed or progressive disease after autologous HSCT; or

b. Recipient has relapsed or refractory disease and is transplant-ineligible based on comorbidities or failure of second-line chemotherapy; or

c. Recipient is post-allogeneic stem-cell transplant.

18. Pediatric Classical Hodgkin Lymphoma (cHL)

a. Recipient is less than or equal to 18 years of age; and

b. Recipient has relapsed or refractory disease; and

c. Used in recipients heavily pretreated with platinum or anthracycline-based chemotherapy or if a decrease in cardiac function was observed; and

1. Used as subsequent therapy (if not previously used); and

a. Used as re-induction therapy; and

2. Used as a single agent or in combination with brentuximab vedotin; or

3. Used in combination with brentuximab vedotin and radiation therapy (ISRT) in highly favorable recipients who may avoid autologous stem cell rescue (ASCR) (i.e., initial stage other than IIIB or IVB, no prior exposure to RT, duration of CR1 greater than one year, absence of extranodal disease or B symptoms at relapse).

19. Renal Cell Carcinoma (RCC)

a. Used in combination with ipilimumab for clear cell histology; and

1. Used as first-line therapy in recipients with poor or intermediate risk advanced, relapsed, or stage IV disease; or

2. Used as first-line therapy in recipients with favorable risk relapsed or stage IV disease; or

3. Used as subsequent therapy in recipients with relapsed or stage IV disease; or

b. Used as a single agent; and

1. Used as subsequent therapy in recipients with advanced, relapsed, or stage IV disease and clear cell histology; or

2. Recipient has relapsed or stage IV disease and non-clear cell histology; or

c. Used in combination with cabozantinib (Cabometyx only); and

1. Recipient has clear cell histology; and

a. Used as first-line therapy for advanced, relapsed, or stage IV disease; or

b. Used as subsequent therapy in recipients with relapsed or stage IV disease; or

2. Recipient has non-clear cell histology; and

a. Recipient has relapsed or stage IV disease.

20. Malignant Peritoneal Mesothelioma (MPeM)

a. Used as a single agent or in combination with ipilimumab as subsequent therapy (if not administered first-line); or

b. Used in combination with ipilimumab as first-line therapy; and

1. Recipient has unresectable diffuse disease; or

2. Recipient has unresectable recurrent benign multicystic or well-differentiated papillary disease.

21. Malignant Pleural Mesothelioma (MPM)

a. Used as a single agent or in combination with ipilimumab as subsequent therapy (if not administered first-line); or

b. Used in combination with ipilimumab as first-line therapy; and

1. Recipient has stage IIIB or IV disease; or

2. Recipient has sarcomatoid or biphasic histology; or

3. Disease is medically inoperable or unresectable.

22. Cutaneous Melanoma

a. Used as first-line therapy for unresectable or metastatic disease; and

1. Used as a single agent or in combination with ipilumumab; or

b. Used as initial therapy for limited resectable disease; and

1. Used as single agent; and

a. Recipient has stage III disease with clinical satellite/in-transit metastases; or

b. Recipient has local satellite/in-transit recurrence; or

c. Used as subsequent therapy for unresectable or metastatic disease; and

1. Used a re-induction therapy in recipients who experienced disease control (i.e., complete or partial response or stable disease) and no residual toxicity from prior anti-PD-1 immunotherapy, but subsequently have disease progression/relapse greater than three months after treatment discontinuation; and

a. Used as a single agent or in combination with ipilimumab; or

2. Used after disease progression or maximum clinical benefit from BRAF-targeted therapy (e.g., dabrafenib/trametinib, vemurafenib/cobimetinib, encorafenib/binimetinib, etc.); and

a. Used as a single agent or in combination with ipilimumab if anti-PD-1 was not previously used; or

b. Used in combination with ipilimumab for recipients who progressed on single agent anti-PD-1 therapy; or

d. Used as adjuvant treatment as a single agent; and

1. Recipient has lymph node involvement and has undergone complete resection, complete lymph node dissection (CLND), therapeutic lymph node dissection (TLND), or nodal basin ultrasound surveillance; or

2. Recipient has satellite/in-transit metastases or recurrence and has no evidence of disease after complete excision; or

3. Recipient has undergone TLND and/or complete excision of disease limited to nodal recurrence; or

4. Recipient has undergone complete resection of metastatic disease; or

5. Recipient has oligometastatic disease and no evidence of disease following metastasis-directed therapy (i.e., stereotactic ablative therapy or complete resection) or systemic therapy.

23. Uveal Melanoma

a. Recipient has distant metastatic disease; and

b. Used as a single agent or in combination with ipilimumab.

24. Merkel Cell Carcinoma

a. Used as a single agent; and

1. Used as neoadjuvant treatment for regional, pathologic N+ disease; or

2. Used for primary or recurrent metastatic disseminated disease.

25. Non-Small Cell Lung Cancer

a. Used for resectable (tumors greater than or equal to four cm or node positive) disease; and

1. Used as neoadjuvant therapy in combination with platinum-doublet chemotherapy (e.g., cisplatin/carboplatin in combination with paclitaxel, pemetrexed, or gemcitabine); or

b. Used for recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence of disseminated disease) or mediatinal lymph node recurrence with prior radiation therapy; and

1. Used as first-line therapy; and

a. Used for one of the following:

1. Recipients with a performance status (PS) zero to one have tumors that are negative for actionable molecular biomarkers and PD-L1 expression less than one percent

2. Recipients with a PS zero to one who are positive for one of the following molecular biomarkers: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2)

3. PD-L1 expression-positive (PD-L1 greater than or equal to one percent) tumors, as detected by an FDA or CLIA compliant test, that are negative for actionable molecular biomarkers; and

b. Used in combination with ipilimumab; or

c. Used in combination with ipilimumab and platinum-doublet chemotherapy (e.g., pemetrexed and either carboplatin or cisplatin for nonsquamous cell histology, or paclitaxel and carboplatin for swuamous cell histology, etc.); or

2. Used as subsequent therapy; and

a. Used as a single agent; or

b. Used for one of the following:

1. Recipients with a PS 0-1 who are positive for one of the following molecular mutations and have received prior targeted therapy: EGFR exon 19 deletion or L858R tumors, EGFR S768I, L861Q, and/or G719X, ALK rearrangement, or ROS1 rearrangement

2. Recipients with a PS 0-1 who are positive for one of the following molecular biomarkers: BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, or RET rearrangement; and

c. Used in combination with ipilimumab; or

d. Used in combination with ipilimumab, pemetrexed, and either carboplatin or cisplatin for nonsquamous cell histology; or

e. Used in combination with ipilimumab, paclitaxel, and carboplatin for squamous cell histology; or

3. Used as continuation maintenance therapy in combination with ipilimumab; and

a. Recipient has achieved a response or stable disease following first-line therapy with nivolumab and ipilimumab with or without chemotherapy.

26. Small Bowel Adenocarcinoma

a. Recipient has advanced or metastatic disease that is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

b. Used as a single agent or in combination with ipilimumab; and

1. Used as initial therapy; or

2. Used as subsequent therapy for recipients with no prior oxaliplatin exposure in the adjuvant treatment setting and no contraindication to oxaliplatin therapy.

27. Small Cell Lung Cancer (SCLC)

    a. Used as subsequent systemic therapy as a single agent; and

        1. Used for relapsed disease in recipients with a complete or partial response or stable disease after primary treatment (excluding use in recipients who progressed on maintenance atezolizumab or durvalumab at time of relapse); or

        2. Used for primary progressive disease.

28. Extranodal NK/T-Cell Lymphomas

    a. Used as a single agent for relapsed or refractory disease; and

    b. Used following additional therapy with an alternative asparaginase-based chemotherapy regimen not previously used; and

    c. Participation in a clinical trial is unavailable.

29. Endometrial Carcinoma (Uterine Neoplasms)

    a. Used as a single agent; and

    b. Used as second-line therapy for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) recurrent or metastatic disease.

30. Vulvar Cancer

    a. Used as single agent; and

    b. Recipient has adenocarcinoma or squamous cell carcinoma; and

    c. Used as second-line therapy for HPV-related advanced, recurrent, or metastatic disease.

31. Pediatric Aggressive Mature B-Cell Lymphomas – Primary Mediastinal Large B-Cell Lymphoma (PMBCL)

    a. Recipient is less than or equal to 18 years of age; and

        1. Used in combination with brentuximab vedotin; and

            a. Used as consolidation/additional therapy if a partial response was achieved after therapy for relapsed or refractory disease; or

2. Used as a single agent for relapsed or refractory disease.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Opdivo® 40mg/four mL single-dose vial: two vials per 14 days

b. Opdivo® 100mg/10mL single-dose vial: three vials per 14 days

c. Opdivo® 120 mg/12mL single-dose vial: three vials per 14 days

d. Opdivo® 240 mg/24mL single-dose vial: four vials per 14 days.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisites therapy), performance status, etc. identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe inf usion-related reactions, complications of allogeneic hematopoietic stem cell

transplantation (HSCT), severe immune-mediated adverse reactions (i.e., pneumonitis, colitis, hepatitis/hepatotoxicity, endocrinopathies, nephritis/renal dysfunction, adverse skin reactions/rash, etc.), etc.; and

3. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

4. For the following indications, recipient has not exceeded a maximum of two years of therapy:

a. Bone Cancer; or

b. Cervical Cancer; or

c. Esophageal Cancer (in combination with fluoropyrimidine- and platinum-containing chemotherapy or ipilimumab); or

d. Esophagogastric/Gastroesophageal Junction Cancer (in combination with fluoropyrimidine-and platinum-containing chemotherapy); or

e. Gastric Cancer; or

f. Malignant Pleural Mesothelioma; or

g. Malignant Peritoneal Mesothelioma; or

h. Non-Small Cell Lung Cancer (in combination with ipilimumab with or without platinum-doublet chemotherapy); or

i. Renal Cell Carcinoma (in combination with cabozantinib); or

j. Vulvar Cancer.

5. Urothelial Carcinoma (adjuvant therapy)

a. Recipient has not exceeded a maximum of one year of therapy.

6. Esophageal and Esophagogastric/Gastroesophageal Junction Cancer (adjuvant therapy)

a. Recipient has not exceeded a maximum of one year of therapy.

7. Classical Hodgkin Lymphoma (in combination with brentuximab vedotin)

a. Recipient has not exceeded a maximum of twelve weeks of therapy.

8. Classical Hodgkin Lymphoma (in combination with ICE)

a. Recipient has not exceeded a maximum of six weeks of therapy.

9. Cutaneous Melanoma (re-induction therapy)

a. Refer to Section III for criteria (see Cutaneous Melanoma – Used for retreatment of disease as re-induction).

10. Merkel Cell Carcinoma (neoadjuvant therapy)

a. Recipient has not exceeded a maximum of two doses.

11. Non-Small Cell Lung Cancer (neoadjuvant therapy in combination with platinum-doublet chemotherapy)

a. Recipient has not exceeded a maximum of three cycles.

12. Non-Small Cell Lung Cancer (maintenance therapy)

a. Refer to Section III for criteria.

d. Prior Authorization Guidelines

1. Use in the treatment of Classical Hodgkin Lymphoma:

a. In combination with brentuximab vedotin can be authorized up to a maximum of twelve weeks of therapy and may not be renewed; and

b. In combination with ICE (ifosfamide, carboplatin, etoposide) can be authorized up to a maximum of six weeks of therapy and may not be renewed.

2. Neoadjuvant treatment of Merkel Cell Carcinoma can be authorized up to a maximum of two doses and may not be renewed

3. Neoadjuvant treatment of NSCLC in combination with platinum-doublet chemotherapy may be authorized for a maximum of three cycles and may not be renewed

4. Adjuvant treatment of the following indications may be renewed up to a maximum of one year of therapy:

a. Cutaneous Melanoma

b. Esophageal and Esophagogastric/Gatroesophageal Junction Cancer

c. Urothelial Carcinoma.

5. The following indications may be renewed up to a maximum of two years of therapy:

a. Bone Cancer

b. Cervical Cancer

c. Esophageal Cancer (in combination with fluoropyrimidine-and platinum-containing chemotherapy or ipilimumab)

d. Esophagogastric/Gastroesophageal Junction Cancer (in combination with fluoropyrimidine-and platinum-containing chemotherapy)

e. Gastric Cancer

f. Malignant Pleural Mesothelioma

g. Malignant Peritoneal Mesothelioma

h. Non-Small Cell Lung Cancer (in combination with ipilimumab with or without platinum-doublet chemotherapy)

i. Renal Cell Carcinoma (in combination with cabozantinib)

j. Vulvar Cancer

6. Initial approval will be given for six months.

7. Recertification will be given for six months.

6. Tecentriq® (atezolizumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age (unless otherwise specified); and

2. Universal Criteria

a. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)=directed therapy (e.g., nivolumab, pembrolizumab, durvalumab, avelumab, cemiplimab, dostarlimab, nivolumab/relatlimab-rmbw, etc.); and

3. Urothelial Carcinoma (Bladder Cancer)

a. Used as a single agent; and

b. Recipient has one of the following diagnoses:

1. Locally advanced or metastatic urothelial carcinoma; or

2. Muscle invasive bladder cancer with local recurrence or persistent disease in a preserved bladder; or

3. Recurrent or metastatic primary carcinoma of the urethra (excluding recurrence of stage T3-4 disease or palpable inguinal lymph nodes); or

4. Primary carcinoma of the urethra that is stage T3-4 cN1-2 or cN1-2 with palpable inguinal lymph nodes; or

5. Metastatic upper genitourinary (GU) tract tumors; or

6. Metastatic urothelial carcinoma of the prostate; and

c. Used as first-line therapy in cisplatin-ineligible recipients; and

1. Recipient is not eligible for any platinum-containing chemotherapy (i.e., both cisplatin and carboplatin-ineligible); or

2. Recipient has a PD-L1 expression of greater than or equal to five percent (PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to five percent of the tumor area) as determined by an FDA-approved or CLIA-compliant test.

4. Non-Small Cell Lung Cancer (NSCLC)

a. Recipient has recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy; and

1. Used as first-line therapy; and

a. Used for tumors that are negative for actionable molecular markers and PD-L1 greater than or equal to 50% (PD-L1 stained greater than or equal to 50% of tumor cells [TC greater than or equal to 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to ten percent of the tumor area [IC greater than or equal to ten percent]), as determined by an FDA-approved test or CLIA-compliant test; and

1. Used as a single agent; or

b. Used for non-squamous disease in one of the following:

1. Recipients with PS 0-1 who have tumors that are negative for actionable molecular markers and PD-L1 less than one percent

2. Recipients with PD-L1 expression positive tumors (PD-L1 greater than or equal to one percent) that are negative for actionable molecular biomarkers

3. Recipients with PS 0-1 who are positive for one of the following molecular mutations: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK1/2/3 gene fusion, MET exon-14 skipping, RET rearrangement, or ERBB2 (HER2); and

c. Used in combination with carboplatin, paclitaxel, and bevacizumab; or

d. Used in combination with carboplatin and albumin-bound paclitaxel; or

2. Used as subsequent therapy; and

a. Used as a single agent; or

b. Used for non-squamous disease in one of the following:

1. Recipients with PS 0-1 who are positive for one of the following molecular mutations: BRAF V600E, NTRK1/2/3 gene fusion, MET exon-14 skipping, or RET rearrangement

2. Recipients with PS 0-1 who are positive for one of the following molecular mutations and received prior targeted therapy: EGFR exon 19 deletion or L858R tumors, EGFR S7681, L861Q, and/or G719X mutation, ALK rearrangement, or ROS1 rearrangement; and

c. Used in combination with carboplatin, paclitaxel, and bevacizumab; or

d. Used in combination with carboplatin and albumin-bound paclitaxel; or

3. Used as continuation maintenance therapy in recipients who have achieved a tumor response or stable disease following initial therapy; and

a. Used in combination with bevacizumab following a first-line regimen with atezolizumab, carboplatin, paclitaxel, and bevacizumab for non-squamous histology; or

b. Used as a single agent following a first-line regimen with atezolizumab, carboplatin, and albumin-bound paclitaxel for non-squamous histology; or

c. Used as a single agent following a first-line regimen with single agent atezolizumab; or

b. Recipient has stage II to IIIA disease; and

1. Used as a single agent; and

2. Used as adjuvant treatment following resection and previous adjuvant chemotherapy; and

3. Tumor expressed PD-L1 greater than or equal to one percent as determined by an FDA-approved test or CLIA-compliant test

5. Small Cell Lung Cancer (SCLC)

a. Recipient has extensive stage disease (ES-SCLC); and

1. Used as first-line therapy in combination with etoposide and carboplatin; or

2. Used as single-agent maintenance therapy after initial therapy with atezolizumab, etoposide, and carboplatin.

6. Hepatocellular Carcinoma (HCC)

a. Used as first-line therapy in combination with bevacizumab; and

b. Recipient has Child-Pugh Class A hepatic impairment; and

1. Recipient has unresectable or metastatic disease; or

2. Recipient has liver confined disease that is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic-disease; or

3. Recipient has extensive liver tumor burden.

7. Malignant Peritoneal Mesothelioma (MPeM)

a. Used as subsequent therapy in combination with bevacizumab.

8. Cutaneous Melanoma

a. Recipient has BRAF V600 mutation-positive disease as detected by an FDA approved or CLIA compliant test; and

b. Recipient has unresectable or metastatic disease; and

c. Used as first-line therapy in combination with cobimetinib and vemurafenib.

9. Alveolar Soft Part Sarcoma (ASPS)

a. Recipient is at least two years of age; and

b. Used as a single agent; and

c. Recipient has unresectable or metastatic disease that is not curable by surgery.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Tecentriq® 1,200 mg single-use vial: one vial per 21 days.

b. Tecentriq® 850 mg single-use vial: one vial per 14 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. MPeM: 120 billable units every 21 days.

b. All other indications: 168 billable units every 28 days.

c. Recertification Request

1. Recipient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in Ssection III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: immune-mediated adverse reactions (e.g., pneumonitis, hepatitis, colitis, endocrinopathies, nephritis/renal dysfunction, rash/dermatitis, etc.), severe infusion-related reactions, complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc.

4. Continuation Maintenance Therapy for NSCLC or SCLC

5. NSCLC (adjuvant treatment)

a. Recipient has not exceeded a maximum of twelve months of therapy

d. Prior Authorization Guidelines

1. Initial approval will be given for six months.

2. Recertification will be given for six months.

3. Neoadjuvant therapy in NSCLC can be authorized up to a maximum of 12 months of therapy.

C. Beovu® (brolucizumab-dbll)

Therapeutic Class: Ophthalmic-Macular Degeneration
Last Reviewed by the DUR Board: N/A

Beovu® (brolucizumab-dbll) are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented

   a. Recipient is at least 18 years of age; and

   b. Universal Criteria

      1. Recipient is free of ocular and/or peri-ocular infections; and

      2. Recipient does not have active intraocular inflammation; and

      3. Therapy will not be used with other ophthalmic VEGF inhibitors (i.e., aflibercept, ranibizumab, pegaptanib, bevacizumab, faricimab-svoa, etc.); and

      4. Recipients best corrected visual acuity (BCVA) is measured at baseline and periodically during treatment; and

      5. Recipient has a definitive diagnosis of the following:

         a. Neovascular (Wet) Age-Related Macular Degeneration (AMD)

         b. Diabetic Macular Edema (DME)

2. Dosing Limits

   a. Quantity Limit (max daily dose) [NDC Unit]

      1. Neovascular age-related macular degeneration (AMD):

         a. Six mg single-dose vial or pre-filled syringe for injection: one vial/syringe per eye every 25 days for three doses initially, then one vial/syringe every eight weeks

      2. Diabetic Macular Edema (DME)

         a. Six mg single-dose vial or pre-filled syringe for injection: one vial/syringe per eye every six weeks for five doses initially, then one vial/syringe every eight weeks.

3. Neovascular age-related macular degeneration (AMD)

a. MU for Initial Dosing

1. 12 billable units every 25 days x three doses

b. MU for Maintenance Dosing

1. 12 billable units every 56-84 days

4. Diabetic Macular Edema (DME)

a. MU for Initial Dosing

1. 12 billable units every six weeks x five doses

b. MU for Maintenance Dosing

1. 12 billable units every 56-84 days

3. Recertification Request

a. Recipient continues to meet the universal and indication-specific relevant criteria as identified in section III; and

b. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity: endophthalmitis and retinal detachment, increase in intraocular pressure, arterial thromboembolic events, retinal vasculitis, and/or retinal vascular occlusion etc.; and

c. Continued administration is necessary for the maintenance treatment of the condition; and

d. Neovascular (Wet) Age-Related Macular Degeneration (AMD)

1. Recipient has had a beneficial response to therapy (e.g., improvement in the baseline corrected visual acuity (BCVA), etc.)); and

2. Decreasing the interval of maintenance doses from 12 weeks to eight weeks will be allowed if the recipient has received all three-loading disease and has evidence of disease activity, indicated by one of the following, at (or beyond) treatment week 16:

a. Decrease in BCVA of greater than or equal to five letters compared to baseline; or

b. Decrease in BCVA of greater than or equal to three letters due to neovascular AMD disease activity compared with week 12; or

c. Decrease in BCVA of greater than or equal to five letters and central subfield thickness greater than or equal to 75 microns compared with week 12; or

d. New or worsening intra-retinal cysts or fluid compared with week 12.

e. Diabetic Macular Edema (DME)

1. Recipient has had a beneficial response to therapy (e.g., improvement in the baseline best corrected visual acuity (BCVA, etc.); and

2. Decreasing the interval or maintenance doses from 12-weeks to either weeks will be allowed if the recipient has received all five loading doses and has evidence of disease activity, indicated by one of the following, at (or beyond) treatment week 28:

a. Decrease in BCVA of greater than or equal to five letters compared to baseline; and

b. Increase in central subfield thickness compared to baseline.

4. PA Guidelines:

a. Initial approval be given for 12 months.

b. Recertification will be approved for 12 months.

D. Avastin®; Mvasi®; Zirabev™; Alymsys®; Vegzelma™ (bevacizumab)

Therapeutic Class: ANP -Human Vascular Endothelial Growth Factor Inhib Rec-MC Antibody
Last Reviewed by the DUR Board: N/A

Avastin®; Mvasi®; Zirabev™; Alymsys®; Vegzelma™(bevacizumab) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Recipient is at least 18 years of age, unless otherwise specified; and

   b. Universal Criteria

      1. Recipient has no recent history of hemoptysis (i.e., the presence of greater than or equal to 2.5mL of blood in sputum); and

      2. Recipient must not have had a surgical procedure within the preceding 28 days or have a surgical wound that has not fully healed; and

   c. Ampullary Adenocarcinoma

      1. Used in combination with a fluoropyrimidine (e.g., five-fluorouracil/five-FU or capecitabine) based regimen for intestinal type disease; and

         a. Used as first-line therapy for unresectable localized or metastatic disease or as subsequent therapy for disease progression; and

            1. Recipient has poor performance status (ECOG PS 2); or

            2. Recipient has good performance status (ECOG 0-1, with good biliary drainage and adequate nutritional intake) and received prior oxaliplatin-based therapy.

   d. Adult Central Nervous System (CNS) Cancers

      1. Used for symptom management related to radiation necrosis, poorly controlled vasogenic edema, or mass effect as single-agent short-course therapy; and

         a. Recipient has a diagnosis of one of the following CNS cancers

            1. Glioma (WHO Grade 1)

            2. Primary CNS Lymphoma

3. Meningiomas

4. Brain or Spine metastases

5. Medulloblastoma

6. Glioblastoma/Gliosarcoma

7. IDH-mutant Astrocytoma (WHO Grade 2-4)

8. IDH-mutant, 1p19q co-deleted Oligodendroglioma (WHO Grade 2 or 3)

9. Intracranial or Spinal Ependymoma (excluding subependymoma); or

2. Used for recurrent disease; and

a. Recipient has a diagnosis of one of the following CNS cancers:

1. IDH-mutant, 1p19q co-deleted Oligodendroglioma (WHO Grade 3)

2. Glioblastoma/Gliosarcoma

3. IDH-mutant Astrocytoma (WHO Grade 3 or 4); and

b. Used as a single agent; or

c. Used in combination with carmustine, lomustine, or temozolomide; and

1. Recipient has failed bevacizumab monotherapy; or

3. Used as a single agent for progressive or recurrent Intracranial or Spinal Ependymoma (excluding subependymoma) after prior radiation therapy; or

4. Used as a single agent for recipients with surgically inaccessible recurrent or progressive Meningioma when radiation is not possible.

e. Cervical Cancer

1. Recipient has persistent, recurrent, or metastatic disease; and

a. Disease has adenocarcinoma, adenosquamous, or squamous cell carcinoma histology; and

1. Used in combination with paclitaxel and either cisplatin, carboplatin, or topotecan; or

2. Used in combination with pembrolizumab, paclitaxel, and cisplatin or carboplatin; and

a. Tumor expresses PD-L1 (Combined Positive Score [CPS] greater than or equal to 1) as determined by an FDA-approved or CLIA compliant test; or

3. Recipient has small cell neuroendocrine carcinoma of the cervix (NECC); and

a. Used as subsequent therapy; and

1. Used in combination with paclitaxel and either cisplatin, carboplatin, or topotecan; or

2. Used in combination with pembrolizumab, paclitaxel, and cisplatin or carboplatin; and

a. Tumor expressed PD-L1 (Combined Positive Score [CPS] greater than or equal to one) as determined by an FDA-approved or CLIA compliant test.

f. Colorectal Cancer (CRC)

1. Will not be used as part of adjuvant treatment; and

a. Used in combination with a fluoropyrimidine (e.g., five-fluorouracil/5-FU or capecitabine) or irinotecan-based regimen as first-line or subsequent therapy for metastatic, unresectable (or medically inoperable), or advanced disease; or

b. Used in combination with a fluoropyrimidine-irinotecan-or fluoropyrimidine-oxaliplatin-based regimen (not used first line) as second-line therapy for metastatic disease that has progressed on a first-line bevacizumab-containing regimen; or

c. Used in combination with trifluridine and tipiracil as subsequent therapy for advanced or metastatic disease after progression on all available regimens.

g. Appendiceal Adenocarcinoma – Colon Cancer

1. Used as initial therapy for advanced or metastatic disease; and

a. Used in combination with a fluoropyrimidine (e.g., 5-fluorouracil/5-FU or capecitabine) based regimen; or

2. Used as subsequent therapy for progression of advanced or metastatic disease; and

a. Used in combination with a fluoropyrimidine (e.g., five-fluorouracil/five-FU or capecitabine) or irinotecan-based regimen following previous oxaliplatin-irinotecan-and/or fluoropyrimidine-based therapy; or

b. Used in combination with trifluridine and tipiracil after progression on all available regimens.

h. Endometrial Carcinoma (Uterine Neoplasms)

1. Used as single agent therapy for recurrent or metastatic disease that has progressed or prior cytotoxic chemotherapy; or

2. Used in combination with carboplatin and paclitaxel for advanced and recurrent disease; or

3. Used in combination with paclitaxel and carboplatin as adjuvant therapy; and

a. Recipient has advanced and recurrent stage III-IV endometroid adenocarcinoma.

i. Hepatocellular Carcinoma (HCC)

1. Used as first-line therapy in combination with atezolizumab; and

2. Recipient has Child-Pugh Class A disease; and

a. Recipient has unresectable or metastatic disease; or

b. Recipient has liver confined disease inoperable by performance status, comorbidity or with minimal or uncertain extrahepatic-disease; or

c. Recipient has extensive liver tumor burden.

j. Malignant Peritoneal Mesothelioma (MPeM)

1. Used as first-line therapy; and

a. Used in combination with pemetrexed and either cisplatin or carboplatin (if cisplatin ineligible) followed by single agent maintenance bevacizumab; and

1. Recipient has unresectable diffuse disease; or

2. Recipient has unresectable recurrent benign multi-cystic or well-differentiated papillary disease; or

2. Used as subsequent therapy; and

a. Used in combination with pemetrexed and either cisplatin or carboplatin (if cisplatin ineligible) followed by single agent maintenance bevacizumab; and

1. Immunotherapy was administered as first-line treatment; or

b. Used in combination with atezolizumab.

k. Malignant Pleural Mesothelioma (MPM)

1. Used as first-line therapy; and

a. Used in combination with pemetrexed and either cisplatin or carboplatin (if cisplatin ineligible) followed by single agent maintenance bevacizumab; and

1. Recipient has unresectable clinical stage I-IIIA disease and epithelioid histology; or

2. Recipient has clinical stage IIIB or IV disease, sarcomatoid or biphasic histology, or medically inoperable tumors; or

2. Used as subsequent therapy; and

b. Used in combination with pemetrexed and either cisplatin or carboplatin (if cisplatin ineligible); and

c. Immunotherapy was administered as first-line treatment.

l. Non-Squamous Non-Small Cell Lung Cancer (NSCLC)

1. Used for recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease with no evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy; and

a. Used as first-line therapy; and

1. Used in combination with erlotinib for EGFR exon 19 deletion or L858R mutations; or

2. Used for one of the following:

a. Recipients with a performance status (PS) less than or equal to one who have tumors that are negative for actionable molecular biomarkers and PD-L1 expression less than one percent; or

b. PD-L1 expression positive tumors (PD-L1 greater than or equal to one percent) that are negative for actionable molecular biomarkers; or

c. Recipients with a PS less than or equal to one who are positive for one of the following molecular biomarkers: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2); and

3. Used in combination with one of the following:

a. Carboplatin and paclitaxel; or

b. Pemetrexed and either carboplatin or cisplatin in recipients with contraindications to PD-1 or PD-L1 inhibitor

c. Atezolizumab, carboplatin, and paclitaxel; or

b. Used for subsequent therapy in recipients with a PS less than or equal to one; and

1. Used for one of the following:

a. EGFR exon 19 deletion or L858R mutation, EGFR S7681, L861Q, and/or G719X mutation, ALK rearrangement, or ROS1 rearrangement positive

tumors and recipient received prior targeted therapy for those aberration

b. BRAF V600E mutation, NTRK1/2/3 gene fusion, MET exon 14 skipping mutation or RET rearrangement positive tumors

c. PD-L1 expression-positive (PD-L1 greater than or equal to one percent) tumors that are negative for actionable molecular biomarkers with prior PD-1/PD-L1 inhibitor therapy but no prior platinum-containing chemotherapy; and

2. Used in combination with one of the following:

a. Carboplatin and paclitaxel in recipient with contraindications to PD-1 or PD-L1 inhibitors

b. Pemetrexed and either carboplatin or cisplatin in recipients with contraindications to PD-1 or PD-L1 inhibitors

c. Atezolizumab, carboplatin, and paclitaxel (excluding use in recipients who have received prior PD-1/PD-L1 inhibitor therapy or who have EGFR exon 19 deletions or L858R mutations or ALK rearrangement positive tumors); or

c. Used as continuation maintenance therapy (bevacizumab must have been included in the recipients first-line chemotherapy regimen) in recipients who achieved a tumor response or stable disease after first-line systemic therapy; and

1. Used as a single agent; or

2. Used in combination with pemetrexed following a first-line bevacizumab/pemetrexed/platinum chemotherapy regiment; or

3. Used in combination with atezolizumab following a first line atezolizumab/carboplatin/paclitaxel/bevacizumab regimen; or

d. Used as continuation of therapy following disease progression on erlotinib with bevacizumab; and

1. Recipient has asymptomatic disease, symptomatic brain lesions, or symptomatic systemic limited metastases; and

2. Recipient has T790M negative disease.

m. Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer

1. Recipient has malignant stage II-IV sex cord-stromal tumors

a. Used a single agent therapy for clinically relapsed disease; or

2. Recipient has epithelial ovarian, fallopian tube, or primary peritoneal cancer; and

b. Recipient has persistent or recurrent disease; and

1. Bevacizumab has not been used previously; and

2. Recipient is not experiencing an immediate biochemical relapse (i.e., rising CA-125 without radiographic evidence of disease); and

a. Recipient has platinum sensitive disease; and

1. Used as a single agent; or

2. Used in combination niraparib; or

3. Used in combination with carboplatin and either gemcitabine, paclitaxel, or PEGylated liposomal doxorubicin; or

b. Recipient has platinum resistant disease; and

1. Used as a single agent; or

2. Used in combination with one of the following: oral cyclophosphamide, PEGylated liposomal doxorubicin, paclitaxel, or topotecan; or

c. Used in combination with paclitaxel and carboplatin for rising CA-125 levels or clinical relapse in recipients who have received no prior chemotherapy; or

d. Used as maintenance therapy; and

1. Used following primary therapy including bevacizumab; and

a. Used as a single agent in recipients that are BRCA1/2 wild-type or unknown and homologous recombination (HR) proficient or status unknown (grade 2/3 endometrioid and high-grade serous histology only); or

b. Used in combination with Olaparib; and

1. Recipient is BRCA1/2 wild-type or unknown and HR deficient (grade 2/3 endometrioid and high-grade serous histology only), or

2. Recipient has a germline or somatic BRCA1/2 mutation (grade 2/3 endometrioid, high grade serous, clear cell, carcinosarcoma histology only), or

2. Used a single agent following recurrence therapy with chemotherapy plus bevacizumab for platinum-sensitive disease; or

3. Used in combination with paclitaxel and carboplatin for stable disease following neoadjuvant therapy as continued treatment (grade 2/3 endometrioid and high-grade serous histology only); or

e. Used as neoadjuvant therapy in combination with paclitaxel and carboplatin (grade 2/3 endometrioid and high-grade serous histology only); and

1. Recipient is a poor surgical candidate or has a low likelihood of optimal cytoreduction; or

f. Used as adjuvant therapy in combination with paclitaxel and carboplatin; and

1. Recipient has pathologic stage II-IV disease; or

2. Used after interval debulking surgery (IDS) in recipients with a response or stable disease to neoadjuvant therapy (grade 2/3 endometrioid and high-grade serous histology only); and

a. Recipient is a poor surgical candidate or has a low likelihood of optimal cytoreduction.

n. Pediatric Central Nervous System (CNS) Cancers

1. Recipient is less than or equal to 18 years of age; and

2. Recipient has diffuse high-grade glioma; and

3. Used for palliation of recurrent or progressive disease (excluding oligodendroglioma, IDH-mutant and 1p/19q co-deleted or astrocytoma IDH-mutant).

o. Renal Cell Carcinoma (RCC)

1. Used in combination with interferon alfa for metastatic disease; or

2. Recipient has metastatic or relapsed disease with non-clear cell histology; and

a. Used as a single agent; or

b. Used in combination with everolimus; or

c. Used in combination with erlotinib in recipients with advanced papillary disease including hereditary leiomyomatosis and renal cell carcinoma (HLRCC)-associated RCC.

p. Small Bowel Adenocarcinoma

1. Recipient has advanced or metastatic disease; and

2. Used in combination with fluoropyrimidine-based regimen.

q. Soft Tissue Sarcoma

1. Used as a single agent for angiosarcoma; or

2. Used in combination with temozolomide for solitary fibrous tumor.

r. Vulvar Cancer

1. Used in combination with paclitaxel and cisplatin; and

2. Recipient has squamous cell carcinoma or adenocarcinoma; and

3. Recipient has unresectable, locally advanced, metastatic, or recurrent disease.

2. Dosage Limits

a. Quantity Limit (max daily dose) [NDC Unit]:

1. 100 mg/4 mL single-dose vial: three vials 21 days

2. 400 mg/16 mL single-dose vial: four vials per 21 days

b. Max Units (per dose and over time) [HCPCS Unit]:

1. Oncology Indications (J9035/Q5107/Q5118/J999/Q5126):

a. Small Bowel Adenocarcinoma/Ampullary Adenocarcinoma:

1. 60 billable units per 14 days

b. NSCLC, Cervical Cancer, HCC, Vulvar Cancer, MPM, & MPeM:

1. 170 billable units per 21 days

c. All other indications:

1. 120 billable units per 14 days

3. Recertification Request:

a. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in Section III; and

b. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

c. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: gastrointestinal perforations and fistulae, surgical/wound healing complications, necrotizing fasciitis, hemorrhage, arterial and venous thromboembolic events (ATE & VTE), uncontrolled hypertension, posterior reversible encephalopathy syndrome (PRES), nephrotic syndrome, proteinuria, severe infusion-related reactions, ovarian failure, congestive heart failure (CHF), etc.; and

d. Adult CNS Cancers – symptom management (short-course therapy):

1. Coverage may not be renewed

e. Adult CNS Cancers – Oligodendroglioma, Glioblastoma, or Astrocytoma (in combination with carmustine, lomustine, or temozolomide):

1. Refer to Section III for criteria

f. Colorectal Cancer (after first-line bevacizumab-containing regimen):

1. Refer to Section III for criteria

g. MPM and MPeM (maintenance therapy):

1. Refer to Section III for criteria

h. Non-Squamous Non-Small Cell Lung Cancer (maintenance therapy or continuation therapy in combination with erlotinib):

1. Refer to Section III for criteria

i. Ovarian Cancer (maintenance therapy):

1. Refer to Section III for criteria

4. Prior Authorization Guidelines:

a. Initial approval will be given for six months.

b. For Adult CNS Cancers (symptom management), coverage will be provided for 12 weeks and may not be renewed.

c. Recertification will be given for six months.

E. Darzalex® (daratumumab)

Therapeutic Class: Antineoplastic
Last Reviewed by the DUR Board: N/A

Darzalex® (daratumumab) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented

   a. Recipient is at least 18 years of age; and

   b. Universal Criteria

      1. Therapy will not be used in combination with other anti-CD38 therapies (i.e., daratumumab and hyaluronidase-fihj, isatuximab, etc,); and

   c. Multiple Myeloma

      1. Used in the treatment of newly diagnosed disease in recipients who are eligible for autologous stem cell transplant (ASCT) in combination with one of the following regimens:

         a. Lenalidomine and dexamethasone; or

         b. Bortezomib, melphalan, and prednisone; or

         c. Cyclophosphamide, bortezomib, and dexamethasone; or

      2. Used in the treatment of newly diagnosed disease in recipient who are eligible for autologous stem cell transplant (ASCT) in combination with one of the following regimens:

         a. Bortezomib, lenalidomide, and dexamethasone; or

         b. Bortezomib, thalidomide, and dexamethasone (VTd); or

         c. Carfilzomib, lenalidomide, and dexamethasone; or

         d. Cyclophosphamide, bortezomib, and dexamethasone; or

      3. Used for disease relapse after six months following primary induction therapy with the same regimen in combination with one of the following regiments:

         a. Lenalidomide and dexamethasone for non-transplant candidates; or

b. Cyclophosphamide, bortezomib, and dexamethasone; or

4. Used as subsequent therapy for relapsed or refractory/progressive disease in combination with dexamethasone and one of the following:

a. Lenalidomide; or

b. Bortezomib; or

c. Carfilzomib; or

d. Cyclophosphamide and bortezomib; or

e. Selinexor; or

5. Used in combination with pomalidomide and dexamethasone after at least two prior therapies including lenalidomide and a proteasome inhibitor (bortezomic, carfilzomib, etc.); or

6. Used as single agent therapy; and

a. Recipient received at least three prior lines of therapy including a proteasome inhibitor (e.g., bortezomib, carfilzomib, etc.) and an immunomodulatory agent (e.g., lenalidomide, pomalidomide, etc.); or

b. Recipient is double refractory to a proteasome inhibitor and immunomodulatory agent; or

7. Used as maintenance therapy for symptomatic disease in transplant candidates; and

a. Used as single agent therapy; and

1. Used after response to primary myeloma therapy; or

2. Used for response or stable disease following an autologous hematopoietic cell transplant (HCT); or

3. Used for response or stable disease following a tandem autologous or allogeneic HCT for high-risk patients.

d. Systemic Light Chain Amyloidosis

1. Used as single agent therapy; and

2. Used for the treatment of relapsed/refractory disease.

2. Dosage Limits

a. Quantity Limit (max daily dose) [NDC Unit]:

1. Darzalex® 100 mg single dose vial for injection: up to three vials per dose

a. Weekly Weeks 1 to 8, then every two weeks 9-24, then every four weeks-week 25 onwards; or

2. Darzalex® 400 mg single dose vial for injections: up to four vial per dose

a. Weekly weeks one to eight, then every two weeks 9-24, then every four weeks – week 25 onwards; or

b. Max Units (per dose and over time) [HCPCS Unit]:

1. Up to 180 billable units per dose

a. Weekly week one to eight, then every two weeks, week 9-24, then every four weeks – week 25 onwards.

c. Max Units (per dose and over time) [HCPCS Unit]:

1. Up to 180 billable units per dose

a. Weekly week one to eight, then every two weeks, week 9-24, then every four weeks – week 25 onwards.

3. Recertification Request

a. Recipient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III: and

b. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

c. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion reactions including anaphylactic reactions, neutropenia, thrombocytopenia, etc.; and

d. Multiple Myeloma

1. Use for newly diagnosed disease in combination with bortezomib, thalidomide, and dexamethasone may not be renewed.

2. Use for newly diagnosed disease in combination with bortezomib, lenalidomide and dexamethasone may be renewed for up to a maximum of two years of maintenance therapy.

3. Use for newly diagnosed or relapsed disease in combination with cyclophosphamide, bortezomib and dexamethasone may be renewed for up to a maximum of 80 weeks (32 weeks of induction therapy and 48 weeks of maintenance therapy).

4. Use for newly diagnosed disease in combination with carfilzomib, lenalidomide, and dexamethasone may be renewed for up to a maximum of 32 weeks.

4. PA Guidelines:

a. Use for newly diagnosed multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone may not be renewed.

b. Use for newly diagnosed multiple myeloma in combination with bortezomib, lenalidomide and dexamethasone may be renewed for up to a maximum of two years of maintenance therapy.

c. Use for newly diagnosed or relapsed multiple myeloma in combination with cyclophosphamide, bortezomib and dexamethasone may be renewed for up to a maximum of 80 weeks (32 weeks of induction therapy and 48 weeks of maintenance therapy).

d. Use for newly diagnosed multiple myeloma in combination with carfilzomib, lenalidomide, and dexamethasone may be renewed for up to a maximum of 32 weeks.

e. Initial approval will be given for six months.

f. Recertification will be given for six months.

F. Darzalex Faspro® (daratumumab and hyaluronidase-fihj)

Therapeutic Class: Antineoplastic – CD38 Specific Recombinant Monoclonal Antibody Agent
Last Reviewed by the DUR Board: N/A

Darzalex Faspro® (daratumumab and hyaluronidase-fihj) are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Recipient is at least 18 years of age; and

   b. Universal Criteria

      1. Therapy will not be used in combination with other anti-CD38 therapies (i.e., daratumumab, isatuximab, etc.); and

   c. Multiple Myeloma

      1. Used in the treatment of newly diagnosed disease in recipients who are ineligible for autologous stem cell transplant (ASCT) in combination with one of the following regimens:

         a. Lenalidomide and dexamethasone; or

         b. Bortezomib, melphalan and prednisone; or

         c. Cyclophosphamide, bortezomib, and dexamethasone; or

      2. Used in the treatment of newly diagnosed disease in recipients who are eligible for autologous stem cell transplant (ASCT) in combination with one of the following regiments:

         a. Bortezomib, lenalidomide, and dexamethasone; or

         b. Bortezomib, thalidomide, and dexamethasone (VTd); or

         c. Carfilzomib, lenalidomide, and dexamethasone; or

         d. Cyclophosphamide, bortezomib, and dexamethasone; or

      3. Used for disease relapse after six months following primary induction therapy with the same regimen in combination with one of the following regimens:

         a. Lenalidomide and dexamethasone for non-transplant candidates; or

b. Cyclophosphamide, bortezomib, and dexamethasone; or

4. Used as subsequent therapy for relapsed or refractory/progressive disease in combination with dexamethasone and one of the following:

a. Lenalidomide; or

b. Bortezomib; or

c. Carfilzomib; or

d. Cyclophosphamide and bortezomib; or

e. Selinexor; or

5. Used in combination with pomalidomide and dexamethasone after prior therapy with lenalidomide and a proteasome inhibitor (bortezomib, carfilzomib); or

6. Used as singe agent therapy; and

a. Recipient received at least three prior lines of therapy including a proteasome inhibitor (e.g., bortezomib, carfilzomib, etc.) and an immunomodulatory agent (e.g., lenalidomide, pomalidomide, etc.); or

b. Recipient is double-refractory to a proteasome inhibitor and an immunomodulatory agent.

d. Systemic Light Chain Amyloidosis

a. Recipient must not have NYHA Class IIIB or Class IV, or Mayo Stage IIIB cardiac disease; and

1. Used in combination with bortezomib, cyclophosphamide and dexamethasone (D-VCd); and

a. Used for newly diagnosed disease; or

b. Used as a repeat of initial therapy for relapsed/refractory disease if the recipient has been relapse-free for several years; or

2. Used as single agent therapy for the treatment of relapsed/refractory disease.

2. Dosage Limits

a. Quantity Limit (max daily dose) [NDC Unit]:

1. Darzalex Faspro® 1,800 mg/30,000 unit single dose vial for injection: 1 vial per dose

a. Weekly weeks one to eight, then every two weeks, weeks nine-24, then every four weeks – week 25 onwards.

b. Max Units (per dose and over time) [HCPCS Unit]:

1. Up to 180 billable units per dose

a. Weekly Weeks one to eight, then every two weeks Weeks nine-24, then every four weeks Week 25 onwards.

3. Recertification Request

a. Recipient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirement (not including prerequisite therapy), performance status, etc. identified in section III; and

b. Disease response with treatment as defined by stabilization of disease and decrease in size of tumor of tumor spread; and

c. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: hypersensitivity and other administration reactions (e.g., systemic administration-related reactions, local injection-site reactions, etc.), neutropenia, thrombocytopenia, cardiac toxicity, etc.; and

d. Multiple Myeloma

1. Used for newly diagnosed disease in combination with bortezomib, thalidomide and dexamethasone may not be renewed.

2. Used for newly diagnosed disease in combination with bortezomib, lenalidomide and dexamethasone may be renewed for up to a maximum of two years of maintenance therapy.

3. Use for newly diagnosed or relapsed disease in combination with cyclophosphamide, bortezomib and dexamethasone may be renewed for up to a maximum of 80 weeks (32 weeks of induction therapy and 48 weeks of maintenance therapy).

4. Use for newly diagnosed disease in combination with carfilzomib, lenalidomide, and dexamethasone may be renewed for a maximum of 32 weeks.

e. Systemic Light Chain Amyloidosis (newly diagnosed disease)

1. Use for newly diagnosed disease or repeat of initial therapy for relapsed/refractory disease (after being relapse-free for several years) in combination with bortezomib, cyclophosphamide and dexamethasone (D-VCd) may be renewed for a maximum of two years of therapy.

4. PA Guidelines:

a. Initial approval will be given for six months.

b. Recertification will be given for six months.

c. Use for newly diagnosed multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone may not be renewed.

d. Used for newly diagnosed multiple myeloma in combination with bortezomib, lenalidomide, and dexamethasone may be renewed for a maximum of 32 weeks.

e. Use for newly diagnosed or repeat of initial therapy for relapsed/refractory (after being relapse-free for several years) systemic light chain amyloidosis in combination with bortezomib, cyclophosphamide and dexamethasone may be renewed for up to a maximum of two years.

G. Elaprase® (idursulfase)

Therapeutic Class: Lysosomal Enzymes
Last Reviewed by the DUR Board: N/A

Elaprase® (idursulfase) are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Recipient is at least 16 months of age; and

   b. Documented baseline age-appropriate values for one or more of the following have been obtained:

      1. Recipients five years of age or greater: six-minute walk test (6MWT), percent predicted forced vital capacity (FVC), joint range of motion, left ventricular hypertrophy, growth, quality of life (CHAQ/HAQ/MPS HAQ), and/or urinary glycosaminoglycan (uGAG); and

      2. Recipients 16 months to less than five years of age: spleen volume, liver volume, FVC, six-MWT, and/or urinary glycosaminoglycan (uGAG); and

   c. Universal Criteria

      1. Recipient does not have severe cognitive impairment; and

      2. Recipient has a definitive diagnosis of MPS II as confirmed by one of the following:

         a. Deficient or absent iduronate 2-sulfate (I2S) enzyme activity in white cells, fibroblasts, or plasma in the presence of normal activity of at least one other sulfatase; or

         b. Detection of pathogenic mutations in the IDS gene by molecular genetic testing.

2. Dose Limits

   a. Quantity Limit (max daily dose) [NDC Unit]:

      1. Elaprase® six mg/three mL vial: 10 vials per seven days.

   b. Max Units (per dose and over time) [HCPCS Unit]:

      2. 60 billable units every seven days.

3. Recertification Request

   a. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

   b. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe hypersensitivity reactions including anaphylaxis, antibody development and serious adverse reactions in Hunter Syndrome recipients with severe genetic mutations, acute respiratory complications, acute cardiorespiratory failure, etc.; and

   c. Recipient has demonstrated a beneficial response to therapy compared to pretreatment age-appropriate baseline values in one or more of the following:

      1. Recipients five years of age or greater: stabilization or improvement in percent predicted FVC and/or six-MWT, increased joint range of motion, decreased left ventricular hypertrophy, improved growth, improved quality of life (clinically meaningful change in the CHAQ/HAQ/MPS HAQ disability index), and/or uGAG levels; or

      2. Recipients 16 months to less than five years of age: reductions in spleen volume and/or liver volume or stabilization/improvement in FVC and/or 6-MWT, and/or uGAG levels.

4. PA Guidelines:

   a. Initial approval will be given for 12 months.

   b. Recertification will be given for 12 months.

H. Anti-Angiogenic Ophthalmic Agents

Therapeutic Class: Anti-angiogenic ophthalmic agents
Last Reviewed by the DUR Board: N/A

Anti-angiogenic Ophthalmic Agents are subject to PA and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Eylea®

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Recipient is free of ocular and/or peri-ocular infections; and

b. Recipient does not have active intraocular inflammation; and

c. Therapy will not be used with other ophthalmic VEGF inhibitors (i.e., brolucizumab-dbll, ranibizumab, pegaptanib, bevacizumab, faricimab-svoa, etc.); and

d. Recipients best corrected visual activity (BCVA) is measured at baseline and periodically during treatment; and

e. Recipient has a definitive diagnosis of one of the following:

3. Neovascular (Wet) Age-Related Macular Degeneration (AMD)

4. Macular Edema following Retinal Vein Occlusion (RVO)

5. Diabetic Macular Edema (DME)

6. Diabetic Retinopathy (DR)

b. Dosage Limit

1. Quantity Limit (max daily dose) [NDC Unit]:

a. 2 mg injection: one vial per eye every 28 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Diagnosis

1. Neovascular age-related macular degeneration (AMD)

a. MU for Initial Dosing

1. Four units every 28 days x three doses.

a. MU for Maintenance Dosing

1. Four units every 28-56 days.

2. Macular edema following retinal vein occlusion (RVO)

a. MU for Initial Dosing

1. Four units every 28 days.

a. MU for Maintenance Dosing

1. Four units every 28 days.

3. Diabetic Macular Edema (DME)/ Diabetic Retinopathy (DR)

a. MU for Initial Dosing

1. Four units every 28 days x five doses.

a. MU for Initial Dosing

1. Four units every 28-56 days.

c. Recertification Request:

1. Recipient continues to meet the universal and indication-specific requirements relevant criteria as identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: endophthalmitis and retinal detachments, increase in intraocular pressure, arterial thromboembolic events: and

3. Recipient has had a beneficial response to therapy (e.g., improvement in the baseline best corrected visual acuity (BCVA), etc.) and continued administration is necessary for the maintenance treatment of the condition.

d. Prior Authorization Guidelines:

1. Initial approval will be given for 12 months.

2. Recertification will be given for 12 months.

2. Lucentis®; Byooviz™; Cimerli™ (ranibizumab)

a. Approval will be given if the following criteria are met and documented

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Recipient is free of ocular and/or peri-ocular infections; and

b. Therapy will not be used with other ophthalmic VEGF inhibitors (i.e., aflibercept, pegaptanib, brolucizumab, bevacizumab, ranibizumab via ocular implant, etc.); and

c. Recipient's best corrected visual activity (BCVA) is measured at baseline and periodically during treatment; and

d. Recipient has a definitive diagnosis of one of the following:

1. Neovascular (Wet) Age-Related Macular Degeneration (AMD)

2. Diabetic Macular Edema (DME) (Lucentis® and Cimerli™ Only)

3. Diabetic Retinopathy (DR) (Lucentis® and Cimerli™ Only)

4. Macular Edema following Rental Vein Occlusion (RVO)

5. Myopic Choroidal Neovascularization (mCNV).

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. 0.3mg vial/prefilled syringe for injection: one vial/syringe per eye every 28 days

b. 0.5mg vial/prefilled syringe for injection: one vial/syringe per eye every 28 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Neovascular Age-related Macular Degeneration (AMD)/Macular Edema following Retinal Vein Occlusion (RVO)/Myopic Choroidal Neovascularization (mCNV)

1. Ten units every 28 days

b. Diabetic Macular Edema (DME)/Diabetic Retinopathy (DR) – (Lucentis and Cimerli Only)

1. Six units every 28 days.

c. Recertification Request

1. Recipient continues to meet the universal and indication-specific relevant criteria as identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: endophthalmitis and retinal detachments, increase in intraocular pressure, arterial thromboembolic events, etc.; and

a. Recipient has had a beneficial response to therapy (e.g., improvement in the baseline best corrected visual acuity (BCVA), etc.) and continued administration is necessary for the maintenance treatment of the condition; or

b. Myopic choroidal neovascularization only: continued administration is necessary due to disease activity (i.e., drop in vision, visual symptoms (e.g., metamorphopsia), or the presence of intra-/sub/retinal fluid or active leakage).

d. Prior Authorization Guidelines

1. Initial approval will be given for three months for myopic choroidal neovascularization (mCNV).

2. Recertification will be given for three months for myopic choroidal neovascularization (mCNV).

3. Initial approval will be given for 12 months for all other indications

4. Recertification will be given for 12 months for all other indications.

3. Susvimo® (ranibizumab)

a. Approval will be given if the following criteria are met and documented

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Recipient is free of ocular and/or peri-ocular infections; and

b. Recipient does not have ocular inflammation; and

c. Therapy will not be used with other ophthalmic VEGF inhibitors (e.g., aflibercept, pergaptanib, brolucizumab, bevacizumab, ranibizumab, faricimab-svoa, etc.) unless supplemental treatment is necessary (see below); and

d. Recipient has not required removal of a Susvimo® implant in the past; and

e. Recipient does not have a hypersensitivity to other ranibizumab products (i.e., Lucentis®, Byooviz™, Cimerli™, etc.); and

f. Recipient's best corrected visual acuity (BCVA) is measured at baseline and periodically during treatment; and

3. Neovascular (Wet) Age-Related Macular Degeneration (AMD)

a. Recipient has previously responded to at least two intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication (e.g., aflibercept, pegaptanib, brolucizumab, bevacizumab, ranibizumab).

b. Dosage and Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Susvimo® 100mg/mL solution for injection SDV: one vial per eye every 24 weeks.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Neovascular Age-related Macular Degeneration

1. 40 billable units (four mg) every 24 weeks.

c. Recertification Request

1. Recipient continues to meet the universal and indication-specific relevant criteria as identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: endophthalmitis, rhegmatogenous retinal detachment, implant dislocation, septum dislodgement, vitreous hemorrhage, conjunctival erosion, conjunctival retraction, and conjunctival blebs, etc.; and

a. Recipient has had a beneficial response to therapy (e.g., improvement in the baseline best corrected visual acuity (BCVA), etc.) and continued administration is necessary for the maintenance treatment of the condition; or

b. Supplemental treatment only: Recipient has had an insufficient response during initial or maintenance therapy with Susvimo administered every 24 weeks and requires supplemental treatment with intravitreal ranibizumab.

d. Prior Authorization Guidelines

1. Initial approval will be given for six months.

2. Recertification will be given for six months.

I. Immune Globulins (immunoglobin)

Therapeutic Class: Immune Globulin
Last Reviewed by DUR Board: N/A

Immune Globulins (immunoglobulin) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Immune Globulins

a. Approval will be given if all the following criteria are met and documented:

1. Baseline valyes for BUN and serum creatinine within 30 days of request; and

2. Primary immunodeficiency (PID)/Wiskott – Aldrich Syndrome

a. Such as: x-linked agammaglobulinemia, common variable immunodeficiency, transient hypogammaglobulinemia of infancy, IgG subclass deficiency with or without IgA deficiency, antibody deficiency with near normal immunoglobulin levels, and combined deficiencies (severe combined immunodeficiencies, ataxia-telangiectasia, x-linked lymphoproliferative syndrome) [list not all inclusive].

1. Recipients IgG level is less than 200 mg/dL or both of the following:

a. Recipient has a history of multiple hard to treat infections as indicated by at least one of the following:

1. Four or more ear infections within one year; or

2. Two or more serious sinus infections; or

3. Two or more months of antibiotics with little effect; or

4. Two or more pneumonias within one year; or

5. Recurrent or deep skin abscesses; or

6. Need for intravenous antibiotics to clear infections; or

7. Two or more deep-seated infections including septicemia; and

b. The recipient has a deficiency in producing antibodies in response to vaccination; and

1. Titers were drawn before challenging with vaccination; and

2. Titers were drawn between four and eight weeks of vaccination.

3. IgG Subclass Deficiency

a. Recipient's IgG level is less than 400 mg/dL; and

b. Recipient has a history of recurrent infections; and

c. Recipient is receiving prophylactic antibiotic therapy.

4. Immune thrombocytopenia/Idiopathic thrombocytopenia purpura (ITP)

a. For acute disease state:

b. To manage acute bleeding due to severe thrombocytopenia (platelet count less than 30 x 10(9)/L); or

c. To increase platelet counts prior to invasive surgical procedures such as splenectomy (platelet count less than 20 x 10(9)/L).

d. Authorization will be given for one month only and cannot be renewed.

e. Chronic Immune Thrombocytopenia (CIT)

1. The recipient is at increased risk for bleeding as indicated by a platelet count less than 30 x 10(9)/L; and

2. History of failure, contraindication, or intolerance to corticosteroids; and

3. Duration of illness greater than six months.

5. Chronic Inflammatory Demyelination Polyneuropathy (CIDP)

a. Recipient's disease course is progressive or relapsing and remitting for greater than two months; and

b. Recipient has abnormal or absent deep tendon reflexes in upper or lower limbs; and

c. Electrodiagnostic testing indicating demyelination:

1. Partial motor conduction block in at least two motor nerves or in one nerve plus one other demyelination criterion listed here in at least one other nerve; or

2. Distal CMAP duration increase in at least one nerve plus one other demyelination criterion listed here in at least one other nerve; or

3. Abnormal temporal dispersion conduction must be present in at least two motor nerves; or

4. Reduced motor conduction velocity in at least two motor nerves; or

5. Prolonged distal motor latency in at least two motor nerves; or

6. Absent F wave in at least two motor nerves plus one other demyelination criterion listed here in at least one other nerve; or

7. Prolonged F wave latency in at least two motor nerves; and

d. Recipient is refractory or intolerant to corticosteroids (e.g., prednisolone, prednisone, etc.) given in therapeutic doses over at least three months; and

e. Baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC muscle strength, 6-MWT, Rankin, Modified Rankin, etc.).

f. Initial approval will be given for three months.

6. Guillain-Barre Syndrome (Acute inflammatory polyneuropathy)

a. Recipient has severe disease (i.e., recipient requires assistance to ambulate); and

b. Onset of symptoms are recent (i.e., less than one month); and

c. Recipient has abnormal or absent deep tendon reflexes in upper or lower limbs; and

d. Recipient has diagnosis is confirmed using a cerebrospinal fluid (CSF) analysis; and

e. Approval will be granted for a maximum of two rounds of therapy within six weeks of onset.

f. Initial approval will be given for two months only and cannot be renewed.

7. Multifocal Motor Neuropathy

a. Recipient has progressive, focal, asymmetric limb weakness (without sensory symptoms) for greater than one month; and

b. Recipient has complete or partial conduction block or abnormal temporal dispersion conduction in at least two motor nerves; and

c. Recipient has normal sensory nerve conduction on all nerves tested: and

d. Baseline in strength/weakness has been documented using an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, etc.).

e. Initial approval will be given for three months.

8. HIV infected children: Bacterial control or prevention

a. Recipient age does not exceed 13 years of age; and

b. Recipients IgG level is less than 400 mg/dL.

9. Myasthenia Gravis

a. Recipient has a positive serologic test for anti-acetylcholine receptor (AchR) antibodies; and

b. Recipient has an acute exacerbation resulting in impending myasthenic crisis (i.e., respiratory compromise, acute respiratory failure, and/or bulbar compromise); and

c. Recipient is failing on conventional immunosuppressant therapy alone (e.g., corticosteroids, azathioprine, cyclosporine,

mycophenolate, methotrexate, tacrolimus, cyclophosphamide, etc.); and

d. Recipient will be on combination therapy with corticosteroids or other immunosuppressant (e.g., azathioprine, mycophenolate, cyclosporine, methotrexate, tacrolimus, cyclophosphamide, etc.).

e. Initial approval will be valid for one course (one month) only and cannot be renewed.

10. Dermatomyositis/Polymyositis

a. Recipient has severe active disease; and

b. Recipient has proximal weakness in all upper and/or lower limbs; and

c. Diagnosis has been confirmed by muscle biopsy; and

d. Recipient has failed a trial of corticosteroids (i.e., prednisone); and

e. Recipient has failed a trial of an immunosuppressant (e.g., methotrexate, azathioprine, etc.); and

f. Must be used as part of combination therapy with other agents; and

g. Recipient has a documented baseline physical exam and muscular strength/function.

h. Initial approval will be given for three months.

11. Complications of transplanted solid organ (kidney, liver, lung, heart, pancreas), and bone marrow transplant

a. Suppression of panel reactive anti-human leukocyte antigen (HLA) antibodies prior to transplantation.

b. Treatment of antibody-mediated rejection of solid organ transplantation.

c. Prevention or treatment of viral infections (e.g., cytomegalovirus, Parvo B-19 virus, and Polyoma BK virus).

12. Stiff-Person Syndrome

a. Recipient has anti-glutamic acid decarboxylase (GAD) antibodies; and

b. Recipient has failed at least two of the following treatments: benzodiazepines, baclofen, gabapentin, valproate, tiagabine, or levetiracetam; and

c. Recipient has a documented baseline on physical exam.

13. Allogeneic Bone Marrow or Stem Cell Transplant

a. Used for prevention of acute Graft-Versus-Host-Disease (aGVHD) or infection; and

b. Recipient's bone marrow (BMT) or hematopoietic stem cell (HSCT) transplant was allogeneic; and

c. Recipients IgG level is less than 400 mg/dL.

d. Initial approval will be given for three months.

14. Kawasaki's Disease

a. Initial approval will be valid for one course (one month) only and cannot be renewed.

15. Fetal Alloimmune Thrombocytopenia (FAIT)

a. Recipient has a history of one or more of the following:

1. Previous FAIT pregnancy; or

2. Family history of the disease.

3. Screening reveals platelet alloantibodies.

b. Initial approval will be given through the delivery date only and cannot be renewed.

16. Neonatal Alloimmune Thrombocytopenia (NAIT)

a. Initial approval will be valid for one course (one month) only and cannot be renewed.

17. Auto-immune Mucocutaneous Blistering Diseases

a. Recipient has been diagnosed with one of the following:

1. Pemphigus Vulgaris

2. Pemphigus Foliaceus

3. Bullous Pemphigoid

4. Mucous Membrane Pemphigoid (a.k.a. Cicatricial Pemphigoid)

5. Epidermolysis Bullosa Aquisita

6. Pemphigus Gestationis (Herpes gestationis)

7. Linear IgA Dermatotis; and

b. Recipient has severe disease that is extensive and debilitating; and

c. Diagnosis has been confirmed by biopsy; and

d. Recipient's disease is progressive; and

e. Disease is refractory to a trial of conventional therapy with corticosteroids and concurrent immunosuppressive treatment (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil, etc.); and

f. Recipient has a documented baseline on physical exam.

18. Acquired Immune Deficiency secondary to Acute Lymphoblastic Leukemia (ALL)

a. Used for prevention of infection; and

b. Recipient's IgG level is less than 400 mg/dL.

19. Acquired Immune Deficiency secondary to Chronic Lymphocytic Leukemia or Multiple Myeloma

a. Recipients IgG level is less than 200 mg/dL or both of the following:

1. Recipient has a history of multiple hard to treat infections as indicated by at least one of the following:

a. Four or more ear infections within one year; or

b. Two or more serious sinus infections within one year; or

c. Two or more months of antibiotics with little effect; or

d. Two or more pneumonias within one year; or

e. Recurrent or deep skin abscesses; or

f. Need for intravenous antibiotics to clear infections; or

g. Two or more deep-seated infections including septicemia; and

2. The recipient has a deficiency in producing antibodies in response to vaccination: and

a. Titers were drawn before challenging with vaccination; and

b. Titers were drawn between four and eight weeks of vaccination.

20. Toxic Shock Syndrome

a. Initial approval be given for one course (one month) only and cannot be renewed.

21. Management of Immune-Checkpoint-Inhibitor Related Toxicity

a. Recipient has been receiving therapy with immune checkpoint inhibitor (e.g., nivolumab, pembrolizumab, atezolizumab, avelumab, durvalumab, dostarlimab, etc.); and

b. Recipient has one of the following toxicities related to their immunotherapy:

1. Severe (G3) or life-threatening (G4) bullous dermatitis as an as an adjunct to rituximab

2. Stevens-Johnson Syndrome (SJS)

3. Toxic epidermal necrolysis (TEN)

4. Severe (G3-4) myasthenia gravis

5. Transverse myelitis

6. Myocarditis as further intervention if no improvement within 24-48 hours of starting pulse-dose methylprednisolone

7. Moderate (G2) or severe (G3-4) Guillain-Barre Syndrome or severe (G3-4) peripheral neuropathy used in combination with pulse-dose methylprednisolone

8. Moderate (G2) pneumonitis if no improvement after 48-72 hours of corticosteroids

9. Severe (G3-4) pneumonitis if no improvement after 48 hours of methylprednisolone

10. Encephalitis used in combination with pulse-dose methylprednisolone for severe or progressing symptoms or if oligoclonal bands are present

11. Moderate, severe, or life-threatening steroid-refractory myalgias or myositis

22. Management of CAR T-Cell-Related Toxicity

a. Recipient has been receiving treatment with anti-CD19 chimeric antigen receptor (CAR) T-cell therapy (e.g., axicabtagene ciloleucel, brexucabtagene autoleucel, idecabtagene vicleucel, lisocabtagene, maraleucel, tisagenlecleucel, etc.); and

1. Used for the management of G4 cytokine release syndrome that is refractory to high-dose corticosteroids and anti-IL-6 therapy (e.g., tocilizumab); or

2. Recipient has hypogammaglobulinemia as confirmed by serum IgG levels less than 600 mg/dL and serious, persistent, or recurrent bacterial infections; or

a. Used as prophylactic therapy prior to receiving treatment with anti-CD19 chimeric antigen receptor (CAR) T-cell therapy (e.g., axicabtagene ciloleucel, brexucabtagen autoleucel, idecabtagene vicleucel, lisocabtagene maraleucel, tisagenlecleucel, etc.); and

b. Recipient has hypogammaglobulinemia as confirmed by serum IgG levels less than or equal to 400 mg/dL and serious persistent, or recurrent bacterial infections.

23. Supportive Care after Rethymic transplant

a. Used as immunoglobulin replacement therapy in pediatric recipients with congenital athymia after surgical implantation of Rethymic; or

b. Used as re-initiation of treatment two months after stopping immunoglobulin replacement therapy in pediatric recipients who have an IgG trough level lower than normal range for age.

b. Dosage Limits

1. Dosing should be calculated using adjusted body weight if one or more following criteria are met:

a. Recipient's body mass index (BMI) is 30 kg/m(2) or more; or

b. Recipient's actual body weight is 20% higher than his or her ideal body weight (IBW).

c. Recertification Request:

1. Recipient continues to meet indication-specific relevant criteria identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include renal dysfunction and acute renal failure, thrombosis, hemolysis, severe hypersensitivity reactions, pulmonary adverse reactions/transfusion-related acute lung injury (TRALI), hyperproteinemia, increased serum viscosity, hyponatremia, aseptic meningitis syndrome, hypertension, volume overload, etc.; and

3. BUN and serum creatinine have been obtained within the last six months and the concentration and rate of infusion have been adjusted accordingly; and

4. Recipient meets the disease-specific criteria identified below:

5. Primary Immunodeficiency (PID)

a. Disease response as evidence by one or more of the following:

1. Decrease in the frequency of infection.

2. Decrease in the severity of infection.

6. IgG Subclass Deficiency

   a. Disease response as evidenced by one or more of the following:

      1. Decrease in the frequency of infection

      2. Decrease in the severity of infection; and

   b. Recipient is at a decreased risk of infection as a result of treatment necessitating continued therapy.

7. Chronic Immune Thrombocytopenia/ITP

   a. Disease response as indicated by the achievement and maintenance of a platelet count of greater than or equal to 30 x 10(9)/L and at least doubling the baseline platelet count.

8. Chronic Inflammatory Demyelinating Polyneuropathy

   a. Renewals will be authorized for recipients that have demonstrated a clinical response to therapy based on an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, etc.).

9. Guillain-Barre Syndrome (Acute Inflammatory polyneuropathy)

   a. May not be renewed.

10. Multifocal Motor Neuropathy

   a. Renewals will be authorized for recipients that have demonstrated a clinical response to therapy based on an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength, 6-MWT, Rankin, Modified Rankin, etc.).

11. HIV infected children: Bacterial control or prevention

   a. Disease response as evidenced by one or more of the following:

      1. Decrease in the frequency of infection

      2. Decrease in the severity of infection; and

   b. Recipient continues to be at an increased risk of infection necessitating continued therapy as evidenced by an IgG level less than 400 mg/dL.

12. Myasthenia Gravis

    a. May not be renewed.

13. Dermatomyositis/Polymyositis

    a. Recipient had an improvement from baseline on physical exam and/or muscular strength and function.

14. Complications of transplanted solid organ (kidney, liver, lung, heart, pancreas), and bone marrow transplant

    a. Disease response as evidenced by one or more of the following:

        1. Decrease in the frequency of infection

        2. Decrease in the severity of infection; and

    b. Recipient is at a decreased risk of infection as a result of treatment necessitating continued therapy.

15. Stiff Person Syndrome

    a. Documented improvement from baseline on physical exam.

16. Allogeneic Bone Marrow or Stem Cell Transplant

    a. Patients IgG trough is less than 400 mg/dL.

17. Kawasaki's Disease

    a. May not be renewed.

18. Fetal Alloimmune Thrombocytopenia (FAIT)

    a. Authorization is valid through the delivery date only and cannot be renewed.

19. Neonatal Alloimmune Thrombocytopenia

    a. May not be renewed.

20. Auto-Immune Mucocutaneous Blistering Diseases

    a. Documented improvement from baseline on physical exam.

21. Acquired Immune Deficiency secondary to Acute Lymphoblastic Leukemia (ALL), Chronic Lymphocytic Leukemia (CLL), or Multiple Myeloma

    a. Disease response as evidenced by one or more of the following:

        1. Decrease in the frequency of infection

        2. Decrease in the severity of infection; and

    b. Recipient is at a decreased risk of infection as a result of treatment necessitating continued therapy.

22. Toxic Shock Syndrome

    a. May not be renewed.

23. Management of Immune Checkpoint Inhibitor related Toxicity

    a. May not be renewed.

24. Management of CAR T-Cell-Related Toxicity

    a. Recipient is still receiving treatment with anti-CD19 CAR T-cell therapy (e.g., axicabtagene ciloleucel, brexucabtagene autoleucel, lisocabtagene maraleucel, tisagenlecleucel, etc.); and

    b. Recipient has serum IgG levels less than 600 mg/dL.

25. Supportive Care after Rethymic transplant

    a. Renewals for use as initial immunoglobulin replacement therapy will be authorized until all of the following criteria are met:

        1. Recipient is no longer on immunosuppression (at least ten percent of CD3+ T cells are naïve in phenotype); and

        2. Recipient is at least nine months post-treatment; and

        3. Recipient's phytohemagglutinin (PHA) response within normal limits; or

    b. Renewals for use as re-initiation of treatment after stopping immunoglobulin replacement therapy for recipients with an IgG trough level lower than normal range will be continued for one year before being retested using the above guidelines.

d. Prior Authorization Guidelines:

1. Initial and renewal authorization periods vary by specific covered indication.

2. Unless otherwise specified, the initial approval will be given for six months.

3. Recertification will be approved for 12 months.

2. SCIG (immune globulin SQ): Hizentra®, Gammagard Liquid®, Gamunex®-C, Gammaked®, HyQvia®, Cuvitru®, Cutaquig®, Xembify®

a. Approval will be given if the following criteria are met and documented

1. Baseline values for BUN and serum creatinine obtained within 30 days of request; and

2. Primary immunodeficiency (PID)/Wiskott-Aldrich Syndrome

a. Such as: x-linked agammaglobulinemia, common variable immunodeficiency, transient hypogammaglobulinemia of infancy, IgG subclass deficiency with or without IgA deficiency, antibody deficiency with near normal immunoglobulin levels) and combined deficiencies (severe combined immunodeficiencies, ataxia-telangiectasia, x-linked lymphoproliferative syndrome)

1. Recipient is greater than or equal to two years old [HyQvia only: recipient must be greater than or equal to 18 years old]; and

2. Recipient's IgG level is less than 200 mg/dL or both of the following:

a. Recipient has a history of multiple hard to treat infections as indicated by at least one of the following:

1. Four or more ear infections within one year

2. Two or more serious sinus infections within one year

3. Two or more serious months of antibiotics within little effect

4. Two or more pneumonias within one year

5. Recurrent or deep skin abscesses

6. Need for intravenous antibiotics to clear infections

7. Two or more deep-seated infections including septicemia; and

b. The recipient has a deficiency in producing antibodies in response to vaccination; and

1. Titers were drawn before challenging with vaccination; and

2. Titers were drawn between four and eight weeks of vaccination.

3. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) [Hizentra® Only]

a. Recipient must be greater than or equal to 18 years old; and

b. Physician has assessed baseline disease severity utilizing an objective measure/tool (e.g., INCAT, Medical Research Council (MRC) muscle strength, six-MWT, Rankin, Modified Rankin, etc.); and

1. Used as initial maintenance therapy for prevention of disease relapses after treatment and stabilization with intravenous immunoglobulin (IVIG); or

2. Used for re-initiation of maintenance therapy after experiencing a relapse and requiring pre-induction therapy with IVIG (see Section IV for criteria).

4. Acquired Immune Deficiency secondary to Chronic Lymphocytic Leukemia

a. Recipient's IgG level is less than 200 mg/dL or both of the following:

1. Recipient has a history of multiple hard to treat infections as indicated by at least one of the following:

a. Four or more ear infections within one year

b. Two or more serious sinus infections within one year

c. Two or more months of antibiotics with little effect

d. Two or more pneumonias within one year

e. Recurrent or deep skin abscesses

f. Need for intravenous antibiotics to clear infections

g. Two or more deep-seated infections including septicemia; and

2. The recipient has a deficiency in producing antibodies in response to vaccination; and

a. Titers were drawn before challenging with vaccination; and

b. Titers were drawn between four and eight weeks of vaccination.

b. Dosage Limits

1. Quantity Limits

a. Hizentra®

1. Dose/week: 46g

2. Dose/28 days: 184g

b. Gamunex®-C & Gammaked™

1. Dose/week: 24g

2. Dose/28 days: 96g

c. Gammagard Liquid

1. Dose/week: 24g

2. Dose/28 days: 96g

d. HyQvia

1. Dose/week: 17.5g

2. Dose/28 days: 69g

e. Cuvitru®

1. Dose/week: 23g

2. Dose/28 days: 92g

f. Cutaquig®

1. Dose/week: 24g

2. Dose/28 days: 96g

g. Xembify®

1. Dose/weel: 24g

2. Dose/28 days: 96g

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Hizentra®

a. Billable units/28 days: 960 (PID)/1840 (CIDP)

b. Gamunex®-C & Gammaked™

1. Billable units/28 days: 192

c. Gammagard liquid

1. Billable units/28 days: 192

d. HyQvia

1. Billable units/28 days: 690

e. Cuvitru®

1. Billable units/28 days: 920

f. Cutaquig®

1. Billable units/28 days: 960

g. Xembify®

1. Billable units/28 days: 960

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe hypersensitivity/anaphylaxis, thrombosis, aseptic meningitis syndrome, hemolytic anemia, hyperproteinemia, acute lung injury, etc.; and

3. BUN and serum creatinine obtained within the last six months and the concentration and rate of infusion have been adjusted accordingly; and

4. Primary immunodeficiency (PID)/Wiskott-Aldrich Syndrome

a. Disease response as evidenced by one or more of the following:

1. Decrease in the frequency of infection

2. Decrease in the severity of infection.

5. Chronic Inflammatory Demyelination Polyneuropathy (CIDP) [Hizentra® Only]

a. Renewals will be authorized for recipients that have demonstrated a beneficial clinical response to maintenance therapy, without relapse, based on an objective clinical measuring tool (e.g., INCAT, Medical Research Council (MRC) muscle strength, six-MWT, Rankin, Modified Rankin, etc.); or

b. Recipient is re-initiating maintenance therapy after experiencing a relapse while on Hizentra®; and

1. Recipient improved and stabilized on IVIG treatment; and

2. Recipient was not receiving maximum dosing or Hizentra® prior to relapse.

6. Acquired Immune Deficiency secondary to Chronic Lymphocytic Leukemia

a. Disease response as evidenced by one or more of the following:

1. Decrease in the frequency of infection

2. Decrease in the severity of infection; and

b. Recipient is at a decreased risk of infection as a result of treatment necessitating continued therapy.

d. Prior Authorization Guidelines

1. Initial approval will be given for six months.

2. Recertification approval will be given for 12 months.

J. Antineoplastic-Anti-Programmed Cell Death Receptor-1 (PD-1)

Therapeutic Class: Antineoplastic-Anti-Programmed Cell Death Receptor-1 (PD-1)
Last Reviewed by DUR Board: N/A

Antineoplastic-Anti-Programmed Cell Death Receptor-1 (PD-1) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Jemperli® (dostarlimab-gwly)

   a. Approval will be given if the following criteria are met and documented:

      1. Recipient is at least 18 years of age; and

      2. Universal Criteria

         a. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)-directed therapy (e.g., cemiplimab, avelumab, nivolumab, atezolizumab, durvalumab, pembrolizumab, nivolumab/relatlimab-rmbw, etc.), unless otherwise specified; and

      3. Mismatch Repair Deficient (dMMR/Microsatellite Instability-High (MSI-H) Cancer

         a. Recipient has mismatch repair deficient (dMMR) or microsatellite instability-high (MSI-H) cancer as determined by an FDA-approved or CLIA-compliant test; and

         b. Used as a single agent; and

         c. Recipient has, but is not limited to, one of the following cancers:

            1. Endometrial Carcinoma

               a. Recipient does not have endometrial sarcoma (excluding carcinosarcoma); and

               b. Used for advanced or recurrent disease; and

               c. Disease has progressed on or following prior treatment with a platinum-containing regimen.

            2. Ampullary Adenocarcinoma

a. Used as subsequent therapy for recurrent or advance disease; and

b. Disease has progressed on or following prior treatment; and

c. Recipient has no satisfactory alternative treatment options.

3. Breast Cancer

a. Used for recurrent unresectable or metastatic disease; and

b. Disease has progressed on or following prior treatment; and

c. Recipient has no satisfactory alternative treatment options.

4. Appendiceal Adenocarcinoma – Colon Cancer

a. Used as subsequent therapy for advanced or metastatic disease; and

b. Disease has progressed following treatment with oxaliplatin-, irinotecan- and/or fluropyrimidine-based therapy.

5. Colorectal Cancer (CRC)

a. Used as subsequent therapy for advanced or metastatic disease; and

b. Disease has progressed following treatment with oxaliplatin-, irinotecan- and/or fluoropyrimidine-based therapy.

6. Esophageal and Esophagogastric Junction Cancer

a. Used as subsequent therapy for recipients who are not surgical candidates or who have unresectable locally advanced, recurrent, or metastatic disease; and

b. Disease has progressed on or following prior treatment; and

c. Recipient has no satisfactory alternative treatment options.

7. Gastric Cancer (adenocarcinoma)

a. Used as subsequent therapy for recipients with locoregional disease who are not surgical candidates or who have unresectable locally advanced, recurrent, or metastatic disease; and

b. Disease has progressed on or following prior treatment; and

c. Recipient has no satisfactory alternative treatment options.

8. Occult Primary/Cancer of Unknown Primary (CUP)

a. Used in symptomatic recipients with performance status (PS) 1-2 or asymptomatic recipients with PS 0 and aggressive recurrent or advanced disease; and

b. Recipient has adenocarcinoma or carcinoma not otherwise specified; and

c. Disease has progressed on or following prior treatment; and

d. Recipient has no satisfactory alternative treatment options; and

e. Recipient has one of the following:

1. Axillary involvement in those with a prostate or post-prostatectomy if clinically indicated.

2. Lung nodules or breast marker-negative pleural effusion.

3. Resectable liver disease.

4. Peritoneal mass or ascites with non-ovarian histology.

5. Retroperitoneal mass of non-germ cell histology in selected recipients.

6. Unresectale liver disease or disseminated metastases.

9. Ovarian, Fallopian Tube, and Primary Peritoneal Cancers

a. Recipient has Grade 1 Endometrioid Carcinoma, Carcinosarcoma (Malignant Mixed Mullerian Tumors), Mucinous Carcinoma of the Ovary, Epithelial Ovarian/Fallopian Tube/Primary Peritoneal Cancer, Clear Cell Carcinoma of the Ovary; and

1. Recipient has persistent, recurrent, or advanced disease; and

2. Recipient is not experiencing an immediate biochemical relapse (i.e., rising CA-125 with no radiographic evidence of disease); or

b. Recipient has Low-Grade Serous Carcinoma; and

1. Recipient has recurrent or advanced tumors.

10. Small Bowel Adenocarcinoma

a. Used for advanced or metastatic disease; and

1. Used for initial therapy in recipient with prior oxaliplatin exposure in the adjuvant treatment setting or with a contraindication to oxaliplatin; or

2. Used as subsequent therapy in recipients without prior oxaliplatin exposure in the adjuvant treatment setting and without a contraindication to oxaliplatin.

b. Dosage Limits

1. Administer 500 mg intravenously every three weeks for doses one through four, followed by subsequent doses of 1,000 mg every six weeks (dose five begins three weeks after the fourth dose) until disease progression or unacceptable toxicity.

c. Recertification Request:

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion-related reactions, severe immune-mediated adverse reactions (e.g., pneumonitis, hepatitis, colitis, endocrinopathies, nephritis with renal dysfunction, dermatologic adverse reactions/rash), complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc.

d. PA Guidelines:

1. Initial approval will be given for six months.

2. Recertification will be given for six months.

2. Keytruda® (pembrolizumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age (unless otherwise specified); and

2. Universal Criteria

a. Recipient has not received previous therapy with a programmed death (PD-1/PD-L1)-directed therapy (e.g., cemiplumab, avelumab, nivolumab, atezolizumab, durvalumab, dostarlimab, nivolumab/relatlimab-rmbw, etc.), unless otherwise specified; and

3. Anal Carcinoma

a. Recipient has metastatic squamous cell carcinoma; and

b. Used as a single agent for subsequent therapy.

4. Primary Mediastinal Large B-Cell Lymphoma (PMBCL)

a. Used as single agent; and

1. Recipient is at least six months of age; and

2. Recipient has relapsed or refractory disease; and

3. Recipient does not require urgent cytoreductive therapy; or

b. Used in combination with brentuximab vedotin; and

1. Recipient is at least six months to 39 years of age; and

2. Used as consolidation/additional therapy in recipients who achieve a partial response after therapy for relapsed or refractory disease.

5. Urothelial Carcinoma (Bladder Cancer)

a. Used as a single agent; and

1. Recipient has Bacillus Calmette-Guerin (BCG)-unresponsive, high-risk, non-muscle invasive bladder cancer (NMBIC) defined as one of the following:

a. Persistent disease despite adequate BCG therapy

b. Disease recurrence after an initial tumor free state following an adequate BCG course of therapy

c. T1 disease following a single induction course of BCG therapy; and

d. Recipient has carcinoma in situ (CIS); and

e. Recipient is ineligible for or has elected not to undergo cystectomy; or

2. Recipient has one of the following diagnoses:

a. Locally advanced or metastatic urothelial carcinoma; or

b. Muscle invasive bladder cancer with local recurrence or persistent disease in a preserved bladder

c. Metastatic or local bladder cancer recurrence post-cystectomy

d. Recurrent or metastatic primary carcinoma of the urethra (excluding recurrence of stage T3-4 disease or palpable inguinal lymph nodes)

e. Primary carcinoma of the urethra that is stage T3-4 cN1-2 or cN1-2 with palpable inguinal lymph nodes (first-line therapy only)

f. Metastatic upper genitourinary (GU) tract tumors

g. Metastatic urothelial carcinoma of the prostate; and

h. Used for disease that progressed during or following platinum-containing chemotherapy; or

i. Used as second-line treatment after chemotherapy other than a platinum; or

j. Used as first-line therapy in cisplatin-ineligible recipients; and

1. Recipient is not eligible for any platinum-containing chemotherapy (i.e., both cisplatin and carboplatin-ineligible).

6. Triple-Negative Breast Cancer

a. Recipient has recurrent unresectable or metastatic disease or inflammatory breast cancer with no response to preoperative systemic therapy; and

1. Used in combination with chemotherapy; and

2. Tumor expresses PD-L1 (combined positive score [CPS] greater than or equal to 10) as determined by an FDA-approved or CLIA-compliant test; or

b. Recipient has high-risk early-stage disease; and

1. Used as neoadjuvant therapy in combination with chemotherapy; and

2. Used as adjugvant therapy as a single agent following use as neoadjuvant therapy in combination with chemotherapy.

7. Adult Central Nervous System (CNS) Cancer

a. Used as a single agent; and

b. Primary tumor is due to BRAF non-specific melanoma or PD-L1 positive non-small cell lung cancer (NSCLC); and

1. Used as initial treatment in recipients with small asymptomatic brain metastases; or

2. Used for relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options; or

3. Used for recurrent limited brain metastases; or

4. Used for recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options.

8. Pediatric Central Nervous System (CNS) Cancers

a. Recipient is less than or equal to 18 years of age; and

b. Recipient has hypermutated diffuse high-grade glioma; and

1. Used for recurrent or progressive disease as a single agent (excluding oligodendroglioma, IDH-mutant and 1p/19q co-deleted or astrocytoma IDH-mutant); or

2. Used as adjuvant therapy (excluding diffuse midline glioma, H3 K27-altered or pontine location); and

a. Recipient is less than three years of age and used as a single agent; or

b. Recipient is greater than or equal to three years of age and used following standard brain radiation therapy (RT) with or without concurrent temozolomide.

9. Cervical Cancer

a. Recipient has persistent, recurrent, or metastatic disease; and

b. Tumor expressed PD-L1 (CPS greater than or equal to one) as determined by an FDA-approved or CLIA-compliant test; and

1. Used as a single agent; and

a. Disease has progressed on or after chemotherapy; or

2. Used in combination with chemotherapy.

10. Esophageal or Gastroesophageal Junction Cancer:

a. Recipient is not a surgical candidate or has unresectable locally advanced, recurrent, or metastatic disease; and

1. Used in combination with platinum-and fluoropyrimidine-based chemotherapy; and

    a. Used as first-line therapy; or

2. Used in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy; and

    a. Used as first-line therapy for HER2-positive disease; and

    b. Recipient has adenocarcinoma; or

3. Used as a single agent; and

    a. Recipient has squamous cell carcinoma; and

        1. Tumor expresses PD-L1 (CPS greater than or equal to 10) as determined by an FDA-approved or CLIA compliant test; and

        2. Recipient progressed after one or more prior lines of systemic therapy.

11. Gastric Cancer

    a. Recipient is not a surgical candidate or has unresectable locally advanced, recurrent, or metastatic disease; and

    b. Recipient has adenocarcinoma; and

    c. Used in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy; and

    d. Used as first-line therapy for HER2-positive disease.

12. Gestational Trophoblastic Neoplasia

    a. Used as a single agent or multiagent chemotherapy-resistant disease; and

        1. Recipient has intermediate placental site trophoblastic (PSTT) or epithelioid trophoblastic tumor (ETT); and

            a. Used for recurrent or progressive disease; and

            b. Recipient has previously treated with a platinum-based regimen; or

2. Recipient has high risk disease (i.e., greater than or equal to seven prognostic score or stage IV disease).

13. Squamous Cell Carcinoma of the Head and Neck (SCCHN)

a. Recipient has Cancer of the Nasopharynx; and

1. Used in combination with cisplatin and gemcitabine; and

b. Recipient has Very Advanced Head and Neck Cancer; and

1. Recipient has nasopharyngeal cancer; and

a. Recipient has a performance status 0-1; and

b. Used in combination with cisplatin and gemcitabine; and

c. Used for one of the following:

1. Unresectable locoregional recurrence with prior radiation therapy (RT)

2. Unresectable second primary with prior RT

3. Unresectable persistent disease with prior RT

4. Recurrent/persistent disease with distant metastases; or

2. Recipient has NON-nasopharyngeal cancer; and

a. Recipient is unfit for surgery or has locally advanced disease; and

1. Used as a single agent as first-line therapy in recipients with a performance status (PS) 3; and

2. Tumor expresses PD-L1 (CPS greater than or equal to one) as determined by an FDA-approved or CLIA-compliant test; or

b. Recipient has unresectable, recurrent, persistent, or metastatic disease; and

1. Used as a single agent; and

a. Tumor expresses PD-L1 (CPS greater than or equal to one) as determined by an FDA-approved or CLIA-compliant test; or

b. Used as subsequent therapy for disease that has progressed on or after platinum-containing chemotherapy; or

2. Used in combination with fluorouracil and a platinum chemotherapy agent or in combination with docetaxel and either carboplatin or cisplatin; and

a. Recipient has a performance status zero through one.

14. Hepatocellular Carcinoma (HCC)

a. Used as a single agent; and

b. Recipient was previously treated with sorafenib; and

c. Recipient has Child-Pugh Class A liver impairment (i.e., excluding Child-Pugh Class B and C).

15. Adult Classical Hodgkin Lymphoma (cHL)

a. Recipient has relapsed or refractory disease; and

1. Used as a single agent; or

2. Used in combination with GVD (gemcitabine, vinorelbine, liposomal doxorubicin); or

b. Used as a palliative therapy in recipients greater than 60 years of age; and

1. Recipient has relapsed or progressive disease after high-dose therapy (HDT)/autologous stem cell transplantation (ASCT); or

2. Recipient has relapsed or refractory disease and is transplant-ineligible based on comorbidities or failure of second-line chemotherapy; or

3. Recipient is post-allogeneic stem-cell transplant.

16. Pediatric Classical Hodgkin Lymphoma

a. Recipient is at least six months of age; and

b. Used as a single agent; and

1. Recipient has refractory disease; or

2. Recipient has relapsed disease; and

a. Used after two or more prior lines of therapy; or

b. Used as subsequent therapy in recipients heavily pretreated with platinum or anthracycline-based chemotherapy; or

c. Used as subsequent therapy in recipients with an observed decreased in cardiac function.

17. Renal Cell Carcinoma (RCC)

a. Recipient has clear cell histology; and

1. Used in combination with axitinib or lenvatinib; and

a. Used as first-line therapy for advanced, relapsed, or stage IV disease; or

b. Used as subsequent therapy for relapsed or stage IV disease; or

2. Used as a single agent; and

a. Used as adjuvant therapy; and

1. Recipient has undergone a nephrectomy prior to receiving treatment; and

a. Recipient has stage II disease with grade four tumors (with or without sarcomatoid features); or

b. Recipient has stage III disease; or

2. Recipient has a metastasectomy within one year of having undergone a nephrectomy for relapsed or stage IV disease; or

a. Recipient has non-clear cell histology; and

b. Used as single agent for relapsed or stage IV disease.

18. Cutaneous Melanoma

a. Used as first-line therapy as a single agent for unresectable or metastatic disease; or

b. Used as initial treatment of limited resectable disease; and

1. Used as a single agent; and

a. Recipient has stage III disease with clinical satellite/in-transit metastases; or

b. Recipient has local satellite/in-transit recurrence; or

c. Used as subsequent therapy for unresectable or metastatic disease after disease progression or maximum clinical benefit from BRAF targeted therapy (e.g., dabrafenib/trametinib, vemurafenib/cobimetinib, encorafen/binimetinib, etc.); and

1. Used as a single agent; and

a. Anti-PD-1 therapy was not previously used; or

b. Used as re-induction therapy in recipients who experienced disease control (i.e., complete response, partial response, or stable disease with no residual toxicity) from prior anti-PD-1 therapy, but subsequently have disease progression/relapse greater than three months after treatment discontinuation; or

2. Used in combination with ipilimumab; and

a. Used after progression on single-agent anti-PD-1 therapy and combination ipilimumab/anti-PD-1 therapy was not previously used; or

b. Used as re-induction therapy in recipients who experienced disease control (i.e., complete response, partial response, or stable disease with no residual toxicity) from prior combination ipilimumab/anti-PD-1 therapy, but subsequently have disease progression/relapse greater than three months after treatment discontinuation; or

d. Used as a single agent for adjuvant treatment; and

1. Recipient has stage IIB or IIC melanoma following complete restriction; and

a. Recipient is at least 12 years of age; or

2. Recipient has stage III disease; and

a. Used following complete resection; and

1. Recipient is at least 12 years of age; or

b. Recipient has lymph node involvement and has undergone complete lymph node dissection (CLND), therapeutic lymph node dissection (TLND), or nodal basin ultrasound surveillance; or

c. Recipient has clinical satellite/in-transit metastases and has no evidence of disease (NED) after complete excision; or

3. Recipient has local satellite/in-transit recurrence and has NED after complete excision; or

4. Recipient has undergone TLND and/or complete excision of disease limited to nodal recurrence; or

5. Recipient has oligometastatic disease and NED after receiving metastasis-directed therapy (e.g., stereotactic ablative therapy or complete resection) or systemic therapy.

19. Uveal Melanoma

a. Used as a single parent; and

b. Recipient has distant metastatic disease.

20. Merkel Cell Carcinoma (MCC)

a. Recipient is at least six months of age; and

b. Used as a single agent; and

1. Recipient has recurrent disease and both curative surgery and curative radiation therapy are not feasible; or

2. Recipient has recurrent locally advanced or metastatic disease.

21. Adrenal Gland Tumors

a. Recipient has locoregional unresectable or metastatic adrenocortical carcinoma (ACC); and

b. Used with or without mitotane.

22. Non-Small Cell Lung Cancer (NSCLC)

a. Used for stage III disease; and

1. Used as a first-line therapy as a single-agent in recipients who are not candidates for surgical resection or definitive chemoradiation; and

2. Used in recipients with tumors expressing PD-L1 (TPS greater than or equal to one percent) as determined by an FDA-approved or CLIA compliant test and with no EGFR or ALK genomic tumor aberrations; or

b. Used for stage IB (T2a greater than or equal to four centimeters), II, or IIIA disease; and

1. Used as adjuvant therapy as a single agent; and

2. Used following resection and platinum-based chemotherapy; or

c. Used for recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy; and

1. Used as first-line therapy; and

a. Used for one of the following:

1. PD-L1 expression-positive (TPS greater than or equal to one percent) tumors, as detected by an FDA-approved or CLIA compliant test, that are negative for actionable molecular biomarkers

2. Recipients with performance status (PS) 0-1 who have tumors that are negative for actionable molecular biomarkers and PD-L1 expression less than one percent

3. Recipients with PS 0-1 who are positive for one of the following molecular mutations: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK1/2/3 gene fusion, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2); and

b. Used in combination with pemetrexed and either carboplatin or cisplatin for non-squamous cell historlogy; or

c. Used in combination with carboplatin and either paclitaxel or albumin-bound paclitaxel for squamous cell histology; or

d. Used as single agent therapy (for PD-L1 expression-positive tumors only); or

2. Used as subsequent therapy; and

a. Used in recipients with tumors expressing PD-L1 (TPS greater than or equal to one percent) as determined by an FDA-approved or CLIA compliant test; and

1. Used as single agent therapy; or

b. Used for one of the following:

1. Recipients with PS 0-1 who are positive for one of the following molecular mutations and have received prior targeted therapy; EGFR exon 19 deletion or L858R tumors, EGFR S768I, L861Q and/or G719x-positive tumors, ALK rearrangement, or ROS1 rearrangement

2. Recipients with PS 0-1 who are positive for one of the following molecular mutations: BRAF V600E, NTRK1/2/3 gene fusion, MET Exon 14 skipping, or RET rearrangement; and

c. Used in combination with carboplatin and either paclitaxel or albumin-bound paclitaxel for squamous cell histology; or

d. Used in combination with pemetrexed and either carboplatin or cisplatin for non-squamous cell histology; or

3. Used as continuation maintenance therapy in recipients who have achieved tumor response or table disease following initial therapy; and

a. Used in combination with pemetrexed following a first-line pembrolizumab/pemetrexed/(carboplatin or cisplatin) regimen for non-squamous cell histology; or

b. Used as a single agent following a first-line pembrolizumab/carboplatin/(paclitaxel or albumin-bound paclitaxel) regimen for squamous cell histology; or

c. Used as a single agent following a first-line pembrolizumab monotherapy regimen.

23. Primary Cutaneous Lymphomas

a. Used as a single agent; and

1. Recipient has Mycosis Fungoides/Sezary Syndrome; and

a. Used as primary therapy or as subsequent therapy for relapsed or persistent disease; and

1. Recipient has stage III Mycosis Fungoides or stage IV Sezary Syndrome; or

2. Recipient has generalized cutaneous or extracutaneous lesions with large cell transformation (LCT); or

b. Used as subsequent therapy for disease refractory to multiple previous therapies; or

2. Recipient has primary cutaneous CD30+ T-Cell lymphoproliferative disorders; and

a. Used for relapsed or refractory disease; and

b. Used for primary cutaneous anaplastic large cell lymphoma (ALCL) with multifocal lesions, or cutaneous ALCL with regional node (N1) (excludes systemic ALCL).

24. Small Cell Lung Cancer (SCLC)

a. Used as subsequent therapy as a single agent; and

1. Disease has relapsed following a complete or partial response or stable disease with primary treatment (excluding use in recipients who progressed on maintenance atezolizumab or durvalumab at time of relapse); or

2. Recipient has primary progressive disease.

25. Soft Tissue Sarcoma

a. Used as a single agent; and

1. Recipient has alveolar soft part sarcoma (ASPS); or

2. Recipient has cutaneous angiosarcoma; or

b. Used in combination with axitinib; and

1. Recipient has alveolar soft part sarcoma (ASPS).

26. Cutaneous Squamous Cell Carcinoma (cSCC)

a. Used as a single agent; and

1. Recipient has locally advanced, recurrent, or metastatic disease that is not curable by surgery or radiation; or

2. Recipient has unresectable, inoperable, or incompletely resected regional disease or new regional disease that is not curable by radiation therapy.

27. Extranodal NK/T-Cell Lymphomas

    a. Used as a single agent for relapsed or refractory disease; and

    b. Disease progressed following additional treatment with an alternative asparaginase-based combination chemotherapy regimen not previously used; and

    c. Participation in a clinical trial is unavailable.

28. Thymic Carcinoma

    a. Used as a single agent: and

        1. Used as first-line therapy for unresectable, locally advanced, or metastatic disease in recipients who are unable to tolerate first-line combination regimens; or

        2. Used as postoperative treatment in recipients who are unable to tolerate first-line combination regimens; or

        3. Used as second-line therapy for unresectable or metastatic disease.

29. Endometrial Carcinoma (Uterine Neoplasms)

    a. Recipient has advanced, recurrent, or metastatic disease that is mismatch repair proficient (pMMR) as determined by an FDA-approved or CLIA-compliant test or not microsatellite instability-high (MSI-H); and

    b. Disease has progressed following prior systemic therapy; and

    c. Used in combination with Lenvatinib.

30. Vulvar Cancer

    a. Used as a single agent; and

    b. Recipient has adrenocarcinoma or squamous cell carcinoma; and

    c. Recipient has advanced, recurrent, or metastatic disease; and

    d. Tumor expresses PD-L1 (CPS greater than or equal to one) as determined by and FDA-approved or CLIA-compliant test; and

    e. Used as second-line therapy for disease progression on or after chemotherapy.

31. Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Cancer

    a. Recipient has at least six months of age; and

    b. Used as a single agent; and

    c. Recipient has microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease as determined by an FDA-approved or CLIA compliant test; and

    d. Pediatric recipients must not have a diagnosis of MSI-H central nervous system cancer; and

    e. Recipient has, but is not limited to, one of the following cancers:

        1. Colorectal Cancer

            a. Used for unresectable or medically inoperable, advanced, or metastatic disease; or

        2. Appendiceal Adenocarcinoma – Colon Cancer

            a. Used as initial therapy for advanced or metastatic disease; or

            b. Used as subsequent therapy for advanced or metastatic disease that progressed following previous oxaliplatin-irinotecan-and/or fluoropyrimidine-based therapy.

        3. Pancreatic Adenocarcinoma

            a. Used as subsequent therapy for locally advanced or metastatic disease after progression; or

            b. Used for recurrent or metastatic disease after resection; or

            c. Used as first-line therapy for metastatic disease; or

            d. Used as continuation (maintenance) therapy for metastatic disease if acceptable tolerance and no disease progression after at least four to six months of first-line therapy in recipients with good performance status (i.e., ECOG PS 0-1).

4. Bone Cancer (Ewing Sarcoma, Chordoma [chondroid or conventional histology], Chondrosarcoma [excluding dedifferentiated or mesenchymal subtypes], or Osteosarcoma [excluding high-grade undifferentiated pleomorphic sarcoma])

    a. Used for unresectable or metastatic disease that has progressed following prior treatment; and

    b. Recipient has no satisfactory alternative treatment options.

5. Gastric Cancer (Adenocarcinoma) or Esophageal/Gastrophageal Junction Adenocarcinoma or Squamous Cell Carcinoma

    a. Used as subsequent therapy for recipients who are not surgical candidates or have unresectable locally advanced, recurrent, or metastatic disease.

6. Ovarian Cancer (Epithelial Ovarian, Fallopian Tube, and Primary Peritoneal Cancers)

    a. Used for persistent or recurrent disease; and

    b. Recipients is not experiencing an immediate biochemical relapse (i.e., rising CA-125 with no radiographic evidence of disease).

7. Uterine Neoplasms (Endometrial Carcinoma)

    a. Used as second-line therapy for recurrent or metastatic disease; or

    b. Recipient has advanced disease that has progressed following prior systemic therapy in any setting and is not a candidate for curative surgery or radiation.

8. Penile Cancer

    a. Used as subsequent therapy for unresectable or metastatic disease that has progressed following prior treatment; and

    b. Recipient has no satisfactory alternative treatment options.

9. Vulvular Cancer

   a. Recipient has adenocarcinoma or squamous cell carcinoma; and

   b. Used as second-line therapy for advanced, recurrent, or metastatic diseae that progressed following prior treatment; and

   c. Recipient has no satisfactory alternative treatment options.

10. Testicular Cancer

   a. Used as third-line therapy

11. Hepatobiliary Adenocarcinoma (Gallbladder Cancer, Intra-/Extra-hepatic Cholangiocarcinoma)

   a. Used as primary treatment for unresectable or metastatic disease; or

   b. Used for unresectable or metastatic disease that has progressed on or after prior treatment.

12. Vulvar Cancer

   a. Recipient has adenocarcinoma or squamous cell carcinoma; and

   b. Used as second-line therapy for advanced, recurrent, or metastatic disease.

13. Cervical Cancer

   a. Used as subsequent therapy for persistent, recurrent, or metastatic disease.

14. Small Bowel Adenocarcinoma

   a. Used for advanced or metastatic disease; and

      1. Used as initial therapy; or

      2. Used as subsequent therapy for recipients with no prior oxaliplatin exposure in the adjuvant treatment setting and no contraindication to oxaliplatin therapy.

15. Ampullary Adenocarcinoma

    a. Used as subsequent therapy for disease progression; or

    b. Used as first-line therapy for unresectable localized or metastatic disease.

16. Breast Cancer

    a. Used for recurrent unresectable or metastatic disease or inflammatory breast cancer with no response to preoperative systemic therapy; and

    b. Recipient has progressed following prior treatment; and

    c. Recipient has no satisfactory alternative treatment options.

17. Occult Primary/Cancer of Unknown Primary (CUP)

    a. Used in symptomatic recipients with PS one-two or asymptomatic recipients with PS 0 and aggressive disease; and

        1. Recipient has squamous cell carcinoma; and

            a. Recipient has multiple lung nodules; pleural effusion, or disseminated metastases; or

        2. Recipient has adenocarcinoma or carcinoma not otherwise specified; and

            a. Recipient has one of the following:

                1. Axillary involvement in those with a prostate or post-prostatectomy if clinically indicated

                2. Lung nodules or breast marker-negative pleural effusion

                3. Resectable liver disease

4. Peritoneal mass or ascites with non-ovarian histology

5. Retroperitoneal mass of non-germ cell histology in selected recipients

6. Unresectable liver disease or disseminated metastases.

18. Very Advanced Squamous Cell Carcinoma of the Head and Neck (SCCHN)

a. Recipient has non-nasopharyngeal cancer; and

b. Recipient is unfit for surgery or has locally advanced, unresectable, recurrent/persistent, or metastatic disease

19. Prostate Cancer

a. Recipient has castration-resistant metastatic disease; and

b. Recipient will continue androgen deprivation therapy (ADT); and

c. Recipient received prior docetaxel and prior novel hormone therapy (excluding recipients with visceral metastases).

20. Well-Differentiated Grade 3 Neuroendocrine Tumors

a. Recipient has progressed following prior treatment and has no satisfactory alternative treatment options; and

1. Recipient has locally advanced/metastatic disease with unfavorable biology (e.g., relative high Ki-67 [greater than or equal to 55%], rapid growth rate, negative SSTR-based PET imaging); or

2. Recipient has unresectable locally advanced/metastatic disease with favorable biology (e.g., relatively low Ki-67 [less than 55%], positive SSTR-based PET imaging); or

a. Recipient has locally advanced/metastatic disease with unfavorable biology (e.g., relative high Ki-67 [greater than or equal to 55%], rapid growth rate, negative SSTR-based PET imaging); or

b. Recipient has unresectable locally advanced/metastatic disease with favorable biology (e.g., relatively low Ki-67 [less than 55%], positive SSTR-based PET imaging); and

1. Recipient clinically significant tumor burden or evidence of disease progression.

21. Neuroendocrine Tumors (Extrapulmonary Poorly Differentiated Neuroendocrine Carcinoma/Large or Small Cell Carcinoma/Mixed Neuroendocrine-Non-Neuroendocrine Neoplasm)

a. Recipient has locoregional unresectable or metastatic disease; and

b. Recipient progressed following prior treatment and has no satisfactory alternative treatment options.

32. Tumor Mutational Burden-High (TMB-H) Cancer

a. Recipient is at least six months of age; and

b. Recipient has solid tumors that are tumor mutational burden-high (TMB-H0 [greater than or equal to 10 mutations/megabase 9mut/Mb)] as determined by an FDA-approved or CLIA-compliant test; and

c. Used as a single agent; and

d. Pediatric recipients must not have a diagnosis of TMB-H central nervous system cancer; and

e. Recipient has, but is not limited to, one of the following cancers:

1. Bone Cancer (Ewing Sarcoma, Chordoma [chondroid or conventional histology], Chondrosarcoma [excluding dedifferentiated or mesenchymal subtypes], or

Osteosarcoma [excluding high-grade undifferentiated pleomorphic sarcoma])

a. Recipient has unresectable or metastatic disease that progressed following prior treatment; and

b. Recipient has no satisfactory alternative treatment options.

2. Breast Cancer

a. Recipient has recurrent unresectable or metastatic disease or inflammatory breast cancer with no response to preoperative systemic therapy; and

b. Recipient has progressed following prior treatment; and

c. Recipient has no satisfactory alternative treatment options.

3. Cervical Cancer

a. Used as subsequent therapy for unresectable or metastatic disease; and

b. Recipient has progressed following prior treatment; and

c. Recipient has no satisfactory alternative treatment options.

4. Gastric Cancer (Adenocarcinoma) or Esophageal/Gastroesophageal Junction Adenocarcinoma or Squamous Cell Carcinoma

a. Used as subsequent therapy for recipients who are not surgical candidates or have unresectable locally advanced, recurrent, or metastatic disease.

5. Hepatobiliary Adenocarcinoma (Gallbladder Cancer, Intra-/Extra-hepatic Cholangiocarcinoma)

a. Used for unresectable or metastatic disease that has progressed on or after prior systemic treatment.

6. Head and Neck Cancers

a. Salivary Gland Tumors

1. Used for recurrent metastatic disease in recipients with a PS zero to three; or

2. Used for unresectable locoregional recurrence or second primary with prior radiation therapy.

b. Cancer of the Nasopharynx

1. Used as subsequent therapy for oligometastatic or metastatic disease.

7. Thyroid Carcinoma

a. Anaplastic Carcinoma

1. Used as first- or second-line therapy for metastatic disease

b. Follicular Carcinoma, Papillary Carcinoma, Hurthle Cell Carcinoma

1. Recipient has progressive and/or symptomatic unresectable locoregional recurrent/persistent or metastatic disease not amenable to radioactive iodine (RAI) therapy.

c. Medullary Carcinoma

1. Recipient has unresectable locoregional or recurrent/persistent metastatic disease that is either symptomatic or progressing.

8. Uterine Neoplasms (Uterine Sarcoma [excluding low-grade endometrial stromal sarcoma], Endometrial Carcinoma)

a. Used as second-line therapy for unresectable or metastatic disease that progressed following prior treatment; and

b. Recipient has no satisfactory alternative treatment options.

9. Testicular Cancer

   a. Used as third-line therapy

10. Occult Primary/Cancer of Unknown Primary (CUP)

   a. Used in symptomatic recipients with PS one-two or asymptomatic recipients with PS zero and aggressive disease; and

      1. Recipient has squamous cell carcinoma; and

         a. Recipient has multiple lung nodules, pleural effusion, or disseminated metastases; or

      2. Recipient has adenocarcinoma or carcinoma not otherwise specified; and

         a. Recipient has one of the following:

         b. Axillary involvement in those with a prostate or post-prostatectomy if clinically indicated

         c. Lung nodules or breast marker-negative pleural effusion

         d. Resectable liver disease

         e. Peritoneal mass or ascites with non-ovarian histology

         f. Retroperitoneal mass of non-germ cell history in selected recipients

         g. Unresectable liver disease or disseminated metastases.

11. Ovarian Cancer (Epithelial Ovarian, Fallopian Tube, and Primary Peritoneal Cancers)

   a. Used for persistent or recurrent disease; and

   b. Recipient is not experiencing an immediate biochemical relapse (i.e., rising CA-125 with no radiographic evidence of disease).

12. Penile Cancer

    a. Used as subsequent therapy for unresectable or metastatic disease that has progressed on previously approved lines of therapy.

13. Prostate Cancer

    a. Used as subsequent therapy for unresectable or metastatic disease that has progressed on previously approved lines of therapy.

14. Well-Differentiated Grade 3 Neuroendocrine Tumors

    a. Recipient has progressed following prior treatment and has no satisfactory alternative treatment options; and

        1. Recipient has locally advanced/metastatic disease with unfavorable biology (e.g., relative high Ki-67 [greater than or equal to 55 percent], rapid growth rate, negative SSTR-based PET imaging); and

        2. Recipient clinically significant tumor burden or evidence of disease progression.

15. Neuroendocrine Tumors (Extrapulmonary Poorly Differentiated Neuroendocrine Carcinoma/Large or Small Cell Carcinoma/Mixed Neuroendocrine-Non-Neuroendocrine Neoplasm)

    a. Recipient has locoregional unresectable or mestastatic disease; and

    b. Recipient progressed following prior treatment and has no satisfactory alternative treatment options.

16. Ampullary Adenocarcinoma

    a. Used as subsequent therapy for disease progression; or

    b. Used as first-line therapy for unresectable localized or metastatic disease.

17. Pancreatic Adenocarcinoma

a. Used as subsequent therapy for locally advanced or metastatic disease after progression; or

b. Used for recurrent or metastatic disease after resection; or

c. Used as first-line therapy for metastatic disease; or

d. Used as continuation (maintenance) therapy for metastatic disease if acceptable tolerance and disease no progression after at least four to six months of first-line therapy in recipients with good performance status (i.e., ECOG PS zero to one).

18. Soft Tissue Sarcoma

a. Recipient has myxofibrosarcoma, undifferentiated pleomorphic sarcoma (UPS), cutaneous angiosarcoma, or undifferentiated sarcoma; and

b. Recipient progressed following prior treatment and has no satisfactory alternative treatment options; and

1. Used as subsequent therapy for advanced or metastatic Extremity/Body Wall, Head/Neck disease; or

2. Used as subsequent therapy for recurrent unresectable or recurrent stage IV Retroperitoneal/Intra-Abdominal disease.

b. Dosage Limits

1. Keytruda 100mg/four mL single use vial: 11 vials per 14-day supply.

c. Recertification Requests:

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion-related reactions, severe immune-

mediated adverse reactions (e.g., pneumonitis, hepatitis, colitis, endocrinopathies, nephritis with renal dysfunction, dermatologic adverse reactions/rash, etc.), hepatotoxicity when used in combination with axitinib, complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc.; and

4. For the following indications, recipient has not exceeded a maximum of twenty-four months of therapy:

   a. Adrenal Gland Tumors

   b. Anal Carcinoma

   c. Bladder Cancer/Urothelial Carcinoma

   d. Cervical Cancer

   e. Classical Hodgkin Lymphoma (cHL)

   f. CNS Cancer

   g. Cutaneous Melanoma (in combination with ipilimumab only)

   h. Cutaneous Squamous Cell Carcinoma (cSCC)

   i. Endometrial Carcinoma

   j. Esophageal/Gastroesophageal Junction Cancer

   k. Gastric Cancer

   l. Hepatocellular Carcinoma (HCC)

   m. Merkel Cell Carcinoma (MCC)

   n. MSI-H/dMMR Cancer

   o. Non-Small Cell Lung Cancer (NSCLC) (first-line or subsequent therapy)

   p. Primary Cutaneous Lymphomas

   q. Primary Mediastinal Large B-Cell Lymphoma (PMBCL)

   r. Renal Cell Carcinoma (RCC) (first-line or subsequent therapy)

   s. Small Cell Lung Cancer (SCLC)

   t. Squamous Cell Carcinoma of the Head and Neck (SCCHN)

u. Thymic Carcinoma

v. Tumor Mutational Burden-High (TMB-H) Cancer

w. Triple Negative Breast Cancer (recurrent unresectable or metastatic disease)

x. Uveal Melanoma

y. Vulvar Cancer

z. Cutaneous Melanoma (adjuvant treatment)

1. Recipient has not exceeded a maximum of twelve months of therapy.

aa. NSCLC (adjuvant treatment)

1. Recipient has not exceeded a maximum of twelve months of therapy.

bb. Triple Negative Breast Cancer (neoadjuvant treatment)

1. Recipient has not exceeded a maximum of twenty-four weeks of therapy.

cc. Triple Negative Breast Cancer (adjuvant treatment)

1. Recipient has not exceeded a maximum of twenty-seven weeks of therapy.

dd. Cutaneous Melanoma (subsequent treatment after prior anti-PD-1 immunotherapy)

1. Refer to Section III for criteria.

ee. Continuation Maintenance Therapy for NSCLC

1. Refer to Section III for criteria.

d. PA Guidelines:

1. Initial approval will be given for six months.

2. Recertification will be given for six months.

K. Kadcyla® (ado-trastuzumab emtansine)

Therapeutic Class: Antineoplastic-Antibody Drug Conjugates (ADCs)
Last Reviewed by DUR Board: N/A

Kadcyla® (ado-trastuzumab emtansine) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Recipient is at least 18 years of age; and

   b. Universal Criteria

      1. Left ventricular ejection fraction (LVEF) is within normal limits prior to initiating therapy and will be assessed at regular intervals (e.g., every three months) during treatment; and

      2. Used as a single agent; and

      3. Therapy will not be substituted with or for any trastuzumab-based formulation (i.e., trastuzumab [or trastuzumab biosimilar product], fam-trastuzumab deruxtecan-nxki, trastuzumab-hyaluronidase, pertuzumab/trastuzumab and hyaluronidase-zzxf, etc.); and

   c. Breast Cancer

      1. Recipient has human epidermal growth factor receptor 2 (HER2)-positive* disease as determined by an FDA-approved or CLIA-compliant test; and

         a. Used as adjuvant therapy; and

            1. Recipient has locally advanced or node positive disease; and

               a. Used for residual disease following completion of planned chemotherapy and mastectomy or breast-conserving surgery (BCS); or

               b. Used in recipients not considering pre-operative systemic therapy; or

            2. Recipient has inflammatory breast cancer; and

a. Used in recipients who had a response to preoperative systemic therapy, followed by surgery, and needs to complete planned chemotherapy; or

b. Recipient has residual disease following preoperative therapy; or

3. Recipient has early breast cancer with residual invasive disease after neoadjuvant taxane and trastuzumab-based therapy; or

b. Recipient has metastatic or recurrent unresectable disease or inflammatory breast cancer with no response to preoperative systemic therapy; and

1. Used as second-line therapy and beyond; or

c. Recipient has metastatic disease that recurred during or within six months of completing adjuvant therapy; and

1. Recipient previously received trastuzumab and a taxane, separately or in combination.

d. Central Nervous System (CNS) Cancer

1. Recipient has human epidermal growth factor receptor two (HER2)-positive* disease as determined by an FDA approved or CLIA-compliant test; and

2. Used for the treatment of brain metastases in recipients with breast cancer; and

a. Used as initial treatment in recipients with small asymptomatic brain metastases; or

b. Used for relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options; or

c. Recipient has recurrent limited brain metastases; or

d. Used for recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options.

e. Non-Small Cell Lung Cancer (NSCLC)

1. Recipient has ERBB2 (HER2) mutation positive disease as determined by an FDA-approved or CLIA-compliant test; and

2. Recipient has recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy.

f. Head and Neck Cancer

1. Recipient has human epidermal growth factor receptor 2 (HER2)-positive* disease as determined by an FDA-approved or CLIA-compliant test; and

2. Recipient has salivary gland tumors; and

3. Used for one of the following:

a. Recurrent disease with distant metastases

b. Unresectable locoregional recurrence with prior radiation therapy (RT)

c. Unresectable second primary with prior RT.

2. Dosing Limits

a. Quantity Limit (max daily dose) [NDC Unit]:

1. Kadcyla 100 mg singe-dose vial: one vial every 21 days.

2. Kadcyla 160 mg single-dose vial: three vials every 21 days.

b. Max Units (per dose and over time) [HCPCS Unit]:

1. 480 billable units every 21 days.

3. Renewal Criteria:

a. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in Section III; and

b. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

c. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: hepatotoxicity, pulmonary toxicity (i.e., interstitial lung disease, pneumonitis), thrombocytopenia, neurotoxicity, infusion-related and hypersensitivity reactions, hemorrhage, extravasation at infusion site, etc.; and

d. Left ventricular ejection fraction (LVEF) obtained within the previous 3 months as follows:

1. Metastatic or Recurrent Breast Cancer: LVEF is >45% OR LVEF is 40% to ≤45% and absolute decrease is <10% from baseline; or

2. All other indications: LVEF is ≥50% OR LVEF is 45% to <50% and absolute decrease is <10% from baseline; and

e. Breast Cancer (adjuvant treatment)

1. Recipient has not exceeded a maximum of 14 cycles of therapy (42 weeks total).

L. Aranesp® (darbepoetin alfa)

Therapeutic Class: Recombinant Human Erythropoietins
Last Reviewed by DUR Board: January 19, 2023

Aranesp® (darbepoetin alfa) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Recipient is at least 18 years of age (unless otherwise specified); and

   b. Initiation of therapy Hemoglobin (Hb) less than 10 g/dL and/or Hematocrit (Hct); and

   c. Universal Criteria

      1. Lab values are obtained within 30 days of the date of administration (unless otherwise indicated); and

      2. Recipient has adequate iron stores as demonstrated by serum ferritin greater than or equal to 100 ng/mL (mcg/L) and transferrin saturation (TSAT) greater than or equal to 20% (measured within the previous three months for renewal); and

      3. Other causes of anemia (e.g. hemolysis, bleeding, vitamin deficiency, etc.) have been ruled out; and

      4. Recipient does not have uncontrolled hypertension; and

   d. Anemia Due to Myelodysplastic Syndrome (MDS)

      1. Endogenous serum erythropoietin level of less than or equal to 500 mUnits/mL; and

      2. Recipient has lower risk disease (i.e., defined by IPSS-R [Very Low, Low, Intermediate]); and

      3. Recipient has symptomatic anemia.

   e. Anemia Due to Myeloproliferative Neoplasms (MPN) – Myelofibrosis

      1. Endogenous serum erythropoietin level of less than 500 mUnits/mL.

   f. Anemia Due to Chemotherapy Treatment

      1. Recipient is receiving concomitant myelosuppressive chemotherapy; and

2. Recipient's chemotherapy is not intended to cure their disease (i.e., palliative treatment); and

3. There are a minimum of two additional months of planned chemotherapy.

g. Anemia Due to Chronic Kidney Disease (Non-Dialysis Recipients)

1. Recipient at least one month of age.

2. Dosage Limits

a. Quantity Limits (max daily dose) [NDC Unit]

1. Aranesp 10 mcg prefilled syringe: one syringe up to every seven days

2. Aranesp 25 mcg vial or prefilled syringe: one vial or syringe up to every seven days

3. Aranesp 40 mcg vial or prefilled syringe: one vial or syringe up to every seven days

4. Aranesp 60 mcg vial or prefilled syringe: one vial or syringe up to every seven days

5. Aranesp 100 mcg vial or prefilled syringe: one vial or syringe up to every seven days

6. Aranesp 150 mcg prefilled syringe: one syringe up to every seven days

7. Aranesp 200 mcg vial or prefilled syringe: one vial or syringe up to every seven days

8. Aranesp 300 mcg vial or prefilled syringe: one vial or syringe up to every 14 days (MPN may be as frequent as every seven days)

9. Aranesp 500 mcg prefilled syringe: one syringe up to every 14 days

b. Max Units (per dose and over time) [HCPCS Unit]:

1. MDS (J0881 only): 500 billable units every 14 days

2. MPN (J0881 only): 300 billable units every seven days

3. CKD (Non-Dialysis Recipients):

a. Initial: 100 billable units every 14 days

b. Maintenance: 600 billable units every 28 days

4. Chemotherapy-induced: 600 billable units every 21 days

3. Recertification Requests:

a. Recipient continues to meet universal and other indication-specific relevant criteria identified in section III; and

b. Previous dose was administered within the past 60 days; and

c. Disease response with treatment as defined by improvement in anemia compared to pretreatment baseline; and

d. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: pure red cell aplasia, severe allergic reactions (anaphylaxis, angioedema, bronchospasm, etc.), severe cardiovascular events (stroke, myocardial infarction, congestive heart failure, thromboembolism, etc.), uncontrolled hypertension, seizures, increased risk of tumor progression/recurrence in recipients with cancer, severe cutaneous reactions (erythema multiforme, Stevens-Johnson Syndrome [SJS]/Toxic Epidermal Necrolysis [TEN], etc.), etc; and

e. Anemia Due to Myelodysplastic Syndrome (MDS):

1. Hemoglobin (Hb) less than 12 g/dL and/or Hematocrit (Hct) less than 36%

f. Anemia Due to Myeloproliferative Neoplasms (MPN) – Myelofibrosis:

1. Hemoglobin (Hb) less than 10 g/dL and/or Hematocrit (Hct) less than 30%

g. Anemia Due to Chemotherapy Treatment:

1. Refer to Section III for criteria

h. Anemia Due to Chronic Kidney Disease (Non-Dialysis Recipients):

1. Pediatric recipients: Hemoglobin (Hb) less than 12 g/dL and/or Hematocrit (Hct) less than 36%

2. Adult recipients: Hemoglobin (Hb) less than 11 g/dL and/or Hematocrit (Hct) less than 33%.

4. PA Guidelines:

a. Initial approval will be given for 45 days.

b. Recertification will be given for 45 days.

M. Colony Stimulating Factors

Therapeutic Drug Class: Colony Stimulating Factors
Last Reviewed by DUR Board: January 19, 2023

Colony Stimulating Factors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Pegfilgrastim

a. Approval will be given if the following criteria are met and documented:

1. Prophylactic use in recipients with solid tumors or non-myeloid malignancy

a. Recipient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20%; or

b. Recipient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of 10% to 20% and one or more of the following co-morbidities:

1. Age is greater than or equal to 65 years receiving full dose intensity chemotherapy

2. Extensive prior exposure to chemotherapy

3. Previous exposure of pelvis, or other areas of large amounts of bone marrow, to radiation

4. Persistent neutropenia (ANC less than or equal to 1000/mm(3))

5. Bone marrow involvement by tumor

6. Recipient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)

7. Recent surgery and/or open wounds

8. Poor performance status

9. Renal dysfunction (creatinine clearance less than 50 mL/min)

10. Liver dysfunction (elevated bilirubin greater than 2.0 mg/dL)

11. Chronic immunosuppression in the post-transplant setting, including organ transplant

2. Recipient who experience a neutropenic complication from a prior cycle of the same chemotherapy

3. Recipients acutely exposed to myelosuppressive doses from radiation (Hematopoietic Acute Radiation Syndrome [H-ARS])

4. Bone marrow transplantation (BMT) failure or engraftment delay

5. Peripheral blood progenitor cell (PBPC) mobilization and transplant

6. Wilms Tumor (Nephroblastoma)

a. Recipient has favorable histology disease; and

b. Used in combination with a cyclophosphamide-based chemotherapy regimen (i.e., Regimen M or I only)

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Neulasta® six mg prefilled syringe: one syringe per 14 days

b. Neulasta® Onpro® kit: one kit per 14 days

c. Fulphila® six mg prefilled syringe: one syringe per 14 days

d. Udenyca® six mg prefilled syringe: one syringe per 14 days

e. Ziextenzo® six mg prefilled syringe: one syringe per 14 days

f. Nyvepria™ six mg prefilled syringe: one syringe per 14 days

g. Fylnetra® six mg prefilled syringe: one syringe per 14 days

h. Stimufend® six mg prefilled syringe: one syringe per 14 days

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Acute Radiation Exposure

1. 12 billable units weekly x two doses

2. 12 billable units x two doses

b. All other indications:

1. 12 billable units per 14 days

c. Recertification Requests:

1. Coverage for all other indications can be renewed based upon the following criteria:

a. Recipient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

b. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: splenic rupture, acute respiratory distress syndrome (ARDS), serious allergic reactions/anaphylaxis, sickle cell crisis, glomerulonephritis, leukocytosis, thrombocytopenia, capillary leak syndrome, potential for tumor growth stimulation of malignant cells, aortitis, myelodysplastic syndrome and acute myeloid leukemia, etc.

d. PA Guidelines:

1. Bone marrow transplantation (BMT) failure or engraftment delay: Coverage will be provided for one dose only and may not be renewed.

2. Peripheral blood progenitor cell (PBPC) mobilization and transplant: Coverage will be provided for one dose only and may not be renewed.

3. Initial approval will be given for four months.

4. Recertification will be given for four months.

N. Pemetrexed

Therapeutic Drug Class: Antimetabolites
Last Reviewed by DUR Board: N/A

Antimetabolites are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   a. Recipient is at least 18 years of age; and

   b. Primary Central Nervous System (CNS) Lymphoma

      1. Used as single agent: and

         a. Used as induction therapy in recipients unsuitable for or intolerant to high-dose methotrexate (MTX); or

         b. Used for relapsed or refractory disease.

   c. Malignant Peritoneal Mesothelioma (MPeM)

      1. Used as first-line therapy; and

         a. Used in combination with bevacizumab and cisplatin followed by single-agent maintenance bevacizumab (preferred) as first-line systemic therapy for unresectable disease; or

         b. Used as a single agent or in combination with cisplatin or carboplatin (if cisplatin ineligible) for diffuse or recurrent disease; or

      2. Used as subsequent therapy; and

         a. Used in combination with cisplatin or carboplatin (if cisplatin ineligible), with or without bevacizumab, if immunotherapy was administered as first-line treatment; or

         b. Used as a single agent; and

            1. Pemetrexed was not administered first-line; or

            2. Used as rechallenge if pemetrexed was administered first-line with a good sustained response at the time initial chemotherapy was interrupted.

d. Malignant Pleural Mesothelioma (MPM)

1. Used as induction therapy; and

a. Used in combination with cisplatin or carboplatin (if cisplatin ineligible) in recipients with epithelioid histology; or

2. Used as first-line therapy; and

a. Used in combination with bevacizumab and cisplatin followed by single-agent maintenance bevacizumab (preferred) as first-line systemic therapy; or

b. Used as a single agent; or in combination with cisplatin or carboplatin (if cisplatin ineligible) for resected or recurrent disease; or

c. Used in combination with cisplatin or carboplatin (if cisplatin ineligible), with or without bevacizumab, if immunotherapy was administered as first-line treatment; or

1. Pemetrexed was not administered first-line; or

2. Used as rechallenge if pemetrexed was administered first-line with a good sustained response at the time initial chemotherapy was interrupted.

e. Non-Squamous Non-Small Cell Lung Cancer (NS-NSCLC)

1. Used in combination with carboplatin or cisplatin-containing regimen; or

2. Used as single-agent therapy; and

a. Recipient has recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy; and

1. Used as first-line therapy for PD-L1 greater than one percent tumors that have negative actionable molecular biomarkers; or

2. Used as first-line therapy for PD-L1 less than or equal to one percent and tumors that have negative actionable molecular markers or BRAF V600E-mutation, NTRK1/2/3 gene fusion, MET exon-14 skipping mutation, EGFR exon 20 mutation, KRAS G12C mutation, or RET rearrangement positive tumors; or

3. Used as subsequent therapy for first progression after initial systemic therapy; or

4. Used continuation or switch maintenance therapy in recipients who have achieved tumor response or stable disease following initial therapy.

f. Thymomas/Thymic Carcinoma

1. Used as a single agent; and

a. Used as first-line therapy or postoperative treatment in recipients who are unable to tolerate first-line combination regimens; or

b. Used as second-line therapy for unresectable or metastatic disease.

g. Ovarian Cancer (Epithelial Ovarian/Fallopian Tube/Primary Peritoneal Cancer)

1. Used as single-agent therapy; and

a. Recipient has recurrent or persistent disease; and

1. Recipient is not experiencing an immediate biochemical relapse (i.e., rising CA-125 without radiographic evidence of disease); or

b. Recipient has recurrent low-grade serous carcinoma.

2. Dosage Limits

a. Quantity Limit (max daily dose) [NDC Unit]:

1. Alimta® 100mg powder for injection in a single-use vial: four vials every 21 days

2. Alimta® 500 mg powder for injection in a single-use vial: four vials every 21 days

3. Pemfexy® 500 mg solution for injection in a multi-dose vial: four vials every 21 days

4. Pemetrexed disodium 750mg powder for injection: two vials every 21 days

5. Pemetrexed disodium 1000mg powder for injection: two vials every 21 days

6. Pemetrexed disodium 100mg/four mL solution for injection: four vials every 21 days

7. Pemetrexed disodium 500mg/20mL solution for injection: four vials every 21 days

8. Pemetrexed disodium 1000mg/40mL solution for injection: two vials every 21 days.

b. Max Units (per dose and over time) [HCPCS Unit]:

1. CNS Lymphoma and Ovarian Cancer: 230 billable units every 21 days

2. All other indications: 130 billable units every 21 days.

3. Recertification Request

a. Recipient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

b. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: myelosuppression (e.g., neutropenia, febrile neutropenia, thrombocytopenia, anemia), renal toxicity (CrCl less than 45 mL/min), bullous and exfoliative skin toxicity (e.g., Stevens-Johnson Syndrome/Toxic epidermal necrolysis), interstitial pneumonitis, radiation recall, etc.; and

c. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

d. MPeM and MPM

1. May not be renewed when used in combination with platinum therapy and bevacizumab.

e. Thymomas/Thymic Carcinoma

1. May not be renewed

4. Prior Authorization Guidelines

a. Initial approval will be given for six months

1. Thymomas/Thymic Carcinoma: Coverage will be provided for six 21-day cycles and may not be renewed

2. MPeM and MPM: Coverage will be provided for six 21-day cycles and may not be renewed when used in combination with platinum therapy and bevacizumab

b. Recertification will be approved for six months.

O. HER2 Inhibitors

Therapeutic Drug Class: HER2 Inhibitors
Last Reviewed by DUR Board: N/A

HER2 Inhibitors are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits

1. Perjeta® (pertuzumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Left ventricular ejection fraction (LVEF) is within normal limits prior to initiating therapy and will be assessed at regular intervals (e.g., every three months) during treatment; and

b. Recipient has human epidermal growth factor receptor 2 (HER2)-positive disease as determined by an FDA-approved or CLIA-compliant test; and

c. Therapy will not be used in combination with pertuzumab/trastuzumab and hyaluronidase-zzxf (Phesgo); and

3. Breast Cancer

a. Used as neoadjuvant or preoperative therapy; and

1. Recipient has locally advanced, node positive, or inflammatory disease; and

2. Used in combination with trastuzumab and chemotherapy; or

b. Used as adjuvant therapy; and

1. Recipient has locally advanced, node positive, or inflammatory disease; and

a. Used in combination with trastuzumab and chemotherapy; or

b. Used in combination with trastuzumab; or

c. Used for recurrent unresectable or metastatic disease or inflammatory breast cancer with no response to preoperative systemic therapy; and

1. Used as first-line therapy in combination with trastuzumab and either paclitaxel or docetaxel; or

2. Used as subsequent therapy in combination with trastuzumab with or without cytotoxic therapy; and

a. Recipient was previously treated with trastuzumab and chemotherapy; and

b. Recipient has not previously received pertuzumab.

4. Central Nervous System (CNS) Cancer

a. Used for the treatment of brain metastases in recipients with breast cancer; and

b. Used in combination with high-dose trastuzumab; and

1. Used as initial treatment in recipients with small asymptomatic brain metastases; or

2. Used for relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options; or

3. Recipient has recurrent limited brain metastases; or

4. Used for recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options.

5. Colorectal Cancer (CRC)

a. Used for RAS and BRAF wild-type (WT) disease in combination with trastuzumab; and

b. Recipient has not previously received HER2-targeted therapy; and

1. Used as primary treatment for unresectable (or medically inoperable), locally advanced, or metastatic disease if intensive therapy is not recommended; or

2. Used as subsequent therapy for progression of advanced or metastatic disease after at least one prior line of treatment in the advanced or metastatic disease setting.

6. Appendiceal Adenocarcinoma – Colon Cancer

a. Used for RAS and BRAF wild-type (WT) disease in combination with trastuzumab; and

b. Recipient has not previously received HER2-targeted therapy; and

1. Used as initial therapy for advanced or metastatic disease if intensive therapy is not recommended; or

2. Used as subsequent therapy for progression of advanced or metastatic disease after at least one prior line of treatment in the advanced or metastatic disease setting.

7. Head and Neck Cancer

a. Recipient has salivary gland tumors; and

b. Used in combination with trastuzumab; and

c. Recipient has recurrent disease with one of the following:

1. Distant metastases; or

2. Unresectable locoregional recurrence with prior radiation therapy (RT); or

3. Unresectable second primary with prior RT.

8. Hepatobiliary Cancers

a. Recipient has gallbladder cancer, extrahepatic cholangiocarcinoma, or intrahepatic cholangiocarcinoma; and

b. Used as subsequent treatment for progression on or after systemic treatment for unresectable or metastatic diseae; and

c. Used in combination with trastuzumab.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Perjeta® 420 mg/14 mL solution for injection:

1. Loading Dose: two vials

2. Maintenance Dose: one vial every 21 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Loading Dose: 840 billable units x one dose

b. Maintenance Dose: 420 billable units every 21 days.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: left ventricular dysfunction, severe infusion-related reactions, hypersensitivity reactions/anaphylaxis, etc; and

4. Left ventricular ejection fraction (LVEF) obtained within the previous three months as follows:

a. Neoadjuvant and adjuvant treatment of breast cancer: LVEF is greater than or equal to 50% OR LVEF has had an absolute decrease of less than 10% from baseline

b. All other indications: LVEF is greater than 45% OR LVEF is 40% to 45% and absolute decrease is less than 10% from baseline.

5. Breast Cancer (neoadjuvant or adjuvant therapy)

a. Recipient has not exceeded a maximum of one year or treatment (total of 18 cycles).

d. Prior Authorization Guidelines

1. Initial approval will be given for six months

2. Recertification will be given for six months.

2. Herceptin®; Ogivri®; Kanjinti™; Trazimera™; Herzuma®; Ontruzant® (trastuzumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Left ventricular ejection fraction (LVEF) is within normal limits prior to initiating therapy and will be assessed at regular intervals (e.g., every three months) during treatment; and

b. Recipient has human epidermal growth factor receptor two (HER2)-positive disease as determined by an FDA-approved or CLIA-compliant test; and

c. Therapy will not be substituted with or for ado-trastuzumab emtansine (Kadcyla®) or famtrastuzumab deruxtecan-nxki (Enhertu®); and

d. Therapy will not be used in combination with trastuzumab and hyaluronidase-oysk (Herceptin Hylecta™) or pertuzumab/trastuzumab and hyaluronidase-zzxf (Phesgo®); and

3. Breast Cancer

a. Used as adjuvant therapy; and

1. Recipient has locally advanced, node positive, or inflammatory disease; and

a. Used in combination with taxane-based regimen (e.g., docetaxel, paclitaxel, etc.) with or without pertuzumab; or

b. Used as a single agent; or

c. Used in combination with pertuzumab; or

b. Used as neoadjuvant or preoperative therapy; and

1. Recipient has locally advanced, node positive, or inflammatory disease; and

2. Used in combination with a taxane-based regimen (e.g., docetaxel, paclitaxel, etc.) with or without pertuzumab; or

c. Used for recurrent unresectable or metastatic disease or inflammatory breast cancer; and

1. Used as a single agent in recipients who have received one or more prior chemotherapy regimens for metastatic disease; or

2. Used in combination with one of the following:

a. Paclitaxel as first-line therapy for metastatic disease; or

b. Endocrine therapy (e.g., tamoxifen, fulvestrant, or aromatase inhibition with or without lapatinib) in recipients with hormone-receptor positive disease; and

1. Recipient is post-menopausal; or

2. Recipient is pre-menopausal and is treated with ovarian ablation/suppression; or

3. Recipient is a male (sex assigned at birth).

c. Pertuzumab and a taxane (e.g., docetaxel, paclitaxel) as first-line therapy

d. Capecitabine and tucatinib as second-line therapy and beyond

e. Cytotoxic chemotherapy as third-line therapy and beyond

f. Lapatinib (without cytotoxic therapy) as third-line therapy and beyond

g. Pertuzumab with or without cytotoxic therapy as subsequent therapy in recipients previously treated with chemotherapy and trastuzumab (without pertuzumab).

4. Central Nervous System (CNS) Cancer

a. Recipient has leptomeningeal metastases from breast cancer; and

1. Trastuzumab will be administered intrathecally; or

b. Recipient has brain metastases from breast cancer; and

1. Used in combination with one of the following:

a. Pertuzumab

b. Capecitabine and tucatinib in recipients previously treated with at least one HER2-directed regimen; and

2. Used in one of the following treatment settings:

a. Used as initial treatment in recipients with small asymptomatic brain metastases; or

b. Recipient has recurrent limited brain metastases; or

c. Recipient has recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options; or

d. Recipient has relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options.

5. Gastric, Esophageal, and Esophagogastric Junction Cancers

a. Recipient is not a surgical candidate or has unresectable locally advanced, recurrent, or metastatic adenocarcinoma; and

b. Used as first-line therapy in combination with chemotherapy with or without pembrolizumab (excluding use in combination with DCF [docetaxel, carboplatin, and fluorouracil]).

6. Endometrial Carcinoma – Uterine Neoplasms

a. Used in combination with carboplatin and paclitaxel; and

b. Recipient has stage III/IV or recurrent uterine serous carcinoma.

7. Colorectal Cancer (CRC)

a. Recipient has RAS and BRAF wild-type (WT) disease; and

b. Used in combination with pertuzumab or lapatinib; and

c. Recipient has not previously received HER2-directed therapy; and

1. Used as primary treatment for unresectable (or medically inoperable), locally advanced, or metastatic disease if intensive therapy is not recommended; or

2. Used as subsequent therapy for progression of advanced or metastatic disease after at least one prior line of treatment in the advanced or metastatic disease setting.

8. Appendiceal Adenocarcinoma – Colon Cancer

a. Recipient has RAS and BRAF wild-type (WT) disease; and

b. Used in combination with pertuzumab or lapatinib; and

c. Recipient has not previously received HER2-targeted therapy; and

1. Used as initially therapy for advanced or metastatic disease if intensive therapy is not recommended; or

2. Used as subsequent therapy for progression of advanced or metastatic disease after at least one prior line of treatment in the advanced or metastatic disease setting.

9. Head and Neck Cancer

a. Recipient has salivary gland tumors; and

b. Used as a single agent or in combination with either docetaxel or pertuzumab; and

c. Recipient has recurrent disease with one of the following:

1. Distant metastases

2. Unresectable locoregional recurrence with prior radiation therapy (RT)

3. Unresectable second primary with prior RT.

10. Hepatobiliary Cancers

a. Recipient has gallbladder cancer, extrahepatic cholangiocarcinoma, or intrahepatic cholangiocarcinoma; and

b. Used as subsequent treatment for progression on or after systemic treatment for unresectable or metastatic disease; and

c. Used in combination with pertuzumab.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. 150 mg single-dose vial: six vials day one, then five vials every 21 days thereafter

b. 420 mg multiple-dose vial: three vials day one, then two vials every 21 days thereafter.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisites therapy), performance status, etc. identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: cardiotoxicity (e.g., left ventricular dysfunction, cardiomyopathy, etc.), pulmonary toxicity (e.g., dyspnea, interstitial pneumonitis, etc.), severe or febrile neutropenia, severe infusion-related reactions, etc.; and

4. Left ventricular ejection fraction (LVEF) obtained within the previous three months as follows:

a. LVEF is within the institutional normal limits, and has not had an absolute of greater than or equal to 16% from pre-treatment baseline; or

b. LVEF is below the institutional lower limits of normal and has not had an absolute decrease of greater than or equal to ten percent from pre-treatment baseline.

5. Breast Cancer (neoadjuvant and adjuvant therapy)

a. Recipient has not exceeded a maximum of 52 weeks of treatment (total 18 cycles).

d. Prior Authorization Guidelines

1. Initial approval will be given for six months

2. Recertification will be given for six months

a. Neoadjuvant and adjuvant treatment in Breast Cancer may be authorized up to a maximum of 52 weeks of treatment [18 cycles]

3. Herceptin Hylecta™ (trastuzumab and hyaluronidase-oysk)

a. Approval will be given if the following criteria are met and documented

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Left ventricular ejection fraction (LVEF) is within normal limits prior to initiating therapy and will be assessed at regular intervals (e.g., every three months) during treatment; and

b. Recipient has human epidermal growth factor receptor two HER2)-positive disease as determined by an FDA-approved or CLIA-compliant test; and

c. Therapy will not be substituted with or for ado-trastuzumab emtansine (Kadcyl®) or famtrastuzumab deruxtecan-nvki (Enhertu); and

d. Therapy will not be used in combination with intravenous chemotherapy agent; and

e. Therapy will not be used in combination with trastuzumab (or any of its biosimilar products [e.g., Ogivri®, Kanjiti®, Trazimera®, Herzuma®, Ontruzant®]) or pertuzumab/trastuzumab and hyaluronidase-zzxf (Phesgo®); and

3. Breast Cancer

a. Used as adjuvant therapy; and

1. Used as a single agent following anthracycline-based therapy; or

b. Used for metastatic disease; and

1. Used a single agent in recipients who have received one or more prior chemotherapy regimens for metastatic disease.

b. Dosage Limits

1. Quantity Limits (max daily dose) [NDC Unit]:

a. Herceptin Hylecta (600 mg trastuzumab/10,000 units hyaluronidase) single-dose: one vial every 21 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. 60 billable units every 21 days.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

2. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

3. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: cardiotoxicity (e.g., left ventricular dysfunction, cardiomyopathy), pulmonary toxicity (e.g., dyspnea, interstitial pneumonitis), neutropenia, severe administration-related reactions (e.g., hypersensitivity, anaphylaxis), etc.; and

4. Left ventricular ejection fraction (LVEF) within the previous three months as follows:

   a. LVEF is within the institutional normal limits, and has not had an absolute decrease of greater than 16% from pre-treatment baseline; or

   b. LVEF is below the institutional lower limits of normal, and has not had an absolute decrease of greater than or equal to 10% from pre-treatment baseline; and

5. Breast Cancer (adjuvant treatment)

   a. Recipient has not exceeded a maximum of 52 weeks of therapy.

d. Prior Authorization Guidelines

1. Initial approval will be given six months.

2. Recertification will be given six months.

   a. Adjuvant therapy may be authorized for a total of fifty-two weeks.

P. CD20 Monoclonal Antibodies

Therapeutic Class: Antirheumatic, CD20 Monoclonal Antibodies
Last Reviewed by the DUR Board: N/A

CD20 Monoclonal Antibodies are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Rituxan®, Truxima®, Ruxience™, Riabni™ (rituximab)

a. Approval will be given if the following criteria are met and documented

1. Recipient is at least 18 years of age (unless otherwise specified); and

2. Universal Criteria

a. Recipient does not have a severe, active infection; and

b. Recipient has been screened for the presence of hepatitis B (HBV) infection (i.e., HBsAg and anti-HBc) prior to initiating therapy and recipients with evidence of current or prior HBV infection will be monitored for HBV reactivation during treatment; and

c. Recipient has not received a live vaccine within 28 days prior to starting treatment and live vaccines will not be administered concurrently while on treatment; and

3. Oncology Indications

a. Recipient CD20 antigen expression is positive (excluding use for cGVHD, Hematopoietic Cell Transplantation, and Management of Immunotherapy-Related Toxicity); and

4. Pediatric Mature B-Cell Acute Leukemia

a. Recipient is at least six months of age; and

b. Used in combination with chemotherapy for previously untreated disease

5. Adult Acute Lymphoblastic Leukemia (ALL)

a. Recipient has Philadelphia chromosome-negative (Ph-) disease; and

1. Used for induction/consolidation treatment; and

a. Used in combination with a regimen containing an anthracycline and vincristine; or

2. Used for relapsed/refractory treatment; and

a. Used in combination with MOpAD regimen (methotrexate, vincristine, pegaspargase, dexamethasone).

6. Central Nervous System (CNS) Cancer

a. Recipient has leptomeningeal metastases from lymphomas; and

1. Rituximab will be administered intrathecally; or

b. Recipient has primary CNS lymphoma; and

1. Used as a component of induction therapy in combination with a methotrexate-containing regimen, temozolomide, lenalidomide, or as a single agent; or

2. Used as a component of consolidation therapy in combination with a methotrexate-containing regimen; or

3. Used for relapsed or refractory disease as a single agent, or in combination with either temozolomide, lenalidomide, or high-dose methotrexate.

7. Adult Hodgkin Lymphoma

a. Recipient has nodular lymphocute-predominant disease.

8. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)

a. Used in combination with fludarabine and cyclophosphamide (FC); or

b. Recipient has disease without del (17p)/TP53 mutation; and

1. Used as first-line therapy in combination with bendamustine (excluding use in frail recipients); or

2. Used as subsequent therapy in combination with one of the following:

a. Bendamustine (recipients less than 65 years of age without significant comorbidities; excluding use in frail recipients)

b. Idelalisib

c. Lenalidomide

d. Venetoclax; or

c. Recipient has disease with del(17p)/TP53 mutation; and

1. Used as first-line therapy in combination with one of the following:

a. Alemtuzumab

b. High-dose methylprednisolone; or

2. Used as subsequent therapy in combination with one of the following:

a. Alemtuzumab

b. High-dose methylprednisolone

c. Idelalisib

d. Lenalidomide

e. Venetoclax; or

3. Used as first-line therapy for histologic (Richter's) transformation to diffuse large B-cell lymphoma; and

a. Used in combination with cyclophosphamide, doxorubicin, and vincristine-based regimens or as a component of OFAR (oxaliplatin, fludarabine, cytarabine, and rituximab).

9. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma

10. Adult B-Cell Lymphomas

a. AIDS-Related B-Cell Lymphoma

1. Disease is related to Burkitt lymphoma, diffuse large B-cell lymphoma (DLBCL), HHV8-positive DLBCL (not otherwise specified), or primary effusion lymphoma (PEL)

b. Burkitt Lymphoma

1. Used in combination with chemotherapy

c. Castleman Disease

1. Recipient has multicentric disease; or

2. Recipient has unicentric disease; and

a. Used as second-line therapy for relapsed or refractory disease; or

b. Used for unresectable disease or symptomatic disease after incomplete resection

d. Diffuse Large B-Cell Lymphoma

e. Low-Grade (grade 1-2) or Follicular Lymphoma

f. Gastric & Non-Gastric (Noncutaneous) MALT Lymphoma

g. High Grade B-Cell Lymphomas

h. Mantle Cell Lymphoma

i. Nodal & Splenic Marginal Zone Lymphoma

j. Histologic Transformation of Indolent Lymphomas to Diffuse Large B-Cell Lymphoma

k. Post-Transplant Lymphoproliferative Disorder (PTLD) (B-Cell Type).

11. Primary Cutaneous B-Cell Lymphomas

12. Pediatric Aggressive Mature B-Cell Lymphomas (Primary Mediastinal Large B-Cell Lymphoma, Diffuse Large B-Cell Lymphoma, Burkitt Lymphoma, and Burkitt-like Lymphoma)

a. Recipient is at least six months of age; and

b. Used in combination with chemotherapy.

13. Hairy Cell Leukemia

a. Used as a single agent; and

1. Used for less than complete responses or relapsed disease in recipients unable to receive purine analogs (i.e., cladriine or pentostatin); or

b. Used in combination with cladribine; or

c. Used in combination with pentostatin; and

1. Used for less than complete response or relapsed disease; or

d. Used in combination with vemurafenib; and

1. Used for less than complete response or relapsed disease; or

2. Used for progression after relapsed or refractory therapy.

14. Histiocytic Neoplasms – Rosai-Dorfman Disease

a. Used as a single agent for nodal, immune-cytopenia, or immunoglobulin G4 (IgG4) diseases; and

1. Used for symptomatic unresectable unifocal disease; or

2. Used for symptomatic multifocal disease; or

3. Used for relapsed/refractory disease.

15. Pediatric Hodgkin Lymphoma

a. Recipient is less than or equal to 18 years of age; and

b. Recipient has nodular lymphocyte-predominant; and

c. Used in combination with CVbP (cyclophosphamide, vinblastine, prednislone); and

d. Used as primary treatment for stage IA or IIA disease (incomplete resection and non-bulky disease).

16. Chronic Graft-Versus-Host Disease (cGVHD)

a. Recipient is post-allogeneic stem cell transplant (generally three or more months); and

b. Used as additional therapy in combination with corticosteroids; and

c. Recipient has no response (e.g., steroid-refractory disease) to first-line therapy options; and

d. Recipient must try and have an inadequate response, contraindication, or intolerance to at least a three-month trial of ibrutinib.

17. Hematopoietic Cell Transplantation

a. Used as conditioning for allogeneic transplant as part of a non-myeloablative regimen in combination with cyclophosphamide and fludarabine.

18. Management of Immunotherapy-Related Toxicities

a. Recipient has been receiving therapy with an immune checkpoint inhibitor (e.g., cemiplimab, nivolumab, pembrolizumab, atezolizumab, avelumab, durvalumab, ipilumamb, dostarlimab, nivolumab/relatlimab-rmbw, etc.); and

1. Recipient has non-viral encephalitis related to immunotherapy; and

a. Recipient is autoimmune-encephalopathy-antibody positive; or

b. Recipient has had limited to no improvement after seven to 14 days on pulse-dose methylprednisolone with or without intravenous immunoglobulin (IVIG); or

2. Recipient has bullous dermatitis related to immunotherapy; and

a. Used as additional therapy for moderate (G2), severe (G3) or life-threatening (G4) disease; or

3. Recipient has moderate or severe steroid-refractory myalgias or myositis, or life-threatening steroid-refractory myositis related to immunotherapy; or

4. Recipient has myasthenia gravis related to immunotherapy; and

a. Used as additional therapy for severe (G3-4) disease that is refractory to plasmapheresis or IVIG.

19. Non-Oncology Indications

a. Recipient is not on concurrent treatment with another TNF-inhibitor, biologic response modifier or other non-biologic agent (i.e., apremilast, tofacitinib, baricitinib, upadacitinib, etc.); and

20. Rheumatoid Arthritis (RA)

a. Documented moderate to severe active disease; and

b. Used in combination with methotrexate unless the recipient has contraindication or intolerance; and

c. Recipient tried and failed at least three-month trial with one oral disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, azathioprine, auranofin, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.); and

d. Previous failure with one or more preferred TNF antagonists at least one of which should be a self-injectable; and

e. Physician has assessed baseline disease severity utilizing an objective measure/tool; and

f. Recipient has not had treatment with rituximab in the previous four months.

21. Pemphigus Vulgaris

a. Recipient has a diagnosis of pemphigus vulgaris as determined by one or more of the following clinical features:

1. Appearance of lesions, erosions and/or blisters

2. Nikolsky sign (induction of blistering via mechanical pressure at the edge of a blister or on normal skin)

3. Characteristic scarring and lesion distribution; and

b. Histopathologic confirmation by skin/mucous membrane biopsy; and

c. Positive direct immunofluorescence (DIF) microscopy result OR presence of autoantibodies as detected by indirect immunofluorescence (IIF) or enzyme-linked immunosorbent assay (ELISA); and

d. Recipient has moderate to severe disease as assessed utilizing an objective measure tool (i.e., PDAI, PSS, ABSIS, etc.); and

e. Used in combination with glucocorticoids (e.g., prednisone, prednisolone, etc.); and

f. Other causes of blistering or erosive skin and mucous membrane diseases have been ruled out.

22. Granulomatosis with Polyangiitis (GPA) (Wegener's Granulmatosis) and Microscopic Polyangiitis (MPA)

a. Recipient is at least two years of age; and

b. Used in combination with glucocorticoids (e.g., prednisone, methylprednisolone, etc.).

23. Thrombocytopenic Purpura

a. Recipient has previously failed or has a contraindication or intolerance to therapy with corticosteroids; and

b. Recipient is at increased risk for bleeding as indicated by platelet count (within the previous 28 days) less than 30 x 109/L (30,000mm (3)); and

c. Diagnosis includes one of the following:

1. Primary thrombocytopenia or Idiopathic (Immune) thrombocytopenia purpura (ITP).

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24. Thrombotic Thrombocytopenic Purpura (TTP)

a. Recipient is at increased risk for bleeding as indicated by platelet count (within the previous 28 days) less than 30x109/L (30,000/mm(3)); and

b. Recipient has immune-mediated or acquired disease with ADAMTS13-deficiency; and

1. Used in combination with corticosteroids and therapeutic plasma exchange (TPE); or

2. Used as a single agent as prophylactic therapy for recipients in remission.

25. Autoimmune Hemolytic Anemia (AIHA)

    a. Recipient has warm-reactive disease refractory to or dependent on glucocorticoids; or

    b. Recipient has cold agglutinin disease with symptomatic anemia, transfusion-dependence and/or disabling circulatory symptoms.

26. Lupus Nephritis

    a. Recipient has disease that is non-responsive or refractory to standard first-line therapy (e.g., mycophenolate mofetil, mycophenolic acid, cyclophosphamide, calcineurin inhibitors [e.g., tacrolimus]); and

    b. Used as a single agent or add-on therapy in combination with mycophenolate mofetil, mycophenolic acid, cyclophosphamide.

27. Myasthenia Gravis (unrelated to immunotherapy-related toxicity)

    a. Recipient has muscle-specific tyrosine kinase (MuSK)-antibody positive disease; and

    b. Recipient is refractory to standard first-line therapy (e.g., glucocorticoids, azathioprine, mycophenolate mofetil, etc.)

28. Complications of Transplanted Solid Organ (kidney, liver, lung, heart, pancreas) in Adult and Pediatric Recipients

    a. Used for suppression of panel reactive anti-human leukocyte antigen (HLA) antibodies prior to transplantation; or

    b. Used for treatment of antibody-mediated rejection of solid organ transplantation.

29. Neuromyelitis Optica Spectrum Disorder (NMOSD)

    a. Recipient has confirmed diagnosis based on the following:

        1. Recipient is seropositive for aquaporin-4 (AQP-4) IgG antibodies; and

            a. Recipient has at least one core clinical characteristic; and

            b. Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection, etc.); or

2. Recipient is seronegative for AQP-4 IgG antibodies or has unknown AQP-4-IgG status; and

a. Recipient has at least two core clinical characteristics occurring as a result of one or more clinical attacks; and

b. Recipient experienced all of the following:

1. At least one core clinical characteristic must be optic neuritis, acute myelitis with LETM, or area postrema syndrome

2. Dissemination in space (greater than or equal to two different core clinical characteristics)

3. Fulfillment of additional MRI requirements, as applicable

c. Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection, etc.); and

b. Used as a single agent or in combination with immunosuppressive therapy (e.g., azathioprine, methotrexate, mycophenolate, etc.).

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Rituxan® 100mg/10mL injection: 12 vials per 28-day supply

b. Rituxan® 500mg/50mL injection: eight vials per 28-day supply

c. Truxima® 100mg/10mL injection: 12 vials per 28-day supply

d. Truxima® 500mg/50mL injection: eight vials per 28-day supply

e. Ruxience® 100mg/10mL injection: 12 vials per 28-day supply

f. Ruxience® 500mg/50mL injection: either vials per 28-day supply

g. Riabni™ 100mg/10mL injection: 12 vials per 28-day supply

h. Riabni™ 500mg/50mL injection: eight vials per 28-day supply.

2. Max units (per dose and over time) [HCPCS Unit]:

a. Oncology Indications

1. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Leukemia (SLL):

a. Initial therapy:

1. Loading dose: 100 billable units x one dose

2. Subsequent doses: 130 billable units every 28 days x five doses per six months

b. Renewal therapy: 130 billable units every eight weeks.

2. All

a. 100 billable units twice weekly x 18 doses.

3. Hairy Cell Leukemia

b. 100 billable units weekly x eight doses.

4. Histiocytic Neoplasms – Rosai-Dorfman Disease

a. 130 billable units weekly x six doses in a six-month period.

5. Pediatric Hodgkin Lymphoma

a. 100 billable units x three doses.

6. cGVHD

a. 100 billable units weekly x eight doses.

7. Hematopoietic Cell Transplantation

a. Initial dose: 100 billable units x one dose before transplant

b. Subsequent doses: 250 billable units x three doses after transplant.

8. All other oncology indications:

a. Initial therapy: 100 billable units weekly x eight doses per six months

b. Renewal therapy: 100 billable units x four doses per six months.

b. Non-Oncology Indications

1. Rhematoid Arthritis (RA):

a. 100 billable units every 14 days x two doses in a 16-week period.

2. Pemphigus Vulgaris:

a. Initiation: 100 billable units weekly x four doses in a 12-month period

b. Maintenance: 50 billable units every 16 weeks.

3. GPA(WG)/MPA:

a. Induction: 100 billable units weekly x four doses in a four-month period

b. Initial Maintenance: 50 billable units x two doses in a six-month period

c. Subsequent Maintenance: 50 billable units every six months.

4. All other non-oncology indications:

a. 100 billable units weekly x four doses in a six-month period.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe infusion-related reactions, tumor lysis syndrome (TLS), severe mucocutaneous reactions, progressive multifocal

leukoencephalopathy (PML), hepatitis B virus reactivation, serious infections (bacterial, fungal, or viral), cardiovascular adverse reactions (e.g., ventricular fibrillation, myocardial infarction, cardiogenic shock, cardiac arrhythmias), renal toxicity, bowel obstruction or perforation, etc.; and

3. Oncology Indications

   a. Recipient has not exceeded dosing or duration limits as defined in Section I, II, and V; and

4. Adult Acute Lymphoblastic Leukemia (ALL)

   a. Treatment response or stabilization of disease as indicated by CBC, bone marrow cytogenic analysis, QPCR, or FISH

5. Hairy Cell Leukemia

   a. Coverage may not be renewed

6. Pediatric B-Cell Acute Leukemia and Aggressive Mature B-Cell Lymphomas (induction or consolidation therapy)

   a. Coverage may not be renewed

7. Pediatric Hodgkin Lymphoma

   a. Coverage may not be renewed

8. Chronic Graft-Versus-Host Disease (cGVHD)

   a. Coverage may not be renewed

9. Hematopoietic Cell Transplantation

   a. Coverage may not be renewed

10. Management of Immunotherapy-Related Toxicities

    a. Coverage for use in the treatment of myalgias/myositis/myasthenia gravis/encephalitis may not be renewed

    b. Coverage for use in bullous dermatitis: Recipient has not exceeded a maximum of 18 months of therapy (four total doses)

11. All Other Oncology Indications

    a. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor space

12. Non-Oncology Indications

    a. Rheumatoid Arthritis (RA)

        1. Disease response as indicated by improvement in signs and symptoms compared to baseline such as the number of tender and swollen joint counts, reduction of C-reactive protein, improvement of recipient global assessment, and/or an improvement on a disease activity scoring tool [e.g. an improvement on a composite scoring index such as Disease Activity Score-28 (DAS28) of 1.2 points or more of a greater than or equal to 20% improvement on the American College of Rheumatology-20 (ARC20) criteria]; and

        2. Dose escalation (up to the maximum dose and frequency specified below) may occur upon clinical review on a case-by-case basis provided that the recipient has:

            a. Shown an initial response to therapy; and

            b. Received a minimum of one maintenance dose at the dose and interval specified below; and

            c. Responded to therapy with subsequent loss of response

    b. Thrombocytopenic Purpura (ITP or Evan's Syndrome)

        1. Disease response as indicated by the achievement and maintenance of a platelet count of at least 50 x 10(9)/L as necessary to reduce the risk for bleeding

    c. Thrombotic Thrombocytopenic Purpura (TTP)

        1. Disease response as indicated by an increase in ADAMTS13 activity with a reduction in thrombotic risk

    d. Granulomatosis with Polyangiitis (GPA) (Wegener's granulomatosis) and Microscopic polyangiitis (MPA)

1. Disease response as indicated by disease control and improvement in signs and symptoms of condition compared to baseline; and

2. Decreased frequency in the occurrence of major relapse (defined by the reappearance of clinical and/or laboratory signs of vasculitis activity that could lead to organ failure or damage, or could be life threatening)

e. Pemphigus Vulgaris

1. Recipient is currently receiving tapering doses of corticosteroids or has discontinued use of corticosteroids; and

a. Disease response as indicated by complete epithelialization of lesions and improvement in signs and symptoms of condition compared to baseline; or

b. Recipient has not experienced continued development of new lesions and improvement in signs and symptoms of condition compared to baseline; or

1. For Relapses only: Recipient previously had active disease control; and

2. Recipient has the appearance of three or more new lesions a month that do not heal spontaneously within one week, or by the extension of established lesions

f. Autoimmune Hemolytic Anemia (AIHA)

1. Disease response as indicated by improvement in anemia signs and symptoms (e.g., dyspnea, fatigue, etc.) as well as: improvement in laboratory values (Hb/Hct), reduced transfusion needs, and/or reduced glucocorticoid use

g. Lupus Nephritis

1. Coverage may only be renewed in recipients experiencing a disease relapse (e.g., increased serum creatinine, increase in protein urine excretion, decrease in eGFR, etc.)

h. Myasthenia Gravis (unrelated to immunotherapy-related toxicity)

1. Disease response as indicated by a decrease in the daily dose of corticosteroids and/or an improvement in signs and symptoms compared to baseline

i. Complications of transplanted solid organ

1. Coverage may not be renewed

j. NMOSID

1. Disease response as indicated by stabilization/improvement in any of the following: neurologic symptoms as evidenced by a decrease in acute relapses, stability reduced hospitalizations, reduction/discontinuation in plasma exchange treatments, and/or reduction/discontinuation of corticosteroids without relapse.

d. Prior Authorization Guidelines

1. Initial approval will be given for six months (12 months initially for pemphigus vulgaris)

2. Recertification will be given for six months

a. Maintenance therapy for oncology indications (excluding ALL, Hairy Cell Leukemia, Mantle Cell Lymphoma, induction/consolidation of Pediatric B-Cell Acute Leukemia/Aggressive Mature B-Cell Lymphomas, and Pediatric Hodgkin Lymphoma) may be renewed for up to a maximum of two years

1. ALL and Mantle Cell Lymphoma may be renewed until disease progression or intolerable toxicity (ALL may be renewed for up to a total of 18 doses)

2. Hairy Cell Leukemia may not be renewed

3. Induction/Consolidation of Pediatric B-Cell Acute Leukemia and Aggressive Mature B-Cell Lymphomas may not be renewed

4. Pediatric Hodgkin Lymphoma may not be renewed.

b. Management of Immunotherapy-Related Toxicities:

1. Myalgias/Myositis/Myasthenia Gravis/Encephalitis may not be renewed

2. Bullous dermatitis may be renewed for a maximum of 18 months (four total doses)

c. Relapse therapy for Pemphigus Vulgaris must be at least 16 weeks past a prior infusion

d. Chronic Graft-Versus-Host Disease (cGVHD) may not be renewed

e. Hematopoietic Cell Transplantation may not be renewed

f. Lupus Nephritis may be renewed only in recipients experiencing a disease relapse

g. Complications of transplanted solid organ may not be renewed.

2. Rituxan Hycela® (rituximab and hyaluronidase human)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age; and

2. Universal Criteria

a. Recipient does not have a severe, active infection; and

b. Recipient has been screened for the presence of hepatitis B virus (HBV) infection (i.e., HBsAg and anti-HBc) prior to initiating therapy and recipients with evidence of current or prior HBV infection will be monitored for HBV reactivation during treatment; and

c. Recipient is CD20 antigen expression positive; and

d. Recipient has received at least one full dose of a rituximab product by intravenous infusion prior to initiating therapy; and

e. Rituxan Hycela will not be used with intravenous chemotherapy agents; and

f. Recipient has not received a live vaccine within 28 days prior to starting treatment and live vaccines will not be administered concurrently while on treatment; and

3. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)

4. B-Cell Lymphomas

a. Follicular Lymphoma (FL)

b. Diffuse Large B-Cell Lymphomas

c. High Grade B-Cell Lymphomas

d. Castleman Disease

e. Gastric & Non-gastric MALT Lymphoma
f. Mantle Cell Lymphoma

g. Nodal and Splenic Marginal Zone Lymphoma

h. Histologic transformation of Nodal Marginal Zone Lymphoma to Diffuse Large B-Cell Lymphoma

i. Post-transplant lymphoproliferative disorder (PTLD)

5. Hairy Cell Leukemia

6. Primary Cutaneous B-Cell Lymphoma

7. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Rituxan Hycela® 1,400mg/23,400 Units per 11.7 mL single-dose vial: four vials per 28-day supply

b. Rituxan Hycela® 1,600mg/26,800 Units per 13.4 mL single-dose vial: one vial per 28-day supply.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Follicular Lymphoma (FL):

1. Relapsed-Refractory

a. 1,400 mg/23,400 U (140 billable units) weekly up to seven doses

2. Previously Untreated

a. 1,400 mg/23,400 U (140 billable units) every 21 days x seven doses

b. 1,400 mg/23,400 U (140 billable units) every 21 days x seven doses

3. Non-progressing after first line CVP chemotherapy

a. 1,400 mg/23,400 U (140 billable units) weekly x three doses at six months intervals (up to a maximum of 15 doses).

b. Diffuse Large B-Cell Lymphoma (DLBCL);

1. 1,400 mg/23,400 U (140 billable units) every 14 or 21 days x seven doses

c. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma (CLL/SLL)

1. 1,600 mg/26,800 U (160 billable units) every 28 days x five doses

d. Hairy Cell Leukemia

1. 1,400 mg/23,400 U (140 billable units) weekly up to seven doses

e. Other indications:

1. 1,400 mg/23,400 U (140 billable units) weekly for x seven doses in a six-month period; or

2. 1,400 mg/23,400 U (140 billable units) every eight weeks (maintenance treatment).

c. Recertification Request

1. Recipient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe hypersensitivity or other administration reactions (i.e., local cutaneous reactions), tumor lysis syndrome (TLS), severe

mucocutaneous reactions, progressive multifocal leukoencephalopathy (PML), hepatitis B virus reactivation, serious bacterial, fungal, or viral infections, cardiac adverse reactions, renal toxicity, bowel obstructions or perforation, etc.; and

3. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

4. Recipient has not exceeded dosing or duration limits as defined in Sections I, II, and V.

d. Prior Authorization Guidelines

1. Initial approval will be given for six months
2. Recertification will be given for six months

3. Maintenance therapy for mantle cell lymphoma may be renewed until disease progression or intolerable toxicity

4. Hairy Cell Leukemia may not be renewed

5. Maintenance therapy for all other indications may be renewed for up to a maximum of two years.

Q. Selective Immunosuppressants

Therapeutic Class: Selective Immunosuppressants
Last Reviewed by the DUR Board: N/A

Selective Immunosuppressants are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Soliris® (eculizumab)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age (unless otherwise specified); and

2. Prescriber is enrolled in the Soliris Risk Evaluation and Mitigation Strategy (REMS) program; and

3. Universal Criteria

a. Recipient must be vaccinated with meningococcal disease at least two weeks prior to initiation of therapy and will continue to revaccinated according to current medical guidelines for vaccine use (if urgent Soliris therapy is indicated in an unvaccinated recipient, administer meningococcal vaccine(s) as soon as possible and provide recipients with two weeks of antibacterial drug prophylaxis); and

b. Recipient does not have an unresolved, serious systemic infection (e.g., Neisseria meningitidis, etc.); and

c. Will not be used in combination with other immunomodulatory biologic therapies (i.e., efgartigimod, ravulizumab, pegcetacoplan, satralizumab, inebilizumab, etc.).

4. Paroxysmal Nocturnal Hemoglobinuria (PNH)

a. Diagnosis must be accompanied by detection of PNH clones of at least 10% by flow cytometry diagnostic testing; and

1. Demonstrate the presence of at least two different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g., CD55, CD59, etc.) within at least two different cell lines (e.g., granulocytes, monocytes, erythrocytes); and

b. Recipient has laboratory evidence of significant intravascular hemolysis (i.e., LDH greater than or equal to one and a half x ULN) with symptomatic disease and at least one other indication for therapy from the following (regardless of transfusion dependence):

1. Recipient has symptomatic anemia (i.e., hemoglobin less than seven g/dL or hemoglobin less than 10 g/dL, in at least two independent measurements in a recipient with cardiac symptoms

2. Presence of a thrombotic event related to PNH

3. Presence of organ damage secondary to chronic hemolysis (i.e., renal insufficiency pulmonary insufficiency/hypertension)

4. Recipient is pregnant and potential benefit outweighs potential fetal risk

5. Recipient has disabling fatigue

6. Recipient has abdominal pain (requiring admission or opioid analgesia), dysphagia, or erectile dysfunction; and

c. Documented baseline values for one or more of the following (necessary for renewal): serum lactate dehydrogenase (LDH), hemoglobulin level, packed RBC transfusion requirement, and history of thrombotic events; and

d. Recipient had an inadequate response, contraindication, or intolerance to a trial of ravulizumab (Ultomiris®).

5. Atypical Hemolytic Uremic Syndrome (aHUS)

a. Recipient is at least two months of age; and

b. Recipient shows signs of thrombotic microangiopathy (TMA) (e.g., changes in mental status, seizures, angina, dyspnea, thrombosis, increasing blood pressure, decreased platelet count, increased serum creatinine, increased LDH, etc.); and

c. Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out by evaluating ADAMTS-13 level (i.e., ADAMTS-13 activity level greater than or equal to ten percent); and

d. Shiga toxin E. coli related hemolytic uremic syndrome (STEC-UHS) has been ruled out; and

e. Other causes have been ruled out such as coexisting diseases or conditions (e.g., bone marrow transplantation, solid organ transplantation, malignancy, autoimmune disorder, drug-induced, malignant hypertension, HIV infection, Streptococcus pneumoniae sepsis or known genetic defect in cobalamin C metabolism, etc.); and

f. Documented baseline values for one or more of the following (necessary for renewal): serum lactate dehydrogenase (LDH), serum creatinine/eGFR, platelet count, and plasma exchange/infusion requirement; and

g. Recipient had an inadequate response, contraindication, or intolerance to a trial of ravulizumab (Ultomiris®).

6. Generalized Myasthenia Gravis (gMG)

a. Recipient has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease; and

b. Recipient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; and

c. Recipient has had a thymectomy (Note: Applicable only to recipients with thymomas or non-thymomatous recipients who are 50 years of age or younger); and

d. Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., including, but not limited to, the Quantitative Myasthenia Gravis (QMG) score, etc.); and

e. Recipient has a MG-Activities of Daily Living (MG-ADL) total score of greater than or equal to six; and

f. Recipient will avoid or use with caution medications known to worsen or exacerbate symptoms of MG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine, etc.); and

g. Recipient had an inadequate response after a minimum one-year trial with two or more immunosuppressive therapies (e.g., corticosteroids plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate, etc.); or

1. Recipient required chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy; and

h. Recipient had an inadequate response, contraindication, or intolerance to a trial of ravulizumab (Ultomiris®).

7. Neuromyelitis Optica Spectrum Disorder (NMOSD)

a. Recipient has a confirmed diagnosis based on the following:

1. Recipient was found to be seropositive for aquaporin-four (AQP4) IgG antibodies; and

2. Recipient has at least one core clinical characteristics; and

3. Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection, etc.); and

b. Recipient has a history of at least two relapses in the last 12 months or three relapses in the 24 months, with at least one relapse in the last 12 months; and

c. Recipient has an Expanded Disability Status Score (EDSS) of less than or equal to seven (i.e., presence of at least limited ambulation with aid); and

d. Recipient is receiving concurrent corticosteroid therapy of 20 mg per day or less and those receiving immunosuppressive therapy (e.g., azathioprine, glucocorticoids, mycophenolate, etc.) are on a stable dose regimen; and

e. Recipient has not received therapy with rituximab or mitoxantrone in the last three months; and

f. Received has not received intravenous immune globulin (IVIG) in the last three weeks; and

g. Recipient had an inadequate response, or has a contraindication or intolerance, to rituximab or inebilizumab, and

h. Recipient will not concomitantly receive therapy with any of the following:

1. IL6-inhibitor (e.g., satralizumab); and

2. Anti-CD20-directed antibody (e.g., rituximab); and

3. Anti-CD19-directed antibody (e.g., inebilizumab).

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Loading Doses:

1. Three vials Days 1, 8, 15 and 22; then four vials Day 29

b. Maintenance Doses:

1. Four vials every 14 days.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Indication: PNH

1. Loading Doses: 60 billable units Days one, eight, 15, and 22; then 90 billable units Day 29

2. Maintenance Dose: 90 billable units every 14 days

b. Indication: aHUS, gMG, NMOSD

1. Loading Doses: 90 billable units Day one, eight, 15, and 22; then 120 billable units Day 29

2. Maintenance Dose: 120 billable units every 14 days.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious meningococcal infections (septicemia and/or meningitis), infusion reactions, serious infections, thrombotic microangiopathy complications (TMA), etc.; and

3. Paroxysmal Nocturnal Hemoglobinuria (PNH)

a. Recipient has not developed severe bone marrow failure syndrome (i.e., aplastic anemia or myelodysplastic syndrome) or experienced a spontaneous disease remission or received curative allogeneic stem cell transplant; and

b. Disease response indicated by one or more of the following:

1. Decrease in serum LDG from pretreatment baseline Stabilization/improvement in hemoglobin level from pretreatment baseline

2. Decrease in packed RBC transfusion requirement from pretreatment baseline (i.e., reduction of at least 30%)

3. Reduction in thromboembolic events.

4. Atypical Hemolytic Uremic Syndrome (aHUS)

a. Disease response indicated by one or more of the following:

1. Decrease in serum LDH from pretreatment baseline

2. Stabilization/improvement in serum creatinine/eGFR from pretreatment baseline

3. Increase in platelet count from pretreatment baseline

4. Decrease in plasma exchange/infusion requirement from pretreatment baseline.

5. Generalized Myasthenia Gravis (gMG)

a. Recipient experienced an improvement (i.e., reduction) of at least three-points from baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score; or

b. Recipient experienced an improvement of at least five-points from baseline in the Quantitative Myasthenia Gravis (QMG) total score.

6. Neuromyelitis Optica Spectrum Disorder (NMOSD)

a. Recipient has stabilization and/or improvement of neurologic symptoms as evidenced by a decrease in acute relapses, EDSS, hospitalizations, or plasma exchange treatments.

c. Prior Authorization Guidelines

1. PNH and aHUS: Initial approval will be given for 12 months

2. PNH and aHUS: Recertification will be given for 12 months

3. gMG and NMOSD: Initial approval will be given for six months

4. gMG and NMOSD: Recertification will be given for six months.

2. Ultomiris® (ravulizumab-cwvz)

a. Approval will be given if the following criteria are met and documented:

1. Recipient is at least one month of age (unless otherwise specified); and

2. Prescribed is enrolled in the Ultomiris Risk Evaluation and Mitigation Strategy (REMS) program; and

3. Universal Criteria

a. Recipients must be administered a meningococcal vaccine at least two weeks prior to initiation of therapy and will continue to be revaccinated according to current medical guidelines for vaccine use (If urgent Ultomiris® therapy is indicated in an unvaccinated recipient, administer meningococcal vaccine(s) as soon as possible and provide recipients with two weeks of antibacterial drug prophylaxis); and

b. Will not be used in combination with other immunomodulatory biologic therapies (i.e., efgartigimod, eculizumab, pegcetacoplan, satralizumab, inebilizumab, etc.); and

4. Paroxysmal Nocturnal Hemoglobinuria (PNH)

a. Used as switch therapy; and

1. Recipient is currently receiving treatment with Soliris and has shown a beneficial disease response and absence of unacceptable toxicity while on therapy; or

b. Recipient is complement inhibitor treatment-naïve; and

1. Diagnosis must be accompanied by detection of PNH clones of at least five by flow cytometry diagnostic testing; and

a. Demonstrate the presence of at least two different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g., CD55, CD59, etc.) within at least two different cell lines (e.g., granulocytes, monocytes, erythrocytes); and

b. Recipient has laboratory evidence of significant intravascular hemolysis (i.e., LDH greater than or

equal to one and a half x ULN) with symptomatic disease and at least one other indication for therapy from the following (regardless of transfusion dependence):

1. Recipient has symptomatic anemia (i.e., hemoglobin less than seven g/dL or hemoglobin less than 10 g/dL, in at least two independent measurements in a recipient with cardiac symptoms

2. Presence of a thrombotic event related to PNH

3. Presence of organ damage secondary to chronic hemolysis (i.e., renal insufficiency, pulmonary insufficiency/hypertension)

4. Recipient is pregnant and potential benefit outweighs potential fetal risk

5. Recipient has disabling fatigue

6. Recipient has abdominal pain (requiring admission or opioid analgesia), dysphagia, or erectile dysfunction; and

c. Documented baseline values for one or more of the following (necessary for renewal); serum lactate dehydrogenase (LDH), hemoglobin level, and packed RBC transfusion requirement, history of thrombotic events.

5. Atypical Hemolytic Uremic Syndrome (aHUS)

a. Used as switch therapy; and

1. Recipient is currently receiving treatment with Soliris and has shown a beneficial disease response and absence of unacceptable toxicity while on therapy; or

b. Recipient is complement inhibitor treatment-naïve; and

1. Recipient shows signs of thrombotic microangiopathy (TMA) (e.g., changes in mental status, seizures, angina, dyspnea, thrombosis, increasing blood pressure, decreased

platelet count, increased serum creatinine, increased LDH, etc.); and

2. Thrombotic Thrombocytopenic Purpura (TTP) has been ruled out by evaluating ADAMTS-13 level (ADAMTS-13 activity level greater than or equal to 10%); and

3. Shiga toxin E. Coli related hemolytic uremic syndrome (STEC-HUS) has been ruled out; and

4. Other causes have been ruled out such as coexisting diseases or conditions (e.g., bone marrow transplantation, solid organ transplantation, malignancy, autoimmune disorder, drug-induced, malignant hypertension, HIV infection, Streptococcus pneumoniae sepsis or known genetic defect in cobalamin C metabolism, etc.); and

5. Documented baseline values for one or more of the following (necessary for renewal); serum lactate dehydrogenase (LDH), serum creatinine/eGFR, platelet count, and dialysis requirement.

6. Generalized Myasthenia Gravis (gMG)

a. Used as switch therapy; and

1. Recipient is at least 18 years of age; and

2. Recipient is currently receiving treatment with Soliris and has shown a beneficial disease response and absence of unacceptable toxicity while on therapy; or

b. Recipient is complement inhibitor treatment-naïve; and

1. Recipient is at least 18 years of age; and

2. Recipient has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease; and

3. Recipient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; and

4. Recipient has had a thymectomy (note: applicable only to recipients with thymomas or non-thymomatous recipients who are 50 years of age or younger); and

5. Physician has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., including, but not limited to, the Quantitative Myasthenia Gravis (QMG) score, etc.); and

6. Recipient has a MG-Activities of Daily Living (MG-ADL) total score of greater than or equal to six; and

7. Recipient will avoid or use with caution medications known to worsen or exacerbate symptoms of MG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine, etc.); and

8. Recipient had an inadequate response after a minimum of one-year trial with two or more immunosuppressive therapies (e.g., corticosteroids, plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate, etc.); or

a. Recipient required chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy.

b. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Ultomiris® 10 mg/mL – 30 mL SDV: 10 vials on day zero followed by 13 vials starting on day 14 and every eight weeks thereafter

b. Ultomiris® 100 mg/mL – three mL SDC: 10 vials on day zero followed by 13 vials starting on day 14 and every eight weeks thereafter

c. Ultomiris® 100 mg/mL – 11mL SDV: three vials on day zero followed by three vials starting on day 14 and every eight weeks thereafter

d. Ultomiris® 245 mg/3.5mL single-dose cartridge on-body delivery system: two on-body delivery systems weekly.

2. Max Units (per dose and over time) [HCPCS Unit]:

a. Ultomiris® IV

1. PNH/aHUS/gMG: 300 units on Day zero followed by 360 units on Day 14 and every eight weeks thereafter

b. Ultomiris® SQ

1. PNH/aHUS: 49 units weekly.

c. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria identified in section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious meningococcal infections (septicemia and/or meningitis), infusion-related reactions, other serious infections, thrombotic microangiopathy (TMA) complications, etc.; and

3. Paroxysmal Nocturnal Hemoglobinuria (PNH)

a. Recipient has not developed severe bone marrow failure syndrome (i.e., aplastic anemia or myelodysplastic syndrome) or experienced a spontaneous disease remission or received curative allogeneic stem cell transplant; and

b. Disease response indicated by one or more of the following:

1. Decrease in serum LDH from pretreatment baseline Stabilization/improvement in hemoglobin level from pretreatment baseline

2. Decrease in packed RBC transfusion requirement from pretreatment baseline (i.e., reduction of at least 30%)

3. Reduction in thromboembolic events.

4. Atypical Hemolytic Uremic Syndrome (aHUS)

a. Disease response indicated by one or more of the following:

1. Decrease in serum LDH from pretreatment baseline

2. Stabilization/improvement in serum creatinine/eGFR from pretreatment baseline

3. Increase in platelet count from pretreatment baseline

4. Decrease in plasma exchange/infusion requirement from pretreatment baseline.

5. Generalized Myasthenia Gravis (gMG)

a. Recipient experienced an improvement (i.e., reduction) of at least three-points from baseline in the Myasthenia Gravis-Specific Activities of Daily Living scale (MG-ADL) total score; or

b. Recipient experienced an improvement of at least five-points from baseline in Quantitative Myasthenia Gravis (QMG) total score.

6. Switch therapy from Soliris to Utomiris®

d. Prior Authorization Guidelines

1. Initial approval will be given for 12 months

2. Recertification will be given for 12 months.

R. Yervoy® (ipilimumab)

Therapeutic Class: Anti-CLTA-4 Monoclonal Antibodies
Last Reviewed by the DUR Board: N/A

Yervoy® (ipilimumab) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

A. Approval will be given if the following criteria are met and documented:

1. Recipient is at least 18 years of age, unless otherwise specified; and

2. Ampullary Adenocarcinoma

a. Recipient's disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

b. Used in combination with nivolumab; and

1. Used as first-line therapy for unresectable or metastatic intestinal type disease; or

2. Used as subsequent therapy for disease progression.

3. Bone Cancer

a. Recipient has one of the following: Ewing sarcoma, chondrosarcoma (excluding mesenchymal chondrosarcoma), osteosarcoma, or chordoma; and

b. Recipient has tumor mutation burden-high (TMB-H) tumors [greater than or equal to 10 mutations/megabase (mut/mB)] as determined by an FDA-approved or CLIA-compliant test; and

c. Used in combination with nivolumab; and

d. Recipient has unresectable or metastatic disease that progressed following prior treatment; and

e. Recipient has no satisfactory alternative treatment options.

4. Central Nervous System (CNS) Cancer

a. Used for the treatment of brain metastases in recipients with BRAF non-specific melanoma; and

b. Used in combination with nivolumab or as a single agent; and

1. Used as initial treatment in recipients with small asymptomatic brain metastases; or

2. Used for relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options; or

3. Recipients has recurrent limited brain metastases; or

4. Used for recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options.

5. Colorectal Cancer (CRC)

a. Recipient is at least 12 years of age; and

b. Recipient's disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

c. Recipient has not previously received treatment with a checkpoint inhibitor (e.g., nivolumab, pembrolizumab, etc.); and

d. Used in combination with nivolumab; and

1. Used as subsequent therapy for advanced or metastatic disease that progressed following treatment with one of the following:

a. Fluoropyrimidine-, oxaliplatin-, and/or irinotecan-based chemotherapy; or

b. Non-intensive therapy in recipients with improvement in functional status; or

2. Used as primary treatment; and

a. Used as neoadjuvant therapy for clinical T4b colon cancer; or

b. Used as neoadjuvant therapy of resectable liver and/or lung metastases; or

c. Used if resection is contraindicated following neoadjuvant therapy for advanced, locally unresectable, or medically inoperable rectal cancer; or

d. Used for unresectable (or medically inoperable) or metastatic disease.

6. Appendiceal Adenocarcinoma – Colon Cancer

   a. Recipient's disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

   b. Recipient has not previously received treatment with a checkpoint inhibitor (e.g., nivolumab, pembrolizumab, etc.); and

   c. Used in combination with nivolumab; and

      1. Used as subsequent therapy for advanced or metastatic disease that progressed following previous oxaliplatin- irinotecan- and/or fluoropyrimidine-based therapy; or

      2. Used as initial therapy for advanced or metastatic disease.

7. Esophageal Cancer and Esophagogastric/Gastroesophageal Junction Cancers

   a. Recipient has esophageal squamous cell carcinoma (ESCC); and

   b. Recipient has not previously received treatment with a checkpoint inhibitor (e.g., nivolumab, pembrolizumab, etc.); and

   c. Used as first-line treatment with combination with nivolumab; and

   d. Recipient is not a surgical candidate or has unresectable advanced, recurrent, or metastatic disease.

8. Hepatocellular Carcinoma (HCC)

   a. Used in combination with nivolumab; and

   b. Used as subsequent therapy for progressive disease; and

   c. Recipient has Child-Pugh Class A hepatic impairment; and

      1. Recipient was previously treated with sorafenib; or

      2. Recipient has unresectable disease and is not a transplant candidate; or

      3. Recipient has liver-confined disease that is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic-disease; or

      4. Recipient has metastatic disease or extensive liver tumor burden.

9. Renal Cell Carcinoma (RCC)

   a. Used in combination with nivolumab for clear cell histology; and

      1. Used as first-line therapy in recipients with poor or intermediate risk advanced, relapsed, or stage IV disease; or

      2. Used as first-line therapy in recipients with favorable risk relapsed or stage IV disease; or

      3. Used as subsequent therapy in recipients with relapsed or stage IV disease.

10. Malignant Peritoneal Mesothelioma (MPeM)

   a. Used in combination with nivolumab; and

      1. Used as subsequent therapy (if not administered first-line); or

      2. Used as first-line therapy; and

         a. Recipient has unresectable diffuse disease; or

         b. Recipient has unresectable recurrent benign multicystic or well-differentiated papillary disease.

11. Malignant Pleural Mesothelioma (MPM)

   a. Used in combination with nivolumab; and

      1. Used as subsequent therapy (if not administered first-line); or

      2. Used as first-line therapy; and

         a. Recipient has stage IIIB or IV disease; or

         b. Recipient has sarcomatoid or biphasic histology; or

         c. Disease is medically inoperable or unresectable.

12. Cutaneous Melanoma

   a. Used as first-line therapy for unresectable or metastatic disease in combination with nivolumab; or

   b. Used as initial therapy for limit resectable local satellite/in-transit recurrence; and

1. Used as a single agent; and

2. Recipient has prior exposure to anti-PD-1 therapy (e.g., nivolumab or pembrolizumab); or

c. Used as subsequent therapy for unresectable or metastatic disease; and

1. Used after disease progression or maximum clinical benefit from BRAF-targeted therapy (e.g., dabrafenib/trametinib, vemurafenib/cobimetinib, encorafenib/binimetinib, etc.); and

a. Used as a single agent in recipients at least 12 years of age if not previously used alone or in combination with anti-PD-1 therapy; or

b. Used in combination with nivolumab if not previously used or for recipients who progress on single agent anti-PD-1 therapy; or

c. Used in combination with pembrolizumab, if not previously used alone or in combination with anti-PD-1 therapy, for recipients who progress on single agent anti-PD-1 therapy; or

2. Used as re-induction therapy in recipients who experienced disease control (i.e., complete or partial response or stable disease) and no residual toxicity from prior use, but subsequently have disease progression/relapse greater than three months after treatment discontinuation; and

a. Used as single agent or in combination with anti-PD-1 therapy; and

b. Recipient has completed initial induction ipilimumab therapy (i.e., completion of four cycles within a 16 week period); or

d. Used a single agent for adjuvant therapy; and

1. Recipient has pathologic involvement of regional lymph nodes of more than one mm and has undergone complete resection including total lymphadenectomy; or

2. Recipient has prior exposure to anti-PD-1 therapy (e.g., nivolumab or pembrolizumab); and

a. Recipient has local satellite/in-transit recurrence and has no evidence of disease (NED) after complete excision; or

b. Recipient has undergone complete therapeutic lymph node dissection (TLND) and/or complete excision of nodal recurrence; or

c. Recipient has oligometastatic disease and no evidence of disease following metastasis-directed therapy (i.e., stereotactic ablative therapy or complete resection) or systemic therapy.

13. Uveal Melanoma

a. Used as a single agent or in combination with nivolumab; and

b. Recipient has distant metastatic disease.

14. Non-Small Cell Lung Cancer (NSCLC)

a. Used for recurrent, advanced, or metastatic disease (excluding locoregional recurrence or symptomatic local disease without evidence of disseminated disease) or mediastinal lymph node recurrence with prior radiation therapy; and

1. Used as first-line therapy; and

a. Used for one of the following:

1. Recipients with a performance status (PS) zero to one who have tumors that are negative for actionable molecular biomarkers and PD-L1 less than one percent

2. Recipients with a PS zero to one who are positive for one of the following molecular biomarkers: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK 1/2/3 gene fusion, MET exon 14 skipping, RET rearrangement, or ERBB2 (HER2)

3. PD-L1 expression positive (PD-L1 greater than or equal to one percent) tumors, as detected by an FDA or CLIA compliant test, that are negative for actionable molecular biomarkers; and

b. Used in combination with nivolumab; or

c. Used in combination with nivolumab and platinum-doublet chemotherapy (e.g., pemetrexed and either carboplatin or

cisplatin for non-squamous cell histology, or paclitaxel and carboplatin for squamous cell histology, etc.); or

2. Used as subsequent therapy; and

a. Used for one of the following:

1. Recipients with a PS zero to one who are positive for one of the following molecular mutations and have received prior target therapy: EGFR exon 19 deletion or L858R tumors, EGFR S7681, L861Q, and/or G719X, ALK rearrangement, or ROS1 rearrangement; or

2. Recipients with a PS zero to one who are positive for one of the following molecular biomarkers: BRAF V600E, NTRK 1/2/3 gene fusion, MET exon 14 skipping, or RET rearrangement; and

b. Used in combination with nivolumab; or

c. Used in combination with nivolumab, pemetrexed, and either carboplatin or cisplatin for non-squamous cell histology; or

d. Used in combination with nivolumab, paclitaxel and carboplatin for squamous cell histology; or

3. Used as continuation maintenance therapy in combination with nivolumab; and

a. Recipient has achieved a response or stable disease following first-line therapy with nivolumab and ipilimumab with or without chemotherapy.

15. Small Bowel Adenocarcinoma (SBA)

a. Recipient has advanced or metastatic disease that is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and

b. Recipient has not previously received treatment with a checkpoint inhibitor (e.g., nivolumab, pembrolizumab, etc.); and

c. Used in combination with nivolumab; and

1. Used as initial therapy; or

2. Used as subsequent therapy for recipients with no prior oxaliplatin exposure in the adjuvant treatment setting and no contraindication to oxaliplatin therapy.

B. Dosage Limits

1. Quantity Limit (max daily dose) [NDC Unit]:

a. Yervoy® 200mg/40mL injection:

1. Five vials per 84 days (initially up to five vials per 21 days x four doses)

b. Yervoy® 50mg/10mL injection:

1. Three vials per 84 days (initially up to three days per 21 days x four doses).

C. Recertification Request

1. Recipient continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in Section III; and

2. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: immune-mediated reactions (e.g., colitis, hepatitis, dermatitis/rash, pneumonitis, nephritis/renal dysfunction, endocrinopathies, etc.), severe infusion reactions, complications of allogeneic hematopoietic stem cell transplantation (HSCT), etc.; and

3. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread; and

4. Coverage may not be renewed for the following indications:

a. Colorectal Cancer (subsequent therapy/disease progression); or

b. Appendiceal Adenocarcinoma (subsequent therapy/disease progression)

c. CNS metastases from Melanoma (combination therapy with nivolumab)

d. Cutaneous Melanoma (first-line or subsequent therapy)

e. Hepatocellular Carcinoma

f. Renal Cell Carcinoma

g. Small Bowel Adenocarcinoma

h. Ampullary Adenocarcinoma

i. Uveal Melanoma

5. For the following indications, recipient has not exceeded a maximum of two years of therapy:

a. Bone Cancer

b. Esophageal and Esophagogastric/Gastroesophageal Junction Cancer

c. Peritoneal Mesothelioma

d. Malignant Pleural Mesothelioma

e. Non-Small Cell Lung Cancer

6. Cutaneous Melanoma (re-induction therapy)

7. Cutaneous Melanoma (adjuvant treatment – maintenance therapy)

a. Recipient has not exceeded a maximum of three years of therapy

8. Non-Small Cell Lung Cancer (continuation maintenance therapy).

D. Prior Authorization Guidelines

1. Initial approval will be given for six months

2. Recertification will be given for six months

3. The following indications may be authorized up to a maximum of twelve weeks of therapy and may not be renewed (coverage may be extended to 16 weeks if four doses were not administered within the 12-week time frame)

a. Colorectal Cancer (subsequent therapy/disease progression)

b. Appendiceal Adenocarcinoma (subsequent therapy/disease progression)

c. CNS metastases from Melanoma (combination therapy with nivolumab)

d. Cutaneous Melanoma (first-line or subsequent therapy)

e. Hepatocellular Carcinoma

f. Renal Cell Carcinoma

g. Small Bowel Adenocarcinoma

h. Ampullary Adenocarcinoma

i. Uveal Melanoma

4. The following indications may be renewed up to a maximum of two years of therapy:

a. Bone Cancer

b. Esophageal and Esophagogastric/Gastroesophageal Junction Cancer

c. Malignant Peritoneal Mesothelioma

d. Malignant Pleural Mesothelioma

e. Non-Small Lung Cancer

5. Cutaneous Melanoma (adjuvant treatment)

a. Coverage will be provided for six months and may be renewed for up to a maximum of three years of maintenance therapy.

S. Zynlonta® (loncastuximab tesirine-lpyl)

Therapeutic Class: Miscellaneous Antineoplastics
Last Reviewed by the DUR Board: N/A

Miscellaneous Antineoplastics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the SSA Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Approval will be given if the following criteria are met and documented:

   A. Recipient is at least 18 years old; and

   B. Recipient advised to minimize or avoid exposure to direct natural or artificial sunlight including exposure through glass windows; and

   C. Universal Criteria

      1. Used as single agent therapy; and

      b. Recipient has not received prior anti-CD19 therapy, (e.g., tafasitamab, CAR-T) or recipient previously received anti-CD19 therapy and re-biopsy indicates CD-19 positive disease; and

      c. Recipient does not have active graft-versus-host disease; and

      d. Recipient has not had an autologous stem cell transplant (ASCT) within 30 days or allogeneic stem cell transplant (AlloSCT) with 60 days, prior to start of therapy; and

      e. Recipient does not have active CNS lymphoma (includes leptomeningeal disease); and

      f. Recipient does not have a clinically significant active infection (e.g., Grade 3 or 4 infections); and

      g. Recipient does not have any clinically significant third space fluid accumulation (i.e., ascites requiring drainage or pleural effusion that is either requiring drainage or associated with shortness of breath); and

   D. Large B-Cell Lymphoma

      1. Recipient has relapsed or refractory disease (includes diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low grade lymphoma, and high-grade B-cell lymphoma); and

      2. Recipient has received at least two prior lines of therapy.

2. Dosage Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

1. Zynlonta® 10mg powder for injection: two vials every 21 days for the first two doses followed by one vial every 21 days thereafter.

B. Max Units (per dose and over time) [HCPCS Unit]:

1. Relapsed or Refractory B-Cell Lymphoma

a. Cycle 1-2

1. 230 billable units (17.25mg) per each 21-day cycle

b. Subsequent Cycles

1. 115 billable units (8.63mg) per each 21-day cycle.

3. Recertification Request

A. Recipient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirement (not including prerequisite therapy), performance status, etc. identified in section III; and

B. Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe effusion and edema (e.g., pleural effusion, pericardial effusion, ascites, peripheral edema, and general edema), myelosuppression, infections, severe cutaneous reactions (e.g., photosensitivity, rash), etc.; and

C. Disease response with treatment defined by stabilization of disease or decrease in size of tumor or tumor spread.

4. Prior Authorization Guidelines

A. Initial approval will be given for six months.

B. Recertification will be given for six months.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 25, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR /Cody L. Phinney/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1300 – DME DISPOSABLE SUPPLIES AND SUPPLEMENTS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1300 – DME Disposable Supplies and Supplements are being proposed to update the invoice verbiage for consistency throughout, referenced provider type (PT 33) billing guideline, removed the Insulin Pump policy and made reference along with Continuous Glucose Monitors that they will now be under the pharmacy benefit, removed the rental option verbiage for Osteogenesis Stimulators to allow straight purchase and removed facility based polysomnogram verbiage which opens up to allow home based sleep studies.

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: DME (PT 33) and Pharmacy (PT 28).

Financial Impact on Local Government: Unknown at this time.

These changes are effective February 26, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 09/20 MSM Chapter 1300 – DME Disposable Supplies and Supplements	MTL 07/18 MSM Chapter 1300 – DME Disposable Supplies and Supplements

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.2(A)(2)	**Detailed Product Description**	Removed “of cost” for the type of invoice.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.4(C)	**Provider Responsibility**	Added verbiage to direct providers to the (PT 33) DMEPOS specific billing guide.
Appendix B, pages 16 and 17	**Diabetic Services**	Added verbiage referring External Ambulatory Infusion Pump, Insulin systems and Continuous Glucose Monitors are now under the pharmacy program.
Appendix B, page 48	**Osteogenesis Stimulator Devices, Qualifications and Misc. policy Statements**	Changed six months to three or more months for non-spinal. Removed the rental requirement verbiage for both to match Medicare and allow access to care.
Appendix B, pages 56, 57, 61	**Respiratory Services, BiPAP and CPAP, Qualifications**	Removed facility based, attended verbiage and added complete.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS

1300 INTRODUCTION

Durable Medical Equipment, Prosthetics, Orthotics and Disposable Medical Supplies (DMEPOS) are a covered benefit for Nevada Medicaid recipients. All items are subject to program criteria and reimbursement restrictions as outlined throughout this chapter. Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Items classified as educational or rehabilitative by nature are not covered by Provider Type 33. Administrative authorization for additional services may be made by the Division of Health Care Financing and Policy (DHCFP) in collaboration with the Quality Improvement Organization (QIO)-like vendor for exceptional cases where medical need is adequately documented.

Products must have received approval from the federal Food and Drug Administration (FDA) and be consistent with the approved use. Products or usage considered experimental or investigational are not covered services. Consideration may be made on a case-by-case basis for items approved by the FDA as a Humanitarian Device Exemption (HDE) under the Safe Medical Device Act of 1990 and as defined by the FDA. That is, a device that is intended to benefit patients by treating or diagnosing a disease or condition that affects fewer than 4,000 individuals in the United States per year.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), except as indicated in the NCU Manual Chapter 1000. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program, Addendums Chapter and MSM Definitions for further information.

1301 AUTHORITY

The Division of Health Care Financing and Policy (DHCFP) covers Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) as a mandatory program under Title XIX of the Social Security Act (SSA).

The citations denoting the amount, duration and scope of services can be found in 42 Code of Federal Regulations (CFR), Part 440, Sections 70 and 230, Section 1902 (a)(10)(d) of Title XIX of the Social Security Act, 42 United States Code (USC) Chapter 7, Section 1396a and 1397jj.

Reference Title XIX State Plan Attachment 3.1-A Page 2h and 3c, Attachment 4.19-B page 1b and page 2.

1302 DEFINITIONS

ANKLE-FOOT ORTHOSES

Ankle-foot orthoses extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics, which are shoe inserts that do not extend above the ankle.

CUSTOM FABRICATED ORTHOSIS

A custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather or cloth in the form of sheets, parts, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending or making other modifications to a substantially prefabricated item.

DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies are those health care items which are not reusable, and are primarily and customarily used to serve a medical purpose, and generally are not useful to a person in the absence of an individual disability, illness or injury.

DURABLE MEDICAL EQUIPMENT (DME)

DME is defined as equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of disability, illness or injury and is appropriate for use in the home.

DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR (DME MAC)

The Centers for Medicare and Medicaid Services (CMS) utilize four insurance companies to process durable medical equipment, prosthetic, orthotic and disposable medical supply claims for Medicare in four distinct jurisdictions. Nevada is in Jurisdiction D. This was formerly referred to as Durable Medical Equipment Regional Carrier (DMERC).

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

Aggregate term used under the Medicare program and by some Medicaid programs, which incorporates all durable medical equipment, prosthetics, orthotics and disposable medical supplies. The acronym is pronounced “demipose.”

MEDICAL DOCUMENTATION

For the purposes of obtaining DMEPOS through Nevada Medicaid and Nevada Check Up (NCU), medical documentation used to support medical necessity is part of a medical record which is completed, signed and dated by a licensed medical professional. Clinical reports or assessments required to support medical necessity must be from a licensed/certified professional performing within their scope of practice. Information used as medical documentation cannot be compiled or composed by the recipient, their relatives or representatives.

MISUSE

To use in a manner in which an item is not intended, excessive use or to use incorrectly.

MOLDED TO PATIENT MODEL ORTHOSIS

A molded-to-patient-model orthosis is a particular type of custom fabricated orthosis in which an impression of the specific body part is made (by means of a plaster cast, CAD-CAM technology, etc.) and this impression is then used to make a positive model (of plaster or other material) of the body part. The orthosis is then molded on this positive model.

ORTHOSIS

An orthosis (brace) is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. An orthosis can be either prefabricated or custom-fabricated.

PREFABRICATED ORTHOSIS

A pre-fabricated orthosis is one which is manufactured in quantity without a specific patient in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat) or otherwise modified for use by a specific patient (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

PROSTHETIC DEVICES

Prosthetic devices are replacement, corrective or supportive devices prescribed by a physician (or other licensed practitioner of the healing arts within the scope of his practice as defined by state law) to:

a. Artificially replace a missing portion of the body;

b. Prevent or correct physical deformity or malfunction; or

c. Support a weak or deformed portion of the body (as defined by 42 CFR § 440.120(c)).

For Nevada Medicaid's DMEPOS program purposes, dentures and eyeglasses are not included as a prosthetic device.

SPEECH GENERATING DEVICE (SGD)

SGDs, also commonly known as "Augmentative and Alternative Communication" (AAC) devices are electronic aids, devices or systems that correct expressive communication disabilities that preclude an individual from meaningfully participating in activities of daily living. SGDs are covered as DME. Requests for SGDs must provide the information required in Appendix B to this Chapter of the Medicaid Services Manual (MSM).

1303 POLICY

1303.1 DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTIC DEVICES, DISPOSABLE MEDICAL SUPPLIES (DMEPOS) PROGRAM

A. GENERAL INFORMATION

1. DMEPOS Program coverage areas include parenteral and enteral nutrition (PEN), medical foods, and oxygen and oxygen equipment, all of which must meet the definition of durable medical equipment, a prosthetic device, an orthotic device or disposable medical supply.

2. Durable Medical Equipment (DME) of a medical nature, needed as a result of a medical condition and which lasts a considerable time without significant deterioration and appropriate for use where normal life activities take place, is covered by the DHCFP and NCU for eligible recipients. New equipment, repairs or replacement requires medical documentation and are subject to limitations of model, cost and frequency, which are deemed reasonable by the program.

3. Disposable medical supplies are covered by the DHCFP and NCU for eligible recipients only if they are necessary for the treatment of a medical condition and would not generally be useful to a person in the absence of an illness, disability or injury.

4. All DMEPOS products and services must be medically necessary, safe and appropriate for the course and severity of the condition, using the least costly and equally effective alternative to meet the recipient's medical needs.

5. Deluxe equipment will not be authorized when it is determined that a standard model will meet the basic medical needs of the recipient. The recipient must have a medical need for each component of the item(s) requested. This includes accessory items and features not included in the standard models of the product.

6. Equipment which the program determines is principally for education or rehabilitation will not be approved.

7. Refer to Appendix A of this Chapter for non-covered services, and for special coverage considerations that are based on medical necessity outside of the DMEPOS Program or that is considered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids Program.

8. Refer to Appendix B of this Chapter, for Coverage and Limitation Policies regarding specific coverage information, qualifications, documentation requirements and miscellaneous information.

9. Refer to the Provider Type 33 DMEPOS Fee Schedule for specific item coverage under the DMEPOS program.
Access http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain.

10. The DHCFP does not reimburse for items that are the same or similar to items that the recipient has already acquired or has access to such as, but not limited to, back-up equipment, unless allowed in the specific policy for that item. Duplicate items intended to be used within the same span of time are not considered medically necessary.

11. Individuals deemed eligible for Nevada Medicaid or NCU and who have ownership of existing equipment from any prior resource must continue using that equipment. Existing equipment, regardless of who purchased it, must be identified, including the estimated date of purchase or age of equipment and medical documentation showing evidence of need for replacement. All documentation must be submitted with a prior authorization request.

12. Some items not covered under the DMEPOS Program may be covered under other Medicaid programs such as Pharmacy, Audiology or Ocular programs. Additional resources may be available through other agencies or through waiver programs for items not covered under the DMEPOS Program or by the Medicaid State Plan.

B. PROVIDER RESPONSIBILITY

1. All DMEPOS providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DMEPOS. Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program for further information on enrollment and provider responsibilities. Also refer to the Enrollment Checklist posted on the following website at: https://www.medicaid.nv.gov.

2. Suppliers of products covered under the Medicare Part B program are required to be enrolled in the Medicare Part B program in order to provide those services to Medicare and Medicaid dually eligible recipients. This includes obtaining and maintaining the Centers of Medicare and Medicaid Services (CMS) required accreditation and surety bond.

3. Potential providers who are not enrolled with the Medicare Part B program and who will not be supplying products covered under the Medicare Part B program to individuals eligible for Medicare are required to provide a statement on/with their application that requests a waiver of the requirements for Medicare Part B enrollment. This statement must indicate that they do not service Medicare-eligible individuals and include a listing of the products they plan to supply.

4. A DMEPOS provider must adhere to all Federal Rules and Regulations applicable to their provider type including, but not limited to, 42 CFR Part 440 for enrollment. i.e. not limited to: storefront, background checks, etc.

5. A Medicaid-contracted DMEPOS provider may be reimbursed for services rendered to Medicaid eligible recipients when provided in accordance with established policies, guidelines and timeframes.

6. The provider is responsible for ensuring the equipment is appropriate for the recipient and the recipient's location of normal life activities prior to billing the DHCFP.

7. The provider is responsible for providing a manufacturer's suggested retail pricing (MSRP) invoice for certain items, where no rate has been established.

8. The DMEPOS provider must comply with additional requirements as specified throughout this Chapter and its Appendices, Medicaid Services Manual (MSM) Chapter 100, the Provider Type (PT) 33 DMEPOS Fee Schedule, the Provider Billing Manual and DMEPOS Billing Guidelines.

9. The provider is responsible to teach the recipient, caregivers or authorized representative(s) about the operation, proper use, maintenance requirements and any unacceptable use of the medical equipment.

C. RECIPIENT RESPONSIBILITY

The eligible Nevada Medicaid or NCU recipient and/or their authorized representative will:

1. Make and keep appointments necessary for securing medical services/equipment;

2. Present current verification of Nevada Medicaid or NCU eligibility;

3. Present any forms or identification necessary to utilize other health insurance coverage;

4. Contact and return to the provider of services/equipment for any necessary adjustment within the time allotted for such adjustments;

5. Maintain the equipment provided by routinely cleaning and caring for the devices according to user information and supplier's guidance. Provide safe, secure storage for item(s) when not in use to protect item(s) from loss or theft;

6. Not misuse, abuse or neglect purchased or rented item(s) in a way that renders the item(s) unsafe, non-usable or shortens the lifetime of the item;

7. Return all rented equipment to the DMEPOS provider when no longer being used, or upon the DME provider's request. Failure to return rented equipment could result in a recipient's financial responsibility for the retail price of the rented equipment, even if the equipment is lost/stolen, the recipient has moved or they are no longer eligible for Nevada Medicaid/NCU.

8. Comply with additional requirements as specified throughout this Chapter and its Appendices and MSM Chapter 100.

1303.2 DOCUMENTATION REQUIREMENTS

A. Supplier/provider records must substantiate the medical necessity for all DMEPOS items dispensed to recipients. The following describes the requirements for specific types of documentation associated with DMEPOS.

1. ORDERS/PRESCRIPTIONS

a. All DME items, Prosthetics, Orthotics or Disposable Supplies (POS) dispensed must have an order/prescription from the treating physician or practitioner, (To determine included practitioners, refer to MSM Chapter 600 – Physician's Services), such as a Physician's Assistant (PA) or Advanced Practitioner of Nursing (APN), when within their scope of practice and in accordance with federal and state laws governing that entity, prior to dispensing the item.

In accordance with the Patient Protection and Affordable Care Act (PPACA) (The Affordable Care Act) of 2010 (Public Law 111-148), all orders for DMEPOS items, whether verbal or written, must be incidental/relevant to the treating physician-documented face-to-face encounter between the recipient and the prescribing physician/practitioner (as allowed by The Act) within 30 - 60 days prior to the start date of the order/script. The encounter must be clearly documented and relevant to the need for the prescribed DMEPOS.

Refer to Appendix B of this Chapter for additional order requirements on specific products.

General standards of care/practice mandate that if an order is not clear, a clarification of the order must be obtained from the ordering practitioner prior to acting on it.

b. Verbal Orders:

1. Verbal orders from the prescribing physician/practitioner may be accepted for DMEPOS items that do not require prior authorization

by the DHCFP (except when Medicare is primary and Medicaid co-payment will be requested, and Medicare requires a written order for that item prior to delivery). Refer online to the DME MAC Jurisdiction D Supplier Manual, Chapter 3 – Documentation Requirements, for a current listing of those items at: https://med/noridianmedicare.com/web/jddme/education/supplier-manual

2. The verbal dispensing order must include:

   a. A description of the item;

   b. The recipient's name;

   c. The physician's name;

   d. The start date and length of need of the order; and

   e. Additional information sufficient to allow appropriate dispensing of the item.

3. Suppliers must maintain written documentation of the verbal order and, if the verbal order is used for dispensing the item, the supplier must obtain a detailed written order prior to billing the DHCFP.

c. Written Orders:

1. Written orders are acceptable for all transactions involving DMEPOS and must be obtained prior to submitting a prior authorization for any DMEPOS items. Written orders may take the form of a photocopy, facsimile image, electronically maintained or original "pen-and-ink" document.

2. All written orders must, at a minimum:

   a. Clearly specify the start date of the order;

   b. Include the length of need;

   c. Be sufficiently detailed, including all options or additional features that are needed to meet the recipient's needs. The description must be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number; and

d. Be signed and dated by the treating physician/practitioner. Signature includes computer signature and pen and ink, no signature stamps allowed.

3. Certain items require additional elements in the written orders, as follows:

a. If the written order is for supplies that will be provided on a periodic basis, the written order must include appropriate information on the quantity used, frequency of change and duration of need. (For example, an order for surgical dressings might specify one 4x4-hydrocolloid dressing that is changed one to two times per week for one month or until the ulcer heals).

b. If the written order is for an item such as, but not limited to, enteral formula, oxygen, etc., the order must specify the name of the product, concentration (if applicable), dosage, frequency and route of administration and duration of infusion (if applicable).

c. Custom-fabricated items must be clearly indicated on the written order that has been signed and dated by the prescribing physician/practitioner.

4. There are additional specifications for orders for certain items, such as, but not limited to, Power Mobility Devices (PMDs). Refer to Appendix B for details.

5. The detailed description of the item(s) may be completed by an employee of the ordering physician/practitioner; however, the prescriber must review the detailed description and personally indicate agreement by signing and dating the order.

6. Medical necessity information (such as the most current appropriate diagnosis code(s) (ICD), narrative description of the recipient's condition, abilities and limitations) is not in itself considered to be part of the order although it may be put on the same document as the order.

d. New Orders Are Required When:

1. There is a change in the order of a specific DMEPOS item;

2. There is a change in the resident's condition that warrants a change in the order, a change in the treating physician/practitioner or DMEPOS supplier;

3. An item is replaced for any reason; or

4. An ongoing unchanged order continues to be medically necessary one year after the original order (orders are only valid for up to one year, unless documented with a shorter length of time).

2. DETAILED PRODUCT DESCRIPTION

The detailed product description must contain the Healthcare Common Procedure Coding System (HCPCS) code, manufacturer, make and model and the provider's/supplier's invoice for each item supplied. The warranty information must also be included. This may be completed by the provider/supplier but can also be documented by the physician.

3. PROOF OF DELIVERY (POD)

A POD is a supplier's delivery receipt, which is dated and timed.

NOTE: Item(s) ordered must be delivered within 120 days of the date of the order.

4. ADDITIONAL MISCELLANEOUS MEDICAL RECORDS

The recipient's medical records must contain sufficient documentation of the recipient's medical condition to substantiate the necessity for the type and quantity of items ordered and the frequency of the use or replacement. The information must include the recipient's diagnosis and other pertinent information, including but not limited to: duration of recipient's condition, clinical course (deteriorating or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The records must include physician's office records, hospital, nursing home or home health records, records from other professionals including but not limited to: nursing, physical and occupational therapists, prosthetists and orthotists, although medical necessity for item(s) requested must be stated by the prescribing physician/practitioner.

5. ADVANCED DETERMINATION OF MEDICARE COVERAGE (ADMC)

When Medicare is the primary payer, for all items requiring an ADMC (refer online to the DME MAC Jurisdiction D, Supplier Manual, Chapter 9). The ADMC determination must be submitted to the Quality Improvement Organization (QIO)-like vendor at the same time the prior authorization is submitted.

B. PROVIDER RESPONSIBILITY

1. The provider must obtain the required documentation in a timely manner as described under each section listed previously.

2. The provider must maintain records at the physical location of their business for each item billed to, and paid by, the DHCFP for at least six years from the Remittance Advice (RA) date. At a minimum, this includes the original signed order/prescription, all supporting medical documentation, and proof of delivery.

3. The provider must maintain records in a readily accessible location and, for audit and investigation purposes, to make available upon request by Medicaid staff or its contractors, all supporting information related to prior authorizations, dispensed items and/or paid clams for DMEPOS items.

1303.3 RENTAL AND PURCHASE OPTIONS

Items identified in the DMEPOS Fee Schedule with an RR modifier for rental and an NU modifier for purchase option may require prior authorization to determine if the recipient's needs justify rental or purchase based on the item prescribed, the individual's anticipated length of need and prognosis (as determined by the prescriber) and cost effectiveness to the DHCFP and NCU. If a Nevada Medicaid rate has not been assigned, an MSRP invoice is required to be submitted with the prior authorization (PA) request or claim, if a PA is not already required for that item.

A. RENTAL

1. In addition to all other requirements and qualifications for specific products, if the DMEPOS Fee Schedule allows a rental option, a device may be rented when:

   a. the anticipated length of need (per physician's/practitioner's order) is short term (six months or less) and rental would be more cost effective than purchase;

   b. a temporary trial period is required for the item according to Medicaid's policy;

   c. the item is only available as a rental per the DMEPOS Fee Schedule; or

   d. a temporary rental is needed while a recipient-owned like item is being repaired.

2. During a rental period, rental rates include all supplies and accessories necessary to render the equipment useable and safe, delivery and set up services, education and training for recipient and family, routine maintenance and servicing (such as testing, cleaning, regulating and checking equipment), repairs, non-routine

maintenance and servicing (such as breaking down sealed components and performing tests which require specialized equipment and skills of a technician) and replacement of items. These services are the responsibility of the owner, the DMEPOS supplier.

3. Throughout any rental period, there must be an active physician's/practitioner's order for ongoing use, the prior authorization effective dates are still applicable and there is a continued medical need for the item. The DMEPOS supplier must contact the recipient or their representative within five business days prior to each billing cycle to verify the rented item is still medically necessary, in working condition and being used by the recipient (contact does not include system generated correspondence). Verification must be documented and maintained in the DMEPOS supplier's records and be accessible for audits.

4. Rent-to-Purchase Option:

   a. The DHCFP allows rental of certain DMEPOS items up to the maximum Medicaid allowable purchase price of the item.

   b. Only certain equipment, as specifically defined by Medicaid, will be rental only. Once the total cumulative payments have reached the maximum Medicaid allowable purchase rate, then the item is considered purchased in full and recipient-owned.

   c. The provider shall automatically transfer the title for the equipment to the recipient. Providers are not to submit prior authorizations to transfer titles. Providers are also not to submit prior authorizations coded as a purchase after the Medicaid allowable purchase rate is reached. No rental or purchase payments will be made for the remaining reasonable useful lifetime of the device (usually not less than five years (60 months)). The provider's records must include the date the title was transferred to the recipient.

   d. When an item was new at the time of issuance, and it is later determined the recipient will need the item long term, rental payments will be applied toward the total purchase rate (the Medicaid allowable or if no Medicaid rate exists, the MSRP invoice). Refer to "Purchase Used Equipment Option" in Section 1303.

   e. Equipment that was not new at the time of issuance, such as items from the provider/supplier rental fleet, supplied as a temporary short term rental item must be replaced with new equipment as soon as it is identified the recipient will need the device long term (no later than in the sixth month of rental). Payments made on rental fleet-type items will not be applied to the purchase price of a new item. Purchase or transfer of titles to recipients when the used equipment is from a rental fleet is not allowed.

f. For this option, non-routine maintenance and servicing or repairs may be covered for service dates after the item is owned by the recipient; no sooner than the month following the last rental month.

5. Rental Only Option:

a. Only specific equipment will be identified by Nevada Medicaid as a rental only. For these items, a monthly rental will be allowed as long as the recipient continues to meet all qualifications and requirements, and the recipient continues to use the device.

b. For this option, the DMEPOS supplier retains ownership of the equipment, regardless of the length of rental. As the owner, the DMEPOS supplier is responsible to ensure the equipment remains in safe working condition for the reasonable useful lifetime of the device. The rental rates include all supplies and accessories, repairs including routine and non-routine maintenance and servicing, and replacement of items when needed.

B. PURCHASE

1. Purchase New Equipment Option:

a. Certain products are identified by Nevada Medicaid in the DMEPOS Fee Schedule with a purchase option for new equipment, or can only be purchased, such as disposable supplies and custom-made items which can only be used by that recipient. These will be considered for purchase when, in addition to all other requirements and qualifications for a specific item/device:

1. the anticipated length of need (per physician's order) is long term (more than six months); and

2. the provider will be supplying a new device/item to the recipient; or

3. the item is only available for purchase.

2. Purchase Rental Equipment Option:

a. Nevada Medicaid identifies specific products for purchase when an item was new at the time it was dispensed to a recipient for rental purposes, and prior to billing the third month of rental, if it is determined the item will be needed indefinitely, the DHCFP may purchase the item for the recipient for ongoing use. The DHCFP does not purchase used equipment from the provider's inventory of rental items used for re-issuance to same or multiple persons over time (rental fleets, etc.).

b. The DHCFP will only purchase equipment when, in addition to all other requirements and qualifications for the item:

1. the recipient meets the criteria for purchase of new equipment;

2. the item was new when placed in the recipient's use and has been used for less than three months; and

3. the item is currently being used by the same recipient during a trial period and it has been determined the length of need will now be indefinite.

c. A prior authorization must be submitted to request purchase of a rented piece of equipment with all supportive medical documentation to show the date the item was initially issued to the recipient and that the recipient continues to have an ongoing need for the item.

1303.4 PRIOR AUTHORIZATION

A. Prior authorization is a review conducted by the Quality Improvement Organization (QIO)-like vendor's medical professionals who review the prior authorization form and any additional information submitted to evaluate medical necessity, appropriateness, location of service and compliance with the DHCFP's policy, prior to delivery of service. Reference MSM Chapter 100 and the general Billing Manual for detailed information on prior authorizations and Medicaid eligibility for all providers at: http://www.medicaid.nv.gov/providers/BillingInfo.aspx.

1. Submission:

a. Prior authorizations must be completed and submitted by a current Medicaid provider (requestor), and the approval must be received prior to delivery of services. The exception to this is if the recipient is determined eligible for Medicaid retroactively or if number four of this section applies.

b. A prior authorization is required for most durable medical equipment, prosthetics, orthotics and oxygen.

c. A Medicaid provider may submit the prior authorization electronically using the QIO-like vendor's on-line prior authorization system or may fax or mail the prior authorization to the QIO-like vendor. For more information, refer to the prior authorization section posted at: https://www.medicaid.nv.gov.

d. Requestors must submit a prior authorization with the most appropriate HCPCS code available and may not unbundle items included in the HCPCS

code description. If an item has a designated code available, the miscellaneous code cannot be used. Providers may contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor or the DME MAC for guidance on correct coding.

e. Documentation requirements are the same regardless of which mode of submission is used (e.g. the on-line prior authorization system, faxed or mailed). Documentation submitted for consideration of the request must include the physician's order and must clearly support coverage qualifications and recipient's medical need for the equipment. Failure to provide all of the supporting medical documentation in its entirety, and within the required timeframes, will result in a denial of the prior authorization request, regardless of mode of submission.

f. Unless otherwise stated in policy, a prior authorization may be submitted to request authorization to exceed established quantity limitations when the medical documentation supports medical necessity for the increased quantity or frequency.

2. Review Consideration:

a. In addition to the specifications mentioned previously for reviewing the prior authorization, products and services must be medically necessary, safe and appropriate for the course and severity of the condition using the least costly equally effective alternative to meet the recipient's needs.

b. The recipient must have a medical need for and the requested item must be suitable for use for locations in which normal life activities take place. Consideration will also be based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: attending school, work and shopping. This information must be included in the supportive documentation submitted with the prior authorization.

c. For durable medical equipment, prosthetics, orthotics and disposable medical supplies and appliances where coverage and limitation policies have not been established within this Chapter or its Appendices, the DHCFP may defer to DME MAC Jurisdiction D, Local Coverage Determination (LCD) and policy articles for coverage and limitation criteria. These can be accessed at: https://med.noridianmedicare.com/web/jddme. The item must meet the definition of durable medical equipment, prosthetic, orthotic or disposable medical supply and must be necessary to meet the medical needs of the recipient and must be part of the prescribing physician's/practitioner's Plan of Care (POC).

d. The DHCFP has the option of requesting an Independent Medical Evaluation (IME) to determine the recipient's limitations and abilities to support medical necessity.

3. Prior Authorization Requirements for Third Party Liability (TPL) and Medicare Crossovers:

a. Refer to MSM Chapter 100, for more information on TPL, and Medicare Crossovers and the requirements for securing prior authorizations.

4. Prior Authorization Emergency Situations:

a. In an emergency situation, when an order is received by the supplier after the QIO-like vendor working hours or over weekends or State holidays, dispensing of a 72-hour supply of those DMEPOS items that require prior authorization will be allowed only when:

1. A delay of 24 hours of treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self or bodily harm to others; and

2. The treating physician/practitioner indicates the most current appropriate diagnosis code(s)/ICD code on the prescription that supports the use of the emergency policy.

b. The provider/supplier must submit the prior authorization the next business day with all required supportive documentation. The documentation must include proof of the date and time the order was received by the supplier and documentation to support both 1303.4(a)(1) and (2).

5. DMEPOS Specific Prior Authorization Forms:

All forms must be completed and submitted by a current Medicaid provider. Forms used must be the most current version.

a. Specific DME prior authorization forms are found on the QIO-like vendor's website: https://www.medicaid.nv.gov/providers/forms/forms.aspx. All DMEPOS items that require prior authorization must be requested on these forms and submitted electronically, by fax or by mail to the QIO-like vendor for approval.

b. Usage Evaluation – For Continuing Use of Bi-Level and Continuous Positive Airway Pressure (BIPAP and CPAP) Devices use the form, FA-1A

found on the QIO-like vendor's website. This form may be completed and submitted for continuing usage of BIPAP or CPAP devices.

c. Mobility Assessment for Mobility Devices, Wheelchair Accessories and Seating Systems, form FA-1B found on the QIO-like vendor's website. This form must be submitted for all mobility devices, wheelchair accessories and seating systems. The Clinical Assessment must be completed and signed by the treating physician.

6. Denied Prior Authorization Requests:

a. There are various processing levels associated with prior authorization requests which do not support medical necessity. These may include but are not limited to: a contact to the provider by the QIO-like vendor, a system generated technical denial, a system generated denial or reduction of services, a provider-requested reconsideration, a provider-requested peer-to-peer review with the physician. For additional information on the below time limits and an explanation of each, refer to the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/billinginfo.aspx.

1. If a prior authorization request is denied or reduced, the provider and recipient will be sent a Notice of Decision (NOD) with a citation/reason to provide a general explanation of the denial.

a. The provider may request a peer-to-peer review within 10 days of the date of decision via phone contact to the QIO-like vendor.

b. The provider may request consideration of the denial by submitting additional medical documentation and requesting a reconsideration in writing via fax within 30 days of denial.

c. If a reconsideration is not appropriate or is also denied, the recipient may be entitled to request a hearing within 90 days from the date of decision. Refer to MSM Chapter 3100 – Hearings.

B. COVERAGE AND LIMITATIONS

1. Coverage and limitations are explained throughout this Chapter, including its appendices. Appendix B details coverage qualifications, prior authorization documentation requirements, and limitations for specific items.

2. Refer to the Nevada Medicaid Provider Type 33 – DME Fee Schedule posted at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ for covered services. The Fee Schedule identifies covered services/items (listed in alpha-numeric order according to HCPCS code), and rates. Codes are updated yearly. Codes not included in the fee schedule after the yearly update are considered non-covered.

C. PROVIDER RESPONSIBILITY

1. The requesting DME provider (supplier) and the prescribing physician/practitioner must work collaboratively to accurately and timely complete and submit prior authorization requests, including all supportive documentation in order to ensure the item(s) being requested is/are the most appropriate to meet the recipient's medical needs. This must be done prior to dispensing any DMEPOS item requiring a prior authorization. Refer to the prior authorization section of the general Billing Manual for all providers and PT 33 Billing Guidelines at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx for detailed information on form completion and submission/transmission of prior authorization requests.

2. In the event additional information is requested by the QIO-like vendor, the provider should submit the requested information within established time limits, and/or review the notice of decision to determine the reason for denial, make any necessary corrections, continue to work collaboratively with the prescribing physician/practitioner to obtain medical justification, and/or when appropriate, request a reconsideration by providing additional supportive information to justify the medical need for the equipment. Refer to the general Billing Manual for all providers for details on denied requests.

D. RECIPIENT RESPONSIBILITY

1. The recipient and/or their representative must accurately represent their needs in relationship to obtaining medical equipment.

2. The recipient must attend appointments with Physical Therapy (PT), Occupational Therapy (OT) and/or physician/ practitioners for the purpose of evaluation for DMEPOS, and with DME providers for adjustments and servicing of equipment.

3. The recipient and/or representative must provide the written order/prescription from the physician/practitioner. If assistance is needed to obtain DMEPOS, the recipient or their authorized representative should contact the local Nevada Medicaid District Office Care Coordination unit for assistance. The exception to this is if the ordering physician/practitioner submits the information directly to the DME provider/supplier on behalf of the recipient.

4. The recipient and/or their authorized representative must present proof of identity and provide documentation of Medicaid coverage and any form of identification necessary to utilize other health insurance coverage.

1303.5 DISPENSING AND DELIVERY OF DMEPOS

A. Dispensing/Duration of Orders

Medical supply orders must be dispensed at a monthly interval. DMEPOS is dispensed according to the physician's orders, subject to coverage limitations. The physician's order for medical supplies is valid up to one year. Suppliers may not ship items on a regular, monthly basis without documentation from the recipient, family member or authorized representative that the supply is needed. Documentation of this need must be kept on file. It is acceptable for the supplier to contact the recipient to verify a re-order.

B. Delivery of DMEPOS

1. Delivery Method 1. Supplier delivering items directly to the recipient or authorized representative:

   a. The delivery receipt must include the signature and the signature date which must match the date the DMEPOS item was received by the recipient or their authorized representative to verify the DMEPOS item was received.

   b. The delivery receipt must include the recipient's name, quantity, a detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable) and date and time of delivery.

   c. The date of service on the claim must be the date the DMEPOS item was received by the recipient or their authorized representative. An exception to this would be when an item must be billed using a date span and the quantity dispensed crosses over into the next month.

2. Delivery Method 2. Suppliers utilizing a delivery/shipping service to deliver items:

   a. An acceptable delivery/shipping service receipt POD includes the supplier's shipping invoice (Bill of Lading (BOL or BL)).

   b. The supplier's BOL must include the recipient's name, quantity, detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable), date and time of delivery/shipment and delivery service package identification number associated with recipient's package(s).

c. The POD must reference the recipient's package(s), delivery address and the corresponding package identification number given by the delivery service.

d. Without the POD that identifies each individual package with a unique identification number and delivery address, the item will be denied and any overpayment will be recouped.

e. Nevada Medicaid only reimburses out-of-state providers for mail order supplies for a recipient who is on Medicare and the supply is Medicare covered. Nevada Medicaid does not reimburse for shipping or delivery service costs.

1303.6 REPAIR, REPLACEMENT AND WARRANTY OF EQUIPMENT

A. REPAIR

1. Repair means to fix or mend a non-functioning part of equipment and to return damaged or worn equipment back to a safe operating condition. Repair of a base piece of equipment is appropriate when the lifetime limit of five years has not been exceeded and repair of the item is more cost effective than replacement.

2. Reimbursement to the provider may be made for repairs of recipient-owned medically necessary equipment. Medical documentation by the prescribing practitioner must be submitted to support the recipient's ongoing medical necessity for the item needing repair. Additionally, the prior authorization must substantiate use within normal life activities and the absence of inappropriate use, culpable neglect, malicious involvement or wrongful disposition on the part of the recipient, their legal representative or their caregivers. It must indicate the equipment was being used appropriately in a manner prescribed or recommended. The prior authorization and claim must include HCPCS modifier RB for all DMEPOS parts furnished as part of the repair.

3. If a recipient-owned piece of medically necessary equipment requires repairs that will take more than a day and the recipient needs the device while the repairs are being performed, the provider must submit a prior authorization to request temporary (up to one month) rental of an equivalent item which can meet the recipient's basic medical needs while the recipient-owned item is being repaired.

4. Repairs to equipment owned or rented by a DMEPOS provider or an institutional facility in which the recipient is receiving services will not be covered by Nevada Medicaid or NCU.

5. Repair HCPCS codes are not to be used for: routine serving, cleaning, installation, delivery, set-up, travel necessary to make a repair or for services covered by warranty as these costs are included in the cost of the item.

6. A re-manufactured part with a warranty used to make a repair is considered used equipment and must be billed as such, using the HCPCS modifier UE.

B. REPLACEMENT

1. Replacement of recipient-owned equipment refers to the provision of an identical or nearly identical item. Replacement may be considered on a case–by–case basis when prior authorization request substantiates the need for the replacement and is a result of either:

   a. Irreparable Wear: due to significant deterioration sustained from day-to-day use over time and a specific event (as indicated below) cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the useful lifetime limit of five years and distances or locations in which a person that is not disabled, ill or injured would not exceed for mobility purposes. The prior authorization must substantiate use within normal life activities and the absence of culpable neglect, inappropriate use, malicious involvement or wrongful disposition on the part of the recipient, their legal representative or their caregiver. Intentional utilization of DME in a manner not prescribed or recommended, such as an excessive form of transportation may be reason for denial of equipment replacement.

   b. Irreparable Damage: due to a specific accident or natural disaster (e.g., fire, flood) which resulted in irreparable damage or loss. These requests may be considered only when the prior authorization request includes a copy of a police or fire report, documentation from Federal Emergency Management Agency (FEMA), the American Red Cross or a newspaper article that indicates the recipient's residence was affected by the disaster. Police or fire reports will only be considered if filed/dated within ten business days of the loss. The prior authorization must substantiate the absence of inappropriate use, culpable neglect, malicious involvement or wrongful disposition on the part of the recipient, their legal representative or their caregiver. The prior authorization and claim must include HCPCS modifier code RA for all DMEPOS provided as a replacement. Nevada Medicaid and NCU are payers of last resource and would be secondary to any insurance claim/reimbursement. Reference MSM Chapter 100 – Medicaid Program.

2. Replacement of any recipient-owned item, regardless of how it was originally acquired, requires a new physician's/practitioner's order and the recipient must meet current qualifications for the item. Any assessment(s) necessary to support

medical necessity must have been completed within six months of the date of request.

3. Lost or stolen DMEPOS resulting from failure to maintain possession or properly secure the item is not covered by Nevada Medicaid or NCU.

C. WARRANTY

1. The purchase of many items includes a product warranty by the manufacturer and/or the DMEPOS provider. Any service (item or labor) covered by warranty cannot be billed to Nevada Medicaid or NCU, the recipient or their representative.

2. The requesting provider must obtain verification that any repairs or replacement items being requested are not covered under the existing warranty. This documentation must be submitted with the prior authorization.

1303.7 SECTION RESERVED FOR FUTURE USE

1303.8 SECTION RESERVED FOR FUTURE USE

1303.9 DME AT INSTITUTIONAL FACILITY (IF)

A. The DHCFP's hospital and nursing facility rates for an inpatient stay are all inclusive and cover all items needed by the patient during the length of stay. Refer to MSM Chapter 500 Nursing Facilities for information on nursing facility policy. This includes all:

1. Disposable supplies;

2. Wound care supplies;

3. Urological supplies;

4. Respiratory supplies;

5. Metabolic, Nutritional and Temperature supplies;

6. Endocrine supplies;

7. Fluid and Electrolyte supplies;

8. Dental supplies;

9. Emollient supplies; and

10. Supplements.

B. Prosthetics and Orthotics

Prosthetics and Orthotics: Are included in the all-inclusive per-diem if provided to a patient during an inpatient hospital prior to discharge and the patient uses item for medically necessary inpatient treatment or rehabilitation. (e.g. after spinal surgery).

C. DME that cannot be utilized by another recipient due to its unique custom features (e.g. seating system), are not part of the institution's inclusive rate.

1. All DME must be prior authorized for exception to inclusive facility rates.

2. Hospital and nursing facility patients may be approved for wheelchairs in preparation for discharge. The DHCFP may approve power chairs one month in advance of discharge. Physician documentation to substantiate discharge date may be required.

3.

1303.10 SECTION RESERVED FOR FUTURE USE

1303.11 SECTION RESERVED FOR FUTURE USE

1303.12 SECTION RESERVED FOR FUTURE USE

1303.13 SECTION RESERVED FOR FUTURE USE

1303.14 SECTION RESERVED FOR FUTURE USE

1303.15 UTILIZATION CONTROL

A. Pre-Service

The coverage, limitations and exclusions outlined in this chapter constitute pre-service controls on over-utilization.

B. Pre-Payment

The QIO-like vendor will screen each claim for existence and/or application of prior resources, correct coding of services and appropriate authorization form. In addition, each

claim will be screened for accuracy in computation and compliance with published procedures.

C. Post-Payment

All providers offering services to Medicaid recipients are subject to post-payment review. The Medicaid Program Integrity Section is responsible for review of any improper, abusive or fraudulent practices. Definition of abuse and the sanctions to be imposed are delineated in the Nevada MSM Chapter 100.

1304 HEARINGS

Please reference the Division of Health Care Financing and Policy (DHCFP) Medicaid Services Manual (MSM) Chapter 3100 for the Medicaid Hearings process

APPENDIX A

NON-COVERED SERVICES

1. The DHCFP's DMEPOS program does not cover items if they either do not meet the definition of durable medical equipment, prosthetic, orthotic or disposable medical supplies; or are not considered primarily medical in nature; or are not FDA approved or the approved use by the FDA is not applicable.

2. The DHCFP has the authority to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396(a)) based on such criteria as medical necessity or utilization control (42 CFR 440.230 (d)). The DHCFP has an approved list of covered DMEPOS items. The Provider Type 33 – DMEPOS Fee Schedule is available on the DHCFP website at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

    a. The DHCFP is required to have a process and criteria for seeking modifications or exceptions to established coverage policies. This process is available to recipients on a case-by-case basis for DMEPOS items excluded from the DMEPOS Fee Schedule. Because a provider prescribes, orders and/or recommends a service or supply does not, of itself, make it an eligible benefit.

    b. Consideration will be made on a case-by-case basis using the following criteria:

        1. The item must meet the definition of durable medical equipment, prosthetic, orthotic or disposable medical supply as defined in Section 1302 – the Addendum Medicaid Services Manual (MSM) Definitions;

        2. The prescribing physician/practitioner must submit supporting documentation identifying the individual's specific medical needs that meet the standard definition of medical necessity as defined in MSM Chapter 100 (e.g. physical assessment indicating the limitations to be ameliorated by the use of the item(s), peer review documentation indicating this is an accepted standard of care within Nevada's medical community); and

        3. The prescribing physician/practitioner must document that other items have been used and were found ineffective. The requested item(s) must be the most cost-effective alternative, medically necessary service, provided at the most appropriate level to meet the medical needs of the recipient, that it is reasonable and accessible to the recipient.

    c. Review chapter and fee schedule for coverage. If not located under this provider type but possibly might be covered under other programs i.e.: EPSDT, nursing home, etc. please review the coverage criteria and fee schedule for that specific provider type.

Policy: INTRODUCTION AND GENERAL INFORMATION

Introduction

1. Appendix B is a supplement to the main body of Chapter 1300 and provides: specific coverage qualifications, forms and documentation requirements, and miscellaneous policies related to specific items of durable medical equipment, prosthetic devices, orthotic devices or disposable medical supplies (DMEPOS).
2. For DMEPOS where coverage and limitations have not been addressed in this Chapter, its Appendices or the DMEPOS Fee Schedule, the Division of Health Care Financing and Policy (DHCFP) may defer to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction D, Local Coverage Determinations (LCD) and Policy Articles for coverage and limitations information. This information is available at https://www.noridianmedicare.com.

QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
1. Qualifications identified for each specific item listed within this Appendix must all be met for coverage by the DHCFP. 2. All DMEPOS products and services must be medically necessary, safe and appropriate for the course and severity of the condition, using the least costly equally effective alternative to meet the recipient's medical needs. 3. If all qualifications are not met, refer to Appendix A for other possible coverage options.	1. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional form completion requirements are found in the Form Release Memorandums or Instructions on the QIO-like vendor's website at: http://www.medicaid.nv.gov/providers/forms/forms.aspx 2. All documentation, reports, evaluations and testing must support medical necessity as specified under the Qualifications section. Requirements must be met for each specific item listed within this Appendix and as specified for that item. a. Physician's/Practitioner's Order/Prescription. b. Prior authorization form (when indicated) - Durable Medical Equipment Prior Authorization Forms are available on the QIO-like vendor's website at the above link. There are specific forms for certain items of DMEPOS. Refer to policies to determine if a specific form is required. Prior authorization is required to exceed program limitations. c. All services provided in an institutional facility require a prior authorization. d. Detailed Product Description. e. Proof of Delivery. f. Additional Miscellaneous Medical Records. g. Manufacturer's Suggested Retail Price (MSRP) Invoice (to determine pricing) for certain items, where the DHCFP rate has not been established.	Refer to the main body of Chapter 1300 for general DMEPOS policies. 1. For all items, documentation must support all criteria in the Qualifications section, as specified in each category. 2. Providers must submit an approved prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description. 3. Rented devices are to be considered purchased by the DHCFP once the purchase price has been reached. The exception to this is when the item is deemed as a rental only by the DHCFP. Refer to main body of Chapter 1300 and the DMEPOS Fee Schedule. 4. Inclusion of a HCPCS code in this Appendix is not an indication of coverage. Refer to the DMEPOS Fee Schedule and Appendix A. 5. The DHCFP will not reimburse providers who supply DMEPOS prior to PA approval except in certain situations, such as retro eligibility.

Policy: BATHING AND TOILETING AIDS			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	
Commodes-standard **Commode pail** **Toilet Safety Frame-(versaframe)** **Raised Toilet Seat** **Bed Pan-plastic** **Urinal**	1. Medical evidence/ documentation recipient is physically incapable of utilizing regular toilet facilities; and 2. Recipient has a supporting diagnosis.	1. Physician's/Practitioner's Order/Prescription.	
Shower Chairs (with back and without back) **Tub Transfer Bench (padded and non-padded)**	1. Recipient shows medical evidence/ documentation of incapability to utilize regular bathing facilities; and 2. Recipient has a supporting diagnosis.	1. Physician's/Practitioner's Order/Prescription.	

Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Fixed Height Hospital Bed	Medical evidence/documentation showing: 1. Recipient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition lasting at least one month; 2. Alleviation of pain due to positioning of the body in ways not feasible with an ordinary bed; 3. Elevation of the head more than 30 degrees due to a medical condition, i.e.: Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), aspiration problems.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	**NOTE:** **Total Electric Hospital Beds**; the electric height adjustment feature is typically a convenience feature. **Safety Beds/Enclosure Beds/Canopy** are primarily intended for prevention of injury and use is not primarily medical in nature. Per policy, medically necessary services and supplies are medically needed to diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. Although these beds may prevent injury, they are not considered **care or treatment** of disease or injury.
Variable Height Hospital Bed (Manual)	Recipient meets the criteria for Fixed Height Bed and requires a bed height different than a fixed height bed to permit transfers to chair, wheelchair or standing position.		
Semi-Electric Hospital Bed	Recipient meets the criteria for a Fixed Height Bed and requires frequent changes in body position and/or has an immediate need for a change in body position.		
Heavy Duty Extra Wide Hospital Bed	Recipient meets the criteria for a Fixed Height Hospital Bed and the recipient's weight is more than 350 pounds, but does not exceed 600 pounds.		
Extra Heavy Duty Hospital Bed	Recipient meets the criteria for a hospital bed and the recipient's weight exceeds 600 pounds.		

Policy: BEDS (HOSPITAL) AND ACCESSORIES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Trapeze Bars	1. Medical evidence/documentation recipient needs assistance to sit up due to respiratory conditions, change body positions or to assist in transfers in/out of bed.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	
Lifts and Lift Slings	1. Medical evidence/documentation showing the recipient requires more than one person in assisting in transfers from bed/bath, bed/commode or bed/chair. 2. Must have an environment able to accommodate equipment. 3. Capable caregiver to assist with transfers.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	
Group 1 Support Surfaces	Recipient must meet the following criteria: 1. Completely immobile (recipient cannot make changes in body position without assistance); 2. Limited mobility (recipient cannot independently make changes in body position significant enough to alleviate pressure); or 3. Any stage pressure ulcer on the trunk or pelvis; and a) At least one of the following: i) Impaired nutritional status; ii) Fecal or urinary incontinence; iii) Altered sensory perception; iv) Compromised circulatory status.	1. Prescription and/or MD signed PA Form. 2. Medical documentation supporting qualifying factors.	Product needs to be adequate enough to prevent the recipient from bottoming out.

Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Pressure Pad for Mattress: Non-Powered Pressure Reducing Mattress Overlays	(E0185) Gel/gel-like mattress overlay, with gel layer 2 inches or greater (E0197) Air mattress overlay interconnected air cells having a cell height of three inches or greater that are inflated with an air pump. (E0198) Water mattress overlay with a filled height of three inches or greater. (E0199) Foam mattress overlay with base thickness of two inches or greater and a peak height of three inches or greater if it is a convoluted overlay (egg-crate) or an overall height of at least three inches if it is a non-convoluted overlay. Foam with a density and other qualities that provide adequate pressure reduction, and durable waterproof cover. 1. Recipient must meet Group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	
Non-Powered Pressure Reducing Mattress	(E0184) Foam height of five inches or greater, and foam with a density and other qualities that provide adequate pressure reduction, and can be placed directly on a hospital bed frame. (E0186, E0187, E0196) Air, water or gel mattress, height of five inches or greater of the air, water or gel layer (retrospectively), and durable, waterproof cover and can be placed directly on a hospital bed frame. 1. Recipient must meet Group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	

Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Powered Pressure Reducing Mattress Overlay Systems	(E0181, E0182, A4640) Alternating pressure or low air loss systems; Air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for APP overlays) and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out. Recipient must meet Group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	
Group 2 Support Surfaces	Recipient must meet the following criteria: 1. Multiple stage II pressure ulcers located on the trunk or pelvis; 2. Recipient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface. a. Treatment includes patient/caregiver education, regular assessment by a licensed healthcare practitioner, appropriate turning and positioning, appropriate wound care, appropriate management of moisture/incontinence, nutritional assessment and intervention consistent with the overall plan of care; and 3. Ulcers have worsened or remained the same over the past month; OR 4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis; OR 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	

Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Group 2 Support Surfaces**	within the past 60 days); and 6. Recipient has been on a Group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).		
Powered Pressure Reducing Mattress	(E0277) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, inflated cell height of the air cells through which air is being circulated is five inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out and surface designed to reduce friction and shear. Can be placed directly on a hospital bed frame. (E0193) Describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics previously defined. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	
Non-Powered Pressure Reducing Mattress Overlay	(E0371) Height and design of individual cells which provide significantly more pressure reduction than a Group 1 overlay and prevents bottoming out, and total height of three inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 surfaces. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	

Policy: BEDS (HOSPITAL) AND ACCESSORIES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Powered Pressure Reducing Mattress Overlay	(E0372) Low air loss, powered flotation without low air loss or alternating pressure which is characterized by all of the following: Air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	
Advanced Non-Powered Pressure Reducing Mattress	(E0373) Height and design of individual cells which provide significantly more pressure reduction than a Group 1 mattress and prevents bottoming out, and total height of five inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces, and can be placed directly on a hospital bed frame. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	
Group 3 Air-fluidized Bed	(E0194) Device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid. 1. Recipient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore; 2. Is bedridden or chair bound as a result of severely limited mobility; 3. In the absence of an air fluidized bed, the recipient would require institutionalization;	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. An MSRP Invoice if there is no rate established by the DHCFP.	

Policy: BEDS (HOSPITAL) AND ACCESSORIES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Group 3 Air-fluidized Bed**	4. Ordered in writing by recipient's attending physician after comprehensive assessment and evaluation after completion of conservative treatment. Evaluation performed within one month prior to indication of therapy with air fluidized bed; 5. Conservative treatment must have been at least one month in duration without progression toward wound healing. Treatment should include: a. Frequent repositioning of recipient (usually every two hours); b. Use of Group 2 support surface; c. Necessary treatment to resolve any wound infection; d. Optimization of nutrition status to promote wound healing; e. Debridement by any means, including wet-to-dry gauze dressings to remove devitalized tissue from the wound bed; f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering while the wound heals; g. Education of the recipient and caregiver on the prevention and management of pressure ulcers; h. Assessment by a physician, nurse or other licensed healthcare practitioner at least weekly; and i. Appropriate management of moisture /incontinence.		

Policy: BEDS (HOSPITAL) AND ACCESSORIES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Group 3 Air-fluidized Bed**	6. Trained adult caregiver is available to assist the recipient with ADL's, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management and support of the air-fluidized bed system and its problems such as leakage; 7. A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; and 8. All other equipment has been considered and ruled out.		

Policy: COMMUNICATION DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Speech Generating Device (SGD) *(also known as Augmentative Communication Device (ACD) or Augmentative and Alternative Communication (AAC) Device* **(E2500 – E2510)** **Digitized Speech Devices: (E2500, E2502, E2504, E2506)** **Synthesized Speech Devices: (E2508, E2510)**	1. A dedicated speech generating device (SGD) may be covered when it is medically necessary to restore the function of speech to an individual with a functional disability caused by a long term (lasting more than one year) and severe speech impairment; and 2. When **all** of the following are met: a. The recipient has had a formal written evaluation of their cognitive and communication abilities by a speech-language pathologist (SLP) which contains all of the items specified in the Forms/Documentation column; b. The recipient's medical condition is one resulting in a long term (lasting more than one year) and severe expressive speech impairment; c. The recipient's speaking needs cannot be met using natural communication methods; d. Other forms of treatment have been considered and ruled out; e. The recipient's speech impairment will benefit from the device ordered; and f. A copy of the SLP's written evaluation and recommendation was forwarded to the recipient's treating physician/ practitioner and the prescribing physician/ practitioner agreed with, and ordered the specific device and accessories as recommended.	1. Physician's/Practitioner's Order/Prescription. 2. Prior Authorization. 3. Detailed Product Description. 4. Additional Miscellaneous Medical Records (if needed); and: 5. Speech and Language Pathologist (SLP)'s formal written evaluation which includes, at a minimum, all of the following: a. Current communication impairment, including the type, severity, language skills, cognitive ability and anticipated course of the impairment; b. An assessment of whether the recipient's daily communication needs could be met using other natural modes of communication or with low-technology devices; c. A description of the functional communication goals expected to be achieved and treatment options; d. Rationale for selection of a specific device and any accessories; e. Demonstration that the recipient possesses a treatment plan that includes a training schedule for the selected device; f. The cognitive and physical abilities to effectively use the selected device and any accessories to communicate; and g. An attestation statement from the SLP performing the recipient evaluation and/or recommending the product(s) indicating they are not an employee of,	1. For all items, documentation must support all criteria in the Qualifications section. 2. Providers must submit prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description. 3. Codes E2500 – E2510 perform the same essential function - speech generation and may not be issued in conjunction with E2511. 4. Code E2511 – SGD software program for Personal Computers (PC) or Personal Digital Assistant (PDA) may not be issued in conjunction with E2500 – E2510. 5. Computer-based and PDA-based AAC devices/speech generating devices are covered when they have been modified to run only AAC software and will not be reimbursed in conjunction with another SGD. Laptop computers, desktop computers, personal digital assistants (PDAs), tablets or other devices that are not dedicated SGDs do not meet the definition of durable medical equipment (DME). 6. Expected lifespan of SGD E2500-E2510 or E2511 is considered 60 months and are limited accordingly. Replacement equipment may be authorized prior to the 60 months based on medical necessity.

Policy: COMMUNICATION DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Speech Generating Device (SGD)**		and have no financial relationship with the supplier/manufacturer of the SGD. h. For a subsequent upgrade to a previously issued SGD, documentation must support the medical necessity regarding the functional benefit to the recipient of the upgrade compared to the initially provided SGD. i. SLP evaluations and recommendations should consider recipient's needs both at present and over the useful lifespan of the device being recommended. 6. Prior authorizations for synthesized speech output SGDs and digitized speech output SGDs with dynamic displays must include the software required for operation of the device. Any requests for supplemental software for a synthesized speech output SGD must be established as specifically medically necessary. 7. Prior authorizations for digitized speech output SGDs with static displays must identify the symbol set that will be used to operate the device. 8. For all products and accessories, the MSRP Invoice which includes: name of product, make, model, HCPCS code and cost.	The recipient's condition and product performance will be taken into review. 7. Refer to Section 1303.4 for exceptions to quantity and frequency limitations. Refer to Section 1303.6 for policy regarding lost, stolen, or damaged equipment. 8. Reimbursement for Codes E2500, E2502, E2504, E2506, E2508 and E2510 is intended to include all applicable software programs (whether they are on the device when shipped by the manufacturer or added by the supplier prior to delivery) necessary to render the device operational, batteries, battery chargers and AC adapters and a carrying case. These items may not be billed separately at the time of initial issuance. 9. Non-integrated keyboards provided with an SGD are not separately reimbursable. 10. One symbol set may be billed separately using Code E2599. <u>Device Descriptions</u>: 1. Digitized speech devices, sometimes referred to as devices with "whole message" speech output, utilize words or phrases that have been recorded by an individual other than the SGD user for playback upon command of the SGD user. 2. Synthesized speech devices translate a user's input into device-generated speech. Users of synthesized speech SGDs are not limited to pre-recorded messages but rather can independently create messages as their communication needs dictate.

Policy: COMMUNICATION DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Speech Generating Device (SGD)**			3. Devices that have the capability to generate both digitized and synthesized speech are coded as E2508 or E2510, depending on the method of synthesized speech formulation and device access. 4. E2508 devices require that the user make physical contact with a keyboard, touch screen or other display containing letters. 5. E2510 devices permit the user multiple methods of message formulation and multiple methods of device access. a. Multiple methods of message formulation must include the capability for message selection by two or more of the following methods: letters, words, pictures or symbols. b. Multiple methods of access must include the capability to access the device by two or more of the following: direct physical contact with a keyboard or touch screen, indirect selection techniques with a specialized access device such as a joystick, head mouse, optical head pointer, switch, light pointer, infrared pointer, scanning device or Morse Code.
Speech Generating Device (SGD) Accessories (E2599)	1. Accessories (E2599) for E2500 – E2510 may be covered if the basic coverage qualifications previously described for the base device are met and medical necessity for each accessory is clearly documented in the formal evaluation by the SLP and ordered by the physician/practitioner.	1. As previously described for SGD.	

Policy: COMMUNICATION DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Speech Generating Software Programs for Personal Computer (PC) or Personal Digital Assistant (PDA) (E2511)	1. All of the previously described qualifications for a Speech Generating Device are met; and 2. The recipient currently owns the PC or PDA to which the software will be applied to enable the device to function as a Speech Generating Device (SGD).	1. As previously described for SGD. 2. An MSRP Invoice if there is no rate established by the DHCFP.	1. Installation of the software program or technical support that enables a recipient-owned laptop computer, desktop computer or PDA to function as an SGD is included in the cost of the software program, therefore is not separately reimbursable. 2. Medically necessary upgrades to speech generating devices and/or software programs may be reimbursed 60 months after the month of initial issuance of the device. 3. Repairs to, or replacement of recipient-owned equipment (PC and PDA) is not reimbursable.
Access Device (E2599) *(such as, but not limited to: optical head pointers, joysticks, switches and scanning devices)*	1. All of the previously described qualifications for a Speech Generating Device (SGD) are met; and 2. The access device has been determined to be medically necessary.	1. Documentation by a licensed medical professional, such as a physician, speech-language pathologist or physical therapist, which supports the medical necessity for the requested access device. 2. An MSRP Invoice if there is no rate established by the DHCFP.	1. An access device enables the selection of letters, words or symbols via direct or indirect selection techniques. 2. Any components such as software programs, interfaces, cables, adapters, interconnects or switches necessary for the access device to interface with the SGD should be included in the charge for the access device itself and is therefore not separately reimbursable.
Electronic Components (E2599)	1. All of the previously described qualifications for a Speech Generating Device (SGD) are met; and 2. The electronic components are necessary to allow the SGD to be operated by the drive control interface of a power wheelchair.	1. Documentation must include that the recipient requires the use of a power wheelchair and must address the recipient's ability to operate the SGD from the power wheelchair. 2. An MSRP Invoice if there is no rate established by the DHCFP.	

Policy: COMMUNICATION DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
SGD Mounting Systems (E2512)	1. All of the previously described qualifications for a Speech Generating Device are met; and 2. The accessories are needed to place the SGD, switches or other access devices within the reach of the recipient.	1. Documentation supporting medical necessity for the mounting system and that the recipient has a medical need for, and owns the device to which the SGD is to be mounted.	
SGD Batteries, Battery Chargers, and AC Adapters	1. All of the previously described qualifications for a Speech Generating Device are met; and 2. The accessories are needed to replace an SGD battery, a battery charger or AC adapter that was provided with initial issuance of the SGD and is no longer functioning.		
SGD Carrying Case	1. All of the previously described qualifications for a Speech Generating Device are met; and 2. A carrying case may be paid separately with the initial issuance of an SGD when it would be charged separately to the general public or to the primary insurer; or 3. Replacement is needed to protect a medically necessary device due to wear and tear; no more frequently than one unit per calendar year.		

Policy: DIABETIC SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
External Ambulatory Infusion Pump, Insulin (E0784)	Covered ICD codes: Diabetes Mellitus Gestational Diabetes All of the following conditions must be met: 1. Fasting serum C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method or as an alternative must be beta cell autoantibody positive. 2. Recipient has completed a comprehensive diabetic education program within the last year. 3. Recipient is motivated to achieve and maintain improved glycemic control. 4. Recipient has been on a program of multiple daily injections of insulin (e.g., at least three injections per day), with frequent self-adjustments of insulin doses for at least six months prior to request for the insulin pump. 5. Documented frequency of glucose self-testing is an average of at least four times per day during the two months prior to starting the insulin pump. 6. Glycosylated hemoglobin level (HbA1C) > 7.0% In addition, one or more of the following indications must be present: 1. History of recurring hypoglycemia; 2. Wide fluctuations in blood glucose before mealtime (e.g., preprandial blood glucose level commonly exceeds 140 mg/dl; 3. Dawn phenomenon with fasting blood sugars frequently >200 ml/dl;	1. A prescription from a physician who manages recipients with insulin pumps and who works closely with a team including nurses, diabetes educators and dietitians. 2. Prior authorization is required for the insulin pump with all of the following documentation: a. Certification of Diabetic Education Class with first time request. b. Signed statement from the physician acknowledging medical necessity and the following: 1. Recipient is motivated to achieve and maintain improved glycolic control, indicated by showing documented finger sticks (at least four times per day) with multiple injections. 2. Recipient has been on a program of multiple injections of insulin (at least three times per day) with frequent self- adjustment of insulin doses at least six months prior to initiation of the insulin pump. 3. Cognitive ability to operate pump and calculate insulin dosages. 3. Qualifying lab results per qualifications. 4. Physician current history and physical including one or more of the additional indications listed in the qualification column. 5. Documentation requirements for recipients using the insulin pump prior to Medicaid eligibility requires a PA with the following documentation: a. A HbA1C level (within last 60 days). b. Signed narrative from the physician documenting the recipient's compliance.	1. External ambulatory infusion pump recipients with Gestational Diabetes whom do not meet conditions one through six but do meet qualifications under Gestational Diabetes approval of the insulin pump will be on a rental basis until the end of the pregnancy. 2. Insulin Pump-related Supplies through the DMEPOS program: E0784 - External Ambulatory Infusion pump, Insulin A4230 - Infusion set for external pump, non-needle cannula type A4231 - Infusion set for external pump, needle type A4232 - Syringe with needle for external insulin pump, sterile, 3cc Note: Available under DHCFP Pharmacy Program, billed through point of sale (POS).

Policy: DIABETIC SERVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **External Ambulatory Infusion Pump, Insulin (E0784)**	4. Extreme insulin sensitivity; or 5. Gestational diabetes or when pregnancy occurs or is anticipated within three months in a previously diagnosed diabetic with ANY of the following indications: a. Erratic blood sugars in spite of maximal recipient compliance and split dosing; or b. Other evidence that adequate control is not being achieved. Qualifications for recipients on the external ambulatory infusion pump prior to Medicaid eligibility: 1. A Glycosylated hemoglobin level (HbA1C) within the last 60 days. 2. Recipient has been compliant with using the insulin pump and has the ability of self-adjusting the insulin pump according to glucose levels.	and ability to self adjust the insulin pump according to glucose levels. 6. An MSRP Invoice if there is no rate established by the DHCFP.	
Diabetic Equipment and Supplies		1. Physician's/Practitioner's Order / Prescription	1. Diabetic shoes, fitting, and modification A5500 – A5507, A5512 – A5513 2. Diabetic equipment and supplies, such as Glucometers, Test strips, Lancet Device, Lancets, Insulin syringes for self-injection, Insulin systems and Continuous Glucose Monitors are not covered under the DHCFP's DME program. These items are covered under the DHCFP's pharmacy program and must be billed through the Point of Sale (POS). Refer to MSM Chapter 1200, Pharmacy Services.

Policy: DISPOSABLE SUPPLIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Disposable Incontinent Supplies	1. Disposable briefs/diapers, pull-ons/protective underwear, liners/ shields/ guards/ pads/ undergarments and underpads may be covered for individuals age four years and older with a medical diagnosis (1) of a neurological or neuromuscular disorder or other diagnosis of a medical condition that causes urinary or bowel incontinence, and (2) a diagnosis of urinary and/or bowel incontinence. 2. Diagnoses must be supported by medical documentation which includes other recent (within past six months) interventions used to treat or ameliorate the incontinence, such as but not limited to a bowel and bladder training/retraining program, other toileting programs, exercise and strengthening regimens. 3. The individual's weight, waist/girth measurements and belt-to-belt measurements must be consistent with manufacture's recommendations for the sizing of their products. 4. Recipients with waist size greater than 60 inches may be considered for Bariatric size briefs/diapers. 5. Individuals under four years of age must have a diagnosis of Human Immune Deficiency Virus (HIV) positive or Acquired Immune Deficiency Syndrome (AIDS) with an accompanying gastrointestinal abnormality causing frequent or intractable diarrhea which is documented by the prescribing practitioner.	1. A physician's order. In addition to other requirements for written orders, the prescriber must indicate on the written order all of the following: a. Diagnosis of medical condition causing incontinence with a diagnosis of urinary and/or bowel incontinence; b. The specific item (diaper/brief, pull-on, liner/ shield/ guard/ pad, underpads) and the order must specify the recipient's measurements for the ordered item; c. Frequency of replacement and/or changes needed and monthly quantity of each item to be dispensed; d. The size of the item to be dispensed including the individual's current weight, waist/girth and belt to belt measurements to support the size of product needed. The size of the product supplied must be consistent with the manufacturer's recommendation for their product. 2. Documentation of other interventions tried or currently in progress to treat or ameliorate the incontinence. 3. Documentation must be included in the medical record and must be part of the treatment plan for the individual. The supplier must retain copies of all supporting documentation for audits. 4. Prior authorization is always required for code T4543, Bariatric size brief/diapers or to exceed established quantity limitations, or for ages less than four years old.	1. Use of diapers and related products for individuals under the age of four years are considered age appropriate and are non-covered, unless the individual meets the qualifications and the order was a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening. These would require prior authorization. 2. Refer to the DMEPOS Fee Schedule. Prior authorization may be submitted to exceed established limits for these products when medical documentation clearly indicates a greater quantity is medically necessary. 3. Use of multiple types of briefs, diapers, pull-ons or protective underwear in any size combination cannot exceed the maximum limit (either 100 units or 186 units per month depending on the item) without PA. Liners, shields, guards, pads and underpads in any combination cannot exceed the maximum limit of 100 units per month without prior authorization and may be in addition to diapers, briefs, pull-ons or protective underwear. 4. Gloves, sterile or non-sterile and disposable wipes/washcloths are not considered medically necessary for use with incontinence care and are non-covered. 5. Underpads used for tube feedings or other procedures not related to incontinence are

Policy: DISPOSABLE SUPPLIES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Disposable Incontinent Supplies**			considered convenience items. 6. Any products used for menses are non-covered items. Note: Failure of the provider to maintain required documentation could result in post-payment recoupment of monies paid.

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
MAE General Information ***(pertains to all items in this policy section)***	The qualifications identified in this "general information" section must all be met for any items included in this policy section. Each specific item may also have additional qualifications listed further in this appendix that must be met. Items may be covered if all of the following qualifications are met: 1. The recipient has a mobility limitation that significantly impairs his/her ability to participate in one or more Mobility-Related Activities of Daily Living (MRADL) performed in the home and in each of the environments the recipient is likely to encounter in their daily routines, such as but not limited to: attending school, work and shopping. The MRADLs to be considered in this and all other statements in this policy are: toileting, grooming, bathing, dressing, eating and transferring. **Note:** A mobility limitation is one that: a. Prevents the recipient from accomplishing the MRADL entirely; b. Places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or c. Prevents the recipient from completing the mobility-related Activities of Daily Living (ADL) within a reasonable time frame. 2. All required assessments, evaluations and physician/practitioner's orders as indicated	The forms and specifications as described in this "general information" section pertain to all MAE items. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional completion requirements are found in the Form Release Memorandums/Instructions for the Division's forms on the following website: https://www.medicaid.nv.gov/providers/forms/forms.aspx Each specific item may also have additional form requirements and specifications listed further that must be met. 1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization forms found on the QIO-like vendor's website (when indicated) refer to the DMEPOS Fee Schedule to determine need for a prior authorization for each item. **Note**: For items that require prior authorization and have a Nevada Medicaid assigned rate of less than $500.00, use the DME Prior Authorization, Form FA-1; for items with a Nevada Medicaid assigned rate of $500.00 or more, the Mobility Assessment and Prior Authorization Form, FA-1B is required. 3. An MSPR Invoice if there is no rate established by the DHCFP. 4. Detailed Product Description. 5. Proof of Delivery. 6. Additional Miscellaneous Medical Records.	Refer to the main body of MSM Chapter 1300 for general DMEPOS policies. The comments/policy statements identified in this "general information" section pertain to all MAE items. **Note**: Special attention to MSM Section 1303.6 Repair, Replacement and Warranty of Equipment section of chapter. 1. For all MAE items, documentation must support all criteria in the Qualifications section, as specified in each category. a. All rented mobility devices are to be considered purchased by the DHCFP once the purchase price is reached. b. Providers must submit prior authorization and claim with the most appropriate HCPCS code and may not unbundle items included in the HCPCS code description. c. Inclusion of a HCPCS code in this policy section is not an indication of coverage. Refer to the DMEPOS Fee Schedule. d. The recipient must have a medical need within the locations of normal life activities for the requested item. In addition, consideration will include: 1. recipient's medical needs; 2. use of the item; and 3. the conditions in each of the environments the recipient is likely to encounter in their daily

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **MAE General Information** ***(pertains to all items in this policy section)***	throughout this section were completed within the required time limits.		routines, such as, but not limited to: a. attending school; b. work; and c. shopping. This information must be included in the supportive documentation submitted with the prior authorization.
Canes and Crutches **Cane Accessories** **Crutch Accessories**	1. The MAE General Qualifications are met and the recipient: a. has a medical condition causing impaired ambulation and there is a potential for ambulation; b. is able to safely use the cane or crutches; and c. has functional mobility deficit that can be sufficiently resolved by use of the item.	1. Physician's/Practitioner's Order/Prescription.	1. Cane and/or crutch accessory items may be provided as replacement items for recipient-owned MAE. When the cane or crutch HCPCS description includes the accessory item, these items cannot be billed separately with the initial purchase.
Crutch Substitute, Lower Leg Platform, With or Without Wheels (E0118)	1. The MAE General Qualifications are met and the recipient: a. has a below-the-knee injury and/or surgery causing impaired ambulation and there is a potential for ambulation; b. is medically unable to safely use a cane(s), standard crutches, a walker or a wheelchair; c. has functional mobility deficit that can be sufficiently resolved by use of the item; and d. (self) or care giver is not requesting the device for convenience.	1. Physician's/Practitioner's Order/Prescription. 2. Prior Authorization. 3. The additional medical documentation by the prescribing physician/practitioner, submitted with the prior authorization, must indicate why the recipient is not able to use an alternative, more cost-effective mobility device, such as: cane(s), crutches, walker or a wheelchair.	
Walkers **Walker Accessories**	1. If the MAE General Qualifications are met, a standard walker may be covered if the recipient:	1. Physician's/Practitioner's Order/Prescription. 2. Prior Authorization, when indicated. 3. A heavy-duty walker requires a prior authorization to verify weight.	All from General Information Miscellaneous Policy Statement section; and

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Walkers** **Walker Accessories**	a. is *unable* to safely use appropriately fitted canes or crutches to resolve functional mobility deficits; and b. is *able* to safely use the walker; and c. has functional mobility deficit that can be sufficiently resolved with use of a walker. 1. In addition to #1 and #2 in the MAE General Information Qualification section and #1 of this section, a heavy-duty walker may be covered if the recipient's weight is greater than 300 pounds.		1. Walker accessory items may be provided as replacement items for recipient-owned MAE. When the walker HCPCS description includes the accessory item, these items cannot be billed separately with the initial purchase.
Gait Trainers	1. EPSDT only. 2. Mobility Assistive Device for moderate to maximum support for walking. 3. Functional mobility deficit cannot be resolved using a walker.	1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization documenting recipient's inability to utilize a standard or reverse walker and how the gait trainer will meet the recipient's needs. 3. Must demonstrate the capability of independently walking with the use of a gait trainer. 4. An MSRP Invoice if there is no rate established by the DHCFP.	Note: Rehab equipment and physical/ occupational therapy equipment for home use is not covered under the DME benefit. Please review policies applicable to therapies and rehabilitation.
Wheelchairs *(pertains to all wheelchair types – manual and power)*	1. In addition to the MAE General Qualification section, a wheelchair may be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches or a walker; and 2. The recipient meets the specific qualifications listed further in this section for the type of wheelchair being requested. The recipient must have a medical need for, and the requested item must be suitable for use in the home and other locations the recipient is likely to encounter in their normal life activities, in accordance with 42 CFR	All from MAE General Qualification section; and 1. Mobility Assessment form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300. 2. An MSRP Invoice if there is no rate established by the DHCFP.	1. Medicaid allows only one wheelchair at a time. Backup chairs are denied as a duplicate benefit. For all Medicare/Medicaid dual eligible recipients, Medicaid is payer of last resort. Therefore, any MAE that qualifies as an Advanced Determination of Medicare Coverage (ADMC) item must be submitted to Medicare prior to requesting approval by Medicaid. After the ADMC decision is received from Medicare, provider/supplier must submit a copy of the ADMC written

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Wheelchairs** *(pertains to all wheelchair types – manual and power)*	440.70(b)(3). Consideration for prior authorization is also based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines.		decision by Medicare with the prior authorization. 3. Reimbursement for all wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support, such as emergency services, delivery, set-up education and on-going assistance with use of the wheelchair. 4. For all wheelchairs (manual or power) recipient weight capacity is: Standard Duty = 300 lbs or less; Heavy Duty = 301-450 lbs; Very Heavy Duty = 451 – 600 lbs; Extra Heavy Duty = 601 lbs or more.
Manual – *Standard* **Adult size**	1. The recipient's home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided; 2. Use of an optimally configured manual wheelchair will significantly improve the recipient's ability to participate in MRADLs. **Note:** an optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options and other appropriate non-powered accessories; 3. The recipient's weight is within the established weight limitations of the wheelchair that is requested/provided;		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Manual – *Standard* Adult size**	4. The recipient will use it on a regular basis in the home and other location where normal life activities take place; 5. The recipient or their caregiver has not expressed an unwillingness to use the manual wheelchair that is provided in the home; and 6. The recipient has sufficient upper extremity strength, function, and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home and other location where normal life activities take place during a typical day, or the recipient has a caretaker available, willing and able to assist in the operation of the wheelchair.		
Manual – *Standard* Pediatric Size	1. The pediatric recipient must meet the qualifications in relationship to his/her age-appropriate developmental stages and mobility limitations for all qualifications for a Manual – Standard Adult Size Wheelchair; 2. Pediatric wheelchairs are covered only for a pediatric recipient (or an adult of very small stature). Recipient's weight cannot exceed 125 pounds; and 3. Recipient has not mastered age appropriate sensory and motor development requirements (e.g., two years old is unable to ambulate/walk). 4. Stroller-type pediatric wheelchair devices, rigid or folding, will be considered only when: a. classified by the DME Pricing, Data Analysis and Coding (PDAC) contractor as pediatric wheelchairs, when all of the previous criteria are met; b. due to severity of illness, injury and/or absence of or malfunction of a body part, there is a medical need for the features of	1. All requirements from the Forms/ Documentation section under "Wheelchairs" plus: 2. All pediatric device requests must include the growth capabilities of the equipment requested and address how that equipment can accommodate for the recipient's growth over the 60-month period that follows approval. This information should be included on the Mobility Assessment form found on the QIO-like vendor's website.	1. Stroller-type devices readily available without a prescription in commercial or retail stores, and which have not been coded by the DME Pricing, Data Analysis and Coding (PDAC) contractor as medical devices, will be denied. 2. Stroller-type devices used for children absent of illness, injury and/or a missing or malfunction of a body part do not meet the definition of DME.

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Manual – *Standard* Pediatric Size**	the device requested to provide for the recipient's proper alignment/positioning, transportation of the individual, and any medical devices attached to the individual; and c. a manual wheelchair would not be more beneficial to the individual's developmental needs and there is no potential for the recipient to participate in self propelling a manual wheelchair.		
Manual Specialty	1. May be covered if, in addition to the general qualifications for a wheelchair and a manual wheelchair, the qualifications for the following specified devices are met and determined to be medically necessary.		
Standard Hemi-Wheelchair (K0002)	1. May be covered when the recipient requires a lower seat height (17" to 18") because of short stature or to enable the recipient to place his/her feet on the ground for propulsion.		
Lightweight Wheelchair (K0003)	1. May be covered when a recipient: a. cannot self-propel in a standard wheelchair; and b. the recipient can and does self-propel in a lightweight wheelchair.		
High Strength Lightweight Wheelchair (K0004)	1. May be covered when a recipient: a. self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair; and/or b. requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair and spends at least two hours per day in the wheelchair. **Note:** This type of wheelchair is rarely medically necessary if the expected duration of need is less		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
	than three months (e.g., post-operative recovery).		
Ultra-light-weight Wheelchair (K0005) **Ultra-light-weight Wheelchair (K0005)**	1. May be determined for coverage on an individual consideration basis, as follows: a. Recipient must have a medical condition which is progressively deteriorating, or be at risk for injury due to use of another optimally-configured mobility device; and b. Recipient must have a medical need for anticipated future adaptations of the wheelchair that can only be accommodated by the K0005 device.	1. Additional documentation of the medical necessity must include a description of the recipient's routine activities, types of activities the recipient frequently encounters and whether the recipient is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed and not available in the K0001 - K0004 bases. This may be included in the Mobility Assessment form.	
Heavy Duty Wheelchair (K0006)	1. May be covered if the recipient weighs more than 250 pounds or has severe spasticity.		
Extra Heavy-Duty Wheelchair (K0007)	1. May be covered if the recipient weighs more than 300 pounds.		
Power Mobility Devices (PMDs) *(pertains to all POVs and PWCs below)*	1. May be covered if the recipient meets all previously described qualifications for a wheelchair (either adult or pediatric, whichever is appropriate); and the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, walker or an optimally-configured manual wheelchair; 2. The recipient does not have sufficient upper extremity strength or function needed to safely self-propel an optimally configured manual wheelchair to perform MRADLs during a typical day. **Note:** Limitations of strength, endurance, range of motion, coordination, presence of pain or deformity or absence of one or both upper extremities are to be assessed in the Mobility Assessment; and	1. Additional Documentation Requirements for a Power Mobility Device or Power Wheelchair: a. Orders: The physician/ practitioner's order must contain all of the following components: 1. Recipient's name. 2. Description of the item ordered. This may be general – e.g., "power wheelchair," "power operated vehicle," or "power mobility device" – or may be more specific. 3. Pertinent diagnosis/conditions that relate to the need for the power device. 4. Length of need. 5. Physician/practitioner's signature. b. Order must be received by the provider within 45 days after the completion of the Mobility Assessment.	1. Purchase of any Power Mobility Device is not considered medically necessary when the underlying condition is reversible, and the length of need is less than six months. The item may be approved for rental if all qualifications are met. 2. The Mobility Assessment and written supportive documentation must be performed by an individual who is fiscally, administratively and contractually independent from the DME provider/supplier, and who receives no form of compensation from the billing DME provider / supplier. **Note:** The exception to this is information about whether the

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Power Mobility Devices (PMDs)** *(pertains to all POVs and PWCs below)*	3. The recipient meets the additional qualifications for the specific device requested, as indicated further in this section.	2. Mobility Assessment form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300 Prior Authorization section. 3. Additional supporting documentation may include the Medicare-required Face-to-Face evaluation/examination.	recipient's home can accommodate the requested equipment, which may be obtained from or documented by the DME provider/supplier. 3. Prescribing physician/practitioners may bill an additional fee using HCPCS code G0372 on the claim for the office visit (CPT 99211) during which the Medicare-required Face-to-Face examination was completed.
Power Operated Vehicle (POV)	1. The recipient is able to: a. safely transfer to and from the POV; b. operate the tiller steering system; and c. maintain postural stability and position while operating the POV for normal life; 2. The recipient's mental capabilities (e.g., cognition and judgment) and physical capabilities (e.g., vision and hearing) are sufficient for safe mobility using a POV in the home; 3. The recipient's home provides adequate access between rooms, maneuvering space and surfaces for use of the POV that is requested/provided; 4. Use of a POV will significantly improve the recipient's ability to participate in MRADLs; 5. The recipient will use it on a regular basis; 6. The recipient or their caregiver has not expressed an unwillingness to use the POV that is provided in the home; 7. If unable to operate the POV independently, the recipient has a caretaker available, willing and able to assist in the operation of the POV;		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) Power Operated Vehicle (POV)	8. The recipient's weight is within the established weight limitations of the POV that is requested/provided; and 9. Documented outcome of the Mobility Assessment for the recipient determines this to be the most appropriate device for their needs.		
Power Wheelchairs (PWC) - Adult	1. May be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, walker, an optimally-configured manual wheelchair or a POV; 2. Recipient *does not have* sufficient strength, postural stability or other physical or mental capabilities needed to safely operate a POV; 3. Recipient *does have* the mental and physical capabilities, or has a willing and capable caregiver to safely operate the power wheelchair that is requested/provided; 4. Recipient's home *does not* provide adequate access between rooms, maneuvering space and surfaces for the operation of a POV with a small turning radius; 5. Recipient's home *does* provide adequate access between rooms, maneuvering space and surfaces for the operation of the power wheelchair that is requested/ provided; Use of a power wheelchair will significantly improve the recipient's ability to participate in MRADLs; 6. Recipient will use it on a regular basis;		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) Power Wheelchairs (PWC) – Adults	7. Recipient or their caregiver has not expressed an unwillingness to use the power wheelchair that is requested/provided in the home; 8. If the recipient is not able to operate the power wheelchair independently, the recipient has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing and able to safely operate the power wheelchair that is provided; and 9. The recipient's weight is within the established weight limitations of the power wheelchair requested/provided.		
Power Wheelchair (PWC) – Pediatric	1. The recipient is expected to grow in height with a maximum weight of 125 pounds; and 2. The outcome of the Mobility Assessment has determined this item to be the most appropriate for the individual over the 60-month period following approval.		
Power Wheelchairs *(listed by specific groups)*	1. Meets above qualifications for a PWC (either adult or pediatric, whichever is appropriate); and as indicated for each specific item below.		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS

Power Wheelchairs (PWCs) are categorized into Groups based on their performance and the following specifications table:

CHARACTERISTICS	GROUP 1	GROUP 2	GROUP 3	GROUP 4	GROUP 5
Length	<= 40”	<= 48”	<= 48”	<= 48”	<= 48”
Width	<= 24”	<= 34”	<= 34”	<= 34”	<= 28”
Minimum Obstacle Height	20mm	40mm	60mm	75mm	60mm
Minimum Top-end Speed – flat surface	3 MPH	3 MPH	4.5 MPH	6 MPH	4 MPH
Minimum Range	5 miles	7 miles	12 miles	16 miles	12 miles
Dynamic Stability Incline	6 degrees	6 degrees	7.5 degrees	9 degrees	9 degrees
Chair Accommodates	Non-powered options and seating systems (recline-only, manually elevating leg rests – except captain’s chair)	Seating and positioning items (seat and back cushions, headrests, lateral trunk supports, lateral hip supports, medial thigh supports - except captain’s chair)	Same as Group 2	Same as Group 2	Weight capacity up to 125#; and Same as Group 1 and Group 2; and Adjustability for growth (minimum of 3” for width, depth and back height adjustments)

Group 1, 2, or 3 PWC “Standard”	1. As previously stated for Power Wheelchairs. No additional qualifications.		
Group 2 PWC “Single Power Option”	1. Recipient requires a drive control interface other than a hand or chin-operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control); or 2. Recipient meets qualifications for a power tilt or recline seating system and the system is being used on the wheelchair.		
Group 2 PWC “Multiple Power Option”	1. Same as Group 2 Single Power Option qualifications; and 2. The recipient meets the qualifications for a power tilt and/or recline seating system with three or more actuators; or 3. The recipient uses a ventilator, which is mounted on the wheelchair.		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Group 3 PWC "Single Power Option"	1. Same as Group 2 Single Power Option qualifications; and 2. The recipient's mobility limitation is due to a neurological condition, myopathy or skeletal deformity in which the mobility limitation cannot be accommodated by a Group 2 option.		
Group 3 PWC "Multiple Power Option"	1. Same as Group 2 Multiple Power Option qualifications; and 2. The recipient's mobility limitation is due to a neurological condition, myopathy or skeletal deformity in which the mobility limitation cannot be accommodated by a Group 2 option.		
Group 4 PWC "Any Power Option"	This group of PWC is rarely considered medically necessary due to the added features, such as increased speed, climbing ability and travel distance which are not needed to complete MRADLs. 1. The recipient must meet the qualifications for a Group 1, Group 2 or Group 3 PWC with the same power option being requested for the Group 4 PWC. 2. The recipient must have additional medical needs and mobility limitations that cannot be accommodated by an appropriately configured Group 1, 2 or 3 PWC.	As listed previously; additional documentation from the prescribing physician/practitioner that specifically addresses why the Group 4 PWC and accompanying accessories are medically necessary and why a Group 1, 2, or 3 PWC with accompanying accessories will not meet the recipient's medical needs.	
Group 5 Pediatric PWC "Single Power Option"	1. Same as Group 2 Single Power Option qualifications; and 2. The recipient is expected to grow in height.		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Wheelchair Options, Accessories, and Seating Systems	1. Options and accessories for wheelchairs may be covered if: a. The recipient meets the wheelchair qualifications as indicated previously, and has either a manual or power wheelchair; b. The device is an appropriate option/accessory for the type of chair the individual has; c. The option/accessory itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website; d. When the option/accessory is not a required component of the mobility device at the time of initial dispensing; e. The option/accessory is not covered under an existing warranty; and f. As indicated for each specific item listed further in this section. 2. All wheelchair seating system items in this category may be covered if: a. The recipient meets the wheelchair qualifications as indicated above, and has either a manual or power wheelchair; b. The item is appropriate for the type of chair the individual has; c. The item itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website; d. When the item is not a required component of the mobility device at the time of initial dispensing;	For all items under this heading: all from General Information section above; and 1. Mobility Assessment form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section. 2. An MSRP Invoice if there is no rate established by the DHCFP.	See also General Information and Coverage and Limitations that may include items desired for reasons other than medical necessity: 1. An option/accessory that is primarily to allow the recipient to perform leisure or recreational activities. 2. Electronic interface used to control lights or other electrical devices. 3. Power seat elevation feature and power standing feature. 4. Non-medically necessary power wheelchair features may include, but not limited to: stair climbing (A9270), electronic balance (A9270), ability to balance on two wheels (A9270), remote operation (A9270), an attendant control (E2331) provided in addition to a patient-operated drive control system are considered duplicative and contradictory as one option indicates recipient's ability to operate safely and the other indicates it is not safe for the recipient to operate.

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Wheelchair Options, Accessories, and Seating Systems**	e. The item is not covered under an existing warranty; and f. As indicated for each specific item further.		
Anti-rollback Device (E0974)	1. May be covered if the recipient propels himself/herself and needs the device because of ramps which enable the individual to gain access to and from or within the home.		
Arm of Chair Adjustable Arm Height Option (E0973, K0017, K0018, K0020)	1. May be covered if the recipient requires an arm height that is different than that available using nonadjustable arms and the recipient spends at least two hours per day in the wheelchair.		
Arm Trough (E2209)	1. May be covered if recipient has quadriplegia, hemiplegia or uncontrolled arm movements.		
Batteries / Chargers	1. Up to two batteries (E2361, E2363, E2365, E2371, K0731 and K0733) at any one time are allowed if required for a power wheelchair.		1. Replacements only when not covered under warranty.
Footrest / Leg rest **Elevating Leg rests (E0990, K0046, K0047, K0053, K0195)**	1. May be covered if: a. The recipient has a musculoskeletal condition or the presence of a cast or brace which prevents 90-degree flexion at the knee; b. The recipient has significant edema of the lower extremities that requires having an elevating leg res; or 2. The recipient meets he qualifications for and has reclining back on the wheelchair.		
Hardware Swing away, Retractable, Removable for Joystick, Other Control Interface, or	May be covered if recipient needs to move the component out of the way to perform a slide transfer to a bed or chair, or to enable performance of MRADLs, unless the hardware is included in the allowance for the item (such as E2325, a sip and puff interface).		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) Hardware Swing away, Retractable, Removable for Joystick, Other Control Interface, or Positioning Accessory (E1028)	1. May be covered if recipient needs to move the component out of the way to perform a slide transfer to a bed or chair, or to enable performance of MRADLs, unless the hardware is included in the allowance for the item (such as E2325, a sip and puff interface).		
Headrest (E0955)	1. May be covered when the recipient has a manual tilt-in-space, manual semi or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair or power tilt and/or recline power seating system.		1. A headrest for a POV or a power wheelchair with a captain's chair seat is not covered as the chair does not tilt or recline
Manual Fully Reclining Back option (E1226)	1. May be covered if the recipient has one or more of the following conditions: a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.		
Non-Standard Seat Frame Dimensions **Non-Standard Seat Width and/or Depth for a Manual Wheelchair (E2201-E2204)**	1. May be covered only if the recipient's dimensions justify the need.		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Power Tilt and/or Recline Seating Systems: (E1002-E1010) **Power Seating System** *(tilt only, recline only, or combination tilt and recline – with or without power elevating leg rests)*	1. May be covered if the recipient meets the criteria for a power wheelchair and the outcome of the Mobility Assessment, form found on the QIO-like vendor's website has determined the specific feature to be medically necessary; and a. The recipient is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; b. The recipient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 2. The power seating system is needed to manage increased tone or spasticity.		
Power Wheelchair Drive Control Systems An Attendant Control (E2331)	1. May be covered in place of a patient-operated drive control system if recipient meets MAE qualifications for a wheelchair, is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.		
Power Wheelchair Electronic Interface (E2351) *(to allow a Speech Generating Device to be operated by the PWC control interface)*	1. May be covered if the recipient meets the criteria for, and has a covered speech generating device.		
Push-Rim Activated Power Assistive Device (E0986) for a Manual Wheelchair	1. May be covered if the recipient meets all qualifications for a power mobility device; and the recipient has been self-propelling in a manual wheelchair for at least one year.		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Safety Belt / Pelvic Strap (E0978)	1. May be covered if the recipient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning.		
Seating Systems (wheelchair):	As listed for Wheelchair Options, Accessories and Seating Systems.	For all items under this heading: all from MAE General Information; and 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section.	All from MAE General Information; and 1. All seating and positioning devices/ material and included components must meet the requirements of CMS and as set forth in the DME MAC Local Coverage Determination (LCD) – L15670 (or more current) and related Policy Articles at the time of dispensing. 2. Coverage and Limitations/Non-Covered are typically not medically necessary but may be reviewed under special criteria, see Appendix A: a. Powered seat cushion (E2610) (effectiveness has not been established). b. A seat or back cushion provided for a transport chair (these are for short term sitting). c. A prefabricated seat cushion, a prefabricated positioning back cushion or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the DME Pricing, Data Analysis and Coding (PDAC) contractor.

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
General Use Seat Cushion (E2601, E2602) and Wheelchair Back	1. May be covered if the recipient has a manual or power wheelchair with a sling/solid seat/back.		1. General use seat cushion or wheelchair back cushion for a POV or a PWC with a captain's chair seat are included in these seating systems.
Custom Fabricated Seat Cushion (E2609)	1. May be covered if the recipient meets all qualifications for a prefabricated skin protection seat cushion or positioning seat cushion; and 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.		
Custom Fabricated Back Cushion (E2617)	1. May be covered if the recipient meets all qualifications for a prefabricated positioning back cushion; and 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.		
Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)	1. May be covered for a recipient who has a manual or power wheelchair with a sling/solid seat/back; and either of the following: a. Current or past history of a pressure ulcer on the area of contact with the seating surface; or b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)	sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease or Parkinson's disease.		
Positioning Seat Cushion (E2605, E2606), Positioning Back Cushion (E2613-E2616, E2620, E2621) and/or Positioning Accessory (E0955-E0957, E0960)	1. May be covered for a recipient who: a. Has a manual or power wheelchair with a sling/solid seat/back; and b. Has any significant postural asymmetries that are due to one of the diagnoses listed in Skin Protection Seat Cushion qualification 1.b. above, or to one of the following diagnoses: monoplegia of the lower limbor hemiplegia due to stroke, traumatic brain injury or other etiology, muscular dystrophy, torsion dystonia spinocerebellar disease.		
Combination Skin Protection and Positioning Seat Cushion (E2607, E2608, K0736, K0737)	1. May be covered for a recipient who meets the qualifications for both a Skin Protection Seat Cushion and a Positioning Seat Cushion as indicated previously.		

Policy: NUTRITIONAL SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Parenteral Nutrition	1. Total Parenteral Nutrition (TPN) is covered for a recipient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition. Permanence does not require a determination that there is no possibility that the recipient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met. 2. The recipient must have: a. A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or b. Disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the gastrointestinal (GI) system.	1. Physician's/Practitioner's Order/Prescription 2. All TPN services require prior authorization. Medical coverage will be determined by the DHCFP QIO-like vendor. 3. A new authorization would be required when: a. Nutrients billed with a different code are ordered; b. The number of days per week administered is increased or decreased; or c. Parenteral nutrition services are resumed when they are not required for two consecutive months. 4. There must be objective evidence supporting the clinical diagnosis.	1. Parenteral nutrition may be covered in situations involving permanent impairments.
Infusion Pumps Equipment and Supplies: (B9004 and B9006)	1. Infusion pumps (B9004 and B9006) are covered for recipients in whom parenteral nutrition is covered.	1. An MSRP Invoice if there is no rate established by the DHCFP.	1. Only one pump (stationary or portable) will be covered at any one time. Additional pumps will be denied as duplicative.
Supply Kit, (B4220 or B4222) Administration Kit	1. If the coverage requirements for parenteral nutrition are met, one supply kit (B4220 or B4222) and one administration kit will be covered for each day that parenteral nutrition is administered, if such kits are medically necessary and used.		

Policy: NUTRITIONAL SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Enteral Nutrition	1. Enteral equipment and supplies are a Medicaid program benefit that requires a prior authorization. The following diagnoses and conditions are acceptable for medical coverage, based on severity and the QIO-like vendor determination: a. AIDS wasting syndrome (as indicated by a weight loss of 20 pounds or 10% of reference weight); b. Carcinoma of gastrointestinal tract; c. Disease of pancreas; d. Dysphagia; e. Failure to thrive; f. Fistulas of the gastrointestinal tract; g. Gastrostomy tube, artificial opening status; h. Gastrostomy tube, attention to artificial opening; i. Inborn errors of metabolism; j. Inflammatory bowel disease; k. Intestinal malabsorption; l. Malabsorption; m. Malnutrition; n. Necrotizing enterocolitis; o. Noninfectious gastroenteritis and colitis; p. Pancreatitis and pancreatic insufficiency; q. Radiation or chemotherapeutic enteropathy; r. Short bowel syndrome; and/or s. Vascular disease of the small bowel. 2. As a non-allergenic source of food in infants when all (e.g., soy base formulas) other food formulas are not tolerated; or 3. Other medical conditions with appropriate medical justification.	1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization when indicated. 3. A MSRP Invoice if there is no rate established by the DHCFP.	Reminder: 1. Nutritional supplies and products: a. Enteral nutrition are covered in situations involving permanent impairments. b. Enteral nutrition are covered for recipients with a non-functioning gastrointestinal tract whose need for enteral nutrition is not due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc. c. Enteral nutrition products and related supplies cannot be administered orally. d. Baby food and other regular grocery products that can be blenderized and used with the enteral system are not considered an enteral benefit. 2. Nutritional supplements carved out from institutional per diem if clinical coverage criteria are met.

Policy: NUTRITIONAL SERVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Medical Foods for Inborn Errors of Metabolism **(S9435)**	1. Authorization of "medical foods" will be considered for recipients under the age of 21 years as an EPSDT service with a diagnosis of an inherited metabolic disease in which treatments are restricted and a monitored diet consisting of specially formulated low-protein foods are an established standard of care. The following inherited metabolic conditions fit the category, but are not limited to: Phenylketonuria (PKU) Homocystinuria Maple Syrup Urine Disease 2. Definitions and qualifications: a. Medical foods refer to products designed for the specific nutrition management of a disease or condition for which distinctive nutrition requirements based on recognized scientific principles are established by medical evaluation. b. "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law. c. Medical foods are products specially formulated or modified to have less than one gram of protein per serving. This does not include a food that is naturally low in protein. d. Medical food is prescribed by and consumed under the direction of a physician for the dietary treatment of a qualifying metabolic disease. e. The recipient is currently receiving comprehensive nutrition services by a physician and dietician for the dietary	1. A prescription signed by the requesting physician specializing in the treatment of metabolic conditions for requested "medical foods"; 2. A completed prior authorization form that includes: a. types of medical food (e.g., LP baking mix); b. product line company names and product code numbers; c. total amount (units or case) of each medical food; d. number of servings for each product unit (number of servings per box, can or case); e. cost per unit or case for each medical food product; f. total cost of all products submitted; and g. Dates and duration of request 3. History and physical examination and current evaluation (within the last six months) which includes all existing diagnoses and medical conditions from the physician specializing in the treatment of metabolic conditions or an appropriate specialist. Documentation must include test results used in establishing the diagnosis and any other pertinent medical data/reports to justify products being requested; 4. A copy of the nutritional assessment and treatment plan by a registered dietitian and/or physician specializing in nutritional assessment and treatment of metabolic conditions; and including: a. Daily number of phenylalanine exchange	1. Medical foods may be approved after review of submitted documentation if found to meet the following conditions: a. Documentation supports dietary treatment of the metabolic disease or conditions mentioned in this policy for which nutritional requirements are established by medical evaluation, but does not include a natural food that is naturally low in protein; b. Submitted supporting documentation is found to support inherited metabolic diagnosis; and c. Approved time-frame will be for a maximum of six-months and the servicing provider can only be a Medicaid Pharmacy or DME provider. Grocery stores, health food stores and/or retail vendors may not be authorized as providers for medical foods.

Policy: NUTRITIONAL SERVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Medical Foods for Inborn Errors of Metabolism (S9435)**	treatment of a qualifying metabolic disease. f. Medical foods specifically used to meet the distinctive nutritional requirements of a qualifying metabolic disorder and not generally used by persons in the absence of a qualifying metabolic disorder. g. Medical foods should be requested as part of an EPSDT supplement service. h. Medical foods are not food products readily available in the grocery stores and health food stores. For example, a child with diabetes could find a variety of foods in the grocery store to meet the child's nutritional requirements without specially formulated medical foods. i. Approval will be limited to $2,500.00 per year unless proof of medical necessity exceeds that amount.	or total protein intake for disorders requiring a protein restriction. Snack foods do not exceed 10% of total cost of foods requested; and b. Documentation that the medical food is specially formulated and necessary for specific dietary management of the metabolic disorder.	

Policy: ORTHOTIC AND PROSTHETIC DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Orthotics and/or Prosthetics **Adjustments, Repairs and Component Replacements**	1. Replacement of a prosthesis, prosthetic component or orthosis is covered if the treating physician orders a replacement device or part because of any of the following: a. A change in the physiological condition of the recipient; b. Irreparable wear of the device or a part of the device, without evidence of recipient negligence; or c. The condition of the device or part of the device requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device or of the part being replaced.	1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization, when indicated.	1. Adjustments, routine periodic servicing (testing, cleaning and checking) to a prosthesis needed for wear or by a change in the recipient's condition are covered under the initial physician's order for the prosthesis for the life of the prosthetic. 2. Maintenance recommended by the manufacturer that must be performed by the prosthetist is a covered repair. 3. Repairs are covered when necessary to make the prosthesis functional. The cost of the repairs must not exceed the cost for a replacement.
Orthopedic Shoe-Related Services (inserts, arch supports, footwear, lifts, wedges, heels, and related services) – HCPCS "L" codes	1. Devices are covered for individuals under age 21 years when determined to be medically necessary through EPSDT screening and recommendations. 2. A surgical boot/shoe or Plastazote sandal may be covered for individuals of any age when ordered and determined to be medically necessary.	1. Physician's order. 2. Prior authorization is required when "L" code product rate is $250.00 or more per unit.	1. Refer to Diabetic Services section and HCPCS "A" codes in Fee Schedule for diabetic shoe insert coverage information.

Policy: ORTHOTIC AND PROSTHETIC DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Orthotics **Ankle-Foot Orthoses (AFO)** **Knee-Ankle-Foot Orthoses (KAFO)**	1. Appliances necessary for the straightening or correction of a deformity are covered by the DHCFP for eligible recipients. 2. <u>AFOs used in non-ambulatory recipients</u>: A static AFO (L4396) is covered if all of the following criteria are met: a. Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least 10 degrees (e.g., a non-fixed contracture); b. Reasonable expectation of the ability to correct the contracture; c. Contracture is interfering or expected to interfere significantly with the recipient's functional abilities; and d. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons. 3. <u>AFO/KAFOs used in ambulatory recipients:</u> A molded-to-patient-model or custom-fabricated are covered for ambulatory recipients if the following are met: a. The recipient could not be fit with a prefabricated AFO; b. The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months); c. There is a need to control the knee, ankle or foot in more than one place; d. The recipient has a documented neurological, circulatory or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or e. The recipient has a healing fracture which	1. Physician order. 2. Prior Authorization. 3. Original orthotics, adjustments, repairs, replacement of parts or an entire orthosis require medical documentation and may be subject to limitations of costs and frequency which are deemed reasonable by the program.	1. Orthotics include but may not be limited to: braces, orthopedic shoes, elastic stockings, back supports/ corsets, splints and garments for treating burn patients. 2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association.

Policy: ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Orthotics** **Ankle-Foot Orthoses (AFO)** **Knee-Ankle-Foot Orthoses (KAFO)**	lacks normal anatomical integrity or anthropometric proportions.		
Thoracic-Lumbar-Sacral Orthoses (TLSO) **Lumbar-Sacral Orthoses (LSO)**	1. TLSO or LSO are covered when it is ordered for one of the following indications: a. To reduce pain by restricting mobility of the trunk; b. To facilitate healing following an injury to the spine or related soft tissue; c. To facilitate healing following a surgical procedure on the spine or related soft tissue; or d. To otherwise support weak spinal muscles and/or a deformed spine.		Note: The use of a LSO or TLSO brace for patients with chronic low back pain is not recommended because there is no pertinent medical evidence of any long-term benefit or evidence that brace therapy is effective in the treatment of patients with chronic (>6 months) low back pain.

Policy: ORTHOTIC AND PROSTHETIC DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Prosthetic Devices	Appliances necessary to replace a missing part by an artificial substitute are covered by the DHCFP for eligible recipients. A determination of the medical necessity for certain components/additions to the prosthesis is based on the recipient's potential functional abilities. 1. Potential functional ability is based on the reasonable expectations of the prosthetist and treating physician, considering factors including but not limited to: a. The recipient's past history (including prior prosthetic use if applicable); b. The recipient's current condition including the status of the residual limb and the nature of other medical problems; c. The recipient's desire to ambulate; and d. Clinical assessments of recipient rehabilitation potential must be based on the following classification levels: <u>Level 0</u>: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility. <u>Level 1</u>: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulatory. <u>Level 2</u>: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.	1. Initial prosthetics, adjustments for which payment is to be made, repairs, replacement of parts or an entire prosthetic device require medical documentation and may be subject to limitations of cost and frequency which are deemed reasonable by the program. 2. Sufficient clinical documentation of functional need for the technology or design feature of a given type of prosthesis is required to be retained in the physician's or prosthetist's files and must be available for Medicaid review.	1. Myoelectrically controlled prostheses and related equipment are considered deluxe equipment. 2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association. 3. The following items are included in the reimbursement for a prosthesis and are not separately billable: a. Evaluation of the residual limb and gait; b. Fitting of the prosthesis; c. Cost of base component parts and labor contained in HCPCS base codes; d. Repairs due to normal wear or tear within 90 days of delivery; e. Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the recipient's functional abilities.

Policy: ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Prosthetic Devices**	Level 3: Has the ability or potential for ambulation with variable cadence. Typical for the community ambulatory who has the ability to traverse most environmental barriers and may have vocational, therapeutic or exercise activity that demands prosthetic utilization beyond simple locomotion. Level 4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of the child, active adult or athlete. Services billed for this functional level are considered deluxe by Medicaid. Foot and Knee Prosthesis: Foot and knee prosthesis coverage will be based on medical necessity by the QIO-like vendor. The recipient's functional level will be taken into consideration. Sockets: 1. Test (diagnostic) sockets for immediate prostheses (L5400-L5460) are not medically necessary. 2. No more than two test (diagnostic) sockets for an individual prosthesis are medically necessary without additional documentation. 3. No more than two of the same socket inserts (L5654-L5665) are allowed per individual prosthesis at the same time.		

Policy: OSTEOGENESIS STIMULATOR DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Osteogenesis Stimulator ***(Non-spinal Noninvasive Electrical)***	Device may be covered if: 1. Non-union of a long bone fracture after three or more months have elapsed without healing of the fracture; 2. Failed fusion of a joint, other than in the spine, where a minimum of nine months has elapsed since the last surgery; or 3. Congenital pseudarthrosis	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Electric Implantable Osteogenic Stimulators are included in the surgical service thus are non-covered under this chapter.
Osteogenesis Stimulator ***(Spinal Noninvasive Electrical)***	Device may be covered if: 1. Failed spinal fusion where a minimum of nine months has elapsed since the last surgery; 2. Following a multilevel spinal fusion surgery involving three or more vertebrae; or 3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Electric Implantable Osteogenic Stimulators are included in the surgical service thus are non-covered under this chapter.

Policy: PHOTOTHERAPY UNITS			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Phototherapy Unit	1. Bilirubin levels must be at or greater than 12.0 with bilirubin therapy on initial day of treatment. 2. Authorization is for a maximum of three days.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	

Policy: PNEUMATIC COMPRESSION DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Pneumatic Compression Devices ***(used for lymphedema)***	1. One or more limbs involved; and 2. Radical surgical procedure with removal of regional groups of lymph nodes (after radical mastectomy); or 3. Post radiation fibrosis; 4. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction; 5. Scarring of lymphatic channels, 6. Onset of puberty (Milroy's disease); or 7. Congenital anomalies; and 8. Must be treatment of last resort with documented evidence that elevation and custom fabricated gradient pressure stockings or sleeves are ineffective; and 9. Continuous oversight by treating physician (including instruction, treatment plan, fracture and duration of use ongoing monitoring and evaluation).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	**Note**: Rental only.

Policy: PREGNANCY-RELATED EQUIPMENT

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Home-Based (outpatient) Terbutaline Infusion Pump Therapy	Terbutaline infusion pump therapy is a covered benefit when the following conditions are met: 1. The recipient is at high risk for preterm labor and delivery based on one or a combination of factors: a. Current diagnosis of preterm labor with uterine contractions of four or more per hour and progressive cervical change; b. Cervical dilatation is less than four centimeters; c. History of preterm labor/delivery with previous pregnancies. 2. The recipient is currently or has recently been under treatment to prevent preterm labor with a combination of the following methods: a. Bed rest or restricted activity; b. Oral tocolytic therapy (document ineffectiveness); c. Increased office visits or phone contact for counseling; d. Hospitalization. 3. Appropriate alternative treatment has been tried and was not successful or was contraindicated. 4. Physician states recipient is capable of complying with home Terbutaline infusion pump therapy. 5. Recipient is not less than 20 weeks gestation or more than 37 weeks gestation. 6. Fetus is alive and well with an estimated weight of less than 2,500 grams. 7. Costs associated with Terbutaline infusion pump therapy do not exceed $240/day.	1. Physician's/Practitioner's Order/Prescription. 2. Requires a prior authorization. 3. Medical records from physician must be submitted to substantiate all qualifications. 4. Prior authorization will not be processed without medical records to substantiate request.	Note: Rental only.

Policy: PREGNANCY-RELATED EQUIPMENT

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Home Uterine Activity Monitor	1. Recipient has a current diagnosis of pre-term labor and a history of previous pre-term labor/delivery with pregnancies. 2. Records from physician showing pre-term labor with uterine contractions of four or more per hour and progressive cervical changes. 3. Cervical dilation is less than four centimeters. 4. Recipient is ordered on bed rest or restricted activities. 5. Tocolytic therapy initiated (oral, subcutaneous or intravenous route). 6. Documentation will show there is an increase in physician/patient contact due to pre-term labor symptoms. 7. The recipient is, in the opinion of the physician, capable of complying with the home monitoring program. 8. Recipient is not less than 24 weeks gestation or more than 37 weeks gestation.	1. Prescription and/or MD signed Prior Authorization Form. 2. Prior Authorization **Note**: Prior authorization submitted more than ten days after onset of service may be denied. 3. Medical documentation supporting qualifying factors	1. Reimbursement only for days of documented telephone contact between recipient/physician and monitoring device. **Note**: Rental only.

Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Apnea Monitor	1. One-year qualification for at least one of: a. Prematurity (gestational age must be listed on CMS 1500); b. Substantially small for gestational age; c. HX of maternal alcohol abuse; d. HX of maternal narcotics abuse; and/or e. HX of maternal hallucinogenic agent abuse. 2. Six-month qualification for at least one of: a. Gastro-esophageal reflux; b. Abnormal pneumogram indicating desaturating apnea; c. Periodic respirations; d. Significant bradycardia or tachycardia of unknown or specified origin; e. Congenital heart defect; f. Bronchopulmonary dysplasia or newborn respiratory distress; g. Respiratory distress; h. Family history of SIDS (siblings only); i. Respiratory Syncytial Virus (RSV); j. Apparent Life-Threatening Episode (ALTE) with subsequent visits to physician or emergency room; k. Laryngotracheal malacia; l. Tracheal stenosis; and/or m. Swallowing abnormality.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Program limit to one year for diagnoses including prematurity and maternal substance abuse. 2. Other diagnoses limited to six months. 3. An Apnea Monitor is a non-reimbursable service in conjunction with a pressure ventilator, with pressure control pressure support and flow triggering features.
Bi-Level Positive Airway Pressure (BiPAP) Device **BiPAP "S" (E0470) (without back u)** **BiPiAP "ST" (E0471) (with back up)**	1. For an E0470 or E0471 Respiratory Assist Device (RAD) to be covered, the treating physician must fully document in the recipient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470) (without back up)** **BiPAP 'ST' (E0471) (with back up rate)**	2. For an E0470 or E0471 Respiratory Assist Device (RAD) to be covered, the treating physician must fully document in the recipient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc. A RAD (E0470, E0471) used to administer Noninvasive Positive Pressure Respiratory Assistance (NPPRA) therapy is covered for those recipients with clinical disorder groups characterized as (Group I) restrictive thoracic disorders (e.g., progressive neuromuscular diseases or severe thoracic cage abnormalities), (Group II) severe chronic obstructive pulmonary disease (COPD), (Group III) central sleep apnea (CSA), or (Group IV) obstructive sleep apnea (OSA) (E0470 only) and who also meet the following criteria: <u>Group I: Restrictive Thoracic Disorders:</u> a. There is documentation in the recipient's medical record of a progressive neuromuscular disease (e.g., amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (e.g., post-thoracoplasty for TB); and b. An arterial blood gas PaCO2, done while awake and breathing the recipient's usual FIO2 is > 45 mm Hg; or c. Sleep oximetry demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing the recipient's usual FIO2; or	1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Sleep Study (Diagnostic and Titrated sleep studies). 3. Medical documentation supporting qualifying factors. 4. Refer to specific documentation requirements specified in the Qualifications section for each scenario. 5. MSRPs Invoice is required when no rate is established by the DHCFP.	1. The initial rental will be for three months. 2. Further approval requires: a. A letter of compliance from the recipient; or b. A completed form found on the QIO-like vendor's website; or c. Follow up notes from physician documenting compliance with the BiPAP; or d. A readout/printout from the BiPAP supplier documenting regular usage of the BiPAP. 3. BiPAP replacement requires proof of compliance or medical necessity. **<u>Note</u>**: The BiPAP will be rented until the purchase price is reached; this includes the initial three-month rental period.

Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470) (without back up)** **BiPAP 'ST' (E0471)** ***(with back up rate)***	d. For a progressive neuromuscular disease (**only**), maximal inspiratory pressure is < 60 cm H20 or forced vital capacity is < 50% predicted; and e. Chronic Obstructive Pulmonary Disease (COPD) does not contribute significantly to the recipient's pulmonary limitation. 3. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients within this group of conditions for the first three months of NPPRA therapy (see continued coverage after the initial three months). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary. <u>Group II: Severe COPD</u>: a. An arterial blood gas $PaCO_2$ done while awake and breathing the recipient's usual FIO_2 is $\underline{\geq}$ 52 mm Hg; and b. Sleep oximetry demonstrates oxygen saturation $\underline{\leq}$ 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual FIO_2 (whichever is higher); c. An arterial blood gas $PaCO_2$, done while awake and breathing the recipient's usual FIO_2, is $\underline{\geq}$ 52 mm Hg; and d. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out.		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	4. If all of the previously described criteria for recipients with COPD are met, an E0470 device will be covered for the first three months of NPPRA therapy (see Continued Coverage). An E0471 device will not be covered for a recipient with COPD during the first two months, because therapy with a E0470 device with proper adjustments of the device's settings and recipient accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. (See further in this section for coverage of an E0471 device for COPD after two month's use of an E0470 device). 5. If all of the previously described criteria are not met, E0470 and related accessories will be denied as not medically necessary. If E0471 is billed, even if the criteria for an E0470 device are met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary. <u>Group III: Central Sleep Apnea (e.g., apnea not due to airway obstruction)</u>: Prior to initiating therapy, a complete polysomnogram must be performed documenting the following: a. The diagnosis of central sleep apnea (CSA); b. The exclusion of obstructive sleep apnea (OSA) as the predominant cause of sleep-associated hypoventilation; c. The ruling out of CPAP as effective		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	therapy if OSA is a component of the sleep-associated hypoventilation; and d. Oxygen saturation ≤ 88% for at least five continuous minutes, done while breathing the recipient's usual FIO_2; and e. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the recipient's usual FIO_2. 6. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients with documented CSA conditions for the first three months of NPPRA therapy (see Continued Coverage). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary. Group IV: Obstructive Sleep Apnea (OSA): Criteria (a) and (b) are both met: a. A complete polysomnogram has established the diagnosis of obstructive sleep apnea according to the following criteria: 1. The apnea-hypopnea index (AHI) is ≥ 15 events per hour; or 2. The AHI is from five to 14 events per hour with documented symptoms of: a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or b. Hypertension, ischemic heart		

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EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	disease or history of stroke; and c. A single level device E0601, Continuous Positive Airway Pressure (CPAP) device has been tried and proven ineffective. 7. If the previously described criteria is met, an E0470 device will be covered for the first three months of NPPRA therapy (see Continued Coverage). If E0470 is billed and these criteria are not met but the coverage criteria in the DMEMAC LCD and/or Policy Articles for Continuous Positive Airway Pressure System (CPAP) are met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601. 8. An E0471 device is not medically necessary if the primary diagnosis is OSA. If E0471 is billed, since the E0471 is in a different payment category than E0470 and E0601 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary. Continued Coverage for E0470 And E0471 Devices Beyond First Three Months of Therapy: 1. Recipients covered for the first three months for an E0470 or E0471 device must be re-evaluated to establish the medical necessity of continued coverage beyond the first three months. While the recipient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which will base a decision to continue coverage beyond this time must occur no sooner than 61		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	days after initiating therapy by the treating physician. Medicaid will not continue coverage for the fourth and succeeding months of NPPRA therapy until this re-evaluation has been completed. 2. There must be documentation in the recipient's medical record about the progress of relevant symptoms and recipient usage of the device up to that time. Failure of the recipient to be consistently using the E0470 or E0471 device for an average of four hours per 24-hour period by the time of the re-evaluation (on or after the 31st day, but no later than 91 days after initiation of therapy) would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute reason to deny continued coverage as not medically necessary. 3. The following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months: a signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, declaring that the recipient is compliantly using the device (an average of four hours per 24-hour period) and that the recipient is benefiting from its use. A "Usage Evaluation" form FH-1A, found on the QIO-like vendor's website is available for use at: https://www.medicaid.nv.gov/, select "Provider" then "Forms." It is not mandatory that this form be used as long as the above information is provided by the treating physician.		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	4. If the above criteria are not met, continued coverage of an E0470 or E0471 device and related accessories will be denied as not medically necessary. 5. For Group II (COPD) recipients who qualified for an E0470 device, if at a time no sooner than 61 days after initial issue and compliant use of an E0470 device, the treating physician believes the recipient requires an E0471 device, the E0471 device will be covered if the following criteria are met: a. an arterial blood gas $PaCO_2$, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the recipient's usual FIO_2, still remains $\geq$ 52 mm Hg; b. a sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of an E0470 device, and while breathing with the E0470 device, demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual FIO_2 (whichever is higher); and c. a signed and dated statement from the treating physician, completed no sooner than 61 days after initiation of the E0470 device, declaring that the recipient has been compliantly using the E0470 device (an average of four hours per 24-hour period) but that the recipient is NOT benefiting from its use. 6. If the above criteria for an E0471 are not met, since the E0471 is in a different payment category than E0470 and a least costly		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.		
Continuous Positive Airway Pressure Device **CPAP (E0601)**	1. A single level continuous positive airway pressure (CPAP) device (E0601) is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by complete polysomnogram and meets either of the following criteria (a or b): a. The AHI is ≥ 15 events per hour; or b. The AHI is from five to 14 events per hour with documented symptoms of: 1. Excessive daytime sleepiness, impaired cognition, mood disorders or insomnia; or 2. Hypertension, ischemic heart disease, or history of stroke. **Note**: The AHI must be calculated based on a minimum of two hours of recorded sleep and must be calculated using actual recorded hours of sleep (e.g., the AHI may not be an extrapolated or a projected calculation). 2. Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 31st day but no later than 91 days after initiating therapy, the supplier ascertain from either the recipient or the treating physician that the recipient is continuing to use	1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Sleep Study (Diagnostic and Titrated sleep studies). 3. Medical documentation supporting qualifying factors. 4. MSRP Invoice is required when no rate is established by the DHCFP. 5. Refer to specific documentation requirements specified in the Qualifications section for each scenario.	1. The initial rental will be for three months. 2. Further approval requires: a. letter of compliance from the recipient; or b. a completed form found on the QIO-like vendor's website; or c. follow up notes from physician documenting compliance with the CPAP; or d. a readout/printout from the CPAP supplier documenting regular usage of the CPAP. 3. CPAP replacement requires proof of compliance or medical necessity. **Note**: The CPAP will be rented until the purchase price is reached; this includes the initial three-month rental period.

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Continuous Positive Airway Pressure Device** **CPAP (E0601)**	the CPAP device. Continued use is defined as an average of four hours per 24-hour period. A "Usage Evaluation" form FH-1A, found on the QIO-like vendor's website is available for use at: https://www.medicaid.nv.gov/, select "Provider" then "Forms." It is not mandatory that this form be used as long as the previously listed is provided by the treating physician. The supplier cannot provide answers to any of the information, as it must be obtained from the recipient, caregiver, spouse or attending physician. Information should include: a. Number of hours a day the machine is used. b. Number of months using machine. c. Will the recipient continue to use the machine in the future? Identify who has answered the information (cannot be the supplier).		

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483) **(Rental and the initial purchase includes hose and vest)** **Replacement Items:** **High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)** **High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)**	FDA-approved high frequency chest compression (HFCC) device (vest coupled to a pneumatic compressor) is a covered benefit for recipients who meet all of the following qualifications: 1. Documented medical justification for the need and length of time the HFCC system will be utilized; and 2. Recipient must have one of the following diagnoses which causes excessive, tenacious secretions and impairs ability to clear secretions: a. Cystic fibrosis; b. Chronic bronchiectasis; or c. Chronic neuromuscular disorder with prior history of pneumonia or other significant worsening of pulmonary functioning; 3. Well-documented failure of other methods, or inability to use other airway clearance therapies including chest physical therapy (CPT), flutter valve, etc. to adequately mobilize retained secretions; 4. Documentation of physician's treatment plan that includes external manipulation of the thorax at least daily to release retained secretions; 5. Documented evidence that recipient is having difficulty with secretion clearance, or presence of atelectasis caused by mucus plugging confirmed by high resolution, spiral or standard CT scan; 6. Age greater than 2 years; and 7. Recipient and caregiver cannot adequately perform the needed bronchial drainage treatment (such as having more than one child requiring CPT or a valid medical reason that prohibits the CPT).	1. Physician's order/prescription. 2. Completed prior authorization form. 3. Physician's assessment to include the diagnosis for treatment. Clearly defined medical need for airway clearance as evidenced by retained secretions, prior history of pneumonia or other significant worsening pulmonary function, presence of atelectasis caused by mucus plugging by report. 4. Documented failure of CPT, type used, frequency, duration of use and outcomes. 5. Current medications, route of administration, dosage and frequency. 6. Diagnostic studies such as high resolution, spiral or standard CT scan. 7. Number of times per day recipient requires CPT. 8. Age of recipient. 9. Identify primary caregiver and the caregiver availability. 10. The prescribing physician will need to submit periodic follow-up reports. 11. MSRP Invoice is required when no rate is established by the DHCFP.	1. Disease conditions such as: cystic fibrosis (CF), bronchiectasis and immotile cilia syndrome can lead to abnormal airway clearance which is a source of increased sputum production, often purulent and tenacious; chest physiotherapy (CPT) becomes necessary. In conditions such as CF, excessive tenacious secretions necessitate routine CPT to prevent airway obstruction leading to secondary infection, the principal cause of morbidity and mortality. 2. The standard method of CPT is manual percussion and postural drainage. In the home setting, CPT is administered to the recipient by a trained adult one to three times a day for 20 - 30 minutes per session. 3. FDA approved HFCC (oscillating devices) have been utilized as an alternative to conventional manual chest physical therapy to promote the clearance of respiratory secretions in patients with impaired ability to cough or otherwise expel them on their own. 4. For purchase to be considered, a three-month trial period on a rental basis is required. After the trial period and receipt of the follow up documentation showing evidence of compliance and effectiveness, the HFCC device may be approved for purchase. 5. The QIO-like vendor will provide authorization to include the 61st through 120 days if medically necessary.

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)** **(Rental and the initial purchase includes hose and vest)** **Replacement Items:** **High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)** **High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)**	Recipients who have a documented diagnosis, other than those listed under Item 2, which causes excessive, tenacious secretions and impairs ability to clear secretions may be reviewed on a case-by-case basis to determine Medical Necessity (e.g., not experimental or investigational). For consideration, the recipient must meet the following qualifications: 1. Recipient meets qualifications 1 through 7, excluding item 2; and 2. Documented evidence of a recent prior history of pneumonia or other significant worsening pulmonary functioning. **Qualifications for Continued Use** Continued coverage of the HFCC device beyond the three-month trial of therapy requires documentation dated no sooner than the 61st day, but not later than 120 days after initiating therapy in one of the following formats: 1. The treating physician submits documentation to include the effectiveness of treatment, recipient's compliance and tolerance of the therapy; or 2. Report via monthly usage meter checks documenting use at least 67% of prescribed frequency.		**Not Medically Necessary** 1. When the criteria in this policy are not met. 2. Recipient receiving duplication of services. 3. The DHCFP will not reimburse providers for bronchial drainage performed by a therapist or other health care professional while the recipient has the bronchial drainage vest (e.g., home health services where a physical therapist, nurse and/or aide is performing CPT and postural drainage). 4. Recipients who have contraindication of external manipulation of the thorax as defined by American Association of Respiratory Care (AARC) contained in their clinical practice guidelines for Postural Drainage Therapy which include, but are not limited to: a. unstable head or neck injury; b. active hemorrhage with hemodynamic instability; c. subcutaneous emphysema; d. spinal fusion or spinal anesthesia; e. recent skin grafts or flaps on the thorax; f. burns, open wounds; g. skin infections of the thorax; h. recently placed trans-venous pacemaker or subcutaneous pacemaker; i. suspected pulmonary tuberculosis; j. lung contusion; k. bronchospasm;

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EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)** **(Rental and the initial purchase includes hose and vest)** **Replacement Items:** **High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)** **High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)**			l. osteoporosis; m. osteomyelitis of the ribs; n. coagulopathy; and/or o. complaint of significant chest wall pain. **Note**: The DHCFP will not reimburse providers when items are provided prior to PA approval.
Humidifiers and Supplies	1. Medical evidence/documentation recipient is a new start or compliant with current positive airway pressure therapy. 2. Sleep study or equipment fitting documentation showing recommended type and sizing. 3. Quantity limited to reimbursable guidelines.	1. Prescription and/or MD signed Prior Authorization Form 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 fee schedule.

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Nebulizers and Compressors	1. A small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570, E0571) are covered when: a. It is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids and cromolyn for the management of obstructive pulmonary disease; b. It is medically necessary to administer gentamicin, tobramycin, amikacin or dornase alfa to a recipient with cystic fibrosis; c. It is medically necessary to administer pentamidine to recipients with HIV and complications of organ transplants; or d. It is medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions. **Note**: For criterion (a) to be met, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs. The reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an MDI must be documented in the recipient's medical record and be available to Medicaid on request. 2. A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A7018 or A4216) are covered when it is medically necessary to deliver humidity to a recipient with thick, tenacious secretions, who has cystic fibrosis, a tracheobronchial stent.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 fee schedule. 2. Small volume ultrasonic nebulizer (E0574) and large volume ultrasonic nebulizer (E0575) will be reimbursed at the least costly alternative of a pneumatic compressor (E0570).

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EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Nebulizers and Compressors**	Combination Code E0585 will be covered for the same indications. An E0565 or E0572 compressor and filtered nebulizer (A7006) are also covered when it is medically necessary to administer pentamidine to recipients with HIV. If a large volume nebulizer, related compressor/generator and water or saline are used predominantly to provide room humidification it will be denied as non-covered.		
Oximeter: **E0445- device for measuring blood oxygen levels, non-invasive** **Accessories:** **Oxygen probe (A4606) for use with continuous oximeter device, replacement**	1. The DHCFP covers Pulse Oximetry in the home as medically necessary when one of the following criteria is met: a. Any age determination: 1. Recipient is dependent on both a ventilator and supplemental oxygen; 2. Recipient has a tracheostomy and is oxygen dependent; 3. Recipient is on supplemental oxygen and weaning is in process; or 4. Recipient is discharged from inpatient stay for pulmonary diagnosis.	1. Prescription by physician; 2. Prior authorization; and 3. Documentation by the physician of recipient's medical condition, which documents the need for in-home use of an oximeter, finger or continuous models, duration of use and responses for decreased O_2. 4. MSRP Invoice is required when no rate is established by the DHCFP. **Recertification of Prior Authorization:** 1. Recertification is allowed until the recipient no longer meets criteria, the device is removed from the home or purchase price has been met; and 2. Physician progress notes/narratives to substantiate the continued need to use the oximeter for decreased O_2 saturations. Allowable notations to include family, recipient and/or caregivers' responses.	1. Initial approval may be for 30-90 days. 2. Approval for a Continuous Oximeter model requires medical necessity for all additional features i.e.: pulse, Alarm, O_2 Stats, etc. 3. Oximeter testing is not a reimbursable service for DME providers. 4. Requires plans for training/instructions of family/caregiver.
Oxygen (O_2): **Concentrators** **Portables** **Regulators**	1. Arterial blood gases or an ear oximetry reporting: a. PO_2 Level of 60 mmHG or less on room air; or	1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Oximetry spot check or overnight tape results. 3. Medical documentation supporting qualifying factors.	1. Oximetry test must be performed by a physician or qualified laboratory. O_2 saturations (sats) will not be accepted from an oxygen supplier.

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EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
O_2 Carts **Oxygen Supplies:** **Tubing** **Cannulas** **O_2 Masks** **Humidifiers**	b. 80 mmHG or less on O_2; or c. O_2 saturation (sat) level of 89% or less; and d. Medical Necessity; e. Must list conditions of study (rest, sleeping, exercising, room air, on oxygen). 2. CHILDREN: 92% or less room air saturation, at rest. O_2 sats must be performed within 60 days of requested dates of service.		2. Liquid oxygen and related equipment are non-covered Medicaid services unless recipient does not have electrical utilities at residence. Reimbursement will be only for stationary at the same rate as concentrator.
Respirometers	1. Medical evidence/documentation supporting a related diagnosis for equipment.		
Suction Pumps	1. Recipients who have difficulty raising and clearing secretions due to: a. Cancer or surgery of the throat or mouth; b. Dysfunction of the swallowing muscles; c. Unconsciousness or obtunded state; or d. Tracheostomy (V44.0).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 Fee Schedule for quantity limits.
Ventilators	1. Medical evidence/documentation supporting a related diagnosis for equipment (e.g., tracheostomy).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. MSRP Invoice is required when no rate is established by the DHCFP.	1. Medical Supplier must keep back up inventory available for rented equipment in emergent situations. Reimbursement for a backup ventilator provided in the recipient's home will only be allowed if it is medically prohibitive for a provider to respond in an emergent situation such as a recipient being on 24-hour ventilation support.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 8, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE / Marta Stagliano/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1400 – HOME HEALTH AGENCY

BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 1400, Home Health Agency, has been revised to remove the Definitions and References/Cross References sections. The Definitions were moved to the MSM Addendum and the References/Cross References to MSM Chapter 100.

These policy changes are effective November 9, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 26/11 CHAPTER 1400 – HOME HEALTH AGENCY	MTL 35/03, 23/07, 11/09 CHAPTER 1400 – HOME HEALTH AGENCY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1402	**Reserved**	Removed Definition Section.
1405	**References and Cross References**	Removed References.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

HOME HEALTH AGENCY

1400 INTRODUCTION

HOME HEALTH AGENCY (HHA) SERVICES

The Division of Health Care Financing and Policy (DHCFP) Home Health Agency (HHA) Program is a mandated home health care benefit provided to recipients in his/her residence. HHA services are a component in the continuum of care which allows recipients to remain in his/her home. HHA services may be provided to eligible recipients, based on medical necessity, program criteria, utilization control measures and the availability of the state' resources to meet recipient needs. HHA services are provided on an intermittent basis, certified by a physician and provided under a physician approved Plan of Care (POC). The Home Health Agency (HHA) service benefit provides Skilled Nursing (SN) services, and other therapeutic services such as Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), and Home Health Aides or Certified Nursing Aides (CNAs). Respiratory Therapists (RT) and Registered Dieticians (RD) are also a benefit with limitations. Services are generally provided on a short-term basis as opposed to long-term custodial 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 Chapter 3700.

1401 AUTHORITY

A. The Home Health Agency (HHA) program is a mandatory benefit under 1905(1)(18) of the Social Security Act.

B. The citation, which explains and interprets the federal regulations governing Home Health services, is found in the Code of Federal Regulations (CFR) Title 42, Part 440.70 and 441.15.

1402 RESERVED

1403 POLICY

1403.1 POLICY STATEMENT

The home health care benefit reimburses for medically necessary and appropriate home visits by skilled nurses, physical therapists, occupational therapists, speech therapists, respiratory therapists, dieticians and home health aides to Medicaid recipients. A home health agency provides skilled services and non-skilled services to recipients on an intermittent and periodic basis.

Services are intended to provide skilled intervention with emphasis on recipient/caregiver teaching. Legally responsible adults, willing caregivers and recipients are expected to be taught care which can be rendered reasonably and safely by non medical persons.

1403.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

To be determined eligible for HHA services, the following are necessary:

a. The recipient must be program eligible for Title XIX (Medicaid) or Title XXI (Nevada Check Up) services;

b. A Legally Responsible Adult (LRA) or other willing caregiver is not available or capable of providing all services;

c. The recipient must have a need for a qualifying skilled service.

d. Services must be reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipients' unique medical condition and the standard of practice within the community.

e. Services must be sufficient in amount, duration and scope to reasonably achieve its purpose;

f. Services must be provided under a Plan of Care (POC) signed by the physician;

g. Services must be provided on an intermittent and periodic basis;

h. Services must have prior authorization;

i. Services must be provided in the recipient's place of residence;

j. Services cannot be provided in a physician's office, clinic or other outpatient setting.

k. Home care services may be appropriate when one or more of the following situations exist:

1. The recipient's illness, injury or disability precludes going to the physician's office, clinic or outpatient setting;

2. A hardship would occur if service were provided outside the home, i.e., a recipient just out of the hospital following major surgery;

3. The service is contraindicated outside the home based on recipient's medical condition, i.e., a recipient who must be protected from infection;

4. The service outside the home would interfere with the effectiveness of the service, i.e., traveling an extreme distance or a recipient whose frequent service need, such as IV therapy three times per day, cannot reasonably be accommodated outside the home;

5. The recipients documented medical condition is so fragile or unstable that the physician state that leaving the home is undesirable; and

6. The service, such as teaching, can be more effectively accomplished at home.

2. COVERED SERVICES

a. Skilled nursing services provided by a licensed nurse performing skilled interventions to maintain or improve the recipient's health status.

b. Physical therapy services provided by a licensed physical therapist to restore, maintain or improve muscle tone, joint mobility or physical function.

c. Occupational therapy services provided by a licensed occupational therapist to improve or restore function.

d. Speech therapy provided by a licensed speech pathologist for the treatment of speech and language disorders, communicative disabilities or swallowing disorders.

e. Respiratory therapy provided by a licensed respiratory therapist.

f. Dietician services provided by a registered dietician for consultative services for nutritional deficits or recipients at risk of nutritional deficits.

g. Home Health Aide services provided by a Certified Nursing Aide (CNA) under the supervision of a registered nurse and in accordance with the Nurse Practice Act.

3. NON-COVERED HHA SERVICES

No reimbursement or coverage will be provided for:

a. Services provided to a recipient that is ineligible or becomes ineligible for Title XIX or Nevada Check Up;

b. Services normally provided by an immediate relative, legally responsible adult or other willing and capable caregiver;

c. Services provided to a recipient who is a resident in a hospital, skilled nursing facility including a Nursing Facility for the Mentally Ill (NF/MI) or Intermediate Care Facility for the Mentally Retarded (ICF/MR) or an institution for the treatment of chemical addiction;

d. Services rendered to recipients in pediatric or adult day care centers;

e. Services rendered at school sites which provide “school based health service” pursuant to IDEA 300.24;

f. Services provided to someone other than the intended recipient;

g. Services that the DHCFP determines could reasonably be performed by the recipient;

h. Services provided without authorization;

i. Services provided by the HHA that were not noted on the initial physician or subsequent medical orders, or Plan of Care (POC);

j. Service requests that exceed program limits;

k. Services provided at a recipients home that could have been obtained in an outpatient setting (e.g. lab work for an ambulatory recipient);

l. Services determined not medically necessary by DHCFP;

m. Homemaker services;

n. Medical Social Services (MSS);

o. Companion care that is intended to provide friendly or social time with a recipient;

p. Sitter or services that are intended for individuals to watch or supervise a recipient in the absence of a legally responsible adult or primary caregiver and that provide no skilled care;

q. Respite care;

r. Duplication of services;

s. Transportation of recipients to Medicaid reimbursable settings, unless the HHA is a Medicaid transportation provider. Refer to Chapter 1900;

t. Travel time to and from the recipients residence;

u. Routine services such as physical checkups or assessments that are performed without relationships to a treatment of diagnosis for a specific illness;

v. Routine newborn teaching and post-partum follow ups and assessments;

w. Skilled nursing visits to children for the administration of Synagis outside the guidelines of Nevada Medicaid policy;

x. Routine supplies customarily used during the course of HHA visits. These supplies are included in the staff's supplies and are not designated for a specific recipient. Routine supplies may include but are not limited to non-sterile gloves and thermometer covers. These supplies are included in the cost-per-visit of HHA service;

y. Routine personal hygiene supplies may include, but are not limited to such items as shampoos, soaps, lotions or powders, toothpaste, combs, etc.;

z. Routine disposable supplies required on a monthly basis. These supplies must be obtained from a DME or pharmacy provider (refer to Chapters 1200 and 1300);

aa. Personal comfort items which do not contribute to the treatment of an illness or injury or the functioning of a malformed body part. Personal comfort items may include but are not limited to items such as air conditioner, radios, etc.

1403.1B PROVIDER RESPONSIBILITY

The provider shall furnish skilled nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, home health aides or certified nursing aides, respiratory therapists and registered dieticians to eligible recipients as identified in the physician's written Plan of Care (POC). Services are to be provided as specified in this Chapter.

1. PROVIDER QUALIFICATIONS

The provider must be enrolled as a Medicare Certified Home Health Agency (HHA) licensed and authorized by state and federal laws to provide health care services in the home.

2. MEDICAID ELIGIBILITY

HHAs must verify the recipient's eligibility for Medicaid. Authorization for home health care is valid only if the recipient is eligible for Medicaid during the month the service is provided. The provider must verify each month the continued Medicaid eligibility for each recipient. Verification of Medicaid eligibility is the responsibility of the HHA.

3. THIRD PARTY LIABILITY (TPL)

HHAs must determine, on admission to HHA services, the primary payer. If Medicaid is not the primary payer, the provider must bill the third party payor before billing Medicaid.

4. PHYSICIANS ORDER AND PLAN OF CARE

HHA services are initiated per a physicians order. HHA program services are provided per the Plan of Care (POC) which is documented on a CMS 485. The POC is a written set of medical orders signed by the physician which certify the specific HHA services that will be provided, the frequency of the services, and the projected time frame necessary to provide such services. The Plan of Care is reviewed by the physician every 60 days. A new POC is required when there is a change in the recipient's condition, change in orders following hospitalization, and/or change in the physician.

5. PRIOR AUTHORIZATION

HHAs must obtain proper authorization for all Home Health Agency services prior to the start of care. Refer to the authorization process 1403.1D.

6. PLACE OF SERVICE

HHA services must be provided in the recipient's place of residence.

7. HOME HEALTH AGENCY VISITS

a. Evaluation visit

HHA's are required to have written policies concerning the acceptance of the recipient by the agency. This includes consideration of the physical facility available in the recipient's place of residence, homebound status and the attitudes of family members for the purpose of evaluating the feasibility of meeting the recipient's medical needs in the home health setting.

When personnel of the HHA make an initial visit to assess the recipient the cost of the visit is considered an administrative cost and is not reimbursable as a visit at this point since the recipient has not been accepted for care. If during the course of the initial visit, the recipient is determined appropriate for home health care by the agency and the recipient received the first skilled service as ordered under the POC, the visit becomes the first billable visit as an RN extended visit.

b. Supervisory visit

A supervisory visit made by a registered nurse to complete a recertification visit or to evaluate the delivery of specific needs of the recipient by a CNA or LPN can be authorized only once every 60-62 days. This is authorized as a RN extended visit.

c. Visit types

Two types of visits may be provided under skilled nursing. These are: An extended visit, which is defined as any visit exceeding 30 minutes but not more than 90 minutes; and the nurse's brief visit, which is defined as a visit of 30 minutes or less. Visits for certified nursing aides are approved for the first hour and each additional ½ hour thereafter.

8. RECIPIENT RIGHTS

The Home Health Agency (HHA) has an obligation to protect and promote the exercise of the recipient rights. A patient has the right to exercise his rights as a patient of the provider. A patient's family or guardian may exercise a patient's rights when a patient has been judged incompetent. The recipient has the right to be notified in writing of his rights and obligations before treatment is begun. HHA's must provide each patient and family with a written copy of the recipient's bill of rights. A signed and dated statement acknowledging receipt of the patient's Bill of Rights will be included in the patient's medical record. Refer to recipient rights later in this Chapter.

9. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The Division expects that all Medicaid providers will be in compliance with all laws relating to incidents of abuse, neglect, or exploitation.

a. CHILD ABUSE

State law requires that certain persons employed in certain capacities must make a report to a child protective services agency or law enforcement agency immediately, but in no event later than 24 hours, after there is reason to suspect a child has been abused or neglected. For minors under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected abuse.

Refer to NRS 432B regarding child abuse or neglect.

b. ELDER ABUSE

For adult aged 60 and over, the Division for Aging Services (DAS) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

Refer to NRS 200.5091 regarding elder abuse or neglect.

c. OTHER AGE GROUPS

For all other individuals, contact local social services and/or law enforcement agencies.

10. COMPLAINT RESOLUTION

The provider must respond to all complaints in a reasonable and prompt manner. The provider must perform recipient/provider problem solving and complaint resolution.

a. The provider must maintain records that identify the complaint, the date received and the outcome; and

b. The provider must submit documentation regarding the complaint to Nevada Medicaid Central office (NMCO) immediately upon request.

11. TERMINATION OF SERVICES

a. The provider may terminate services for any of the following reasons:

1. The recipient or other persons in the household subjects home care staff to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

2. The recipient is ineligible for Medicaid;

3. The recipient requests termination of services;

4. The place of service is considered unsafe for the provision of HHA services;

5. The recipient is admitted to an acute hospital setting or other institutional setting;

6. The recipient or caregiver refuses to comply with the physician's POC;

7. The recipient or caregiver is non cooperative in the establishment or delivery of services;

8. The recipient no longer meets the criteria for HHA services;

9. The recipient refuses service of a skilled nurse based solely or partly on the race, religion, sex, marital status, color, age, disability or national origin;

10. The provider is no longer able to provide services as authorized (i.e. no qualified staff).

Note: A provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's HHA program. The recipient may choose another provider.

b. IMMEDIATE TERMINATION

The provider may terminate HHA services immediately for reasons one through five listed above.

Note: The nurse provider must comply with 632.895.6 of the Nurse Practice Act. Other licensed professionals must comply within their standard practice act.

c. ADVANCE NOTICE TERMINATION

The provider must provide at least five calendar days advance written notice to recipients when HHA services are terminated for reasons six through ten listed above.

d. NOTIFICATION REQUIREMENTS

The provider must notify the recipient and all other appropriate individuals and agencies when services are to be terminated. The QIO-like vendor must be informed of the termination of services as the Nevada Medicaid District Office (NMDO) Care Coordinator within two working days. The provider must submit written documentation regarding the termination to the NMDO within five working days.

12. RECORDS

The provider must maintain medical records which fully disclose the extent and nature of the service provided to the recipient and which supports fees or payments made. Medical and financial records and all other records provided must be maintained for an interval of not less than six years. Following HIPAA Privacy Regulations contained in 45 CFR 160 and 164, the provider must make records available upon request to the Division.

1403.1C RECIPIENT RESPONSIBILITY

1. The recipient or personal representative shall:

a. Provide the HHA with a valid Medicaid card;

b. Provide the HHA with accurate and current medical information, including diagnosis, attending physician, medication regime, etc.;

c. Notify the HHA of all insurance information, including the name of other third party insurance coverage, such as Medicare, CHAMPUS and Veterans Administration;

d. Inform the HHA of any other home care benefit that he or she is receiving through state plan services, such as Personal Care Aide (PCA) services, Private Duty Nursing (PDN) visits or therapy services. Services provided through another agency or program such as respite, case management or participation in a Waiver program must also be identified;

e. Sign the HHA visit form to verify services were provided;

f. Cooperate in establishing the need for and the delivery of services;

g. Comply with the delivery of service as outlined in the Plan of Care;

h. Notify the HHA when scheduled visits cannot be kept or services are no longer required;

i. Notify the HHA of unusual occurrences or complaints regarding delivery of services or dissatisfaction with specific staff;

j. Provide the HHA with a copy of Advance Directives, if applicable;

k. Not request the provider agency staff to work more hours than authorized or to change the days/hours approved;

l. Not request the provider agency staff to provide care to non-recipients or to provide service not on the POC (babysitting, housekeeping tasks, etc.); not subject the provider to physical and/or verbal abuse, sexual harassment, exposure to the use of illegal substances or threats of physical harm; and

m. Not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability, and/or national origin.

2. Recipient Rights

Every Medicaid recipient, their LRA or legal guardian is entitled to receive a statement of "Patient Rights" from their provider. The recipient should review and sign a statement acknowledging receipt of this document. The patient rights should include, at a minimum, the following:

a. A patient has the right to courteous and respectful treatment, privacy, and freedom from abuse;

b. A patient has the right to be free from discrimination because of race, creed, color, sex, national origin, sexual orientation, and diagnosis;

c. A patient has the right to have his property treated with respect;

d. A patient has the right to confidentiality with regard to information about his health, social and financial circumstances, and about what takes place in his home;

e. A patient has the right to access information in his own record upon written request;

f. A patient has the right to voice grievances regarding treatment of care that is, or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the HHA and must not be subjected to discrimination or reprisal for doing so;

g. A patient has the right to be informed of the provider's right to refuse admission to, or discharge any patient whose environment, refusal of treatment, or other factors prevent the HHA from providing care;

h. A patient has the right to be informed of all services offered by the agency prior to, or upon admission to the agency;

i. A patient has the right to be informed of his condition in order to make decisions regarding his or her home health care;

j. The HHA must advise a patient in advance of the disciplines that will be furnished, the care to be furnished, and the frequency of visits;

k. The patient must be notified in advance of any changes in the plan of care before the change is made;

l. A patient has the right to participate in the development of the plan of care, treatment, and discharge planning;

m. A patient has the right to refuse services or treatment; and

n. A patient has the right to request a Fair Hearing when disagreeing with the DHCFP's action to deny, terminate, reduce or suspend service.

1403.1D AUTHORIZATION PROCESS AND REIMBURSEMENTS

1. PRIOR AUTHORIZATION

Home Health Agency (HHA) services may be authorized after providers fax a completed Home Health Prior Authorization form to Nevada Medicaid's Quality Improvement Organization (QIO-like vendor). The request should be submitted two days prior to the start of care. The QIO-like vendor will review and complete the authorization process for Home Health Agency (HHA) services utilizing criteria identified in a clinical decision support guide. QIO-like vendor staff will use this criterion to review for medical necessity and utilization control procedures.

The authorization number will be issued by the QIO-like vendor using a numbering system. The QIO-like vendor will fax the authorization to the requesting provider with the

authorization number. The QIO-like vendor will specify the exact number of services approved. The QIO-like vendor will generate the Notice of Decision (NOD) if the services approved are less than requested and/or constitute an adverse action. A copy will be sent to the recipient and the provider.

All requests, except initial assessments, require prior authorization request. The Home Health prior authorization form must be complete, including the primary diagnosis, ICD-9 codes, descriptions of wound(s), social situation, Dates of Service (DOS), Third Party Liability (TPL), Plan of Care (POC), and specific services requested. Processing may be delayed, or a technical denial issued, if information submitted is illegible or incomplete.

In an emergent situation when the QIO-like vendor is closed, such as nights or weekends, the request for authorization must be submitted to the QIO-like vendor within two working days after the start date. An emergent situation exists when skilled nursing services are required to be implemented immediately such as in the case of wound care, IV medication, etc.

2. HOLIDAY RATES

For recipients who require seven day-per-week home care service, an increased rate will be paid for visits made on State recognized holidays. The holiday rate must be requested on the Home Health Prior Authorization form, which covers the certification period in which the State recognized holiday(s) occur.

Nevada Medicaid currently recognizes the following holidays: New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Nevada Admission Day (last Friday in October), Veteran's Day, Thanksgiving Day, Family Day (the day after Thanksgiving), and Christmas Day. The recognized holiday is the same days that State offices are closed.

Reimbursement: Time and one-half will be reimbursed for State recognized holidays. Use modifier TV to designate holiday rate.

a. PRIOR RESOURCES

When the HHA has a recipient that has another insurance (Medicare or Private Insurance) and the agency has identified the services requested are not a covered benefit of the third party payor, HHA must request "bypass Medicare" or "bypass other" when requesting prior authorization.

b. DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies require a prior authorization request at the time of request for HHA services and are to be listed on the Home Health Prior Authorization Form. Wound care supplies will be authorized for the HHA for a ten day period only. Supplies will be authorized only for the specific procedure or treatment requested. Each item must be listed separately. Supplies must be specifically prescribed by the physician and designated in the POC. A copy of the physician's orders specifying supplies required for home care should be retained in the recipient's HHA file and submitted to Nevada Medicaid upon request. Routine supplies or disposable supplies must be obtained from a Durable Medical Equipment (DME) or pharmacy provider.

Reimbursement: Unit price per fee schedule. Refer to reimbursement code table for specific billing code.

c. MILEAGE

Actual mileage is reimbursed one way from the HHA office to the recipient’s residence. Actual mileage should be listed on the Home Health prior authorization request form to establish a base line for reimbursement. Reimbursement: Mileage is paid per actual miles. Refer to the reimbursement code table for specific billing code.

3. AUTHORIZATION INTERVALS

Services will be authorized for three distinct periods. They are:

a. The initial authorization for all requests. Services may be authorized up to a 60 day interval, beginning with the start date.

b. The reauthorization covers an additional 60 day interval following the completion of the initial visits. This applies to the recipient who requires an extension of the same services that were requested during the initial authorization period. This period, combined with the initial authorization may be up to 120 days.

c. The long-term authorization covers the recipient with continued needs following 120 day episode. This additional authorization interval may be up to one year if services are documented as medically necessary and are expected to continue unchanged for a prolonged interval. (i.e. monthly suprapubic catheter change).

4. ONGOING AUTHORIZATION

Request for continuing HHA services must be submitted to the QIO-like vendor a minimum of ten working days but no more than 30 days prior to the expiration of the current authorization.

The authorization request must include adequate information to support medical necessity, availability of willing and able caregiver or the presence of a qualified LRA. The QIO-like vendor will review for appropriate number of hours using the decision guide and based on program criteria. HHA services may be authorized for a maximum authorization period of one year.

5. ADDITIONAL AUTHORIZATION

An additional authorization request for an additional/PRN one time only visit during a current authorization period may be submitted for authorization approval. Information must be submitted that supports the need for the additional visit. (i.e. foley catheter leaking and a needed replacement). In this situation, the Prior Authorization Request (PAR) must be submitted within 30 days of the service being provided.

6. REVIEW FOR RETROACTIVE AUTHORIZATION

If Medicaid eligibility is established retroactively, Medicaid may authorize retroactive payment to the agency for covered services within limitations of program criteria. The Home Health Prior Authorization form must include the Date of Determination (DOD) of eligibility. Retroactive authorization must be requested within 30 days from the DOD.

7. WOUND MANAGEMENT

a. Authorization for wound care will be based on the clinical decision support guide (Interqual) based on the data submitted following a skilled nursing assessment. The assessment should include the primary diagnosis, pertinent medical, surgical and social history, medication, wound history (e.g. onset, longevity, current management) and pain. Clinical data should include a complete wound assessment (e.g. location, size, depth, partial/full thickness, tissue appearance, sinus tracts, tunneling, stages for pressure ulcers, status of wound edges, condition of skin around the wound, exudates (color, odor, amount) other wound characteristics, and the treatment plan as prescribed by the physician.

b. All initial requests for wound care will be authorized for up to a 60 day interval. All Home Health Prior Authorization forms must be submitted with the required information.

c. Ongoing request for additional visits will be approved according to the criteria identified in the clinical decision support guide. Supporting information must be submitted to the QIO-like vendor. For long-term authorizations, diagnostics studies and nutritional assessments or other evaluations may be required. Authorizations for identified services, such as a registered dietician will be approved if identified as medically necessary.

d. Disposable wound supplies will be authorized for the Home Health Agency (HHA) for an initial ten-day supply only. Thereafter the supplies must be obtained from a Durable Medical Equipment or Pharmacy provider.

e. Specialty beds or other wound care items must be obtained as required per Nevada Medicaid Services Manual, Chapter 1300.

8. ORAL MEDICATIONS

The recipient is expected to self-administer his or her oral medications. The authorization of daily visits for the administration of oral medications is not a covered benefit. A weekly visit for a medication set up may be authorized. Whether it is a brief or extended visit depends on the number of medications and the number of times per day the medications are taken. One visit may be authorized per week. A request should include a substantiating diagnosis, such as mental illness that would limit the recipient's ability to set up his/her own medications. The names and frequency of the medication taken should be on the request.

9. INJECTIONS

Requests for injections are and routinely covered and must meet medical necessity for HHA service. If determined to be medically necessary Intramuscular (IM) or Subcutaneous (SC) may be approved for brief visits only. The sole exception for this is Synagis injections. Synagis may be approved for an RN/LPN extended visit. No more than two brief visits per day may be approved (usually this is for administration of insulin). The recipient, LRA and other willing caregivers should be taught this skill.

10. LABORATORY DRAWS

Requests for laboratory draws may be authorized for brief RN visits only. An extended visit may be authorized, if there is supporting documentation that it was a difficult blood draw and required multiple attempts.

11. HOME HEALTH AGENCY CLAIMS/BILLING GUIDELINES

The Division of Health Care Financing and Policy establishes reimbursement rates for covered services. Providers submit claims using an established revenue code, HCPCS code and modifier. Reimbursement codes for HHA services are listed in the QIO-like vendor billing manual or via mail with a hard copy of the form.

a. Third Party Liability

If there is another insurance that covers or partially covers HHA services, a claim must be submitted to that entity first and a copy of the EOB must be attached to the Medicaid reimbursement claim. For services that are not a benefit of Medicare or other private insurance, it is not necessary to bill the other insurance first. Instead, note on each claim the date, phone number and the name of the person from whom the information on the insurance status was obtained. Indicate "Bypass Medicare" or "Bypass Private Insurance" (specify insurance name) on the claim.

b. HOME HEALTH AGENCY RATE

Home Health Agency rates are based on the recipient's place of residence at the time the service is rendered.

Reimbursement: Reimbursement is made according to regions, urban, rural and out of state, defined in the following manner:

1. Urban: In Southern Nevada, urban is Boulder City and the portion of Clark County within Las Vegas Valley including the cities of Las Vegas, North Las Vegas, Henderson and the urbanized townships. In Northern Nevada, urban includes the cities of Reno, Sparks, and Carson City, and unincorporated areas of Washoe County that are within 30 miles of Reno, as approved by the District Office.

2. All other areas within Nevada are classified as rural. Providers should utilize modifiers related to service area when billing to assure appropriate payment. Instructions for claims coding can be found in the Fiscal Agent's Nevada Medicaid and Nevada Check Up UB-92 Provider Billing Manual.

3. All outside Nevada services use Rural modifier TN.

1403.2 SKILLED NURSING SERVICES (SN)

Skilled nursing services are a covered service when provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse in accordance with the POC, to be safe

and effective. In determining whether a service requires the skill of a nurse, consideration must be given to the inherent complexity of the service, the condition of the patient and the accepted standards of medical and nursing practice.

1403.2A COVERAGE AND LIMITATIONS

1. Observation and Assessment

Nursing visits for observation and assessment will be reimbursed by the home health agency benefit when:

a. There is a reasonable likelihood that the recipient will experience an acute episode;

b. There is reasonable likelihood that the recipient will develop a complication (either as a result of his/her disease process or as a result of prescribed medical therapy);

c. The skills of a nurse are required to assess the recipient's health status and identify significant change;

d. The change in the recipient's health status (as a result of another acute episode or complication) is likely to respond to a change in the recipient's plan of treatment or prescribed medical therapy.

2. Performance of Skilled Procedures

Nursing visits for the performance of skilled procedures of a nurse in the home setting will be reimbursed as a skilled nursing service when the procedure can only be performed safely by a nurse.

Factors that the DHCFP considers when determining if the performance of a specific procedure requires the skill of a nurse include:

a. The complexity of the procedure to be performed;

b. The recipient's physical and functional status;

c. The presence/absence of a willing, able, and competent caregiver in the home; and

d. The service is reasonable and necessary to the treatment of the patient.

3. Examples of covered skilled nursing procedures include but are not limited to:

a. Administration of intravenous, intra-muscular, or subcutaneous medications or

infusions;

b. Vitamin B-12 injections, when administered for the treatment of certain conditions, such as pernicious anemia, megaloglastic anemia, fish tapeworm anemia, certain gastrointestinal disorders or certain neuropathics with the supporting lab work;

c. Insulin administration when the recipient is unable to self-administer the insulin and there is no other willing and able caregiver available. The recipient's plan of care must continue to document that there is no willing and able caregiver available and the recipient continues to be unable to self administer the insulin with each re-certification period. Nursing visits to perform glucometer testing are not covered as it does not require the skill of a nurse to perform;

d. The administration of Synagis for recipients under the age of two years who meet established Medicaid criteria;

e. Skilled nursing visits for venipuncture are covered when the collection of the specimen cannot be performed in the cause of regularly scheduled absences from the home and is necessary for the monitoring of therapeutic blood levels of medications, monitoring of blood counts and electrolyte levels when affected by the recipient's medication regimen, and related to the recipient's illness or medical condition;

f. Nasogastric tube and gastronotomy tube feeding;

g. Ostomy care during the immediate post-operative period;

h. Tracheotomy aspiration;

i. Catheter care (uretenal or suprapublic) insertion and replacement (every 30 days for jelly or 60-90 for silicone catheters) and irrigation;

j. Wound care, when the skills of the nurse are required to safely/effectively perform the wound care; and

k. Total Parenteral Nutrition (TPN).

4. Teaching Recipient/Family to Manage Care at Home

Teaching the recipient/family/caregiver how to manage the recipient's care at home will be reimbursed on a limited and short term basis as a skilled nursing service when the teaching or training is appropriate to the recipient's functional loss, illness or injury.

Teaching and/or training activities must include a time frame in the POC when goals will be accomplished. Teaching visits will be authorized according to the following criteria:

a. The skills of the nurse are required to teach the recipient/family/caregiver how to manage the recipient's care at home. The care itself may be considered to be "unskilled" (not requiring the skills or expertise of the nurse to perform the care), but the amount of skill needed to teach the care must require the skills of a nurse;

b. The teaching is reasonable and necessary for the treatment/management of the recipient's health problem(s);

c. The initial authorization for teaching visits will be authorized according to the criteria identified in the clinical decision support guide. The initial authorization may be up to a 60 day interval. Additional teaching visits may be authorized if documentation is submitted that supports the ability of the recipient and/or the caregiver to learn the material. The content or skill covered by the teaching is new to the learner and does not represent reinforcement or review of previously learned, repeated, or taught content. Teaching will not be covered when the recipient or caregiver is not able to learn or be trained.

Examples of teaching and training activities which require the skill of a licensed nurse include, but are not limited to the following:

d. Self administration of injectable medications;

e. New complex medications;

f. Complex wound care;

g. Self catherization;

h. Administration of enteral feedings; and

i. Care and maintenance of intravenous or central lines and administration of medication through such lines.

5. Skilled Psychiatric Nursing Services

Evaluation of the recipient and the performance of psychotherapy require the skills of a nurse who meets criteria for credentialing as a psychiatric nurse. Services of a non-psychiatric nurse may be ordered by the psychiatrist for visits to administer injections or behavior modifying medications.

Psychiatric mental health services are covered services and are authorized according to the criteria identified in the clinical decision support guide, when the following conditions are met:

a. The psychiatric mental health services are reasonable and necessary for the treatment of the recipient's health status; and

b. The home care services are ordered by a psychiatrist and provided under a written POC. Medical orders must be established and reviewed by the primary physician.

1403.2B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.2C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.2D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.3 SKILLED PHYSICAL THERAPY SERVICES

Periodic home visits may be made by licensed physical therapists, to provide services as ordered by a physician and identified in the POC, when the services are inherently complex and can only be performed safely and effectively by a skilled therapist, and when the recipient cannot access out-patient services.

Reimbursement is based on the diagnosis of a medical condition plus the presence of functional limitations, which can respond or improve as a result of the prescribed POC. There must be an expectation the condition will improve in a reasonable, predictable period of time.

1403.3A COVERAGE AND LIMITATIONS

Skilled physical therapy services may be authorized for home care recipients; HHA visits are included in the total available outpatient limits up to 24 visits per year. These include visits for one or more of the following:

1. Assessment of the recipient's rehabilitation needs and potential;

2. Development and implementation of a physical therapy program when it is medically necessary to the recipient's treatment;

3. Objective tests and measurements such as range of motion, strength, balance coordination, endurance, and functional ability;

4. Performance of therapeutic exercises which require the skills and expertise of a physical therapist to implement safely/effectively;

5. Gait evaluation and gait training for persons who have an impaired ability to ambulate secondary to a neurological, muscular, or skeletal abnormality;

6. Services are required to maintain a person's function that involves complex and sophisticated procedures and the judgment/skill of a physical therapist;

7. Administration of ultrasound treatments; and

8. Administration of heat treatments only when the recipient's overall condition is such that the skills and judgment of a physical therapist are required to safely administer these treatments.

1403.3B PROVIDER RESPONSIBILITY

In addition to 1403.1B, the provider must monitor that the total number of paid visits, do not exceed the total available therapy visits (24) per year.

1403.3C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C

1403.3D AUTHORIZATION PROCESS

Refer to Section 1403.1D

In addition to 1403.1D the physical therapist must submit the completed evaluation along with the Home Health Prior Authorization form to the QIO-like vendor. The provider should contact the QIO-like vendor to determine the number of authorized visits.

1403.4 SKILLED OCCUPATIONAL THERAPY SERVICES

Periodic home visits may be made by licensed occupational therapists to provide services as ordered by the physician and identified in a signed POC. Reimbursement is based on the diagnosis of a medical condition plus the presence of a limitation, which can respond or improve as a result of the prescribed POC. There must be an expectation that the condition will improve in a reasonable period of time.

1403.4A COVERAGE AND LIMITATIONS

Skilled occupational therapy services may be authorized for home care recipients. HHA visits are included in the total available outpatient limits of up to 24 visits per year. These visits include one or more of the following:

1. Assessment of the recipient's rehabilitation potential and needs.

2. Plan/implement/supervise a therapeutic program to:

   a. Restore physical function;

   b. Restore sensory-integrative function;

   c. Provide individualized therapeutic activity as part of an overall active treatment program for persons with diagnoses of psychiatric illness;

   d. Teach compensatory techniques to improve functional independence in the performance of activities of daily living; and

   e. Provide vocational and prevocational assessment and training that is directed toward the restoration of function in ADL's lost due to illness or injury.

1403.4B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B.

1403.4C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.4D AUTHORIZATION PROCESS

A Home Health Prior Authorization form must be submitted along with the completed evaluation to the QIO-like vendor prior to the initiation of service. The initial evaluation does not require prior authorization. Refer to Section 1403.1D.

1403.5 SKILLED SPEECH LANGUAGE PATHOLOGY SERVICES

Nevada Medicaid may pay for the services of a licensed speech pathologist to provide service as ordered by the physician and identified in a signed POC. Reimbursement is based upon diagnosis and treatment of speech and language disorders that result in communications disabilities and for the diagnosis and treatment of swallowing disorders, regardless of the presence of a

communication disability. There must be an expectation that the condition will improve in a reasonable period of time.

1403.5A COVERAGE AND LIMITATIONS

Skilled speech language therapy service may be authorized for home care recipients. HHA visits are included in the total outpatient limits up to 24 visits per year. These include visits for the following:

1. Diagnosis and treatment of expressive and receptive communication disorders;

2. Diagnosis and treatment of swallowing disorders;

3. Assessment of a recipient's rehabilitation needs and potential;

4. Services directed toward specific speech or voice production if a deficit exists resulting from an illness or an injury; Establishment of a hierarchy of speech-voice-language communication tasks and cueing that is directed toward the achievement of specific communication goals;

5. Training the recipient/family/caregiver to augment: the speech language communication; treatment; or to establish a maintenance program;

6. Assisting persons who are aphasic in rehabilitation of speech and language skills; and

7. Assisting a person with voice disorders to learn to control vocal or respiratory systems for correct voice production.

1403.5B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.5C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.5D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.6 RESPIRATORY THERAPY SERVICES

Respiratory therapy is a covered service through a HHA provider, when it is prescribed by a physician and provided under assigned plan of care by a licensed respiratory therapist.

1403.6A COVERAGE AND LIMITATIONS

The services of a respiratory therapist that may be provided to recipients in a home setting include:

1. Ventilator management.

    a. Weaning the recipient off a ventilator; and

    b. Changing settings on ventilators, C-PAP, Bi-PAP, Bi-PAP-ST.

2. Drawing arterial blood gases when a nurse is incapable of doing so. The services of a respiratory therapist will not be reimbursed for the setting up of rental equipment.

1403.6B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.6C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.6D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.7 REGISTERED DIETICIAN SERVICES

Registered dietician services are covered by the Medicaid HHA program. A registered dietician may provide consultative services when the recipient has a nutritional deficit or is at risk for a deficit.

1403.7A COVERAGE AND LIMITATIONS

Home health agency dietician services are appropriate for but not limited to recipients with diagnoses of cachexcia, failure to thrive, poor wound healing and newly diagnosed diabetics who are unable to go outside the home for dietician services.

1403.7B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B.

1403.7C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.7D AUTHORIZATION PROCESS

In addition to Section 1401.1D the provider must submit a copy of the completed evaluation must be submitted to the QIO-like vendor along with the Home Health Prior Authorization Form. The QIO-like vendor will review the evaluation to determine if medical necessity has been met. The initial evaluation does not require prior authorization.

1403.8 HOME HEALTH AIDE SERVICES

To receive home health aide services through the HHA program, the recipient must have a qualifying skilled service and must have an impairment or deficit so that he/she requires assistance with routine activities of daily living. Services must be reasonable and necessary to the treatment of the recipient's illness or injury. Home health aides can be appropriately utilized to assist in carrying out the plan of care. Home health aide services must be incorporated into an outcome specific nursing plan. Home health aides must meet the qualifications specified by 42 CFR 484.36. When it is identified that recipient has an ongoing need for assistance with ADLs, the HHA must advise the recipient and/or caregiver about other available services (e.g. personal care aide services) that may be more appropriate to their needs.

1403.8A COVERAGE AND LIMITATIONS

Home Health Aide services may provide assistance with:

1. Personal care services, such as bathing;

2. Simple dressing changes that do not require the skills of a licensed nurse;

3. Assistance with medications that are self administered;

4. Assistance with activities that are directly supportive of skilled therapy services but do not require the skills of a therapist, such as, routine maintenance exercise;

5. Routine care of prosthetic and orthotic device;

6. Monitoring vital signs;

7. Reporting of changes in recipient condition and needs;

8. Any task allowed under Nevada Revised Statutes (NRS), Chapter 632 – Nursing, and directed in the physician's approved plan of care (POC).

1403.8B PROVIDER RESPONSIBILITY

In addition to Section 1401.1B the HHA RN must make a supervisory visit to the recipient's residence at least once every 60 days.

1403.8C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.8D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.9 END STAGE RENAL DISEASE (ESRD) SERVICES

ESRD recipients may qualify for HHA services. A recipient diagnosed with ESRD must meet all the general requirements for the HHA program plus the recipient must require skilled services that are not directly related to his/her dialysis treatments.

1403.9A COVERAGE AND LIMITATIONS

Refer to Section 1403.1A of this Chapter.

1403.9B PROVIDER RESPONSIBILITY

Refer to Section 1403.1B of this Chapter.

1403.9C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.9D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.10 OUT-OF-STATE SERVICES

HHA services are allowed out-of-state for Medicaid recipients absent from the state pursuant to 42 CFR 431.52. Payment for services furnished in another state are reimbursed to the same extent that Nevada would pay for services provided within Nevada boundaries. Out-of-state HHA services are reimbursed at the rural rate, using rural modifier TN.

1403.10A COVERAGE AND LIMITATIONS

Out-of-state services may be allowed when:

1. There is a medical emergency and the recipient's health would be endangered if he/she were required to return to the State of Nevada to obtain medical services;

2. The recipient travels to another state because DHCFP has determined the required medical services are not available in Nevada, or it is determined that the needed medical services or necessary supplementary resources are more readily available in another state;

3. DHCFP determines that it is general practice for recipients in a particular locality to use medical services in another state (e.g., Nevada counties that border other state lines);

4. The recipient is on personal business. DHCFP may reimburse for these services; however, they will be limited to those currently listed on the recipient's Plan of Care (POC).

1403.10B PROVIDER RESPONSIBILITY

1. The out-of-state provider must contact First Health Services Corporation (FHSC) provider enrollment unit to become enrolled as a DHCFP Home Health Agency provider.

2. The out-of-state provider must also comply with all provisions in Section 1403.1D.

1403.10C RECIPIENT RESPONSIBILITY

1. The recipient or their personal representative must contact Home Health Agency providers in the geographic region of which they wish service to be provided, to determine the availability of HHA service providers.

2. The recipient must notify an out-of-state provider who is not a DHCFP provider, but who is interested in becoming a provider to contact the QIO-like vendor.

3. The out-of-state provider must also comply with all provision in Section 1403.1C.

1403.10D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.11 EARLY & PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Nevada Medicaid may authorize HHA services for medically necessary therapies on children ages 0-20 with chronic special health care needs who are referred to the program through an EPSDT screening. Physical therapy, speech therapy and occupational therapy may be authorized for six months at a time when the child has an EPSDT screening examination, which identifies the medical diagnosis and the need for such therapy. EPSDT screening examinations for these services must be updated at six-month intervals. EPSDT therapies may be authorized beyond the 24 visits per year, if medically necessary as determined by DHCFP.

Reimbursement is based on the diagnosis of a medical condition plus the presence of functional limitations, which can respond or improve as a result of the prescribed POC. There must be an expectation the condition will improve significantly in a reasonably, predictable period of time.

1403.11A COVERAGE AND LIMITATIONS

Refer to Section 1403.1A.

1403.11B PROVIDER RESPONSIBILITY

The therapist must complete the initial evaluation; identify the treatment need, therapy goals, frequency and expected duration of therapy treatment whether for occupational therapy, physical therapy, and/or speech therapy. The provider must comply with all other requirements in Section 403.1B.

1403.11C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C.

1403.11D AUTHORIZATION PROCESS

The following documentation needs to be provided:

1. A completed Home Health Prior Authorization Form requesting therapy(s);

2. A copy of the evaluation and/or POC which includes therapy goals, frequency and expected duration;

3. Referral from EPSDT Screening; and

4. The provider must also comply with all other requirements of Section 1403.1D.

1403.12 SERVICES TO CHILDREN

HHA services are not intended to relieve a parent of their child caring or other legal responsibilities. HHA services for children may be appropriate when the parent is unqualified or otherwise unable to provide care. Home health agency services are intended to provide intermittent skilled intervention with emphasis on caregiver education. Legally responsible adults and other willing primary caregivers are expected to be taught care which can be rendered reasonably and safely by non-medical persons.

1403.12A COVERAGE AND LIMITATIONS

Children are not considered homebound based upon their age. Home health, intermittent skilled nursing and therapy services are available only when the child is considered so medically fragile that leaving the home poses eminent danger to the health of the child. Home health agency services are not to be provided as a convenience to parents, the physician or the physician supplier. In authorizing services to children, consideration will be given to the inherent complexity of the skilled intervention, the capacity of available primary caregivers to be taught, and the availability of these caregivers. It is expected that the legally responsible adult or willing caregiver, after demonstrating competency, will provide the service.

1403.12B PROVIDER RESPONSIBILITY

Verify the availability and capability of the legally responsible adult or primary caregiver and include such information with request.

1403.12C RECIPIENT RESPONSIBILITY

Refer to Section 1403.1C of this Chapter.

1403.12D AUTHORIZATION PROCESS

Refer to Section 1403.1D of this Chapter.

1403.13 FAMILY PLANNING

Home health agencies providing post partum home visiting service to Medicaid eligible women, may bill for family planning education.

1403.13A COVERAGE AND LIMITATIONS

This service must be provided:

1. In conjunction with the newborn assessment screening;

2. Be provided by a registered nurse; and

3. Consist of counseling and education about:

   a. Appropriate spacing of pregnancies

   b. Family planning options.

1403.13B PROVIDER RESPONSIBILITY

Refer to Section 1401.1B of this Chapter.

1403.13C RECIPIENT RESPONSIBILITY

Refer to Section 1401.1C of this Chapter.

1403.13D AUTHORIZATION PROCESS

No prior authorization is required. Submit on UB-92 0581 -- H1011 FP, TD (Old CPT Code = C98970).

1404 HEARINGS

Please reference Medicaid Services Manual, Chapter 3100 Hearings, for hearing procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 27, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres* Casey Angres (Jan 10, 2023 08:30 PST)

MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1500 – HEALTHY KIDS PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids Program are being proposed to update the policy and to allow payment to providers for a Well Check Visit and a Sick Visit for the same recipient at the same time of service with the same provider.

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: These proposed changes affect all Medicaid enrolled providers delivering Healthy Kid Exams / annual wellness visits and sick visits. Those Provider Types (PT) include but are not limited to: Outpatient Hospital (PT 12), Physician (PT 20), Advanced Practice Registered Nurse (PT 24), and Physician Assistant (PT 77).

Financial Impact on Local Government: No impact on local government known at this time.

These changes are effective: December 28, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 17/22 MSM Chapter 1500 Healthy Kids Program	MTL 19/15, 29/15, 16/16 MSM Chapter 1500 Healthy Kids Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1500	**Introduction**	Added the word “years old.”
1501	**Authority**	Added the word “years old.”

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1503.1A(4)	**Coverage and Limitations**	Added the word 'services' to the title for MSM Chapter 2600 to read Audiology Services.
1503.1B	**Provider Responsibility**	Updated the term immunizations to vaccinations throughout this section. Deleted Hewlett Packard Enterprise Services (HPES), added PT 20, PT 24, and PT 77. Included updated link to the fiscal agent website for billing guides. Deleted 'Physicians Billing Guide.'
1503.3A	**Coverage and Limitations**	Updated the term immunizations to vaccinations throughout this section. Deleted Hewlett Packard Enterprise Services (HPES) and added PT 20, PT 24 and PT 77. Included updated link to the fiscal agent website for billing guides. Replaced 'encouraged' with the term 'must' and added 'pharmacies' with respect to enrollment with the Vaccines for Children (VFC) program. Updated the title to MSM Chapter 1200 to "Prescribed Drugs."
1503.3A(3)	**Coverage and Limitations**	Updated policy language to allow reimbursement for a Sick Visit and a Healthy Kids Exam for the same recipient on the same Date of Service (DOS) and for the same provider.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HEALTHY KIDS PROGRAM

ATTACHMENT A

1500 INTRODUCTION

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are preventive and diagnostic services available to most recipients under age 21 years old. In Nevada, the EPSDT Program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary treatment to correct such conditions. Healthy Kids offers the opportunity for optimum health status for children through regular, preventive health services and the early detection and treatment of disease.

1501 AUTHORITY

A. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21 years old.

Services available under the Healthy Kids Program are provided as defined in the following:

1. Omnibus Budget Reconciliation Act of 1989;
2. Social Security Act 1905 (a) and (r);
3. Social Security Act 1902 (a);
4. Social Security Act 1903 (i);
5. 42 Code of Federal Regulations (CFR), Subpart B, 441.50 – 441.62;
6. State Medicaid Manual (Part 5); and
7. Nevada Medicaid's State Plan.

1502 RESERVED

1503 POLICY

1503.1 EARLY PERIODIC SCREENINGS

A child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated. Assessment of a child's health at regularly scheduled intervals assures that a condition, illness or injury is not developing or present. The Healthy Kids Program has established a periodicity schedule for screening, vision, hearing and dental services based upon the American Academy of Pediatrics (AAP). The periodicity schedule utilized by the Healthy Kids Program can be found at the Bright Futures/AAP website: http://brightfutures.aap.org.

1503.1A COVERAGE AND LIMITATIONS

1. The Healthy Kids Program encourages providers to follow the recommended schedule for developmental screenings offered by the AAP. Recipients will be sent letters by the Division's Quality Improvement Organization (QIO)-like vendor reminding them to schedule a screening visit on a periodic basis.

2. Dental services are outlined in Medicaid Services Manual (MSM) Chapter 1000, Dental. Dental services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, they must include relief of pain and infection, restoration of teeth, and maintenance of dental health. Generally, dental services should be age-appropriate and must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.

3. Vision services are outlined in MSM Chapter 1100, Ocular Services. Vision services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services must include diagnosis and treatment for defects in vision, including eyeglasses. Generally, vision services should be age-appropriate and must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.

4. Hearing services are outlined in MSM Chapter 2000, Audiology Services. Hearing services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services should be age-appropriate and must include diagnosis and treatment for defects in hearing including hearing aids. Generally, hearing services must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.

1503.1B PROVIDER RESPONSIBILITY

1. The provider is expected to follow the periodicity guidelines as recommended when conducting Healthy Kids examinations whenever possible. The provider should offer services as deemed medically appropriate.

2. The provider shall determine whether a screening request is medically necessary when it falls outside the periodicity schedule and will conduct the intervention necessary to address the suspected medical problems.

3. The provider should assure the elements listed in Section 1503.3A are included in a screening examination. The provider should seek out and incorporate information regarding the child's usual functioning from parents, teachers and others familiar with the child when conducting an examination. Medical records should document the assessments and significant positive and negative findings. Discussions with the child and family about the findings should be an integral part of every examination and documented as well. A referral to another Medicaid provider should occur if the provider is unable to perform any screening component. EPSDT screening forms and EPSDT Participation Reports can be found on the Division of Health Care Financing and Policy (DHCFP) website: https://dhcfp.nv.gov/epsdt.htm.

4. Medical records should contain the following information specific to EPSDT screening services:

   a. Reason for the visit;

   b. The date screening services were performed, the specific tests or procedures performed, the results of these tests and the person who provided the service;

   c. Documentation of medical contraindication or a written statement from a parent or a guardian of a screened child, for whom vaccinations were due and not given and attempts the screening provider made to bring the child up-to-date on vaccinations;

   d. Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening;

   e. Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as the medical screening;

   f. Documentation of declination of screening services by the parent;

   g. Referrals made for diagnosis, treatment or other medically necessary health services for conditions found in the screenings;

h. Date the next screening is due; and

i. Documentation of direct referral for age-appropriate dental services.

5. Providers should submit claims using the established billing codes related to the Healthy Kids screening examination. These examination codes can be found in the Medicaid Billing Guides, for Provider Types (PTs) 20 and 24 and 77, located at: www.medicaid.nv.gov/providers/BillingInfo.aspx.

6. The provider should make referrals for diagnostic testing after discussing the need for such services with the recipient/parent/legal guardian during a post screening interview. The physician's progress notes should indicate the need for such testing.

7. A dated written referral should be given to the recipient or parents or forwarded to the referral service provider. The referral should include the following information:

a. The name of the child;

b. The Medicaid ID number of the child;

c. The date of the screening;

d. The abnormality noted;

e. The name, address, telephone and fax numbers of the child's primary physician if different from the screening provider; and

f. The physician to whom the referral applies if known.

8. The provider should advise recipients of possible resources for obtaining testing as appropriate.

1503.2 INTERPERIODIC SCREENINGS

Healthy Kids screenings are provided to all eligible persons under the age of 21 years old, which may include medically necessary intervals that are outside an established periodicity schedule, also known as interperiodic screenings.

1503.2A COVERAGE AND LIMITATIONS

1. The DHCFP has identified a periodicity schedule that allows for access to screening, vision, hearing and dental services at intervals which meet reasonable standards of medical practice. The periodicity schedule can be found at the Bright Futures/AAP website: http://brightfutures.aap.org.

2. A recipient may request a health care screening or any component of the health screening at any time. Screening services which are medically necessary, such as when a new health problem has occurred or when a previously diagnosed condition has become more severe or changed sufficiently to require a new examination, will be offered, regardless of whether the request falls into the periodicity schedule established by the State.

1503.3 COMPREHENSIVE SCREENING EXAMINATION

A comprehensive child health assessment is provided to determine if a child has a condition, illness or injury that should be referred for further evaluation and/or treatment. A Healthy Kids screening examination must comply with 1905(r) of the Social Security Act (SSA). http://www.socialsecurity.gov/OP_Home/ssact/title19/1905.htm.

1503.3A COVERAGE AND LIMITATIONS

1. Screening services are designed to evaluate the general physical and mental health, growth, development and nutritional status of infants, children and adolescents.

   The following is a description of each of the required age-appropriate screening components:

   a. COMPREHENSIVE HEALTH AND DEVELOPMENTAL/BEHAVIORAL HISTORY

      At the initial screening, the provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

      1. Family medical history (health of the parents and current family members, identification of family members with chronic, communicable or hereditary diseases);

      2. Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies, current health problems and medications);

      3. Nutritional history;

      4. Vaccination history;

      5. Environmental risk;

6. Family background of emotional problems, problems with drinking or drugs, or history of violence or abuse;

7. Patient history of behavioral and/or emotional problems;

8. History of sexual activity, if appropriate; and

9. Menstrual and obstetrical history for females, if appropriate.

b. DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

1. Assessment of developmental and behavioral status should be completed at each visit by observation, interview, history and appropriate physical examination. The developmental assessment should include a range of activities to determine whether or not the child has reached an age-appropriate level of development.

2. Nevada Medicaid will reimburse separately for developmental screenings, provided that a valid, standardized developmental screening tool, (i.e. Parents Evaluation of Developmental Status (PEDS), Ages and Stages, Early Language Milestone Screen) has been utilized and entered into the child's health care record. Although the AAP recommends the use of a standardized screening tool at ages nine, 18 and 30 months, and three and four years of age, the exact frequency of standardized testing depends on the clinical setting and provider's judgment as to medical necessity. Asking questions about development as part of the general informal developmental survey or history is not a "standardized screening" and is not separately reportable. Providers may be subject to a random audit of records to assure the use of the screening tool. For billing instructions, see the PTs 20, 24, and 77 Billing Guides at: www.medicaid.nv.gov/providers/BillingInfo.aspx.

c. COMPREHENSIVE UNCLOTHED PHYSICAL EXAM

A completed unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques. The examination must include all body parts and systems listed below:

1. Cranium and face;

2. Hair and scalp;

3. Ears;

4. Eyes;

5. Nose;

6. Throat;

7. Mouth and teeth;

8. Neck;

9. Skin and lymph nodes;

10. Chest and back;

11. Abdomen;

12. Genitalia;

13. Musculoskeletal system;

14. Extremities; and

15. Nervous system.

16. The examination should include screening for congenital abnormalities and responses to voices and other external stimuli.

d. APPROPRIATE VACCINATIONS

1. The child's vaccination status must be reviewed each screening visit. Appropriate vaccinations that are due must be administered during the screening visit and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html.

2. Nevada Medicaid cannot reimburse for vaccines (except administration fees) that are available through the Division of Public and Behavioral Health (DPBH) as part of the Vaccines for Children (VFC) Program. Providers and pharmacies must enroll with the VFC Program which provides the VFC vaccines at no cost to eligible children. Medicaid cannot be billed for the cost of a vaccine obtained through VFC, (even if the provider is not enrolled with VFC) unless there is a documented statewide shortage. To become a VFC provider, please access the website via https://dpbh.nv.gov/Programs/VFC/VFC_-_Home/.

3. Nevada Check Up (NCU) provides the same vaccines through a different funding source, but providers must use the same billing guidelines.

4. For specific guidelines for the Human Papilloma Virus (HPV) vaccine, please refer to MSM Chapter 1200, Prescribed Drugs.

e. LABORATORY PROCEDURES

Age-appropriate laboratory procedures must be performed at intervals in accordance with the Healthy Kids periodicity schedule. These include blood lead level assessment appropriate to age and risk, urinalysis, Tuberculin Skin Test (TST), Sickle-cell, hemoglobin or hematocrit and other tests and procedures that are age-appropriate and medically necessary, such as pap smears.

f. HEALTH EDUCATION

1. Health education related to the physical assessment should be provided at each screening visit. It is designed to help children and their parents understand the health status of the child as well as provide information which emphasizes health promotion and preventive strategies. Health education explains the benefits of a healthy lifestyle, prevention of disease and accidents, normal growth and development and age-appropriate family planning services.

2. Anticipatory guidance should be offered which includes discussion of information on what to expect in the child's current and next developmental phase. It is given in anticipation of health problems or decisions which may occur before the next periodicity visit.

3. Information should also include a summarization of the results of the screening and laboratory tests, review of the child's health status and discussion regarding any specific problems detected in the screening.

g. VISION SCREENING

The purpose is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malformations, eye diseases, color blindness and refractive errors. The screening should include distance visual acuity, color perception and ocular alignment tests. The vision screening is part of the complete physical examination and should be given by age three years old. Screening for amblyopia may be separately reimbursed.

h. HEARING SCREENING

The purpose is to detect sensorineural and conductive hearing loss, congenital abnormalities, noise-induced hearing loss, central auditory problems or a history of conditions that may increase the risk for potential hearing loss. The examination must include information about the child's response to voice and other auditory stimuli, speech and language development and specific factors or health problems that place a child at risk for hearing loss.

i. DENTAL SCREENING

An oral inspection must be performed by the screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries should be noted. The oral inspection is not a substitute for a complete dental screening examination provided by a dentist. An initial dental referral should be provided for children three years or older unless it is known that the child is already receiving regular dental care. When the screening indicates a need for dental services at an earlier age, referral must be made. The importance of regular dental care should be discussed with the family (and the child as appropriate) on each screening visit for children three years and older.

2. Vaccines and laboratory tests should be billed separately from the screening visit. Objective vision and hearing testing performed during the same visit as the physical examination should not be billed separately, with the exception of testing for amblyopia. If hearing and vision testing needs to be performed separately from the exam, these procedures should be billed as outlined in applicable MSM chapters.

3. Nevada Medicaid may cover "sick" visits and a Healthy Kids examination for the same recipient, at the same time of service, and with the same provider. All screening elements must be completed during a Healthy Kids examination as indicated in the Periodicity Schedule/Bright Future and Section 1503.3A of this chapter. Appropriate diagnosis must be billed for each respective visit

a. Vaccines may be administered during a sick visit at the medical professionals' discretion.

1503.4 DIAGNOSTIC SERVICES

Nevada Medicaid provides diagnostic services as indicated through a Healthy Kids screening.

1503.4A COVERAGE AND LIMITATIONS

1. Any condition discovered during a screening should be followed up for diagnosis. Prior authorization is not necessary for these diagnostic examinations if they are part of or referred through a Healthy Kids screening. Referrals can include but are not limited to:

   a. Vision Services.

   b. Dental Services.

   c. Hearing Services.

   d. Other Necessary Health Care.

2. Although preferred, a Healthy Kids screening is not a requirement for medically necessary diagnostic services.

1503.5 TREATMENT

Nevada Medicaid provides for medically necessary treatment as indicated through a Healthy Kids screening and diagnosis.

1503.5A COVERAGE AND LIMITATIONS

1. Health care and treatment is available to correct or improve defects and physical and mental illnesses or conditions discovered by Healthy Kids screening and diagnostic services. Covered services include all mandatory and optional services that a state can cover under the benefit plan, whether or not such services are covered for adults. The scope of medical services available are described in the SSA, Section 1905(a).

2. Services that are not medical in nature, including educational interventions, are excluded. Treatment must be medically necessary and prior authorized if not typically included in the benefit plan. The QIO-like vendor will review the suggested treatment to ensure it meets with current medical practice standards for the given diagnosis.

3. When treatment is needed to correct or improve identified conditions, the DHCFP's established requirements for prior authorization apply. See the MSM Chapters related to the requested service to determine if prior authorization is needed before treatment is rendered.

4. Although it is preferred, a Healthy Kids screening is not a requirement for medically necessary treatment under EPSDT guidelines (SSA, Section 1905(r).

1503.6 FAMILY PLANNING

Family planning services are available to recipients.

1503.6A COVERAGE AND LIMITATIONS

Family planning information should be offered during a Healthy Kids examination as appropriate and requested.

1503.7 TRANSPORTATION

Assistance with transportation is available to and from a Healthy Kids examination. Please reference MSM Chapter 1900, Transportation Services.

1503.7A COVERAGE AND LIMITATIONS

Nevada Medicaid pays for transportation in order for a recipient to receive medically necessary care and services. Transportation requires prior authorization in all but emergency situations. The guidelines outlined in MSM Chapter 1900 should be followed.

1503.8 PREGNANCY RELATED ONLY

The Healthy Kids benefit package is not available to recipients who are eligible solely because of pregnancy.

1503.8A COVERAGE AND LIMITATIONS

A recipient who is less than 21 years old and whose eligibility status is pregnancy related only (P) is not eligible for Healthy Kids. She is eligible for pregnancy related services only, which includes prenatal care, labor and delivery services and postpartum care for 60 days after the date of delivery, including the month in which the 60th day falls. The recipient may be eligible for services that relate to conditions that might complicate the pregnancy, but those services cannot be billed as a Healthy Kids service.

1504 HEARINGS

Please reference MSM Chapter 3100 for Medicaid Recipient Hearing process policy.

POLICY #15-1	CLINICAL STUDIES	EFFECTIVE DATE: November 1/ 2014

For policy related to clinical studies, please refer to MSM 600 – Physician Services, Attachment A, Policy #6-01, Qualifying Clinical Trials (QCT).

POLICY #15-2	EXPERIMENTAL TREATMENT	EFFECTIVE DATE: November 1/ 2014

For policy related to experimental treatment, please refer to MSM 600 – Physician Services, Attachment A, Policy #6-01, Qualifying Clinical Trials (QCT).

POLICY #15-2	EXPERIMENTAL TREATMENT	EFFECTIVE DATE: NOVEMBER 1, 2014

DESCRIPTION/POLICY

Nevada Medicaid does not cover any item or service that is not medically necessary, that is unsafe or is not generally recognized as an accepted method of medical practice or treatment.

PRIOR AUTHORIZATION IS REQUIRED

If experimental treatment is medically necessary, providers must request prior authorization for services which may fall into the above category prior to rendering service.

COVERAGE AND LIMITATIONS

Nevada Medicaid completes prior authorization on medical services to assure that the care and the services proposed are actually needed, are equally effective, less expensive alternatives have been given consideration and the proposed service and materials conform to commonly accepted standards.

Nevada Medicaid's QIO-like vendor completes the authorization review.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 21, 2011

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1600 – INTERMEDIATE CARE FOR THE MENTALLY RETARDED

BACKGROUND AND EXPLANATION

The policy has been revised in the area of transportation to provide examples of services not reimbursable to the facility and refer the reader to Medicaid Services Manual (MSM) Chapter 1900, Transportation Services. The changes reduce conflict of information between program chapters and provide additional direction regarding transportation to an Adult Day Health Care (ADHC) setting. The second revision addresses a provider's use of ADHC services. Further changes direct the provider to the Rates and Cost Containment Unit for information regarding the Uniform Cost Report. Lastly, additional direction has been provided for the management of a patient's trust fund account.

To bring the chapter into formatting consistent with other manual chapters the Definitions section and the References and Cross References section have been deleted and are being reserved for future use.

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.

These policy changes are effective July 22, 2011.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 12/11 CHAPTER 1600 - INTERMEDIATE CARE FOR THE MENTALLY RETARDED	MTL 36/03, 38/08, 21/10 CHAPTER 1600 - INTERMEDIATE CARE FOR THE MENTALLY RETARDED

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1602	**Definitions**	The section was deleted and is being reserved for

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		future use.
1603.4	**Transportation**	Added types of transportation a facility must provide that are not reimbursable, the word "ambulance" to specify the type of emergency transportation that is reimbursable, and reference to Chapter 1900 as the authority regarding transportation policy.
1603.6	**Professional Services**	Added explanation of ADHC as part of an Active Treatment Program but separate reimbursement is not allowed.
1603.7	**Reimbursement Rate and Allowable Costs**	Revisions made to directions regarding contact and instructions for Uniform Cost Report. Added new sub-section "Patient Trust Fund Management" explaining the handling of patient trust funds and refers reader to MSM Chapter 500, Nursing Facilities
1605	**References and Cross References**	The section was deleted and is being reserved for future use.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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INTERMEDIATE CARE FOR THE MENTALLY RETARDED

1600 INTRODUCTION

Nevada Medicaid's Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Program was established in 1971 to provide reimbursement for individuals residing in institutions for people with mental retardation or other related conditions. The Social Security Act specifies that these institutes must provide active treatment in addition to other Conditions of Participation. Many of the residents who are served by the program are also non-ambulatory, may have seizure disorders, behavioral problems, mental illness, can be visually or hearing impaired or have a combination of these conditions.

The Division of Health Care Financing and Policy (DHCFP) has opted to provide services for people residing in an ICF/MR as a benefit under the State Plan for Medical Assistance.

All DHCFP (Nevada – Medicaid) policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

1601 AUTHORITY

Federal Statutes, Regulations, and Policies Governing the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program.

The following are the relevant statutes, regulations, and State Operations Manuals (SOM) that govern the ICF/MR Program.

FEDERAL STATUTES governing ICF/MR – Social Security Act:

- Section 1905(d) – Defines ICF/MR
- Section 1905(a)(15) – Defines ICF/MR
- Section 1902(a)(33) – Directs Centers for Medicare and Medicaid Services (CMS) to make independent and binding determinations
- Section 1902(i)(1) – State plans for medical assistance and the ICF/MR program.
- Section 1922 – Correction and Reduction Plans for ICF/MR
- REGULATIONS governing the ICF/MR program – Title 42 of the Code of Federal Regulations (CFR)
- 42 CFR 435.1009 – Definitions relating to institutional status for the purpose of Federal Financial Participation (FFP)
- 42 CFR 440.150 – ICF/MR services
- 42 CFR 440.220 – Required services for the medically needy
- 42 CFR 442.118-119 – Denial of new admissions
- 42 CFR 483.10 – Resident Rights
- 42 CFR 483.400-480 – Conditions of Participation for ICF/MR
- 42 CFR 498.3-5 – Appeals procedures for determinations that affect participation in the Medicare program and for determinations that affect the participation of ICF/MR and certain Nursing Facilities in the Medicaid program.
- SURVEY procedures governing the ICF/MR program – State Operations Manual (SOM), Chapters 1, 2, 3, 9 – Exhibit 80 and Appendix J.

1602 RESERVED

1603 POLICY

1603.1 Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must be certified and comply with all Federal Conditions of Participation in eight areas, including management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment and dietetic services.

In Nevada, the Bureau of Health Care Quality and Compliance (HCQC) of the State Health Division licenses ICF/MR facilities, conducts surveys and recommends certification of the facilities as Medicaid providers.

1603.1A COVERAGE AND LIMITATIONS

1. ADMISSION AND CONTINUED STAY CRITERIA

a. The recipient must be diagnosed as mentally retarded or have a condition related to mental retardation. Some standardized scales which can be used to determine level of mental retardation include, but are not limited to, the Vineland Social Maturity Scale, the Adaptive Behavior Scale, and the Behavior Development Survey.

b. The recipient must have an Individual Program Plan (IPP).

c. A physician must certify the need for ICF/MR care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/MR, before the Nevada Medicaid Office (NMO) authorizes payment).

d. The certification must refer to the need for the ICF/MR level of care, be signed and dated by the physician, and be incorporated into the resident's record in the physician's orders.

e. Recertification by a physician or a nurse practitioner of the continuing need for ICF/MR care is required within 365 days of the last certification.

In no instance is recertification acceptable after the expiration of the previous certification.

f. The physical exam must document the resident does not have any active communicable, contagious, or infectious disease.

g. The Interdisciplinary Team (IDT) evaluation documents that the recipient needs more intensive treatment than can be provided in a day treatment program or a community residential program.

The IDT evaluation documents that the recipient needs and can probably benefit from the active treatment program. The program is directed toward the acquisition of behaviors necessary to maximize the recipient's possible independence and self determination or to prevent or decelerate regression or loss of the recipient's current level of functioning for a recipient for whom no further positive growth is demonstrable.

h. The IDT has developed an appropriate IPP based on its evaluation and reevaluated the plan as required.

i. The recipient had Medicaid Eligibility on the date(s) of service.

j. Services are provided in a Medicaid certified participating facility.

1603.1B PROVIDER RESPONSIBILITY

1. MEDICAID ELIGIBILITY

The provider is responsible to verify a recipient's Medicaid eligibility. The Electronic Verification System (EVS) may be used.

Refer to Chapter 100 of the Medicaid Services Manual (MSM) for detailed information on application and eligibility categories.

2. FACILITY CERTIFICATION

Certification of compliance with federal requirements for participation in the Medicaid program is required; contact the HCQC of the State Health Division for information and procedures.

The facility must also have a valid Provider Agreement with the Nevada Medicaid Office; the Agreement must be co-terminus with Medicaid's period of certification, including any automatic cancellation dates imposed by Centers for Medicare and Medicaid Services (CMS). The maximum duration of a Provider Agreement is 12 months.

3. PRELIMINARY ASSESSMENT

The IDT must complete a preliminary assessment of each recipient prior to admission to the facility.

The preliminary assessment must include background information and current valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the recipient's needs, if the recipient is likely to benefit from placement in the facility, and what services are needed to meet those needs.

4. PSYCHOLOGICAL EVALUATION

There must be a psychological evaluation documenting the need for care which must be completed within three months before admission and prior to authorization of payment.

For an urgent or emergency initial ICF/MR placement, a psychologist may review the most recent psychological evaluation and document with a progress note or addendum to the psychological evaluation that the recipient is eligible and needs ICF/MR placement. The note or addendum must confirm the recipient's specific level of retardation or identify the condition related to mental retardation and be signed and dated within 90 days prior to admission or on the admission date. This progress note or addendum must be attached to the most recent psychological evaluation.

For readmission and discharge to another ICF/MR, a new psychological evaluation is not required unless the IDT determines the existing evaluation is no longer accurate.

5. PHYSICIAN'S CERTIFICATION AND MEDICAL PLAN OF CARE

The physician must complete a medical plan of care if the resident requires 24-hour licensed nursing care. It must include:

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

b. Any orders for:

1. medications;

2. treatments;

3. restorative and rehabilitative services;

4. activities;

5. therapies;

6. diet;

7. medical equipment utilized to help treat medical conditions, such as helmets or orthopedic splints; and

8. special procedures designed to meet the objectives of the plan of care.

6. THIRTY–DAY EVALUATION RECORD REQUIREMENTS

Within 30 days of admission, the following assessments and evaluation which were completed (as appropriate to the recipient's needs) must be entered in the resident's record.

a. A physical examination and history which was completed within five days prior to or 30 days after admission. The examination and history may be conducted by an advanced practitioner of nursing or physician's assistant, if within their scope of practice, or a physician. The examination must include screening for vision and hearing.

b. A complete dental examination which is completed within 12 months prior to or one month after admission.

c. Evaluation of nutritional status which includes the determination of diet adequacy, total food intake, potential need for additives or supplements, and the skills associated with eating or feeding, food services practices, monitoring, and supervision of the resident's own nutritional status.

d. Routine laboratory examinations as determined necessary by a physician.

e. Speech and language screening.

f. Social assessment which includes, but is not limited to, family history, social relationships and interactions with peers, friends and relatives, and social development.

g. Active Treatment Schedule.

h. A nursing assessment which includes medication and immunization history, developmental history, and current health care needs.

i. Assessment of sensorimotor development which includes the development of perceptual skills which are involved in observing the environment and making sense of it; the development of those behaviors which primarily involve muscular,

neuromuscular, or physical skills and varying degrees of physical dexterity; identifying the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status.

j. Assessment of affective development which includes the development of behaviors which relate to the recipient's interests, attitudes, values, and emotional expressions.

k. Assessment of cognitive development which refers to the development of those processes by which information received by the senses is stored, recovered, and used including the development of the processes and abilities involved in memory and reasoning.

l. Assessment of adaptive behaviors and independent living skills which includes the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected of their age and cultural group and skills such as meal preparation, laundry, bed making, budgeting.

m. Assessment of vocational or prevocational development, as applicable, which includes work interests, work skills, work attitudes, work related behaviors and present and future employment options.

All of the assessments must describe what recipients can and cannot do in terms of skills needed within the context of their daily lives.

In addition, the assessments must:

n. Identify the recipient's present problems and disabilities and where possible, their causes;

o. Identify the recipient's specific developmental strengths;

p. Identify the recipient's specific developmental and behavioral management skills;

q. Identify the recipient's need for services without regard to the actual availability of services needed.

7. INDIVIDUAL PROGRAM PLAN (IPP)

a. Within 30 days of admission, the IDT develops an IPP for each resident based on the interdisciplinary professional comprehensive evaluations.

b. The purpose of the IPP is to help the individual function at the greatest physical, intellectual, social, or vocational level the recipient has presently or can potentially achieve.

c. The interdisciplinary team must prepare an IPP which includes opportunities for individual choice and self management and identifies the discrete measurable criteria-based objective the recipient is to achieve, and the specific individualized program of specialized and generic strategies, supports and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the recipient to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

8. IMPLEMENTATION OF CONTINUOUS ACTIVE TREATMENT

a. The ICF/MR must provide active treatment. Once the IDT has developed the recipient's IPP, the recipient must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the plan.

b. The individual's time in the home or living unit must maximize toward further development and refinement (including self-initiation) of appropriate skills.

c. For the active treatment process to be effective, the overall pattern of interaction between staff and a recipient must be related to the comprehensive functional assessment and the IPP.

d. Except for those facets of the IPP which must be implemented by licensed personnel, each recipient's program plan must be implemented by all staff who work with the recipient, including professional, para-professional, and other staff, including direct care staff.

e. The facility must ensure that during staff time spent with each recipient, the staff members are able to provide needed interventions or reinforce acquired skills in accordance with the program plan. The activities of the ICF/MR must be coordinated with other habilitation and training activities in which the recipient may participate outside of the ICF/MR and vice versa, i.e. school or Community Training Center (CTC).

9. ACTIVE TREATMENT SCHEDULE

Within 30 days of admission to the facility, staff must develop an active treatment schedule which outlines the current active treatment program and is readily available for

review by relevant staff. The schedule should direct the intensity of the daily work of the staff and the recipient in implementing the individual program plan. To the extent possible, the schedule should allow for flexible participation of the recipient in a broad range of options, rather than on a fixed regimen.

The facility must develop an active treatment schedule for each recipient which:

a. Does not allow for periods of unscheduled activity of longer than three continuous hours;

b. Allows free time for individual or group activities using appropriate materials;

c. Includes planned outdoor period year-round;

d. Reflects some of the specific programs for the individual rather than a facility or unit-wide generic calendar.

10. QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP) REVIEWS

a. Reviews

A facility must have one or more QMRP's review the IPP and assure it is revised as necessary. The frequency of the QMRP reviews are determined by the facility. The duties of the QMRP are:

1. Monitoring the delivery of each IPP;

2. Integrating and coordinating the various aspects of the active treatment program;

3. Reviewing each recipient's program plan and insuring it is revised as necessary, including but not limited to, situations in which the recipient:

a. Has successfully completed an objective or objectives identified in the IPP;

b. Is regressing or losing skills already gained;

c. Is failing to progress toward identified objectives after reasonable efforts have been made; or

d. Is being considered for new training.

4. Obtaining input and review by other IDT members when the revisions result in significant differences from the team's original intent;

5. Documents information relevant to the IPP, assuring it is recorded as changes occur.

11. ANNUAL INTERDISCIPLINARY TEAM (IDT) REVIEW

Within one year of the resident's admission date and at least once annually thereafter, the IDT must re–evaluate each recipient and revise the IPP. Revisions must be developed and implemented and recommendations acted upon within 30 days of the IDT meeting, unless other time frames are justified.

a. The annual review must include:

1. The advisability of continued ICF/MR placement versus an alternative placement;

2. When the recipient is an adult, the need for guardianship and how the recipient can exercise his/her civil and legal rights;

3. The continuing appropriateness of the IPP objectives;

4. The continuing appropriateness of services provided to reach the plan's objectives;

5. The progress or failure to progress toward the plan's objectives;

6. Modification of the activities, objectives and/or training programs of the IPP as are necessary; and

7. A comprehensive functional reassessment to be based upon:

a. Physical examination including a vision and hearing screening, which may be completed by a physician or an advanced nurse practitioner;

b. Dental examination;

c. Social reassessment;

d. Physician's recertification of need for ICF/MR;

e. Nursing reassessment;

f. Routine screening laboratory tests as determined necessary by the physician;

g. Nutritional reassessment;

h. The IDT must determine whether other assessments are still accurate.

8. Accurate assessments must include:

a. Current, relevant and valid data;

b. Skills, abilities and training needs identified which correspond to the resident's actual status; and

c. The cultural background and experiences of the resident are reflected in the choice, administration and interpretation of the assessments.

Assessments which are no longer accurate must be revised. The case record must document that the IDT has reviewed the assessments and determined which need updating.

Assessments which must be reviewed by the IDT and revised as recommended by the IDT are:

d. Sensorimotor, affective and cognitive development;

e. Adaptive behaviors and independent living skills; and

f. Vocational and prevocational development as applicable.

12. OCCUPANCY REPORTS

To assist in appropriate use of available beds, the facility must complete the Monthly Facility Occupancy Report indicating the actual census as of the first day of each month. This report is due by the fifth day of each month. The occupancy report may be submitted by fax to Division of Health Care Financing and Policy (DHCFP), Continuum of Care Unit, (775) 687-8724.

13. INCIDENT REPORTS

Incidents involving any potential harm to a resident in or around the facility must be:

a. Recorded on an adequate form;

b. Reported to the resident's physician or his alternate immediately if there is serious harm;

c. Reported to the family member, authorized representative or legal guardian; and

d. Evaluated by a nurse.

Incident documentation may be maintained apart from the resident's chart but, upon request, must be made available to authorized representatives of the DHCFP and/or Nevada State Health Division.

A facility must report to the Nevada Medicaid Office by telephone, within 48 hours, any incident in or about the facility that results in the death of or serious injury to any Medicaid resident by other than natural causes.

1603.1C RECIPIENT RESPONSIBILITY

1. Recipients and/or their authorized representative are responsible to apply for and to maintain Nevada Medicaid eligibility by cooperating with the Division of Welfare and Supportive Services (DWSS) in providing information necessary to determine eligibility.

2. Application for services is made directly through the service provider in conjunction with the Health Division’s Mental Health and Development Services (MHDS).

3. The recipient and the recipient’s family/guardian should participate in developing the IPP unless the QMRP documents that such participation is inappropriate or unobtainable. If the recipient is a legally competent adult, he/she may request that his/her family not be involved in the planning process.

4. The recipient is responsible to participate in the active treatment program as described in the IPP.

1603.1D AUTHORIZATION PROCESS

1. GENERAL REQUIREMENTS

a. Prior authorization by the Quality Improvement Organization (QIO-like vendor) is required for payment for care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

b. Authorization will be given only after a determination by the QIO-like vendor that ICF/MR admission criteria have been met.

c. Authorization cannot be given for a resident whose eligibility status is pending. However, if eligibility is established retroactively, Medicaid may authorize retroactive payment to the facility for necessary services at the ICF/MR level of care which have been certified by a physician.

2. ICF/MR TRACKING FORM

The facility must submit an ICF/MR Tracking Form within 72 hours of an admission, readmission, discharge, Medicaid eligibility determination or annual continued stay review.

This form is to be submitted to the DHCFP or their QIO-like vendor. Failure to submit the Tracking form may result in a delay or denial of payment.

3. PRE-PAYMENT REVIEW

Pre-Payment Review packets must be submitted to Nevada Medicaid's QIO-like vendor within 45 days of admission, readmission, or newly Medicaid eligible (first time billing).

The below required attachments are referred to as a Pre-Payment Review packet. The pre-payment review packet serves as documentation to assess the appropriateness of placement. Once the Pre-Payment Review packet has been approved the facility will be notified by receiving a Billing Authorization letter. An ICF/MR will not be able to bill for services until they have received the Billing Authorization letter.

a. Required Attachments for Pre-Payment Review Packets

1. Copy of the original ICF/MR Tracking Form;

2. History & Physical Examination (most recent);

3. Acute Discharge Summary (if there was a hospital stay which lasted longer than 48 hours);

4. The most recent psychological test results documenting the recipient's level of retardation or existence of a "related condition";

5. Minutes of the most recent IDT meeting (Initial, Readmission, or Annual) that includes a dated sign-in sheet, a Nursing Assessment, Nutritional Assessment, Social Services Assessment and documentation of a dental exam within the past year.

6. The current IPP developed by the IDT and Active Treatment Schedule.

7. Physicians admission orders and certification for ICF/MR level of care.

b. Complete Pre-Payment Review Packet

If the packet has information which is incomplete or inaccurate, the packet will be returned to the facility, with the Additional Information form identifying the problem. The facility must review this request, make necessary corrections or provide additional information to assure all areas are addressed prior to resubmitting the packet. A facility staff member(s) must initial any alterations.

4. ANNUAL CONTINUED STAY PAYMENT REVIEW PACKET

Annually, the ICF/MR must submit to Nevada Medicaid documentation verifying the need for a recipient's continued stay.

a. Required attachments for the Annual Continued Stay Payment Review Packets:

1. Most recent annual IDT review with signatures and titles of the participants.

2. The Physician's signed recertification of continued need for ICF/MR level of care.

3. Most recent annual History and Physical with listed diagnoses.

4. Copy of the ICF/MR Tracking form.

Continued payment will not be approved without the annual review packet.

1603.2 READMISSION PROCEDURES

1603.2A COVERAGE AND LIMITATIONS

Refer to Section 1603.1A of this Chapter.

1603.2B PROVIDER RESPONSIBILITIES

1. HOSPITAL OR NURSING FACILITY DISCHARGE/READMISSION

If a recipient is discharged to a hospital or nursing facility from the ICF/MR and returns to the same ICF/MR, the following procedures are required:

a. Within 72 hours of the recipient's discharge, the facility must complete and submit to the DHCFP QIO-like vendor an ICF/MR Tracking Form.

b. Within 72 hours of the recipient's return to the ICF/MR, the facility must complete and submit the ICF/MR Tracking form.

c. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification and update the physician's orders.

d. The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

On or prior to the date of admission, the IDT must review and revise the IPP. If the IDT finds the objectives are appropriate and do not need revising, they must so note in the case records. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

e. The facility must obtain the hospital's discharge summary if the hospital stay was for longer than 48 hours and file it in the recipient's record.

f. Within 45 days submit the Pre-Payment packet to Nevada Medicaid’s QIO-like vendor.

g. If the recipient has been out of the ICF/MR for more than 30 days, all the requirements for a new admission must be met.

h. Admission to an ICF/MR from another ICF/MR is a new admission to the accepting facility. Each ICF/MR has a separate Medicaid provider number and each is considered a separate facility even if multiple facilities share a governing body.

2. DISCHARGE/READMISSION TO/FROM HOME OR COMMUNITY BASED PLACEMENT

If a recipient is transferred from an ICF/MR into a residential community based home or home placement, the following procedures apply:

a. The facility must submit the ICF/MR Tracking form to Nevada Medicaid's QIO-like vendor within 72 hours of when the recipient is transferred.

b. If the recipient returns to the ICF/MR within the trial placement period (within 30 days of leaving the ICF/MR) the facility must:

1. Complete the tracking form within 72 hours of the recipient's return and submit it to Nevada Medicaid's QIO-like vendor.

2. On or prior to the date of readmission, the IDT determines whether assessments are still accurate. Assessments which are no longer accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating.

c. If a recipient is transferred from one ICF/MR to another ICF/MR, the following procedures must be followed:

1. The discharging facility must complete an ICF/MR tracking form within 72 hours of discharge and submit to Nevada Medicaid's QIO-like vendor.

2. The discharging facility must develop a final summary of the recipient's developmental, behavioral, social, health and nutritional status and plan to help the recipient adjust to the new placement. With the consent of the recipient/parents (if a minor child)/legal guardian, the summary must be provided to authorized persons and agencies.

3. Within 30 days after admission, the admitting ICF/MR IDT must perform accurate assessments or reassessments as needed (defined in Manual Section 1603.1B11.a.8 of this chapter).

On or prior to the date of readmission, the IDT must review and revise the IPP. If the IDT finds that the objectives are appropriate and do not need

revising, it must be noted in the case record. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

a. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification (See Manual Section 1603.1A2) and update the physician's orders.

b. Within 45 days of the readmission, the facility must submit the Pre-Payment Review Packet, defined in Manual Section 1603.1D.3 of this chapter, to Nevada Medicaid's QIO-like vendor.

c. If the recipient returns to the ICF/MR after the trial placement period has ended, all the requirements for a new admission must be met with one exception.

The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

1603.3 OUT-OF-STATE ICF/MR PLACEMENT

Nevada Medicaid must prior authorize all out-of-state ICF/MR placements for all Medicaid recipients arranged by any agency, individual, or district office. Nevada Medicaid will issue a Prior Authorization (PA) to the out-of-state facility and the Medicaid District Office may assist to arrange transportation. A recipient residing in an out-of-state facility without Medicaid authorization may place the out-of-state facility at risk for delayed or non-payment of services and the resident may be considered a resident of the state of location.

1603.3A COVERAGE AND LIMITATIONS

PRE-PLACEMENT PROCEDURES

The following pre-placement procedures must be followed before Nevada Medicaid will authorize an out-of-state ICF/MR placement:

1. All appropriate facilities within Nevada must first be contacted for a possible placement. The facilities contacted and reasons for not accepting the recipient must be documented.

2. Documentation, if applicable, is required from a state or county agency verifying responsibility for payment of educational expenses, since this is not a Medicaid benefit. Documentation is required for recipients under age 22 and who have not completed state schooling requirements.

3. If there is no burial coverage and family is not willing/able to purchase it, a burial guarantee must be obtained from the Division of Child and Family Services (DCFS), or the county of origin.

4. If the individual is incompetent or suffers from diminished capacity and there is no family, legal guardian or significant other involvement, efforts must be made to have the Public Administrator or a guardian appointed to handle possible legal, health or financial matters prior to out-of-state placement.

5. The individual (and family or custodial agency if applicable) must agree in writing to out-of-state placement.

6. The out-of-state ICF/MR must be a Nevada Medicaid provider.

1603.3B PROVIDER RESPONSIBILITY

All of the following are required for authorization for an out–of–state placement:

1. Completed Out–of–State Intake Questionnaire.

2. Current History and Physical exam and list of current medications.

3. Proof of burial coverage or guarantee (if available) and a signed statement from the recipient or responsible party acknowledging that Medicaid benefits end with death of the recipient.

4. Statement from the recipient, if a minor from his/her parent, or from a legal guardian agreeing to an out–of–state placement.

5. A list of all Nevada ICF/MR facilities contacted including date contacted the name of the person at the ICF/MR who denied placement and the reason for denial.

6. A letter verifying coverage of educational costs for a recipient who is under age 22 and has not completed high school.

7. Social history and assessment.

8. Psychological evaluation verifying the person with mental retardation or with a condition related to mental retardation will benefit from placement in an ICF/MR.

All documents must be sent to the DHCFP, Attention: Out–of–State Placement Coordinator.

1603.4 TRANSPORTATION

Transportation for services that a facility is required to provide is not reimbursable, such as but not limited to medical appointments, social events and Adult Day Health Care (ADHC) attendance.

Medicaid will reimburse for ambulance transportation in a medical emergency situation.

Refer to MSM Chapter 1900, Transportation Services, for further details on transportation.

1603.5 ABSENCES

1603.5A COVERAGE AND LIMITATIONS

1. Payment for therapeutic leave of absence, or reserved beds, may be made to an ICF/MR, subject to the following conditions:

   a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;

   b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;

   c. An ICF/MR 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 twenty-four (24) days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.

2. An absence for hospitalization or placement in a nursing facility which exceeds the Medicaid authorized maximum is not reimbursable.

3. If a recipient does not return from a home visit or family emergency and if the absence has been appropriately documented by the recipient's physician and the facility, the facility will not be penalized for the recipient's failure to return. This absence will be treated as a discharge effective the day the recipient was expected to return from leave.

1603.6 PROFESSIONAL SERVICES

In order to qualify for Medicaid reimbursement and provide services necessary to assure a comprehensive Active Treatment Program, ICF/MR employ or contract with individuals who can assess recipient needs, participate in the IPP, and provide appropriate training and habilitation services. These support staff assist in providing those physical and social modifications or interventions allowing the recipient to function and adapt to his/her physical and social environment.

ADHC services may be considered part of an Active Treatment Program. This service is not Medicaid reimbursable outside of the facility's routine per diem rate.

1603.6A COVERAGE AND LIMITATIONS

1. RECREATION

a. Services for Recipients with Handicapping Conditions

Multiple handicapped or non-ambulatory recipients must:

1. Spend a major portion of the waking day out of bed;

2. Spend a portion of the waking day out of the bedroom area;

3. Have planned daily activity and exercise periods;

4. Move around with various methods and devices whenever possible; and

5. Have recreation areas and facilities designed and constructed or modified so that they, regardless of their disabilities, have access to them.

b. Coordination with the IPP

Recreation services should be a coordinated part of the recipient's IPP.

A recreation assessment must be completed or updated within 30 days of admission into an ICF/MR. If recreation therapy is provided, an annual re-evaluation by the recreational therapist is required. If the IDT recommends during an IDT meeting that a re-assessment be completed by the recreational therapist, one must be completed within 30 days of the recommendation.

c. Recreation Services Objectives

Recreation services should:

1. Provide activities designed to meet individual, personal, and therapeutic needs in self-expression, social interaction, and entertainment;

2. Develop skills, including physical and motor skills, and interests leading to enjoyable and satisfying use of leisure time; and

3. Improve socialization and increase interaction with others.

d. Recreational Staff Qualifications

1. To be designated as a professional recreation therapist the staff member must have a Bachelor's Degree in recreation, or a related specialty area, such as art, dance, music, or physical education.

2. Sufficient qualified staff and support staff should be available to carry out recreational services in accordance with the stated objective(s) in the IPP.

2. SOCIAL SERVICES

a. Purpose of Social Services

Social Services must be directed toward:

1. Maximizing the social functioning of each recipient;

2. Enhancing the coping capacity of each recipient's family;

3. Asserting and safeguarding the human and civil rights of the recipient and his/her family; and

4. Fostering the human dignity and personal worth of each recipient.

b. Pre-Admission Services

During the evaluation process to determine whether or not admission to the ICF/MR is necessary, social workers must help the recipient and his/her family:

1. Consider alternative services, based on the individual's status and relevant family and community factors; and

2. Make a responsible choice as to whether and when residential placement is indicated.

c. Ongoing Evaluation and Monitoring of Residents

Social workers must participate in the IDT meetings for each recipient for the purposes of monitoring and following up on program plans.

d. Liaison with Recipient's Family and the Community

The social worker must, as appropriate, provide liaison between the recipient, the ICF/MR, the family, and the community.

e. Discharge Planning

1. In addition to participation in the development of the discharge plan, social workers must:

a. Help the family participate in planning for the recipient's return to home or other community placement; and

b. Provide systematic follow-up to assure referral to appropriate community agencies after the recipient leaves the facility.

2. If a recipient is to be either transferred or discharged, the facility must:

a. Have documentation in the resident's record that the resident was transferred or discharged for good cause.

Transfer means the temporary movement of an individual between facilities or the permanent movement of an individual between living units of the same facility. Discharge means the permanent movement of an individual to another residence that is not under the jurisdiction of the facility's governing body. Moving an individual for good cause means for any reason that is in the best interest of the individual.

The recipient, his/her family, advocate and/or guardian should be involved in any decision to move him/her.

b. Provide a reasonable time to prepare the recipient and his or her parents or guardian for the transfer or discharge (except in emergencies).

f. Social Work Staff Qualifications

A social worker must be licensed as an Associate in Social Work or a Social Worker by the Nevada State Board of Examiners for Social Work.

3. PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

a. Purpose of Psychological Services

Psychological services must be provided to:

1. Maximize each recipient's development; and

2. Help recipients acquire:

a. Perceptual skills;

b. Sensorimotor skills;

c. Self-help skills;

d. Communication skills;

e. Social skills;

f. Self-direction;

g. Emotional stability; and

h. Effective use of time, including leisure time.

b. Psychological Services

The facility must provide a psychological service program for recipients which includes:

1. Evaluations which must be done at least every three years for recipients under age 18 and every five years for recipients aged 18 or older. The evaluations must document that the resident has mental retardation. The level of retardation may be two levels if the recipient's functioning is in between them, e.g., moderate-severe.

2. Consultation;

3. Therapy;

4. Program development;

5. Administration and supervision of psychological services;

6. Staff training;

7. Continuing inter-disciplinary evaluation of each recipient and development of plans for habilitation services; and

8. When appropriate, periodic review and revision of program plans.

c. Psychological Staff Qualifications

1. A psychologist must have at least a Master's degree from an accredited program and experience or training in the field of mental retardation. If hired or subcontracted with after July 1, 1986, the psychologist must be certified by the Nevada State Board of Psychological Examiners.

2. A psychologist who is the facility's QMRP must meet the qualifications in Manual Section 1603.1B.10 of this chapter.

d. Psychiatric Services

1. Psychiatric services should be provided when indicated by the IDT for psychotherapy, medication management and/or consultation.

2. To provide services in an ICF/MR a psychiatrist must be a medical doctor licensed to practice psychiatry in the State of Nevada.

4. DENTAL SERVICES

Through a formal arrangement with a dentist licensed to practice dentistry or dental surgery as defined in Nevada Revised Statutes (NRS) 631.215, the ICF/MR facility must provide:

a. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within the 12 months prior to admission.

b. Periodic examination and diagnosis done at least annually for each recipient.

c. Necessary access to the services specified under the MSM Chapter 1000, excluding sealants, orthodontia, pharmacy services, fluoride treatments, and fluoride treatments with prophylaxis.

d. For children under 21 years of age residing in an ICF/MR referred for dental care through the Healthy Kids Program, also known as Early and Periodic Screening Diagnosis and Treatment (EPSDT), a Medicaid dental provider may bill directly to Medicaid.

e. For adults 21 years and older residing in an ICF/MR, dental treatment for emergency extractions, palliative care, and dentures can be billed to Medicaid by a Medicaid dental provider in accordance with the MSM Chapter 1000 guidelines and limitations.

f. If appropriate, the dentist or dental hygienist may participate in the development, review, and updating of the IPP as part of the IDT process, either in person or by written report.

5. PHARMACEUTICAL SERVICES

a. Pharmacist Duties

1. Upon admission, the pharmacist or registered nurse must obtain a history of prescription and non-prescription drugs used and enter this in the resident's record. This must be updated yearly.

2. The pharmacist must receive a copy for each resident of the physician's drug treatment order.

3. The pharmacist must maintain for each resident a record of all prescription and non-prescription medications dispensed including quantities and frequency of refills.

4. As appropriate the pharmacist should participate in the ongoing IDT evaluations and development of the individual program plan.

5. The pharmacist must establish quantity specifications for drug purchases and insure that they are met.

6. The pharmacist must review each resident's drug regimen at least quarterly.

7. On a monthly basis the pharmacist must complete the Checklist for Pharmacist Consultant (3232). The facility must retain the checklist for a period of three fiscal years from the year to which they pertain (NRS 239.073).

b. Staff or Consultant

1. If a facility does not employ a licensed pharmacist, it must have an agreement, with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal, and recording of drugs and biologicals.

2. Payment for consultant pharmacist services are separate from payment for filling of prescriptions. With the consultant pharmacist, payment is made by the facility for a service to the facility. In the case of prescribed drugs, a provider payment is made by Medicaid to a pharmacy on behalf of the recipient. The individual furnishing consultant pharmacist services to a facility may or may not also be providing prescribed drugs to residents in that facility. However, when it is feasible, separation of consultant services and prescription services is encouraged.

c. Limitations

Nevada Medicaid reimburses the pharmaceutical provider directly for prescriptions that meet the definition of essential in Section 1602.6 of this chapter.

The consultant pharmacist must review every drug ordered for compliance with this definition.

If drug therapy is observed which does not meet the definition of essential as stated in Section 1602.11 of this chapter, future charges for the medication will be denied. Before this sanction is imposed, the facility and the pharmacy will receive advance notice. If Nevada Medicaid does not receive appropriate justification within 10 days from the date of notification, all future charges for the medication will be denied.

6. PHYSICAL AND OCCUPATIONAL THERAPY (OT)

a. Services

1. Physical and OT staff must provide treatment training programs which are designed to:

a. Preserve and improve abilities for independent function such as range of motion, strength, tolerance, coordination, and activities of daily living; and

b. Prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

2. Services must be coordinated with the recipient's physician and other medical specialists.

3. Services must include:

a. Evaluation;

b. Participation in developing treatment objectives as part of the IPP;

c. Procedures to reach objectives; and

d. Revision of objectives and procedures based on progress (or lack of progress).

b. Staff and Qualifications

1. The ICF/MR must have available enough qualified staff and support personnel available either on staff or under contract to carry out the various physical and occupational therapy services in accordance with stated objectives in recipients' individual treatment plans.

2. Therapy assistants must work under the supervision of a qualified therapist.

3. To be designated as an occupational therapist, an individual must have a current registration issued by the American Occupational Therapy Association or another comparable body.

4. To be designated as a physical therapist an individual must have a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners.

7. SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

a. Services

Speech pathology and audiology services available to the ICF/MR must include:

1. Screening of recipients with respect to hearing functions which is completed by the physician or advanced nurse practitioner as part of the annual physical examination, and screening of recipients regarding speech functions;

2. Comprehensive audiological assessments of recipients as indicated by screening results, which were part of the recipient's physical examination, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;

3. Assessment of the use of amplification;

4. Provision for procurement, maintenance, and replacement of hearing aids, as specified by a qualified audiologist;

5. Comprehensive speech and language evaluations of recipients as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;

6. Participation in the IDT Process and IPP development for individual recipients;

7. Treatment services as an extension of the evaluation process, which include:

a. Direct counseling with recipients;

b. Consultation with appropriate staff for speech improvement and speech education activities; and

c. Work with appropriate staff to develop specialized programs for developing each recipient's communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization, and skills in expression, including improvement in articulation, voice, rhythm, and language;

8. Participation in in-service training programs for direct-care and other staff.

b. Staff and Qualifications

A speech pathologist or audiologist must be licensed by the State of Nevada Board of Audiology and Speech Pathology and have a current certificate of clinical competence issued by the American Speech and Hearing Association or a comparable body.

8. LABORATORY SERVICES

a. Management Requirements

If a facility chooses to provide laboratory services, the laboratory must:

1. Meet the management requirements specified in 42 CFR 405.1316; and

2. Provide personnel to direct and conduct the laboratory services.

b. Qualifications of Laboratory Director

The laboratory director must be technically qualified to supervise the laboratory personnel and test performance and must meet licensing or other qualification standards established by the State with respect to directors of clinical laboratories. For those States that do not have licensure or qualification requirements pertaining to directors of clinical laboratories the director must be either:

1. A pathologist or other doctor of medicine or osteopathy with training and experience in clinical laboratory services; or

2. A laboratory specialist with a doctoral degree in physical, chemical, or biological sciences, and training and experience in clinical laboratory services.

c. Duties of Laboratory Director

The laboratory director must provide adequate technical supervision of the laboratory services and assure that tests, examinations and procedures are properly performed, recorded, and reported.

The laboratory director must ensure that the staff:

1. has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;

2. is sufficient in number for the scope and complexity of the services provided; and

3. receives in-service training appropriate to the type and complexity of the laboratory services offered.

d. Other Laboratory Requirements

1. The laboratory must meet the proficiency testing requirements specified in 42 CFR 405.1314(a).

2. The laboratory must meet the quality control requirements specified in 42 CFR 405.1317.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved by the Medicare program either as a hospital or an independent laboratory.

1603.7 REIMBURSEMENT RATE AND ALLOWABLE COSTS

1603.7A COVERAGE AND LIMITATIONS

1. PUBLIC ICF/MR – COST REIMBURSEMENT

A public ICF/MR is reimbursed under Medicare principles of retrospective reimbursement described in the Medicaid State Plan, Attachment 4.19D and HCFA Publication 15.

Each facility is paid the lower of either billed charges or an interim rate. In no case will payment exceed audited allowable costs.

2. PRIVATE ICF/MR – SMALL PROSPECTIVE RATE

Non state-operated ICF/MR – Small is defined as a facility having six beds or less.

Private ICF/MR–Small facilities are paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per–patient–day basis. Day

training costs and property costs, excluded from the basic prospective rate, are reimbursed under Medicare principles of retrospective cost reimbursement.

The daily rate is to include services and items such as, but not limited to nursing services, dietary services, activity programs, laundry services, room/bed maintenance services, medically related social services, routine personal hygiene supplies, and active treatment programs.

Day training must be arranged by the ICF/MR, and must be approved by MHDS.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

3. PRIVATE ICF/MR – LARGE

Non state-operated ICF/MR-Large (is defined as a facility having more than six beds). It will be paid the lower of 1) billed charges or 2) an all-inclusive prospective per diem rate.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

4. ALLOWABLE COSTS

Any question of an allowable cost that is not addressed within this chapter will be resolved by reference to MSM Chapter 700, Rates and Cost Containment, and the CMS Publication 15.

Nevada Medicaid allows the costs for nutritional supplements (e.g., Ensure, Pediasure, etc.) when recommended in writing by a registered dietician and prescribed by a physician. The cost is included in the facility cost reports under Raw Food or Dietary.

5. UPPER LIMITS

In no case may Medicaid payment for an ICF/MR exceed the facility's customary charges to the general public.

In no case may Medicaid payment for an ICF/MR caring for more than 6 persons, exceed an upper limit determined by application of principles of reimbursement for provider costs under Title XVIII of the Social Security Act. All payment schedules under Medicaid are subject to the general payment limits imposed in 1861(v) and 1866 of the Act and implemented by regulations at 42 CFR 405.460 and 405.461.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

6. ANCILLARIES

Medicaid may make direct payment for ancillary services provided to recipients when:

a. Such services are not directly provided by the facility as part of the rate; and

b. Required prior authorization has been obtained from the Nevada Medicaid Office.

1603.7B PROVIDER RESPONSIBILITY

COST REPORTING AND AUDIT

To obtain the Uniform Cost Report and instructions for completion contact DHCFP's Rates and Cost Containment Unit. Submission of alternate forms or any forms other than the most current does not constitute an acceptable filing.

A cost report must be submitted according to MSM Chapter 700, Rates and Cost Containment, Section 703.4.

Each facility must maintain financial and statistical records sufficient to substantiate its reported costs for three calendar years after submission. These records must be available upon request.

An annual audit of the facility's cost report will be completed by the DHCFP or its representative.

Refer to MSM Chapter 700, Rates and Cost Containment, for additional details.

PATIENT TRUST FUND MANAGEMENT

The ICF/MR must follow the requirements for appropriate handling of patient trust funds. Refer to MSM Chapter 500, Nursing Facilities, Section 503.8 and 42 CFR 483.420 for direction.

1603.8 PATIENT LIABILITY (PL)

DETERMINATION OF AMOUNT

PL is determined by eligibility personnel in the local DWSS district office.

1603.8A COVERAGE AND LIMITATIONS

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.

1603.8B 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 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.

When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by the Welfare District Office 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.

The facility may not charge recipients for items and services such as diapers, over the counter drugs (non-legend), combs, hairbrushes, toothbrushes, toothpaste, denture cream, shampoo, shaving cream, laxatives, shaves, shampooing, skin-care items, bedside tissues, disposable syringes, nail care, pads, catheters, laundry, durable or disposable medical equipment/supplies, stipends paid, based on recipient's needs, as part of the active treatment program, or any item covered by Medicaid in reimbursement to the facility or to other providers of care such as pharmacies, therapists, etc.

1603.8C RECIPIENT RESPONSIBILITY

PERSONAL NEEDS

If a recipient so requests, the facility may provide and charge the recipient for such items as cosmetics, after shave lotion, non-medical equipment, smoking supplies, stationery, postage, pens, pencils, newspapers, periodicals, alcoholic beverages, personal clothing, professional haircuts, long-distance telephone calls, dry cleaning of personal clothing, and services in excess of program limitations. If a recipient is charged for the above, accurate records must be kept including the recipient's authorization for payment.

1604 HEARINGS

Please reference Chapter 3100 for Medicaid Hearing process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1700 - THERAPY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1700 are being proposed to comply with the transition to International Classification of Disease 10th Revision, Clinical Modification (ICD 10-CM) as required by the Health Insurance Portability and Accountability Act (HIPAA) mandate. In order to be in compliance with this mandate, the Division of Health Care Financing and Policy (DHCFP) is proposing the removal of ICD 9-CM codes and adding verbiage regarding current diagnosis code(s).

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 28/15 CHAPTER 1700 - THERAPY	MTL 16/11, 04/14 CHAPTER 1700 - THERAPY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1703.1	**Policy**	Added the word Registered to Advanced Practitioner of Nursing to now read Advanced Practitioner of Registered Nursing (APRN).
1703.2A.7	**Covered Services**	Removed ICD-9-CM reference and added with "current"
1703.3A.1	**Coverage and Limitations**	Removed ICD-9-CM reference and added "coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs".

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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THERAPY

1700 INTRODUCTION

Nevada Medicaid reimbursement for outpatient Physical Therapy (PT), Occupational Therapy (OT), Speech/Communication Therapy (ST) and Respiratory Therapy/Care (RT) is based on the provision of medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. Therapy services must be prescribed by a physician, physician's assistant or an Advanced Practitioner of Nursing (APN).

Services related to activities for the general health and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute restorative or rehabilitative therapy services for Medicaid purposes.

Outpatient Physical, Occupational and Speech therapy under 42 Code of Federal Regulations (CFR) 440.110 is an optional service under State Medicaid Programs.

Therapy services provided by the Home Health Agency (HHA) Program is a mandatory home health care benefit provided to recipients in his/her residence. See Medicaid Service Manual (MSM), Chapter 1400 for HHA Therapy coverage.

Nevada Medicaid provides therapy services for most Medicaid-eligible individuals under the age of 21 as a mandated service, a required component of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Therapy services provided by an outpatient hospital under 42 CFR 440.20 is a mandatory service under State Medicaid Programs.

All Medicaid policies and requirements are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU Manual, Chapter 1000.

1701 AUTHORITY

1701.1 The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulations (CFR), Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Act.

1701.2 The State Legislature grants authority to the relevant professional licensure boards to set the standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

a. NRS Chapter 640 Physical Therapy (PT)

b. NRS Chapter 640A Occupational Therapy (OT)

c. NRS Chapter 637B Audiologists and Speech Pathologists

d. NRS Chapter 630 Practice of Respiratory Care

1702 RESERVED

1703 POLICY

1703.1 Medicaid will reimburse physical, occupational, speech therapy services rendered to eligible Medicaid recipients and eligible participants in the Nevada Check Up (NCU) Program. Therapy must be medically necessary (reference Medicaid Services Manual (MSM) Chapter 100; section 103.1) to restore or ameliorate functional limitations that are the result of an illness or injury which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. It must be rendered according to the written orders of the physician, physician's assistant or an Advanced Practitioner of Registered Nursing (APRN) and be directly related to the active treatment regimen designed by the therapist and approved by the professional who wrote the order.

Requests for therapy must specify the functional deficits present and include a detailed description assessing the measurable degree of interference with muscle and/or joint mobility of persons having congenital or acquired disabilities, measurable deficits in skills for daily living, deficits of cognitive and perceptual motor skills and integration of sensory functions. Identify measurable speech and/or communication deficits through testing, identification, prediction of normal and abnormal development, disorders and problems, deficiencies concerning the ability to communicate and sensorimotor functions of a person's mouth, pharynx and larynx.

A written individualized plan addressing the documented disabilities needs to include the therapy frequency, modalities and/or therapeutic procedures and goals of the planned treatment. The primary diagnosis must identify the functional deficit which requires therapeutic intervention for the related illness or injury diagnosis.

Therapy services provided in the community-based and/or hospital outpatient setting are subject to the same coverage and therapy limitations.

Services that are provided within the School Based Child Health Services (SBCHS) Program are covered under MSM Chapter 2800.

1703.2 COVERAGE AND LIMITATIONS

1703.2A COVERED SERVICES

1. Medicaid covers outpatient therapy for individual and/or group therapy services administered by the professional therapist within the scope of their license for the following:

   a. An individual therapy session may be covered up to a max of one hour when service is provided to the same recipient by the same therapist on the same day.

   b. Group therapy (comprised of no more than two to four individuals) may be covered up to a max of 90 minutes per session when the service is provided to the

same recipient by the same therapist on the same day. The leader of the group must be a Medicaid provider. Documentation in the medical record is expected to be available on each Medicaid recipient in the group.

2. Therapy services may be ordered under an EPSDT referral by a physician, physician's assistant or an APN. The examination must identify a functional limitation to either acquire or correct/ameliorate a functional deficit/condition based upon medical necessity, not withstanding in relation to illness or injury which includes realistic and obtainable therapy goals.

3. The application of a modality that does not require direct (one-on-one) patient contact by the licensed therapist may be provided by a licensed therapy assistant under the supervision of the licensed Medicaid therapist.

4. Evaluations administered per therapy discipline within the scope of their license and meets the following criteria:

   a. Initial evaluations.

   b. Re-evaluations may be covered when there is a break in service greater than 90 days.

5. To be considered reasonable and medically necessary all of the following conditions must be met:

   a. Meet the definition of medical necessity in MSM Chapter 100.

   b. The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's functional deficit/condition.

   c. The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or qualified assistant under the therapist's supervision.

   d. There must be an expectation that the functional deficit/condition will improve in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient's realistic rehabilitative/restorative potential in consultation with the qualified therapist

   e. The amount, frequency, and duration for restorative therapy services must be appropriate and reasonable based on best practice standards for the illness or injury being treated.

6. Cochlear Implant Therapy: Speech and Language Pathologist (SLP) services are covered under cochlear implantation protocol for speech evaluation and therapy services. Codes used by speech therapists will require the appropriate therapy modifier. (Refer to MSM Chapter 2000 for comprehensive cochlear policy.)

7. Therapy for Development Delay disorders may be covered for speech and language, fine motor and/or gross motor skills development when the functional deficit(s), identified by current diagnosis code(s) meet all medical necessity requirements.

8. Respiratory therapy is considered reasonable and necessary for the diagnosis and/or treatment of an individual's illness or injury when it is:

   a. Consistent with the nature and severity of the recipient's medical symptoms and diagnosis;

   b. Reasonable in terms of modality, amount, frequency and duration of the treatment; or

   c. Generally accepted by the professional community as being safe and effective treatment for the purpose used.

9. In certain circumstances the specialized knowledge and judgment of a qualified therapist may be covered when medically necessary to establish a safe and effective home maintenance therapy program in connection with a specific disease state.

10. SLP evaluations may be covered according to MSM Chapter 1300, Appendix B for a dedicated speech generating device evaluation and therapeutic services.

1703.2B PRIOR AUTHORIZATION REQUIREMENTS

1. With the exception of initial therapy evaluations and re-evaluations, all therapy services must be prior authorized by the Quality Improvement Organization (QIO-like) vendor.

2. Initial and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be accomplished and submitted with prior authorization requests.

3. To obtain prior authorization for therapy services, all coverage and limitations requirements must be met (Section 1703.2A).

1703.2C NON-COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.

2. Personal comfort items, which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body part.

3. Services that do not require the performance or supervision of a licensed therapist, even if they are performed or supervised by a licensed therapist.

4. Wound care requested by a therapist or a hospital based therapy department unless it is part of a comprehensive therapy treatment plan, (e.g., whirlpool with debridement & ROM exercises etc.).

5. Reimbursement for licensed nurses when wound care is ordered as a Physical Therapist (PT) or Occupational Therapist (OT) service.

6. Outpatient therapy provided to patients admitted in an acute or rehabilitation hospital.

7. Reimbursement for an all inclusive Respiratory Rehabilitation Program.

8. Medicaid does not reimburse or require re-evaluations to update other third party payer plans of progress for outpatient rehabilitation.

1703.2D PROVIDER RESPONSIBILITY

1. Providers must comply with prior authorization requirements set forth in the MSM, Chapter 100 (Medicaid Program), Section 103.2 (Authorization).

2. The provider will allow, upon request of proper representatives of the Division of Health Care Financing and Policy (DHCFP), access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.

3. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.

4. For Provider Responsibilities refer to MSM Chapter 100.

1703.2E RECIPIENT RESPONSIBILITY

For Recipient Responsibilities refer to MSM Chapter 100.

1703.3 LYMPHEDEMA THERAPY POLICY

Nevada Medicaid will reimburse a qualified lymphatic therapist (OT or PT) for a combination of therapy techniques recommended by the American Cancer Society and the National Lymphedema Network for primary and secondary lymphedema.

1703.3A COVERAGE AND LIMITATIONS

1. Complete or Combined Decongestive Physiotherapy (CDP) coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs when all of the following conditions are met:

   a. A treating or consulting practitioner (MD, DO, DPM, APN, and PA), within their scope of practice, documents a diagnosis of lymphedema due to a low output cause and specifically orders CDP therapy;

   b. The lymphedema causes a limitation of function related to self-care, mobility, and/or safety;

   c. The recipient or recipient caregiver has the ability to understand and provide home-based CDP;

   d. CDP services must be performed by a health care professional who has received CDP training;

   e. The frequency and duration of the services must be necessary and reasonable; and

   f. Lymphedema in the affected area is not reversible by exercise or elevation.

2. A CDP course of treatment by either OT or PT is considered a once in a lifetime benefit consisting of 90 minutes (six units) per session, three to five times per week for a maximum of three consecutive weeks with prior authorization.

1703.3B PRIOR AUTHORIZATION REQUIREMENTS

1. All lymphedema therapy services must be prior authorized by the QIO-like vendor.

2. To obtain prior authorization for therapy services, all coverage and limitations requirements must be met (Section 1703.2A).

1703.3C NON-COVERED SERVICES

1. Non-covered services include the following:

   a. Therapy limited to exercise or elevation of the affected area;

   b. Other services such as skin care and the supplies associated with the compressions wrapping (they are included in the services and are not paid separately);

c. OT and PT services performed concurrently for the therapeutic exercise portion of the session is duplicative (Only one service type per therapeutic session is allowed); and

d. Therapy designed principally for temporary benefit/without ongoing patient education.

1703.3D PROVIDER RESPONSIBILITIES

For Provider Responsibilities, refer to MSM Chapter 100.

1703.3E RECIPIENT RESPONSIBILITIES

For Recipient Responsibilities, refer to MSM Chapter 100.

1703.4 RESPIRATORY THERAPY POLICY

1703.4A COVERAGE AND LIMITATIONS

Medicaid will reimburse contracted practitioners of respiratory care for individual services provided in the outpatient setting. See MSM Chapter 600 for outpatient services general limitations. The term “respiratory care” includes inhalation and respiratory therapy, diagnostic testing, control and care of persons with deficiencies and abnormalities associated with the cardiopulmonary system.

1703.4B PRIOR AUTHORIZATION REQUIREMENTS

1. Respiratory therapy services must be prior authorized by the QIO-like vendor.

2. To obtain prior authorization for respiratory therapy services, all coverage and limitations requirements must be met. (Section 1703.2A).

1703.4C NON-COVERED SERVICES

1. Reimbursement for an all inclusive Respiratory Rehabilitation Program is not a Medicaid covered benefit, which may include the following:

a. Psychological monitoring.

b. Therapeutic procedures to increase strength or endurance.

c. Procedures to improved respiratory function, increase strength or endurance of respiratory muscles.

1703.5 MAINTENANCE THERAPY POLICY

The DHCFP will reimburse for skilled therapy necessary to develop and safely implement a maintenance program. During the last visits of a rehabilitative treatment, the clinician may develop a maintenance program. The goals of a maintenance program are to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Maintenance therapy is a covered service when the specialized skill, knowledge and judgment of a therapist are required to design or establish the plan, assure patient safety, train the patient, family members and/or unskilled personnel and make necessary reevaluations of the plan.

1703.5A DEFINITIONS

Skilled activities include:

1. Ongoing evaluation of patient performance.

2. Adjustments to the maintenance program that help the patient achieve appropriate functional goals.

Unskilled activities are:

1. Repetitive tasks or exercises that do not involve any variation in complexity, level of cueing or progressive independence.

2. Observations of a patient or caregiver's performance of a learned activity with no feedback and/or modification of the plan.

1703.5B COVERAGE AND LIMITATIONS

1. Evaluation and development of a maintenance plan without rehabilitative treatment- An initial evaluation of the extent of the disorder, illness or injury is required. If the treating skilled therapist determines after the initial evaluation the potential for rehabilitation is insignificant, prior to discharge an appropriate maintenance program may be established. Services are covered when the skills of the therapist are required for the development of the maintenance program and training of the patient or caregivers.

2. Skilled maintenance therapy for safety- Due to the severity or complexity of the therapy procedures to maintain function, the judgment and skill of a therapist may be necessary to implement the safe and effective delivery of the maintenance program. When the patient's safety is at risk, those reasonable and necessary services will be covered for the initiation of the maintenance program, even if the skills of a therapist are not ordinarily needed to carry out the activities performed as part of the maintenance program.

3. Maintenance therapy must meet at least one of the following:

   a. Prevent decline of function;

   b. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; or

   c. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

4. Maintenance therapy must have expected outcomes that are:

   a. Functional;

   b. Realistic;

   c. Relevant;

   d. Transferable to the recipients current or anticipated environment; and

   e. Consistent with best practice standards and accepted by the professional community as being safe and effective treatment for the purpose used.

5. Documentation requirements

   a. Plan of care must address a condition for which therapy is an accepted method of treatment as defined by standards of medical practice.

   b. Plan of care must be for a condition that establishes a safe and effective skilled maintenance program.

6. Management of a maintenance program is covered only when provided by a skilled therapist (reference MSM Section 1701.2).

1703.5C PRIOR AUTHORIZATION REQUIREMENTS

1. All Maintenance therapy services require prior authorization.

2. Services are limited to ten sessions every three years per each recipient, from the date of initial visit. EPSDT is exempt from service limitations.

1703.5D NON-COVERED SERVICES

1. Services which are not authorized.

2. Services, which do not require the management of a skilled therapist for the oversight of the maintenance program, will no longer be considered reasonable and necessary and are excluded from coverage.

3. Maintenance program is not safe and/or effective.

1704 HEARINGS

1704.1 Please reference Medicaid Services Manual (MSM) Chapter 3100 for hearings procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 31, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres* Casey Angres (Feb 22, 2023 08:34 PST)
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1800 – 1915(i) HCBS STATE PLAN OPTION ADULT DAY HEALTH CARE AND HABILITATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1800 – 1915 (i) – Home and Community Based State Plan Option Adult Day Health Care and Habilitation Services are being proposed to clarify language specific to Coverage and Limitations for the program, Provider Responsibilities, Recipient Responsibilities, Serious Occurrence Reports (SOR), Plan of Care (POC), Service Plan (SP) and Program Procedures.

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: The proposed changes affect all Medicaid-enrolled providers delivering Adult Day Health Care Services. Those Provider Types (PT) include Adult Day Health Care services (PT 39) and Habilitation Services (PT 55).

Financial Impact on Local Government: There is no anticipated fiscal impact known at this time.

These changes are effective February 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 02/23 CHAPTER 1800 – 1915(i) HCBS STATE PLAN OPTION ADULT DAY HEALTH CARE AND HABILITATION SERVICES	MTL 07/20 CHAPTER 1800 – 1915(i) HCBS STATE PLAN OPTION ADULT DAY HEALTH CARE AND HABILITATION SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.1A (2)b	COVERAGE AND LIMITATIONS	Added language as diagnosed by a physician.
1803.1A(2)(c)		Added language as diagnosed by a physician.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.1A(3)d		Reconstructed sentence for clarification.
1803.1B(5)	PROVIDER RESPONSIBIITIES	Deleted sentence referencing NRS 200.5091 to 200.50995 regarding elder abuse or neglect.
1803.1B(6)		Added language to clarify the dates of initial discovery and required updates for Serious Occurrence Reports (SOR).
1803.1B(6)c		Added language to include abuse, abandonment, or unexpected death.
1803.1B(6)h		Added language to include ages 18 years old and above.
1803.1B(6)l		Added another category for SOR to include Elopement.
1803.1B(7)		Added language to clarify the duration of the Service Plan (SP) and to ensure person-centered planning.
1803.1B(7)(a)		Created a new section titled Timeframes and moved language from 1803.1(B)(7) to this section. Added language regarding the timeframe of completion of the SP.
1803.1B(7)(b)		Created a new section titled Signatures.
1803.1B(7)(b)(1)		Added language regarding appropriate staff that may sign the SP.
1803.1B(7)(b)(2)		Moved language regarding recipient's signature on SP from 1803.1(B)(7) to this section.
1803.1B(7)(b)(3)		Moved language regarding creation of a signature page from 1803.1(B)(7) to this section and added language regarding designated representative signatures.
1803.2C	RECIPIENT RESPONSIBILITIES	Added language regarding recipient or recipient's designated representative responsibilities.
1803.2F		Updated language to clarify reportable occurrences.
1803.2H		Added language regarding how to request a transfer.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.3	ADULT DAY HEALTH CARE (ADHC) SERVICES	Added language regarding frequency of service.
1803.3A(4)	COVERAGE AND LIMITATIONS ADHC	Updated language regarding ADLs.
1803.3B(1)(b)	PROVIDER RESPONSIBILITIES ADHC	Added language to require reporting on any closure, suspension or adverse licensure issues.
1803.3B(2)(a)		Updated language regarding development of the SP.
1803.3B(3)		Moved language regarding documentation of daily attendance from 1803.3(B)(2)(d) to this section.
1803.3B(3)(b)		Moved language regarding the delivery of services from 1803.3B(2)(d) to this section and updated terminology. Also, moved language regarding who is responsible for documentation in Nursing Log from 1803.3B(2)(d) to this section.
1803.3B(3)(b)(1)		Added language to clarify what needs to be contained in the nursing log.
1803.3B(3)(b)(2)		Added language regarding timeframe for signature of Nursing Log.
1803.3B(3)(c)		Created a new section for Signatures to clarify the appropriate staff that may sign the documents.
1803.3B(3)(c)(2)		Added language regarding who must sign or initial the provider's SP and attendance log. Also, moved language regarding the recipient's signature and designated representative from 1803.3B(2)(d) to this section.
1803.3B(3)(c)(3)		Moved language for the creation of the signature page from 1803.3B(2)(d) to this section and added language regarding designated representative.
1803.4	DAY HABILITATION	Added language regarding frequency of services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.4B(2)		Replaced Attendance Records and Daily Logs with Documentation to be consistent throughout.
1803.4B(2)(a)		Created a new section for Attendance Log. Moved language regarding documentation in daily attendance from 1803.4(B)(2) to this section.
1803.4B(2)(b)		Created a new section for Service Log. Also, moved language regarding specific services required by the POC and outlined in the SP from 1803.4(B)(2) to this section.
1803.4B(2)(b)(1)-(2)		Added the components of the Service Log including time frames and appropriate staff signatures. Moved language regarding verification of services for claims from 1803.4(B)(2) to this section.
1803.4B(2)(c)		Created a new section for Signatures.
1803.4B(2)(c)(1)		Moved language regarding staff member signatures on records from 1803.4B(2) to this section. Added language to identify the appropriate staff that may be required to sign or initial each document.
1803.4B(2)(c)(2)		Added language to clarify the recipient must sign the SP and the Attendance Log. Also moved language regarding signature of a designated representative from 1803.4B(2) to this section.
1803.4B(2)(c)(3)		Moved language regarding creation of a signature page from 1803.4B(2) to this section and added language regarding designated representative.
1803.5	RESIDENTIAL HABILITATION	Added language regarding 24 hours a day to clarify the time for protective oversight and supervision.
1803.5B(2)	PROVIDER RESPONSIBILITIES	Replaced Attendance Records and Daily Logs with Documentation to be consistent throughout.
1803.5B(2)(a)		Created a new section for Service Log. Also moved language regarding specific services required by the POC and outlined in the SP from 1803.5(B)(2) to this section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.5B(2)(a)(1)		Moved language regarding documentation of daily service from 1803.5(B)(2) to this section and added minimum criteria for Service Log.
1803.5B(2)(a)(2)		Added language regarding the appropriate staff member that may sign the Service Log and the timeframe. Also moved language regarding verification of services for claims from 1803.5(B)(2) to this section.
1803.5B(2)(b)		Created a new section for Signatures.
1803.5B(2)(b)(1)		Moved language regarding the staff member that may sign each record from 1803.5(B)(2) to this section and added language regarding the appropriate staff member that may sign each record.
1803.5B(2)(b)(2)		Added language regarding signature for the provider's SP and Service Log and the timeframes. Moved language regarding signature of the designated representative from 1803.5(B)(2) to this section.
1803.5B(2)(b)(3)		Moved language regarding creation of signature page from 1803.5(B)(2) to this section and added language regarding when the designated representative should sign on behalf of the recipient.
1803.5B(2)(c)		Created new section for Notifications and added language regarding evictions and discharges.
1803.5B(2)(c)(1)		Created a new section for Eviction. Added language regarding the timeframe and content of the written eviction notice.
1803.5B(2)(c)(2)		Created a new section for Discharge and added language regarding types of discharges.
1803.6	PROGRAM PROCEDURES	Changed title of Intake and Ongoing to Program Procedures regarding how a person can obtain services. Added language to clarify the process required to obtain and maintain services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.6A		Changed title Intake Procedures to Assessment.
1803.6A(1)		Created a new section for New Referrals. Added language regarding how to request services including the referral form.
1803.6A(1)(d)		Moved language regarding the assessment process and timeframe from 1803.6(A)(2) to this section.
1803.6A(2)		Added new section titled Re-Assessment. Moved language regarding length of authorization period from 1803.6(C)(1) to this section.
1803.6A(2)(a)		Moved language regarding timeframe related to re-assessment from 1803.6(C)(1)(a) to this section. Added language to include contact via telehealth under certain circumstances.
1803.6A (2)(b)		Moved language regarding a change of condition during the authorization period from 1803.6(C)(2) to this section and added that the POC should be updated, as applicable.
1803.6B		Created new section titled Transfer. Moved language regarding the process to transfer to another provider from 1803.6(C)(3) to this section. Added reference to authorization period and the 1915(i) Transfer form.
1803.6B(1)-(4)		Added language regarding completion of the transfer form, review by DHCFP, approval process and when the recipient may start services at the newly chosen provider.
1803.6C		Added language regarding Plan of Care (POC) development process.
1803.6C(1)		Deleted Initial POC and Initial assessment.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1803.6C(5)		Updated language from Statement of Understanding (SOU) to Statement of Choice (SOC).
1803.6C(7)(c)		Added language regarding a designated representative and the need to have the Designated Representative Attestation form completed and signed.
1803.6C(8)		Moved language regarding sending the recipient's POC to the provider from 1803.6(B)(6) to this section and adding the timeframe for signatures to within 60 days of the POC start date.
1803.6D		Created a new section titled Notice of Decision (NOD) for 1915(I) Services. Added language regarding a NOD for adverse action, reason, and effective date.
1803.6D (1)		Created a new section titled Denial Nod for Services. Moved language regarding recipient eligibility criteria, basis of denial and subsections from 1803.6(A)(3) to this section. Added new denial reasons.
1803.6D (2)		Created new section titled Termination NOD for Services and moved language regarding ineligibility from 1803.7 to this section. Added termination reasons and moved a, b, c, d, f, g, h, I, j, k, l, and m.
1803.6D(3)		Created a new section titled Reduction of Services and added language regarding reasons for reduction of services.
1803.7	TERMINATION OF 1915(i) SERVICES	Deleted Section Title and moved into 1803.6D(2) items a. – l.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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1915(i) HCBS STATE PLAN OPTION ADULT DAY HEALTH CARE AND HABILITATION

1800 INTRODUCTION

Under Section 1915(i) of the Social Security Act (SSA) states can provide Home and Community-Based Services (HCBS) to individuals who require less than institutional level of care and therefore would otherwise not be eligible for such services through an 1915(c) HCBS Waiver.

Specifically, Section 1915(i) of the Act allows the Nevada Division of Health Care Financing and Policy (DHCFP) to provide State Plan HCBS similar to that of a 1915(c) HCBS Waiver using a needs-based eligibility criterion rather than an institutional level of care criteria. Additionally, a 1915(i) HCBS State Plan Option has no cost neutrality requirement as required under a 1915(c) HCBS Waiver. This significant distinction affords the Nevada DHCFP the opportunity to offer HCBS to recipients whose needs are substantial, but are not severe enough to qualify them for institutional or waiver services.

1801 AUTHORITY

Section 6086 of the Deficit Reduction Act, added Section 1915(i) to the SSA, allowing states the option to offer home and community-based services previously only available through a traditional 1915(c) Waiver.

Statutes and Regulations:

- Social Security Act: 1915(i) (1)(a) through (j)
- Code of Federal Regulations (CFR)
  - 42 CFR 441.710 State Plan Home and Community-Based Services under Section 1915(i)(1) of the Act
  - 42 CFR 441.715 Needs-Based Criteria and Evaluation
  - 42 CFR 441.720 Independent Assessment
  - 42 CFR 441.725 Person-Centered Service Plan
  - 42 CFR 441.730 Provider Qualifications
- Nevada Revised Statutes (NRS) Chapter 449
- Nevada Administrative Code (NAC) Chapter 449

1802 RESERVED

1803 POLICY

1803.1 NEEDS-BASED ELIGIBILITY CRITERIA

The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors.

In order to be eligible, a recipient must need assistance or prompting in at least two Activities of Daily Living (ADL) which includes bathing, dressing, grooming, toileting, transfer, mobility, eating and must also have one of the following risk factors:

1. At risk of social isolation due to lack of family or social supports;
2. At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse (RN); or
3. A history of aggressive behavior if not supervised or if medication is not administered by an RN.

The DHCFP Health Care Coordinator (HCC) conducts the needs-based eligibility determinations.

1803.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY
   a. An individual must meet and maintain Medicaid eligibility.
   b. An individual must be 18 years of age or older.
   c. An individual must meet the needs-based eligibility requirements.
   d. The individual must reside in the community.
2. COVERED SERVICES
   a. Adult Day Health Care.
   b. Day Habilitation-targeted to individuals with Traumatic Brian Injury (TBI) or Acquired Brain Injury (ABI) as diagnosed by a physician.
   c. Residential Habilitation-targeted to individuals with TBI or ABI as diagnosed by a physician.

3. NON-COVERED SERVICES

The following services are not covered benefits under the 1915(i) HCBS State Plan Option and are therefore not reimbursable:

a. Services provided to an individual who is not eligible for Nevada Medicaid.

b. Services rendered to a recipient who no longer meets the needs-based eligibility criteria.

c. Services rendered to a recipient who is no longer in the community setting but is institutionalized (hospital, nursing facility, correction or Intermediate Care Facility (ICF) for intellectual or developmental disabilities).

d. A recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible.

e. For Day Habilitation or Residential Habilitation, services provided to an individual who does not have a TBI or ABI diagnosis.

1803.1B PROVIDER RESPONSIBILITIES

1. PROVIDER QUALIFICATION

In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service.

2. MEDICAID ELIGIBLITY

All providers must verify each month continued Medicaid eligibility for each recipient. This can be accomplished by utilizing the electronic verification system (EVS) or contacting the eligibility staff at the welfare office hotline. Verification of Medicaid eligibility is the sole responsibility of the provider.

3. DIRECT MARKETING

Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid 1915(i) recipient. Providers may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or other type of cold-call marketing activities. All marketing activities must be limited to the general education about the benefits of 1915(i) services.

Marketing material must be accurate and not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

a. The recipient must enroll with a specific provider in order to obtain benefits or in order to not lose benefits; or

b. The provider is endorsed, certified or licensed by the DHCFP.

Additionally, compensation or incentive of any kind which encourage a recipient to transfer from one provider to another is strictly prohibited.

4. HIPAA, PRIVACY AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other Protected Health Information (PHI).

5. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

The Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

6. SERIOUS OCCURRENCE REPORTS (SORS)

Providers must report any serious occurrences within 24 hours of the initial discovery. Providers must complete the web-based Nevada DHCFP SOR Form; available at https://medicaid.nv.gov/ under Provider Forms. After the initial notification, any changes to the information initially reported about the serious occurrence(s) must be updated by a provider within five business days and maintained in the provider's recipient record.

Serious occurrences involving either the provider, employee or recipient may include, but are not limited to the following:

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization;

c. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;

d. Theft;

e. Sexual harassment or sexual abuse;

f. Injuries requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Adult Protective Services (ages 18 years old and above) or law enforcement agencies;

i. Death of the recipient during the rendering of 1915(i) services;

j. Loss of contact with the recipient for three consecutive scheduled days;

k. Medication errors resulting in injury, hospitalization, medical treatment, or death.

l. Elopement of a resident residing in a residential facility for the care of adults.

7. SERVICE PLAN

The Service Plan (SP) is developed by the provider using the 1915(i) HCBS Plan of Care (POC). At the minimum, a provider's SP must include: the description of services, duration, and amount of time (hourly, daily, weekly). The provider must also ensure the recipient, or the recipient's designated representative, is fully involved in the person-centered planning process which is documented on the SP.

a. TIMEFRAMES

The completed, signed, and dated SP must be sent to 1915i@dhcfp.nv.gov within 60 calendar days of the recipient beginning or continuing services.

b. SIGNATURES

1. The SP must be signed by the appropriate staff as referenced in 1803.3B(3)(c)(1), 1803.4B(2)(c)(1), 1803.5B(2)(c)(1), as applicable.

2. The recipient must also provide a signature on the SP.

3. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign for the recipient as referenced in 1803.6C(7)(c). The provider may create a signature page which a designated representative should sign on behalf of the recipient for the SP

and any other signature requirements. If the provider uses a signature page, it must be included in the recipient file.

8. TRAINING REQUIREMENTS

All employees must participate in a program of general orientation and must receive training on a regular basis, but not less than 12 hours per year.

General orientation training includes, but is not limited to:

a. policies, procedures and expectations of the provider, including recipient and provider rights and responsibilities;

b. record keeping and reporting including daily records and attendance records;

c. interpersonal and communication skills and appropriate attitudes for working effectively with recipients including:

1. understanding care goals,

2. respecting recipient rights and needs.

d. respect for age, cultural and ethnic differences;

e. recognizing family relationships;

f. confidentiality;

g. respecting personal property;

h. ethics in dealing with the recipient, family and other providers;

i. handling conflict and complaints; and

j. other topics as relevant.

NOTE: At least one employee trained to administer first aid and cardiopulmonary resuscitation (CPR) must be on the premises at all times.

1803.2 RECIPIENT RESPONSIBILITIES

Individuals receiving 1915(i) services are entitled to their privacy, to be treated with respect and be free from coercion and restraint.

The recipient or the recipient's designated representative will:

A. Notify the provider(s) and Health Care Coordinator (HCC) of a change in Medicaid eligibility.

B. Notify the provider(s) and HCC of changes in medical status, service needs or changes of status of designated representative.

C. Cooperate with the HCC by assisting with the assessment process.

D. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations.

E. Notify the HCC if services are no longer requested or required.

F. Notify the provider(s) and the HCC of serious occurrences, complaints regarding delivery of services or specific staff.

G. Not request a provider(s) to perform services not authorized in the plan of care.

H. Review and sign the 1915(i) transfer form when requesting a change in provider.

1803.3 ADULT DAY HEALTH CARE (ADHC) SERVICES

Adult Day Health Care services provide assistance with the ADL, medical equipment and medication administration. Services include health and social services needed to ensure the optimal functioning of the participant. ADHC services are activities on a regularly scheduled basis, for a minimum of one day per week.

1803.3A COVERAGE AND LIMITATIONS

Services provided by the appropriate professional staff include the following:

1. nursing services to include assessment, care planning, treatment and medication administration, evaluation and supervision of direct care staff;

2. nutritional assessment and planning;

3. care coordination to assist the recipient and family to access services needed by the recipient to maintain or improve their level of functioning or to minimize a decline in the level of functioning due to the progression of a disease or other condition that may not be remedied;

4. assist with ADL(s) as identified in the POC;

5. medical supervision and assistance to assure the recipient's well-being and that care is appropriate to meet the recipient's needs;

6. social and recreational activities to enhance the recipient's functioning and/or to maintain or improve the recipient's quality of life; and

7. meals provided as a part of these services shall not constitute a "full regimen" which is three meals per day.

NOTE: A recipient who resides in a residential setting such as group home, assisted living or other type of residential facility where a per diem rate is paid for 24-hour care is not eligible for ADHC services.

1803.3B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering ADHC services:

1. PROVIDER QUALIFICATIONS

   a. Each provider of ADHC services must obtain and maintain licensure as required in the 1915(i) State Plan and NAC Chapter 449. Furthermore, providers must adhere to all requirements of NAC 449 as applicable to licensure.

   b. The provider must notify DHCFP via email to 1915i@dhcfp.nv.gov within 24 hours of the event of closure, suspension or adverse action taken by Health Care Quality and Compliance (HCQC).

2. STAFFING REQUIREMENTS

   In addition to the requirements of NAC 449, each ADHC center must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by Nevada licensed/certified personnel and staff files maintained as required by the licensing entity.

   a. REGISTERED NURSE (RN)

      The center must employ a full time RN to oversee and provide medical services, particularly for physician ordered services. The RN must have at least one year of experience with the senior population, individuals with disabilities or individuals with a history of aggressive behavior. Within the first 60 calendar days of

admission, the RN must develop a SP to indicate the management of each recipient's care and treatment. An RN or Licensed Practical Nurse (LPN) under the supervision of an RN, will administer medications provided to the recipient while in the center's care. An RN, or LPN under the supervision of an RN, must be physically on the premises during the hours in which a Medicaid recipient is in attendance at the center.

b. PROGRAM DIRECTOR

The center must employ a full time Program Director who has a minimum of two or more years of education and/or experience with the senior population, individuals with disabilities or individuals with a history of aggressive behavior.

The duties of the Program Director will include at a minimum the development of plans and policies for the center's operation, recruitment, employment and training of qualified staff, supervision and appropriate disciplinary action of staff, maintenance of employee and recipient information and records, maintenance of the center's physical plant, housekeeping and nutritional services and the development and implementation of an evaluation plan of recipient services and outcomes.

c. DIRECT CARE STAFF

The center must have direct care staff who observes the recipient's functioning and provide assistance to the recipient in the skills of daily living. Direct care staff must have education, experience and necessary qualifications to work with the senior population, individuals with disabilities or individuals with a history of aggressive behavior.

The center must also provide for janitorial, housekeeping and activity staff or other staff as necessary to provide the required services and ensure each recipient's needs are met.

3. DOCUMENTATION

a. ATTENDANCE LOG

The facility must have documentation of daily attendance recorded on a log which includes: recipient's full name, date, time-in, time-out, and recipient's initials or signature.

b. NURSING LOG

The delivery of specific services required by the POC and outlined in the SP, must be documented in the nursing log. The RN on duty or an LPN under the supervision of an RN, during the provision of services is responsible for documenting in the recipient's file.

1. Nursing logs shall include the following information, but not limited to: recipient's full name, health component of the services, date of service provided, and initials of the direct care staff.

2. An appropriate provider staff member must sign and date the nursing log at minimum on a monthly basis indicating services were provided.

c. SIGNATURES

1. The appropriate staff member includes, but not limited to: the RN, the LPN under the direct supervision of the RN, or the Program Director.

2. In addition to a provider's SP, the recipient must also sign or initial the attendance log.

If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in 1803.6C(7)(c).

3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the attendance log and any other signature requirements.

1803.4 DAY HABILITATION

Day Habilitation services are activities scheduled on a regular basis, a minimum of one day per week. These services are provided in a non-residential setting, separatefrom the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing ADL and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independent and personal choice. Services are identified in the recipient's POC according to recipient's need and individual choices. Meals

provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's POC such as physical, occupational or speech therapy.

1803.4A COVERAGE AND LIMITATIONS

Day habilitation services are targeted to individuals who have a TBI or ABI.

1803.4B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering Day Habilitation services.

1. PROVIDER QUALIFICATIONS

a. Each provider of Day Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan.

2. DOCUMENTATION

a. ATTENDANCE LOG

The facility must have documentation of daily attendance logs which includes: recipient's full name, date, time-in, time-out, and recipient's initials or signature.

b. SERVICE LOG

The delivery of specific services required by the POC and outlined in the SP must be documented in the daily service log and maintained in the recipient's file.

1. The service log shall include the following information, but not limited to: recipient's full name, health component of the services, date of service provided, and initials of the direct care staff.

2. An appropriate provider staff member must sign and date the service log at minimum on a monthly basis indicating services were provided.

This documentation is verification of service provision and may be used to review claims paid.

c. SIGNATURES

1. The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Director of the facility or designated acting Director.

2. In addition to a provider's SP, the recipient must also sign or initial the attendance log.

3. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient's file. A designated representative may sign on behalf of the recipient as referenced in 1803.6C(7)(c).

4. The facility may create a signature page which a designated representative should sign on behalf of the recipient signature for the SP and any other signature requirements.

1803.5 RESIDENTIAL HABILITATION

Residential Habilitation means individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These services include adaptive skill development, assistance with ADL, community inclusion, adult educational supports, social and leisure skill development that assist the recipient to reside in the most integrated setting appropriate to their needs. Residential Habilitation also includes personal care, protective oversight and supervision 24 hours a day.

1803.5A COVERAGE AND LIMITATIONS

Residential Habilitation services are targeted to individuals who have a TBI or ABI.

Additionally, payment for room and board is prohibited.

1803.5B PROVIDER RESPONSIBILITIES

In addition to the Provider Responsibilities listed in Section 1803.1B, providers must adhere to the following requirements specific to rendering Residential Habilitation services.

1. PROVIDER QUALIFICATIONS

Each provider of Residential Habilitation services must obtain and maintain certification as required in the 1915(i) State Plan

2. DOCUMENTATION

a. SERVICE LOG

The delivery of specific services required by the POC and outlined in the SP must be documented in the daily service log and maintained in the recipient's file.

1. The facility must have documentation of daily service recorded on a log which includes: recipient's full name and date, health component of this service, date of service provided and initials of the direct care staff.

2. An appropriate provider staff member must sign and date the service log at minimum on a monthly basis indicating services were provided.

This documentation is verification of service provision and may be used to review claims paid.

b. SIGNATURES

1. The recipient and the appropriate staff member must sign or initial each record. The appropriate staff member would include, but not limited to: Administrator or the employee designated to be in charge of the facility when the administrator is absent.

2. In addition to a provider's SP, the recipient must also sign the service log at minimum on a monthly basis. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A designated representative may sign on behalf of the recipient as referenced in 1803.6C(7)(c).

3. The facility may create a signature page which a designated representative should sign on behalf of the recipient for the service log and any other signature requirements.

c. NOTIFICATIONS

If the facility issues an eviction notice or discharges a recipient from the facility, the facility should notify DHCFP via email to 1915i@dhcfp.nv.gov within 48 hours. Facility must adhere to all requirements of NRS 449A as applicable regarding recipient's rights.

1. EVICTION

If a facility chooses to evict a resident from a Residential Habitation facility, the facility must provide the resident or their designated representative with a 30-day written notice indicating the reason(s) for the eviction.

2. DISCHARGE

A recipient voluntary or involuntarily discharges from the facility under any certain circumstances.

1803.6 PROGRAM PROCEDURES

The following procedures describe how a person can obtain DHCFP 1915(i) HCBS services and the process required to maintain services utilizing a needs-based criteria to assess and re-assess whether an individual is eligible.

A. ASSESSMENT

1. NEW REFERRAL

a. A family member or applicant who is interested in receiving 1915(i) services may initiate a new referral by email, phone, mail, fax, in person, or by another party on behalf of the potential applicant.

b. A referral form can be found on the DHCFP website.

c. All required fields must be completed, and request documented included, in order for the referral to be accepted.

d. If an applicant appears to meet program criteria, a face-to-face assessment or via telehealth under certain circumstances will be scheduled to determine needs-based eligibility using the Comprehensive Social Health Assessment (CSHA) tool. The DHCFP HCC will contact the applicant/representative within seven working days of the referral date to schedule a time to conduct an assessment.

2. RE-ASSESSMENT

Once a recipient is authorized for 1915(i) services, that authorization period is for 12-months from the date of authorization.

a. Prior to the 12-month authorization period ending, the HCC will contact the recipient within 30 days to initiate a re-evaluation. The re-evaluation

includes a face-to-face assessment or via telehealth under certain circumstances, to determine whether the recipient meets the needs-based criteria.

b. If a recipient has a change in condition during the authorization period, the HCC will contact the recipient/designated representative to discuss the changes and update the POC as applicable.

B. TRANSFER

Once a recipient is approved for services, their authorization is for a year period. During that year, if a recipient chooses to transfer to a different service provider, the recipient or representative must contact DHCFP Health Care Coordinator to initiate the transfer process by using the 1915(i) transfer form.

1. The recipient or representative and the new provider must complete and sign the Transfer form.

2. The DHCFP will review the transfer request and may conduct a visit to verify the recipient's needs if there is a change of condition since the last assessment or other circumstances occur.

3. Once the DHCFP approves the transfer request, DHCFP will authorize the new provider for the remainder of the year period.

4. A recipient may not begin services at the newly chosen provider until the transfer request has been approved and authorized.

C. PERSON-CENTERED PLAN OF CARE

Once an applicant or recipient is determined eligible for 1915(i) services, a person-centered POC will be developed that includes, at a minimum, the individual's needs, goals to meet those needs, identified risks, and services to be provided.

The recipient, family, support systems and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible. The POC development process includes the following:

1. The POC is developed based on information obtained during the assessment.

2. The POC is person-centered, based on personalized goals, needs, preferences and developed with participation from the recipient, the family, the designated representative and anyone else the recipient chooses. The HCC documents this information in the CSHA narrative.

3. The POC reflects the recipient's service needs and includes both 1915(i) and non-1915(i) services in place at the time of POC completion, along with informal supports that are necessary to address those needs. The HCC is responsible for identifying services needed.

4. The POC development process considers risk factors, equipment needs, behavioral status, current support system and unmet service needs (this list is not all inclusive). The personalized goals are identified by the recipient and documented in the POC and each time the POC is updated with information obtained during the contacts with the recipient.

5. Facilitation of individual's choice regarding services and supports and who provides the services is given during the assessment. The recipient must sign the Statement of Choice (SOC) they had the right to choose the services and providers.

6. The POC identifies the services required, including type, scope, amount, duration and frequency of services.

7. A recipient will receive a copy of the POC which must be signed within 60 calendar days of the date of the assessment.

   a. If the recipient signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient.

   b. The HCC shall document the recipient's verbal approval in the CSHA narrative and obtain the signature and date on the finalized POC.

   c. If the recipient authorizes an individual to be their designated representative, then the Designated Representative Attestation form must be completed and signed.

8. The service providers are given a copy of the recipient's POC which must be signed and dated within 60 calendar days of the POC start date. The HCC ensures the provider returns a signed copy of the POC and SP for the case file.

9. The DHCFP HCCs are responsible for prior authorizing 1915(i) services.

D. NOTICE OF DECISION (NOD) FOR 1915(i) SERVICES

When DHCFP takes an adverse action such as denial, termination, or reduction of services, a NOD will be sent to the address on file with the Division of Welfare and Supportive Services or other address as instructed. The NOD will identify the service type, the reason, and the effective date.

1. DENIAL NOD FOR SERVICES

If during the assessment, the HCC determines the applicant does not appear to meet the eligibility criteria, a NOD will be mailed to the address on file and the applicant will be referred to other agencies for needed services or assistance not included under the 1915(i) program.

The following reasons will serve as a basis for denial:

a. The applicant is not eligible for Medicaid.

b. The applicant is under the age of 18 years.

c. The applicant does not meet the needs-based criteria.

d. The applicant has withdrawn his or her request for 1915(i) services.

e. The applicant has failed to cooperate with the DHCFP HCC in completing the application process including the assessment.

f. The applicant's support system is not adequate to provide a safe environment during the time when services are not being provided.

g. The DHCFP HCC has lost contact with the applicant.

h. The applicant has moved out of state.

i. Another agency or program will provide the services.

j. The applicant is in an institution (hospital, nursing facility, correctional or ICF) and discharge within 30 days is not anticipated.

k. The applicant has chosen a provider that is not an enrolled or qualified Medicaid provider.

l. There are no enrolled Medicaid providers in the applicant's area.

2. TERMINATION NOD FOR SERVICES

Once a recipient is eligible for 1915(i) services, there may be circumstances which result in a recipient becoming ineligible for services. The following reasons serve as a basis for terminating a recipient from the 1915(i) HCBS State Plan Option:

a. The recipient is no longer eligible for Medicaid.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 29, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER Jessica Kemmerer

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1900 – TRANSPORTATION SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1900 – Transportation Services are being proposed to align with the requirements outlined in the upcoming contract held with the current Non-Emergency Medical Transportation (NEMT) vendor, Medical Transportation Management, Inc. (MTM). The proposed changes include renaming the service "Non-Emergency Transportation (NET)" to "Non-Emergency Medical Transportation (NEMT)" throughout the entire chapter. Transportation Network Companies are being added as an approved mode of transport under NEMT services. Transportation requests to the NEMT vendor because of a hospital discharge must now be provided within three hours of the request, reduced from eight hours. Meal reimbursement and lodging are being added back in as a covered NEMT benefit. In addition, the exclusion of travel costs for attendants accompanying a recipient to or from a Residential Treatment Center (RTC) has been removed and will now be a covered benefit. Policy is also being updated to require recipients to request transportation to non-urgent appointments at least three days in advance instead of five days, and 14 days for out-of-area appointments instead of 21 days. The NEMT vendor may bypass the public transportation assessment process for recipients who are considered to have a high-risk pregnancy or are past their eighth month of pregnancy and should be authorized a higher mode of transport. Minor revisions are also being proposed to the emergency transportation policy section for clarity and improved readability.

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: This proposed change affects the following provider types (PT): Air or Ground (PT 32:); Nevada Medicaid's NEMT vendor: MTM, Inc.

Financial Impact on Local Government: There is no anticipated financial impact on local government that is known at this time.

These changes are effective July 1, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 10/21	MTL 13/20, 18/20, 01/21
MSM 1900 – Transportation Services	MSM 1900 – Transportation Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1903.1	**EMERGENCY MEDICAL TRANSPORTATION**	Language reworded as "medical condition" instead of "physical emergency or behavioral health condition." Changed "member" to "recipient." Removed language regarding "serious physical harm to self or another person." Removed language regarding prior authorization.
1903.1A(2)(c)	**NON-IMMEDIATE MEDICALLY NECESSARY TRANSPORTS**	Removed language regarding facility-to-facility transfer of SMI adult and examples of non-immediate medically necessary transports provided by NEMT broker.
1903.3	**NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES**	Removed language regarding specific waiver services. Reworded language regarding ride scheduling for clarity. Rearranged order of NEMT modes, added Transportation Network Company and Rail service as an approved mode.
1903.3A(1)	**PROGRAM ELIGIBLITY CRITERIA**	Language regarding ineligible recipients updated for clarity. Removed language regarding special payment arrangements with NEMT broker.
1903.3A(2)	**QUALIFYING CONDITIONS**	Introduction language reworded for improved readability. Removed reference to LRIs. Changed bus tickets to bus passes for consistency.
1903.3A(3)	**SCHEDULING TIMEFRAMES**	Added subsection titled "Scheduling Timeframes" to include language that local, non-urgent trips should be requested no less than three days in advance of appointment when possible; with moved language and new language specifying NEMT that should be scheduled in advance versus same day services. Removed repetitive language regarding level of care exceeding scope of services of an EMT basic and reference to NCU funds.
1903.3A(4)(b)	**SPECIAL POPULATIONS**	Added language that certain Medicaid populations such as those with an intellectual disability can be allowed to select their preferred NEMT provider within authorized mode. Added language that the NEMT vendor may bypass public transportation for high-risk pregnancy patients or patients past eighth month of pregnancy and may authorize higher mode. Language added to specify Emergency Medical Only (EMO) recipients may utilize NET only if they are authorized for Dialysis services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1903.3A(4)(c)	**GAS MILEAGE REIMBURSEMENT**	Changed term "volunteer drivers" to "community non-professional drivers." Added family members and friends as being eligible for regular gas mileage reimbursement (GMR) and that they may also apply to become community non-professional driver. Clarified that recipients who are assigned to public transportation may also use GMR when cost-effective.
1903.3A(4)(e)	**OUT-OF-AREA TRAVEL**	Reduced requirement to request NEMT to out-of-area appointments from 21 days to 14 days in advance. Added language for meal and lodging benefit and removed exclusion.
1903.3A(4)(f)	**RURAL AREAS**	Language added to specify authorization and scheduling for recipients living in rural areas will follow the standard scheduling process and will not be considered an out-of-area trip.
1903.3A(4)(g)	**ATTENDANTS TO RECIPIENTS**	Changed title to "Attendants to Recipients." Changed "escort" to "attendant." Removed language that meal reimbursement and lodging expenses are not a covered benefit for attendant or recipient. Language added clarifying attendant travel covered only when a recipient is being transported with the exception of family members needing to return home. Added language clarifying meal and lodging not provided for attendant once recipient is inpatient and that attendants must share lodging with recipient. Removed reference to LRI, changed to "other adult." Language regarding attendants for PCS recipients reworded for clarity. Language regarding adoptive/foster parents of foster/adopted children utilizing NEMT reworded for improved readability.
1903.3A(4)(h)	**INPATIENT TREATMENT FACILITIES**	Language regarding utilizing NEMT for purpose of therapeutic home passes condensed and reworded for improved readability. Removed exclusion of transportation costs not being covered for attendants accompanying recipients to/from a Residential Treatment Center (RTC) as it will now be covered. Language added that NEMT broker must cover transportation costs of attendant to accompany recipient if necessary but travel costs for facility staff not covered when not accompanying a recipient. Added children in custody of Child Welfare as included out-of-state residents who may obtain NEMT.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1903.3A(5)	**NON-COVERED SERVICES**	Added language that oxygen tanks are allowed if portable and self-administered. Deadheading definition reworded for clarity. “Escort” changed to “attendant.”
1903.3B	**ASSESSMENT AND AUTHORIZATION PROCESS**	Removed reference to LRI and added language to specify that family members, friends or community partners may request NEMT for a recipient.
1903.3D(g-j)	**NEMT RECIPIENT RESPONSIBILITY**	Removed reference to LRI to instead include “individuals scheduling on behalf of a recipient.” Reduced requirement to request NEMT for local non-urgent appointments from five days to three days and no more than 60 days prior to travel. Added language to specify that paratransit rides must be requested from the NEMT vendor no more than three days in advance of the recipient’s medical appointment. Language regarding recipients being ready for scheduled ride reworded for clarity.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

TRANSPORTATION SERVICES

1900 INTRODUCTION

Nevada Medicaid provides emergency and non-emergency medical transportation (NEMT) services for eligible Medicaid recipients, to access medically necessary covered services. These transportation services are provided to and from enrolled Medicaid and Managed Care Organizations (MCOs) providers. Transportation is provided via the most appropriate and cost-effective mode of transportation.

Emergency Medical Transportation (ground or air) is available to all eligible Nevada Medicaid and Nevada Check Up (NCU) recipients.

NEMT services ensure that necessary non-ambulance transportation services are available to recipients to eliminate transportation barriers for recipients to access needed medical services. NCU recipients are not eligible for NEMT services.

1901 AUTHORITY

Statutes and Regulations:

- Social Security Act (SSA)
  - Title XIX Section 1902(a)(70)
  - Title XXI
- Code of Federal Regulations (CFR)
  - 42 CFR 431.53 Assurance of transportation.
  - 42 CFR 440.170 Any other medical care of remedial care recognized under State law and specified by the Secretary.
  - 45 CFR 92.36 (b-f) Procurement.
- Nevada Revised Statute (NRS)
  - Chapter 422 Health Care Financing and Policy
  - Chapter 706 Motor Carriers
- Nevada Medicaid State Plan
  - Title XIX

    Attachment 3.1-A Amount, duration, and scope of medical and remedial care and services provided to the categorically needy; page 9, 9a – 9h.

    Attachment 3.1-D Transportation.
  - Title XXI

    Section 3.1. Delivery Systems

1902 DEFINITIONS

Program definitions can be found in the Medicaid Services Manual (MSM) Addendum.

1903 POLICY

1903.1 EMERGENCY MEDICAL TRANSPORTATION

Emergency transportation is medically necessary to manage a sudden onset of a medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in placing the recipient's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

These services are covered in emergent situations in which specially staffed and equipped ambulance transportation is required to safely manage the recipient's medical condition. Advanced Life Support, Basic Life Support, Neonatal Emergency Transport and Air Ambulance services are covered, depending upon the recipient's medical needs.

1903.1A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

   a. Recipient must be eligible for Nevada Medicaid or NCU services.

   b. Emergency medical transportation must be:

      1. Medically necessary.

      2. In accordance with the recipient's medical condition and needs.

      3. To the nearest, appropriate Medicaid health care provider or appropriate medical facility.

2. COVERED SERVICES

   a. GROUND EMERGENCY MEDICAL TRANSPORT

      1. Recipients may be transported from any point of origin to the nearest hospital, critical access hospital (CAH), dialysis facility or appropriate specialty clinic (e.g. substance abuse agency, federally qualified health center, rural health clinic, Indian health program).

      2. May also transport skilled nursing facility (SNF) residents when the required level and type of care for the recipient's illness or injury cannot be met by the SNF, to the nearest supplier of medically necessary services. The hospital or CAH must have available the type of physician specialist needed to treat the recipient's condition. However, the utilization of emergency transportation may not be used in lieu of non-emergency transportation.

b. AIR AMBULANCE TRANSPORT

Air ambulance transports are only covered to acute care hospitals and may be provided via:

1. Rotary wing.

2. Fixed wing.

c. NON-IMMEDIATE MEDICALLY NECESSARY TRANSPORTS

When the recipient's in-transit care needs exceed the capabilities of the Non-Emergency Medical Transportation (NEMT) broker a non-immediate medically necessary transport can be provided by an enrolled Nevada Medicaid emergency transportation provider. Non-immediate medically necessary transports may be arranged by a hospital, physician, emergency transportation provider or by DHCFP's NEMT broker. A prior authorization is not required for these types of non-immediate medically necessary transports.

The following scenarios are examples of non-immediate medically necessary transports that would exceed the capabilities of the NEMT broker and can be provided by an enrolled Nevada Medicaid emergency transportation provider:

1. Transportation of a critically ill recipient to a location where an organ transplant will occur; or

2. Hospital-to-hospital transfer of a seriously injured or ill recipient when medically necessary tests or treatment are not available at the dispatching hospital and the recipient's care needs during transit requires the attendance of medical personnel and/or the attachment to medical apparatus that would be included in a basic life support or advanced life support vehicle (ambulance).

d. SPECIALTY CARE TRANSPORT

Specialty care transport (SCT) is hospital-to-hospital transportation of a critically injured or ill recipient by a ground or air ambulance, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) - intermediate or paramedic.

3. NON-COVERED SERVICES

The following services are not covered benefits under emergency transportation and are therefore not reimbursable.

a. ALL EMERGENCY TRANSPORTATION

1. Response with "Non-transport".

2. Routine or special supplies, including oxygen, defibrillation, IV's, intubation, ECG monitoring or air transport excise taxes (agreed upon rates between DHCFP and specific transportation providers are all inclusive);

3. Ambulance charges for waiting time, stairs, plane loading;

4. Deadheading (an empty trip to or from a destination); or

5. Transportation of deceased persons.

b. GROUND EMERGENCY MEDICAL TRANSPORT

1. Hospital to the scene of an accident/acute event;

2. Recipient's residence to the scene of an accident/acute event;

3. Scene of an accident/acute event to recipient's residence;

4. Scene of an accident/acute event to the scene of an accident/acute event; and

5. Residence to Residence.

The following types of transports are primarily covered by the NEMT broker and are therefore considered non-covered emergency transportation services:

1. Residential, domiciliary or custodial facility to a physician's office;

2. Physician's office to a residential, domiciliary or custodial facility;

3. Physician's office to recipient's residence; and

4. Recipient's residence to a freestanding ESRD facility (dialysis.)

c. AIR AMBULANCE TRANSPORT

1. Nursing facilities;

2. Physician's offices; and

3. Recipient's residence.

1903.1B AUTHORIZATION PROCESS

Emergency medical transportation does not require prior authorization. No prior or post authorization is required for emergency medical transportation that originates with a "911" call. According to the Centers for Medicare and Medicaid Services (CMS), emergency response to "911" calls normally result in a basic life support (BLS) or advanced life support level 1 (ALS-1) service level. Emergency medical transportation providers who submit claims coded as advanced life support level 2 (ALS-2) must present supporting documentation to verify that the transport included the type of care described in the ALS-2 definition in the MSM chapter addendum.

DHCFP has contracts with MCOs that are contractually obligated to cover air emergency medical transportation services for their enrollees. For MCO enrolled recipients, claims for air emergency transportation are to be submitted to the MCO in which the recipient is enrolled. Claims submitted to the recipient's MCO must only be for air emergency medical transportation and not ground emergency medical transportation. Ground emergency medical transportation claims for all Nevada Medicaid recipients, including MCO enrolled recipients must be submitted to Nevada Medicaid's fiscal agent.

Providers are to submit all ground emergency medical transportation claims to Nevada Medicaid's fiscal agent. If the recipient is enrolled in Fee-for-Service Medicaid, air emergency transportation claims may also be submitted to Nevada Medicaid's fiscal agent.
Specialty care and non-immediate medically necessary transports do not require prior or post authorization

1903.1C PROVIDER RESPONSIBILITY

Emergency medical transportation providers must submit all appropriate documentation to the MCOs or to the Nevada Medicaid fiscal agent to enroll as an emergency medical transportation provider.

The transportation provider is solely responsible for verifying Medicaid eligibility for each recipient. Whenever possible, this should be done prior to rendering services. Information concerning eligibility and enrollment verification is located in Chapter 100, of the Nevada Medicaid Services Manual (MSM).

The provider must ensure the confidentiality of recipient medical records and other information, such as the health, social, domestic and financial circumstances learned or obtain while providing services to recipients.

The provider shall not release information related to a recipient without first obtaining the written consent of the recipient or the recipient's legally authorized representative, except as required by law. Providers meeting the definition of a "covered entity" as defined in the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 CFR 160) must comply with

the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

DHCFP expects that providers will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable.

1903.1D RECIPIENT RESPONSIBILITY

The recipient or legally authorized representative shall:

1. Provide the emergency transportation provider with a valid Medicaid/NCU Identification card at the time the service is rendered, if possible, or as soon as possible thereafter.

    a. Recipients shall provide the emergency transportation provider with accurate and current medical information, including diagnosis, attending physician, medication regime, etc., at the time of request, if possible;

    b. Recipients shall notify the emergency transportation provider of all third-party insurance information, including the name of other third-party insurance, such as Medicare, Tricare, Workman's Compensation or any changes in insurance coverage at the time of service, if possible, or as soon as possible thereafter; and

    c. Recipients shall not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability and/or national origin.

1903.2 NON-EMERGENCY SECURE BEHAVIORAL HEALTH TRANSPORTS

Non-emergency secure behavioral health transport services means the use of a motor vehicle, other than an ambulance or other emergency response vehicle, that is specifically designed, equipped and staffed by an accredited agent to transport a person alleged to be in a mental health crisis or other behavioral health condition; including individuals placed on a legal hold. Accredited agents are licensed though the Nevada Division of Public and Behavioral Health. These types of transports are outside the scope of services provided by the NEMT broker.

1903.2A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY AND CRITERIA

    a. Recipients must be eligible for Nevada Medicaid or Nevada Check Up (NCU) services.

    b. A recipient must be experiencing a behavioral health crisis as evidenced by extreme emotional distress that includes but is not limited to an acute episode of mental

illness and/or suicidal thoughts and/or behavior that may co-occur with substance use and other disorders.

2. COVERED SERVICES

a. Non-emergency secure behavioral health transport services may be used for the following transports:

1. Facility-to-facility transport between facilities including but not limited to hospitals, public or private mental health facilities and medical facilities.

2. Transport to and from a facility arranged by individuals authorized by NRS 433A.160 to arrange for transportation.

3. Transport of an individual seeking voluntary admission pursuant to NRS 433A.140 to a public or private mental health facility.

b. Recipients must be transported to the nearest, appropriate Medicaid health care provider or appropriate medical facility. Long distance or out-of-state transports are allowable when medically necessary.

3. LIMITATIONS

a. Family members or other unaccredited agents are not allowed to travel in the secure vehicle with the recipient.

1903.2B AUTHORIZATION PROCESS

Non-emergency secure behavioral health transports do not require prior authorization. Claims must be submitted to Nevada Medicaid's fiscal agent.

1903.2C PROVIDER RESPONSIBILITY

Non-emergency secure behavioral health transport providers must apply to become an accredited agent. Once accredited, providers must enroll as a Medicaid non-emergency secure behavioral health transportation provider.

Providers are solely responsible for verifying Medicaid eligibility for each recipient. Whenever possible, this should be done prior to rendering services. Information concerning eligibility and enrollment verification is located in Chapter 100, of the Nevada Medicaid Services Manual (MSM).

The provider must ensure the confidentiality of the recipient medical records and other information, such as the health, social, domestic and financial circumstances learned or obtained while providing services to recipients.

The provider shall not release information related to a recipient without first obtaining the written consent of the recipient or the recipient's legally authorized representative, except as required by law.

DHCFP expects that providers will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable.

1903.2D RECIPIENT RESPONSIBILITY

The recipient or legally authorized representative shall:

1. Provide the non-emergency secure behavioral health transport provider with a valid Medicaid/NCU Identification card at the time the service is rendered, if possible, or as soon as possible thereafter.

    a. Recipients shall provide the non-emergency secure behavioral health transport provider with accurate and current medical information, including diagnosis, attending physician, medication regime, etc., at the time of request, if possible;

    b. Recipients shall notify the non-emergency secure behavioral health transport provider of all third-party insurance information, including the name of other third-party insurance, such as Medicare, Tricare, Workman's Compensation, or any changes in insurance coverage at the time of service, if possible, or as soon as possible thereafter; and

    c. Recipients shall not refuse service of a provider based solely or partly on the provider's race, creed, religion, sex, marital status, color, age, disability and/or national origin.

1903.3 NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

DHCFP has contracted with a NEMT broker to provide transportation to medically necessary Medicaid covered services including certain Waiver services. NEMT never originates from a "911" call. NEMT is utilized by recipients whose level of care needs do not exceed the scope of service of an EMT-Basic.

Although ride scheduling will only be accommodated during the NEMT broker's scheduled business hours, transportation may be scheduled for confirmed after-hours medical appointments. After-hours and holiday rides that are not prior authorized may be reimbursed only when the recipient requires urgent medical care. The transportation must be to an emergency care facility,

such as an emergency room or after-hours clinic. The transportation broker provides services on a statewide and out-of-state basis.

All NEMT services, including out-of-state and long distant transport, require prior authorization by DHCFP's NEMT broker with the exception of NEMT services provided by Indian Health Programs. The NEMT broker is required to authorize the least expensive mode of transport available consistent with the recipient's medical condition and needs. Examples of NEMT services may include the following:

A. Ground ambulance;

B. Stretcher accommodating vehicle.

C. Commercial air;

D. Rail service;

E. Bus, local city;

F. Bus, out of town;

G. Paratransit;

H. Private vehicle;

I. Transportation Network Company; and

J. Taxi.

1903.3A COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

a. The eligibility functions for Title XIX Medicaid determinations are the responsibility of the Division of Welfare and Supportive Services (DWSS).

b. The following recipients are ineligible for NEMT services:

1. Title XXI NCU recipients;

2. Title XIX recipients who are Medicaid eligible solely for the purpose of payment of Medicare premiums, co-insurance, deductibles, or co-pays i.e., Qualified Medicare Beneficiaries (QMBs), Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Individuals (QI-1s); and

3. Not qualified" non-citizens.

c. Residents of skilled nursing facilities are entitled to NEMT services through the facility; NEMT costs are included in the nursing facilities' rate structures.

d. Medicaid recipients are eligible for NEMT services only from the date of determination forward. No payment will be made for NEMT provided while a recipient's Medicaid application is pending. Retroactive eligibility does not apply to NEMT services.

2. QUALIFYING CONDITIONS

NEMT for Medicaid eligible recipients to and from Medicaid medical providers for covered medically necessary services is included but not limited to the following terms:

a. The recipient is unable to provide his/her own transportation:

b. Free Transportation: Recipients must use free transportation when it is available. Free transportation includes, but is not limited to, when the recipient is able and capable of providing their own transportation or when another individual or an agency is willing to provide transportation to the recipient to obtain eligible Medicaid services.

c. Recipients should make every reasonable effort to find day care for their minor children when they use non-emergency transportation services; however, this may not always be possible. When appropriate care for a minor child cannot be obtained, the minor child may accompany the recipient. The broker must provide bus passes for minor children unless the minor child is able to accompany the recipient at no additional cost. More than one minor child may accompany the recipient if the transportation provider is notified in advance.

d. The least expensive form of transportation is utilized in accordance with the recipient's medical condition and needs.

3. SCHEDULING TIMEFRAMES

a. SCHEDULED IN ADVANCE: Transportation should be requested from the NEMT broker no less than three days in advance of the recipient's medical appointment for local, non-urgent trips. The following list includes but is not limited to:

1. Transportation to/from a routine Medicaid-reimbursable medical or dental appointment; and

2. Transportation to/from regular standing medical services such as dialysis, chemotherapy treatments, adult day care, job and day training.

b. SAME DAY SERVICES: Transportation services for a Medicaid eligible recipient as a result of a hospital discharge must be provided as soon as possible and in any event is not to exceed a three-hour time span. The following list includes but is not limited to:

1. The transport from an acute general hospital to an acute psychiatric hospital;

2. Transportation to an urgent care clinic; and

3. Transportation to/from pharmacies for medical necessities.

Medicaid funds may not be used to pay for transportation services that are otherwise available without charge to both Medicaid and non-Medicaid recipients. In addition, Medicaid is generally the payor of last resort except for certain Federal programs such as Title V Maternal and Child Health Block Grant funded services or special education related health services funded under the Individuals with Disabilities Education Act (IDEA).

4. COVERED SERVICES

a. PUBLIC TRANSPORTATION

Recipients who do not have free transportation available and live within the service area of any public transit systems must use public transit where possible and cost-effective.

1. Recipients are deemed to live within the public transit system service area when they reside within 3/4 mile of a transit stop. If the recipient qualifies for public paratransit service and this is available in the area where the recipient resides, the recipient is deemed to live within the public transit area, whether or not the recipient resides within 3/4 mile of the transit stop.

2. Recipients who do not have free transportation available must ride fixed-route public transit unless they reside outside the service area or their medical appointment is outside of the service area; they are assessed to be medically unable to board, disembark, or ride buses; or public transit buses cannot accommodate the recipient's wheelchair or other medical equipment that must accompany the recipient in transit.

3. Recipients who reside within the service area of the public transit system and are assessed to be unable to ride fixed-route buses will be referred for

assessment for public paratransit services. If qualified for public paratransit services, the recipient will be required to ride only public paratransit services, unless traveling to a destination that is outside the public transit system service area. If traveling outside of the paratransit service area, the recipient's transport must be authorized by the NEMT broker.

4. A recipient who requires frequent travel on fixed route transit will be provided with a multiple ride pass, when this is cost effective.

5. If a recipient who is qualified for public transit level of service requires transport to a medical appointment that is not accessible by public transit, the recipient must receive specific authorization for the transport from the NEMT broker, who will require evidence of medical necessity for the trip and verify that the recipient is accessing the nearest appropriate provider. Recipients have freedom of choice when selecting medical providers but are only eligible for NEMT to access these services if using the nearest appropriate provider. The nearest health care provider or facility is not always the most appropriate. The NEMT broker should consider existing relationships between the recipient and their medical provider, or appointment availability, when the provider is within a reasonable distance. DHCFP will assist the NEMT broker in making these decisions. The NEMT broker will assign the recipient to ride with the least expensive transportation provider available.

6. Recipients are required to comply with all policy and rules of the public transit system. Recipients who are suspended from service by public transit agencies because of recipient misbehavior, persistent no-shows, or failure to cancel rides in a timely manner are ineligible for other NEMT services unless they can provide medical evidence that their inability to access medical care during the suspension period will result in serious exacerbation of their medical condition or pose an unacceptable risk to their general health. Recipients who have been suspended will not be provided NEMT for routine medical appointments. Recipients who have been suspended must exhaust the public transit system appeal process before being assessed for another level of service. Recipients who are suspended indefinitely from public transit will be suspended indefinitely from access to NEMT, except in cases where they can provide medical evidence that their inability to access medical care will result in serious exacerbation of their medical condition or pose an unacceptable risk to their general health.

a. SPECIAL POPULATIONS

1. Certain Medicaid populations, such as those with an intellectual disability can be allowed to select their preferred provider within the authorized mode of transportation. If no specific provider is preferred, the vendor will assign whichever mode is most appropriate.

2. The NEMT vendor may bypass the public transportation assessment process for recipients who are considered to have a high-risk pregnancy or are past their eighth month of pregnancy. These recipients should be authorized a higher mode of transport.

3. Within Nevada Medicaid eligibility categories there are certain recipients who are eligible for Emergency Medical Services only which would typically make them ineligible for NEMT. In certain circumstances, DHCFP authorizes dialysis services for recipients with an Emergency Medical aid category. Those recipients with an Emergency Medical aid category authorized for dialysis services are subsequently also eligible for NEMT to dialysis appointments only.

c. GAS MILEAGE REIMBURSEMENT

Under certain circumstances, recipients, Legally Responsible Individuals (LRIs), family members, friends, or community non-professional drivers may receive mileage reimbursement for driving a recipient to medical services.

1. Recipients, LRIs, family members or friends may be authorized to receive mileage reimbursement if the recipient is traveling to access medical services. Compensation will be at the IRS rate for medical/moving mileage reimbursement. Recipients must have prior authorization from the NEMT broker for drivers to be eligible for mileage reimbursement

2. Recipients who are assigned to public fixed-route transit or paratransit may also utilize gas mileage reimbursement if it is determined to be cost-effective.

3. Community non-professional drivers (private citizens who contract with the NEMT broker) who are not LRIs, nonprofit organizations, or Indian Health Programs may receive mileage reimbursement for driving a recipient to medical services, when this is the least expensive mode of transportation. Friends, families, and neighbors may apply to become a community non-professional driver. Reimbursement will be at twice the current IRS per mile rate for business use, as found on the IRS website at http://www.irs.gov. Mileage reimbursement is provided to the driver for the vehicle's miles actually driven from the point of where a recipient has been picked up and does not exceed twice the IRS business mileage rate unless a different rate

is negotiated by the NEMT broker due to limited transportation availability and cost effectiveness. In cases of disputes over actual mileage, MapQuest or other geo-mapping software will be used as the final determining factor. Current Medicaid recipients are not allowed to enroll with the NEMT broker as a community non-professional driver.

d. INDIAN HEALTH PROGRAMS

Several tribes and/or Indian Health Programs offer ambulance and/or van services for both emergency and NEMT. Community health representatives (CHR) may provide NEMT services to recipients who are eligible for NEMT services in private vehicles to medically necessary covered services and are reimbursed at a per mile rate that is double the IRS business mileage rate. The Indian Health Programs' NEMT services do not require prior authorization. All claims for reimbursement by the Indian Health Programs for non-emergency transportation services are submitted to the NEMT broker for adjudication and payment.

e. OUT-OF-AREA TRAVEL

Recipients may be eligible to receive NEMT for out-of-area, out-of-state or airline travel if certain conditions are met. A medical appointment is considered to be out-of-area when the facility is located 101 or more miles from the recipient's home.

1. Recipients must receive prior authorization for out-of-area medical services from DHCFP's fiscal agent or their MCO prior to requesting authorization for transportation. The NEMT broker may also require a distance verification form to be completed by the referring physician.

2. Recipients must request authorization for out-of-area and commercial airline a minimum of 14 days prior to the travel date.

   a. Exceptions to the 14-calendar day requirement may be granted if the recipient has a medical necessity to travel and could not have known 14 days in advance, as in the case of a donor organ becoming available for a transplant surgery that must occur out of the area.

   b. Exceptions to the 14-day requirement will be granted for recipients who are discharged to or from an out-of-area acute-care facility; an out-of-state nursing facility; or otherwise detained in a juvenile detention facility.

   c. Other exceptions may be granted from time to time if they are in the best financial interest of the State.

d. Recipients are required to travel by the least expensive mode of transportation available that will accommodate their medical requirements.

e. Meal and lodging shall only be authorized for out-of-area trips when an overnight stay is necessary due to the timing of the recipient's medical appointment or scheduling of the recipient's commercial travel such as flight, train, or bus. Recipients must utilize free lodging when available, such as the Ronald McDonald House, or the NEMT broker will arrange for lodging. Meal reimbursement shall be paid in accordance with General Services Administration (GSA) rates.

3. Recipients must submit their trip log for gas mileage or meal reimbursement within 60 calendar days after completing the out-of-area trip.

4. Recipients who have recurring requirements to receive out-of-area trips for a single treatment or multiple treatments for the same diagnoses, may have multiple trips a month authorized but no more than five trips may be authorized at one time.

f. RURAL AREAS

Authorization and scheduling requirements for trips originating in certain rural counties will follow the standard process for scheduling and will not be considered an out-of-area trip for recipients residing in rural areas of Nevada.

g. ATTENDANTS TO RECIPIENTS

1. The NEMT broker must allow at least one attendant, who must be a minimum of 18 years of age (or any age if the attendant is the parent of a minor child) to accompany a recipient or group of recipients when attendant services are determined medically necessary or for those recipients who are minor children. A Medicaid recipient who is physically disabled or developmentally disabled may be authorized to be accompanied by an attendant(s) during the assessment to access NEMT services. A person under the age of 18 must be accompanied by one attendant unless that person is married, legally emancipated, or obtaining family planning services and/or family planning products. If a parent or guardian with a physical or mental disability is taking their child to a medical appointment, a second attendant may be authorized to assist the parent in accompanying the child when it is deemed medically necessary.

2. During the NEMT assessment, the assessor or a physician's statement will determine whether the recipient requires an attendant(s) and specify the circumstances under which an attendant(s) may accompany the recipient while utilizing NEMT services. Multiple attendants may be authorized to accompany a recipient when determined medically necessary.

3. The NEMT broker will cover the transportation costs of an attendant(s) to accompany the recipient, if medically necessary. Attendant travel is a covered expense only when a recipient is being transported with the exception of family members needing to return to their residence. If during travel, a recipient requires an overnight stay, one room is reserved for the recipient and the attendant is expected to share lodging in order to care for the recipient. When a recipient is admitted to an inpatient facility, the recipient would no longer be in travel status, therefore meals and lodging would not be provided for the attendant.

4. NEMT services may not be authorized for minor children unless a parent (regardless of the parent's age) or another adult accompanies the child. Exceptions include but are not limited to:

   a. A minor child transported for the purpose of obtaining family planning services and/or products.

   b. If a delay of a minor child transport from one facility to another for treatment is medically detrimental, and a parent or LRI is not available, a Consent and Release of Liability form must always be signed by the facility case worker prior to the transport.

   c. Other specific exceptions may be made on a case-by-case basis by DHCFP.

5. In addition, and pursuant to Nevada MSM Chapter 3500, an attendant(s) may be authorized to accompany a recipient who requires personal care services (PCS) in route to, or at, a destination to obtain Nevada Medicaid covered, medically necessary services. An attendant(s) may be a parent or legal guardian, caretaker, LRI, friend or a personal care attendant (PCA) who accompanies the recipient.

6. Pursuant to 42 CFR 440.250 and the Nevada State Plan, an adoptive parent under the auspices of an Adoption Assistance Program (AAP) agreement or a foster parent of a program eligible child may utilize NEMT services for the foster/adopted child to obtain Medicaid covered services. The agency that maintains custody of a foster child or the adoptive/foster parents must coordinate medical transportation services through the NEMT broker.

h. INPATIENT TREATMENT FACILITIES

1. Transportation services for the parent(s) of a newborn less than 12 months of age receiving treatment on an inpatient basis in a facility are covered.

2. NEMT services may be authorized for a recipient residing in an inpatient treatment facility to allow the recipient to attend a therapeutic home visit, in-state or out-of-state, when such visits are part of the recipient's treatment plan. It is the responsibility of the inpatient treatment facility to obtain transportation for eligible recipients for all therapeutic home visits by calling the NEMT broker. The NEMT broker covers the transportation costs of an attendant(s) when accompanying the recipient, if medically necessary as referenced in 1903.3A(4)(g). Attendant travel costs for facility staff are not covered when not accompanying a recipient. NEMT services are not available for family members to visit a recipient residing in an inpatient treatment facility. The NEMT broker may authorize transportation for therapeutic home visits in accordance with Nevada MSM Chapter 400 and MSM Chapter 1600.

3. Program recipients who live out-of-state may obtain NEMT services similarly to those eligible recipients who reside within the State of Nevada. Such out-of-state recipients may include children in the custody of Child Welfare, foster children, children placed in an adoptive home under the auspices of an Adoption Assistance Program (AAP) agreement, or children in residential treatment centers (RTC). Authorization of ~~NET~~NEMT services for eligible recipients residing out-of-state is the same as for those eligible recipients who reside within Nevada

5. NON-COVERED SERVICES

The following are non-covered NEMT services:

a. When one or more eligible recipients make the same trip in a private vehicle or van, reimbursement is made for only one recipient;

b. Transportation to or from any non-covered service, except for exclusion due to Third Party Liability (TPL) coverage under the Medicaid program;

c. Travel to visit a recipient in an inpatient treatment facility, except in the case of a parent or parents visiting a newborn that is in a facility

d. Transportation between hospitals for outpatient or inpatient care or services (e.g., MRI, CAT scan, etc.); exceptions may be granted when services to treat the recipient's condition are not available at the originating hospital and/or are not part

of the all-inclusive prospective rate or the recipient is transferring to a hospital closer to home following an out-of-area hospital stay;

e. "Deadheading," this refers to an empty trip to or from a destination;

f. The cost of renting an automobile for private vehicle transport;

g. A non-transport charge for a recipient who did not show up for their scheduled ride;

h. Wages or salary for attendant(s);

i. Charges for waiting time, stairs, plane loading;

j. Routine or special supplies including oxygen unless oxygen tanks are portable and self-administered. Special services such as: defibrillation; IVs; intubation or ECG monitoring. Recipients requiring any type of medical care, medical supervision, physical monitoring, attachment to medical intravenous therapy, EMT-intermediate or paramedic services, etc. during transport are not eligible for non-emergency transportation.

k. Transportation of a recipient in a personal care attendant's private vehicle is not a reimbursable service;

l. Transportation from a nursing facility to a medical appointment; and

m. Basic life support (BLS), and advanced life support (ALS) transports.

1903.3B ASSESSMENT AND AUTHORIZATION PROCESS

With the exception of services provided by Indian Health Programs (see Section 1903.3A(3)(c)), the need for NEMT services must be assessed as specified in this section and authorized by the NEMT broker.

The goal of the combined assessment and authorization processes is to determine the required level of non-emergency transportation services.

1. Recipients wishing to use NEMT services will be assessed for the proper level of transportation prior to being authorized access to NEMT.

   a. Lower levels of ground transportation, i.e. mileage reimbursement or fixed-route public bus, will be assessed and authorized by the NEMT broker.

   b. If the request is for a greater level of ground transportation than mileage reimbursement or fixed-route public bus, the NEMT broker uses due diligence in questioning the recipient to see if a lower-level transport is acceptable and sufficient for their medical condition. If the recipient agrees to the lower level, then that transport will be authorized by the NEMT broker.

c. If the recipient does not believe the lower level transport is appropriate or acceptable, then they will be referred to the public paratransit services agency for a level of service needs evaluation. If the recipient resides outside the parameter of a paratransit agency, the NEMT broker will provide transportation to and from the recipient's primary care physician (PCP) at the level of service requested. The PCP will provide documentation and/or a NEMT broker form that will identify the correct level of transportation service based on the recipient's medical needs.

d. If the recipient has been authorized for NEMT, and has been assessed by the public paratransit service, the Regional Transportation Commission (RTC) has 21 days to notify the recipient of the results of the assessment. Until the assessment has been reviewed and submitted to the recipient, the transportation broker will continue to provide transportation at the level of service requested by the recipient. In the event the recipient has been denied the use of paratransit services and is now receiving a lower level of transportation service than requested, the recipient must inform the transportation broker of their dissatisfaction, if applicable, with the level of service assigned. The transportation broker will then review the assessment as well as the recipient's medical documents and determine if the recipient is eligible for the broker's paratransit or curb-to-curb services. The transportation broker will notify the recipient of their determination within 48 hours of review. If the decision negatively impacts the recipient, the transportation broker will also provide the recipient with a Notice of Decision (NOD).

e. If the recipient requests a hearing, until the higher level of transportation is either approved or denied by the State Fair Hearing process, the NEMT broker will provide rides at the requested level of service.

f. The NEMT broker will maintain a list of all assessment referrals sent to the paratransit service agencies.

g. If the NEMT broker believes that a recipient is receiving unnecessarily expensive transportation, then the broker is expected to conduct a reassessment to determine the correct level of transportation needed.

h. When recipients contact the NEMT broker requesting a ride, they will be screened for prior authorization and will be permitted to ride within the level of service authorized.

i. If the recipient requires NEMT prior to the time of the assessment including a ride to the paratransit service agency for an assessment, the NEMT broker will authorize the rides at the level requested.

1. Recipients residing within the service area of a public transit systems where paratransit services are available, who require transportation above the level

of fixed route, must receive an assessment disqualifying them from public paratransit prior to being authorized for a higher level of service.

2. Once a recipient has been referred to the paratransit service agency for an assessment, the recipient has five days in which to contact the paratransit service agency to schedule an assessment. The paratransit service agency has up to 45 days to complete an assessment. The level of service requested by the recipient will be provided until an assessment has been completed. Failure to complete the paratransit assessment within 45 days will result in the recipient being placed on a fixed route bus service for all NEMT unless the recipient can show in writing, that paratransit service agency was unable to complete an assessment within the 45 days.

j. Recipients may be authorized for mileage reimbursement or private commercial transportation in addition to use of public transit if they must travel outside the public transit system service area to access the nearest appropriate provider.

k. For authorization other than the public transit, the NEMT broker will supply the name of the provider, the provider's location, and the frequency of the transit that the recipient is permitted, to the transportation company.

l. Recipients who submit evidence from an assessment showing they do not qualify for public paratransit may be qualified for a higher level of service.

m. The NEMT broker will provide written documentation to the recipient regarding the recipient's authorization status and level of service.

2. If the recipient provides evidence that they are unable to ride at the level of service assigned due to a significant change in condition or circumstance, the recipient will be re-evaluated by the broker who may direct the recipient to the RTC for an assessment for paratransit services.

a. Recipients contesting their assessed level of service will be authorized NEMT at the requested level, pending an evaluation.

b. Recipients are required to ride the least expensive transport within a level of service and will not be placed on a higher cost transport because of personal preference or convenience.

c. Recipients may be reassessed for a greater level of service if they no longer have access to the assigned transportation level of service.

3. Family members, friends, or community partners (hospitals, medical facilities, social workers, case managers, tribal entities, etc.) may request transportation on behalf of an eligible recipient~~,~~ from the NEMT broker.

4. The NEMT broker must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider and/or DHCFP when appropriate.

5. The NEMT broker and DHCFP must provide standard authorization decisions within reasonable time frames. If the broker determines, or a provider indicates, that the standard service authorization timeframe could seriously jeopardize the recipient's condition or circumstance, the NEMT broker must make an expedited authorization decision and provide notice as expeditiously as the recipient's health condition requires.

1903.3C NEMT BROKER RESPONSIBILITY

1. The NEMT broker provides all or most services ancillary to transporting Medicaid recipients, but provides transportation only through subcontracting or non-contract arrangements with third parties.

   a. The NEMT broker shall not hold ownership in any NEMT provider with whom the broker sub-contracts or arranges NEMT through, as a non-contractual relationship.

   b. The broker will submit all subcontracts or other documentation pertaining to the terms and conditions for the provision of NEMT services by third parties to DHCFP for approval.

   c. The broker shall advise DHCFP in writing of all financial relationships and transactions between itself and NEMT providers (for instance, loans, grants, etc.) that are not included in the NEMT instrument, specifying the nature of the relationship and the terms and conditions governing them. Such relationships and transactions are not permitted without written approval of DHCFP administrator.

   d. The NEMT broker will work cooperatively with DHCFP and the Regional Transportation Commission for handling ride cancellations.

2. Commercial Transportation Vendors: The NEMT broker may subcontract with various private vendors to provide transportation to Medicaid recipients.

   a. The NEMT broker shall directly facilitate transportation for recipients requiring bus passes, public paratransit and mileage reimbursement. Recipients who request higher levels of service will need to be assessed for the level of service by the NEMT broker, and if necessary, the appropriate paratransit services agency.

   b. Recipients may not be assigned to ride with a commercial vendor if they have been prior authorized for a lesser level of service, unless the authorized level of service does not provide access to necessary medical care that complies fully with Medicaid's NEMT policy. For instance, if a recipient is authorized for fixed-route

bus services, but the bus does not pass within 3/4 of a mile of the provider's office, then the NEMT broker may authorize a higher level of transportation.

c. Recipients must be assigned to the least expensive commercial vendor who provides the level of service and geographic access required.

d. Where there is public transit available in a rural county, and that provider is capable of offering the level of service required for the recipient, commercial vendors may not be used for the convenience of the recipient or the NEMT broker.

3. Using monthly enrollment downloads from DHCFP or systems maintained by DHCFP's fiscal agent, the NEMT broker is solely responsible for verifying program eligibility for each recipient prior to authorizing and scheduling the NEMT service. The NEMT broker must also verify the existence of an appointment and that the appointment is a Medicaid covered service, which may require contacting the health care provider, DHCFP's fiscal agent, or the contracted MCO, before authorizing transportation.

4. Neither the NEMT broker nor its providers shall release information related to a recipient without the written consent of the recipient or the recipient's legal or authorized representative, except as required by law or except to verify medical appointments in accordance with policy. The NEMT broker and any of its providers meeting the definition of a "covered entity" as defined in the HIPAA Privacy Regulations (45 CFR 164) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and 164 for recipient health information.

5. DHCFP expects that the NEMT broker and its provider network will be in compliance with all laws with regard to the reporting requirements related to suspected abuse, neglect, or exploitation, as applicable, in accordance with NRS 200.508 and 200.5091.

   Pursuant to 42 CFR 438.100(c), the NEMT broker shall ensure that each recipient is free to exercise his or her rights and that by the exercise of those rights, no adverse effect will result in the way the NEMT broker treats the recipient.

6. Recipients have freedom of choice when selecting medical providers but are only eligible for NEMT to access these services if using the nearest appropriate provider (taking existing relationships between the providers and recipients into account as well as access to care) according to section 1903.3A(3)(a)(5)of this chapter.

   1. The NEMT broker will be responsible for verifying that the recipient is using the nearest appropriate Medicaid provider for the applicable services.

   2. The NEMT broker will develop written procedures, approved by DHCFP for verifying that the nearest appropriate Medicaid provider is being used.

3. The procedures shall include an exception procedure that specifies the conditions under which the recipient may access a provider other than the nearest, if exception to the requirement might, in some cases, be appropriate.

4. DHCFP will provide the NEMT broker with a quarterly list of Medicaid providers and their addresses, including FFS providers and providers within each MCO's network.

5. DHCFP will periodically review rides to verify that the NEMT broker has transported to the nearest appropriate provider.

6. When DHCFP determines that a recipient has employed NEMT to access a provider other than the provider located nearest to the recipient's residence and there is no justification documented, the NEMT broker may be required to refund the capitation payment for that recipient for all months that the recipient accessed a geographically inappropriate provider.

7. A transportation provider must wait at least fifteen (15) minutes after the scheduled pick-up time before "no-showing" the recipient at the pick-up location. The NEMT broker or contracted transportation providers shall not charge recipients for transportation services or for no shows.

8. Recipients who are repeated no-shows or fail to cancel in a timely manner for rides provided by its commercial vendors may be subject to suspensions of services. Recipients who receive a suspension will have the right to a State Fair Hearing.

9. Access to transportation services shall be at least comparable to transportation resources available to the general public. Capacity shall include all of the modes of transportation listed in Section 1904 of this chapter.

10. The NEMT broker shall ensure all drivers of vehicles transporting program recipients meet the following requirements:

    a. All drivers, at all times during their employment, shall be at least 18 years of age and have a current valid driver's license from the State of Nevada to operate the transportation vehicle to which they are assigned.

    b. Drivers shall have no more than one chargeable accident and two moving violations in the last three years. Drivers shall not have had their driver's license, commercial or other, suspended or revoked in the previous five years. Drivers shall not have any prior convictions for substance abuse, sexual abuse or crime of violence. Approval of any such driver who has been convicted of a felony shall be obtained from DHCFP before employment by the vendor.

c. All drivers shall be courteous, patient and helpful to all passengers and be neat and clean in appearance.

d. No driver or attendant shall use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time. The transportation provider shall not use drivers who are known abusers of alcohol or known consumers of narcotics or drugs/medications that would endanger the safety of recipients.

e. All drivers and attendants shall wear or have visible, easily readable proper organization identification.

f. At no time shall drivers or attendants smoke while in the vehicle, while involved in recipient assistance, or in the presence of any recipient.

g. Drivers shall not wear any type of headphones or use cell phones, except for dispatch purposes, at any time while on duty. Drivers shall not use cell phones while operating vehicles.

h. Drivers shall assist passengers in the process of being seated and confirm that all seat belts are fastened properly, and that wheelchairs and wheelchair passengers are properly secured.

i. Drivers shall provide necessary assistance, support, and oral directions to passengers. Such assistance shall include assistance with recipients of limited mobility and movement, including the storage of mobility aids and wheelchairs.

j. The NEMT broker shall provide, or ensure that its subcontractors provide, classroom and behind-the-wheel training for all drivers within 30 days of beginning service under this agreement. Driver training shall, at a minimum, include defensive driving techniques, wheelchair securement and lift operation, cultural and disability sensitivity training, passenger assistance techniques, first aid, and general customer service. The training curriculum is subject to DHCFP's approval.

11. The NEMT broker shall ensure that all transportation providers maintain all vehicles adequately to meet the requirements of the contract. Vehicles and all components shall comply with or exceed State, Federal, and the manufacturer's safety, mechanical, and maintenance standards for the vehicles. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations. All vehicles shall meet the following requirements:

a. The transportation provider shall provide and use a two-way communication system linking all vehicles used in delivering the services under the contract with the transportation provider's major place of business. Pagers are not an acceptable substitute.

b. All vehicles shall be equipped with adequate heating and air-conditioning.

c. All vehicles shall have functioning, clean and accessible seat belts for each passenger seat position when required by law. Each vehicle shall utilize child safety seats when transporting children as prescribed by NRS 484B.157.

d. All vehicles shall have a functioning speedometer and odometer.

e. All vehicles shall have two exterior side view mirrors, one on each side of the vehicle.

f. All vehicles shall be equipped with an interior mirror for monitoring the passenger compartment.

g. The interior and exterior of the vehicle shall be clean and the exterior free of broken mirrors or windows, excessive grime, major dents or paint damage that detract from the overall appearance of the vehicles.

h. The vehicle shall have passenger compartments that are clean, free from torn upholstery, floor, or ceiling covering; damaged or broken seats; protruding sharp edges; and be free of dirt, oil, grease or litter.

i. All vehicles shall have the transportation provider's name, vehicle number, and the NEMT broker's toll free and local phone number prominently placed within the interior of each vehicle. This information and the complaint procedures shall be available in written form in each vehicle for distribution to recipients on request.

j. Smoking is prohibited in all vehicles while transporting program recipients. All vehicles shall have the following signs posted in all vehicle interiors, easily visible to the passengers:

"NO SMOKING""ALL PASSENGERS MUST USE SEAT BELTS"

k. All vehicles shall include a vehicle information packet containing vehicle registration, insurance card and accident procedures and forms.

l. All vehicles shall be provided with a fully equipped first aid kit.

m. Each vehicle shall contain a current map of the applicable state(s) with sufficient detail to locate recipients and medical providers.

n. All vehicles shall have a minimum of $1,500,000 combined single limit insurance coverage for vehicles at all times during the contract period in accordance with State regulations and contract requirements (NAC 706.191). If NAC 706.191

minimum insurance coverage is amended, the amount that is greater of either the Code or this Chapter will be the mandated amount of coverage.

o. Any vehicle or driver found out of compliance with the contract requirements, or any State or Federal regulations shall be removed from service immediately until the NEMT broker verifies correction of deficiencies. Any deficiencies and actions taken shall be documented and become a part of the vehicle's and the driver's permanent records.

p. The NEMT broker shall develop and implement an annual inspection process in addition to the applicable State vehicle inspection requirements to verify that vehicles used by subcontracted transportation providers meet the above requirements and that safety and passenger comfort features are in good working order (e.g., brakes, tire, tread, signals, horn, seat belts, air conditioning/heating, etc.).

12. The NEMT broker shall ensure adequate oversight of subcontracted transportation providers and ensure that providers comply with all applicable State and Federal laws, regulations and permit requirements. This duty includes, but is not limited to verification that each provider maintains at all times:

a. Insurance which complies with the standards at 49 CFR 387 subpart B, NAC §191(1-3), and which provides for notice of the status of the policy to DHCFP upon expiration, termination, or at any time requested by DHCFP;

b. An alcohol and substance abuse testing program which complies with the standards of 49 CFR Part 382;

c. Criminal background checks conducted periodically that assure the criteria of MSM Chapter 100 are met;

d. Signage on all vehicles identifying those operating under any exemption from Nevada Transportation Authority (NTA) regulation;

e. Documentation in each vehicle of any exemption from NTA regulation; and

f. Current provider agreements with Nevada Medicaid.

As a contracted agent of the Director of the Department of Health and Human Services (DHHS), subject to the requirements of NRS § 422.2705 and NRS § 706.745 the NEMT broker may utilize the services of motor carriers that are exempt from certain certification requirements of the NTA of the Department of Business and Industry. Prior to exercising this option, the NEMT broker shall, with the assistance of the NTA, establish and utilize an inspection program designed to

ensure that vehicles used by these motor carriers, and their operations, are safe. The NEMT broker shall also require these same motor carriers to submit proof of a liability insurance policy, certificate of insurance or surety which is substantially equivalent in form and is in the same amount or in a greater amount than the policy, certificate or surety required by the Department of Motor Vehicles (DMV) pursuant to NRS 706.291 for a similar situated motor carrier. The NEMT broker shall certify the transportation providers meet insurance requirements, vehicle safety standards, and driver background and drug tests cited in this chapter before a letter of exemption will be issued by DHCFP for that transportation provider.

13. The NEMT broker is encouraged and expected to use recipient vouchers and/or volunteer programs to provide the most cost-efficient transportation service to the recipient if such transportation is appropriate to meet the needs of the recipient. The broker shall verify and document that vehicles and drivers used in reimbursement and volunteer programs comply with appropriate State operating requirements, driver's licensure, vehicle registration and insurance coverage requirements.

14. The NEMT broker will be available as a resource to DHCFP's fiscal agent or contracted MCO when medically necessary covered services must be provided outside a recipient's community. The NEMT broker will advise the fiscal agent or contracted MCO regarding such factors as distance and transportation availability.

15. The NEMT broker must submit claims for service outside of capitation to DHCFP utilizing the nationally recognized International Classification of Diseases (ICD) and current electronic data interchange (EDI) standards, as approved by the Centers of Medicare and Medicaid Services (CMS).

1903.3D NEMT RECIPIENT RESPONSIBILITY

1. The recipient shall:

   a. Use personal transportation or transportation of an LRI whenever possible;

   b. Explore alternative resources first, and when such a resource exists at no cost to the recipient, use the alternative transportation resource;

   c. If free transportation is not available, use public transportation when residing within 3/4 of a mile of a bus stop (unless medical documentation is provided to support the recipient's or LRI's physical or mental condition that prohibits the recipient from utilizing public transport);

   d. Participate in the assessment process to determine the appropriate level of service needed for transportation. The recipient must follow through when referred for a public paratransit evaluation;

e. If eligible for paratransit services, the recipient is required to access available paratransit programs;

f. Make and keep all appointments and travel schedules, and phone to cancel when an unforeseen event makes it impossible to keep an appointment;

g. Recipients or individuals scheduling on behalf of the recipient are responsible to schedule rides by contacting the NEMT broker;

h. Recipients or individuals scheduling on behalf of the recipient are urged to schedule rides (except out-of-area travel) not less than three days and no more than 60 days prior to travel;

i. Requests for paratransit rides from the NEMT vendor must be scheduled no more than three days in advance of the recipient's medical appointment;

j. Recipients must be ready and available for their scheduled ride15 minutes before the scheduled ride and up to 30 minutes after the scheduled pick up time;

1. Recipients who are using subcontracted transportation vendors will follow the NEMT broker policy concerning late rides.

k. Notify the NEMT broker immediately when an urgent service need for NEMT transportation is discovered;

l. Notify the NEMT broker of all third party insurance information, including the name of other third party insurance, or any changes in insurance coverage at the time of service, if possible, or in a timely manner thereafter;

m. Not refuse service of a provider based solely or partly on the provider's race, color, national origin, sex, religion, disability or age; and

n. Provide car seats, wheelchairs, other devices or equipment, and any extra physical assistance, not required of providers, necessary to make the trip.

1903.4 GEOGRAPHIC AREA

Nevada residents living near the state line or border may be geographically closer to out-of-state providers than to in-state providers for both primary and specialty care. In such cases, covered medically necessary services may be routinely provided by out-of-state providers in what DHCFP refers to as the "primary catchment areas." Such services are treated the same as those provided within the state borders for purposes of authorization and transportation.

The primary catchment areas are listed in the MSM Chapter 100.

The NEMT broker provides services statewide and in catchments areas. The NEMT broker provides services to and from out-of-state facilities.

1903.5 SPECIAL REQUIREMENTS FOR SELECTED COVERED NEMT SERVICES

A. Out-of-Network-Providers network Providers

The NEMT broker generally uses transportation providers who have executed a contract to be part of the NEMT broker's network. However, occasionally it may be necessary for enrolled recipients to obtain NEMT services from an out-of-network provider (e.g., the recipient needs specialized transportation for which the NEMT broker has no such specialist in its network), in which case the broker must:

1. Arrange transportation with out-of-network providers with respect to services and payment;

2. Offer the opportunity to the out-of-network provider to become part of the network; and

3. Negotiate a contract to determine the rate prior to services being rendered.

B. Family Planning Services

Pursuant to policies set forth in Chapter 600 of the Nevada MSM, the NEMT broker will authorize NEMT services to family planning services for any eligible recipient to any qualified provider.

C. Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs.

Transplant services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Title XIX State Plan. When a transplant recipient's care needs during transit are within the scope of the NEMT broker, transportation should be prior authorized and provided through the NEMT broker. When the recipient's care needs during transit exceed the capabilities of the NEMT broker and/or the timeframe for transport is less than four hours, transportation may be treated as a non-immediate medically necessary transport. (Refer to Section 1903.1A(2)(c) for guidance.)

D. Paratransit Transportation

Paratransit transportation may be provided based on assessed medical need. When paratransit transportation is indicated, such transportation services shall be "curb to curb" or "door-to-door", whichever service is necessary for the recipient. All paratransit providers are responsible for assisting riders into and out of their vehicles.

1903.6 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

The eligibility and enrollment functions are the responsibility of DHCFP and the DWSS. The NEMT broker shall accept each recipient who is enrolled in or assigned to the NEMT broker by DHCFP and/or its enrollment sections.

Pursuant to the State of Nevada's Medicaid State Plan §3.1 for NEMT Services, eligible recipients do not have the option of disenrolling from the NEMT broker, nor does the NEMT broker have the option of disenrolling any eligible recipient. Copies of the State of Nevada Medicaid State Plan §3.1for NEMT Services are available on DHCFP'S website at http://dhcfp.nv.gov.

"Pending" Medicaid recipients (those whose applications for assistance have been submitted but not adjudicated) are not eligible for transportation services provided by the NEMT broker.

The NEMT broker is not financially responsible for any services rendered during a period of retroactive eligibility.

1903.7 INFORMATION REQUIREMENTS

The NEMT broker must have written information about its services and access to services available upon request to recipients. This written information must be available in English and Spanish. The NEMT broker must make free, oral, Spanish interpretation services available to each recipient, if necessary. The broker may supply telephone interpretation services for other non-English languages. DHCFP must approve all materials distributed to recipients.

A. The NEMT broker's written material must use an easily understood format. The NEMT broker must also develop appropriate alternative methods for communicating with people with vision or hearing impairments and must accommodate recipients with a physical disability in accordance with the requirements of the ADA. All recipients must be informed that this information is available in alternative formats and how to access those formats.

1904 RESERVED

1905 NEMT GRIEVANCES, APPEALS AND PROVIDER DISPUTES

1905.1 NOTICE OF DECISION

The NEMT broker may take action on a recipient's request for transportation based on DHCFP's coverage policy and guidelines as set forth in the Nevada MSM. The request may be approved, denied, or limited (i.e. denied in part, or reduced) based on these eligibility and coverage policies. The broker shall notify each recipient in writing of the reason for any action which is taken to deny or otherwise limit a recipient's request, within five business days of such action; such notification is called a Notice of Decision (NOD).

Pursuant to 42 CFR 438.10 (g), the NOD shall include information regarding the recipient's right to a State Fair Hearing (see Chapter 3100 of the Nevada MSM), the method for obtaining a State Fair Hearing, and the rules that govern the recipient's right to representation. The broker must also provide a NOD to the requesting provider, if applicable.

The NOD must include the following information:

A. The action the broker or its network provider has taken or intends to take;

B. The reasons for the action;

C. The recipient's right to request a State Fair Hearing;

D. The method of obtaining a State Fair Hearing;

E. The rules that govern representation at a State Fair Hearing;

F. The right of the recipient to request a State Fair Hearing and how to do so;

G. The right to request to receive benefits while the hearing is pending and how to make this request; and

H. That the recipient may be held liable for the cost of those benefits if the hearing decision upholds the broker's action.

The NEMT broker shall provide any reasonable assistance to recipients in filing a State Fair Hearing, including transportation to the hearing, if necessary.

The NEMT broker is required to maintain records of all grievances received and NODs provided, which the State will review as part of the State's contract monitoring and management oversight.

1905.2 RECIPIENT GRIEVANCES AND PROVIDER DISPUTES

The NEMT broker must have a process with which to address recipient grievances and provider disputes. DHCFP will refer all recipient grievances and provider disputes to the NEMT broker for resolution. The NEMT broker must provide information about its recipient grievance process to all providers and subcontractors, at the time they enter into a contract.

The NEMT broker is required to dispose of each recipient grievance and provide notice as expeditiously as the recipient's health condition requires or no more than 90 days from the date the grievance is received by the NEMT broker or a network provider. The NEMT broker shall attempt to respond verbally to the recipient, authorized representative, DHCFP or provider grievances and disputes within 24 hours of receipt of the grievance or dispute. The NEMT broker shall issue an initial response or acknowledgement to written grievances and disputes in writing within 72 hours.

In addition, the NEMT broker must:

A. Provide recipients any reasonable assistance in completing forms and taking other procedural steps. This includes but is not limited to providing interpreter services and toll-free numbers that have adequate TDD and interpreter capability;

B. Acknowledge receipt of each recipient grievance;

C. Ensure that the individuals who make decisions on recipient grievances were not involved in any previous level of review or decision-making; and

D. Notify the recipient of the disposition of grievances in written format. The written notice must include the results of the resolution process and the date it was completed.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 23, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER /Jessica Kemmerer/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2000 - AUDIOLOGY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2000 – Audiology are being proposed for cochlear implants to update the age for coverage to 9 months from 12 months.
.
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: This proposed change affects all Medicaid-enrolled providers delivering cochlear services. Those provider types (PT) include but are not limited to: Audiology (PT 23), hearing aid suppliers (PT 76), Therapy (PT 34).

Financial Impact on Local Government: Unknown.

These changes are effective February 24, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 06/21 MSM 2000 – Audiology	MTL 12/09 MSM 2000 – Audiology

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2003.4A (2)(b).	**Coverage and Limitations**	Updated age for coverage from 12 months to nine months of age.
2003.4A(6)	**Children**	Updated age for coverage from 12 months to 9 months.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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AUDIOLOGY SERVICES

2000 INTRODUCTION

The Nevada Medicaid Audiology program reimburses medically necessary audiology services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Audiology services are an optional benefit within the Nevada Medicaid program. All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of three areas where Medicaid and NCU policies differ. For further clarification, please refer to the NCU Manual, Chapter 1000.

2001 AUTHORITY

The citation denoting the amount, duration and scope of services are found in the Code of Federal Regulations (CFR) Part 440.110 and the Nevada Medicaid State Plan Attachment 3.1-A.

The State Legislature grants authority to the relevant professional licensure boards to set the standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- NRS – Chapter 630 – Physicians
- NRS – Chapter 637A – Hearing Aid Specialists
- NRS – Chapter 637B – Audiologists and Speech Pathlogists

2002 RESERVED

2003 AUDIOLOGY POLICY

2003.1 COVERAGE AND LIMITATIONS

Audiology services and supplies are covered by Nevada Medicaid for eligible recipients. Audiological services must be performed by a certified and licensed audiologist as described in the NRS 637B. Refer to specific coverage and limitations for each service.

2003.1A PROVIDER RESPONSIBILITY

Providers must verify recipient eligibility before rendering services. The presence of a Medicaid and NCU identification card does not guarantee eligibility. It is the provider's responsibility to ask the recipient if there is additional audiology coverage through third party payers.

The provider will allow, upon request of proper representatives of the Division of Health Care Financing and Policy (DHCFP), access to all records which pertain to Medicaid or NCU recipients for regular review, audit or utilization review. Providers must inform Nevada Medicaid of any misuse of the Medicaid or NCU card or inappropriate utilization.

2003.1B RECIPIENT RESPONSIBILITY

Services requested by the recipient, but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid. Prior to service, the recipient must be informed in writing he/she will be responsible for payment. The recipient is responsible for:

1. presenting a valid Nevada Medicaid and NCU card to the provider at each visit;
2. presenting any form or identification necessary to utilize other health insurance coverage;
3. making and keeping appointments with the provider; and
4. notifying providers immediately of any change in eligibility status, e.g., eligibility changes from Fee-for-Service (FFS) to managed care.

2003.2 AUDIOLOGICAL TESTING

2003.2A COVERAGE AND LIMITATIONS

1. Audiological testing is limited to once per 12 rolling months for eligible recipients and must be referred by an M.D.

2. A physician must examine the hearing aid beneficiary for pathology or disease no more than six months prior to the fitting of the aid(s) and submit a statement certifying the medical necessity of the evaluation to the audiologist.

3. One audiogram testing per 12 rolling months does not require prior authorization. The audiogram should be no more than six months old.

4. To qualify for coverage by Medicaid, the report must show levels of hearing loss as follows:

   a. Adults: at least 30 decibels for the frequency range of 500-3000 Hz.

   b. Children: at least 20 decibels for the frequency range of 500-3000 Hz.

2003.2B PRIOR AUTHORIZATION

1. A prior authorization request is needed for any hearing aid(s) exceeding the allowed amount of $350.00 per aid. The audiologist's testing reports must be attached and show the following:

   a. hearing levels and discrimination scores including the type of hearing loss conductive or neuron-sensory; and

   b. a copy of the audiogram which should be no older than six months; and

   c. patient's capabilities for use of the hearing aid(s), physical dexterity, mental capabilities and motivation; and

   d. type of hearing aid(s) recommended including the cost.

2. Additional hearing evaluations outside the normal program guidelines must be prior authorized. The audiologist must keep a copy of the referral and test results in the recipient's medical record

2003.3 HEARING AIDS

2003.3A COVERAGE AND LIMITATIONS

Medicaid will reimburse only licensed physicians, licensed audiologists and certified hearing aid dispensers for hearing aid fitting and dispensing.

1. Hearing aids and related supplies are covered by Nevada Medicaid for eligible recipients. Coverage is limited to once every 24 rolling months. This may be exceeded through Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids if it is

determined to be medically necessary by the Quality Improvement Organization (QIO)-like vendor. Refer to Chapter 1500 of the MSM for more information.

2. The manufacturer must be willing to accept the payment for the hearing aid(s) from the Medicaid hearing aid dispensers. Such payment constitutes payment in full. Shipping and handling for the hearing aid(s) is not a covered benefit. Recipients are not to be billed for any additional charges.

3. Hearing Aid Batteries: Hearing aid batteries are limited to one package of four per hearing aid per month. Requests for batteries more frequently for recipients age 21 and older require prior authorization. Children under age 21 may exceed the limitation, when medically necessary.

4. Ear Molds: Ear molds are to be provided with each new behind-the-ear hearing aid. Replacement for children is covered without prior authorization through Healthy Kids (EPSDT). Replacement for adults and children on NCU is covered when medically necessary without prior authorization up to two in 24 months.

5. Hearing Aid Fitting and Dispensing: Hearing aid fitting and dispensing includes selecting, ordering, fitting, evaluating of appropriate amplification and dispensing the hearing aid(s). It also includes an initial supply of batteries. Medicaid reimburses for ear impressions and ear molds as a separate procedure.

   Non-audiology providers of hearing aids (Durable Medical Equipment (DME) providers) may provide hearing aids and hearing aid related services and items but no professional audiology services for which an audiologist's academic credentials and licensing are required.

   Non-audiology providers of hearing aids are covered to provide hearing aid counseling, hearing aid fitting and sale of the hearing aid(s) itself. Coverage also includes revision of hearing aid accessories, replacement of parts and repairs.

   The provider must allow the recipient to have a 30-day trial period with a money back guarantee if the aid(s) does not benefit the patient. A recheck of the patient with the aid(s) must be offered two weeks or sooner following dispensing to determine if there are improved hearing levels and discrimination scores. The visit(s) should also include counseling on the use and care of the hearing aid(s) and ensure proper fit of the ear molds.

6. Warranty: Hearing aids must include a minimum 12-month warranty from the manufacturer that covers repair, damage and loss of the hearing aid(s). The provider must maintain the warranty in the recipient's medical record. A second-year warranty or insurance is required. If the manufacturer does not include a second year warranty, the provider should request a prior authorization for additional insurance.

7. Replacement: Hearing aids may be replaced when:

   a. the current aid(s) cannot be repaired as determined by the Medicaid provider;

   b. the recipient's hearing deficit requires a different type of device for maximum benefit;

   c. the manufacturer's warranty has expired; or

   d. there is no other insurance.

8. Broken or Lost Hearing Aids: If replacement of a hearing aid(s) becomes necessary after 12 rolling months or more, the recipient will have a reevaluation by the audiologist prior to fitting of the replacement aid(s). The replacement aid(s) must be prior authorized if the aid(s) is no longer covered by a manufacturer's warranty or other insurance.

9. Supplies/Accessories: Hearing aid supplies/accessories (i.e. ear hooks, tubes) do not need prior authorization.

10. Testing/Repairs: Reimbursement will not be made for repairs covered by the manufacturer's warranty or other insurance.

    If testing/repair of the hearing aid(s) is needed after this time period, it is limited to once every 12 rolling months per aid. The provider will need to identify which aid (right or left) is being repaired. Repairs must be covered by a six-month warranty.

    Medicaid will reimburse for repairs on hearing aids that were not purchased by Medicaid. Medicaid does not reimburse for repairs if the hearing aid was damaged by tampering or misuse. Recipients are not to be billed for any additional charges.

11. Non-Covered Hearing Aids: Semi-implantable middle ear hearing aids are not a covered benefit as they are considered investigational.

2003.3B PRIOR AUTHORIZATION

1. Hearing aids exceeding the allowed amount of $350.00 per aid require prior authorization from the QIO-like vendor and need to include medical necessity for the more expensive aids, including cost.

2. Prior authorization with medical necessity is required for any additional aid(s) needed during the 24-rolling month period.

3. Additional evaluations, fitting and dispensing, ear molds, testing/repair, replacement of broken or lost hearing aid(s), supplies or insurance outside the normal program guidelines

will require prior authorization from the QIO-like vendor. Each request must have the appropriate documentation attached.

2003.3C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. routine maintenance;

2. purchase of additional batteries beyond the limitation of one package of four per hearing aid per month when a prior authorization has been denied; however, children under age 21 may exceed the limitation, when medically necessary;

3. repairs and replacement of the hearing aid(s) if the recipient loses Medicaid eligibility; and

4. picking up the hearing aid(s) and returning for any necessary adjustments within the hearing aid trial period established with the provider.

2003.4 COCHLEAR AND AUDITORY BRAINSTEM IMPLANTS

2003.4A COVERAGE AND LIMITATIONS

1. Bilateral and unilateral cochlear implants are a Nevada Medicaid covered benefit when determined to be medically necessary for eligible recipients with profound hearing impairment. Covered services include but are not limited to:

   a. otologic examination.

   b. audiological evaluation.

   c. physical examination.

   d. psychological evaluation.

   e. surgical implantation of the device.

   f. postoperative follow-up evaluation and rehabilitation.

2. Coverage is restricted to those recipients who meet the following audiologic/medical criteria as determined by a physician or audiologist:

   a. recipient must be referred by an M.D. or Ear, Nose and Throat specialist with documentation to determine medical candidacy for such a device. This is to include recent (within six months) results of a CT or MRI scan to evaluate the anatomy of the inner ear; and

b. must be at least nine months of age or older; and

c. must suffer from severe to profound pre-or-post lingual hearing loss (70 decibels or greater) confirmed by audiologic testing that obtains limited or no benefit from appropriate hearing aids for six months or greater; and

d. must have the cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation; and

e. must be free of middle ear infection; and

f. must have an accessible cochlear lumen that is structurally suited to implantation; and

g. be free of lesions in the auditory nerve and acoustic areas of the central nervous system; and

h. have no contraindications for the surgery.

3. Use of the device must be in accordance with the Food and Drug Administration (FDA) approved labeling.

4. There must be good family support with self-motivation, as determined by a physician or audiologist. Education of families/caregiver and the recipient must be conducted to ensure understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the therapeutic program and the ability to adequately care for the external equipment.

5. Adults

Cochlear implants may be covered for prelinguistically (before the development of language), perilinguistically (during the development of language), and postlinguistically (after language has fully developed) deafened adults (over age 21). Postlinguistically deafened adults must demonstrate test scores of 40% or less on sentence recognition scores from tape recorded tests in the recipient's best listening condition.

6. Children

Cochlear implants may be covered for prelinguistically and postlinguistically deafened children from 9 months through 20 years of age. Bilateral profound sensorineural deafness must be demonstrated by the inability to improve on age appropriate closed set word identification tasks with amplification.

7. Rehabilitation Program

A post-cochlear implant rehabilitation program is necessary to achieve benefit from the cochlear implant for both children and adults. The program is performed by an audiologist and speech-language pathologists. The rehabilitation program includes development of skills in understanding running speech, recognition of consonants, vowels and tests of speech perception ability. Refer to Chapter 1700 for Therapy Services of the MSM.

8. Warranty

The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

9. Damage and Loss

Damage and loss insurance is required at the time of implant. Insurance must be all-inclusive for replacement and loss, no deductibles or co-pays are allowed. There must be continuous insurance coverage for five years. Insurance is not to exceed $250/year.

2003.4B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the cochlear implant.

2003.4C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. wearing a helmet while bicycling, roller blading, playing football and soccer; players must not “head” the ball.

2. keeping equipment out of reach of animals.

3. removing the speech processor and headset before entering a room where an MRI scanner is located.

4. wearing the special harness that secures the speech processor during active sports. For water sports and activities that generate high levels of static electricity, such as playing on trampoline and plastic slides, the equipment must be removed.

2003.5 AUDITORY BRAINSTEM IMPLANT (ABI)

2003.5A COVERAGE AND LIMITATIONS

1. An ABI is a covered benefit as medically necessary when all of the following criteria are met;

a. the recipient is 12 years of age or older; and

b. the recipient has been diagnosed with Neurofibromatosis Type 2 (NF2); and

c. the recipient is undergoing bilateral removal of tumors of the auditory nerves; and

d. it is anticipated that the recipient will become completely deaf as a result of surgery; or

e. the recipient had bilateral auditory nerve tumors removed and is now bilaterally deaf.

2. Warranty: The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

3. Rehabilitation Program: The recipient must have multiple sessions with the audiologist to test, adjust the sound processor and learn to interpret new sounds.

2003.5B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the auditory brainstem implant.

The physician who performs the cochlear implant or auditory brainstem implant surgery must obtain prior authorization from the QIO-like vendor before providing the service. Authorization is determined based on medical necessity. Each request must include documentation to show the recipient has met Medicaid guidelines for the procedure.

2003.6 BONE-ANCHORED HEARING AID (BAHA) SYSTEM

2003.6A COVERAGE AND LIMITATIONS

Bone Anchored Hearing Aid (BAHA), also called an implantable bone conduction hearing aid, is a Nevada Medicaid covered benefit when it is determined medically necessary for eligible recipients five years and older. The BAHA is an alternative hearing device for recipients unable to use conventional hearing instruments.

BAHA Softbands and BAHA Headbands are a covered benefit for children of any age who have conditions that are eligible for a BAHA implant. The BAHA system is designed to treat:

1. Conductive or Mixed Hearing Loss from possible causes of:

a. chronic otitis media.

b. congenital malformations where the cochlear function is good but there are no ear canals.

c. Cholesteatoma.

d. middle ear dysfunction/disease.

e. external otitis.

2. Unilateral Sensorineural Deafness or Single Sided Deafness (SSD) from possible causes of:

a. acoustic neuroma tumors, other surgical intervention.

b. sudden deafness.

c. neurological degenerative disease.

d. trauma.

e. ototoxic treatments.

f. genetic.

g. Meniere's Disease.

3. Audiologic/Medical criteria:

Recipients must be referred by an M.D. or Ear, Nose and Throat Specialist with documentation to determine medical candidacy for such a device. This may include a radiology report. Assessment by an audiologist to determine if the type and degree of hearing loss meet the necessary criteria is also required.

a. Mixed and Conductive Hearing Loss with the following criteria:

1. >5 years of age.

2. <45 dB HL BC pure tone average (PTA) (measured at 0.5, 1, 2 and 3K Hz).

3. >or equal to 60% speech discrimination scores (using standardized test).

4. bilateral fitting-symmetric bone conduction thresholds are defined as no more than 10 dB difference of the PTA or less than 15 dB individual frequencies.

b. Single Sided Deafness with the following criteria:

1. >5 years of age.

2. normal hearing in contralateral ear. (Normal hearing is defined as pure tone average air conduction (PTAAC) threshold equal to or better than 20 dB HL [measured at 0.5, 2 and 3 kHz]).

3. Functions by transcranial routing of the signal.

c. Additional qualifying criteria should include:

1. sufficient bone volume and bone quality present for successful implant placement; and

2. no contraindications to anesthesia or surgery; and

3. careful consideration given to the recipient's physical, psychological and emotional state as determined by physician or audiologist; and

4. well informed recipients who have the right expectations of the BAHA system and are highly motivated, as determined by physician or audiologist; and

5. recipients who are able to maintain and clean the skin around the abutment or with the aid of others. For children, the responsibility falls on the parents or guardians; and

6. recipients trained in the care, use of the device and comfortable with connecting and disconnecting the sound processor from the abutment, prior to the fitting of the speech processor.

4. Warranty: The limited warranty must be included in the documentation from the product manufacturer. Services beyond the warranty must be prior authorized.

5. Follow-Up: It is important the audiologist provides a follow-up program for the recipient.

2003.6B PRIOR AUTHORIZATION

Prior authorization is required with medical documentation to substantiate the request for the BAHA implant, softband or headband.

The physician who performs the BAHA implant surgery must obtain prior authorization from the QIO-like vendor before providing the service. Authorization is based on medical necessity. Each

request must include documentation to show the recipient has met Medicaid criteria for the procedure.

2003.6C RECIPIENT RESPONSIBILITY

Along with previously mentioned responsibilities, the recipient is also responsible for:

1. removing the sound processor prior to bathing, showering, swimming or engaging in any water activities, as it is not water proof;

2. never exposing the sound processor to extreme heat or cold; and

3. avoiding the loss of the sound processor during physical activity by removing it or using the safety line provided.

2004 APPEALS AND HEARINGS

Please reference MSM Chapter 3100 for Medicaid Recipient Hearings.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

November 29, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES Casey Angres (Dec 12, 2022 13:43 PST)
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2100 – HCBS Waiver for Individuals with Intellectual and Developmental Disabilities (ID Waiver) are being proposed to align with the current approved Appendix K to include the addition of Dental Services for ID Waiver recipients ages 21 and over.

Additional proposed changes to this chapter include updating language throughout to match with the Centers for Medicare and Medicaid Services (CMS) settings requirements to fully comply with the HCBS Final Regulation by March 17, 2023.

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: Dentists (Provider Type (PT 22) – all specialties)).

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 16/22 CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES	MTL 02/21 CHAPTER 2100 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2101	**Authority**	Added 42 CFR 441.301(c)(1) – (c)(5) Federal Person Centered Planning and Settings Requirements. Added NRS 449A.114 (Care of Patients). Added NRS Chapter 631 (Dentistry and Hygiene) for added Dental Services. Added State Plan Amendment (SPA) Attachment 3.1-A Page 5c 12b for added Dental Services. Added SPA Attachment 4.19-B Page 2c for added Dental Services.
2103.1A	**Coverage and Limitations**	Added 'Waitlist Priority' section for clarity.
2103.2	**Waiver Services**	Added L. Dental Services as a covered Waiver service.
2103.2A	**Provider Responsibilities**	Updated beginning paragraph to clarify that provider responsibilities listed are for ID Waiver (PT 38) and that specific provider responsibilities for Dentist (PT 22) are listed under MSM Section 2103.14B.
2103.2B	**Recipient Rights and Responsibilities**	Added language indicating recipients must be informed of their rights prior to initiation of waiver services and annually thereafter.
2103.4	**Residential Support Services**	Added language to incorporate the HCBS Final Regulation allowing waiver recipients individual freedom and choice to the same extent as non-Medicaid waiver recipients. To include option for a private room and/or choice of roommate, and options documented in the Primary Care Provider (PCP).
2103.4B	**Provider Responsibilities**	Added language to incorporate the HCBS Final Regulation indicating that providers must make reasonable accommodations to ensure recipients may use and enjoy their dwelling. Added language to incorporate the HCBS Final Regulation indicating that a recipient's lease/other agreement must not differ from non-Medicaid recipients. Recipients must be provided a 30-day

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		written notice before discharging/transferring to another facility and the Service Coordinator must also be notified. Additional language added to indicate the recipient must be allowed 10 days to meet in person after receiving notification of discharge/transfer from a facility. Added language to incorporate the HCBS Final Rule regulation for additional provider responsibilities to ensure the recipient has privacy in their sleeping/living unit, freedom/control of schedules and activities, access to food at any time and able to have visitors of their choosing at any time. Reworded #7 for clarity.
2103.6	**Supported Employment**	Added language to incorporate the HCBS Final Regulation allowing Medicaid waiver recipients individual freedom and choice to the same extent as non-Medicaid recipients.
2103.14	**Dental Services**	Created section for new waiver service for dental. Added introduction paragraph indicating the importance of dental health for ID Waiver recipients.
2103.14A	**Coverage and Limitations**	Created new section indicating what specific Dental Services are provided to ID Waiver recipients and that they must be prior authorized.
2103.14B	**Provider Responsibilities**	Created new section outlining specific provider responsibilities for Dental Service providers enrolled as PT 22.
2103.14C	**Recipient Responsibilities**	Created new section outlining Recipient Responsibilities specific to Dental Services.
2103.15	**Intake Procedures**	This section was renumbered from 2103.14 to 2103.15. Added language to C. detailing requirements that must be included in the recipient's PCP as outlined in the HCBS Final Rule regulation.
2103.16	**Permanent Case File**	This section was renumbered from 2103.15 to 2103.16.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2103.17	**Service Coordinator Recipient Contacts**	This section was renumbered from 2103.16 to 2103.17.
2103.18	**DHCFP Annual Review**	This section was renumbered from 2103.17 to 2103.18.
2103.19	**Medicaid Provider Enrollment Process**	This section was renumbered from 2103.18 to 2103.19.
2103.20	**Medicaid Enrollment Process**	This section was renumbered from 2103.19 to 2103.20.
2104.3	**Denial of Waiver Application**	Added letter j. denial reason when recipient moves out of state. Added letter k. denial reason when agency has lost contact with the applicant.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

HOME AND COMMUNITY BASED WAIVER

2100 INTRODUCTION

Division of Health Care Financing and Policy (DHCFP) and the Aging and Disability Services Division (ADSD) recognizes that many individuals at risk of being placed in Intermediate Care Facilities (ICFs) can be cared for in their homes and communities, preserving their independence and ties to family and friends at a cost no higher than that of institutional care.

The Home and Community Based Services (HCBS) Program for Individuals with Intellectual and Developmental Disabilities (ID Waiver) is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes DHCFP the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This waiver allows the provision of services based on the identified needs and is designed to provide eligible Medicaid waiver recipients access to both state plan as well as certain extended Medicaid covered services.

Nevada acknowledges that people who have intellectual and developmental disabilities are able to lead satisfying and productive lives when they are provided the needed services and supports to do so. DHCFP is committed to the goal of providing individuals with intellectual and developmental disabilities with the opportunity to remain in a community setting in lieu of institutionalization.

2101 AUTHORITY

Section 1915(c) of the Social Security Act permits states the option to waive certain Medicaid statutory requirements in order to offer an array of HCBS to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization. DHCFP's HCBS for Individuals with Intellectual and Developmental Disabilities is approved by the CMS. This waiver is designed to provide eligible Medicaid waiver recipients access to both 1905(a) State Plan services as well as certain extended Medicaid covered services unique to this waiver. The goal is to allow recipients to live in their own homes or community settings.

Statutes and Regulations:

- Social Security Act: 1915 (c)
- Title 42 Code of Federal Regulations (CFR) Section 441, Subpart I (Community Supported Living Arrangements Services)
- Title 42 CFR Section 483.430(a) (Qualified Intellectual Disabilities Professional (QIDP))
- Title 42 CFR Section 441.301(c)(1) - (c)(5) (Federal Person-Centered Planning and Settings Requirements)
- Nevada Revised Statute (NRS) Chapter 435 (Individuals with Intellectual Disabilities and Developmental Disabilities)
- NRS 449A.114 (Care of Patients)
- Nevada Administrative Code (NAC) Chapter 435 (Individuals with Intellectual Disabilities and Developmental Disabilities)
- NAC Chapter 632 (Nursing)
- Health Insurance Portability and Accountability Act (HIPAA)
- Medicaid Service Manual (MSM) Chapter 100
- NRS Chapter 631 (Dentistry and Hygiene)
- State Plan Amendment (SPA) Attachment 3.1-A Page 5c 12b
- SPA Attachment 4.19-B Page 2c

- Section 3715 of the CARES Act

2102 RESERVED

2103 POLICY

2103.1 WAIVER ELIGIBILITY CRITERIA

The HCBS ID Waiver waives certain statutory requirements and offers waiver services to eligible recipients to assist them to remain in the community. The target population for this waiver includes all individuals who are diagnosed with intellectual disabilities or developmental disabilities and who have been found eligible and have an open case with an ADSD Regional Center. Individuals are eligible if they meet Medicaid's eligibility requirements and are either in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or are at risk for ICF/IID placement without the provision of HCBS and supports.

Eligibility for the ID Waiver is determined by the combined efforts of ADSD, DHCFP and the Division of Welfare and Social Services (DWSS). Two separate determinations must be made to be eligible for and receive services under the ID Waiver:

A. Service eligibility for the ID Waiver is determined by an ADSD's Regional Center.

1. An ADSD Regional Center Intake Team, based on assessments and/or supporting documentation, establishes the existence of an intellectual disability or developmental disability.

2. Each applicant/recipient must meet and maintain Level of Care (LOC) for admission into an ICF/IID. Specifically, the individual would require imminent placement in an ICF/IID facility (within 30 to 60 days) if HCBS Waiver services or other supports were not available.

3. Each applicant/recipient must demonstrate a continued need for a waiver service(s) to prevent placement in an ICF/IID. Sole utilization of Medicaid State Plan Services does not support the qualifications to be covered by the waiver.

4. The applicant/recipient must have a support system in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when services are not being provided. HCBS Waiver services are not a substitute for available natural and informal supports provided by family, friends or other available community resources.

B. The financial eligibility determination for Medicaid benefits is made by DWSS. Waiver applicants/recipients must meet and maintain Medicaid eligibility coverage for all months in which waiver services are provided.

C. Services from the ID Waiver cannot be provided until and unless the applicant is found eligible in both determination areas.

2103.1A COVERAGE AND LIMITATIONS

1. Waiver recipients must meet and maintain Medicaid's eligibility coverage through DWSS for all months waiver services are being provided.

2. The ID Waiver is limited by legislative mandate and available matching state funding to a specific number of recipients who can be served throughout the biennium. A waitlist is utilized to prioritize applicants who have been presumed to be eligible for the waiver as defined below.

3. Waitlist Priority

   a. Individuals residing in an ICF/IID or other institutional settings.

   b. Individuals who are at risk of institutionalization due to loss of their current support system or crisis situation.

   c. Individuals, deemed appropriate for waiver services, who do not fall under priority one or two, based on the date of request for a waiver service.

4. DHCFP must assure the CMS that Medicaid's total expenditures for waiver and Medicaid State Plan services will not, in any waiver year, exceed 100% of the amount that would be incurred by Medicaid for these individuals in an institutional setting in the absence of the waiver. DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.

5. Waiver services must not be billed when an individual is admitted to an institutional setting, such as a hospital, ICF/IID or nursing facility (NF) for the duration of the stay. Residential settings that bill per diem may bill the per diem rate for admit and discharge days only when services were provided and documented for some part of the days in question. Residential settings that bill by the unit or hour may bill for services provided and documented on admit and discharge days.

   Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting if those services are:

   a. Identified in an individual's person-centered support plan (or comparable Plan of Care (POC));

   b. Provided to meet needs of the individual that are not met through the provision of hospital services;

c. Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

d. Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

6. If an applicant/recipient is determined eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such 1915(c) waivers at the same time. The applicant/recipient must choose one HCBS Waiver and receive services provided by that waiver.

7. Recipients of the ID Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Collaborative case coordination between the hospice agency and the waiver Service Coordinator is required to prevent any duplication of services. Refer to MSM Chapter 3200 for additional information on hospice services.

8. An able and/or capable parent, spouse or Legally Responsible Individual (LRI) of a recipient has a duty/obligation to provide the necessary maintenance, education, supervision and support. Necessary maintenance includes but is not limited to, the provision of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Payment will not be made for the routine care, supervision or services normally provided for the recipient without charge as a matter of course in the usual relationship among members of the nuclear family. Waiver services are not a substitute for available natural and informal supports provided by family, friends or other available community resources; however, they are available to supplement those support systems, so the recipient is able to remain in their home.

   Allowance may be given in individual circumstances when:

   a. There is no LRI residing in the recipient's home; or

   b. There is no other LRI residing in the home and an able and/or capable spouse/parent's employment requirements result in prolonged or unexpected absences from the home; or

   c. When such employment requirements require the able and/or capable spouse/parent or LRI to work uninterrupted at home in order to meet the requirement of his or her employer; or

d. When employment requirements include unconventional work weeks or work hours; or

e. The recipient's support team has documented a need for ADL or IADL habilitative services to be provided by direct support staff.

The LRI may be asked to provide verification from a physician, place of employment, or school that they are not capable, due to illness or injury, or unavailable, due to hours of employment and school attendance, to provide services. Additional verification may be required on a case by case basis.

9. LRIs may not be reimbursed for HCBS Waiver services.

10. Legal guardians of individuals age 18 and over are considered LRIs.

11. The children made eligible for Medicaid through their enrollment in the Waiver for Individuals with Intellectual and Developmental Disabilities receive all the medically necessary Medicaid coverable services available under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary services that are required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2103.1B PROVIDER RESPONSIBLITIES

Providers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.

2103.1C RECIPIENT RESPONSIBLITIES

Applicants or recipients must meet and maintain all criteria to be eligible, and to remain on the ID Waiver.

2103.2 WAIVER SERVICES

ADSD, the operating agency for the ID waiver, in conjunction with DHCFP, the administrating agency determines which services will be offered under the ID Waiver.

Under this waiver, the following services are available:

A. Day Habilitation.

B. Residential Support Services.

C. Prevocational Services

D. Supported Employment.

E. Behavioral Consultation, Training and Intervention

F. Counseling Services

G. Residential Support Management

H. Non-Medical Transportation

I. Nursing Services

J. Nutrition Counseling Services

K. Career Planning

L. Dental Services

2103.2A PROVIDER RESPONSIBILITIES

For Provider Type (PT) 22, refer to Section 2103.14B for details, and the Provider Enrollment Checklist at https://www.medicaid.nv.gov/providers/checklist.aspx.

For PT 38:

1. Provider Requirements:

   a. Must obtain approval or certification, as applicable, from ADSD/Developmental Services (DS) pursuant to Nevada Revised Statute (NRS) 435, Nevada Administrative Code (NAC) 435 and ADSD Policy and Procedures.

   b. Must obtain a Master Service Agreement through Department of Administration Purchasing Division and a Provider Service Agreement through ADSD.

   c. Must enroll as a PT 38 with Fee-for-Service Nevada Medicaid, meet and maintain all the requirements to be enrolled as a Medicaid provider pursuant to MSM Chapter 100 and 2100.

   d. May not bill for services provided by an LRI.

e. May only provide and bill for services that have been authorized in the PCP. Prior authorization for waiver services is made through the recipient's PCP and Service Authorization.

f. Must verify the Medicaid eligibility status of each HCBS Waiver recipient each month.

g. Upon renewal of professional licenses/certifications, providers must submit copies of renewals to ADSD as applicable.

h. Each provider must cooperate with ADSD, DHCFP and/or State or Federal reviews or inspections.

i. Must have the ability to communicate with the recipient, understand the recipient and implement the recipient's PCP.

2. Criminal Background Checks:

A criminal background check is required for all owners, administrators, subcontractors, volunteers and employees who have contact with recipients or access to their financial or personal information.

Refer to MSM Chapter 100 for provider requirements.

All background check information must be maintained on file and available for review, including the initial check and a recheck for each five (5) year period. Refer to NRS 435.220, 435.333, 435.537 and 435.893, NAC 435.515, 435.518, 435.520, 435.537, 435.845, 435.855, 435.860 and 435.893.

3. Required Training for Providers:

a. Employees must have cardiopulmonary resuscitation (CPR) and First Aid training within 30 days of hire and prior to working alone with recipients, if providing direct service. Documentation of training must be kept on file and available for review.

b. Must complete required training and new employee orientation, per ADSD policy, within six months of beginning employment. Documentation of training to be kept on file and available for review.

c. All providers are required to provide annual training to employees on recipient rights; confidentiality; abuse, neglect, exploitation, isolation and abandonment including definitions, signs, symptoms, and prevention; as well as incident and serious occurrence reporting requirements. Providers will also complete established

training requirements as directed by ADSD. Documentation of training must be kept on file and available for review.

d. Supported Living provider employees who administer medication must maintain current certification for Medication Administration pursuant to NAC 435.675. Documentation of training must be kept on file and available for review.

e. Any employee who is likely to utilize restraint procedures in accordance with NRS 433 must maintain current certification in a Crisis Prevention/Intervention training program approved by ADSD. Approved training programs require national recognition and evidence of annual review and update of curriculum based on the best legal, behavioral and ethical practices of standards of care. Documentation of training must be kept on file and available for review.

4. Exemptions from Training:

a. ADSD may exempt a prospective service provider from those parts of the required training where the agency judges the person to possess adequate knowledge or experience, or where the provider's duties will not require the particular skills.

b. The exemption and its rationale must be provided in writing and a copy of the exemption must be placed in the recipient's case record. Where the recipient or other private third-party functions as the employer, such individuals may exercise the exemption authority identified above.

5. Documentation:

Providers must maintain relevant documentation of services provided on one or more documents, including documents that may be created or maintained in electronic format. This documentation must be kept in a manner as to fully disclose the nature and extent of services delivered and must be readily available for review.

The documentation must include:

a. Type of service.

b. Date of service.

c. Name of recipient receiving service.

d. Recipient record number.

e. Name of provider.

f. Full written or electronic signature or initials of the person delivering the service if a signature and corresponding initials are on file with the provider. For electronic signatures, systems and software products must include protections against modification, with administrative safeguards that correspond to policies and procedures of the operating agency. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to. For example, an attendance record must have daily initials and documentation of time in and time out.

g. Number of units of the delivered service during which time the service was provided.

h. Signatures or initials of the recipient must be included on the Jobs and Day Training (JDT) and Residential Support Services logs. If the recipient is unable to provide initials due to a cognitive and/or physical limitation, this will be clearly documented in the Person Centered Plan (PCP).

i. Recipient's living in 24 hour Residential Support settings must have individualized service logs, even if they have shared support hours with roommates living in the home.

j. Providers are required to have copies of side effect information sheets for all medications taken by the recipient on-hand and available for staff.

6. Incidents and Serious Occurrences:

Each Provider must report any recipient incidents to ADSD. Serious occurrences are to be reported to ADSD within 24 hours. All other reportable incidents are to be reported to ADSD within two business days. All Serious Occurrence Reports must be maintained on file by the provider. ADSD will submit quarterly data to DHCFP for serious occurrence reports.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

a. Unplanned hospitalization or ER visit;

b. Injury or fall requiring medical intervention;

c. Physical, verbal, emotional, sexual abuse or sexual harassment;

d. Assault, violence, or threat;

e. Suicide threat or attempt;

f. Criminal activity or legal involvement;

g. Theft or exploitation;

h. Medication error per ADSD policy;

i. Loss of contact with the recipient;

j. Elopement of a recipient residing in a 24-hour setting;

k. Death of the recipient;

l. HIPAA violation;

m. Major property damage;

n. Auto accident (involving the recipient);

o. Staff injury/illness/accident requiring medical attention;

p. Environmental incident requiring emergency assistance; and

q. Death of unpaid caregiver.

7. Notification of Suspected Abuse, Neglect, Exploitation, Isolation, or Abandonment:

State law requires that individuals employed in certain capacities must make a report to the appropriate law enforcement or applicable reporting agency immediately, but in no event later than 24 hours after there is reason to suspect the abuse, neglect, exploitation, isolation, or abandonment of a minor child, vulnerable adult or older individual. DHCFP requires that all providers be in compliance with the intent of all applicable laws.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For vulnerable adults' age 18 and over, or any adult 60 or over, Adult Protective Services within ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation.

a. Child Abuse - Refer to NRS 432B regarding child abuse or neglect.

b. Abuse of a Vulnerable Adult or Oder Person- Refer to NRS 200.5091 to 200.50995 regarding elder abuse, exploitation, isolation neglect or abandonment.

c. Vulnerable adult (NRS 200.5091 to 200.50995) is defined as "a person 18 years of age or older who:"

1. Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or

2. Has one or more physical or mental limitations that restrict the ability of the person to perform the normal ADLs.

8. Complaint Procedure:

The Provider must respond to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received and the response, outcome and resolution of the incident.

The Provider must investigate and respond in writing to all written complaints within ten calendar days of receipt.

The Provider will provide the recipient written notification of the complaint and its outcome. As appropriate, written notification must also be provided to the Regional Center Service Coordinator.

9. HIPAA, Privacy, and Confidentiality:

Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other Protected Health Information (PHI).

10. ADSD:

An Interlocal Agreement between ADSD and DHCFP is maintained to outline responsibilities of both agencies in the operation and administration of HCBS for the ID Waiver.

11. Provider Agencies:

a. All employees must have a file which includes reference checks, CPR/First Aid certification and documentation of new employee orientation and ongoing training. All background check information must be maintained in a separate individual employee file

2103.2B RECIPIENT RIGHTS AND RESPONSIBILITIES

The Recipients are entitled to their privacy; to be treated with respect; and be free from coercion and restraint. Recipients are informed of their rights prior to initiation of services and annually thereafter.

Additionally, applicants or recipients must meet and maintain all criteria to be eligible and to remain on the ID Waiver.

The recipient or the recipient's designated representative/LRI will:

1. Notify the provider(s) and Service Coordinator of a change in Medicaid eligibility.
2. Notify the provider(s) and Service Coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.
3. Notify the provider(s) and Service Coordinator of changes in medical status, service needs, address, and location, or changes of designated representative/LRI.
4. Treat all staff and providers appropriately with respect and in a safe manner.
5. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to intellectual and/or physical limitations.
6. Notify the provider when scheduled visits cannot be kept.
7. Notify the provider and Service Coordinator of missed visits by provider staff.
8. Notify ADSD and the provider if services are no longer requested or required.
9. Notify the provider and ADSD Service Coordinator of unusual occurrences, complaints regarding delivery of services or specific staff, or to request a change in caregiver.
10. If applicable, furnish the provider with a copy of their Advance Directives (AD).
11. Not request a provider to work more than the hours authorized in the PCP.
12. Not request a provider to provide service for a non-recipient, family, or household members.
13. Not request a provider to perform services not included in the PCP.
14. Contact the Service Coordinator to request a change of provider.

15. Sign all required forms unless otherwise unable to perform this task due to intellectual and/or physical limitations.

16. Cooperate with all ADSD meetings and contacts such as phone/face-to-face as per the PCP.

2103.3 DAY HABILITATION

Day Habilitation Services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive skills that include performing ADL's and community living.

Activities and environments are designed to foster the acquisition of skill, building positive social behavior and interpersonal competence, greater independence, and personal choice. Services will include opportunities for volunteer work in community settings and opportunities for community integration through participation in social, recreational, and cultural activities. Services furnished are identified in the recipient's PCP.

Day Habilitation services focus on enabling the recipient to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's person-centered services and support plans, such as physical, occupational, or speech therapy.

Day Habilitation services may also be used to provide supported retirement activities. This may involve alternating schedules to allow for more time throughout the day or supports to participate in hobbies, clubs, and/or activities in the community.

2103.3A COVERAGE AND LIMITATIONS

1. Recipients who receive Day Habilitation services and supports may have two or more types of non-residential services. However, different types of non-residential habilitation services may not be billed during the same time period of the day.

2. Day Habilitation may not provide for the payment of services that are vocational in nature (i.e. for the primary purpose of producing goods or performing services).

3. Documentation is maintained in the file of each recipient receiving Day Habilitation that the service is not available under a program funded by Section 110 of the Rehabilitation Act of 1973 or Individuals with Disabilities Education Improvement Act (IDEA) (20 U.S.C. 1401 et seq.).

2103.3B DAY HABILITATION PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.3C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.4 RESIDENTIAL SUPPORT SERVICES

Residential Support Services are designed to ensure the health and welfare of the recipient, as well as the welfare of the community at large, through protective oversight and supervision activities in addition to support to assist in the acquisition, improvement, retention, and maintenance of the skills necessary for recipients to reside in their community successfully, safely, and responsibly.

Residential Support Services are provided throughout the course of normal ADLs, as well as in specialized training opportunities outlined in the recipient's PCP. These services are individually planned and coordinated, assuring the non-duplication of services with other Medicaid State Plan Services. PCP teams may identify priority areas to address through habilitation plans, however that does not limit additional supports that a person may need to live in the community. These additional supports do not require habilitation plans.

Residential Support Services staff are trained and responsible for implementing the Individual Habilitation Plans, goals and objectives, and other service supports related to residential and community living. These supports include but are not limited to:

A. The facilitation of personal care;

B. ADLs and IADLs;

C. Supports for health and welfare needs;

D. Effective communication skills;

E. Community inclusion;

F. The development of natural support networks;

G. Mobility training;

H. Survival and safety skills;

I. Support and teaching of interpersonal and relationship skills;

J. Making choices and problem-solving skills;

K. Community living skills;

L. Social and leisure skills;

M. Money management skills and;

N. Support and skill training related to health care needs, to include medication management.

Residential Support Services emphasize positive behavioral strategies, including interventions and supervision designed to maximize community inclusion while safeguarding the recipient and general public. The Service Coordinator will ensure the recipient has freedom in their residential setting. Services also support exercising recipient's rights and protect against rights violations and infringements without due process.

Intermittent Supported Living Services are services provided by an individual or organizational provider to recipients residing in their own homes who do not require one-on-one supervision and/or 24-hour care.

A Shared Living Arrangement is an arrangement in which an individual with a disability, and a person, couple or family choose to live together in an integrated community neighborhood which provides Residential Support Services through an intermittent Supported Living Arrangement (SLA).

Twenty-four hour Supported Living Services are Residential Support Services provided up to 24 hours per day by an organizational provider. These services are delivered within homes in integrated neighborhood settings.

Residential Support Services cannot duplicate the scope and nature of Medicaid State Plan Personal Care Services (PCS). Services must be coordinated to ensure there is no duplication. Waiver services must be authorized in the recipient's PCP.

The setting is selected by the individual from among setting options including non-disability specific settings, and an option for a private unit in a residential setting. The setting options are identified and documented in the PCP and are based on the individual's needs and preferences, including choice of roommates as applicable.

2103.4A COVERAGE AND LIMITATIONS

1. Residential Support Services staff receives training and are responsible for implementing PCPs, goals, objectives, and service supports related to residential living and community life.

   These services include but are not limited to:

   a. The participation in the development of the PCP.

b. Adaptive skill development.

c. Facilitation of personal care and ADLs.

d. Facilitation of community inclusion.

e. Facilitation of IADLs to include teaching community life skills; interpersonal and relationship skills; building of natural support networks; choice making skills; social and leisure skills; budgeting and money management skills.

f. Providing assistance with medication administration by a staff certified in an ADSD approved Medication Program. Verification of certification must be maintained in the employee files.

g. Providing assistance with support and skill training in health care needs.

h. Facilitation of mobility training, survival and safety skills.

2. Residential Support Services may be provided on a continuum of service delivery model ranging from intermittent up to 24-hour SLA, as determined by the PCP team. Residential Support Services are provided in either the service recipient's natural family home or in a non-provider owned home or apartment; owned or leased in the service recipient's name or on behalf of the service recipient, with the exception of approved Shared Living services and provider owned homes that have been approved by the Regional Center. The provider is required to have a lease with each service recipient living in a provider owned home. Residential Support Services are provided in integrated settings within community residential neighborhoods. In 24-hour SLA, protective oversight hours must be shared with other recipients in the home unless clear documentation exists that shows a need for one-on-one supervision due to health and safety needs of the recipient which are supported in the PCP and approved by the Regional Center Program Manager.

3. Under this service category, the responsibility for the living environment rests with the service agency and encompasses a variety of SLAs:

a. Residential Support Services in a 24-hour setting are limited to four recipients unless otherwise authorized by the Regional Center Program Manager.

b. SLAs are limited to two service recipients residing in one home, unless otherwise authorized by the Regional Center Program Manager.

Individual SLA homes do not require state licensure; however, individual providers and provider agencies must be certified by ADSD in order to render services to ID Waiver recipients.

2103.4B PROVIDER RESPONSIBILITIES

Refer to MSM 2103.2A, in addition to the provider responsibilities listed:

1. Providers must ensure the recipient has the freedom to furnish and decorate their sleeping or living units. The provider may make reasonable accommodations in rules, policies, practices, or services if those accommodations are necessary to ensure that the person with the disability may use and enjoy the dwelling. If accommodations cannot be met due to behavioral reason, medical condition etc., it must be documented and justified in the person-centered service plan.

2. The recipient's lease or other agreement must not differ from those individuals who do not receive Medicaid HCBS and must include:

   a. At least a 30-calendar day notification to the recipient before transferring or discharging them with the exception of a voluntary transfer or discharge, or the requirement to transfer or discharge the recipient to another facility because the condition of the recipient necessitates a higher level of care;

   b. Provide the recipient and Service Coordinator with written notice of the intent to transfer or discharge the recipient; and

   c. Allow the recipient and any other person authorized by the recipient the opportunity to meet in person with the administrator of the facility to discuss the proposed transfer or discharge within 10 calendar days after providing written notice.

3. The Provider will ensure the setting is physically accessible to the recipient. The Provider will ensure the units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. The provider will ensure each recipient has privacy in their sleeping or living unit.

4. The provider will ensure recipients have the freedom and support to control their own schedules and activities and have access to food at any time.

5. The provider will ensure that recipients are able to have visitors and associate with people of their choosing at any time.

6. For settings where landlord/tenant laws do not apply, the provider must ensure that a written residential agreement is in place for the HCBS Waiver recipient and that it provides comparable protections as those under the jurisdiction's landlord/tenant law.

7. Exceptions to any of the above requirements must be supported by assessed need and clearly justified and documented in the PCP.

2103.4C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM 2103.2B.

2103.5 PREVOCATIONAL SERVICES

Prevocational Services should enable recipients to attain the highest level of vocation in the most integrated setting and by matching the recipient's interests, strengths, priorities, abilities, and capabilities to the job while following applicable Federal wage guidelines. The services are intended to develop and teach general skills. Examples include but are not limited to: ability to communicate with supervisors, co-workers and customers in the workplace setting; generally accepted workplace conduct and dress; an ability to follow directions; an ability to complete tasks; workplace problem solving skills and strategies; and workplace safety and mobility training.

Prevocational Services provides for learning and work experience, which may include volunteer work, where a recipient can develop general, non-job or task-specific strengths and skills that contribute to employability in paid employment within integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as identified in the recipient PCP. The services are designed to create a path to integrated, community-based employment for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Recipients receiving Prevocational Services must have employment-related goals in their PCP; the general habilitative activities must be designed to support such employment goals Competitive, integrated employment in the community for which a recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, considered to be the optimal outcome for Prevocational Services.

2103.5A COVERAGE AND LIMITATIONS

The Prevocational Services provided under this waiver are not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the IDEA (20 U.S.C. 1401 (16 and 17)). Documentation will be maintained in the file of each recipient receiving Prevocational Services that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

1. Recipients who receive Prevocational Services may include two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same time period of the day.

2103.5B PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.5C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.6 SUPPORTED EMPLOYMENT

Supported Employment Services are individualized and may include any combination of the following services: Vocational job related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefit supports, training and planning, transportation training, asset development and career advancement services and other workplace support services including services not specifically related to job skill training that enable the recipient to be successful in integrating into the job setting.

The setting is integrated in and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, and engage in community life. The setting is selected by the individual from among setting options including non-disability specific settings. The service optimizes but does not regiment individual initiative, autonomy, and independence in making life choice including but not limited to, daily activities, physical environment and with whom to interact. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time within the parameters of their employment. Individuals are able to have visitors and associate with people of their choosing as applicable to their employment policy. The setting is physically accessible to the individual.

There are two sub-categories of Supported Employment – Individual Supported Employment and Small Group Supported Employment.

1. Individual Supported Employment

Individual Supported Employment is for recipients who need intensive ongoing supports to obtain and maintain a job that meets their personal and career goals in competitive, customized employment, or self-employment, in an integrated work setting within the general workforce for which an individual is compensated at or above the minimum wage,

but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Individual Supported Employment services do not include payment for supervision, training, support, or adaptations typically available to other workers without disabilities in similar positions in the business. Individual Supported Employment services also do not include supports needed for unpaid, volunteer opportunities.

One approach to individual supported employment is Customized Employment. Customized Employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of the strengths, needs and interest of the recipient, and is also designed to meet the specific needs of the employer. Customized Employment assumes the provision of reasonable accommodations and support necessary to perform the function of a job that is individually negotiated and developed.

2. Small Group Supported Employment

Small Group Employment Supports are services and training activities provided in regular business, industry, and community settings of two to eight workers with disabilities. Examples include mobile crews which employ small groups of recipients in integrated employment in the community with the goals of sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the recipient is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Supported employment services do not include payment for supervision, training, support, or adaptations typically available to other workers without disabilities in similar positions in the business. Small Group Employment services also do not include supports needed for unpaid, volunteer opportunities.

The desired outcome of Supported Employment services is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which the recipient is compensated at or above the minimum wage, but not less than the customary wage and level benefits paid by the employer of the same or similar work performed by individuals without disabilities.

2103.6A COVERAGE AND LIMITATIONS

1. When Supported Employment services are provided at a work site in which individuals without disabilities are employed, payment will be made only for the adaptations, supervision and training required by recipients as a result of their disabilities, and will not

include payment for the supervisory activities rendered as a normal part of the business setting.

2. Supported Employment furnished under the ID Waiver may not include services available under a program funded under Section 110 of the Rehabilitation Act of 1973 or section 602 (16) and (17), of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C 1401 (16 and 17).

3. Supported Employment services do not include supports needed for unpaid, volunteer.

4. Federal Financial Participation (FFP) will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

   a. Incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment services;

   b. Payments that are passed through to users of Supported Employment services; or

   c. Payments for vocational training that is not directly related to a recipient's Supported Employment services.

5. Supported Employment services do not include facility-based work settings, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workforce.

6. Recipients who receive Supported Employment services may receive two or more types of non-residential support services; however, different types of non-residential support services may not be billed during the same period of the day.

2103.6B PROVIDER RESPONSIBILITIES

Refer to MSM Section 2103.2A.

2103.6C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.7 BEHAVIORAL CONSULTATION, TRAINING AND INTERVENTION

Behavioral Consultation, Training and Intervention Services provide behaviorally based assessment and intervention for recipients, as well as support, training, and consultation to family members, caregivers, paid residential support staff, or jobs and day training staff. This service also includes participation in the development and implementation of the PCP and/or Positive Behavior

Support Plans, necessary to improve a recipient's independence and inclusion in their community, increase positive alternative behaviors, and/or address challenging behavior. These services are not covered under the State Plan and are provided by professionals in Psychology, Behavior Analysis and related fields.

2103.7A COVERAGE AND LIMITATIONS

1. Behavioral Consultation, Training and Intervention may be provided in the recipient's home, school, workplace, and in the community. The services include:

   a. Functional behavioral assessment and an assessment of the environmental factors that are precipitating a problem behavior;

   b. Development of Behavior Support Plan in coordination with the team members;

   c. Consultation and/or training on how to implement positive behavior support strategies and/or Behavior Support Plan;

   d. Consultation or training on data collection strategies to monitor progress;

   e. Monitoring of recipient and the provider(s) in the implementation and modification of the support plan, as necessary;

   f. Participation in the PCP;

   g. Team meeting and medical appointments to provide resources information and recommendations, as necessary; and

   h. Providing a monthly summary of progress.

Behavioral Consultation, Training and Intervention may not exceed $5,200.00 per year per recipient. Written authorization by the Regional Center is required for amounts in excess of the limit.

2103.7B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to the provider responsibilities listed in MSM Section 2103.2A:

1. Employees of behavioral provider agencies and individual providers have:

   a. Professional holding Bachelor's level licensure and/or certification per NRS 437; or has a Bachelor's degree in psychology, special education or closely related field plus at least one year professional clinical experience using behavior intervention

and functional assessment procedures as well as developing, implementing and monitoring of behavior support plans in applied setting; or

b. Professional holding Master's level licensure and/or certification per NRS 437; or has a Master's degree in psychology, special education or closely related field with expertise in functional assessment and the provision of positive behavioral supports.

2. Experience working with individuals with intellectual disabilities or developmental disabilities is preferred.

2103.7C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.8 COUNSELING SERVICES

Counseling Services provide assessment/evaluation, consultation, therapeutic interventions, support and guidance for recipients and/or family members, caregivers, and team members, which are not covered by the Medicaid State Plan and which improve the recipient's personal adaptation and inclusion in the community. This service is available to recipients who have intellectual and/or developmental disabilities and provides problem identification and resolution in areas of interpersonal relationships, community participation, independence, and attaining personal outcomes, as identified in the recipient's PCP.

Counseling Services are specialized and adapted in order to accommodate the unique complexities of enrolled recipients and may include:

A. Consultation with team members, including family members, support staff, service coordinators and other professionals comprising the participant's support team;

B. Individual and group counseling services;

C. Assessment/evaluation services;

D. Therapeutic interventions strategies;

E. Risk assessment;

F. Skill development;

G. Psycho educational activities;

H. Participating in PCP Team meetings and appointments to provide resource information and recommendations, as necessary; and

I. Providing a monthly summary of progress.

Counseling services are provided based on the recipient's need to assure his or her health and welfare in the community and enhance success in community living.

2103.8A COVERAGE AND LIMITATIONS

Counseling services may not exceed $1,500.00 per year per recipient. Written authorization by the Regional Center is required for amounts in excess of the limit.

2103.8B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to the provider responsibilities listed in MSM Section 2103.2A:

1. Providers must have graduated from an accredited college or university with a Master's degree in a two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely related academic field. A closely related field is licensed by the State of Nevada by appropriate categories; or

2. A graduate level intern who is enrolled in a Master's level program at an accredited college or university that provides at least two year curriculum in counseling, marriage and family therapy, psychology, social work or a closely related academic field or doctor level program in a clinical field; and are supervised by a licensed clinician or mental health counselor.

3. Professional experience in a setting serving individuals with intellectual disabilities is preferred.

2103.8C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.9 RESIDENTIAL SUPPORT MANAGEMENT

Residential Support Management is designed to ensure the health and welfare of recipients receiving Residential Support Services from agencies. This service is intended to ensure the supports are planned, scheduled, monitored, and implemented according to the recipient's preferences and needs depending on the frequency and duration of approved services.

2103.9A COVERAGE AND LIMITATIONS

1. Residential Support Management staff will assist the recipient in managing their supports within the home and community settings.

   This service includes:

   a. Assisting the recipient to develop one's goal(s);

   b. Scheduling and attending interdisciplinary meetings;

   c. Develop habilitation plans specific to Residential Support Services, as determined in the recipient's PCP and training residential support staff in implementation and data collection;

   d. Assisting the recipient to apply for and obtain community resources and benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Housing and Urban Development (HUD), Supplemental Nutrition Assistance Program (SNAP), housing, etc.;

   e. Assisting the recipient in locating residences;

   f. Assisting the recipient in arranging for and effectively managing community resources and informal supports;

   g. Assisting the recipient to identify and sustain a personal support network of family, friends, and associates;

   h. Providing problem solving and support with crisis management;

   i. Supporting the recipient with budgeting, bill paying, and with scheduling and keeping appointments;

   j. Observing, coaching, training and providing feedback to direct service staff to ensure they have the necessary and adequate training to carry out the supports and services identified in the PCP;

   k. Following up with health and welfare concerns and remediation of deficiencies;

   l. Completing required paperwork on behalf of the recipient (as needed);

   m. Making home visits to observe the recipient's living environment to assure health

and welfare; and

n. Providing information to the Service Coordinator (Targeted Case Manager) and support team members to allow evaluation and assurance that support services provided are those defined in the PCP and are effective in assisting the recipient to reach his or her goals.

2. Residential Support Managers must work collaboratively with the recipient's Service Coordinator as well as other support team members. Residential Support Management services are different from Targeted Case Management as the Service Coordinator is responsible for the development of the PCP, which is the overall HCBS support plan, in consultation with the PCP Team.

2103.9B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to provider listed in 2103.2A, Residential Support Managers must have:

1. A High School Diploma or equivalent and two years' experience providing direct service in a human services field and remain under the direct supervision/oversight of a Qualified Intellectual Disabilities Professional (QIDP) or its equivalent; or

2. Completion of a Bachelor's degree from an accredited college or university in psychology, special education, counseling, social work, or closely related field and one year of experience meeting the qualification of a QIDP.

2103.9C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.10 NON-MEDICAL TRANSPORTATION

Non-Medical Transportation service are offered to enable recipients to gain access to community activities. Non-Medical Transportation service allows recipients to engage in normal day-to-day non-medical activities such as going to the grocery store or bank, participating in social and recreational events or attending a worship service; activities are not all inclusive. Whenever possible, family, neighbors, friends, or community agencies should provide this service without charge.

2103.10A COVERAGE AND LIMITATIONS

1. This service will not duplicate or impact the amount, duration and scope of the Medical Transportation benefit provided under the Medicaid State Plan. Refer to MSM Chapter

1900 for more information regarding the coverage and limitations of State Plan Medical Transportation.

2. Non-Medical Transportation services under this waiver must be described or identified in the recipient's PCP before the service is utilized. The use of Non-Medical Transportation must be summarized in the provider's quarterly progress report.

3. Non-Medical Transportation fees cannot exceed $100.00 per month per recipient.

2103.10B PROVIDER RESPONSIBILITIES

In addition to provider responsibilities listed in 2103.2A, providers must have:

1. A valid Nevada Driver's License and provide verification of safe driving record and proof of driver's liability insurance.

2. Evidence of vehicle safety inspection completed prior to transporting recipient's and completion of ongoing periodic vehicle safety inspections. Providers are responsible for obtaining vehicle safety inspections and providing them to ADSD upon request.

2103.10C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.11 NURSING SERVICES

There are three components of Nursing Services: Medical Management, Nursing Assessment, and Direct Services, (over and above State Plan).

1. Medical Management

These services will be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) licensed in the state. Services are geared toward the development of health services support plans; training of direct support staff or family members to carry out treatment; monitoring of staff knowledge and competence to improve health outcomes; assistance with revision of health support plans in response to new or revised treatment orders or lack of positive outcomes of current supports by staff; monitoring/ assessment of the recipient's condition in response to current health supports provided; and as needed assistance with referrals to other medical providers. This service includes professional observation and assessment, individualized program design and implementation, training of recipients and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs

from case management in that this service relates directly to the medical needs of the individual.

In addition, nurses may attend PCP team meetings and physician visits as needed to provide advocacy, resource information and recommendations to team and treating physicians in order to facilitate health supports.

2. Nursing Assessment

This service will be completed by a RN to identify the needs, preferences, and abilities of the recipient. The assessment includes: an interview with the recipient; and/or their designated representative/LRI, an observation by the nurse to consider the symptoms and signs of condition, verbal and nonverbal communication skills, medical and social history, medication and any other information available.

The nurse will assess vital signs, skin color and condition, motor and sensory nerve function, reproduction, dentition, height, nutrition, rest, sleep patterns, physical activities, elimination, and level of consciousness. Additionally, the following social and emotional factors will be assessed which include religion, occupation, attitudes on health care, mood, emotional tones, family ties and responsibility. The assessment is extremely important because it provides recommendations for medical and mental health care and follow-up which are shared with the recipient's team for review and inclusion in the PCP. Nursing assessments may be performed and completed upon approved referral and authorization of the service coordinator. Assessments are completed by a RN and provide the basis for recommendations for medical and mental health care and follow-up, which are shared with the person's team for review and inclusion in the individual's support plan.

3. Direct Services

This service provides routine medical and health care services that are integral to meeting the daily needs of participants. This includes the routine administration of medication by nurses tending to the needs of participants who are ill and providing care to participants who have ongoing medical needs. Direct skilled nursing services are intended to be provided by an RN or LPN in a community setting, including home or work, as described and approved in the recipient's PCP. LPNs must be under the supervision of a RN licensed in the state. Services include skilled medical care that is integral to meeting the daily medical needs of recipient. These services are intended to allow individuals under this waiver to live safely within an integrated community setting.

Services are limited to those that only a licensed professional can provide versus non-skilled care that unlicensed staff can provide such as, activities of daily living.

Skilled services include, but are not limited to: medication administration, wound care, nasogastric or gastronomy tube feeding, ostomy care, tracheotomy aspiration care, and catheter care, only when the procedure can be performed safely by a RN or LPN.

2103.11A COVERAGE AND LIMITATIONS

1. Nursing Services must be provided within the Scope of the Nevada Nurse Practice Act.

2. Nursing Services must be provided by an RN or LPN under the supervision of an RN who is licensed to practice as a nurse in the State of Nevada.

3. Nursing Services under the ID Waiver must include nursing progress notes and summaries on all nursing activities.

4. Nursing Services may be provided in the recipient's home, work site, or in other community settings as described in the PCP.

5. Nursing Services provided in this waiver will not duplicate the Nursing Services covered under the Medicaid State Plan.

2103.11B PROVIDER RESPONSIBILITIES AND QUALIFICATIONS

In addition to provider responsibilities listed in 2103.2A providers must be:

1. An RN in accordance with NRS 632 licensing requirements; or

2. An LPN under the supervision of an RN in accordance with NRS 632 licensing requirement.

2103.11C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.12 NUTRITION COUNSELING SERVICES

Nutrition Counseling Services include assessment of the recipient's nutritional needs, development and/or revision of recipient's nutritional plan, nutritional counseling and nutritional intervention, observation and technical assistance related to successful implementation of the nutritional plan. These services include:

a. Nutritional training, education and consultation for recipients and their families or support staff involved in the day-to-day support of the recipient;

b. Completing comprehensive assessment of nutritional needs;

c. Developing, implementing and monitoring of nutritional plan incorporated in the PCP, including updating and making changes in the PCP as needed;

d. Assisting in menu planning and healthy menu options; and

e. Providing monthly case notes on nutritional activities and summaries of progress on the nutritional plan.

These waiver-covered nutritional duties are above and beyond those approved and covered under Medicaid State Plan Services.

2103.12A COVERAGE AND LIMITATIONS

This service is limited to $1,300.00 per year, per recipient. This service does not include the cost of meals or food items.

2103.12B PROVIDER ADDITIONAL RESPONSIBILITIES AND QUALIFICATIONS

In addition to the provider responsibilities/qualifications listed in MSM Section 2103.2A, providers must be:

1. A registered Dietician as certified by the American Dietetic Association.

2. Licensed to practice in the State of Nevada.

2103.12C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.13 CAREER PLANNING

Career Planning is a person-centered, comprehensive employment planning and support service that provide assistance for recipients to obtain, maintain, or advance in competitive employment or self-employment. It is time limited and focuses on engaging a recipient in identifying a career direction and developing a plan for achieving integrated employment at or above minimum wage.

Career Planning includes activities that are primarily directed at assisting a recipient with identification of an employment goal and creating a plan to achieve this goal that are associated with performing competitive work in community integrated employment. This can be achieved by job exploration, job shadowing, informational interviewing, assessment of interests and labor market research.

The providers coordinate, evaluate and collaborate with recipients, designated representative/LRI, support team, employers and others who can assist with discovering recipients' skills, abilities, interests, preferences, conditions and needs. This support and evaluation should be provided to the maximum extent possible in the presence of the recipient and should be conducted in the community, but completion of activities in the home or without the presence of the recipient should not be precluded.

A. If a waiver recipient is employed, career planning may be used to explore other competitive employment career objectives which are more consistent with the person's skills and interests, or to explore advancement opportunities in his or her chosen career.

B. Career Planning should be reviewed and considered as a component of a recipient's person-centered services and support plan, no less than annually, more frequently as necessary, or as requested by the recipient.

C. These services should be designed to support successful employment outcomes consistent with the recipient's goals.

D. Career Planning may include social security benefits support, training, consultation and planning as well as assessments for the use of assistive technology in the workplace to increase independence.

E. The setting for the delivery of services must be aligned with the individualized need and that which is most conducive in developing a career objective and a career plan.

The outcome of this service is documentation of the individual's stated career objective and career plan used to guide individual employment support. Services include planning for sufficient time and experiential learning opportunities to allow for appropriate exploration, assessment and discovery processes for learning about career options, as well as the participant's skills and interests. Career Planning may include informational interviewing, job tours, job shadowing, community exploration, community and business research, benefit supports, job preference inventories, situational and community-based assessments, job sampling, training and planning, as well as assessments for the use of assistive technology in the workplace to increase independence.

2103.13A COVERAGE AND LIMITATIONS

1. The PCP may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed simultaneously. If a waiver recipient is receiving Pre-Vocational Services or Day Habilitation Services, Career Planning may be used to develop additional learning opportunities and career options consistent with the recipient's skills and interest.

2. Career Planning will be limited to 216 hours within a six-month time period each year per recipient. The six-month periods may not be provided consecutively.

3. Career Planning furnished under the waiver may not include services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17).

2103.13B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in MSM Section 2103.2A, providers of Career Planning must have:

1. Experience in working with individuals with intellectual and developmental disabilities providing employment service and job development.

2. Knowledge of person-centered career planning, job analysis, supported employment services, situational and community-based assessments, best practices in customized employment, and knowledge of the business needs of an employer.

3. A Valid Nevada Driver's License. Must also have access to an operational and insured vehicle and be willing to use it to transport recipients. (Providers will bill Career Planning unit rate for time spent transporting, this is not a separate rate); And

4. Evidence of vehicle safety inspection completed prior to transporting recipient's and completion of ongoing periodic vehicle safety inspections. Providers are responsible for obtaining safety inspections and providing them to the ADSD upon request.

2103.13C RECIPIENT RIGHTS AND RESPONSIBILITIES

Refer to MSM Section 2103.2B.

2103.14 DENTAL SERVICES

Oral health has a direct impact on the ID Waiver recipient's overall health and quality of life. Adults with Intellectual or Developmental Disability (IDD) often have specific challenges during treatment such as the need for behavioral modifications.

2103.14A COVERAGE AND LIMITATIONS

1. The dental services under this waiver are only provided for individuals age 21 and over. All Medicaid medically necessary dental services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

2. Dental services include but are not limited to:

   a. Restoration (e.g. amalgam filling, resin-based composite filling, prefabricated stainless steel crown and resin-crown, core buildup, etc.); and

   b. Preventative care such as regular check-ups, cleaning, fluoride treatments, x-rays, fillings, periodontal maintenance, periodontal scaling and root planning and root canal therapy.

   c. For a complete list of covered dental services for ID Waiver recipients age 21 and over refer to https://www.medicaid.nv.gov in the PT 22 Billing Guide.

   NOTE: The scope and nature of this service differs from the State Plan Dental Service for Adults, which only offers emergency extractions, palliative care, and removable prosthesis with prior authorization.

3. Dental services do not include extractions for cosmetic purposes.

4. Dental services exceeding program limitations are not considered Medicaid benefits and are the financial responsibility of the recipient.

5. Dental services must be prior authorized before rendering services.

2103.14B PROVIDER RESPONSIBILITIES

1. Provider requirements for PT 22:

   a. Dental providers must be licensed by the Nevada State Board of Dental Examiners.

   b. Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Nevada MSM Chapter 100 and MSM Chapter 2100.

   c. Dentists, public health endorsed dental hygienists, and dental therapists enrolled with Nevada Medicaid can bill for services provided to eligible ID Waiver recipients.

2. Reference Nevada Medicaid's Dental Benefit Schedule (Attachment A of the "PT 22" Billing Guide) document located at https://www.medicaid.nv.gov in Dentist (PT 22) Billing Guide for a list of Current Dental Terminology (CDT) codes detailing prior authorization requirements and service limitations.

3. Request for Prior Authorization must be submitted electronically to the DHCFP fiscal agent website at https://www.medicaid.nv.gov before rendering dental services.

4. Providers must verify the Medicaid eligibility status of each recipient prior to rendering services.

5. Providers must inform the recipient of their financial responsibility before rendering any uncovered service.

6. For details on reporting Incidents and Serious Occurrences refer to Section 2103.2A.(7).

7. For information on notification of suspected abuse, neglect, exploitation, isolation, or abandonment refer to Section 2103.2A.(8).

8. Refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other PHI.

9. Each provider must cooperate with DHCFP and/or State or Federal reviews or inspections.

2103.14C RECIPIENT RIGHTS AND RESPONSIBILITIES

The recipient or the recipient's designated representative/LRI will:

1. Notify the provider(s) and Care Coordinator of a change in Medicaid eligibility.

2. Notify the provider(s) and Care Coordinator of current insurance information, including the name of other insurance coverage, such as Medicare.

3. Notify the provider(s) and Care Coordinator of changes in medical status, service needs, address, and location, or changes of designated representative/LRI.

4. Notify the provider when scheduled visits cannot be kept.

5. Not request a provider to perform services not included in the PCP.

6. Contact the Care Coordinator to request a change of provider.

7. The recipient and/or designated representative/LRI must sign and date all required forms.

2103.15 INTAKE PROCEDURES

A. WAIVER REFERRAL AND PLACEMENT ON THE WAIT LIST

1. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting the local ADSD Regional Center. The Regional Center staff will discuss waiver services, including eligibility requirements with the referring party or potential applicant.

2. The Service Coordinator must conduct a LOC screening to verify eligibility for the wait list.

   NOTE: If the applicant does not meet an LOC, they will receive a Notice of Decision (NOD) which includes the right to a fair hearing.

3. All applicants who meet waiver criteria must be placed on the statewide waiver wait list by priority and referral date. The following must be completed before placement on the wait list:

   A. The applicant must meet LOC criteria for placement in an ICF/IID.

   B. The applicant must require at least one ongoing waiver service.

   C. The applicant must meet criteria for an intellectual or developmental disability.

Applicants will be sent a NOD indicating "no slot available. ADSD will notify the DHCFP Long Term and Services and Supports (LTSS) Unit when no slot is available. The applicant will remain on the waiting list until a waiver slot is available.

The allocation of waiver slots is maintained with ADSD. As waiver slots become available, ADSD determines how many slots may be allocated.

B. WAIVER SLOT ALLOCATION

Once a waiver slot is allocated by ADSD, the applicant will be processed for the waiver.

The procedure used for processing an applicant will be as follows:

1. The ADSD Service Coordinator will schedule a face-to-face visit with the applicant to complete the full waiver assessment to include diagnostic data, LOC determination, and will obtain all applicable forms, including but not limited to the Authorization for Release of Information.

The applicant and/or designated representative/LRI must understand and agree that personal information may be shared with providers of services and others as specified on the form.

The ADSD Service Coordinator will inform the applicant and/or designated representative/LRI that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services (DHHS) may share confidential information between themselves without a signed authorization for release of information.

The Service Coordinator will provide an application to apply for Medicaid benefits through DWSS if the applicant does not have these benefits already in place. The applicant is responsible for completing the application and submitting all requested information to DWSS. The Service Coordinator will assist upon request.

2. The applicant/recipient will be given the right to choose waiver services in lieu of placement in an ICF/IID. If the applicant/recipient and/or designated representative/LRI prefers placement in an ICF/IID, the service coordinator will assist the applicant/recipient in arranging for facility placement.

3. The applicant/recipient will be given the right to request a hearing if not given a choice between HCBS Waiver and ICF/IID placement.

4. When the applicant/recipient is approved by ADSD for the ID Waiver services, the following will occur:

   a. A team meeting is held, and a written PCP is developed in conjunction with the recipient and the PCP Team to determine specific service needs and to ensure the health and welfare of the recipient. The applicant/recipient and/or designated representative/LRI and provider(s) must sign and date the PCP. Interim PCP's, unsigned by the applicant/recipient and/or designated representative/LRI and the provider(s), may be authorized for up to 60 days from the PCP development meeting.

   NOTE: Applicant/recipients already receiving services via ADSD State General Funds will already have a PCP in place.

   b. The applicant/recipient, the applicant/recipient's family, or the designated representative/LRI, providers, and participants of the applicant/recipient's choice are included in the development of the PCP.

c. Applicants/recipients will be given the free choice of all qualified available Medicaid providers of each Medicaid covered service included in the written individual support plan. Current PCP must be given to all service providers and kept in the recipient's record.

d. All forms must be complete with signatures and/or initials and dates by the applicant/recipient and/or designated representative/LRI and provider(s), where required. Electronic signatures are acceptable, as pursuant to NRS 719, on forms that require a signature.

e. ADSD will forward a completed waiver packet requesting to add a benefit plan to the DHCFP LTSS Unit.

1. The HCBS Waiver Eligibility Status form will be sent by the DHCFP LTSS Unit to the ADSD Service Coordinator.

2. ADSD is responsible for notifying DWSS of approval to coordinate waiver slot allocation.

3. DWSS is responsible for notifying ADSD of the applicants' status, to initiate waiver services.

C. SUPPORT PLAN DEVELOPMENT

Developmental Services uses a person-directed planning process. Assessment information assists the team with identifying barriers to reaching the person's vision, desired outcomes, and support needs. Goals related to reaching the vision are developed based on the person's desired life outcomes, as well as any needs for maintaining appropriate health and welfare. This information is provided to the person-centered team for plan development at the PCP meeting. This process provides direction for the identification of goals and assures that the meeting focuses on the participant and his or her priorities, preferences, and perspective.

The PCP is developed utilizing applicable assessments that may include a social assessment, health assessment, risk assessment, or self-medication administration assessment tool.

The support plan is inclusive of the services and supports that are provided to meet the assessed needs of the participant. The service coordinator is responsible for understanding all services provided to the service recipient, gathering assessment, information, developing the PCP based on team recommendations, facilitating plans for any necessary referrals, and monitoring all services, as part of the support plan implementation. The support plan also identifies the priority areas to be addressed based upon the person-

centered planning process. The PCP will identify which priority areas of support require habilitation plans. Additional supports, including general supervision, can be provided as needed to assist the individual with their daily life living in the community without the need for habilitation plans.

In addition to 42 CFR 443.301(c)(2)(i)-(xii), any modifications of the Support Plan must be supported by a specific assessed need and justified in the PCP. The following requirements must be documented in the PCP:

1. Identify a specific and individualized assessed need.

2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3. Document less intrusive methods of meeting the need that have been tried but did not work.

4. Include a clear description of the condition that is directly proportionate to the specific assessed need.

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7. Include the informed consent of the individual.

8. Include an assurance that interventions and supports will cause no harm to the individual.

D. EFFECTIVE DATE FOR WAIVER SERVICES

The effective date for waiver services approval is the completion date of all the intake forms, or the waiver eligibility determination date by DWSS, whichever is later. If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

Waiver services will not be backdated beyond the first of the month in which the waiver eligibility determination is made by DWSS.

E. SERVICE COORDINATION

Service Coordination is provided under the Medicaid State Plan Targeted Case Management service. This is an integral part of the management of the ID Waiver.

Refer to MSM Chapter 2500 for allowable activities under Targeted Case Management.

F. WAIVER COST

DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100% of the average per capita expenditures for the institutional LOC under the Medicaid State Plan that would have been made in that fiscal year, had the waiver not been granted.

2103.16 PERMANENT CASE FILE

A. For each approved ID Waiver recipient, the Service Coordinator must maintain a permanent record that documents services provided under the ID Waiver. The service provider is also required to maintain their billing documents and service records.

B. These records must be retained for six years from the date the last claim is paid.

2103.17 SERVICE COORDINATOR RECIPIENT CONTACTS

A. Recipient Contact

1. The Service Coordinator must have monthly contact with each waiver recipient, or a recipient's designated representative/LRI, or the recipient's Supported Living or Jobs and Day Training provider. The contact must be sufficient to address health and safety needs of the recipient, needed support plan changes, recipients' goals and satisfaction with services and supports. At a minimum, there must be a face-to-face visit with each recipient quarterly.

2. During quarterly contacts, the Service Coordinator will monitor whether the habilitation plans are meeting identified goals and provide any necessary follow up on needs or concerns.

a. The Service Coordinator must show due diligence to hold the established contacts as outlined in the PCP and every attempt to contact the recipient must be documented. At least three attempts must be completed on separate days within the quarter, if no response is received after the 3rd attempt, a letter must be sent to the recipient requesting a return contact. If the

recipient fails to respond by the date indicated in the letter, the recipient may be terminated.

b. When DHCFP is conducting a review of a recipient and the Service Coordinator has clearly documented the above steps were attempted during any given quarter wherein a quarterly contact was required, DHCFP shall waive that quarterly contact requirement.

B. Reassessment

1. Recipients must be reassessed at least annually within the same month. The recipient and provider(s) must sign and date the PCP. Interim PCP's, unsigned by the recipient and provider(s), may be authorized for up to 60 days.

2. The recipient must also be reassessed when there is a significant change in his/her condition.

3. The number of hours specified on each recipient's Service Authorization for each specific service, are considered the maximum number of hours allowed to be provided by the provider and paid by ADSD and DHCFP, unless the Service Coordinator has approved additional hours due to a temporary condition or circumstances. Providers are allowed to provide fewer services than stated on the Service Authorization if the reason for providing less service is adequately documented.

4. When the recipient's service needs increase, due to a temporary condition or circumstance, the Service Coordinator must thoroughly document the increased service needs in their case notes. The PCP does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days.

5. Residential Support Management hours are defined in the PCP. A temporary increase in the residential support management hours for the recipient must receive prior authorization from ADSD, within the month of the temporary increase, and be justified based on health, safety and welfare concerns. If an increase is warranted to exceed a 30-day period, there must be a reassessment based on thorough documentation in the Residential Support Managers case notes reflecting the health, safety and welfare concerns and the Service Authorization must be revised.

a. Reassessment Procedures
During the reassessment process, the Service Coordinator must:

1. Re-affirm the recipient meets the waiver criteria outlined in Section 2103.1.

2. Re-assess the recipient's ability to perform ADLs and IADLs, his/her medical and mental status and support systems.

3. Re-evaluate the services being provided and progress made toward the goal(s) stated in the PCP.

4. Develop a revised PCP.

5. Re-assess the recipient's LOC.

6. Inform recipients about their rights, including the right to be free from abuse, neglect, exploitation, isolation and abandonment.

2103.18 BILLING PROCEDURES

The State assures that claims for payment of ID Waiver services are made only when a recipient is Medicaid eligible and only when the service is included in the approved PCP plan.

Refer to the fiscal agent's website at: www.medicaid.nv.gov for the Provider Billing Guide Manual.

2103.19 DHCFP ANNUAL REVIEW

DHCFP (administrative authority) conducts an annual program review of the ID Waiver operated by ADSD to assess policy adherence, recipient quality of life, and the health and welfare of recipients receiving waiver services. The State must operate this waiver in accordance with certain "assurances" identified in Federal regulations. CMS has designated waiver assurances and sub assurances that states must include as part of an overall quality improvement strategy, which are:

1. The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating a recipient's LOC consistent with care provided in a hospital, NF or ICF/IID.

   a. An evaluation for LOC is provided to all recipients for whom there is reasonable indication that services may be needed in the future.

   b. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial recipient LOC.

2. Support Plan: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of supportive service plans for waiver recipients.

   a. Support Plans address recipients assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means as determined by the PCP team through the person-centered planning process.

   b. Support Plans are updated/revised at least annually or when warranted by changes in the waiver recipient's needs.

   c. Services are delivered in accordance with the support plan, including the type, scope, duration, and frequency specified in the support plan.

3. Qualified Providers: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

   a. The State verifies that providers initially and continually meet required licensure and /or certification standards and adhere to other standards prior to their furnishing waiver services.

   b. The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

4. Health and Welfare: The State demonstrates it has designed and implemented an effective system for assuring wavier recipient health and welfare.

   a. The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation, isolation and unexplained death.

   b. The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

   c. The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

   d. The State assures overall health and safety and monitors these assurances based on the responsibility of the service provider as stated in the approved waiver.

5. Financial Accountability: The State must demonstrate that it has designed and implemented

an adequate system for ensuring financial accountability of the waiver.

a. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

b. The State provides evidence that rates remain consistent with the approved rate methodology through the five-year waiver cycle.

6. Administrative Authority: DHCFP retains ultimate administrative authority and responsibility for the operation of the waiver by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

The annual review is conducted using the above assurances and sub assurances as well as state specified performance measures identified in the approved ID waiver in order to evaluate the operation of the waiver.

Providers must cooperate with DHCFP's annual review process.

2103.20 MEDICAID PROVIDER ENROLLMENT PROCESS

1. All providers should refer to the MSM Chapter 100 for enrollment procedures.

2. All providers must comply with all DHCFP and ADSD enrollment requirements, provider responsibilities/qualifications, DHCFP and ADSD provider agreement and limitations set forth in this chapter.

3. Provider non-compliance with all or any of these stipulations may result in DHCFP's decision to exercise its right to terminate the provider's contract.

2104 HEARINGS REQUEST DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions or suspensions of a recipient's eligibility determination or an applicant's request for services. DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative/LRI in the event an adverse action is taken by DHCFP.

2104.1 SUSPENDED WAIVER SERVICES

A. A recipient's case must be suspended, instead of closed, if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example if a recipient is admitted to an institutional setting, such as a hospital, a NF, or ICF/IID).

B. After receiving written notification from the Service Coordinator with the admission date and the request for suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be provided to the recipient by the DHCFP LTSS unit.

C. If at the end of 60 days the recipient has not been removed from suspension status, the waiver must be terminated.

D. The DHCFP LTSS unit sends a NOD to the recipient and/or designated representative/LRI advising them of the date and reason for the waiver closure/termination.

E. Waiver services will not be paid for the days that a recipient's eligibility is in suspension status.

2104.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from the hospital, NF or an ICF/IID before 60 days from the admit date, the Service Coordinator must do the following within five working days:

A. Notify the DHCFP LTSS Unit of the release of suspension.

B. Complete a new PCP if there has been a significant change in the recipient's condition needs. If a change in services is expected to resolve in less than 30 days, a new PCP is not necessary. Documentation of the temporary change must be made in the Service Coordinator's notes. The date of the resolution must also be documented in the Service Coordinator's notes.

C. Complete a new Service Authorization, if necessary.

D. Contact the service providers(s) to re-establish services.

2104.3 DENIAL OF WAIVER APPLICATION

Reasons an applicant will be denied for waiver services:

A. The applicant does not meet the criteria of being diagnosed with intellectual or developmental disability.

B. The applicant does not meet the LOC criteria for placement in an ICF/IID).

C. The applicant has withdrawn their request for waiver services.

D. The applicant fails to cooperate with the Service Coordinator or the HCBS providers in establishing and/or implementing the PCP implementing waiver services or verifying eligibility for waiver services.

E. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

F. The applicant fails to show a need for HCBS.

G. The applicant would not require imminent placement in an ICF/IID if HCBS were not available. (Imminent placement means within 30 to 60 days.)

H. Another agency or program will provide the services.

I. ADSD has filled the number of slots allocated to the ID Waiver. The applicant has been approved for the waiver waitlist and will be contacted when a slot is available.

J. The applicant has moved out of state.

K. The agency has lost contact with the applicant.

When the application for waiver services is denied, the DHCFP LTSS Unit will issue a Notice of Decision (NOD), within five business days, to the recipient or designated representative/LRI identifying the reason for denial. The Date of Action (DOA) is the same date as the NOD date.

2104.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

A. The recipient no longer meets the criteria of an intellectual or developmental disability.

B. The recipient no longer meets the LOC criteria for placement in an ICF/IID.

C. The recipient has requested termination of waiver services.

D. The recipient has failed to cooperate with the Service Coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.

E. The recipient's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS Waiver services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

F. The recipient fails to show a continued need for HCBS.

G. The recipient no longer requires imminent ICF/IID placement if HCBS Waiver services were not available. (Imminent placement means within 30 to 60 days.)

H. The recipient has moved out of state.

I. Another agency or program will provide the services.

J. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, ICF/IID, or incarcerated) ****See below.

K. ADSD has lost contact with the recipient.

L. Death of the recipient.

When a recipient is scheduled to be terminated from the ID Waiver, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for termination. The DHCFP LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI. The form must be mailed by DHCFP to the recipient at least 13 calendar days before the DOA on the NOD. Refer to MSM Chapter 3100 for exceptions to the advance notice.

NOTE: Service Coordinators must track recipient stays in an institutional setting. Five days prior to the 45th day, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the 60th day of inpatient status, which is the termination date for waiver services.

Waiver slots must be held for 90 days, from the date the NOD is sent to the recipient indicating termination or institutional placement, in case they are released and need waiver services upon release.

2104.5 REDUCTION OR DENIAL OF WAIVER SERVICES

Reasons to reduce or deny waiver services:

A. The recipient no longer needs the number of service/support hours/days which were previously provided.

B. The recipient no longer needs the service/supports previously provided.

C. The recipient's parent and/or designated representative/LRI is responsible for the maintenance, health care, education and support of their minor child or ward.

D. The recipient's support system is providing the service.

E. The recipient has failed to cooperate with the Service Coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.

F. The recipient has requested the reduction of supports/services.

G. The recipient's ability to perform tasks has improved.

H. Another agency or program will provide the service.

I. Another service will be substituted for the existing service.

J. The recipient has reached the authorized unit or annual service limit.

When a recipient has a reduction of waiver services, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for the reduction and what the service is being reduced to. The LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI. The form must be mailed by DHCFP to the recipient at least 13 calendar days before the DOA on the NOD.

When a recipient is denied waiver services, the Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reason for the denial. The LTSS Unit will send a NOD to the recipient or the recipient's designated representative/LRI within five days, identifying the reason for denial. The DOA is the same date of the NOD date.

2104.6 REAUTHORIZATION WITHIN 90 DAYS

When a recipient is placed in an institutional setting such as nursing facility, ICF/IID, or hospital, they must be sent a NOD terminating them from the waiver 60 days from admit date. Their waiver slot must be held for 90 days from the NOD date. A recipient may be placed back in that slot if they are released within 90 days of the NOD date, and request reinstatement, but must continue to meet waiver eligibility criteria. After 90 days, their slot may be given to the next individual on the wait list. If a recipient requests reinstatement after the 90 days expired, they are treated as a new referral.

The Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reinstatement date.

2104.7 HEARINGS PROCEDURES

Please reference MSM Chapter 3100, Hearings, for hearings procedures.

provided in a hospital, NF or ICF/IID.

a. An evaluation for LOC is provided to all recipients for whom there is reasonable indication that services may be needed in the future.

b. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial recipient LOC.

2. Support Plan: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of supportive service plans for waiver recipients.

a. Support Plans address recipients assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means as determined by the PCP team through the person-centered planning process.

b. Support Plans are updated/revised at least annually or when warranted by changes in the waiver recipient's needs.

c. Services are delivered in accordance with the support plan, including the type, scope, duration, and frequency specified in the support plan.

3. Qualified Providers: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

a. The State verifies that providers initially and continually meet required licensure and /or certification standards and adhere to other standards prior to their furnishing waiver services.

b. The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

4. Health and Welfare: The State demonstrates it has designed and implemented an effective system for assuring wavier recipient health and welfare.

a. The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation, isolation and unexplained death.

b. The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the

extent possible.

c. The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

d. The State assures overall health and safety and monitors these assurances based on the responsibility of the service provider as stated in the approved waiver.

5. Financial Accountability: The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver.

a. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

b. The State provides evidence that rates remain consistent with the approved rate methodology through the five-year waiver cycle.

6. Administrative Authority: The DHCFP retains ultimate administrative authority and responsibility for the operation of the waiver by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

The annual review is conducted using the above assurances and sub assurances as well as state specified performance measures identified in the approved ID waiver in order to evaluate the operation of the waiver.

Providers must cooperate with the DHCFP's annual review process.

2103.19 MEDICAID PROVIDER ENROLLMENT PROCESS

1. All providers should refer to the MSM Chapter 100 for enrollment procedures.

2. All providers must comply with all the DHCFP and ADSD enrollment requirements, provider responsibilities/qualifications, the DHCFP and ADSD provider agreement and limitations set forth in this chapter.

3. Provider non-compliance with all or any of these stipulations may result in the DHCFP's decision to exercise its right to terminate the provider's contract.

2104 HEARINGS REQUEST DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions or suspensions of a recipient's eligibility determination or an applicant's request for services. The DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative/LRI in the event an adverse action is taken by the DHCFP.

2104.1 SUSPENDED WAIVER SERVICES

A. A recipient's case must be suspended, instead of closed, if it is likely the recipient will be eligible again for waiver services within the next 60 days (for example if a recipient is admitted to an institutional setting, such as a hospital, a NF, or ICF/IID).

B. After receiving written notification from the Service Coordinator with the admission date and the request for suspension of waiver services, a NOD identifying the effective date and the reason for suspension will be provided to the recipient by the DHCFP LTSS unit.

C. If at the end of 60 days the recipient has not been removed from suspension status, the waiver must be terminated.

D. The DHCFP LTSS unit sends a NOD to the recipient and/or designated representative/LRI advising them of the date and reason for the waiver closure/termination.

E. Waiver services will not be paid for the days that a recipient's eligibility is in suspension status.

2104.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from the hospital, NF or an ICF/IID before 60 days from the admit date, the Service Coordinator must do the following within five working days:

A. Notify the DHCFP LTSS Unit of the release of suspension.

B. Complete a new PCP if there has been a significant change in the recipient's condition needs. If a change in services is expected to resolve in less than 30 days, a new PCP is not necessary. Documentation of the temporary change must be made in the Service Coordinator's notes. The date of the resolution must also be documented in the Service Coordinator's notes.

C. Complete a new Service Authorization, if necessary.

D. Contact the service providers(s) to re-establish services.

2104.3 DENIAL OF WAIVER APPLICATION

Reasons an applicant will be denied for waiver services:

a. The applicant does not meet the criteria of being diagnosed with intellectual or developmental disability.

b. The applicant does not meet the LOC criteria for placement in an ICF/IID).

c. The applicant has withdrawn their request for waiver services.

d. The applicant fails to cooperate with the Service Coordinator or the HCBS providers in establishing and/or implementing the PCP implementing waiver services or verifying eligibility for waiver services.

e. The applicant's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

f. The applicant fails to show a need for HCBS.

g. The applicant would not require imminent placement in an ICF/IID if HCBS were not available. (Imminent placement means within 30 to 60 days.)

h. Another agency or program will provide the services.

i. The ADSD has filled the number of slots allocated to the ID Waiver. The applicant has been approved for the waiver waitlist and will be contacted when a slot is available.

When the application for waiver services is denied the DHCFP LTSS Unit will issue a NOD, within five business days, to the recipient or designated representative/LRI identifying the reason for denial. The Date of Action (DOA) is the same date as the NOD date.

2104.4 TERMINATION OF WAIVER SERVICES

Reasons to terminate a recipient from the waiver:

A. The recipient no longer meets the criteria of an intellectual or developmental disability.

B. The recipient no longer meets the LOC criteria for placement in an ICF/IID.

C. The recipient has requested termination of waiver services.

D. The recipient has failed to cooperate with the Service Coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.

E. The recipient's support system is not adequate to provide a safe environment during the time when HCBS are not being provided. HCBS Waiver services are not a substitute for natural and informal supports provided by family, friends or other available community resources.

F. The recipient fails to show a continued need for HCBS.

G. The recipient no longer requires imminent ICF/IID placement if HCBS Waiver services were not available. (Imminent placement means within 30 to 60 days.)

H. The recipient has moved out of state.

I. Another agency or program will provide the services.

J. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, nursing facility, ICF/IID, or incarcerated) ****See below.

K. The ADSD has lost contact with the recipient.

L. Death of the recipient.

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Waiver slots must be held for 90 days, from the date the NOD is sent to the recipient indicating termination or institutional placement, in case they are released and need waiver services upon release.

2104.5 REDUCTION OR DENIAL OF WAIVER SERVICES

Reasons to reduce or deny waiver services:

a. The recipient no longer needs the number of service/support hours/days which were previously provided.

b. The recipient no longer needs the service/supports previously provided.

c. The recipient's parent and/or designated representative/LRI is responsible for the maintenance, health care, education and support of their minor child or ward.

d. The recipient's support system is providing the service.

e. The recipient has failed to cooperate with the Service Coordinator or HCBS providers in establishing and/or implementing the support plan, implementing waiver services, or verifying eligibility for waiver services.

f. The recipient has requested the reduction of supports/services.

g. The recipient's ability to perform tasks has improved.

h. Another agency or program will provide the service.

i. Another service will be substituted for the existing service.

j. The recipient has reached the authorized unit or annual service limit.

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wait list. If a recipient requests reinstatement after the 90 days expired, they are treated as a new referral.

The Service Coordinator will send a notification to the DHCFP LTSS Unit identifying the reinstatement date.

2104.7 HEARINGS PROCEDURES

Please reference MSM Chapter 3100, Hearings, for hearings procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 27, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

Casey Angres
Casey Angres (Aug 29, 2023 11:51 PDT)

FROM: CASEY ANGRES, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2200 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR THE FRAIL ELDERLY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2200 – HCBS Waiver for the Frail Elderly (FE Waiver) are being proposed to align with the FE Waiver amendment, which was approved by Centers for Medicare and Medicaid Services (CMS) on April 1, 2023, and to bring the Person Centered Planning process into compliance with the HCBS Settings Requirements (42 CFR 441.301(c)(1) – (c)(5)).

Major proposed changes to this chapter include the addition of Legally Responsible Individual (LRI) to the pool of paid caregivers for the provision of personal care like services, addition of private case manager provider, modify waitlist priority, modification to Homemaker Waiver service Coverage and Limitations, updating language throughout to match with CMS requirements regarding the HCBS Settings Final Regulation.

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: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective July 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 09/23 CHAPTER 2200 – HCBS Waiver for the Frail Elderly	MTL 03/21, 12/22 CHAPTER 2200 – HCBS Waiver for the Frail Elderly

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2200	**Introduction**	Reworded for clarity.
2201	**Authority**	Some statutes were added or removed to align with current Federal and State regulations as applicable: Removed Nevada Administrative Code (NAC) Chapters 427A, 441A and 449. Added 42 CFR 441.301(c)(4)(i) through (vi) – HCBS Settings Final Regulation Added NRS 449A.114 – Patient Notification of Intent to Transfer. Added 42 CFR 441.301(c)(1) through (c)(5) – Federal Person-Centered Planning and Settings Requirements.
2203.1	**Waiver Eligibility Criteria**	Terminology and acronyms were updated and reworded for clarity: Section was renumbered.
2203.1A	**Coverage and Limitations**	Terminology and acronyms were updated and reworded for clarity. Waitlist priority was modified and moved to Section 2203.3A – Intake Activities.
2203.1B	**Applicant/Recipient Responsibilities**	Terminology and acronyms were updated and reworded for clarity. Section was renamed to Applicant/ Recipient Responsibilities. Provider Responsibilities moved to Section 2203.2B.
2203.2B	**Provider Responsibilities**	Terminology and acronyms were revised and updated, section reworded, re-formatted, and renumbered for clarity. #4 – Added "Provider Termination Waiver Services." #5 – Added "Discontinuation of Provider Agreement."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		#7 – Added "Flexibility of Service Delivery." #10 – Added section specific to LRI caregivers who can be paid to provide certain waiver services. #12 – Added section "indicating providers must have a backup mechanism in place." #13 – Added section to include "timeframe by which providers must sign and date the finalized Plan of Care (POC)." #14 - Revised language, added "private case management" and detailed public and private case management reporting requirements for Serious Occurrence Reports (SORs). #20 – Removed exemptions from training as it is not applicable to the current requirements. Replaced with "Qualifications and Training."
2203.2C	**Recipient Responsibilities**	Terminology and acronyms were updated. The section reorganized, and language was revised/reworded for clarity. Added language to #5 that provider records must be dated with a signature. Included clarification in the event the recipient is unable to sign documents. Added requirement to #10 to work with case manager and provider to create a back-up plan in case caregiver is unavailable to work. Added requirement that all forms be signed by recipient within 10 calendar days to #15. #17 – Added face-to-face visit, removed "indicating the recipient must meet and maintain all eligibility criteria" as it is duplicative. #20 – Added "actively participate in the person-centered planning process and what must be included in the process."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.3	**Intake Activities**	Case Management section moved to Section 2203.4. Section renamed Intake Activities - detail the intake functions completed by the ADSD Operations Agency.
2203.3A	**Coverage and Limitations**	Added/updated Intake Referral process for new applicants for the FE Waiver program. New process for placing applicants on the waitlist and new waitlist priority levels 1-4 updated/added. Created a new process for waiver slot allocation. Added information on effective date for waiver services once a waiver slot is available. Added information about recipient right to choose Aging and Disability Services Division (ADSD) case manager or private case management agency and process for assigning case management agency once the recipient has chosen and placed on the waiver.
2203.4	**Case Management**	This section was renumbered from Section 2203.3 to Section 2203.4. Added summary description for case management service.
2203.4A	**Coverage and Limitations**	Terminology and acronyms were updated. The content was reorganized, and language was updated/revised, and reworded for clarity and to differentiate between administration case management and billable case management or the purpose of including private case management activities. Created new sections outlining the process for initial assessment, social health assessment, development of the person-centered POC, changes to the POC, POC modifications for individuals in a residential facility for groups (RFG) and/or an assisted living facility for compliance with settings requirements, person-centered contacts, annual reassessments, and other responsibilities to be completed by the case management provider.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.4B	**Provider Responsibilities**	This section was renumbered from Section 2203.3B to Section 2203.4B. #2- Added Private Case Management provider agencies qualifications.
2203.4C	**Recipient Responsibilities**	This section was renumbered from Section 2203.3C to Section 2203.4C. #3 – Added "Choose a Medicaid enrolled case management provider."
2203.5	**Homemaker Services**	This section renumbered from Section 2203.4 to Section 2203.5.
2203.5A	**Coverage and Limitations**	Terminology and acronyms were updated/revised and reworded for clarity. #6 - Added "live-in LRIs are limited to up to two hours per week. Non-live-in LRI service hours will be based on the case manager's assessment."
2203.5B	**Provider Responsibilities**	#1 - Revised language to be more concise and indicate specific training requirements for Homemaking.
2203.5C	**Recipient Responsibilities**	Terminology and acronyms were updated, revised, and reworded.
2203.6	**Chore Services**	Section was reworded and renumbered from Section 2203.5 to Section 2203.6.
2203.6A	**Coverage and Limitations**	#1- Added "The service must be identified on the POC and approved by the case manager."
2203.6B	**Provider Responsibilities**	Removed "be able to read, write and follow written and oral instructions." #1 – Added language to provide adequate training specific to chore services to ensure recipient's safety.
2203.6C	**Recipient Responsibilities**	Renumbered.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.7	**Respite Care**	This section was renumbered from Section 2203.6 to Section 2203.7.
2203.7B	**Provider Responsibilities**	Removed "have the ability to read and write and to follow written or oral directions." #1 – Added language indicating provider must have adequate training specific to respite to be able to provide service to recipient in a safe manner. Moved "to be tolerant of the varied lifestyles of the people served" to All Providers section. Removed sentence indicating providers must demonstrate the ability to perform the care tasks.
2203.7C	**Recipient Responsibilities**	Section was renumbered.
2203.8	**Home Delivered Meals**	Section renumbered from Section 2203.7 to Section 2203.8.
2203.8A	**Coverage And Limitations**	#4 - Added limitation not to exceed two meals per day. #5 - Added to state that case managers determine the services based on assessment and personal interview with the recipient. (Subsequent renumbering).
2203.8B	**Provider Responsibilities**	Deleted section detailing NRS requirements and revised to indicate "All Nutrition Programs must follow the Health and Safety Guidelines for Food and Drink Establishment in accordance with NRS, Chapter 446 or local health code regulations. Removed all Provider requirements to be enrolled as Waiver Medicaid Provider as it is not necessary and can be referred to Provider Enrollment Checklist or Fiscal Agent Website.
2203.8C	**Recipient Responsibilities**	#2 – Reworded for clarity to indicate that the recipient must notify their case manager if the authorized number of meals is not received.
2203.9	**Personal Emergency Response (PERS)**	This section was renumbered from Section 2203.8 to Section 2203.9.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed "connected to recipients' phone," to reflect the updated service technology.
2203.9A	**Coverage and Limitations**	Removed "or as identified to mitigate other safety risks or concerns" in #1 for clarification. Paragraph reworded to reflect the initial installation and ongoing monitoring are covered under the waiver service, for clarity.
2203.9B	**Provider Responsibilities**	Minor deletions and additions were made for clarity. Added # 5 – This service must be prior authorized.
2203.9C	**Recipient Responsibilities**	Minor deletions and additions were made for clarity.
2203.10	**Adult Day Care Services**	This section was reformatted and renumbered from Section 2203.9 to Section 2203.10.
2203.10A	**Coverage and Limitations**	Revised, updated language, and rearranged. Removed "six hours or more" and replaced with "maximum of six hours per day."
2203.10B	**Provider Responsibilities**	Removed meet and maintain the service specifications as an adult day care provider as outlined in NAC 449 "Medical Facilities and other Related Entities." Removed: language detailing service utilization and billing method for simplicity. #1 – Added to detail how provider must bill depending on number of hours attended. #2 – Added CM may authorize up to six hours. #3 – Added detailing recipient's patterns which may require change in service hours.
2203.11	**Adult Companion Services**	This section was renumbered from Section 2303.10 to Section 2303.11.
2203.11A	**Coverage and Limitations**	#5 – Added paid LRI – limit to two hours.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2203.11B	**Provider Responsibilities**	Section was renumbered.
2203.12	**Augmented Personal Care**	This section was renumbered from Section 2203.11 to Section 2203.12. First paragraph updated to include Meets the HCBS settings requirements.
2203.12A	**Coverage and Limitations**	#4 – Was reworded to clarify that Federal Financial Participation (FFP) is not available for room and board. #8 – Removed and moved down to Provider Responsibilities and incorporated HCBS Requirement.
2203.12B	**Provider Responsibilities**	Removed "Augmented Personal Care" from title for consistency. This section was reworded and updated language. #3 and its subsection – Added to include HCBS Settings Requirements.
2203.13	**Electronic Visit Verification (EVV)**	This section was reformatted and renumbered from Section 2203.15 to Section 2203.13.
2203.14	**DHCFP LTSS Initial Review**	Renamed "Annual Waiver Review" and removed language pertaining to annual review. Replaced with language specific to intake reviews by DHCFP Long Term Supportive Services (LTSS).
2203.15	**Waiver Costs**	This title was moved from Section 2203.13A.
2203.16	**Quality Assurance Waiver Review**	This section was added to specify Quality Assurance (QA) review must be conducted in accordance with CMS regulations.
2203.17	**Provider Enrollment**	This section was renumbered from Section 2203.16 to Section 2203.17. Section updated to include language that all providers must maintain a Medicaid services agreement and

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		comply with criteria set forth in Nevada MSM Chapter 100 and MSM Chapter 2200.
2203.18	**Billing Procedures**	This section was renumbered from Section 2203.17 to Section 2203.18.
2203.19	**Advance Directives**	This section was renumbered from Section 2203.18 to Section 2203.19. Language re-worded for clarity to include the case manager must provide information on Advance Directives.
2204	**Hearings Requests Due to Adverse Actions**	Wording updated to include "recipient" and "applicant" to reflect hearing requests from new applicants as well as current waiver recipients.
2204.1	**Suspended Waiver Services**	This section was re-numbered.
2204.2	**Release From Suspended Waiver Services**	This section was re-numbered.
2204.3	**Denial of Waiver Eligibility**	This section was re-titled from Denial of Waiver Application to Denial of Waiver Eligibility, for clarification. Renumbered. #K – Added Waiver waitlist priorities.
2204.4	**Reduction or Denial of Direct Waiver Services**	This section was added to detail the process of when a particular waiver service is denied or reduced.
2204.5	**Termination of Waiver Eligibility**	This section was renumbered from Section 2204.4 to Section 2204.5.
2204.6	**Reauthorization within 90 days of Waiver Termination**	Terminology and acronyms were updated per the description provided in the Background and Explanation section above.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2204.6A	**Coverage and Limitations**	#3 – Reworded and deleted some language for simplicity and clarity.
2204.6B	**Provider Responsibilities**	Section was updated to include a process to ensure that appropriate action is taken by the case manager when a recipient is reauthorized.
2204.6C	**Recipient Responsibilities**	#2 – Added language to indicate that if recipient is discharged after the 90th day from the date of action on the Notice of Decision (NOD) they must re-apply for waiver services.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

HOME AND COMMUNITY BASED WAIVER (HCBW) FOR THE FRAIL ELDERLY

2200 INTRODUCTION

The Home and Community-Based Services (HCBS) Waiver for the Frail Elderly (FE Waiver) recognizes that many individuals at risk of being placed in hospitals or Nursing Facilities (NF) can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of an institutional care.

The FE Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) the flexibility to design this waiver and select the mix of waiver services that best meet the goals of the program. This waiver allows the provision of services based on the identified needs and is designed to provide eligible Medicaid waiver recipients access to both state plan services as well as certain extended Medicaid covered services. Nevada acknowledges that people who are elderly are able to lead satisfying and productive lives when they are provided the needed services and supports to do so.

2201 AUTHORITY

Section 1915(c) of the Social Security Act (SSA) permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization.

Statutes and Regulations:

- Social Security Act: 1915(c) (HCBW)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 629 (Healing and Arts Generally)
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act
- 42 CFR 441.301(c)(4)(i) through (vi) – HCBS Settings Final Regulation
- NRS 449A.114 – Patient Notification of Intent to Transfer
- 42 CFR 441.301(c)(1) through (c)(5) – Federal Person-Centered Planning and Settings Requirements.

2202 RESERVED

2203 POLICY

2203.1 WAIVER ELIGIBILITY CRITERIA

The FE Waiver waives certain statutory requirements and is offered to eligible recipients to assist them to remain in their own homes or community.

Eligibility for the FE Waiver is determined by the Aging and Disability Services Division (ADSD) and the Division of Welfare and Supportive Services (DWSS).

A. Applicants must be 65 years of age or older.

B. Each applicant/recipient must meet and maintain a Level of Care (LOC) for admission into a NF and would require imminent placement in a NF (within 30 days or less) if HCBS or other supports are not available.

C. Each applicant/recipient must demonstrate a continued need for the services offered under the FE Waiver to prevent placement in a NF or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.

D. Each applicant/recipient must require the provision of one ongoing waiver service monthly.

E. Each applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met in order to provide a safe environment during the hours when HCBS services are not being provided.

F. Applicants may be placed from a NF, an acute care facility, another HCBS program, or the community.

G. Applicants must meet Medicaid financial eligibility as determined by DWSS initially and for redetermination.

H. Additional requirements for Residential Facility for Groups and Assisted Living Facility.

1. Applicant/recipient must meet the criteria for placement in a Category 1 or 2 Residential Facility as defined by NAC 449.1591 and 449.1595.

2. Residential Group Homes for Seniors and Assisted Living Facility must have the appropriate endorsement for the admission from Health Care Quality and Compliance (HCQC).

2203.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or NF) within 30 days or less.

2. Recipients on this waiver must meet and maintain Medicaid's eligibility requirements for the waiver for each month in which waiver services are provided.

3. Services shall not be provided and will not be reimbursed until the applicant/recipient is found eligible for waiver services and must be prior authorized.

4. If an applicant is determined eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBS Waiver and receive services provided by that program.

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

6. Waiver services may not be provided while a recipient is an inpatient of an institution. Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting as long as those services are:

   a. Identified in an individual's person-centered service plan (or comparable Plan of Care (POC);

   b. Provided to meet needs of the individual that are not met through the provision of hospital services;

   c. Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

   d. Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

7. The FE Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When no waiver slots are available, the ADSD utilizes a wait list to prioritize applicants who have been presumed to be eligible for the waiver.

8. DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that DHCFP's total expenditure for HCBS and other State Plan Medicaid services for all recipients under

this waiver will not, in any calendar/waiver year, exceed 100% of the amount that would be incurred by DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.

2203.1B APPLICANT/RECIPIENT RESPONSIBILITIES

Applicants/recipients must meet and maintain all criteria to become eligible and remain on the FE Waiver.

Additionally, applicants and/or their designated representative/Legally Responsible Individual (LRI) must:

1. Participate and cooperate with the Intake Specialist during the intake process;

2. Complete and sign all required waiver forms.

2203.2 WAIVER SERVICES

DHCFP determines which services will be offered under the HCBS Waiver. Providers and recipients must agree to comply with all waiver requirements for service provision.

2203.2A COVERAGE AND LIMITATIONS

Under this waiver, the following services are covered if identified in the POC as necessary to remain in the community and to avoid institutionalization.

1. Case Management.

2. Homemaker Services.

3. Chore Services.

4. Respite Care Services.

5. Home Delivered Meals.

6. Personal Emergency Response System (PERS).

7. Adult Day Care Services.

8. Adult Companion Services.

9. Augmented Personal Care (provided in a residential facility for groups).

2203.2B PROVIDER RESPONSIBILITIES

1. Must obtain and maintain a Medicaid provider number (Provider Type 48, 57, 58 Specialty Code 204 or 59 as appropriate) through DHCFP's Fiscal Agent.

2. All providers must meet all federal, state, and local statutes, rules and regulations relating to the services being provided.

3. In addition to this Chapter, the providers must also comply with rules and regulations as set forth in the MSM Chapter 100 Medicaid Program. Failure to comply with any or all these stipulations may result in DHCFP's decision to exercise its right to terminate the provider's contract.

4. Provider Termination of Waiver Services:

   a. The provider may terminate direct waiver services without notice for any of the following reasons:

      1. The recipient or another person in the household subject the provider to physical or verbal abuse, sexual harassment, and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

      2. The recipient's Medicaid eligibility is found ineligible for waiver services;

      3. The recipient requests termination of services;

      4. The place of service is considered unsafe for the provision of waiver services;

      5. The recipient refuses services offered in accordance with the approved POC;

      6. The recipient is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

      7. The provider is no longer able to provide services as authorized;

      8. The recipient requires a higher level of care that cannot be met by the waiver service.

      NOTE: A provider's inability to provide services for a specific recipient does not constitute termination or denial from the HCBS Waiver program. The recipient may choose another provider.

b. Notification Requirements

As appropriate, the provider must notify the recipient and/or designated representative and agencies of the date when services are to be terminated. The case manager should be notified within five business days prior to the date services will be terminated. The basis for the action and the intervention/resolution(s) attempted must be documented prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

5. Discontinuation of Direct Waiver Service Provider Agreement

If a provider decides to discontinue providing waiver services for any reason not listed in 2203.2B(4) – Provider Termination of Waiver Services, the provider shall:

a. Provide the recipient with written notice at least 30 calendar days in advance of service discontinuation;

b. Provide the recipient's case manager with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and

c. Continue to provide services through the notice period or until all recipients are receiving services through another provider, whichever occurs sooner.

6. Must understand the authorized service specification on the POC, record keeping responsibilities and billing procedures for provided waiver services.

7. Flexibility of Service Delivery

The total weekly authorized hours for ADLs and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.

8. Must be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.

9. Must understand that payment for services will be based on the level of service or specific tasks identified in the POC.

10. LRI may be paid to provide activities that family caregivers would not ordinarily perform or are not responsible for performing. Additional dependence on LRIs is above the scope of normal daily activities such as assistance in bathing, dressing, grooming, and toileting.

    LRIs may furnish homemaker, respite, chore services, and Adult Companion (refer to the direct waiver service type throughout this chapter for additional limitations). It must be the recipient's choice for the LRI to provide the services, which is achieved thorough the person-centered Plan of Care (POC) development.

    a. LRIs cannot provide State Plan Personal Care Services (PCS) in conjunction with any of the waiver services. State Plan PCS does not allow payment of LRIs.

    b. The LRI must be an employee of provider agencies PT 48 with SC 039, 191, 199, and 208.

    c. LRIs must utilize an Electronic Visit Verification (EVV) system for check in/check out.

11. All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required.

12. Must have a backup mechanism to provide the recipient with their authorized service hours in the absence of a regular caregiver due to sickness, vacation, or any other unscheduled event. The provider must notify the recipient's case manager if there is a change in the established back-up plan.

13. Sign and date the finalized POC within 60 calendar days from waiver enrollment. If a service has been included in the POC and there is no provider assigned, the signature would not be required until the provider is selected by the individual and would be required by the next face-to-face visit.

14. Serious Occurrence Report (SOR)

    All direct waiver service providers are required to report a SOR within 24 hours of discovery. A written report must be submitted to the assigned case manager within five business days. All providers are required to maintain a copy of the reported SOR in the recipient's record. It is the provider's responsibility to understand the proper reporting method to the assigned case management provider and participate with any requested follow-up timely.

    Reporting of a SOR can be in paper form or electronic format which is accessible to all direct waiver service providers, public, and State staff via DHCFP's public website and

DHCFP Fiscal Agent's website. The process for reporting incidents will vary depending on the case management provider. The direct waiver service providers are responsible to know who the case manager is and the proper form of submission.

Due to the different databases utilized by case management providers the process for submitting a SOR are as follows:

a. Public ADSD case management:

Providers must complete the web-based Nevada DHCFP SOR Form, available at the Fiscal Agent's website (https://medicaid.nv.gov), under Providers Forms. Upon receipt of the submitted electronic form the ADSD case manager will perform the necessary follow-up.

b. Private Case Management (PCM):

Providers must complete the SOR paper form available on the public facing Fiscal Agent website (https://medicaid.nv.gov) located under Provider Forms. The completed SOR form must be submitted to the DHCFP LTSS inbox at hcbs@dhcfp.nv.gov to be re-routed to the PCM agency who will enter the SOR in their database and perform the necessary follow-up.

Serous occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

1. Suspected physical or verbal abuse;
2. Unplanned hospitalization;
3. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;
4. Injuries requiring medical intervention;
5. Sexual harassment or sexual abuse;
6. Theft;
7. An unsafe living environment;
8. Elopement of a recipient;
9. Medication errors resulting in injury, hospitalization, medical treatment, or death; Death of the recipient while enrolled in the HCBS Waiver program;
10. Loss of contact with the recipient for three consecutive scheduled days;

11. Any event which is reported to the Division of Child and Family Services (DCFS) or the appropriate county agency (under 18 years old); Adult Protective Services (APS) (18 years old and above), or law enforcement agencies.

The State of Nevada has established mandatory reporting requirements of suspected incidents or abuse, neglect, isolation, abandonment, and exploitation. APC, DHCFS, and/or local enforcement are the receivers of sub reports. Suspected abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that a person has been abused, neglected, isolated, abandoned, or exploited. Refer to NRS 200.5091 to 200.50995 "Abuse, Neglect, Exploitation, Abandonment, or Isolation of Older and Vulnerable Persons."

15. Criminal Background Checks

DHCFP policy requires all waiver providers and its personnel, including owners, officers, administrators, managers, employees, and consultants must undergo State and FBI background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred. For complete instructions, refer to the Division of Public and Behavioral Health (DPBH) website at https://dpbh.nv.gov .

DHCFP's fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100 – Medicaid Program.

16. Recipient Records

a. The number of units specified on each recipient's POC, for each specific service will be considered the maximum number of units allowed to be provided by the caregiver and paid by DHCFP's Fiscal Agent, unless the case manager has approved an increase in service due to a temporary condition or circumstance.

b. Cooperate with DHCFP and ADSD, and/or State or Federal reviews or inspections of the records.

c. Provider agencies who provide waiver services in the home must comply with the 21st Century Cures Act. Refer to Section 2203.13 of this chapter for detailed information.

17. Adhere to HIPAA Requirements.

Refer to MSM Chapter 100 – Medicaid Programs for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information (PHI).

18. Obtain and maintain a business license as required by city, county, or state government if applicable.

19. Providers must obtain and maintain required HCQC license if required.

20. Qualifications and Training:

    a. All service providers must arrange training for employees who have direct contact with recipients of the FE Waiver and must have service specific training prior to performing a waiver service. Training at a minimum must include, but not limited to:

        1. Policies, procedures, and expectations of the agency relevant to the provider, including recipient's and provider's rights and responsibilities;

        2. Record keeping and reporting including daily records and SORs;

        3. Information about the specific needs and goals of the recipients to be serviced;

        4. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences, be tolerant of varied lifestyles, recognizing family relationships; confidentiality; abuse, neglect, and exploitation, including signs, symptoms, and prevention; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflict and complaints; and other topics as relevant.

        5. Paid and unpaid staff must receive one hour of training related to the rights of the individual receiving services and individual experience outlined in the HCBS Final Regulation.

2203.2C RECIPIENT RESPONSIBILITIES

The recipient or, if applicable, the recipient's designated representative/LRI will:

1. Notify the provider(s) and the case manager of any change in Medicaid eligibility.

2. Notify the direct provider(s) and DWSS of current insurance information, including the name of the insurance coverage, such as Medicare.

3. Notify the provider(s) and/or case manager of changes in medical status, support systems, service needs, address, or location changes, and/or any change in status of designated representative/LRI.

4. Treat all providers and staff members appropriately. Provide a safe, non-threatening, and healthy environment for caregiver(s) and the case manager(s).

5. Sign and date the provider(s) record(s) as appropriate to verify services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the Statement of Choice (SOC) and/or Plan of Care (POC), as appropriate.

6. Notify the provider or case manager when scheduled visits cannot be kept or services are no longer required.

7. Notify the provider agency or case manager of any missed appointments by the provider agency staff.

8. Notify the provider agency or case manager of any unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver or provider agency.

9. Furnish the provider agency with a copy of their Advance Directive if appropriate.

10. Work with the provider agency to establish a back-up plan in case the caregiver is unable to work at the scheduled time, and report to the case manager if there is a change to the established back-up plan.

11. Not request a provider to work more than the hours authorized in the POC.

12. Understand that a provider may not work or clean for a recipient's family, household members, or other persons living in the home with the recipient.

13. Not request a provider to perform services not included in the POC.

14. Contact the case manager to request a change of provider agency.

15. Complete, sign, date, and submit all required forms within ten calendar days.

16. Understand that at least one annual face-to-face visit is required.

17. Be physically available for authorized waiver services, face-to-face visits, and assessments.

18. Agree to utilize an approved Electronic Visit Verification (EVV) system for the waiver person care-like services being received from the provider agency; and

19. Confirm services were provided by electronically signing or initialing as appropriate per services plan, the EVV record that reflects the service rendered. If Interactive Voice Response (IVR) is utilized, a vocal confirmation is required.

20. Actively participate in the development of the POC which allows the recipient to make informed choices.

2203.3 INTAKE ACTIVITIES

Intake activities are a function of the ADSD Operations Agency and occur prior to an applicant being determined eligible for a waiver.

2203.3A COVERAGE AND LIMITATIONS

1. Intake Referral Process

ADSD Operations Agency has developed policies and procedures to ensure fair and adequate access to services covered under the FE Waiver. All new referrals will be submitted to the ADSD Intake Unit for evaluation and processing.

a. Referral/Application

1. A referral for the FE Waiver may be initiated by completing an ADSD Program Application and submitting it to the appropriate ADSD District Office by mail, email, fax, or in person by the applicant and/or designated representative/LRI.

NOTE: An inquiry for the FE Waiver may be made via phone, mail, email, fax, or in person through any ADSD District Office. An inquiry is not considered an application for the FE Waiver and does not initiate the application process.

2. When an application is received and assigned, the ADSD Intake Specialist will make phone, email, or verbal contact with the applicant and/or designated representative/LRI within 15 working days of receipt of the application.

3. A face-to-face visit is scheduled by the ADSD Intake Specialist within 45 days of the application date to assess the LOC and complete all necessary intake forms. The LOC assessment will determine the applicant's eligibility for waiver services and placement on the waitlist, if appropriate.

application process through DWSS. The applicant will also be referred to other agencies and community resources for services and/or assistance.

2. Placement on the Wait List when No Waiver Slot is Available

a. If no Waiver slot is available, and the ADSD Intake Specialist has determined the applicant meets NF LOC, and has a Waiver service need, the applicant will be placed on the waitlist according to priority and referral date.

Wait List Priority:

Level 1: Applicants previously in a hospital or NF and who have been discharged to the community within six months and have significant change in support systems are in a crisis situation;

Level 2: Applicants who have significant change in support system and/or in a crisis situation and require at least maximum assistance in combination of four or more of the following ADLS: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating, and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

b. Applicants may be considered for an adjusted placement on the waitlist based on a significant change of condition/circumstances.

c. A denial NOD is sent to applicants who are placed on the waitlist indicating "no slot available" and will indicate the applicant's priority level on the waitlist.

3. Waiver Slot Allocation

Once a slot for the waiver is available, the applicant will be processed for the waiver.

The procedure used for processing an applicant is as follows:

a. The ADSD Intake Specialist will work with the applicant to complete any paperwork that was not collected during the initial assessment.

a. The ADSD Intake Specialist will work with the applicant to complete any paperwork that was not collected during the initial assessment.

b. The applicant/designated representative/LRI must understand and agree that personal information may be shared with providers of services and others, as specified on the form.

c. The applicant will be given the right to choose waiver services in lieu of placement in a NF. If the applicant/designated representative/LRI prefers placement in a NF, the ADSD Intake Specialist will provide information and resources to the applicant on who to contact to arrange facility placement.

d. The applicant will be given the right to request a Fair Hearing if not given a choice between HCBS Waiver services and NF placement.

4. The ADSD Intake Specialist will send the NMO-3010 "HCBS Waiver Eligibility Status Form" to DWSS for review and approval of the Medicaid application.

5. Once DWSS has approved the application, waiver services can be initiated.

NOTE: If an applicant is denied for financial eligibility, DWSS will send a denial NOD to the applicant.

6. If the applicant is denied by ADSD for program eligibility, ADSD will submit a request to the DHCFP Long Term Services and Support (LTSS) Unit requesting a denial NOD be sent to the applicant. The request must include the reason(s) for the denial. The DHCFP LTSS Unit will send the applicant the denial NOD. DHCFP will return a copy of the NOD to ADSD for their record.

7. Effective Date for Waiver Services

The effective date for waiver services is determined by eligibility criteria verified by ADSD, the financial eligibility approval date by DWSS, or the residential facility for groups placement move in date, whichever is later.

If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

8. All applicants as applicable will be provided information regarding choice of case management providers by the ADSD Intake Specialist during the initial assessment and allowed the opportunity to choose a case management provider to be assigned once approved for waiver services. If a case management provider is not selected by the applicant/recipient, upon waiver approval one will be assigned by the ADSD Operations Agency based upon rotation.

Once an applicant has been approved and a case management provider is assigned, the ADSD Intake Specialist will forward all supporting documents within five business days to that provider for ongoing case management services.

Supporting documents include a signed and dated SOC, a signed and dated HCBS Acknowledgement Form, copy of the ADSD Program Application, copy of the LOC, any notes from the Intake Specialist needed to support ongoing services, and a copy of the MAABD application submitted to DWSS.

NOTE: If a case management provider is not selected within ten business days by the applicant, one will be assigned by the ADSD Operations Agency based upon a rotation schedule and provider capacity.

2203.4 CASE MANAGEMENT

Case management services assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

2203.4A COVERAGE AND LIMITATIONS

Case managers must provide the recipient with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. case management service is on an as needed basis. case managers must, at a minimum, have an annual face-to-face visit and ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

1. Case management is provided to eligible recipients enrolled in HCBS Waiver programs and must be identified as a service on the POC. Case management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice of case management providers who are actively enrolled with DHCFP under Provider Type (PT) 48.

   There are two components of case management services: administrative activities and those activities that are considered billable:

   Administrative activities include:

   a. Travel

   b. Follow-up conducted from resulting from a negative Participant Experience Survey (PES) finding.

c. Request a NOD when a negative action is taken (denial, suspension, termination, and reduction of services)/

d. Any activities related to program eligibility denials/Fair Hearings.

e. Activities related to coordination of care for recipients in a suspended status.

f. General administrative tasks including but not limited to scheduling of visits, voicemails, email communication with DHCFP, scanning and uploading documents, mailing provider list and/or resources to recipient telephoning providers for general availability, and outreach activities for solicitation.

Billable case management activities include:

a. Completion of the Social Health Assessment (SHA) and LOC with the recipient (annual reassessment of eligibility and any change of condition).

b. POC development and follow-up for initiation of waiver services, including any activity related to the Prior Authorization (PA) requests approval and/or follow-up.

c. POC monitoring/follow-up (includes provider changes, a change in services/delivery, change in condition resulting in an amended POC, etc.)

d. Any mandated reporting activity (APS, HCQC, Law Enforcement, etc.)

e. Direct contact with recipients to aid in resource navigation, facilitation, and coordination with waiver and community resources.

f. Care Conference: collaboration and involvement in discharge planning from a long-term care setting, interdisciplinary meetings, collaboration with other entities on shared cases, coordination of multiple services, and/or providers based on the identified needs in the SHA.

g. Monitoring the overall provision of waiver services, to protect the health, welfare, and safety of the recipient, and to determine that the POC goals are being met.

h. Monitoring and documenting the equality of care through contacts with recipients.

i. Ensuring that the recipient retains freedom of choice in the provision of services.

j. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes on the status of the designated representative/LRI.

k. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient.

l. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff.

m. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

n. Any adverse actions resulting in suspension, terminations, and/or reductions in services.

2. Upon assignment of an HCBS FE Waiver recipient, the case manager is responsible for conducting a face-to-face SHA and is used for the following:

a. Address the recipient's needs, preferences, and individualized goals.

b. Address ADLs, IADLs, service needs, and support systems.

c. Gathering information regarding health status, medical history, and social needs.

d. Considers risk factors, equipment needs, behavioral status, current support system, and unmet service needs.

e. Ensures recipients are afforded the same access to the greater community as individuals who do not receive Medicaid HCBS, regardless of where they reside.

3. The person-centered POC is developed in conjunction with the case manager, recipient/designated representative/LRI, and/or a person of their choosing initially, annually, and when changes occur.

If the recipient chooses to have a designated representative/LRI, they must complete the Designated Representative Attestation form. The case manager is required to document the designated representative/LRI who can sign documents and be provided information about the recipient's care.

a. The initial and annual written POC must reflect the services and supports that are important for the recipient to meet the needs identified through the SHA, as well as what is important to the recipient regarding preference for the delivery of such services and supports and:

1. Reflect that the setting in which the recipient resides was chosen by the recipient;

2. Reflect opportunities to participate in integrated community settings, and seek employment or volunteer activities;

3. Reflect the recipient's strengths and preferences, and cultural considerations of the recipient;

4. Include identified personalized goals and desired outcomes, and reflect the services and supports (paid and unpaid) that will assist the recipient in achieving their identified goals;

5. Reflect risk factors and measures in place to minimize them, including back-up plans and strategies;

6. Be understandable to the recipient receiving the services and supports; and

7. Prevent the provision of unnecessary, duplicative, or inappropriate services and supports.

b. The recipient is afforded choice of service and providers, establishing the frequency, duration and scope, and method of service delivery are integrated in the planning process to the maximum extent possible.

NOTE: During the POC development, if the recipient chooses an LRI to provide personal care like services, the case manager will provide a Designated Representative Attestation form to be signed by the recipient and/or the designated representative/LRI who is NOT the paid caregiver to guard against self-referral of LRIs. The designated representative/LRI indicated on the form is responsible for directing, monitoring, and supervising the provision of services by the caregiver.

c. The POC must identify all authorized waiver services, as well as other ongoing community-support services that the recipient needs to remain in their home and live successfully in the community.

1. During the initial or annual POC development, there is no chosen direct wavier provider. The service must still be listed on the POC to include the other elements with the providers To Be Determined (TBD) and must be signed and dated by the recipient or designated representative/LRI. Documentation to support the efforts made by the case manager and the recipient to choose and assign a provider must be in the recipient's electronic record.

2. Once a provider has been selected, the POC listing the provider must be updated with the date and signatures from the recipient and/or designated representative/LRI and provider during the next face-to-face visit.

d. The POC must include the recipient's chosen method and frequency of scheduled contacts (refer to Section 2203.4A(4) – Person Centered contacts for further information on frequency).

e. Changes to the POC

1. If there is a change (as defined in the MSM Addendum) to the established LOC, the recipient must be reassessed and the LOC and POC must be updated within 30 days of the reported change.

2. The POC does not need to be revised when the recipient's waiver service needs change due to a temporary condition or circumstance lasting eight weeks or less. The case manager must document the change in the electronic record.

3. When the case manager needs to update the current POC, the case manager can print the current POC and note any changes for the recipient and/or designated representative/LRI to sign. The case manager will formalize the updated POC within the electronic case file.

a. The POC with the handwritten changes/amendments containing the recipient and case manager's signature and date must be attached to the formalized POC and kept in the recipient's electronic case file.

b. A copy of the formalized POC and signed handwritten POC must be provided to the recipient and/or designated representative/LRI.

f. The POC must be finalized within 60 calendar days from waiver enrollment, date of reassessment, or significant change. The finalized POC must be signed and dated by the recipient and/or designated representative/LRI, case manager, and provider.

g. The case manager is responsible for distributing the section of the POC which pertains to the specific waiver provider to include the scope, frequency, duration and method of service delivery, recipient's identified goals, risk factors, and mitigation.

h. Residential (RFG and AL Facilities) and Non-Residential (Adult Day Care)

When a modification is made on the POC that restricts a recipient's freedom of choice, it must be supported by a specific assessed need and justified in the POC. The direct service provider must notify the case manager to request modification of the POC.

The case manager must document the following requirements on the POC:

1. Identify a specific and individualized assessed need;

2. Document the positive interventions and supports used prior to any modification to the POC;

3. Document less intrusive methods of meeting the need that have been tried but did not work out;

4. Include a clear description of the condition that is directly proportionate to the specific assessed need;

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

7. Include an assurance that interventions and supports will cause no harm to the individual; and

8. Include the informed consent of the individual.

4. Person-Centered Contacts

a. Person-centered contacts are required to be delivered by the ~~C~~case ~~M~~management provider as agreed to in the signed POC. At a minimum, there must be a face-to-face visit with each recipient and/or designated representative/LRI annually. All other ongoing contact methods may be determined by the recipient.

NOTE: When case management is the only waiver service received, the case manager will continue to have monthly contact with the recipient and/or designated representative/LRI to ensure the health and welfare of the recipient. The duration, scope, and frequency of case management services billed to DHCFP must be adequately documented and substantiated by the case manager's narratives.

b. Person-centered contacts must be documented in the recipient's electronic record and must include at a minimum:

1. Monitoring of the overall provision of waiver services and determining that the personalized goals identified in the POC are being met.

2. Monitoring and documenting the quality of care to include assurance the health and safety of the recipient is maintained.

a. Quality of care included the identification, remediation, and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service, satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.

b. If a recipient resides in a residential setting (AL Facility), the case manager must inquire on the recipient's satisfaction in the residential setting.

3. Case managers must demonstrate due diligence to hold ongoing contacts as outlined in the POC (frequency and method). Ongoing contacts are required, and every attempt to contact the recipient should be documented. At least three telephone calls must be completed on separate days, if no response is received after the third attempt, a letter must be sent to the recipient requesting a return contact. If the recipient fails to respond by the date indicated in the letter, the recipient may be terminated.

4. If an LRI is chosen by the recipient to provide paid personal care like services in their private home, the case manager will conduct more frequent home visits (no less than bi-annually in person and quarterly by telephone) to ensure the recipient is satisfied with the waiver services and caregiver.

5. Annual Reassessments

a. The recipient's LOC and SHA must be reassessed at a minimum annually.

1. Once the case manager has completed the reassessment including the LOC, SHA, and POC, the case manager will submit the completed LOC to the Operations Agency for approval.

2. Once received by the Operations Agency, a review of the LOC will be conducted, and a decision will be supplied to the case manager provider within five business days.

3. Upon receipt of the approval from the Operations Agency, the case manager will complete the PA process for continued services.

4. If the ADSD Operations Agency determined the LOC is not approved, communication will be delivered to the case management provider within five business days identifying the outcome and the next steps as appropriate.

b. The POC is updated using the SHA which is completed in collaboration with the case manager and the recipient and/or designated representative/LRI, and/or person of their choosing, who may not be their paid caregiver.

c. The annual POC is required to be signed no more than 60 calendar days from the date of the reassessment.

6. The case manager may provide support to the recipient and/or designated representative/LRI by assisting with the completion of the DWSS Annual Redetermination (RD).

7. Ensure recipients retain freedom of choice in the provision of services. During the ongoing contact with the recipient the case manager must narrate if a recipient indicates that they are not satisfied with their current waiver services.

8. Notifying all affected providers of any unusual occurrences or change in the recipient's medical status, service needs, address, or designated representative/LRI.

9. Notifying all affected providers of any recipient complaints regarding delivery of service of specific provider staff.

10. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

11. Case closure activities upon termination of service eligibility, to include notifying DWSS and DHCFP LTSS, and closing any existing PAs.

12. If an ongoing recipient chooses to change case management providers, they may request this by contacting the ADSD Operations Agency as outlined in the SOC. The ADSD Operations Agency will provide the recipient with a list of case management providers for them to choose from. If a new case management provider is not chosen within ten calendar days, the currently assigned case manager will continue to provide the service.

a. Upon provider selection by the recipient and/or designated representative/LRI, the Operations Agency will notify the selected case management provider agency of the assignment.

b. The previous case management agency will be given ten business days to provide all requested documentation to the ADSD Operations Agency to assist with the transfer of the recipient to the chosen case management provider.

c. The new case management provider agency must be reflected on the POC which is required to be signed during the next face-to-face visit.

13. Case managers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.

2203.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B: must:

1. Public case managers must meet the following qualifications:

   a. Be currently licensed as Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

   b. Have a valid driver's license and means of transportation to enable face-to face visits.

   c. Adhere to HIPAA requirements.

   d. Complete an FBI criminal background check.

2. Private case management provider agencies must:

   a. Provide documentation showing taxpayer identification number (SS or CP575 or W-9).

   b. Provide proof of Nevada Secretary of State Business license.

   c. Provide proof of Worker's Compensation Insurance.

   d. Provide proof of an Unemployment Insurance Account.

   e. Provide proof of Commercial General Liability of not less than $2 million general aggregate and $1 million each occurrence, with Nevada DHCFP named as an additional insured. DHCFP's address is 1100 East William Street, Suite 101, Carson City, Nevada 89701.

   f. Provide proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. The policy must name DHCFP as an additional insured.

   g. If you provide transportation in any owned, leased, hired, and non-owned vehicles, you must also provide:

1. Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired, and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language. "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired, or borrowed by the Contractor."

h. Provide a signed Business Associate Addendum (NMH-3820). The Addendum is available at https://www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents".

i. Establish a fixed business landline telephone number published in a public telephone directory.

j. Have a business office accessible to the public during established and posted business hours.

k. Case managers/employees of the private case management agency must also meet the following qualifications:

1. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

2. Have a valid driver's license and means of transportation to conduct home visits.

3. Adhere to HIPAA requirements.

4. Complete an FBI criminal background check.

2203.4C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. Participate in the ongoing contacts and reassessment process, accurately representing their skill level needs, preferences, resources, and goals.

2. Together with the case manager, develop and/or review, sign, and the date the POC. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file.

3. Choose a Medicaid enrolled case management provider.

2203.5 HOMEMAKER SERVICES

Homemaker services consist of IADLs such as general household tasks, meal preparation, shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution.

2203.5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided at the recipient's home, or place of residence (community setting).

2. Services must be directed to the individual recipient and related to their health and welfare.

3. DHCFP or its Fiscal Agent and case management providers are not responsible for the replacement of goods damaged in the provision of service.

4. Homemaker services include:

   a. General household tasks including mopping floors, vacuuming, dusting, changing and making beds, washing dishes, defrosting, and cleaning the refrigerator, cleaning bathrooms and kitchens, and washing windows as high as the homemaker can reach while standing on the floor;

   b. Essential shopping to obtain prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient;

   c. Meal preparation menu planning, storing, preparing, serving food, buttering bread, and plating food;

   d. Laundry services: washing, drying, and folding the recipient's personal laundry and linens (sheets, towels, etc.), excluding ironing. The recipient is responsible for any laundromat and/or cleaning fees;

   e. Assisting the recipient and family members or caregivers in learning a homemaker routine and skills so the recipient may carry on normal living when the homemaker is not present;

f. Accompanying the recipient to homemaker activities such as shopping or the laundromat. Any transportation to and from these activities is not reimbursable as a Medicaid expense;

g. Routine clean-up of waste for up to two household pets. Walking a pet is not included unless it is a service animal; or

h. Additional homemaker activities may be approved on a case-by-case basis.

5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

a. Transporting the recipient in a private car;

b. Cooking and cleaning for the recipient's guests, other household members or for the purposes of entertaining;

c. Repairing electrical equipment;

d. Ironing and mending;

e. Giving permanents, dyeing, or cutting hair;

f. Accompanying the recipient to appointments, social events or in-home socialization;

g. Washing walls;

h. Moving heavy furniture, climbing on chairs or ladders;

i. Purchasing alcoholic beverages that were not prescribed by the recipient's physician;

j. Doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-covered areas, and vehicle maintenance; or

k. Providing care to pets unless the animal is a certified service animal.

6. Live-in LRIs are limited up to two hours per week, for non-live in LRIs, the service hours will be based on the case manager's assessment of the recipient's living conditions (e.g., living alone, risk level).

2203.5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Homemaker Providers must:

1. Provide adequate training related to homemaking assistance appropriate for recipients on the FE Waiver completed initially and annually;

2. Ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system; and

3. The service must be prior authorized and documented in an approved EVV System.

2203.5C RECIPIENTS RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.6 CHORE SERVICES

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where the recipient, anyone else in the household, landlord, community volunteer/agency, or third-party payer is not capable of performing nor responsible for, the provision of these services or financially able to provide the services and without these services, the recipient would be at risk of institutionalization.

2203.6A COVERAGE AND LIMITATIONS

1. The service must be identified on the POC and approved by the case manager.

2. This service includes heavy household chores such as:

   a. cleaning windows and walls;

   b. shampooing carpets; tacking down loose rugs and tiles;

   c. moving heavy items of furniture to provide safe access;

   d. packing and unpacking for the purpose of relocation;

   e. minor home repairs; or

   f. removing trash and debris from the yard.

3. This is not a skilled, professional service.

4. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver covered services.

2203.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, individuals performing chore services must:

1. Provide adequate training appropriate for recipients with physical disabilities completed initially and annually to include training in performing heavy household activities and minor home repair;

2. Maintain the home in a clean, sanitary, and safe environment if performing heavy household chores and minor home repair services;

3. Providers are responsible for ensuring that EVV requirements and expectations are met, including the documentation of all services in approved EVV system; and

4. Services must be prior authorized and documented in an approved EVV system.

2203.6C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.7 RESPITE CARE

Respite Care Services are provided to recipients unable to care for themselves. This service is provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite providers perform general assistance with ADLs and IADLs as well as provide supervision to functionally impaired recipients in their private home or place of residence (community setting).

2203.7A COVERAGE AND LIMITATIONS

1. Respite services may be for 24-hour periods.

2. Respite care is limited to 336 hours for the duration of the POC.

3. Services must be prior authorized by the case manager.

2203.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Respite Providers must:

1. Provide adequate training related to personal care assistance appropriate for recipients on the FE Waiver completed initially and annually to include training on personal hygiene needs, and techniques for assisting with ADLs such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment homemaking, and household care;

2. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV System.

3. Service must be prior authorized and documented in an approved EVV System.

2203.7C RECIPIENTS RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC the EVV record that reflects the service rendered. If IVR is utilized, a vocal
3. confirmation is required.

2203.8 HOME DELIVERED MEALS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery or transportation costs of meals to a person's home.

2203.8A COVERAGE AND LIMITATIONS

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

1. Home delivered meals must be prepared by an agency and be delivered to the recipient's home.

2. Meals provided by or in a child foster home, community based residential facility or adult day care are not included, nor is meal preparation.

3. The direct purchase of commercial meals, frozen meals, Ensure or other food or nutritional supplements is not allowed under this service category.

4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient and are not to exceed two meals per day.

5. More than one provider may be used to meet a recipient's assessed need; the case manager is responsible to ensure the PA does not exceed two meals per day.

6. Case managers determine the need for this service based on assessment, and by personal interviews with the recipient related to individual nutritional status.

7. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 1/3% of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

8. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2203.8B PROVIDER RESPONSIBILITIES

1. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in NRS, Chapter 446 or local health code regulations.

2. All kitchen staff must hold a valid health certificate if required by local health ordinances.

3. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to case manager by the next business day.

4. The service must be prior authorized by the case manager.

2203.8C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. The recipient must notify the case manager timely if they need to make any changes to their Home Delivered Meals service.

2. The recipient must notify their case manager if the authorized number of meals is not received.

2203.9 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

PERS is an electronic device, which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is programmed to signal to a response center once the "help" button is activated.

2203.9A COVERAGE AND LIMITATIONS

1. PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day in their residence, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision or as identified to mitigate other safety risks and concerns. The recipient must be capable of using the device in an appropriate and proper manner.

2. The initial installation fee for the device and a monthly fee for ongoing monitoring~~; both~~ are covered under this service.

3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

2203.9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, PERS Providers must:

1. Ensure that the response center is staffed by trained professionals at all times;

2. Complete any replacement or repair needs that may occur and monthly monitoring to ensure the device is working properly;

3. Devices must meet Federal Communication Commission standards, Underwriter's Laboratory, Inc. (UL) standards or equivalent standards;

4. Inform recipients of any liability they may incur as a result of the disposal or loss of provider property.

5. This service must be prior authorized by the case manager.

2203.9C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2203.2C, the recipient must:

1. Be responsible to utilize the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.

2. Return the equipment to the provider when it is no longer needed or utilized, or when the recipient terminates from the waiver program.

3. Not dispose of or damage the PERS equipment. This is leased equipment and belongs to the PERS provider.

2203.10 ADULT DAY CARE SERVICES

Adult Day Care services are provided in a non-institutional community-based setting, including outpatient settings. It encompasses social service needs to ensure the optimal functioning of the recipient. The emphasis is on social interaction in a safe environment.

2203.10A COVERAGE AND LIMITATIONS

1. It is provided on a regularly scheduled basis in accordance with the goals in the POC and must indicate the number of days per week the recipient will attend.

2. The case manager may authorize up to a maximum of six hours per day.

3. If the recipient's overall pattern changes and consistently attends less than six hours a day, a change to the POC and PA will be required.

4. Meals provided are furnished but must not constitute a "full nutritional regimen" (i.e., three meals per day). Meals must be served in a manner suitable for the recipient and prepared with regard for individual preferences. Special diets and nourishments must be provided as ordered by the client's physician.

5. Providers must not bill for days a recipient is not in attendance, even if it is a regularly scheduled day.

2203.10B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Adult Day Care Providers must:

1. Bill the per diem rate if the recipient is in attendance for a maximum of six hours per day. If the authorized hours for attendance is less than six hours then bill the unit rate.

2. Provider must bill in accordance with the approved PA, even if the recipient occasionally attends less than six hours a day.

3. Providers must keep attendance records for each recipient. Claims must reflect dates and times of service as indicated on the attendance records.

2203.11 ADULT COMPANION SERVICES

Adult Companion Services provides non-medical care, supervision and socialization to a functionally impaired recipient in his or her home or place of residence, which are furnished on a short-term basis or to meet the need for relief for the primary caregiver.

2203.11A COVERAGE AND LIMITATIONS

1. Adult companions may assist or supervise the recipient with tasks as meal preparation and clean up, light housekeeping, shopping and facilitate transportation/escort as needed. These services are provided as an adjunct to the Adult Day Care Services and must be incidental to the care and supervision of the recipient.

2. The provision of Adult Companion Services does not entail hands-on medical care.

3. This service is provided in accordance with the personalized goal in the POC and is not purely diversional in nature.

4. Transportation is not a covered service. Reference MSM Chapter 1900 Transportation Services for transportation policies.

5. LRIs are allowed to provide this service only when no other similar services are in place such as Adult Day Care or living in a residential group home. Limit to two hours/day and is based on the case manager's assessment and only if the primary and live-in caregiver needs a break or to run errands, etc.

2203.11B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2203.2B, Adult Companion Providers must:

1. Be able to read, write and follow written or oral instructions; and

2. Have experience or training in how to interact with recipients with disabling and various health conditions.

Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

Service must be prior authorized and documented in an approved EVV System.

2203.11C RECIPIENTS RESPONSIBILITIES

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2203.12 AUGMENTED PERSONAL CARE

Augmented Personal Care (APC) provided in a licensed Residential Facility for Groups (RFG) or Assisted Living (AL) Facility setting that meets the HCBS settings requirements in a 24-hour in home service that provides assistance for elderly recipients with basic self-care and ADLs that include as part of the service:

A. Homemaker Services;

B. Personal Care Services;

C. Chore Services;

D. Companion Services;

E. Therapeutic social and recreational programming;

F. Medication oversight (to the extent permitted under State Law); and

G. Services which will ensure that residents of the facility are safe, secure, and adequately supervised.

This care is over and above the mandatory service provision required by regulation for RFG or AL Facility.

2203.12A COVERAGE AND LIMITATIONS

1. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence; and provides supervision, safety, and security.

2. Once a FE Waiver recipient/applicant expresses an interest in an RFG setting, they are provided with a list of qualified providers. A case manager is available to provide additional information and guidance related to the individual's specific needs.

Consideration may include size of the home, geographic location, proximity to friends and family, available support, activities, food, staff, other residents, likes and dislikes, medical or mental health concerns, whether pets are allowed, and a variety of other individualized preferences.

3. There are four service levels of APC. The service level provided is based on the recipient's functional needs to ensure the recipient's health, safety, and welfare. The case manager determines the service level:

   a. Level One Daily (minimum assistance)

      This level provides supervision and cueing to complete basic self-care and ADLs. In home supervision is available when direct care tasks are not being completed.

   b. Level Two Daily (moderate assistance)

      This level provides physical assistance with moderate hands-on care of basic self-care and ADLs. Some basic self-care may require a moderate level of assistance. This service provides in-home supervision with regularly scheduled checks as needed.

   c. Level Three Daily (maximum assistance)

      This level provides physical assistance to complete basic self-care and ADLs. With maximum hands-on care. Direct 24-hour supervision and/or safety system (alarm) to ensure safety when supervision is not direct. It includes daily home making for clean up after basic self-care tasks, weekly homemaking for general cleaning, and up to twice daily assistance with meal preparation.

   d. Level Four (Critical Behaviors)

      In addition to meeting a level one, two or three for ADLs/IADLs care, level 4 requires substantial and/or extensive assistance with critical behaviors: Behavioral Problems, Resists Care, Socially Inappropriate, Wandering, Physically Abusive to self and/or others, Verbally Abusive, and behaviors that represent a safety risk. Requiring the full attention of staff members when behaviors are present and/or presents a need for additional staffing to redirect and address behaviors. Additional documentation and agency approval required.

      Documentation on the daily log for at least 60 days is required to justify amount and types of care for service level determination and verification of proper billing.

All four service levels provide help with laundry; housekeeping; meal preparation and eating; bed mobility and transfers; bathing, dressing, and grooming; mobility and

ambulation; and access to social and recreational programs. The service level determines the amount, duration and frequency of the services provided.

All service levels are reassessed annually, or as significant changes occur, and may increase or decrease to reflect the recipient's current level of need.

Documentation on the daily log is required to justify amount and types of care for service level determination and verification of proper billing.

4. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep, and improvement.

5. Nursing and skilled services (except periodic nursing evaluations) are incidental, rather than integral to the provision of group care services. Payment will not be made for 24-hour skilled care or supervision.

6. Other individuals or agencies may also furnish care directly, or under arrangement with the RFG or AL Facility. However, the care provided by these other entities supplements what is being provided but does not supplant it.

7. Personalized care furnished to individuals who choose to reside in an RFG or AL Facility based on their individualized POC, which is developed with the recipient, people chosen by the recipient, caregivers and the case manager. Care must be furnished in a way that fosters the independence of each recipient.

2203.12B PROVIDER RESPONSIBILITIES

In addition to the responsibilities listed in Section 2203.2B providers must:

1. Be licensed and maintain standards as outlined by, HCQC under NRS/NAC 449 "Medical and other related entities."

2. Adhere to all HCQC and ADSD training requirements specific to the waiver population being cared for at the RFG or AL facility completed initially and annually.

3. The provider for a RFG or AL Facility must:

   a. Ensure that HCBS Settings requirements and expectations are followed. The HCBS Settings Regulation supports enhanced quality in HCBS programs, adds protections for individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.

   b. Notify the case manager within three business days when the recipient states the desire to leave the facility.

c. Participate with the case manager in discharge planning.

d. Notify the case manager within one working day if the recipient's living arrangements have changed, eligibility status has changed or if there has been a change in health status that could affect recipient's health, safety, or welfare.

e. Notify the case manager agency of any recipient complaints regarding delivery of service or specific staff of the setting. If the recipient is not satisfied with their living arrangements or services, the case manager will work with the recipient and the provider to resolve any areas of dissatisfaction. If the recipient makes the decision to relocate to another setting, the case manager will provide information and facilitate visits to other contracted settings.

f. Maintain privacy, dignity, and respect during the provisions of services, and ensure living units are not entered without permission.

g. Allow recipients to have visitors of their choosing and access to food at any time.

h. Ensure the facility is physically accessible to the recipient.

i. Conduct business in such a way that the recipient is free from coercion and restraint and retains freedom of choice. Providers must render services based on the recipient's choice, direction, and preferences.

j. Coordinate transportation to and from the setting to the hospital, a NF, routine medical appointment, and social outings organized by the facility. Recipients may choose to enjoy their privacy, participate in physical activities, relax, or associate with other residents. Recipients may go out with family members or friends at any time and may pursue personal interests outside of the residence.

Note: For all Medicaid covered services refer to MSM Chapter 1900 – Transportation Services.

k. Accept only those residents who meet the requirements of the HCQC licensure and certification.

l. Provide services to FE recipients in accordance with the recipient's POC.

m. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the FE Waiver except by written consent of the recipient or designated representative/LRI.

n. Have sufficient caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The provider must comply with HCQC staffing requirements for the specific facility type.

o. Have 24-hour on-site staff to meet scheduled or unpredictable needs and provide supervision, safety, and security.

p. Not use Medicaid waiver funds to pay for the recipient's room and board.

q. Ensure that recipients are provided the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources (such as access to bank accounts), and receive services in the community to the same degree as individual not receiving Medicaid HCBS.

r. Allow each recipient privacy in their sleeping or living unit:

1. Units or rooms have lockable doors. A bedroom or bathroom door in a residential group setting which is equipped with a lock must open with a single motion from the inside. Staff must knock before entering; recipients have the right to choose who enters the bedroom.

2. Recipients sharing units have a choice of roommate.

3. Encourage recipients to utilize personal furniture, furnishing, photo and decorative items to personalize their living space.

s. Not have a lease or other agreement that differs from those individuals who do not receive Medicaid HCBS.

The provider must have a written agreement that includes the following:

1. Provide at least a 30-calendar day notification to the recipient before transferring or discharging them with the exception of a voluntary transfer or discharge, or the requirement to transfer or discharge the recipient to another facility because the condition of the recipient necessitates a higher level of care;

2. Provide the recipient and case manager with written notice of the intent to transfer or discharge the recipient; and

3. Allow the recipient and other person authorized by the recipient the opportunity to meet in person with the administrator of the facility to discuss the proposed transfer of discharge within 10-calendar days after providing written notice.

t. Notify the recipient's case manager when a modification is made on the POC that restricts the recipient's freedom of choice.

4. Recipient Records

a. Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC and lease or other agreement.

The documentation will include the recipient's acknowledgment of service. If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC, indicating the designated representative or LRI. Recipients without an LRI can select an individual to act on their behalf by completing the Designated Representative Attestation Form. The case manager will be required to document the designated representative who can sign documents and be provided information about the recipient's care.

b. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make available upon request. For electronic signatures, systems and software products must include protection against modifications, with administrative safeguards that correspond to policies and procedures of the ADSD. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to.

c. Periodically, DHCFP and/or ADSD staff may request daily service documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.

d. Services for waiver recipients residing in a RFG or AL Facility should be provided as specified on the POC and at the appropriate authorized service level.

e. If fewer services are provided than are authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.

2203.12C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in Section 2203.2C, the recipient must:

1. Recipients are to cooperate with the providers of RFG or AL Facility in the delivery of services.

2. Recipients are to report any problems with the delivery of services to the RFG or AL Facility administrator and/or case manager.

2203.13 ELECTRONIC VISIT VERIFICATION (EVV)

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission. Any errors within EVV submissions must be supported by offline documentation.

Agencies must ensure each personal care attendant has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

A. STATE OPTION:

1. The EVV system electronically captures:

   a. The type of service performed, based on procedure code;

   b. The individual receiving the service;

   c. The date of the service;

   d. The location where service is provided;

   e. The individual providing the service;

   f. The time the service begins and ends.

2. The EVV system must utilize one or more of the following:

   a. The agency/personal care attendant's smartphone;

   b. The agency/personal care attendant's tablet;

   c. The recipient's landline telephone;

   e. The recipient's cellular phone (for IVR purposes only);

   f. Other GPS-based devices as approved by DHCFP.

B. DATA AGGREGATOR OPTION:

1. All Personal Care Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

   a. Appropriate forms must be approved by the DHCFP before use of the system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

   b. At a minimum, data uploads must be completed monthly into the data aggregator.

2203.14 DHCFP LTSS INITIAL REVIEW

Once the applicant has been approved for the waiver, DHCFP LTSS will review all initial eligibility packets for completeness to ensure waiver requirements are being met. The eligibility packet for review must include:

1. The NF LOC screening to verify the applicant meets NF LOC criteria;

2. At least one waiver service identified:

3. The SOC complete with signature and dates; and

4. The HCBS Acknowledgement Form complete including initials, signature, and date.

NOTE: Electronic signatures are acceptable pursuant to NRS 719.350 "Acceptance and distribution of electronic records by governmental agencies" on forms that require a signature.

2203.15 WAIVER COSTS

DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100% of the average per capita expenditures for the institutional LOC under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2203.16 QUALITY ASSURANCE WAIVER REVIEW

The state conducts an annual review of active waiver participants. CMS has designated waiver assurances and sub-assurances that states must include as part of an overall quality improvement strategy. The annual review is conducted using the state specified performance measures identified in the approved FE Waiver to evaluate operation.

Case management and direct waiver service providers must cooperate with ADSD Operations and DHCFP's review process.

2203.17 PROVIDER ENROLLMENT

All providers must maintain a Medicaid services provider agreement and comply with the criteria set forth in the Nevada MSM Chapter 100 and MSM Chapter 2200. Provider Enrollment checklists and forms can be found on the Fiscal Agent's website https://www.medicaid.nv.gov.

2203.18 BILLING PROCEDURES

The DHCFP assures that claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service(s) are identified on the approved POC, and the service(s) have been prior authorized.

Refer to the Fiscal Agent's website at: www.medicaid.nv.gov for the Provider Billing Guide Manual.

2203.19 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed providers to provide their recipients with information regarding their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM 100 for further information.

The case manager must provide information on Advance Directives to each recipient and/or designated representative/LRI during the initial assessment and annually thereafter. The signed Acknowledgement form is kept in each recipient's file at the local ADSD office. Whether a recipient chooses to write their own Advance Directives or complete an Advance Directives form in full is the individual choice of each applicant and/or designated representative/LRI.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 27, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES Casey Angres (Aug 18, 2023 08:48 PDT)
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2300 – HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER FOR PERSONS WITH PHYSICAL DISABILITIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2300 – HCBS Waiver for Persons with Physical Disabilities (PD) are being proposed to align this chapter with the current waiver renewal which was approved by the Centers for Medicare and Medicaid Services (CMS) on January 1, 2023, and to bring the Person-Centered Planning process into compliance with the HCBS Settings Requirements (42 CFR 441.301(c)(1) through (c)(5)).

Major proposed changes to this chapter include the addition of Legally Responsible Individuals (LRI) to the pool of paid caregivers for the provision of personal care-like services, addition of Private Case Management (PCM) provider, modifications to the waiver slot waitlist, transferring of the disability determination process to MSM Chapter 2300 from Medicaid Operations Manual (MOM) Chapter 1000 that will be obsolete, and modification to the Homemaker Waiver service Coverage and Limitations.

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: None.

Financial Impact on Local Government: Unknown at this time.

These changes are effective June 28, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 10/23 CHAPTER 2300 – HOME AND COMMUNITY BASED SERVICES	MTL 08/13, CHAPTER 2300 – HOME AND COMMUNITY BASED SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2300	**Introduction**	Terminology and acronyms were updated and reworded for clarity and continuity. The second paragraph was deleted and replaced with a reworded version that better reflects an overview of the waiver. Several sentences were moved from sections of 2301 and modified for clarity.
2301	**Authority**	Terminology and acronyms were updated and reworded for clarity and continuity. Some statutes and regulations were removed and/or updated to align with current Federal and State regulations as applicable: Removed SSA 1916 (e) and 1902 (w), Omnibus Budget Reconciliation Act of 1987, Balanced Budget Act of 1997, State Medicaid Manual Section 44442.3.B.13, State Medicaid Director Letter (SMDL) #01-006 attachment 4-B, and Title 42, CFRs Part 441, 431 and 489. Added NRS Chapters 200, 426, and 427A, 422, 449, 616, 706, and 446. Added NRS 449A.114 – Patient Notification of Intent to Transfer. Removed NAC chapters 441A.375 and 706. Added Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act. Added CFR 435.540 (Definition of Disability) and 441.301(c)(1) through (c)(5) (Federal Person-Centered Planning and Settings Requirements). Removed H.R. 6042 – 115th Congress.
2303.1	**Waiver Eligibility Criteria**	This section was moved and renumbered from 2303.2 to 2303.1 and subsequent sections numbered accordingly.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Terminology and acronyms were updated and reworded for clarity and continuity. Added new sections outlining PD Waiver eligibility criteria to #A through #G.
2303.1A	**Coverage and Limitations**	This section was moved and renumbered from 2303.2A to 2303.1A. Terminology and acronyms were updated and reworded for clarity and continuity. Removed #2 as it is duplicative to 2303.1. Added #3 to indicate services will only be reimbursed for eligible recipients and services must be prior authorized. Added #4 indicating individuals found eligible for more than one waiver program must choose one. Added #5 indicating waiver recipients may enroll in hospice and remain on the waiver if they choose. Added #6 indicating that Section 3715 of the CARES Act may be utilized and included additional clarifications. Removed original #6 indicating HCBS services are not a substitute for natural and informal supports.
2303.1B	**Disability Determination**	Created a new section outlining disability determination process for new PD Waiver applicants. Medicaid Operations Manual (MOM) Chapter 1000 will be obsoleted and combined to this section.
2303.1C	**Applicant/Recipient Responsibilities**	Created a new section outlining recipient responsibility to become eligible and receive waiver services.
2303.2	**Waiver Services**	This section was moved and renumbered from 2303.3 to 2303.2 and subsequent sections numbered accordingly. Terminology and acronyms were updated and reworded for clarity and continuity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2303.2A	**Coverage and Limitations**	This section was renumbered from 2303.3A to 2303.2A. Terminology and acronyms were updated and reworded for clarity and continuity. Services rearranged to follow the order they are listed within the current approved Waiver application as well as the order in which they are listed within this chapter.
2303.2B	**Provider Responsibilities**	This section was renumbered from 2303.3B to 2303.2B. Terminology and acronyms were updated and reworded for clarity and continuity. Changed language under #1 to indicate that all providers must obtain a provider number (PT 58) through DHCFP's Fiscal Agent. Removed requirement for providers to verify recipient's Medicaid eligibility as it is duplicative to other sections of this chapter. Added #2 to state that providers must meet all statutes, rules and regulations related to service being provided. Reworded #3 and added additional language to indicate that a provider's contract may be terminated if they fail to comply with all rules and regulations. Added #4 to include reasons a provider may terminate services as well notification requirements when a provider terminates services. Added #5 regarding "Discontinuation of Provider Agreement". Revised language in #6 to be more concise regarding POC, billing procedures and record keeping responsibilities. Added "Flexibility of Service Delivery" to #7 regarding total authorized hours.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added #8 indicating providers are responsible for any claims/payments received on the recipient's behalf. Added #9 instating providers must understand payment for services are based on POC. Revised language in #10 to indicate that LRIs can be paid for some direct waiver services and included additional information regarding payment of services to Legally Responsible Individuals. Added #11 indicating providers may only provide services identified on POC/have a prior authorization if required. Added #12 indicating providers must have a backup mechanism in place. Added #13 outlining the timeframe by which providers must sign and date the finalized POC. Revised language in #14 detailing Serious Occurrence reports (SOR) and created new sections detailing both public (ADSD) and private case management reporting requirements for SORs. Removed language detailing criminal background checks and created new updated section #15 and a portion removed as it is outlined in MSM 100 and is duplicative. Added #16 regarding recipient record requirements for all providers. Added #17 indicating all providers must adhere to HIPAA requirements. Added #18 stating that providers must maintain a business license, if applicable. Added #19 indicating providers must also obtain HCQC licensure, if required. Removed "Provider Agencies" section and replaced with new section titled "Qualifications and Training" #20 outlining all training requirements for providers.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed section for exemptions from training for Provider Agencies as not applicable to current requirements. Removed "Recipients Providing Training" section. Removed "Completion and Documentation of Training" section. Removed information regarding TB testing as this is outlined in HCQC provider requirements.
2303.2C	**Recipient Responsibilities**	This section was renumbered from 2303.3C to 2303.2C. Terminology and acronyms were updated and reworded for clarity and continuity. Added #2 requiring recipients to notify providers/DWSS or current insurance information. Added criteria of required environment for providers and staff to #4. Added language to #5 that provider records must be dated along with signature. Included clarification in the event the recipient is unable to sign documents. Added requirement to #10 to work with case manager and provider to create a back-up plan in case caregiver is unavailable to work. Added requirement that all forms be signed by recipient within 10 calendar days to #15. Added #16 requirement for annual face-to-face visit. Added requirement that recipient be physically available to #17 and removed section indicating the recipient must meet and maintain all eligibility criteria. Removed section regarding patient liability as this does not pertain to Waiver recipients.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added #20 indicating that recipients have the right to actively participate in the person-centered planning process and what must be included in the process.
2303.3	**Intake Activities**	Created a new section titled "Intake Activities" to detail the intake functions completed by the ADSD Operations Agency.
2303.3A	**Coverage and Limitations**	Added updated Intake Referral process for new applicants for the PD Waiver program. New process for placing applicants on the waitlist and new waitlist priority levels 1-4 updated/added. Created a new process for waiver slot allocation. Added information on effective date for waiver services once a waiver slot is available. Added information about recipient right to choose ADSD case manager or private case management agency and process for assigning case management agency once the recipient has chosen and placed on the waiver.
2303.4	**Case Management**	This section was renumbered from 2303.3D to 2303.4 and subsequent sections renumbered accordingly. Removed "Direct Service" from section title. Added summary description for case management service.
2303.4A	**Coverage and Limitations**	This section was renumbered from 2303.3E to 2303.4A. Terminology and acronyms were updated and reworded for clarity and continuity. Paragraph added summarizing case management service responsibilities. Added Section detailing administrative case management activities and additional section detailing billable case management activities.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Created new sections outlining the initial assessment process, social health assessment, development of the person-centered Plan of Care, changes to the Plan of Care, Plan of Care modifications for individuals in an assisted living facility, person-centered contacts, annual reassessments, and other responsibilities to be completed by the case management provider. Added #12 indicating how a recipient can request to change case management providers.
2303.4B	**Provider Responsibilities**	This section was renumbered from 2303.3F to 2303.4B. Removed "Direct Services Case Management" from the title. Terminology and acronyms were updated and reworded for clarity and continuity. Incorporated case management provider requirements and additional requirements for private case management providers. Removed paragraph indicating case management licensure requirements.
2303.4C	**Recipient Responsibilities**	This section was renumbered from 2303.3G to 2303.4C. Terminology and acronyms were updated and reworded for clarity and continuity. Language updated to be more concise. Updated language in #1 from 'monthly' to 'ongoing' contacts as outlined within current waiver application. Removed sentence regarding provider initials on daily records as this does not pertain to case management. Updated language in #3 to state recipient must choose a Medicaid enrolled case management provider.
2303.5	**Homemaker Services**	This section was renumbered from 2303.4 to 2303.5 and subsequent sections renumbered accordingly.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added summary paragraph detailing what is available under Homemaker services and specified that homemaker services are not available to individuals receiving State Plan personal care services.
2303.5A	**Coverage and Limitations**	This section was renumbered from 2303.4A to 2303.5A. Terminology and acronyms were updated and reworded for clarity and continuity. The following language was added to #1, "at the recipient's home, or place of residence (community setting)" and removed "by agencies enrolled as a Medicaid provider." Removed sentence from #2 regarding temporary absence/unable to manage home for more concise language. Updated language in #3 indicating DHCFP/Fiscal Agent are not responsible for damaged goods during the provision of service. Updated descriptions of homemaker services provided to #4 for more clarity and consistency. Updated language to #5 indicating what services are not approved under homemaker. Added #6 indicating paid LRIs may provide this service and included service limitations.
2303.5B	**Provider Responsibilities**	This section was renumbered from 2303.4B to 2303.5B. "Homemaker" was removed from the section title. Terminology and acronyms were updated and reworded for clarity and continuity. Revised language in #1 to be more concise and indicate specific training requirements for PD recipients.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed #2 stating a LRI cannot be paid for homemaker services. Removed #3 indicating DHCFP is not responsible for damaged goods as this is repetitive. Added sentence stating that service must be prior authorized and documented in an approved EVV system.
2303.5C	**Recipient Responsibilities**	Created a new Recipient Responsibility section. Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature/IVR.
2303.6	**Respite Care**	This section was moved, but numbering remains the same. Added description paragraph of what services may be included under Respite Care to provide clarity and consistency.
2303.6A	**Coverage and Limitations**	Terminology and acronyms were updated and reworded for clarity and continuity. Updated time frame in which respite services may be provided to 24-hour periods. Updated #2 to reflect language in current waiver application stating respite care is limited to 120 hours for the duration of the Plan of Care. Added sentence stating that services must be prior authorized by Case Management provider.
2303.6B	**Provider Responsibilities**	Removed "Respite Care" from the title of this section. Terminology and acronyms were updated and reworded for clarity and continuity. Removed requirement to perform general assistance to ADLs and IADLs as this is duplicative to Coverage and Limitations.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Revised language in #1 to be more concise and indicate specific training requirements for PD recipients. Removed sentence indicating providers must demonstrate the ability to perform the care tasks. Removed language in #3 as this information is stated under 2303.2B. Added sentence stating that service must be prior authorized and documented in an approved EVV system.
2303.6C	**Recipient Responsibilities**	This section was added for consistency. Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature/IVR.
2303.7	**Attendant Care Services**	This section was moved and renumbered from 2303.12 to 2303.7 and subsequent sections renumbered accordingly. "Services" was added to title for consistency and clarity. Added service definition as detailed within the waiver application.
2303.7A	**Coverage and Limitations**	Section moved and renumbered from 2303.12A to 2303.7A. Terminology and acronyms were updated and reworded for clarity and continuity. Added language stating Attendant Care Services are only provided to individuals 21 and over when State Plan PCS has been exhausted. Removed language detailing specific tasks allowed under this service. Removed reference to back up plan in #1 as it is mentioned in sections 2303.2B and 2303.2C and is duplicative. Removed definition of ADLs and IADLs in #2 as this repetitive.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2303.7B	**Provider Responsibilities**	Removed "Attendant Care" from title for consistency. Moved and renumbered section from 2303.12B to 2303.7B. Terminology and acronyms were updated and reworded for clarity and continuity. Removed language stating LRIs may not be paid for providing this service, as LRIs can be paid caregivers. Changed language in #1 to "self-directed skilled" to align with MSM Chapter 2600. Removed CPR certification requirement and requirement for services to be documented in writing. Added #3 indicating providers must receive adequate training specific to persons with physical disabilities and timeframes for training completion. Updated and rearranged language stating that services must be prior authorized and documented in an approved EVV system.
2303.7C	**Recipient Responsibilities**	This section added for consistency. Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature/IVR.
2303.8	**Assisted Living Services**	This section was moved and renumbered from 2303.10 to 2303.8 and subsequent sections renumbered accordingly. Summary description of assisted living service added. Sentence added to include skilled nursing as permitted by state law.
2303.8A	**Coverage and Limitations**	This section was moved and renumbered from 2303.10A to 2303.8A. Terminology and acronyms were updated and reworded for clarity and continuity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed detailed list of services provided in #1 as they are listed in section 2303.8, and it is duplicative. Added #5 indicating personalized plan of care is to be developed with the recipient and people of the recipient's choosing.
2303.8B	**Provider Responsibilities**	Removed "Assisted Living" from title for consistency. Terminology and acronyms were updated and reworded for clarity and continuity. Several sections regarding licensure requirements were removed and replaced with new verbiage. Added #1 indicating AL providers must maintain all licensure standards as outlined by the Bureau of Health Care Quality and Compliance (HCQC). Added #2 indicating AL providers must adhere to training requirements outlined by HCQC and ADSD and specific training timeframes. Added #3 to include HCBS final rule requirements specific to residential facilities. Removed "ADSD" when referencing case managers throughout to encompass both private and public case managers. Section #4 regarding Recipient Records requirements was added.
2303.8C	**Recipient Responsibilities**	This section added for consistency. Added language indicating recipient's responsibility to cooperate with providers as well as responsibility to report any problems with delivery of services.
2303.9	**Chore Services**	This section was renumbered from 2303.5 to 2303.9 and subsequent sections renumbered accordingly. Terminology and acronyms were updated and reworded for clarity and continuity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Paragraph added detailing when Chore services may be provided and added additional language for clarity. Section moved from 'Coverage and Limitations' section and additional language added for clarity.
2303.9A	**Coverage and Limitations**	Section renumbered from 2303.5A to 2303.9A. Minor deletions and additions made for clarity and in accordance with the description provided in the Background and Explanation section above.
2303.9B	**Provider Responsibilities**	Removed "Chore Services" from title for consistency. Moved and renumbered this section from 2303.5B to 2303.9B. Added #1 indicating providers must obtain training specific to service for persons with physical disabilities and timeframes. Added language detailing that services must be prior authorized and documented within an approved EVV system.
2303.9C	**Recipient Responsibilities**	This section added for consistency. Included information regarding recipient's responsibility to utilize an approved EVV system as well as to provide confirmation that services were received via signature.
2303.10	**Environmental Accessibility Adaptations**	This section moved and renumbered from 2303.7 to 2303.10 and subsequent sections renumbered accordingly. Added summary paragraph of environmental accessibility adaptations.
2303.10A	**Coverage and Limitations**	Section renumbered from 2303.7A to 2303.10A. Terminology and acronyms were updated and reworded for clarity and continuity. Added #4 indicating rental properties must receive written approval from landlord prior to authorizing the service.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed sentence indicating service must be prior authorized and limited by budget constraints.
2303.10B	**Provider Responsibilities**	Removed "Environmental Accessibility Adaptations" from title for consistency. Section moved and renumbered from 2303.7B to 2303.10B.
2303.10C	**Recipient Responsibilities**	This section added for consistency. Added additional recipient responsibilities specific to Environmental Adaptations and notification requirements specific to this service.
2303.11	**Home Delivered Meals**	This section moved but the numbering remains the same. The first paragraph under 'Coverage and Limitations' section moved up to this section.
2303.11A	**Coverage and Limitations**	Section moved but numbering remains the same. Terminology and acronyms were updated and reworded for clarity and continuity. Added requirement to #4 indicating service is limited to two meals per day. Added language to #5 indicating it is the case manager's responsibility to ensure the PA does not exceed two meals per day.
2303.11B	**Provider Responsibilities**	Section moved but numbering remains the same. Removed "Home Delivered Meals" from title for consistency. Removed requirement for meal provider to be enrolled with DHCFP and references to NRS. Removed requirements for all employees to pass background checks and proof of taxpayer identification number.
2303.11C	**Recipient Responsibilities**	This section added for consistency.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added requirement recipient notification requirements specific to this service.
2303.12	**Personal Emergency Response Systems (PERS)**	This section moved and renumbered from 2303.9 to 2303.12 and subsequent sections renumbered accordingly. The first paragraph under 'Coverage and Limitations' section moved up to this section and language added to describe the services provided.
2303.12A	**Coverage and Limitations**	Section moved and renumbered from 2303.9A to 2303.12A. Terminology and acronyms were updated and reworded for clarity and continuity. Added sentence detailing that the recipient must be capable of using the device appropriately. Language in #2 revised to indicate that both installation and ongoing monitoring fee are covered under this service. Added #3 regarding the necessity of the service and that it must be documented on the Plan of Care.
2303.12B	**Provider Responsibilities**	Removed "PERS" from title for consistency. Moved and renumbered this section from 2303.9B to 2303.12B. Terminology and acronyms were updated and reworded for clarity and continuity. Removed information stating provider must provide tax identification number. Added monthly monitoring of the PERS device to #2.
2303.12C	**Recipient Responsibilities**	This section moved and renumbered from 2303.9C to 2303.11C. Terminology and acronyms were updated and reworded for clarity and continuity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added language stating recipient cannot dispose of or damage equipment. Removed language stating "when recipient moves out of state" as it is already implied when the recipient has been terminated from the waiver.
2303.13	**Specialized Medical Equipment and Supplies**	This section was moved and renumbered from 2303.8 to 2303.13 and subsequent sections renumbered accordingly. First two paragraphs moved from 'Coverage and Limitations' and second paragraph deleted.
2303.13A	**Coverage and Limitations**	Section renumbered from 2303.8A to 2303.13A. Terminology and acronyms were updated and reworded for clarity and continuity. Rearranged section and added updated language regarding service. Removed specific requirements for vehicle adaptations, assistive technology and supplies.
2303.13B	**Provider Responsibilities**	Section renumbered from 2303.8B to 2303.13B. Removed "Specialized Medical Equipment" from title for consistency. Terminology and acronyms were updated and reworded for clarity and continuity. Removed licensure requirements.
2303.13C	**Recipient Responsibilities**	This section created for consistency. Added recipient notification requirements for this service and that recipient may not request any additional equipment or supplies that were not authorized.
2303.14	**Electronic Visit Verification (EVV)**	This section was removed from "Waiver Services" and a new 2303.14 section created.
2303.15	**DHCFP LTSS Initial Review**	Created a new section outlining specific initial review requirements to be conducted by DHCFP LTSS to align with waiver application.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added additional note indicating electronic signatures are acceptable.
2303.16	**Waiver Costs**	Added new section indicating waiver expenditures must not exceed the cost for institutional care.
2303.17	**Quality Assurance Waiver Review**	This section moved and title updated to 'Quality Assurance Waiver Review'. Terminology and acronyms were updated and reworded for clarity and continuity. Sections removed and revised to reflect current required review criteria.
2303.18	**Medicaid Early and Periodic Screening, Diagnostic and Treatments (EPSDT)**	This section was removed from "Waiver Services" and a new 2303.18 section created. Terminology and acronyms were updated and reworded for clarity and continuity.
2303.19	**Provider Enrollment**	This section was moved and renumbered from 2303.13 to 2303.19. Terminology and acronyms were updated and reworded for clarity and continuity. 'Termination' removed from title. Added Provider Types and website information for enrollment checklists. Removed language regarding termination of providers due to non-compliance.
2303.20	**Billing Procedures**	This section was renumbered from 2303.15 to 2303.20. Terminology and acronyms were updated and reworded for clarity and continuity. Added link to access the fiscal agent's website for the 'Provider Billing Guide Manual.' 'Coverage and Limitations' and 'Provider Responsibility' sections removed as this information

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		is duplicative and can be found in the Provider Billing Guide Manual.
2303.21	**Advance Directives**	This section was renumbered from 2303.16 to 2303.21. Additional language was added detailing the case manager's responsibility to provide each recipient with information on Advance Directives.
2304	**Hearings Requests Due to Adverse Actions**	The title of the section was updated from 'Hearings to 'Hearings Requests Due to Adverse Actions'. Added explanation of the hearings process due to adverse action taken on waiver eligibility.
2304.1	**Suspended Waiver Services**	Section renumbered from 2304.1A to 2304.1. Terminology and acronyms were updated and reworded for clarity and continuity. The language was updated/reworded for clarity throughout the section. Process for case manager revised.
2304.2	**Release from Suspended Waiver Services**	This section was renumbered from 2304.1B to 2304.2. The language was updated/reworded for clarity throughout the section. Removed "(medical, social, or waiver)" from number 2 as it is too specific when discussing POC services and included requirement to record date of resolution to be documented in the case narrative.
2304.3	**Denial of Waiver Services**	This section was renumbered from 2304.1C to 2304.3. Terminology and acronyms were updated and reworded for clarity and continuity. Updated title of 2304.3 to "Denial of Waiver Eligibility" Updated DHCFP Case Manager or HCBS providers to "Case Manager" throughout section.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Removed information regarding establishment of POC from number 4 as this will no longer be done during the intake process. Added waitlist priority levels 1-4 to #11. Removed #13 indicating a recipient may be denied if an LRI can provide the service, as LRIs are now able to provide some services. Added #12 denial reason if there are no enrolled Medicaid providers in the applicant's area. Added #13 denial reason if the applicant is in an institution and discharge within 60 days is not anticipated. Some information was moved to section for "Reduction or Denial of Direct Waiver Services" as they are denial reasons specific to direct waiver services and not the entirety of the waiver program. Added "recipient" to some denial reasons for clarity. Added additional denial reason #14 to deny specific waiver services when a recipient does not have a need or ability for the requested waiver service. Updated NOD request process.
2304.4	**Reduction or Denial of Direct Waiver Services**	Section renamed to "Reduction or Denial of Direct Waiver Services" and reasons from Reductions and Denials section combined. Terminology and acronyms were updated and reworded for clarity and continuity. Added note to clarify when waiver services are reduced to zero it is considered a reduction of services. Revised NOD request process.
2304.5	**Termination of Waiver Program Eligibility**	This section was renumbered from 2304.1D to 2304.5 and renamed "Termination of Waiver Program Eligibility".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Terminology and acronyms were updated and reworded for clarity and continuity. Changed "ADSD" to "Case Manager" throughout to encompass both ADSD and private Case Management. Revised first paragraph to clarify reasons for termination of program eligibility. Removed #1 regarding recipient failure to pay patient liability. Removed #2 indicating recipient no longer meet physical disability criteria. Reworded #3 for clarity and to be consistent with the rest of the MSM, removed specific examples of failure to cooperate in order to cover more termination reasons. Updated the language in #7 to encompass more types of fraudulent activities. Added #11 death of recipient as a termination. Added #12 when a recipient's support system is not adequate to provide a safe environment during the time HCBS waiver services are being provided. Added #13 when HCBS Waiver services are not adequate to ensure the health, welfare, and safety of the recipient. Added #14 when a recipient fails to cooperate. Reworded the last paragraph of this section for clarification that when DWSS receives notification of the recipient's death, DWSS must notify ADSD and DHCFP.
2304.6	**Reauthorization within 90 days of Waiver Termination**	This section was renumbered from 2304.2 to 2304.6. Terminology and acronyms were updated and reworded for clarity and continuity.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The language was updated/reworded for clarity throughout the section.
2304.6A	**Coverage and Limitations**	This section added to clarify the process for slot allocation when someone enters a nursing facility, hospital, or is incarcerated. The slot is held for 90 days from the date on the notice of termination.
2304.6B	**Provider Responsibilities**	This section added to ensure appropriate action is taken by the case manager when a recipient is reauthorized.
2304.6C	**Recipient Responsibilities**	This section added to clarify that recipients must cooperate fully with the reauthorization process.
2305	**Appeals and Hearings**	This section renumbered from 2304.3 to 2305. Terminology and acronyms were updated and reworded for clarity and continuity. Added language to clarify the need to inform the applicants/recipients of the opportunity to request a Fair Hearing.

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2300 INTRODUCTION

The Home and Community Based Services (HCBS) Waiver for Persons with Physical Disabilities (PD Waiver) recognizes many individuals are at risk of being placed in hospitals or Nursing Facilities (NF) can be cared for in their homes and communities, preserving their independence and ties to family and friends at an average cost no higher than that of institutional care.

The PD Waiver is an optional service approved by the Centers for Medicare and Medicaid Services (CMS), which authorizes the Division of Health Care Financing and Policy (DHCFP) the flexibility to design this waiver and select a mix of waiver services based on the identified needs, and is designed to provide eligible Medicaid waiver recipients access to both State Plan Services and certain extended Medicaid covered services.

Nevada acknowledges that persons with disabilities can lead satisfying and productive lives, when they are provided the needed services and supports to do so.

2301 AUTHORITY

Section 1915(c) of the Social Security Act (SSA) permits states the option to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services to eligible individuals who may require such services in order to remain in their communities and avoid institutionalization.

Statutes and Regulations

- Social Security Act (SSA): 1915(c) (HCBS)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Nevada Revised Statutes (NRS) Chapters, 200 (Crimes Against the Person), 426 (Persons with Disabilities), 427A (Services to Aging Persons and Persons with Disabilities), 422 (Health Care Financing and Policy), 449 (Medical and Other Related Facilities), 616 (Industrial Insurance), 706 (Motor Carriers), and 446 (Food Establishments)
- NRS 449A.114 – Patient Notification of Intent to Transfer
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- Section 3715 of The Coronavirus Aid, Relief, and Economic Security (CARES) Act
- 42 CFR 435.540 – Definition of Disability
- 42 CFR 441.301(c)(1) through (c)(5) – Federal Person-Centered Planning and Settings Requirements

2302 RESERVED

2303 POLICY

2303.1 WAIVER ELIGIBILITY CRITERIA

The PD Waiver waives certain statutory requirements and is offered to eligible recipients to assist them to remain in their own homes or community.

Eligibility for the PD Waiver is determined by DHCFP, Aging and Disability Services Division (ADSD), and the Division of Welfare and Supportive Services (DWSS):

A. Each applicant/recipient must meet and maintain a Level of Care (LOC) for admission into a NF and would require imminent placement in a NF (within 30 days or less) if HCBS or other supports are not available.

B. The applicant must have a physical disability as determined by the DHCFP Physician Consultant. For the disability determination process refer to section 2303.1B.

C. Each applicant/recipient must demonstrate a continued need for the services offered under the PD Waiver to prevent placement in a NF or hospital. Utilization of State Plan Services only does not support the qualifications to be covered by the waiver.

D. Each applicant/recipient must require the provision of at least one ongoing waiver service monthly.

E. Each applicant/recipient must have an adequate support system. This support system must be in place to ensure the physical, environmental, and basic care needs of the applicant/recipient are met to provide a safe environment during the hours when HCBS are not being provided.

F. Applicants may be placed from a NF, acute care facility, another HCBS program, or the community.

G. Applicants must meet Medicaid financial eligibility as determined by DWSS initially and for redetermination.

2303.1A COVERAGE AND LIMITATIONS

1. Services are offered to eligible recipients who, without the waiver services, would require institutional care (provided in a hospital or NF) within 30 days or less.

2. Recipients on the waiver must meet and maintain Medicaid's eligibility requirements for the waiver for each month in which waiver services are provided.

3. Services shall not be provided and will not be reimbursed until the applicant/recipient is found eligible for waiver services. Services must be prior authorized.

4. If an applicant is determined to be eligible for more than one HCBS Waiver, the individual cannot receive services under two or more such programs at the same time. The applicant must choose one HCBS Waiver and receive services provided by that program.

5. Recipients of the HCBS Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close coordination between the hospice agency and the case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.

6. Waiver services may not be provided while a recipient is an inpatient of an institution. Section 3715 of the CARES Act may be utilized where HCBS can be provided in an acute care hospital setting as long as those services are:

   a. Identified in an individual's person-centered plan (referred to throughout this chapter as the Plan of Care (POC);

   b. Provided to meet needs of the individual that are not met through the provision of hospital services;

   c. Not a substitute for services that the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement; and

   d. Designed to ensure smooth transitions between acute care settings and home and community-based settings, and to preserve the individual's functional abilities.

7. The PD Waiver is limited by legislative mandate to a specific number of recipients who can be served through the waiver per year (slots). When no waiver slots or case management providers are available, the ADSD utilizes a waitlist to prioritize applicants who have been presumed to be eligible for the waiver.

8. The DHCFP must assure the Center for Medicare and Medicaid Services (CMS) that DHCFP's total expenditure for home and community-based and other State Plan Medicaid services for all recipients under this waiver will not, in any calendar/waiver year, exceed 100% of the amount that would be incurred by DHCFP for all these recipients if they had been in an institutional setting in the absence of the waiver. The DHCFP must also document there are safeguards in place to protect the health and welfare of recipients.

2303.1B DISABILITY DETERMINATION PROCESS

The disability determination process is completed as follows:

1. Request and receive necessary medical evidence from the applicant's acceptable medical sources. Supporting documentation containing sufficient evidentiary information (medical, psychological, and applicable vocational and/or social information) to determine disability.

   Although the ADSD Intake Specialist will assist the applicant in obtaining medical records, each individual is responsible for providing medical evidence showing that they have a physical impairment as well as the severity of the impairment.

2. The applicant must provide acceptable medical evidence demonstrating a physical disability warranting the services needed, which may include one or more of the following:

   a. Primary care office visit notes;

   b. Clinical findings including medical history, diagnosis, physical, and/or discharge summary; and

   c. Treatment and prognosis.

   d. Copies of medical evidence from hospitals, clinics, or other health facilities where an individual has been treated.

3. All medical reports received are considered during the disability determination.

4. Acceptable Medical sources include:

   a. Licensed physicians (medical or osteopathic doctors), Advanced Practice Nurse (APRN), or Physician Assistant (PA/PA-C);

   b. Licensed optometrists, for purposes of establishing visual disorders only;

   c. Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankles, depending on whether the state in which the podiatrist practices permit practice of podiatry on the foot only, or the foot and ankle.

5. The DHCFP Physician Consultant will review the application and determine eligibility based on the most recent edition of Disability Evaluation under Social Security Disability Standards within five business days.

6. Once the disability determination decision has been made by DHCFP, the ADSD Intake Unit must be notified of the decision via the HCBS Waiver Eligibility Status Form within ten business days from the date of the request.

7. The DISA screen located in the NOMADS system cannot be accepted as proof of disability.

NOTE: In the event the DHCFP Physician Consultant determines that the applicant does not meet the physical disability criteria, the DHCFP LTSS Unit will issue a NOD to the applicant indicating "The service(s) is/are not substantiated as medically necessary. Contact your Medicaid provider as there may be additional documentation to submit to demonstrate a medical necessity".

2303.1C APPLICANT/RECIPIENT RESPONSIBILITIES

1. Applicants/recipients must meet and maintain all criteria to become eligible and remain on the PD Waiver.

2. Applicants and/or their designated representative/LRI must:

   a. Participate and cooperate with the Intake Specialist during the intake process;

   b. Provide medical records within 30 days of request; and

   c. Complete and sign all required waiver forms.

2303.2 WAIVER SERVICES

DHCFP determines which services will be offered under the HCBS Waiver. Providers and recipients must agree to comply with all waiver requirements for service provision.

2303.2A COVERAGE AND LIMITATIONS

Under the waiver, the following services are covered if identified in the POC as necessary to remain in the community and avoid institutionalization:

1. Case Management;

2. Homemaker Services;

3. Respite;

4. Attendant Care Services;

5. Assisted Living (AL) Services;

6. Chore Services;

7. Environmental Accessibility Adaptations (EAA);

8. Home Delivered Meals;

9. Personal Emergency Response System (PERS);

10. Specialized Medical Equipment and Supplies;

2303.2B PROVIDER RESPONSIBILITIES

1. Must obtain and maintain a provider number (Provider Type (PT) 58) through DHCFP's Fiscal Agent

2. All providers must meet all federal, state, and local statutes, rules and regulations relating to the services being provided.

3. In addition to this chapter, providers must also comply with rules and regulations as set forth in MSM Chapter 100 - Medicaid Program. Failure to comply with any or all stipulations may result in DHCFP's decision to exercise its right to terminate a provider's contract.

4. Provider Termination of Waiver Services

   a. The provider may terminate direct waiver services without notice for any of the following reasons:

      1. The recipient or another person in the household subjects the provider to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations, or threats of physical harm;

      2. The recipient's Medicaid eligibility is found ineligible for waiver services;

      3. The recipient requests termination of services;

      4. The place of service is considered unsafe for the provision of waiver services;

      5. The recipient refuses services offered in accordance with the approved POC;

      6. The recipient is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

      7. The provider is no longer able to provide services as authorized;

      8. The recipient requires a higher level of care that cannot be met by the waiver service;

      NOTE: A provider's inability to provide services for a specific recipient does not constitute termination or denial from the HCBS Waiver program. The recipient may choose another provider.

b. Notification Requirements

As appropriate, the provider must notify the recipient and/or designated representative/LRI and agencies of the date when services are to be terminated. The case manager should be notified thirty calendar days prior to the date services will be terminated. The basis for the action and the intervention/resolution(s) attempted must be documented prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

5. Discontinuation of Direct Waiver Service Provider Agreement

If a provider decides to discontinue providing waiver services for any reason not listed in 2303.2B(4) – Provider Termination of Waiver Services, the provider shall:

a. Provide the recipient with written notice at least 30 calendar days in advance of service discontinuation;

b. Provide the recipient's case manager with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and

c. Continue to provide services through the notice period or until all recipients are receiving services through another provider, whichever occurs sooner.

6. Must understand the authorized service specification on the POC, record keeping responsibilities, and billing procedures for provided waiver services.

7. Flexibility of Service Delivery

The total weekly authorized hours for Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The provider and recipient will determine how to use the weekly authorized hours on an ongoing basis; however, any changes that do not increase the total authorized hours can be made within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider.

8. Must be responsible for any claims submitted or payment received on the recipient's behalf; such claims should be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws.

9. Must understand that payment for services will be based on the level of service or specific tasks identified on the POC.

10. Legally Responsible Individuals (LRI) may be paid to provide activities that family caregivers would not ordinarily perform or are not responsible for performing. Additional dependence on LRIs is above the scope of normal daily activities such as assistance in bathing, dressing, and grooming, toileting, and with specialized medical care needs.

    LRIs may furnish attendant care, homemaker, respite, and chore services (refer to the direct waiver service type throughout this chapter for additional limitations). It must be the recipient's choice for the LRI to provide the services, which is achieved through the person-centered POC development.

    a. LRIs cannot provide State Plan PCS in conjunction with any of the waiver services. State Plan PCS does not allow payment of LRIs.

    b. The LRI must be an employee of a provider agency or Intermediary Service Organization (ISO) as a PT 58 with Specialty Code(s) 189, 039, 191, and/or 199.

    c. LRIs must utilize an Electronic Visit Verification (EVV) system for check in/check out.

11. All providers may only provide services that have been identified in the POC and have a Prior Authorization (PA), if required.

12. Must have a backup mechanism to provide the recipient with their authorized service hours in the absence of a regular caregiver due to sickness, vacation, or any other unscheduled event.

    The provider must notify the recipient's case manager if there is a change in the established back-up plan.

13. Sign and date the finalized POC within 60 calendar days from waiver enrollment. If a service has been included on the POC and there is no provider assigned, the signature would not be required until the provider is selected by the individual and would be required by the next face to face visit.

14. Serious Occurrence Report (SOR):

    All direct waiver service providers are required to report a SOR within 24 hours of discovery. A written report must be submitted to the assigned case manager within five business days of the incident. All providers are required to maintain a copy of the reported SOR in the recipient's record. It is the provider's responsibility to understand the proper

reporting method to the assigned case management provider and participate with any requested follow-up timely.

Reporting of a SOR can be in paper form or electronic format which is accessible to all direct waiver service providers, public and State staff via the DHCFP's public website and the DHCFP Fiscal Agent's website. The process for reporting incidents will vary depending on the case management provider. The direct waiver service providers are responsible to know who the case manager is and the proper form of submission.

Due to the different databases utilized by case management providers, the process for submitting a SOR are as follows:

a. Public (ADSD) Case Management:

Providers must complete the web-based Nevada DHCFP SOR form, available at the Fiscal Agent's website (https://www.medicaid.nv.gov), under Providers - Forms. Upon receipt of the submitted electronic SOR, the ADSD case manager will perform the necessary follow-up.

b. Private Case Management (PCM):

Providers must complete the paper Nevada DHCFP SOR form, available at the Fiscal Agent's website (https://www.medicaid.nv.gov), under Providers - Forms. The completed SOR form must be submitted to the DHCFP LTSS inbox at hcbs@dhcfp.nv.gov. The paper form will be re-routed to the PCM agency who will enter the SOR in their database and perform the necessary follow-up.

Serious occurrences involving either the provider/employee or recipient may include, but are not limited to the following:

1. Suspected physical or verbal abuse;

2. Unplanned hospitalization;

3. Abuse, neglect, exploitation, isolation, abandonment, or unexpected death of the recipient;

4. Injuries requiring medical intervention;

5. Sexual harassment or sexual abuse;

6. Theft;

7. An unsafe living environment;

8. Elopement of a recipient;

9. Medication errors resulting in injury, hospitalization, medical treatment or death;

10. Death of the recipient while enrolled in the HCBS Waiver program;

11. Loss of contact with the recipient for three consecutive scheduled days;

12. Any event which is reported to the Division of Child and Family Services (DCFS) or the appropriate county agency (under 18 years old), Adult Protective Services (APS) (18 years old and above), or law enforcement agencies.

The State of Nevada has established mandatory reporting requirements of suspected incidents of abuse, neglect, isolation, abandonment, and exploitation. APS, DCFS and/or local law enforcement are the receivers of such reports. Suspected abuse must be reported as soon as possible, but no later than 24 hours after the person knows or has reasonable cause to believe that a person has been abused, neglected, isolated, abandoned or exploited. Refer to NRS 200.5091 to 200.50995 "Abuse, neglect, exploitation, abandonment, or isolation of older and vulnerable persons".

15. Criminal Background Checks

DHCFP policy requires all direct waiver service providers and its personnel, including owners, officers, administrators, managers, employees, and consultants to undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure and then at a minimum of every five years thereafter to ensure no convictions of applicable offenses have been incurred. For complete instructions, refer to the Division of Public and Behavioral Health (DPBH) website at https://dpbh.nv.gov.

DHCFP's Fiscal Agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100 – Medicaid Program.

16. Recipient Records

a. The number of units specified on each recipient's POC, for each specific service will be considered the maximum number of units allowed to be provided by the caregiver and paid by DHCFP's Fiscal Agent, unless the case manager has approved an increase in service due to a temporary condition or circumstance.

b. Cooperate with DHCFP, ADSD, and/or State or Federal reviews or inspections of the records.

c. Provider agencies who provide waiver services in the home must comply with the 21st Century CURES Act. Refer to section 2303.14 of this chapter for detailed information.

17. Adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements. Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other protected health information.

18. Obtain and maintain a business license as required by city, county, or state government, if applicable.

19. Providers must obtain and maintain required Health Care Quality and Compliance (HCQC) licensure, if required.

20. Qualifications and Training:

a. All service providers must arrange training for employees who have direct contact with recipients of the PD Waiver and must have service specific training prior to performing a waiver service. Training at a minimum must include, but is not limited to:

1. Policies, procedures, and expectations of the agency relevant to the provider, including recipient and provider rights and responsibilities;

2. Record keeping and reporting including daily records and SORs;

3. Information about the specific needs and goals of the recipients to be served;

4. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients to include; understanding care goals; respecting recipient rights and needs; respect for age, cultural and ethnic differences; tolerant of the varied lifestyles of the people served, recognizing family relationships; confidentiality; and abuse. Neglect, and exploitation, including signs, symptoms, and prevention; respecting personal property; ethics in dealing with the recipient, family, and other providers; handling conflict and complaints; and other topics as relevant; and

5. Paid and unpaid staff must receive one hour of training related to the rights of the rights of the individual receiving services and individual experience as outlined in the HCBS Final Regulation.

2303.2C RECIPIENT RESPONSIBILITIES

The recipient, or if applicable, the recipient's designated representative/LRI will:

1. Notify the provider(s) and case manager of any change in Medicaid eligibility, upon discovery;

2. Notify the direct service provider(s) and DWSS of current insurance information, including the name of the insurance coverage, such as Medicare;

3. Notify the direct service provider(s) and case manager of changes in medical status, support systems, service needs, address, or location changes, and/or any changes in status of designated representative/LRI.

4. Treat all providers and staff members appropriately. Provide a safe, non-threatening and healthy environment for caregiver(s) and the case manager(s);

5. Sign and date the provider(s) record(s) as appropriate to verify services were provided. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented on the Statement of Choice (SOC) and/or POC, as appropriate;

6. Notify the provider and case manager when scheduled visits cannot be kept or services are no longer required;

7. Notify the provider agency or case manager of any missed appointments by the provider agency staff;

8. Notify the provider agency or case manager of any unusual occurrences, complaints regarding delivery of services, specific staff, or to request a change in caregiver or provider agency ;

9. Furnish the provider agency with a copy of their Advance Directive if appropriate;

10. Work with the provider agency to establish a back-up plan in case the caregiver is unable to work at the scheduled time, and report to the case manager if there is a change to the established back-up plan;

11. Not request a provider to work more than the hours authorized in the POC;

12. Understand that a provider may not work or clean for a recipient's family, household members or other persons living in the home with the recipient;

13. Not request a provider to perform services not included in the POC;

14. Contact the case manager to request a change of provider agency;

15. Complete, sign, date and submit all required forms within ten calendar days;

16. Understand that at least one annual face-to-face visit is required;

17. Be physically available for authorized waiver services, face-to-face visits, and assessments.

18. Agree to utilize an approved Electronic Visit Verification (EVV) system for the waiver personal care like services being received from the provider agency; and

19. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If Interactive Voice Response (IVR) is utilized, a vocal confirmation is required.

20. Actively participate in the development of the POC which allows the recipient to make informed choices.

2303.3 INTAKE ACTIVITIES

Intake activities are a function of the ADSD Operations Agency and occur prior to an applicant being determined eligible for a waiver.

2303.3A COVERAGE AND LIMITATIONS

1. Intake Referral Process

ADSD Operations Agency has developed policies and procedures to ensure fair and adequate access to services covered under the PD Waiver. All new referrals will be submitted to the ADSD Intake Unit for evaluation and processing.

a. Referral/Application

1. A referral for the PD waiver may be initiated by completing an ADSD Program Application and submitting it to the appropriate ADSD District Office by mail, email, fax, or in person by the applicant and/or designated representative/LRI.

NOTE: An inquiry for the PD Waiver may be made via phone, mail, email, fax or in person through any ADSD District Office. An inquiry is not considered an application for the PD Waiver and does not initiate the application process.

2. When an application is received and assigned, the ADSD Intake Specialist will make phone/email/verbal contact with the applicant and/or designated representative/LRI within 15 working days of receipt of the application.

   During the initial phone/email/verbal contact, the applicant is advised they have 30 calendar days to gather medical records demonstrating their physical disability in order to continue the application process.

3. Once medical records have been received, a face-to-face visit is scheduled by the ADSD Intake Specialist within 45 days of the application date to assess the LOC and complete all necessary intake forms. The LOC assessment will determine the applicant's eligibility for waiver services and placement on the waitlist, if appropriate.

4. If the applicant is determined to meet NF LOC criteria, ADSD will provide medical records and LOC determination to DHCFP LTSS for the disability determination. Refer to MSM 2303.1B for more information on the disability determination process.

5. If the applicant does not meet the waiver requirements, the applicant must be sent a Denial NOD issued by the DHCFP LTSS Unit, and verbally informed of the right to continue the Medicaid application process through DWSS. The applicant will also be referred to other agencies and community resources for services and/or assistance.

2. Placement on the Wait List when No Waiver Slot is Available

   a. If no Waiver slot is available, and the ADSD Intake Specialist has determined the applicant meets NF LOC, and has a Waiver service need, the applicant will be placed on the wait list according to priority and referral date.

      Wait List Priority:

      Level 1 Applicants previously in a hospital or NF and who have been discharged to the community within six months and have a significant change in support systems and are in a crisis situation;

      Level 2: Applicants who have a significant change in support systems and/or are in a crisis situation and require at least maximum assistance in a combination of four or more of the following ADLs: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or are in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

b. Applicants may be considered for an adjusted placement on the waitlist based on a significant change of condition/circumstances.

c. A denial NOD is sent to applicants who are placed on the waitlist indicating "no slot available" and will indicate the applicant's priority level on the waitlist.

3. Waiver Slot Allocation

Once a slot for the waiver is available, the applicant will be processed for the waiver.

The procedure used for processing an applicant is as follows:

a. The ADSD Intake Specialist will work with the applicant to complete any paperwork that was not collected during the initial assessment.

b. The applicant/designated representative/LRI must understand and agree that personal information may be shared with providers of services and others, as specified on the form.

c. The applicant will be given the right to choose waiver services in lieu of placement in a NF. If the applicant /designated representative/LRI prefers placement in a NF, the ADSD Intake Specialist will provide information and resources to the applicant on who to contact to arrange facility placement.

d. The applicant will be given the right to request a Fair Hearing if not given a choice between HCBS Waiver services and NF placement.

4. The ADSD Intake Specialist will send the NMO-3010 "HCBS Waiver Eligibility Status Form" to DWSS for review and approval of the Medicaid application.

5. Once DWSS has approved the application, waiver services can be initiated.

NOTE: If an applicant is denied for financial eligibility, DWSS will send a denial NOD to the applicant.

6. If the applicant is denied by ADSD for program eligibility, ADSD will submit a request to the DHCFP LTSS Unit requesting a denial NOD be sent to the applicant. The request must include the reason(s) for the denial. The DHCFP LTSS Unit will send the applicant the denial NOD. DHCFP will return a copy of the NOD to ADSD for their record.

7. Effective Date for Waiver Services

   The effective date for waiver services is determined by eligibility criteria verified by ADSD, the financial eligibility approval date by DWSS, or the residential facility for groups placement move in date, whichever is later.
   If the applicant is in an institution, the effective date cannot be prior to the date of discharge from the institution.

8. All applicants as applicable will be provided information regarding choice of case management providers by the ADSD Intake Specialist during the initial assessment and allowed the opportunity to choose a case management provider to be assigned once approved for waiver services. If a case management provider is not selected by the applicant/recipient, upon waiver approval one will be assigned by the ADSD Operations Agency based upon rotation and geographical location.

   Once an applicant has been approved and a case management provider is assigned, the ADSD Intake Specialist will forward all supporting documents within five business days to that provider for ongoing case management services.

   Supporting documents include a signed and dated SOC, a signed and dated HCBS Acknowledgement Form, copy of the ADSD Program Application, copy of the LOC, copy of the Disability Determination indicated on the NMO-3010, any supporting medical records, any notes from the Intake Specialist needed to support ongoing services, and a copy of the MAABD application submitted to DWSS.

   NOTE: If a case management provider is not selected within ten business days by the applicant, one will be assigned by the ADSD Operations Agency based upon a rotation schedule and provider capacity.

2303.4 CASE MANAGEMENT

Case Management services assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

2303.4A COVERAGE AND LIMITATIONS

Case managers must provide the recipient with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. The case

management service is on an as needed basis. Case managers must, at a minimum, have an annual face-to-face visit and ongoing contact that is sufficient to meet the needs of the recipient. The amount of case management services must be adequately documented and substantiated by the case manager's notes.

1. Case management is provided to eligible recipients enrolled in HCBS Waiver programs and must be identified as a service on the POC. Case management providers are responsible for confirming the recipient's eligibility each month prior to rendering waiver services. The recipient has a choice of case management providers who are actively enrolled with DHCFP under Provider Type (PT) 58.

   There are two components of case management services: administrative activities, and those activities that are considered billable:

   Administrative activities include:

   a. Travel

   b. Follow-up conducted resulting from a negative Participant Experience Survey (PES) finding.

   c. Request a Notice of Decision (NOD) when a negative action is taken (denial, suspension, termination, and reduction of services).

   d. Activities related to program eligibility including denials/Fair Hearings.

   e. Activities related to coordination of care for recipients in a suspended status.

   f. General administrative tasks including but not limited to scheduling of visits, voicemails, email communications with DHCFP, scanning and uploading documents, mailing provider lists and/or resources to recipient, telephoning providers for general availability, and outreach activities for solicitation.

   Billable case management activities include:

   a. Completion of the SHA and LOC with the recipient (annual reassessment of eligibility and any change of condition).

   b. POC development and follow-up for initiation of waiver services, including any activity related to the Prior Authorization (PA) requests approval and/or follow-up.

   c. POC monitoring/follow-up (includes provider changes, a change in services/delivery, change in condition resulting in an amended POC, etc.).

   d. Any mandated reporting activity (APS, HCQC, Law Enforcement, etc.)

e. Direct contact with recipients to aid in resource navigation, facilitation, and coordination with waiver and community resources.

f. Care Conference: collaboration and involvement in discharge planning from a long-term care setting; interdisciplinary meetings; collaboration with other entities on shared cases; coordination of multiple services and/or providers based on the identified needs in the SHA.

g. Monitoring the overall provision of waiver services, to protect the health, welfare, and safety of the recipient and to determine that the POC goals are being met.

h. Monitoring and documenting the equality of care through contacts with recipients.

i. Ensuring that the recipient retains freedom of choice in the provision of services.

j. Notifying all affected providers of changes in the recipient's medical status, service needs, address, and location, or of changes of the status of the designated representative/LRI.

k. Notifying all affected providers of any unusual occurrence or change in status of a waiver recipient.

l. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff.

m. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

n. Any adverse actions resulting in suspensions, terminations and/or reductions in services.

2. Upon assignment of an HCBS PD Waiver recipient, the case manager is responsible for conducting a face-to-face Social Health Assessment (SHA) and is used for the following:

a. Address the recipient's needs, preferences, and individualized goals.

b. Address ADLs, IADLs, service needs, and support systems.

c. Gathering information regarding health status, medical history, and social needs.

d. Consider risk factors, equipment needs, behavioral status, current support system, and unmet service needs.

e. Ensures recipients are afforded the same access to the greater community as individuals who do not receive Medicaid HCBS, regardless of where they reside.

f. Ensures recipients are afforded employment opportunities as desired, regardless of where they reside.

3. The person-centered POC is developed in conjunction with the case manager, recipient/designated representative/LRI and/or a person of their choosing initially, annually, and when changes occur.

If the recipient chooses to have a designated representative/LRI, they must complete the Designated Representative Attestation form. The case manager is required to document the designated representative/LRI who can sign documents and be provided information about the recipient's care.

a. The initial and annual written POC must reflect the services and supports that are important for the recipient to meet the needs identified through the SHA, as well as what is important to the recipient regarding preference for the delivery of such services and supports and:

1. Reflect that the setting in which the recipient resides was chosen by the recipient;

2. Reflect opportunities to participate in integrated community settings, and seek employment or volunteer activities;

3. Reflect the recipient's strengths and preferences, and cultural considerations of the recipient;

4. Include identified personalized goals and desired outcomes, and reflect the services and supports (paid and unpaid) that will assist the recipient in achieving their identified goals;

5. Reflect risk factors and measures in place to minimize them, including back-up plans and strategies;

6. Be understandable to the recipient receiving the services and supports; and

7. Prevent the provision of unnecessary, duplicative, or inappropriate services and supports.

b. The recipient is afforded choice of service and providers, establishing the frequency, duration and scope, and method of service delivery are integrated in the planning process to the maximum extent possible.

NOTE: During the POC development, if the recipient chooses an LRI to provide personal care-like services, the case manager will provide a Designated Representative Attestation form to be signed by the recipient and/or the designated representative/LRI (who is NOT the paid caregiver) to guard against self-referral of LRIs. The designated representative/LRI indicated on the form is responsible for directing, monitoring, and supervising the provision of services by the caregiver.

c. The POC must identify all authorized waiver services; as well as other ongoing community support services that the recipient needs to remain in their home and live successfully in the community.

1. During the initial or annual POC development, and there is no chosen direct waiver provider, the service must still be listed on the POC to include the other elements with the provider as "to be determined (TBD)" and must be signed and dated by the recipient and/or designated representative/LRI. Documentation to support the efforts made by the case manager and the recipient to choose and assign a provider must be in the recipient's electronic record.

2. Once a provider has been selected, the POC must be updated to list the provider, along with signatures and date from the recipient and/or designated representative/LRI and provider during the next face-to-face visit.

d. The POC must include the recipient's chosen method and frequency of scheduled contacts (refer to section 2303.4A.4 – Person-Centered contacts for further information on frequency).

e. Changes to the POC

1. If there is a significant change (as defined in the MSM addendum) to the established LOC, the recipient must be reassessed and the LOC and POC must be updated within 30 days of the reported change.

2. The POC does not need to be revised when a recipient's waiver service needs change due to a temporary condition or circumstance lasting eight weeks or less. The case manager must document the change in the electronic case record.

3. When the case manager needs to update the current POC, the case manager can print the current POC and note any changes for the recipient and/or designated representative/LRI to sign. The case manager will formalize the updated POC within the electronic case file.

a. The POC with the handwritten changes/amendments containing the recipient and case manager's signature and date must be attached to the formalized POC and kept in the recipient's electronic case file.

b. A copy of the formalized POC and signed handwritten POC must be provided to the recipient and/or designated representative/LRI.

f. The POC must be finalized within 60 calendar days from waiver enrollment, date of reassessment, or significant change. The finalized POC must be signed and dated by the recipient and/or designated representative/LRI, case manager and provider.

g. The case manager is responsible to distribute the section of the POC which pertains to the specific waiver provider including the scope, frequency, duration, method of service delivery, the recipient's identified goals, and risk factors and mitigation.

h. Residential and Non-Residential Facilities (Assisted Living Facilities only)

When a modification is made on the POC that restricts a recipient's freedom of choice, it must be supported by a specific assessed need and justified in the POC. The direct service provider must notify the case manager to request modifications of the POC.

The case manager must document the following requirements on the POC:

1. Identify a specific and individualized assessed need;

2. Document the positive interventions and supports used prior to any modification to the POC;

3. Document less intrusive methods of meeting the need that have been tried but did not work;

4. Include a clear description of the condition that is directly proportionate to the specific assessed need;

5. Include regular collection and review of data to measure the ongoing effectiveness of the modification;

6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;

7. Include an assurance that interventions and supports will cause no harm to the individual; and

8. Include the informed consent of the individual.

4. Person-Centered Contacts

a. Person-centered contacts are required to be delivered by the case management provider as agreed to in the signed POC. At a minimum, there must be a face-to-face visit with each recipient and/or designated representative/LRI annually. All other ongoing contact methods may be determined by the recipient.
NOTE: When case management is the only waiver service received, the case manager will continue to have monthly contact with the recipient and/or designated representative/LRI to ensure the health and welfare of the recipient. The duration, scope, and frequency of case management services billed to DHCFP must be adequately documented and substantiated by the case manager's narratives.

b. Person-centered contacts must be documented in the recipient's electronic record and must include at a minimum:

1. Monitoring of the overall provision of waiver services and determine that the personalized goals identified in the POC are being met.

2. Monitoring and documenting the quality of care to include assurance that the health and safety of the recipient is maintained:

a. Quality of care includes the identification, remediation and follow-up of health and safety, risk factors, needs and concerns (to include changes in provider and/or back-up plan or support network) of the recipient, waiver service satisfaction and whether the services are promoting the personalized goals stated in the POC. The case manager also assesses the need for any change in services or providers.

b. If a recipient resides in a residential setting (AL facility), the case manager must inquire on the recipient's satisfaction in the residential setting.

3. Case managers must demonstrate due diligence to hold ongoing contacts as outlined in the POC (frequency and method). Ongoing contacts are required, and every attempt to contact the recipient should be documented. At least three telephone calls must be completed on separate days, if no response is received after the third attempt, a letter must be sent to the recipient requesting a return contact. If the recipient fails to respond by the date indicated in the letter, the recipient may be terminated.

4. If an LRI is chosen by the recipient to provide paid personal care-like services in their private home, the case manager will conduct more frequent

home visits (no less than bi-annually in person and quarterly by telephone) to ensure the recipient is satisfied with the waiver services and caregiver.

5. Annual Reassessments

   a. The recipient's LOC and SHA must be reassessed at a minimum annually.

      1. Once the case manager has completed the reassessment including the LOC, SHA and POC, the case manager will submit the completed LOC to the ADSD Operations Agency for approval.

      2. Once received by the ADSD Operations Agency, a review of the LOC will be conducted, and a decision will be supplied to the case manager provider within five business days.

      3. Upon receipt of the approval from the ADSD Operations Agency, the case manager will complete the PA process for continued services.

      4. If the ADSD Operations Agency determines the LOC is not approved, communication will be delivered to the case management provider within five business days identifying the outcome and the next steps as appropriate.

   b. The POC is updated using the SHA which is completed in collaboration with the case manager and the recipient and/or designated representative/LRI, and/or person of their choosing, who may not be the paid caregiver.

   c. The annual POC is required to be signed no more than 60 calendar days from the date of the reassessment.

6. The case manager may provide support to the recipient and/or designated representative/LRI by assisting with the completion of the DWSS Annual Redetermination (RD).

7. Ensure recipients retain freedom of choice in the provision of services. During the ongoing contact with the recipient the case manager must narrate if a recipient indicates that they are not satisfied with their current waiver services;

8. Notifying all affected providers of any unusual occurrences or changes in the recipient's medical status, service needs, address, or designated representative LRI;

9. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;

10. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency.

11. Case closure activities upon termination of service eligibility, to include notifying DWSS and DHCFP LTSS, and closing any existing prior authorizations.

12. If an ongoing recipient chooses to change case management providers, they may request this by contacting the ADSD Operations Agency as outlined in the SOC. The ADSD Operations Agency will provide the recipient with a list of case management providers for them to choose from. If a new case management provider is not chosen within ten calendar days, the currently assigned case manager will continue to provide the service.

    a. Upon provider selection by the recipient and/or designated representative/LRI, the Operations Agency will notify the selected case management provider agency of the assignment.

    b. The previous case management agency will be given ten business days to provide all requested documentation to the ADSD Operations Agency to assist with the transfer of the recipient to the chosen case management provider.

    c. The new case management provider agency must be reflected on the POC which is required to be signed during the next face-to-face visit.

13. Case managers are responsible for confirming the recipient's Medicaid eligibility each month prior to rendering waiver services.

2303.4B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B:

1. Public case managers must meet the following qualifications:

    a. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

    b. Have a valid driver's license and means of transportation to enable face-to-face visits.

    c. Adhere to HIPAA requirements.

    d. Complete an FBI criminal background check.

2. Private case management provider agencies must:

a. Provide documentation showing taxpayer identification number (SS-4 or CP575 or W-9).

b. Provide proof of Nevada Secretary of State Business license

c. Provide proof of Worker's Compensation Insurance

d. Provide proof of an Unemployment Insurance Account

e. Provide proof of Commercial General Liability of not less than $2 million general aggregate and $1million each occurrence, with the Nevada Division of Health Care Financing and Policy (DHCFP) named as an additional insured. DHCFP's address is 1100 E. William St., Ste. 101, Carson City, Nevada 89701.

f. Provide proof of Commercial Crime Insurance for employee dishonesty with a minimum of $25,000 per loss. The policy must name DHCFP as an additional insured.

g. If you provide transportation in any owned, leased, hired and non-owned vehicles you must also provide:

1. Proof of Business Automobile Insurance, with a minimum coverage of $750,000 combined single limit for bodily injury and property damage for any owned, leased, hired and non-owned vehicles used in the performance of the Medicaid provider's contract. The policy must name DHCFP as an additional insured and shall be endorsed to include the following language: "The State of Nevada shall be named as an additional insured with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or borrowed by the Contractor."

h. Provide a signed Business Associate Addendum (NMH-3820). The Addendum is available at https://www.medicaid.nv.gov on the "Provider Enrollment" webpage under "Required Enrollment Documents."

i. Establish a fixed business landline telephone number published in a public telephone directory.

j. Have a business office accessible to the public during established and posted business hours.

k. Case managers/employees of the private case management agency must also meet the following qualifications:

1. Be currently licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers, licensure as a RN by the Nevada State Board of Nursing or have a professional license or certificate in a medical specialty applicable to the assignment.

2. Have a valid driver's license and means of transportation to conduct home visits.

3. Adhere to HIPAA requirements.

4. Complete an FBI criminal background check.

2303.4C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Participate in the ongoing contacts and reassessment process, accurately representing their skill level needs, preferences, resources, and goals.

2. Together with the case manager, develop and/or review and sign, and date the POC. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file.

3. Choose a Medicaid enrolled case management provider.

2303.5 HOMEMAKER SERVICES

Homemaker services consist of IADLs such as general household tasks, meal preparation, essential shopping, and laundry. These services are provided when the individual regularly responsible for these activities is temporarily absent or unable to manage their private residence and is necessary to avoid placement in an institution. These services are provided to individuals who are not authorized to receive State Plan PCS and require assistance with IADLs.

2303.5A COVERAGE AND LIMITATIONS

1. Homemaker services are provided at the recipient's home, or place of residence (community setting

2. Services must be directed to the individual recipient and related to their health and welfare.

3. DHCFP or its Fiscal Agent and case management providers are not responsible for the replacement of goods damaged in the provision of service.

4. Homemaker services include:

   a. General household tasks: including mopping floors, vacuuming, dusting, changing and making beds, washing dishes, defrosting and cleaning the refrigerator, cleaning bathrooms and kitchens, and washing windows as high as the homemaker can reach while standing on the floor;

   b. Essential shopping to obtain prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient;

   c. Meal preparation: menu planning, storing, preparing, serving food, buttering bread and plating food;

   d. Laundry services: washing, drying, and folding the recipient's personal laundry and linens (sheets, towels, etc.), excluding ironing. The recipient is responsible for any laundromat and/or cleaning fees;

   e. Assisting the recipient and family members or caregivers in learning a homemaker routines and skills, so the recipient may carry on normal living when the homemaker is not present;

   f. Accompanying the recipient to homemaker activities such as shopping or the laundromat. Any transportation to and from these activities is not reimbursable as a Medicaid expense;

   g. Routine clean-up of waste for up to two household pets. Walking a pet is not included unless it is a service animal.

   h. Additional homemaker activities may be approved on a case-by-case basis.

5. Activities the homemaker shall not perform and for which Medicaid will not pay include the following:

   a. Transporting the recipient in a private car;

   b. Cooking and cleaning for the recipient's guests, other household members or for the purpose of entertaining;

   c. Repairing electrical equipment;

   d. Ironing and mending;

   e. Giving permanents, dying, or cutting hair;

f. Accompanying the recipient to appointments, social events, or in-home socialization;

g. Washing walls;

h. Moving heavy furniture, climbing on chairs or ladders;

i. Purchasing alcoholic beverages that are not prescribed by the recipient's physician;

j. Doing yard work such as weeding or mowing lawns, trimming trees, shoveling non-essential snow-covered areas and vehicle maintenance; or

k. Providing care to pets unless the animal is a certified service animal.

6. Live-in LRIs are limited to up to two hours per week, for non-live-in LRIs, the service hours will be based on the case manager's assessment of the recipient's living conditions (e.g. living alone, risk level).

2303.5B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, Homemaker Providers must:

1. Provide adequate training related to homemaking assistance appropriate for recipients with physical disabilities completed initially and annually;

2. Ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system;

3. The service mut be prior authorized by the case manager and documented in an approved EVV system.

2303.5C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.6 RESPITE CARE

Respite Care Services are provided to recipients unable to care for themselves. This service is provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite providers perform general assistance with ADLs and IADLs as well as provide supervision to functionally impaired recipients in their private home or place of residence (community setting).

2303.6A COVERAGE AND LIMITATIONS

1. Respite services may be for 24-hour periods.

2. Respite care is limited to 120 hours for the duration of the POC.

3. Services must be prior authorized by the case manager.

2303.6B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in, Section 2303.2B, Respite providers must:

1. Provide adequate training related to personal care assistance appropriate for recipients with physical disabilities completed initially and annually to include training on personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment, homemaking, and household care;

2. Meet the requirements of NRS 629.091, Section 2303.3B of this Chapter, and MSM Chapter 2600 if a respite provider is providing attendant care services that are considered skilled services; and

3. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

4. Services must be prior authorized by the case manager and documented in an approved EVV system.

2303.6C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.7 ATTENDANT CARE SERVICES

Attendant Care Services are an extension of State Plan Personal Care Services (PCS) intended to support an individual to remain independent within the community. These services are authorized by case managers to assist the recipient's need for ADL and IADL assistance based upon functional deficits.

2303.7A COVERAGE AND LIMITATIONS

The scope and nature of these services do not otherwise differ from State Plan PCS furnished under the State Plan. Attendant Care Services are only provided to individuals aged 21 and over when the limits of the State Plan Option PCS are exhausted. Refer to MSM chapter 3500 for further information.

1. Where possible and preferred, recipients will direct their own service through an ISO. Refer to MSM Chapter 2600. Under the ISO model, the recipient can recruit, select, or terminate a caregiver. If this option is not used, the recipient will choose a provider agency that will otherwise recruit, screen, schedule caregivers, provide backup and assurance of emergency assistance.

2. Extended personal care attendant services in the recipient's POC may include assistance with ADLs and IADLs.

   Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically disabled individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function.

3. Flexibility of Services

   Flexibility of service delivery, which does not alter medical necessity, may occur within a single week period without an additional authorization. Reference 2303.2B.7 of this chapter for details.

2303.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in 2303.2B, the provider must:

1. When the provision of services includes self-directed skilled, qualifications and requirements must be followed in accordance with NRS 629.091, and MSM Chapter 2600.

2. Demonstrate the ability to:

   a. Perform the care tasks as prescribed;

   b. Identify emergency situations and to act accordingly and;

   c. Maintain confidentiality regarding the details of case circumstances.

3. Provide adequate training related to personal care assistance appropriate for recipients with physical disabilities completed initially and annually to include:

   a. Procedures for arranging backup when not available, agency contact person(s), and other information as appropriate. (Note: This material may be provided separate from a training program as part of the provider's orientation to the agency.)

   b. Personal hygiene needs and techniques for assisting with ADLs, such as bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

   c. Home making and household care, including good nutrition, special diets, meal planning and preparation, essential shopping, housekeeping techniques, and maintenance of a clean, safe, and healthy environment.

4. Providers are responsible to ensure that EVV requirements and expectations are met, including the documentation of all services in an approved EVV System.

5. Services must be prior authorized by the case manager and documented in an approved EVV system.

2303.7C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.8 ASSISTED LIVING SERVICES

Assisted Living (AL) services are all inclusive services furnished by an AL services provider that meet the HCBS setting requirements. AL services are intended to provide all support service

needed in the community and may include personal care, homemaker, chore, attendant care, meal preparation, companion, medication oversight (to the extent permitted under state law), transportation, diet and nutrition, orientation and mobility, community mobility/transportation training, advocacy for related social services, health maintenance, active supervision, home and community safety training, provided in a home-like environment in a licensed community care facility.

This service may include skilled nursing care to the extent permitted by state law, nursing and skilled therapy services are incidental rather than integral to the provision of AL services.

2303.8A COVERAGE AND LIMITATIONS

1. AL are all inclusive services furnished by the assisted living provider. Payment is not to be made for 24-hour skilled care. If a recipient chooses AL services, other individual waiver services may not be provided, except case management services.

2. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides supervision, safety, and security.

3. AL providers are expected to furnish a full array of services except when another Federal program is required to provide the service. Other individuals or agencies may also furnish care directly, or under arrangement with the AL provider, but the care provided by other entities supplements that provided by the AL provider and does not supplant it.

4. Federal Financial Participation (FFP) is not available for room and board, items of comfort, or the cost of facility maintenance, upkeep, and improvement.

5. Personalized care furnished to individuals who choose to reside in an AL facility based on their individualized POC, which is developed with the recipient, people chosen by the recipient, caregivers, and the case manager. Care must be furnished in a way that fosters the independence of each recipient.

2303.8B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B providers must:

1. Be licensed and maintain standards as outlined by HCQC under NRS/NAC 449 “Medical and other related entities.”

2. Adhere to all HCQC and ADSD training requirements specific to the waiver population being cared for at the AL facility completed initially and annually.

3. AL facility providers must:

a. Ensure that HCBS Settings requirements and expectations are followed. The HCBS Settings Regulation supports enhanced quality in HCBS programs, adds protections for individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.

b. Notify the case manager within three business days when the recipient states the desire to leave the facility.

c. Participate with the case manager in discharge planning.

d. Notify the case manager within one working day if the recipient's living arrangements have changed, eligibility status has changed, or if there has been a change in health status that could affect recipient's health, safety, or welfare.

e. Notify the case manager of any recipient complaints regarding delivery of service or specific staff of the setting. If the recipient is not satisfied with their living arrangements or services, the case manager will work with the recipient and the provider to resolve any areas of dissatisfaction. If the recipient makes the decision to relocate to another setting, the case manager will provide information and facilitate visits to other contracted settings.

f. Maintain privacy, dignity, and respect during the provisions of services, and ensure living units are not entered without permission.

g. Allow recipients to have visitors of their choosing and access to food at any time.

h. Ensure the facility is physically accessible to the recipient.

i. Conduct business in such a way that the recipient is free from coercion and restraint and retains freedom of choice. AL Facilities must render services based on the recipient's choice, direction, and preferences.

j. Coordinate transportation to and from the setting to the hospital, a NF, routine medical appointment, and social outings organized by the facility. Recipients may choose to enjoy their privacy, participate in physical activities, relax, or associate with other residents. Recipients may go out with family members or friends at any time and may pursue personal interests outside of the residence.

NOTE: For all Medicaid covered services refer to MSM Chapter 1900 – Transportation Services.

k. Accept only those residents who meet the requirements of HCQC licensure and certification.

l. Provide services to PD Waiver recipients in accordance with the recipient's POC.

m. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the PD Waiver except by written consent of the recipient or designated representative/LRI.

n. Have sufficient caregivers present at the facility to conduct activities and provide care and protective supervision for the residents at all times. The provider must comply with HCQC staffing requirements for the specific facility type.

o. Have 24-hour on-site staff to meet scheduled or unpredictable needs and provide supervision, safety, and security.

p. Not use Medicaid waiver funds to pay for the recipient's room and board.

q. Ensure that recipients are provided the opportunity to seek employment and work in competitive integrated settings, engage in community life, control personal resources (such as access to bank accounts), and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

r. Allow each recipient privacy in their sleeping or living unit:

1. Units or rooms have lockable doors. A bedroom or bathroom door in a residential group setting which is equipped with a lock must open with a single motion from the inside. Staff must knock before entering; recipients have the right to choose who enters the bedroom.

2. Recipients sharing units have a choice of roommate.

3. Encourage recipients to utilize personal furniture, furnishing, photo and decorative items to personalize their living space.

s. Not have a lease or other agreement that differs from those individuals who do not receive Medicaid HCBS.

The provider must have a written agreement that includes the following:

1. Provide at least a 30-calendar day notification to the recipient before transferring or discharging them with the exception of a voluntary transfer or discharge, or the requirement to transfer or discharge the recipient to another facility because the condition of the recipient necessitates a higher level of care;

2. Provide the recipient and case manager with written notice of the intent to transfer or discharge the recipient; and

3. Allow the recipient and other person authorized by the recipient the opportunity to meet in person with the administrator of the facility to discuss the proposed transfer of discharge within 10-calendar days after providing written notice.

t. Notify the recipient's case manager when a modification is made on the POC that restricts the recipient's freedom of choice.

4. Recipient Records

a. Each provider must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC, and lease or other agreement.

The documentation will include the recipient's acknowledgment of service. If the recipient is unable to provide the acknowledgment due to cognitive and/or physical limitations, this will be clearly documented on the POC, indicating the designated representative/LRI. Recipients without a designated representative/LRI can select an individual to act on their behalf by completing the Designated Representative Attestation Form. The case manager will be required to document the designated representative/LRI who can sign documents and be provided information about the recipient's care.

b. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file or make them available upon request. For electronic signatures, systems and software products must include protection against modifications, with administrative safeguards that correspond to policies and procedures of ADSD. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information being attested to.

c. Periodically, DHCFP and/or ADSD staff may request daily service documentation to compare it to submitted claims. These records must be maintained by the provider for at least six years after the date the claim is paid.

d. Services for waiver recipients residing in an AL Facility should be provided as specified on the POC.

e. If fewer services are provided than are authorized on the POC, the reason must be adequately documented in the daily record and communicated to the case manager.

2303.8C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Cooperate with the providers of an AL Facility in the delivery of services.

2. Report any problems with the delivery of services to the AL Facility administrator and/or case manager.

2303.9 CHORE SERVICES

Chore services are intermittent in nature and may be authorized as a need arises for the completion of a specific task which otherwise left undone poses a home safety issue. These services are provided only in cases where the recipient, anyone else in the household, landlord, community volunteer/agency, or third-party payer is not capable of performing nor responsible for the provision of these services, or financially able to provide these services, and without these services, the recipient would be at risk of institutionalization.

2303.9A COVERAGE AND LIMITATIONS

1. The service must be identified in the POC and approved by the case manager.

2. This service includes heavy household chores such as:

   a. Cleaning windows and walls;

   b. Shampooing carpets, tacking down loose rugs and tiles;

   c. Moving heavy items of furniture to provide safe access;

   d. Minor home repairs;

   e. Removing trash and debris from the yard; and

   f. Packing and unpacking for the purpose of relocation.

3. This is not a skilled, professional service.

4. In the case of rental property, the responsibility of the landlord pursuant to the lease agreement, must be examined and confirmed prior to any authorization of service. The legal responsibility of the landlord to maintain and ensure safety on the rental property shall supersede any waiver covered services.

2303.9B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed, in Section 2303.2B, individuals performing Chore Services must:

1. Provide adequate training appropriate for recipients with physical disabilities completed initially and annually to include training in performing heavy household activities and minor home repair; and

2. Maintain the home in a clean, sanitary, and safe environment. if performing heavy household chores and minor home repair services.

3. Providers are responsible for ensuring that EVV requirements and expectations are met, including the documentation of all services in approved EVV system.

4. Services must be prior authorized by the case manager and documented in an approved EVV system.

2303.9C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Agree to utilize an approved EVV system for the waiver services being received from the provider agency.

2. Confirm services were provided by electronically signing or initialing, as appropriate per POC, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

2303.10 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS (EAA)

Environmental Accessibility Adaptations are physical adaptations to the residence of the recipient or the recipient's family that have been identified within the recipient's POC. These adaptations must ensure the health, welfare, and safety of the recipient and/or enable the recipient to function with greater independence within their own home.

2303.10A COVERAGE AND LIMITATIONS

1. Adaptations may include the purchase of environmental controls, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies needed for the welfare of the recipient.

2. All services, modifications, improvements, or repairs must be provided in accordance with applicable state or local housing and building codes.

3. Providers who are furnishing EAA services to PD waiver recipients will be able to bill for an assessment fee (maximum of one hour) and a flat rate mileage for a single transport over 30 miles. The purpose of the addition of the assessment fee is to ensure recipients receive maximum services and for waiver providers to have the ability to properly identify needed adaptations. The assessment and travel fees can be billed separately from the maximum amount limit per calendar year to complete the job (material and labor costs).

4. Rental properties must receive written approval from the landlord prior to authorizing any EAA.

5. Excluded Adaptations

   a. Improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

   b. Adaptations which increase the total square footage of the home except when necessary to complete an adaptation, for example, to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair.

2303.10B PROVIDER RESPONSIBILITIES

1. All sub-contractors must be licensed or certified if applicable. Modifications, improvements, or repairs must be made in accordance with local and state housing and building codes.

2. Must have a contractor's license if completing installation.

3. Durable Medical Equipment (DME) providers must meet the standards to provide equipment under the Medicaid State Plan Program.

4. The service including assessment and travel fees must be prior authorized by the case manager.

2303.10C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. The recipient is responsible for notifying the provider and/or case manager of any issues or problems regarding the installation of any authorized equipment or modifications.

2. The recipient may not request any additional modifications that have not been authorized.

3. The recipient must notify their case manager once the modifications have been completed.

2303.11 HOME DELIVERED MEALS

Home delivered meals are the provision of meals to persons at risk of institutional care due to inadequate nutrition. Home delivered meals include the planning, purchase, preparation and delivery, or transportation costs of meals to a person's home.

2303.11A COVERAGE AND LIMITATIONS

Recipients who require home delivered meals are unable to prepare or obtain nutritional meals without assistance or are unable to manage a special diet recommended by their physician.

1. Home delivered meals must be prepared by an agency and be delivered to the recipient's home.

2. Meals provided by or in a child foster home, community based residential facility, or adult day care are not included, nor is meal preparation.

3. The direct purchase of commercial meals, frozen meals, Ensure or other food or nutritional supplements is not allowed under this service category.

4. Home delivered meals are not intended to meet the full daily nutritional needs of a recipient and are not to exceed two meals per day.

5. More than one provider may be used to meet a recipient's assessed need; the case manager is responsible for ensuring the PA does not exceed two meals per day.

6. Case managers determine the need for this service based on the assessment, and by personal interviews with the recipient related to individual nutritional status.

7. All meals must comply with the Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture; and provide a minimum of 33 1/3% of the current daily Recommended Dietary Allowances (RDA) as established by the Food and Nutrition Board, National Research Council of the National Academy of Sciences.

8. Nutrition programs are encouraged to provide eligible participants meals which meet particular dietary needs arising from health or religious requirements or the ethnic background of recipients.

2303.11B PROVIDER RESPONSIBILITIES

1. All Nutrition Programs must follow the Health and Safety Guidelines established for Food and Drink Establishments in NAC, Chapter 446 or local health code regulations.

2. All kitchen staff must hold a valid health certificate if required by local health ordinances.

3. Report all incidents of suspected food borne illness to the affected recipients and local health authority within 24 hours and to the case manager by the next business day.

4. The service must be prior authorized by the case manager.

2303.11C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. The recipient must notify the case manager timely if they need to request any changes to their Home Delivered Meals service.

2. The recipient must notify their case manager if the authorized number of meals is not received.

2303.12 PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

PERS is an electronic device which enables certain recipients at high risk of institutionalization to secure help in an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once the "help" button is activated.

2303.12A COVERAGE AND LIMITATIONS

1. PERS services are limited to those recipients who live alone in a private residence, or who are alone for significant parts of the day, in their residence, have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision or as identified to mitigate other safety risks and concerns. The recipient must be capable of using the device in an appropriate and proper manner.

2. The initial installation fee and a monthly fee for ongoing monitoring are covered under this service.

3. The necessity for this type of emergency safety measure to prevent institutionalization will be identified in the assessment and included in the POC.

2303.12B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, PERS providers must:

1. Ensuring that the response center is staffed by trained professionals at all times;

2. Complete any replacement or repair needs that may occur and provide monthly monitoring to ensure the device is working properly;

3. Devices must meet Federal Communication Commission (FCC) standards, Underwriter's Laboratory (UL) standards or equivalent standards; and

4. Inform recipients of any liability they may incur as a result of the disposal or loss of provider property.

5. This service must be prior authorized by the case manager.

2303.12C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Be responsible for utilizing the leased PERS equipment with care and caution and to notify the PERS provider when the equipment is no longer working.

2. Return the equipment to the provider when it is no longer needed or utilized, or when the recipient terminates from the waiver program.

3. Not dispose of or damage the PERS equipment. This is leased equipment and belongs to the PERS provider.

2303.13 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized medical equipment and supplies are those devices, controls, or appliances specified in POC that enable recipients to increase their abilities to perform ADLs.

2303.13A COVERAGE AND LIMITATIONS

1. Items reimbursed with waiver funds shall exclude those items which are not of direct medical or remedial benefit to the recipient.
2. All items shall meet applicable standards of manufacture, design, and installation and where indicated, will be purchased from, and installed by authorized dealers.

3. This service includes:

   a. Devices, controls, or applications which enable the recipient to perceive, control, or communicate with the environment in which they live;

b. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items; and

c. Vehicle adaptations, assistive technology, and supplies.

4. Durable and non-durable medical equipment that has been exhausted, not available, or covered under the Medicaid State Plan, refer to MSM Chapter 1300 – DME Disposable Supplies and Supplements.

2303.13B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 2303.2B, providers must:

1. Meet the standards to provide equipment under the Medicaid State Plan Program; and

2. The service must be prior authorized by the case manager.

2303.13C RECIPIENT RESPONSIBILITIES

In addition to the Recipient Responsibilities outlined in 2303.2C, the recipient must:

1. Notify the provider and/or case manager of any issues or problems regarding the installation or delivery of any authorized equipment or supplies.

2. Not request any additional specialized medical equipment or supplies that have not been authorized.

3. Notify their case manager once the specialized medical equipment or supplies have been received.

2303.14 ELECTRONIC VISIT VERIFICATION (EVV)

The 21st Century CURES Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own if it meets the 21st Century CURES Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV

record. All claims must be supported by an EVV entry into an EVV system prior to claim submission. Any errors within EVV submissions must be supported by offline documentation.

Agencies must ensure each personal care attendant has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION:

   a. The EVV system electronically captures:

      1. The type of service performed, based on procedure code;

      2. The individual receiving the service;

      3. The date of the service;

      4. The location where service is provided;

      5. The individual providing the service;

      6. The time the service begins and ends.

   b. The EVV system must utilize one or more of the following:

      1. The agency/personal care attendant's smartphone;

      2. The agency/personal care attendant's tablet;

      3. The recipient's landline telephone;

      4. The recipient's cellular phone (for IVR purposes only);

      5. Other GPS-based devices as approved by DHCFP.

2. DATA AGGREGATOR OPTION:

   a. All Personal Care Agencies that utilize a different EVV system (as approved by DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

      1. Appropriate forms must be approved by the DHCFP before use of the system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into the data aggregator.

2303.15 DHCFP LTSS INITIAL REVIEW

Once the applicant has been approved for the waiver, the DHCFP LTSS Unit will review all initial eligibility packets for completeness to ensure waiver requirements are being met. The eligibility packet for review must include:

1. The NF LOC screening to verify the applicant meets the NF LOC criteria;

2. At least one waiver service need identified;

3. The SOC complete with signature and dates; and

4. The HCBS Acknowledgement Form is complete including initials, signature, and date.

NOTE: Electronic signatures are acceptable pursuant to NRS 719.350 "Acceptance and distribution of electronic records by governmental agencies" on forms that require a signature.

2303.16 WAIVER COSTS

DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100% of the average per capita expenditures for the institutional LOC under the state plan that would have been made in that fiscal year, had the waiver not been granted.

2303.17 QUALITY ASSURANCE WAIVER REVIEW

The state conducts an annual review of active waiver participants. CMS has designated waiver assurances and sub-assurances that states must include as part of an overall quality improvement strategy. The annual review is conducted using the state specified performance measures identified in the approved PD Waiver to evaluate operation.

Case management and direct waiver service providers must cooperate with ADSD Operations and DHCFP's review process.

2303.18 MEDICAID EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The children made eligible for Medicaid through their enrollment in the HCBS PD Waiver receive all medically necessary Medicaid covered services available under EPSDT. A child's enrollment in the waiver will not be used to deny, delay, or limit access to medically necessary service(s) required to be available to Medicaid-eligible children under federal EPSDT rules. The waiver service package is a supplement to EPSDT services.

2303.19 PROVIDER ENROLLMENT

All providers must maintain a Medicaid services provider agreement and comply with the criteria set forth in the Nevada MSM Chapter 100 and Chapter 2300. Provider Enrollment checklists and forms can be found on the Fiscal Agent's website https://www.medicaid.nv.gov.

2303.20 BILLING PROCEDURES

DHCFP assures that all claims for payment of waiver services are made only when a recipient is Medicaid eligible, when the service(s) are identified on the approved POC, and the service(s) have been prior authorized.

Refer to the Fiscal Agent's website https://www.medicaid.nv.gov for the Provider Billing Guide Manual.

2303.21 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed providers to provide their recipients with information regarding their decision-making rights about health care, declarations (living wills) and durable powers of attorney for health care decisions. Refer to MSM Chapter 100 for further information.

The case manager must provide information on Advance Directives to each recipient and/or designated representative/LRI during the initial assessment and annually thereafter. The signed Acknowledgement form is kept in each recipient's file. Whether a recipient chooses to write their own Advance Directive or complete an Advance Directive form in full is the individual choice of each recipient and/or designated representative/LRI.

2304 HEARINGS REQUESTS DUE TO ADVERSE ACTIONS

An adverse action refers to denials, terminations, reductions, or suspensions of the applicant's/recipient's request for services or an applicant's/recipient's eligibility determination. DHCFP must grant an opportunity for a hearing to an applicant/recipient/designated representative in the event an adverse action is taken by DHCFP.

2304.1 SUSPENDED WAIVER SERVICES

When a recipient is institutionalized less than 60 days, their waiver services must be suspended.

A. Upon receipt of the suspension notification from the case management provider, DHCFP LTSS will issue a suspension NOD to the recipient.

B. Waiver services will not be paid for the days that a recipient's eligibility is in suspension.

C. If the recipient continues to be institutionalized for 45 days, on the 46th day, the case manager will request DHCFP LTSS to send a termination NOD to the recipient indicating termination from the waiver on the 61st day from the admission date.

2304.2 RELEASE FROM SUSPENDED WAIVER SERVICES

When a recipient has been released from an institution, before the 60th day from the admit date, the case manager must do the following within five business days of the recipient's discharge:

A. Complete a reassessment if there has been a significant change in the recipient's condition or status;

B. Complete a new POC if there has been a change in waiver services. If a change in services is expected to be resolved in less than 30 days a new POC is not necessary. Documentation of the temporary change must be noted in the case manager's narrative; and

C. contact the service provider(s) to reestablish services.

2304.3 DENIAL OF WAIVER ELIGIBILITY

Basis of denial for waiver eligibility:

A. The service(s) is/are not substantiated as medically necessary. Contact your Medicaid provider as there may be additional documentation to submit to demonstrate a medical necessity.

B. The applicant does not meet the LOC criteria for NF placement.

C. The applicant has withdrawn their request for waiver services.

D. The applicant fails to cooperate with the case manager in establishing program eligibility or waiver services (the applicant/recipient's and/or designated representative/LRI's signature is necessary for all required paperwork).

E. The applicant's support system is not adequate to provide a safe environment during the time waiver services are not being provided.

F. The case manager has lost contact with the applicant.

G. The applicant/recipient fails to show a need for ongoing waiver services.

H. The applicant would not require NF placement within 30 days or less if waiver services were not available.

I. The applicant has moved out of the state.

J. Another agency or program will provide the services.

K. ADSD has filled the number of positions (slots) allocated. The applicant will be approved for the waiver waitlist and will be contacted when a slot is available.

Wait List Priority:

Level 1: Applicants previously in a hospital or NF and who have been discharged to the community within six months and have a significant change in support system and are in a crisis situation;

Level 2: Applicants who have a significant change in support system and/or in a crisis situation and require at least maximum assistance in a combination of four or more of the following ADLs: eating, bathing, toileting, transfers, and mobility;

Level 3: Applicants who have a significant change in support system and/or in a crisis situation and require assistance with a combination of five or more of the following ADLs as identified on the LOC screening: medication administration, special needs, bed mobility, transferring, dressing, eating and feeding, hygiene, bathing, toileting, and locomotion;

Level 4: Applicants who do not meet the criteria for priority levels 1-3.

L. There are no enrolled Medicaid providers or facilities in the applicant's area.

M. The applicant is in an institution (e.g. hospital, nursing facility, correctional facility, ICF/IID) and discharge within 60 calendar days is not anticipated.

N. The applicant has chosen a provider or facility that is not an enrolled or qualified Medicaid provider. Note: The case manager should provide a list of Medicaid providers to the applicant. The case manager will inform the provider that all entities providing services must be enrolled as a Medicaid provider and facilitate contact information to the DHCFP's Fiscal Agent.

When the application for waiver services is denied, the case manager will send a NOD request to DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for denial.

2304.4 REDUCTION OR DENIAL OF DIRECT WAIVER SERVICES

Basis of reduction or denial of direct waiver services:

A. The recipient no longer requires the waiver service, number of service hours, or level of service which was previously authorized.

B. The recipient has requested a reduction of services, or a specific waiver service to be discontinued.

C. Another service will be substituted for the existing service, or there is a reduction or termination of a specific waiver service.

D. The recipient has reached or will exceed their annual amount limit for Environmental Adaptations and/or Specialized Medical Equipment.

E. The requested adaptation for the recipient, equipment or supply is not medically necessary to prevent institutionalization.

F. The landlord has not approved requested adaption or modification for the recipient.

G. The recipient does not demonstrate a need or have the capacity/ability for the requested waiver services.

NOTE: A reduction includes when a specific waiver service's hours are reduced to zero.

When there is a reduction of waiver services, the case manager will identify the reason for the reduction and what the service will be reduced to and request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a reduction NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM Chapter 3100 Hearings, for specific instructions regarding notification and recipient hearings.

When the request for a direct waiver service(s) is denied, the case manager will send a NOD request to the DHCFP LTSS Unit. The DHCFP LTSS Unit sends a NOD to the applicant/recipient informing them of the reason for denial.

2304.5 TERMINATION OF WAIVER PROGRAM ELIGIBILITY

Reasons to terminate waiver program eligibility:

A. The recipient no longer meets the LOC criteria for NF placement.

B. The recipient and/or designated representative/LRI have requested termination of waiver services.

C. The recipient and/or designated representative/LRI has failed to cooperate with the case manager or HCBS waiver service provider(s)

D. The recipient fails to show a continued need for HCBS waiver services.

E. The recipient no longer requires NF placement within 30 calendar days if HCBS were not available.

F. The recipient has moved out of state.

G. The recipient and/or designated representative/LRI has participated in activities designed to defraud the waiver program..

H. Another agency or program is providing duplicative services.

I. The recipient has been, or is expected to be, institutionalized over 60 days (in a hospital, NF, intermediate facility for persons with mental retardation or incarcerated).

J. The case manager has lost contact with the recipient.

K. Death of the recipient.

L. The recipient's support system is not adequate to provide a safe environment during the time when HCBS waiver services are not being provided.

M. HCBS waiver services are not adequate to ensure the health, welfare, and safety of the recipient.

N. The recipient has failed to cooperate with the case manager or HCBS waiver service provider(s) in establishing and/or implementing the POC, implementing waiver services or verifying eligibility for waiver services (the recipient and/or designated representative/LRI's signature is necessary on all required paperwork.).

When a recipient is terminated from the waiver program, the case manager will request the DHCFP LTSS Unit to send a NOD. DHCFP LTSS will issue a termination NOD indicating the reason and the date of action which is at least 13 calendar days from the notice date. Refer to MSM Chapter 3100 - Hearings for specific instructions regarding advance notification and recipient hearings.

2304.6 REAUTHORIZATION WITHIN 90 DAYS OF WAIVER TERMINATION

If a recipient is placed in a NF, hospital, or is incarcerated and waiver eligibility has been terminated, the recipient may request to be reinstated within 90 days from the date of action on the NOD.

2304.6A COVERAGE AND LIMITATIONS

1. The waiver slot must be held for 90 days from the date of action listed on the NOD.

2. The recipient may request to be placed back on the waiver if:

   a. They still meet LOC; and

   b. They are released/discharged within 90 days.

3. If 91 calendar days has elapsed, from the date of action on the NOD, the slot is allocated to the next person on the waitlist.

2304.6B PROVIDER RESPONSIBILITIES

The last known case management provider is responsible for resuming case management responsibilities for the recipient within three business days, to include the following:

1. Contact DWSS via the NMO-3010 to reinstate eligibility;

2. Contact DHCFP LTSS Unit via the NMO-3010 to reinstate the waiver benefit line;

3. Contact ADSD Operations Agency to notify of the reinstatement of waiver slot placement; and

4. Notify all direct waiver service providers of waiver reinstatement.

If the case manager determines that there has been a significant change in the recipient's condition as appropriate, refer to MSM section 2303.4A.3.e. for requirements.

2304.6C RECIPIENT RESPONSIBILITIES

1. Recipients must cooperate fully with the reauthorization process to assure approval of request for readmission to the waiver.

2. If the recipient is discharged after the 90th day from the date of action on the NOD, they must reapply for waiver services.

2305 APPEALS AND HEARINGS

Refer to MSM Chapter 3100 for specific instructions regarding notice and hearing procedures. Recipients are informed of their rights to a fair hearing at the initial face-to-face visit and annually thereafter when they are given the Recipient Rights form.

2400 INTRODUCTION

2400.1 HOME BASED HABILITATION SERVICES (HBHS)

Home Based Habilitation Services (HBHS) are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury.

HBHS include services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in a home and community-based settings. HBHS are prescribed by a physician and provided by the appropriate qualified staff.

2401 AUTHORITY

Home Based Habilitation Services (HBHS) is an optional Medicaid State Plan service authorized by the Nevada Medicaid Program under State Plan authority titled Nevada 1915(i) State Plan Home and Community Based Services (HCBS). The State Plan was amended in 2008 in response to the Deficit Reduction Act, Section 6086. Congress amended the Social Security Act with Section 1915(i) allowing states to provide traditional 1915(c) services as covered State Plan benefits. Home Based Habilitation was covered under Nevada's State Plan as Comprehensive Outpatient Rehabilitation (COR) Services.

Statutes and Regulations:

- Social Security Act: 1915(i)
- 42 Code of Federal Regulations (CFR) 440.130
- 42 CFR 440.180
- 34 CFR 300.7
- Nevada Administrative Code (NAC) 388.134

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MEDICAID SERVICES MANUAL	Subject: RESERVED

2402 RESERVED

2403 POLICY

2403.1 HOME BASED HABILITATION SERVICES (HBHS) DAY TREATMENT PROGRAM

HBHS include a day treatment program in which services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Services are prescribed by a physician, provided by the appropriate qualified staff and include the following:

a. Care Coordination.

Adaptive Skill Development.

Assistance with Activities of Daily Living (ADLs).

Community Inclusion.

Transportation (not duplicative of State Plan Non-Emergency Transportation (NET)).

Adult Educational Supports.

Social and Leisure Skill Development.

Physical Therapy.

Speech Therapy.

Occupational Therapy.

Licensed professionals must perform an initial assessment, develop a plan of care, assess the recipient's progress and assume legal responsibility for the services provided.

2403.1A COVERAGE AND LIMITATIONS

1. Admission Criteria for Day Treatment Programs

   a. The recipient is Medicaid eligible;

   b. The recipient has a medically verifiable Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI);

   c. The individual must meet the eligibility requirements of the 1915(i) HCBS Universal Needs Assessment Tool or must qualify for a 1915(c) waiver;

d. The recipient has not previously completed a habilitation program for the same condition, unless a substantial intervening event has occurred that would require an abbreviated program to maintain community placement. The decision to impose such an exception is the sole determination of the Division of Health Care Financing and Policy (DHCFP) and requires supporting medical rationale;

e. The recipient's functional or cognitive impairment is the result of an illness or injury within the past 90 days, or 90 days from the original inpatient hospitalization, or directly after continuous outpatient therapy post the original inpatient hospitalization, or 90 days from Medicaid eligibility determination, or has a chronic illness or injury with recent exacerbation, or complication which resulted in a change in function, or has a more remote injury with recent improvement in condition and/or advancement in technology;

f. The recipient must be medically stable for intensive habilitation as evidenced by the absence of medical conditions requiring acute medical interventions (e.g., acute infectious process, uncontrolled irregular heartbeat, unstable diabetes mellitus, etc);

g. The recipient is willing, and demonstrates capacity for endurance for at least three (3) hours of habilitation services per day, five (5) days per week;

h. The recipient has a prognosis and potential to increase his or her functional independence towards returning to independent or assisted living after discharge, achievable within a reasonable period of time, as determined by the DHCFP or its QIO-like vendor;

i. The recipient has sufficient mental alertness and is able to actively participate in a complete therapy program on a daily basis;

j. The recipient is responsive to verbal or visual stimuli and can consistently follow single step commands in a meaningful way; and

k. The recipient's functional abilities indicate a potential for improvement.

2. Covered Services

a. Day Treatment programs are provided as Full Day – six (6) hours per day of habilitative services or as Half Day – a minimum of three (3) hours per day. All programs provide services five days per week, or more, and may occur in the recipient's home, inpatient settings who provide HBHS services, outpatient settings or in other community-based settings.

b. Day treatment programs must meet the following service requirements, when the specialty area is included in the individual plan of care approved by the primary physician after any needed consultation with the licensed/certified therapy provider (RN, PT, OT, SLP and case manager):

1. Physical Therapy services: Only a licensed physical therapist has the knowledge, training and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function. Implementation of a plan of care should be carried out pursuant to the Practice Act governing physical therapy.

2. Occupational Therapy services: Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function. Implementation of a plan of care shall be carried out pursuant to the Practice Act governing occupational therapy.

3. Speech-Language Pathology (SLP) services: Only a SLP has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore, or compensate for lost function. Implementation of a plan of care shall be carried out pursuant to the Practice Act governing speech-language pathology.

4. Case Management services: Case management services must be provided by a licensed nurse or social worker, or Certified Case Manager (CCM), or other licensed individual eligible to apply for certification or who is working under the direct supervision of a CCM, who has the education, skills abilities and experience to perform case management services. The case manager may also need language skills, cultural sensitivity, and acquired knowledge and expertise unique to a geographic area. The case manager coordinates and implements individualized plans of care in conjunction with recipient's families or legal guardians physicians and others involved in the care of the individual.

5. Cognitive Therapy services:

The provision of this service is included as a component of a habilitation program for the severely neurologically impaired individual such as those

with TB. Other diagnoses that may require cognitive remediation include, but are not limited to, severe Cerebral Vascular Accident (CVA), anoxic injuries, and intracranial hemorrhage. For these diagnoses, as well as with TBI, major impairments exist in arousal or alerting, perception, selective attention, discrimination, orientation, organization, recall and high level thought processes, including convergent thinking, deductive reasoning, inductive reasoning, divergent thinking, and multiprocess reasoning.

6. Therapeutic Recreation services: Therapeutic recreation services are included as a component of a habilitation program when the service is directly related to the plan of care.

7. Prosthetic/Orthotic services: Refer to Medicaid Services Manual (MSM) Chapter 1300 for further information and program requirements.

8. Durable Medical Equipment (DME): Refer to MSM Chapter 500 for DME coverage guidelines for recipients who reside in or will be discharged to an extended care facility.

3. Non-Covered Services

The following are not covered benefits under day treatment programs and therefore are not reimbursable by Nevada Medicaid:

a. A maintenance program is the point at which the recipient demonstrates no further improvement, or the skills of a qualified therapist are not required to carry out an activity to maintain function at the level to which it has been restored;

b. Duplicative services are not considered medically justified and will not be covered by Medicaid. An inquiry or referral for services does not indicate the necessity for services. If the Medicaid recipient is receiving services from another provider, it is the responsibility of the evaluating provider to determine if additional services are appropriate and request prior authorization as indicated;

c. Time spent conducting a team conference is included in the established all-inclusive rate and is not a separately billable service;

d. Pre-Admission screenings completed in order to determine the appropriateness of the recipient for a particular program is considered a cost of doing business and is not a reimbursable visit;

e. Admissions or continued stays for evaluation or training for solely vocational or educational purposes or for developmental or behavioral assessments are not covered services;

f. Admissions solely for the convenience of the recipient, their family or the provider, are not covered services;

g. Pain management services, i.e. relaxation techniques, stress management and biofeedback programs;

h. Day treatment programs are not covered for individuals who have been admitted to an institutional setting such as a hospital, nursing facility or an intermediate care facility; or

i. Day treatment programs will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including: Federal, State, local and private entities. For habilitation services, the State includes, within the record of each individual, an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

4. Continued Stay Criteria for Day Treatment Services

For continued day treatment services, prior authorization must be submitted to the DHCFP's QIO-like vendor in time to meet processing timelines so an interruption in services may be avoided. Supporting documentation must be provided, including the most recent team conference report, which demonstrates that the recipient continues to meet admission criteria and continues to:

a. demonstrate an ability to actively participate in the program;

b. have documented progression toward written goals; and

c. continue to need the services provided by the day treatment program.

Services provided without prior authorization are not reimbursable.

5. Discharge Criteria

A day treatment program is a medically prescribed treatment for improving or restoring functions and must be considered for termination, regardless of the approved length of stay, when further progress toward the established goals is unlikely or further treatment can be achieved in a less intensive setting.

A maintenance program is not a covered benefit and services provided once this level has been reached will not be reimbursed. Specifically, if no further progress is observed, discharge would be required. A recipient in a habilitation program must be considered for discharge, when any one of the following conditions is met:

a. The recipient's needs exceed the scope of the day treatment program so transfer to an inpatient hospital or skilled nursing facility is indicated;

b. The recipient no longer meets the criteria for the day treatment program;

c. The specialized knowledge and skills of the interdisciplinary team are no longer required;

d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three (3) consecutive days;

e. The recipient has reached his or her goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;

f. There is limited motivation on the part of the recipient or caregiver which is impacting the individual's progress for over one week; or

g. The established goals serve no purpose to increase functional or cognitive capabilities towards living in a community based setting.

2403.1B HOME BASED HABILITATION SERVICES (HBHS) PROVIDER RESPONSIBILITY

1. Provider Enrollment

a. Each provider of HBHS must enroll as a Provider Type 55 and enter into the agreement with the DHCFP, through the QIO-like vendor and must submit required licenses, registrations, certificates, etc., upon request, to determine that conditions of participation, as stated in MSM 100, are met.

c. Home Based Habilitation providers must hold current accreditation, in good standing, by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Joint Commission accreditation.

c. Providers must comply with all Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA) and Occupational Safety and Health Administration (OSHA), Local, State, and Federal regulations and applicable statutes.

Criminal Background Checks

Under Nevada Revised Statutes (NRS) 449.176 through NRS 449.188, people who have been convicted of certain crimes may not work at certain long term care facilities or agencies. The complete statute is available at: http://leg.state.nv.us/NRS/NRS-449.html and the requirements applying to agencies are discussed at length at the Bureau of Health Care Quality and Compliance (HCQC) website: http://health.nv.gov/HCQC_CriminalHistory.htm.

Agency personnel, including administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background checks upon licensure or accreditation and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred.

Documentation of the request, and applicable results, must be maintained in each employee personnel record and made available to the DHCFP upon request. Employees must have the criminal background check through their State Department of Public Safety (DPS) or initiated by the hiring/employing agency prior to providing any Medicaid reimbursable services to a recipient.

Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an "undecided" result is received. Documentation must be maintained in the employee's personnel file and submitted to the DHCFP upon request.

1. The DHCFP or their designee must not enroll any person or entity convicted of a felony or misdemeanor for any offense which the State agency determines is inconsistent with the best interests of recipients. Such determinations are solely the responsibility of the DHCFP.

2. The DHCFP applies the requirements of NRS 449.176 through NRS 449.188 and will deny a provider contract to any applicant, or may suspend or revoke all associated provider contracts of any provider, to participate in

the Medicaid program if the requirements of the referenced NRS sections are not met. In addition, see MSM Chapter 100.

a. If the Provider receives information related to NRS 449.176 through NRS 449.188 resulting from the criminal background check or from any other source and continues to employ a person who has been convicted of an offense as listed above, the DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

b. If the hiring/employing agency does not take timely and appropriate action on the results of the background check as defined in NRS 449.176 through 449.188 and on the HCQC website, the DHCFP will take appropriate action, which may include suspension or termination of the agency's Medicaid provider contract.

If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency and the DHCFP in writing. Information regarding challenging a disqualification is found on the HCQC website at:

http://health.nv.gov/HCQC_CriminalHistory.htm.

NOTE: Out-of-state providers must obtain background checks through their local DPS.

Tuberculosis (TB) Testing

Employees of provider facilities must complete either a QuantiFERON R-TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for a Medicaid recipient. If the employee tests negative on initial test, prior to the annual expiration of the initial test, they must receive either a QFT-G blood test or a one step TB skin test. Annually, thereafter, as long as the result is negative, prior to the expiration of the year's previous test, a QFT-G blood or a one step TB skin test must be performed. If the employee tests positive on the initial QFT-G blood test or the two step TB skin test (+10 mm induration or larger), or if the employee has a prior history of a positive test, the individual must have clearance by a chest X-ray prior to initiation of services for a Medicaid recipient. Annually, thereafter, prior to the date of initial clearance by the chest X-ray, the individual must have documentation which demonstrates no signs or symptoms of active tuberculosis (see Nevada Administrative Code (NAC) 441A.375).

If the employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest x-ray, the employee must have documentation annually which demonstrates they are not exhibiting any signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider:

- Has had a cough for more than three (3) weeks;
- Has a cough which is productive;
- Has blood in his sputum;
- Has a fever which is not associated with a cold, flu or other apparent illness;
- Is experiencing night sweats;
- Is experiencing unexplained weight loss; or
- Has been in close contact with a person who has active tuberculosis. Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening.

Documentation of the annual screening, when required as defined herein, and the results must be maintained in the employee's file.

Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results. Any lapse in the required timelines above will result in a finding of non-compliance with this section.

2. Staffing Requirements

- A provider of HBHS must employ persons with the necessary education, skills and training to provide the Medicaid required services. Medical services must be provided by licensed/certified professional. Copies of current licensure, certificates, and education must be maintained in employee files.

b. Habilitation Aides may provide personal assistance services, supervisory care, direction and guidance to assist recipients, following written plan of care and clinical protocols under the direct supervision of the licensed/certified therapy provider.

Habilitation aides must have:

1. a high school diploma or General Education Diploma (GED);

2. some post-secondary educational experience is desired;

3. a minimum of two positive, verifiable employment experiences;

4. two years of related experience is desired

5. job experience that demonstrates the ability to teach, work independent of constant supervision, and demonstrate regard and respect for recipients and co-workers;

6. verbal and written communication skills;

7. the ability to handle many details at the same time;

8. the ability to follow through with designated tasks; and

9. knowledge of the philosophy and principles of independent living for people with disabilities.

Supporting Qualifications include:

10. dependability, able to work with minimal supervision;

11. demonstrates problem solving ability;

12. the ability to perform the functional tasks of the job; and

13. the ability to identify emergency situations and act accordingly including Cardiopulmonary resuscitation (CPR) certification, which may be obtained outside the agency.

3. Initial Evaluation

The intent of HBHS is to increase the individual's functional abilities in order to eventually live in a community setting. The initial evaluation must contain all of the following information and be signed by the treating physician to be considered for authorization:

a. Origin and rationale of referral, including a copy of the order;

b. The principal and significant associated diagnosis;

c. Brief history including the date of onset of illness or injury;

d. Current medical status and confirmation of medical stability;

e. Current and pre-morbid functional status, including baseline evaluation, prognosis and potential for improvement;

f. Indication of medical necessity;

g. Identified barriers;

h. Short and long-term goals that are functional, objective and measurable;

i. The composition of the team, the plan of care and the duration of the habilitation program;

j. Summary of any previous treatment received and results of such treatment;

k. Anticipated time for completion of the program;

l. If the recipient is to participate in any group therapy sessions, documentation must include:

1. the description of the purpose of the group;

2. number of patients and staff members in group;

3. the minimum ratio of staff to patients;

4. duration on each session; and

the number of group sessions anticipated per week.

m. A viable, written discharge plan with appropriate post placement resources, including the identified support system that will facilitate community re-entry.

The proposed plan of care must include specific goals, how those goals will be achieved and the duration of achievement.

Universal Needs Assessment

The 1915(i) HCBS Universal Needs Assessment Tool must be used to evaluate and reevaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:

the inability to perform 2 or more ADL's;

Bathing/Dressing/Grooming;

Mobility;

Toileting;

Eating; and/or

Transferring.

cognitive and/or behavioral impairments;

medical needs;

supervision needs;

substance abuse; and/or

multiple social service system involvement.

This evaluation must be face-to-face.

A physician within the scope of their professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

The individual performing the assessment must be an independent third party and must not be:

a. related by blood or marriage to the individual;

b. any paid caregiver of the individual;

c. financially responsible for the individual;

empowered to make financial or health-related decisions on behalf of the individual; or

service providers or individuals or corporations with financial relationships with any providers.

The physician must re-evaluate the recipient's eligibility annually.

5. Service Plan

The service plan is developed by the service provider. An interdisciplinary team will formulate the plan in conjunction with the recipient. The team must include staff trained in person centered planning, and must include a licensed health care professional and may include other individuals who can contribute to the plan development.

The service plan must include the identified need from the Universal Needs Assessment.

The provider must ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. Recipient, family (when appropriate) and/or legal representative participation in treatment planning must be documented on the service plan. The service plan must include a written statement that the recipient was offered a choice of HBHS providers, if applicable, and must be kept in a file maintained for the recipient.

A service plan must be completed and submitted as part of the prior authorization process. The service plan requires pre-approval by the QIO-like vendor prior to authorizing services and must include the description of services, amount of time (hourly, daily, weekly) and the title of the staff that will be providing the specific services.

The recipient must provide a signature on the service plan. If the recipient is unable to provide a signature due to cognitive and/or physical limitation, this must be clearly documented in the recipient file. A legal representative may sign for the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the plan of care, and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the DHCFP district office and the QIO-like vendor for prior authorization.

Additionally, the DHCFP must review a representative sample of participant service plans each year.

The Service Plan must be re-evaluated annually or when a significant change occurs.

6. Plan of Care

A plan of care must be initiated on the day of admission to HBHS. The plan of care must be in agreement with the Service Plan, and the 1915(i) HCBS Universal Needs Assessment Tool. The individualized plan of care must be developed and meet the requirement of NAC 449.4088.

The plan of care specifically outlines the services and activities of a recipient and must be available to all staff members providing home based habilitation services.

The Plan of Care:

is developed by the licensed interdisciplinary habilitation team using a person-centered process involving the individual, and where appropriate, the individual's family, caregiver, or representative, and the DHCFP care coordinator;

a. identifies the necessary services to be furnished to the individual;

includes objectives and directives for HBHS services needed;

takes into account the extent of, and need for, any family or other supports for the individual;

prevents the provision of unnecessary or inappropriate care;

is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and

is reviewed and updated by the licensed interdisciplinary habilitation team annually or as needed or when there is significant change in the individual's circumstances.

The plan of care must be kept in a file maintained for the recipient and must include a signature of the recipient. If the recipient is unable to provide a signature due to

cognitive and/or physical limitation, this must be clearly documented in the recipient file. A legal representative may sign for the recipient.

The facility may create a signature page which can encompass a recipient signature for the service plan, the plan of care, and any other signature requirements. If the facility uses a signature page, it must be included in the packet to the DHCFP district office and the QIO-like vendor for prior authorization.

Records Requirements

In compliance with NAC 449.40835, the facility must maintain records on each employee.

Employee Records must include:

finger prints and background results;

annual TB tests; and

training, required licenses, registrations, and certificates.

In compliance with NAC 449.40835, the facility must maintain records on recipients including daily records and attendance records. All entries made in the recipient's file must be signed and dated by the employee making the entry. The delivery of specific services including those required by Medicaid must be documented in the daily records.

Recipient records must include the following:

Medicaid Eligibility - The facility must maintain proof of each recipient's Medicaid eligibility. Verification of eligibility is the provider's responsibility. Eligibility should be verified monthly. Refer to MSM Chapter 100 for additional information regarding verification of eligibility.

Universal Needs Assessment.

Service Plan.

Statement indicating recipient made an informed choice in providers.

Plan of Care.

Attendance Records.

Daily Records.

Annual TB tests.

The case manager is responsible for maintaining a record for the recipient.

The facility must maintain an accurate record of the recipient's attendance by using an attendance record as defined in the MSM Addendum. The record must also reflect any absence from the facility by the recipient for purposes of obtaining other services must be documented. This record is to include date, duration of absence and destination or purpose for absence.

8. Confidentiality and Release of Recipient Records

The facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.

9. Provider Liability

Provider liability responsibilities are included in the Medicaid and Nevada Check Up (NCU) Provider Contract and are incorporated in this chapter by reference.

10. Notification of Suspected Abuse and Neglect

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

For adults aged 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. Refer to NRS 200.5091 to 200.50995 regarding elder abuse or neglect.

2403.1C RECIPIENT RESPONSIBILITY

1. Medicaid recipients are required to maintain and provide a valid Medicaid eligibility card to their service providers and to notify their providers of any changes to the type of eligibility, or other insurance benefits that may be in effect such as Medicare.

2. Medicaid recipients are expected to comply with and participate in their development of their plan of care including making and keeping medical appointments.

3. The recipient is responsible to notify the provider of changes in medical status, service needs address, and location.

4. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, protected health information may be disclosed for the purposes of treatment, payment, or health care operations without a signed Authorization for Disclosure from the participant or designated representative. However, most other disclosures require authorization. Additional details about allowable uses and disclosures are available to participants in the DHCFP Notice of Privacy Practices, which is provided to all new enrollees.

Additionally, in accordance with NRS 232.357, an individual's health information may be shared without an Authorization for Disclosure among the divisions of the Department of Human Resources in the performance of official duties and with local governments that help the Department carry out official duties as long as the disclosure is related to treatment, payment, or health care operations.

2403.1D PRIOR AUTHORIZATION

The purpose of prior authorization is to validate that the service being requested is medically necessary and meets Medicaid criteria for reimbursement.

1. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

2. Prior authorizations are specific to a recipient, a provider, a service code, and established quantity of units, and for specific dates of service.

3. Prior authorization is required for all services and must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare crossover claims.

Prior Authorization Process

HBHS must be prior authorized. The HBHS provider must submit the completed 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of HBHS providers) and all relevant assessments to the QIO-like vendor before services are provided. All prior authorization requests must be complete and accurate. If insufficient information is provided to support the completion of a request, the HBHS provider must supply the

needed information within 72 hours of notification. When complete information is submitted, the QIO-like vendor must make a decision within five (5) business days. In the case when an individual becomes eligible for Medicaid during the course of treatment or after services were provided, the HBHS provider may request a retro-eligible authorization by submitting the completed 1915(i) HCBS Universal Needs Assessment Tool and Service Plan (including the statement that the recipient was offered a choice of HBHS providers) and all relevant assessments to the QIO-like vendor.

The retro-eligible request must be submitted within 90 days of the notice of decision from Division of Welfare and Supportive Services (DWSS) on Medicaid eligibility determination. When complete information is submitted, the QIO-like vendor must make a determination within five (5) days.

The QIO-like vendor must review and provide a determination for all service plans and provide a written authorization to the HBHS provider which includes a prior authorization number and service authorization. The prior authorization number must be included on all claims.

Types of prior authorization requests include:

An initial prior authorization request must be submitted before providing services to a Medicaid recipient for the first time.

A concurrent prior authorization is required if a provider believes it is medically necessary for additional services to be rendered beyond that of the current authorization. The concurrent prior authorization must be submitted in time to meet QIO-Like processing timelines so an interruption in services may be avoided.

A retro-eligible request may occur when an individual becomes eligible for Medicaid after services have been provided. Retro-eligible requests must be submitted within 90 days from the eligibility determination date (date of decision).

Unscheduled changes to a current prior authorization are required when a recipient's needs change during the current authorization period. If this occurs, a revision prior authorization must be submitted for approval.

Prior authorization may be approved for a maximum of one (1) year through the end of the eligibility month. The prior authorization is dependent upon meeting the eligibility criteria using the 1915(i) HCBS Universal Needs Assessment Tool and medical necessity as described by medical evidence relating to a TBI/ABI. If services are needed after the current authorization ends, the facility must submit a

new prior authorization request to the QIO-like vendor and include the same information that is required with an initial prior authorization request. Services provided without prior authorization are not reimbursable.

A prior authorization number is required on all claims and must correspond directly to all dates of service on the claim. No dates of service billed outside of the dates approved on the corresponding prior authorization will be paid.

The QIO-like vendor will provide a written authorization to the HBHS facility which includes a prior authorization number and service authorization.

Reimbursement is not available for services furnished by legally responsible individuals.

2403.2 RESIDENTIAL HABILITATION PROGRAM (RHP)

RHPs are a covered benefit when medically necessary services are furnished in a safe, efficient and cost-effective setting to Medicaid eligible recipients who require services 24 hours per day in a normalized living environment.

2403.2A COVERAGE AND LIMITATIONS

Reimbursement is available for time limited RHPs which have been prior authorized by Nevada Medicaid's QIO-like vendor. Programs must include a day treatment program and a 24-hour residential component for those eligible recipients who are not ready to return to independent, or supported independent, living due to their functional or cognitive impairments.

1. Admission Criteria

In addition to the admission criteria identified in Section 2403.1A, of this Chapter, the following criteria apply for residential habilitation programs:

a. Eligible recipients are unable to return to independent living due to a significant cognitive or physical impairment which requires intensive, short-term specialized intervention to reintegrate into the community;

b. A program must consist of an interdisciplinary coordinated team approach, based on supporting medical rational, to improve the recipient's ability to function as independently as possible;

c. The recipient has a viable discharge plan with appropriate post placement resources, including a support system identified that will facilitate community re-

entry and a realistic expectation and plan for non-institutional living post-discharge; and

d. Documentation is made available, upon request, to support that the individual's goals cannot be safely and adequately carried out at a less intensive level such as a day treatment program.

2. Covered Services

a. A residential habilitation program must include a medically necessary day treatment program component focused on community reintegration. This program may consist of community reintegration training, personal care assistance and supervision in a 24 hour residential setting.

b. The residential component of the RHP must provide continued training, supervision and personal care services appropriate in amount and frequency to meet the needs of the recipient in a safe environment 24 hours per day, 7 days per week.

c. The interdisciplinary team must establish a plan of care which is developed and updated annually, or as needed, for each resident.

d. Nevada Medicaid does not reimburse for costs associated with room and board in the residential setting. Arrangements for reimbursement of such costs must be made with the recipient, or their family, prior to the program admission.

e. A component of community reintegration includes community visits. Payment for community visits must be properly documented, and prior authorized subject to the following conditions:

1. The purpose of community visits is for preparation for discharge to the community.

2. The recipient's primary physician authorizes the visit and the plan of care provides for such absences.

The community visit is to be reimbursed the lesser of billed charges or the established community visit per diem rate for a maximum of 2 days per month. For this purpose, a month is any continuous 31 day period.

3. Continued Stay Criteria for Residential Habilitation Program

For continued residential habilitation services, prior authorization must be submitted to Medicaid's QIO-like vendor a minimum in time to meet processing timelines so

an interruption in services may be avoided. To be considered for continued stay, supporting documentation must be provided including the most recent team conference report, which demonstrates that the recipient continues to meet RHP admission criteria and continues to:

a. demonstrate the ability to actively participate in the program;

b. have documented progression toward written goals;

c. need 24-hour habilitation services as described in 2403.1A and 2403.1A.2.a.

If continuation of services is determined to be medically appropriate, a new length of stay will be assigned and continued in this manner until the discharge of the recipient is indicated. Services provided without prior authorization are not reimbursable.

4. Discharge Criteria

A recipient in a residential habilitation program must be considered for discharge, regardless of the authorized length of stay or program completion, when the following conditions are met:

a. The recipient's needs exceed the scope of the residential habilitation program so transfer to an inpatient hospital or skilled nursing facility is indicated;

b. The recipient no longer meets the criteria for the program;

c. The specialized knowledge and skills of the interdisciplinary team are no longer required;

d. Lack of attendance and/or participation in the activities specific to the residential program setting for more than three consecutive days;

e. The recipient has reached his or her goals and a safe and effective program has been developed with informal supports to allow the recipient to live at home or elsewhere in the community;

f. There is limited motivation on the part of the recipient or caregiver which is impacting the individual's progress for over one week; or

g. The established goals serve no purpose to increase functional or cognitive capabilities towards independent or assisted living.

2403.2B PROVIDER RESPONSIBILITY

In addition to the policies discussed in Section 2403.1B "Provider Responsibility" of this Chapter, the following policies apply to the Residential Habilitation Program.

1. Providers must maintain compliance with all regulatory requirements for a residential habilitation provider for the State in which they operate;

2. Providers must maintain either CARF or the Joint Commission accreditation as a residential facility to be in good standing;

3. The provider shall provide qualified habilitation aides at the appropriate staffing ratios as determined by applicable licensure, certification and/or accreditation requirements;

4. Providers establish, maintain and update an emergency plan specific to the recipient, including appropriate emergency information on-site for each recipient at all times;

5. Providers must establish a mechanism for residents or their families to report, without retribution, any complaints or occurrences that may compromise the safety or well being of the residents within the home; and

6. Providers must establish and enforce policies to ensure the safety and well being of all residents of the facility.

2403.2C RECIPIENT RESPONSIBILITY

In addition to the policies discussed in Section 2403.1C "Recipient Responsibility" of this Chapter, the following policies apply to residents of the Residential Habilitation Program:

1. Recipients and their guests must comply with all reasonable and necessary posted "house rules" as established by the provider, in order to maintain a safe environment for all residents.

2. Recipients should notify the provider and the DHCFP of any occurrences that may compromise the safety or well being of residents within the home.

2403.2D AUTHORIZATION PROCESS

The policies discussed in Section 2403.1D "Authorization Process" of this Chapter, apply to the Residential Habilitation Program.

2403.3 COMMUNITY RE-INTEGRATION SERVICES (CRS)

Community reintegration services are designed to provide temporary assistance and support to those recipients with significant neurological impairment, incorporating those skills developed during a Habilitation program into their daily lives as they become reintegrated into their community.

Appropriate services are intended to enable the individual to function with greater independence, to prevent additional disabilities or an increase in the severity of an existing disability, without which the individual would require institutionalization.

2403.3A COVERAGE AND LIMITATIONS

Reimbursement is available for CRS which have been prior authorized by the DHCFP's QIO-like vendor. Services must be ordered by a physician as a reasonable and medically necessary part of the recipient's treatment plan and must be determined safe, efficient and cost-effective by the DHCFP or its QIO-like vendor.

1. Admission Criteria

a. The recipient must be eligible for services under Medicaid and must have behaviors which are manageable in the community re-integration environment;

b. Eligible recipients have successfully progressed through their habilitation plan of care, but they require specialized transition assistance to fully reintegrate into the community;

c. Community reintegration services are required, based on supporting medical rational, to ensure the recipient's ability to function as independently as possible in the community; and

d. Documentation is provided, to support that the reintegration goals cannot be safely and adequately carried out utilizing more informal supports, such as willing family members and neighbors;

e. The recipient has a viable written discharge plan, established by the multidisciplinary team, with appropriate resources in place, including the support system that will facilitate the community reintegration process and a realistic expectation of successful non-institutional living.

f. The medical condition is stable and compatible with an active reintegration program.

2. Covered Services

a. Community reintegration services are a covered benefit for recipients admitted within 14 days of completing a habilitation program or from the date determined to be eligible for Medicaid;

b. Services may be provided in the recipient's residence (non-institutional setting), work environment, or other appropriate community-based setting;

c. Habilitation aides must assist the recipient in utilizing those skills taught by the interdisciplinary team and involve coaching, advising, supporting and cueing recipients in Instrumental Activities of Daily Living (IADLs) such as:

household management;

behavioral management;

safety;

navigating in their immediate community using public transportation; and

socialization skills.

3. Service Limitations

a. Services must be provided in accordance with individualized plan of care under the direction of a habilitation provider;

b. Community reintegration services are limited to a maximum of 20 hours per week, and must be prior authorized.

4. Non Covered Services

a. Maintenance Therapy – is defined as the point where the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative aide are not required to carry out an activity or a home program to maintain function at the level to which it has been restored. Services in this category are non-covered.

b. Duplicative Services are not considered medically justified and will not be covered by Nevada Medicaid. An inquiry or referral for services does not indicate the necessity for services.

c. Community reintegration services solely for vocational, educational or convenience purposes or for developmental or behavioral concerns is not covered services within this program.

5. Continuing Stay Criteria

a. All services must be part of, and specifically related to, an active plan of care that the physician reviews periodically, but not less than every 30 days or when deemed necessary;

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of best medical practice;

b. The re-integration plan of care must incorporate the written discharge plan established during the habilitation program or re-integration stay, identifying formal and informal resources that are currently in place, as well as the identified support system that will be facilitating the community re-entry.

1. The plan of care must also contain:

a. Identified barriers; and corresponding short and long-term goals that are functional, objective and measurable;

b. Specific services to be provided, including the frequency, duration and modalities to be implemented; and

c. The proposed plan of care must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis."

c. Ongoing documentation of discharge planning including appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge. Since discharge planning is an integral part of any habilitation program and should begin upon the patient's admittance to the program, an extended period of time for discharge action is not reasonable after established goals have been reached, or a determination made that further progress is unlikely.

d. The recipient must demonstrate the ability and willingness to actively participate in goal oriented interventions developed with the interdisciplinary team.

This shall be evidenced by regular attendance in interventions that are a part of the reintegration action plan and documented progression toward the established goals;

e. Documentation must reflect that the community reintegration activities are reduced as the recipient's level of independence increases.

6. Discharge Criteria

Community reintegration services must be considered for termination regardless of the pre-authorized length of stay when any one of the following conditions are met:

b. The recipient has a safe discharge plan to the community.

c. The recipient has met all of their established goals.

d. The recipient requires a more restrictive setting.

e. The recipient has an unstable condition that affects their ability to participate in community reintegration activities.

2403.3B PROVIDER RESPONSIBILITY

The policies discussed in Section 2403.1B "Provider Enrollment" of this Chapter, apply to Community Re-integration Services.

2403.3C RECIPIENT RESPONSIBILITY

The policies discussed in Section 2403.1C "Recipient Responsibility" of this Chapter, apply to Community Re-integration Services.

2403.3D PRIOR AUTHORIZATION

The policies discussed in Section 2403.1D "Prior Authorization" of this Chapter, apply to Community Re-integration Services.

QUALITY ASSURANCE

The DHCFP will conduct an annual review to assure the health and welfare, of the recipients served by HBHS. The review will consist of the program requirements identified in this chapter.

Additionally, a review of the providers will be conducted annually to verify that the providers meet requirements established for each service, such as licensure, accreditation, etc, and to ensure claims are paid in accordance with the State Plan and all federal state regulations. Providers must cooperate with the DHCFP's annual review process.

2405 HEARINGS

Please reference Nevada MSM, Chapter 3100, for Medicaid Hearing Process.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 30, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES Casey Angres (Jun 20, 2023 15:10 PDT)
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2500 – CASE MANAGEMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2500 – DHCFP is proposing to amend MSM Chapter 2500 – Case Management to add Nevada local county agencies as qualified providers under provider type (PT) Targeted Case Management (PT 54) to deliver Targeted Case Management (TCM) Services to adults with Serious Mental Illness (SMI). Currently county agencies are identifying recipients with SMI in need of case management services but are unable to be reimbursed for these services to assist. This will allow county agencies to continue to see and provide services to these recipients when the need arises at their prospective agencies. Language is also being clarified to identify a Nevada University Health System as a provider in both the State Plan and MSM rather than the Nevada School of Medicine.

Throughout the section, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity.

Entities Financially Affected: This proposed change affects county agencies enrolling as Medicaid providers and delivering TCM Services. Those PTs include but are not limited to Targeted Case Management (PT 54).

Financial Impact on Local Government: No financial impact is currently anticipated for local government as a result of this change.

These changes are effective: May 31, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 06/23 MSM 2500 – Case Management	MTL 18/22 MSM 2500 – Case Management

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2503.2	**Target Group- Adults with a Serious Mental Illness (SMI)**	Added Nevada local county agencies as qualified providers under PT 54 to deliver TCM to SMI population and to clarify language to identify a Nevada University Health System as a provider in place of the Nevada School of Medicine.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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CASE MANAGEMENT

CASE MANAGEMENT

2500 INTRODUCTION

Case Management is an optional Medicaid service pursuant to federal regulations. It may be provided without the use of a waiver and the state may limit the provision of services to a specific target group or defined location in the state. States are allowed to limit the providers of case management services available for individuals with developmental disabilities or chronic mental illness to ensure that these recipients receive needed services. The receipt of case management services does not alter an individual's eligibility to receive other services under the State Plan and recipients must have free choice of any qualified Medicaid provider. A recipient cannot be compelled to receive case management services, services cannot be a condition of receipt of other Medicaid services and other covered services cannot be a condition to receive case management services. Case management services provided in accordance with Section 1915(g) of the Social Security Act (SSA) will not duplicate payments made to public agencies or private entities under State Plan and other program authorities. Case managers cannot authorize, approve or deny the provision of services.

The intent of case management services is to assist recipients eligible under the State Plan in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Case management services do not include the direct delivery of medical, clinical or other direct services. Components of the service include assessment, care planning, referral/linkage and monitoring/follow-up. Case management services are provided to eligible recipients who are residing in a community setting or transitioning to a community setting following an institutional stay.

There are nine target groups eligible to receive this service. These groups are: (1) children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) with a mental illness; (2) children and adolescents who are Severely Emotionally Disturbed (SED); (3) adults who are Non-Seriously Mentally Ill (Non-SMI) with a mental illness; (4) adults who are Seriously Mentally Ill (SMI); (5) persons with intellectual disabilities or related conditions; (6) developmentally delayed infants and toddlers under age three; (7) Juvenile Parole Population; (8) Juvenile Probation Services (JPS), and (9) Child Protective Services (CPS).

All providers who participate in the Medicaid program must provide services in accordance with the rules and regulations of the Division of Health Care Financing and Policy (DHCFP), all policies and procedures described here in Medicaid Services Manual (MSM) Chapter 2500, as well as state and federal regulations and statutes.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and Nevada Check Up policies differ as documented in the Nevada Check Up Manual, Chapter 1000.

2501 AUTHORITY

A. In 1965, the 89th Congress added Title XIX of the SSA authorizing varying percentages of Federal Financial Participation (FFP) to states that elect to offer medical programs. The state must offer the 11 basic required medical services. FFP is also available, should states elect to cover some optional services. One of these optional services is Case Management.

B. Authorities include:

- Section 1905(a)(19) of the SSA
- Section 1915(b) of the SSA
- Section 1915(c) of the SSA
- Section 1915(g) of the SSA
- 42 Code of Federal Regulations (CFR) Parts 431, 440, and 441
- 42 CFR 483.430
- Section 60-52 of the Deficit Reduction Act of 2005
- The Supplemental Appropriations Act 2008

2502 POLICY

2502.1 CASE MANAGEMENT SERVICES POLICY

2502.2 CASE MANAGEMENT SERVICES

A. Case management services are services which assist an individual in gaining access to needed medical, social, educational and other supportive services and must include the following components:

1. Assessment of the eligible individual to determine service needs.

2. Development of a person-centered care plan.

3. Referral and related activities to help the individual obtain needed services.

4. Monitoring and follow-up.

B. Case management services involve the following activities to assist the eligible recipient in obtaining needed services:

1. Assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. The assessment activities include the following:

a. Taking client history.

b. Identifying the needs of the individual and completing related documentation.

c. Gathering information from other sources, such as family members, medical providers, social workers and educators (if necessary) to form a complete assessment of the eligible recipient.

2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

a. Specifies the goals and actions to address the medical, social, educational and other services needed by the eligible recipient.

b. Includes activities such as ensuring the active participation of the eligible recipient and working with the recipient (or the individual's authorized health care decision maker) and others to develop those goals.

c. Identifies a course of action to respond to the assessed needs of the eligible recipient.

3. Referral and related activities (such as scheduling appointments for the recipient) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

4. Monitoring and follow-up; activities include activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and may be with the individual, family members, service provider or other entities or individuals. The monitoring should be conducted as frequently as necessary, and include at least one annual monitoring, to help determine whether the following conditions are met:

   a. Services are being furnished in accordance with the individual's care plan.

   b. Services in the care plan are adequate.

   c. There are changes in the needs or status of the eligible recipient.

   Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. Monitoring may involve either face-to-face or telephone contact, at least annually.

2502.3 LEAD CASE MANAGER

The Lead Case Manager is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. Certified Community Behavioral Health Centers (CCBHC), Managed Care Organization (MCO), or governmental agencies). The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for a MCO, it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case Manager will coordinate all care with the MCO to ensure there is an elimination of any potential for a duplication of services.

2502.4 CASE RECORD DOCUMENTATION

A case record documentation shall be maintained for each recipient and shall contain the following items:

A. The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.

B. The nature, content and units of case management services received. Units, for documentation purposes, are further defined as actual case management activities performed.

1. If paid per unit, document date, time, number of units and activities completed.

2. If paid per monthly cap rate, document date, time and activities completed.

C. Whether the goals specified in the care plan have been achieved.

D. If an individual declines services listed in the care plan, this must be documented in the individual's case record.

E. Timelines for providing services and reassessment.

F. The need for and occurrences of coordination with case managers of other programs.

The case manager shall make available to Nevada Medicaid or Medicaid's Quality Improvement Organization (QIO-like vendor), upon request, copies of the medical record, progress notes, care plan, case record or summary documents which reflect the ongoing need for case management services and support any additional services requested.

2502.5 COVERAGE AND LIMITATIONS

The maximum hours per target group, per calendar month, per recipient, allowed for case management services are identified below. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate). All service limits may be exceeded with a prior authorization.

Service Limitation Grid by Target Group

Target Group	Service Limitations
Child Protective Services (CPS)	30 hours, per calendar month, per recipient.
Developmentally Delayed Infants and Toddlers Under Age Three	30 hours, per calendar month, per recipient.
Juvenile Parole Population	30 hours, per calendar month, per recipient.
Juvenile Probation Services (JPS)	30 hours, per calendar month, per recipient.
Persons with Intellectual Disabilities or Related Conditions	30 hours, per calendar month, per recipient.

Non-Seriously Mentally Ill (Non-SMI) Adults	10 hours for initial calendar month, five hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year.
Serious Mental Illness (SMI) Adults	30 hours, per calendar month, per recipient.
Non-Severally Emotionally Disturbed (Non-SED) Children and Adolescents	10 hours for initial calendar month, five hours for the next three consecutive calendar months. Services are allowed on a rolling calendar year.
Severe Emotional Disturbance (SED)	30 hours, per calendar month, per recipient.

A. Case management services are reimbursable when:

1. Provided to Medicaid eligible recipients, on a one-to-one (telephone or face-to-face) basis.

2. Medically necessary.

3. Provided by a qualified provider enrolled to serve the target group in which the recipient belongs.

4. Provided by the recipient's chosen provider.

5. Contacts by the case manager with individuals who are not eligible for Medicaid when the purpose of the contact is directly related to the management of the eligible recipient's care.

6. There are no third parties liable to pay for these services, including as reimbursement under a medical, social, educational or other federally funded program. Third party insurance payments for case management services must be pursued for all recipients.

   The provider must determine whether the recipient has other health insurance. Providers may survey health care insurance companies to determine whether case management is a covered benefit. Exception: this is not necessary for Medicare since it is not a covered service. If the health care provider covers case management, it must be billed for all recipients for services provided. For Medicaid recipients, the health care insurance company must be billed before Medicaid is billed. Once payment is received, if the other company did not pay the entire cost of services, Medicaid may be billed. If the health care insurance company will not pay for case management services, documentation of this must be maintained in the recipient’s case record.

7. The service is not an integral component or administrative service of another covered Medicaid service.

B. Case management services not reimbursable under the Nevada Medicaid Program include, but are not limited to:

1. The actual or direct provision of medical services or treatment. Examples include, but are not limited to:

   a. Training in daily living skills;

   b. Training in work skills and social skills;

   c. Grooming and other personal services;

   d. Training in housekeeping, laundry, cooking;

   e. Transportation services;

   f. Individual, group or family therapy services;

   g. Crisis intervention services; and/or

   h. Diagnostic testing and assessments.

2. Services which go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

   a. Paying bills and/or balancing the recipient's checkbook;

   b. Completing application forms, paperwork, evaluations and reports including applying for Medicaid eligibility;

   c. Escorting or transporting recipients to scheduled medical appointments; and/or

   d. Providing childcare so the recipient can access services.

3. Traveling to and from appointments with recipients.

4. Traveling to and from appointments (without recipients).

5. Case management services provided to recipients between 22 and 64 years of age who are in an Institution for Mental Disease (IMD).

6. Using case management codes for billing, when the recipient does not meet the criteria for the target group.

7. Recipient Outreach – Outreach activities in which a state agency or other provider attempts to contact potential recipients of a service do not constitute case management services.

8. The direct delivery of foster care services and therapeutic foster care services. The following activities are not considered to qualify as components of Medicaid case management services:

    a. Research gathering and completion of documentation required by the foster care program.

    b. Assessing adoption placements.

    c. Recruiting or interviewing potential foster care parents.

    d. Serving legal papers and attendance at court appearances.

    e. Home investigations.

    f. Providing transportation.

    g. Administering foster care subsidies.

    h. Making placement arrangements.

    i. Training, supervision, compensation for foster care parents.

9. If the case manager also provides other services under the plan, the State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals. Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the service.

10. Services provided as "administrative case management," including Medicaid eligibility determination, intake processing, preadmission screening for inpatient care, utilization review and prior authorization for Medicaid services are not reimbursable.

11. Administrative functions for recipients under the Individuals with Disabilities Education Act (IDEA) such as the development of an Individual Education Plan and

the implementation and development of an Individual Family Service Plan for Early Intervention Services are not reimbursable as case management services.

2502.6 RECIPIENT RESPONSIBILITIES

A. Medicaid recipients, their families or legal guardians are required to provide a valid Medicaid eligibility card to their case management service providers.

B. Medicaid recipients, their families or legal guardians are expected to comply with the recipient's treatment and care plans.

2502.7 AUTHORIZATION PROCESS

Medicaid recipients are entitled to receive a maximum amount of hours of case management services identified in the Service Limitation Grid, Section 2502.5 per target group, per calendar month, per recipient. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate).

If the recipient requires more than the allotted hours per month, the case manager must thoroughly document in the recipient's case record the justification for the additional hours and submit a prior authorization request to the QIO-like vendor.

2503 TARGET GROUPS

2503.1 TARGET GROUP – ADULTS WITH A NON-SERIOUS MENTAL ILLNESS (NON-SMI)

A. Adults, who are Non-SMI, excluding dementia and intellectual disabilities, are recipients 18 years of age and older with significant life stressors and have:

1. A current International Classification of Diseases (ICD) diagnosis from the current Mental, Behavioral, Neurodevelopmental Disorders section including Z-Codes 55-65, R45.850 and R45.851, which does not meet SMI criteria.

2. A Level of Care Utilization System (LOCUS) score of Level I or II.

B. Service Eligibility

The determination for adults with a Non-SMI is made by a licensed, qualified mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT) or master's degree psychiatric nurse).

C. Provider Qualifications

Minimum qualification of a case manager providing services for Non-SMI adults are a service coordinator with a bachelor's degree in a health-related field, Registered Nurse (RN), master's level professional (LCSW or LMFT), Advanced Practice Registered Nurse (APRN) in mental health, psychologist or mental health professional who works under the direct supervision of a person listed above.

D. Service Criteria

1. Admission Criteria includes:

a. A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section including Z-Codes 55-65, R45.850 and R45.851, which does not meet SMI criteria (including dementia, intellectual disabilities, or primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness that meets current ICD criteria).

b. Recipients require assistance in obtaining and coordinating medical, social, educational and other support services.

2. Continuing Stay Criteria:

a. Continues to meet admission criteria.

b. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.

c. Documentation supports progress towards specific case management goals identified in the established care plan with barriers identified and addressed.

3. Discharge/Exclusionary Criteria:

a. No longer meets Non-SMI determination.

b. No longer meets the admission and continuing stay criteria.

c. Recipient or family chooses not to participate in the program or is non-compliant.

d. Recipient requires inpatient psychiatric hospitalization, IMD or Nursing Facility (NF) placement.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admission.

2503.2 TARGET GROUP — ADULTS WITH A SERIOUS MENTAL ILLNESS (SMI)

A. Adults with an SMI are persons:

1. 18 years of age and older;

2. Who currently, or at any time during the past year (continuous 12-month period);

a. Have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the current ICD (excluding substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities, unless they co-occur with another SMI that meets current ICD criteria);

b. That resulted in functional impairment which substantially interferes with or limits one or more major life activities;

3. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational, or educational. It is seen on a hypothetical continuum of mental health illness and is viewed from the individual's perspective within the environmental context. Functional impairment

is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships, or safety.

B. Service Eligibility Determination

The determination for adults with a SMI is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT, or master's degree psychiatric nurse).

C. Provider Qualifications

Minimum qualifications of a case manager providing services for SMI adults (which can only be provided by a state agency; local county agency, and its employees, contractors, or an organization affiliated with a Nevada University Health System) are a case manager with a Bachelor's degree in a health-related field, RN, master's level professional (LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

D. Service Criteria

1. Admission Criteria

Must meet of all the following:

a. A current ICD diagnosis (excluding Z-Codes, dementia, intellectual disabilities, or a primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness that meets current ICD criteria).

b. Recipient requires assistance in obtaining and coordinating medical, social, educational, and other support services.

2. Continuing Stay Criteria

Must meet all of the following:

a. Continues to meet admission criteria.

b. Individualized care plan identifies all medical, social, educational, and other support services currently being provided, as well as unmet needs of the recipient.

c. Documentation supports progress towards specific case management goals identified in the case management care plan and barriers have been identified and addressed.

d. Treatment plan and goals must be established.

3. Discharge Criteria

Must meet at least one of the following:

a. No longer meets SMI determination.

b. No longer meets the admission and continuing stay criteria.

c. Admission into a psychiatric hospital, IMD, or NF.

d. Recipient or family chooses not to participate in the program or is non-compliant.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute treatment.

4. Exclusionary Criteria

Must meet at least one of the following:

a. No longer meets SMI determination.

b. No longer meets the admission and continuing stay criteria.

c. Admission into a psychiatric hospital, NF, or IMD.

d. Recipient chooses not to participate in the program or is non-compliant.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute treatment.

2503.3 TARGET GROUP — CHILDREN AND ADOLESCENTS WITH A NON-SEVERE EMOTIONAL DISTURBANCE (NON-SED)

A. Children and adolescents, who are Non-SED, excluding dementia and intellectual disabilities, are recipients with significant life stressors and have:

1. A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section which does not meet SED criteria.

2. Z-Codes 55-65, R45.850 and R45.851, as listed in the current ICD Manual which

does not meet SED criteria.

3. Child and Adolescent Services Intensity Instrument (CASII) Level of 0, 1, 2, or above.

B. Service Eligibility Determination

The determination for children and adolescents with a Non-SED is made by a qualified mental health professional (psychiatrist, psychologist, LCSW, LMFT, or master's degree psychiatric nurse).

C. Provider Qualifications

The minimum qualifications of a case manager providing services for a Non-SED child are a case manager with a bachelor's degree in a health related field, doctorate degree and license in psychology, RN, master's level professional (LCSW or LMFT), APRN in mental health or a mental health professional who works under the direct supervision of a person listed above, and LCSW or LMFT interns that are supervised within the scope of their license.

2503.4 TARGET GROUP — CHILDREN AND ADOLESCENTS WITH A SEVERE EMOTIONAL DISTURBANCE (SED)

A. Children with a SED are persons up to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

1. Diagnosable mental, behavioral, or diagnostic criteria that meet the coding and definition criteria specified in the current ICD. This excludes substance abuse or addictive disorders, irreversible dementias, as well as intellectual disabilities and other related conditions and Z-Codes, unless they co-occur with another SMI that meets current ICD criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities; and

2. These disorders include any disorder from the Mental, Behavioral, Neurodevelopmental Disorders section (including those of biological etiology) listed in current ICD Clinical Modification (CM) equivalent (and subsequent revisions), with the exception of Z-Codes, substance use and developmental disorders, which are excluded unless they co-occur with another diagnosable SED. All of these disorders have episodic, recurrent or persistent features; however, they vary in terms of severity and disabling effects; and

3. Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

B. Service Eligibility Determination

The determination for children and adolescents with a SED is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT, or master's degree psychiatric nurse).

C. Provider Qualifications

Minimum qualifications of a case manager providing services for SED children and adolescents (which can only be provided by a state agency or organization affiliated with the University of Nevada School of Medicine) are a case manager with a bachelor's degree in a health-related field, RN, master's level professional (LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

D. Service Criteria

1. Admission

Must meet all of the following:

a. DSM-IV, AXIS I or II, diagnosis (excluding V-Codes, dementia, intellectual disability, or a primary diagnosis of a substance abuse disorder, unless they co-occur with another mental illness that meets DSM-IV criteria).

b. Recipient requires assistance in obtaining and coordinating medical, social, educational, and other support services.

2. Continuing Stay Criteria

Must meet all of the following:

a. Continues to meet admission criteria.

b. Individualized care plan identifies all medical, social, educational, and other support services currently being provided, as well as unmet needs of the recipient.

c. Documentation supports progress towards specific case management goals identified in the case management care plan and barriers have been identified and addressed. Treatment plan and goals must be established.

3. Discharge Criteria

Must meet one of the following:

a. No longer meets SED determination.

b. No longer meets the admission and continuing stay criteria.

c. Recipient or family chooses not to participate in the program or is non-compliant.

d. Requires inpatient psychiatric hospitalization, NF, or Residential Treatment Center (RTC) placement.

e. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria

a. No longer meets SED determination.

b. No longer meets the admission and continuing stay criteria.

c. Requires inpatient psychiatric, NF or RTC hospitalization.

d. Recipient or family chooses not to participate in the program.

E. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 14 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2503.5 TARGET GROUP — CHILD PROTECTIVE SERVICES (CPS)

A. Child Protective Services are:

1. Provided to children and young adults who are Medicaid recipients and abused or neglected or suspected to be at risk thereof as evidenced by being in the care of the Division of Child and Family Services (DCFS), Clark County Department of Family Youth Services, or Washoe County Department of Social Services.

2. Provided to families who are abused or neglected or suspected to be at risk thereof as evidenced by being in the care of DCFS, Clark County Department of Family Services, or Washoe County Department of Social Services.

B. Provider Qualifications

The organization providing case management services for CPS must meet the following requirements:

1. A minimum of five years' experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.

2. A minimum of five years' experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.

3. A minimum of five years' case management experience in accordance and linking community medical, social, educational or other resources needed by the target population on a countywide basis.

4. A minimum of five years working with the target population.

5. A minimum of five years' experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.

6. A minimum of five years' experience of demonstrated capacity in meeting the case management service needs of the target population.

7. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.

8. Qualifications of individual case managers:

   a. Bachelor's degree in a related field; or equivalent college and field experience; and

   b. Ability to work in and with legal systems, including the court system; and

   c. Ability to learn state and federal rules, laws and guidelines relating to the target population and to gain knowledge about community resources.

C. Eligibility Determination

Medicaid eligible recipient's status is determined by the County's Department of Social Services CPS.

D. Service Criteria

Medicaid eligible recipient is under the care of the County's Department of Social Services CPS. Scope of services must be in accordance with federal regulations.

E. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

   a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

   b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2503.6 TARGET GROUP - INFANTS AND TODDLERS DEVELOPMENTALLY DELAYED UNDER AGE THREE

A. Developmentally delayed infants and toddlers are children ages birth through two years determined eligible for early intervention services through the identification of a developmental delay, a term which means:

1. A child exhibits a minimum of 50% delay of the child's chronological age in any one of the areas listed below or a minimum of 25% delay of the child's chronological age in any two of the areas listed below. Delays for infants less than 36 weeks' gestation shall be calculated according to their adjusted age.

2. The delay(s) must be defined in one or more of the following areas:

   a. Cognitive development;

   b. Physical development, including vision and hearing;

   c. Communication development;

   d. Social or emotional development; or

   e. Adaptive development.

3. Children also are eligible who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delays.

4. Informed clinical opinion must be used in determining eligibility for services as a result of a development delay.

B. Service Eligibility Determination

Eligibility is determined by a multidisciplinary team consisting of two early intervention professionals and the parent. Eligibility determination must include the following:

1. Be conducted by personnel trained to utilize appropriate methods and procedures;

2. Be based on informed clinical opinions; and

3. Include the following:

   a. Review of pertinent records related to the child's current health status and medical history.

   b. An evaluation of the child's level of functioning in each of the following developmental areas:

      1. Cognitive development.

      2. Physical development, including vision and hearing.

3. Communication development.

4. Social or emotional development.

5. Adaptive development.

c. An assessment of the unique needs of the child including the identification of services appropriate to meet those needs.

C. Provider Qualifications

Qualifications of a case manager providing services to an infant or toddler with developmental delays in an employee or contractor of the Department of Health and Human Services (DHHS) or one of its qualified Divisions; and

1. An individual with a master's degree from an accredited college or university in early childhood special education, childhood human growth and development, psychology, counseling, social work, or a closely related field; or

2. An individual with a bachelor's degree from an accredited college or university with major work in early childhood growth and development, early childhood special education, psychology, counseling, social work or a closely related field, and one year of full-time professional experience in an early integrated preschool program, mental health facility or a clinical setting providing developmental or special education or treatment-oriented services to preschool or school age children with physical or mental disabilities, or emotional or behavioral disorders.

D. Service Criteria

1. Admission Criteria

a. Medicaid eligible.

b. Meets criteria addressed in Section 2503.6(A).

2. Continuing Stay Criteria

Continues to meet admission criteria.

3. Discharge Criteria

a. Does not meet admission criteria.

b. Child has demonstrated age-appropriate skills for six consecutive months.

c. Child turns age three.

d. Meets criteria for admission to an inpatient facility.

e. Family chooses not to participate in the program or is non-compliant.

f. Has sufficient support system to sustain stability, not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria

a. Does not meet admission criteria.

b. Child is age three or older.

c. Meets criteria for admission to an inpatient facility.

d. Family chooses not to participate in the program or is non-compliant.

E. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2503.7 TARGET GROUP – JUVENILE PAROLE SERVICES

A. Juvenile Parole Services are:

1. Covered services provided to juveniles on parole (referred or under the supervision of juvenile caseworkers) within all counties of Nevada.

2. Covered services provided to family member(s) who are Medicaid eligible whose children are on parole.

3. At high risk for medical compromise due to one of the following conditions:

   a. Failure to take advantage of necessary health care services; or

   b. Non-compliance with their prescribed medical regime; or

   c. An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization; or

   d. An inability to understand medical directions because of comprehension barriers; or

   e. A lack of community support system to assist in appropriate follow-up care at home; or

   f. Substance abuse; or

   g. A victim of abuse, neglect, or violence; and

4. In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

B. Provider Qualifications

The organization providing case management services for Juvenile Parole Services must meet the following provider qualification requirements:

1. A minimum of five years' experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management; and

2. Establish a system to coordinate services for individuals who may be covered under another program which offers components of case management or coordination similar to Targeted Case Management including, but not limited to, the coordination of services with Managed Care providers, DCFS, as well as State waiver programs; and

3. Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability to increase their capability to provide their services to the target group; and

4. Must be an agency employing staff with case management qualifications; and

5. Establish referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and

6. A minimum of five years' experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis; and

7. A minimum of five years' case management experience in coordinating and linking community medical, social, educational, or other resources needed by the target population on a countywide basis; and

8. A minimum of five years' experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements; and

9. A minimum of five years' experience of demonstrated capacity in meeting the case management service needs of the target population; and

10. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.

11. Qualifications of individual case manager

    a. Bachelor's degree in criminal justice, psychology, social work or a closely related field; or equivalent college and two years of experience in the criminal justice system to include conducting casework services, making program eligibility determinations, investigating offenders, preparing detailed reports for the purposes of justifying criminal sanctions and/or prosecution, or coordinating with law enforcement agencies, the juvenile justice system, community-based placements and related State agencies regarding the preparation of parole agreements, placement, program development, obtaining services and the legal process of assigned youth; and

    b. Ability to work in and with legal systems, including the court system and law enforcement; and

    c. Ability to learn state and federal rules, laws and guidelines relating to the target population and to gain knowledge about community resources.

C. Eligibility Determination

Medicaid eligible recipient's status is determined by the Department of Juvenile Parole.

D. Service Criteria

Medicaid eligible recipient is under the care of the Department of Juvenile Parole. Services must be in accordance with federal regulations.

E. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2503.8 TARGET GROUP — JUVENILE PROBATION SERVICES (JPS)

A. Juvenile Probation Services are:

1. Covered services provided to juveniles on probation (referred or under the supervision of juvenile caseworkers) within all counties of Nevada.

2. Covered services provided to family member(s) who are Medicaid eligible whose children are on probation.

B. Provider Qualifications

The organization providing case management services for JPS must meet the following requirements:

1. A minimum of five years' experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.

2. A minimum of five years' experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.

3. A minimum of five years' case management experience in coordinating and linking community medical, social, educational, or other resources needed by the target population on a countywide basis.

4. A minimum of five years working with the target population.

5. A minimum of five years' experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.

6. A minimum of five years' experience of demonstrated capacity in meeting the case management service needs of the target population.

7. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.

8. Qualifications of individual case managers:

   a. Bachelor's degree in a related field; or equivalent college and field experience; and

   b. Ability to work in and with legal systems, including the court system; and

   c. Ability to learn state and federal rules, laws and guidelines relating to the target population and to gain knowledge about community resources.

C. Eligibility Determination

Medicaid eligible recipient's status is determined by the County Department of JPS.

D. Service Criteria

Medicaid eligible recipient is under the care of the County Department of JPS. Scope of coverage services must be in accordance with federal regulations.

E. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

   a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

   b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2503.9 TARGET GROUP — PERSONS WITH INTELLECTUAL DISABILITIES OR RELATED CONDITIONS

A. Persons with intellectual disabilities or related conditions are persons who:

1. Are significantly sub-average in general intellectual functioning (intelligence quotient (IQ) of 70 or below) with concurrent related limitations in two or more adaptive skill areas, such as communication, self-care, social skills, community use, self-direction, health and safety, functional academics, leisure, and work activities.

   Persons with related conditions are individuals who have a severe chronic disability. It is manifested before the person reaches age 22 and is likely to continue indefinitely. The disability can be attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disabilities because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of an intellectually disabled person and requires treatment or services similar to those required by these persons.

   The related condition results in substantial functional limitations in three or more of the following areas of major life activity:

   a. Self-care.

   b. Understanding and use of language.

   c. Learning.

   d. Mobility.

   e. Self-direction.

   f. Capacity for independent living.

B. Service Eligibility Determination

   The determination is made by a Qualified Intellectual Disability Professional (QIDP) as defined in 42 CFR 483.430.

C. Provider Qualifications

1. Employee or contractor of the Division of Aging and Disability Services (ADSD) or the DCFS; and

a. Bachelor's level social worker licensed to practice in Nevada.

b. RN licensed in Nevada to practice professional nursing

.

c. Disabilities specialist with at least a bachelor's degree in human sciences.

d. Psychologist licensed to practice in Nevada.

e. Child development specialist and psychology, nursing, or social work caseworker who works under the direct supervision of a person in classes (a) through (d) above.

D. Service Criteria

1. Admission Criteria.

Meets admission criteria as addressed in Section 2503.9(A)

2. Continuing Stay Criteria.

Continues to meet admission criteria.

3. Discharge Criteria.

a. Does not meet admission criteria.

b. Recipient or family chooses not to participate in program or is non-compliant.

c. Admission into a hospital, NF, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

d. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admissions.

4. Exclusionary Criteria

a. Does not meet admission criteria.

b. Recipient is hospitalized or resides in an ICF/IID.

c. Admission into a hospital, NF or ICF/IID.

E. Transitional Targeted Case Management

1. Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

   a. Transitional Targeted Case Management services are provided 180 days prior to discharge for an institutional stay.

   b. Transitional Targeted Case Management activities are coordinated with and are not a duplication of institutional discharge planning services.

2504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100, Hearings, for hearings procedures.

2505 RESERVED FOR FUTURE USE

2505 RESERVED FOR FUTURE USE

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 25, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMI MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2600 – Intermediary Service Organization are being proposed to add language due to the passage of the 21st Century Cures Act. In December 2016, Congress passed H.R. 34 – 21st Century Cures Act, mandating that all States require the use of an Electronic Visit Verification (EVV) system for all Medicaid-funded personal care services that are provided under a State Plan or a waiver of the plan, including services provided under Section 1915(c).

Throughout the chapter, grammar and punctuation changes were made, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering specific personal care services. Those provider types (PT) include but are not limited to: Intermediary Service Organization (PT 83).

Financial Impact on Local Government: Unknown at this time.

These changes are effective September 25, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 20/19 CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION	MTL 21/16 CHAPTER 2600 – INTERMEDIARY SERVICE ORGANIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2601	**AUTHORITY**	Added 21st Century Cures Act mandate and H.R 6042 – 115th Congress.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2603.1	**SELF-DIRECTED PERSONAL CARE SERVICES (PCS)**	Clarified that all services must be documented in an approved EVV system.
2603.1B	**INITIATING SELF-DIRECTED PERSONAL CARE SERVICES (SD PCS)**	Removed obsoleted form titles.
2603.1F	**ELECTRONIC VISIT VERIFICATION (EVV)**	New section added to highlight the 21st Century Cures Act requirements. There are two options in the State of Nevada for use of an EVV system: state option and data aggregator. Various data points are required and outlined in this section.
2603.8	**PROVIDER RESPONSIBILITIES**	Added the 21st Century Cures Act to the list of local, state and federal regulations that agencies must comply with. Added EVV language to mandate the use of an EVV system for all. Added language that the Intermediary Services Organization (ISO) staff must review with the recipient, legally responsible individual (LRI) or personal care representative (PCR) the EVV requirements and recipient participation to adhere to the 21st Century Cures Act. Added language that all personal care aides (PCAs) must understand the EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system. Removed language regarding records. All record requirements are listed in the newly created Section 2603.1F.
2603.9	**RECIPIENT RESPONSIBILITIES**	Added language to agree to utilize a Medicaid-approved EVV system and to confirm services electronically, per requirements of the 21st Century Cures Act.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2604.1B	**PROVIDER RESPONSIBILITIES**	Added language to agree to utilize a Medicaid-approved EVV system and to confirm services electronically, per requirements of the 21st Century Cures Act. Added EVV language to mandate the use of an EVV system for services performed through the independent contractor model.

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2600 INTRODUCTION

INTERMEDIARY SERVICE ORGANIZATION - (ISO)

An Intermediary Service Organization (ISO) is an entity acting as an intermediary between Medicaid recipients, who elect the Self-Directed (SD) service delivery model and the Personal Care Assistants (PCAs) who provide those services. In the SD service delivery model, the recipient is the managing employer of the PCA and the ISO is the employer of record.

Under the SD service delivery model, Nevada Medicaid allows for the self-direction of two services through an ISO, Personal Care Services (PCS) and Skilled Services. These services are provided where appropriate, when medically necessary and within service limitations. Services may be provided in settings outside the home, including employment sites.

SD PCS and Skilled Services are available to recipients, including those persons with cognitive impairments, who have the ability and desire to manage their own care. When a recipient does not have the ability to manage or direct their own care, a Personal Care Representative (PCR) may be selected on the recipient's behalf to direct the services.

SD PCS and SD Skilled Services are available to recipients who are not inpatients or residents of a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), institutions for mental disease or other excluded settings.

This Medicaid Services Manual (MSM), Chapter 2600, contains Nevada Medicaid's policy for the SD service delivery model of PCS and Skilled Services provided through an ISO. For policy pertaining to the Provider Agency service delivery model of PCS, refer to Chapter 3500.

All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with Chapter 100 and meet certain qualifications and criteria as discussed later in this chapter.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

2601 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security Act (SSA).

Regulatory oversight:

- SSA 1905(a)(24)
- Title 42, Code of Federal Regulations (CFR) Section 440.167
- Nevada State Plan Attachment 3.1-A (26)
- 21st Century Cures Act, H.R. 34, Sec. 12006 – 114th Congress
- H.R. 6042 – 115th Congress

2602 DEFINITIONS

Program definitions can be found in the Medicaid Services Manual (MSM) Addendum.

2603 POLICY

Nevada Medicaid offers two services that can be self-directed by the recipient or their Personal Care Representative (PCR) through an Intermediary Service Organization (ISO): PCS and Skilled Services.

Legally responsible individuals (LRIs) may not be reimbursed for providing Self-Directed (SD) PCS and/or SD Skilled Services.

2603.1 SELF-DIRECTED PERSONAL CARE SERVICES (PCS)

Self-Directed PCS provide assistance to support and maintain recipients living independently in their homes. Services may be provided in the home, locations outside the home or wherever the need for the service occurs. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Services are based on the need of the recipient being served, as determined by a Functional Assessment Service Plan (FASP) approved by the Division of Health Care Financing and Policy (DHCFP). All services must be performed in accordance with the approved service plan, must be prior authorized and documented in an approved Electronic Visit Verification (EVV) system. The time authorized for services is intended to meet the recipient needs within program limits and guidelines, facilitate effective and efficient service delivery and to augment unpaid and paid supports currently in place. Services are not intended to replace or substitute services and/or supports currently in place, or to exchange unpaid supports for paid services.

Services are available to recipients in need of PCS, including persons with cognitive impairments, who have the ability and desire to manage their own care. When the recipient does not have the ability to manage their own care, a PCR may do so on their behalf.

This option is utilized by accessing services through an ISO. The ISO is the employer of record and the recipient is the managing employer for the PCAs that provide the services.

2603.1A ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;

2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;

3. The recipient does not have an LRI who is available and capable of providing the necessary care;

4. The recipient must be able to make choices about ADLs, understand the impact of these choices and assume responsibility for them or have a PCR who is willing to assist the recipient in making choices and assumes responsibility for those choices;

5. The recipient or PCR must be cooperative in establishing the need for the provision of services and comply with the approved service plan;

6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee; and

7. The recipient or PCR must be willing and capable of managing all tasks related to service delivery including, but not limited to: recruitment, selection, scheduling, training and directing PCAs.

2603.1B INITIATING SELF-DIRECTED PERSONAL CARE SERVICES (SD PCS)

The recipient, LRI or their PCR indicates interest in self-directing their PCS by contacting their local DHCFP District Office or Aging and Disability Services Division (ADSD) Office directly.

1. The DHCFP District Office or local ADSD Office staff provides information to the recipient or the PCR about the self-directed services available. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.

2. If the recipient elects to self-direct his or her own PCS, the ISO will provide, and the recipient will sign, the Intermediary Service Organization (ISO) Self-Directed Personal Care Services Unskilled Only Recipient Agreement.

3. If the recipient elects a PCR to direct his or her care, the ISO will provide, and the PCR will sign, the Intermediary Service Organization (ISO) Self-Directed Personal Care Services Unskilled Only Personal Care Representative Agreement.

   A signed copy of either agreement should be given to the recipient and/or PCR and the ISO shall retain the original for their records.

2603.1C COVERAGE AND LIMITATIONS

1. Covered Services

   a. Assistance with the following ADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare.

1. Bathing/dressing/grooming.

2. Toileting needs and routine care of an incontinent recipient.

3. Transferring and positioning non-ambulatory recipients from one stationary position to another, assisting a recipient out of bed, chair or wheelchair, including adjusting/changing recipient's position in a bed, chair or wheelchair.

4. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a walker, cane or crutches or assisting a recipient to stand up or get to his/her wheelchair to begin ambulating.

5. Eating, including cutting up food. Specialized feeding techniques may not be used.

b. Assistance with the following IADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare. See the service limitations section of this chapter for specific eligibility criteria to be considered eligible to receive additional time for assistance with IADLs.

1. Meal preparation, which includes storing, preparing and serving food.

2. Laundry, which includes washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.). Ironing is not a covered service.

3. Light housekeeping, which includes changing the recipient's bed linens, dusting, or vacuuming the recipient's living area.

4. Essential shopping, which includes shopping for prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and nutrition of the recipient.

2. Service Limitations

To be considered eligible to receive additional time for assistance with IADLs, the recipient must be eligible to receive PCS for ADLs and have deficits which directly preclude the individual from completing IADLs. The FASP must demonstrate that the recipient meets the following criteria:

a. The recipient has extensive impairments, Level 2 or higher on the FASP in two or more areas of ADLs; and

b. The recipient has at least one of the deficits listed below:

1. Mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impacts the recipient's ability to safely perform household tasks or meal preparation independently;

2. Cognitive deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently;

3. Endurance deficits directly impacting the recipient's ability to complete a task without experiencing substantial physical stressors;

4. Sensory deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently.

Assistance with the IADLs may only be provided in conjunction with services for ADLs, and only when no LRI is available and/or capable.

3. Non-Covered Services

Duplicative services are not considered medically necessary and will not be covered by Nevada Medicaid. An inquiry or referral for services does not determine the medical necessity for services.

The following are not covered under PCS and are not reimbursable:

a. A task that the DHCFP or its designee determines could reasonably be performed by the recipient.

b. Services normally provided by an LRI.

c. Any tasks not included on the recipient's approved service plan.

d. Services to maintain an entire household, such as cleaning areas of the house not used solely by the recipient(s).

e. Services provided to someone other than the intended recipient.

f. Skilled care services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or

certified by the State. Services include, but are not limited to, the following:

1. Insertion and sterile irrigation of catheters;

2. Irrigation of any body cavity. This includes both sterile and non-sterile procedures such as ear irrigation, vaginal douches, and enemas;

3. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;

4. Administration of injections of fluids into veins, muscles, or skin;

5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions, or the instillation of prescribed eye drops (as opposed to assisting with self-administered medication);

6. Physical assessments;

7. Monitoring vital signs;

8. Specialized feeding techniques;

9. Rectal digital stimulation;

10. Massage;

11. Specialized range of motion (ROM);

12. Toenail cutting;

13. Medical case management, such as accompanying a recipient to a physician's office for the purpose of providing or receiving medical information; and

14. Any task identified within the Nurse Practice Act as requiring skilled nursing, including Certified Nursing Assistant (CNA) services.

g. Chore services.

h. Companion care, baby-sitting, supervision, or social visitation.

i. Care of pets except in cases where the animal is a certified service animal.

j. Respite care intended primarily to relieve a member of the recipient's household, a family member or caregiver from the responsibility of caring for the recipient.

k. A task the DHCFP determines is within the scope of services provided to the recipient as part of an assisted living contract, a supported living arrangement contract or a foster care agreement.

l. Escort services for social, recreational or leisure activities.

m. Transportation of the recipient by the PCA.

n. Any other service not listed under Section 2603.1C.1.

2603.1D AUTHORIZATION PROCESS

PCS authorization requests must be submitted to the QIO-like vendor using the following procedures:

1. Initial Authorization Requests

The recipient, LRI, PCR or an individual covered under the confidentiality requirements of Health Insurance Portability and Accountability Act (HIPAA) may contact the QIO-like vendor to request PCS. Initial requests may not be made by the PCS Agency provider.

The QIO-like vendor validates that the recipient meets PCS criteria, and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS.

After completion, the FASP is forwarded to the QIO-like vendor to process.

If the recipient's request for PCS is approved, the QIO-like vendor will issue a prior authorization number to the recipient's chosen ISO Provider.

a. At Risk Recipient Requests

Upon receipt of a request for an initial FASP, the QIO-like vendor will first complete a risk assessment over the phone to identify those recipients for whom PCS are urgent to avoid institutionalization or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient is determined "at risk," the QIO-like vendor will provide a temporary service authorization. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

The selected ISO Provider is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within 24 hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance.

2. Annual Update Authorization Requests

To prevent a break in service, reassessment requests for ongoing services are recommended to be submitted to the QIO-like vendor at least 60 days, but not greater than 90 days, prior to the expiration date of the current authorization. The request must be submitted on the Authorization Request for PCS form (FA-24). The form must include all required recipient and provider information, as well as the units requested and the dates of service for the service interval requested.

The QIO-like vendor validates that the request meets PCS criteria. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The assigned physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the ISO Provider submitting the request.

3. Significant Change in Condition or Circumstance Authorization Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to significant change in the recipient's condition or circumstances must be submitted on the Authorization Request for PCS form (FA-24) and must be accompanied by documentation from the recipient's physician or health care provider. Requesting a reassessment does not guarantee an increase in previously approved PCS.

a. Significant change in condition may be demonstrated by, for example, an exacerbation of a previous disabling condition resulting in a hospitalization (within past 14 days) or a physician's visit (within past seven days) or a new diagnosis not expected to resolve within eight weeks.

b. Significant change in circumstances may include such circumstances as absence, illness, or death of the primary caregiver or LRI.

c. Significant change in condition or circumstances would result in hospitalization or other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

The QIO-like vendor validates that the request meets PCS criteria and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization

number to the ISO Provider submitting the request.

4. Temporary Service Authorization Requests

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than eight weeks) modification of the current authorization, a new FASP is not required.

Such a modification is considered when additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

The following procedure must be followed for all short-term modifications of the approved service plan:

a. Documentation must be maintained in the recipient's record of the circumstances that required the short term modification(s) of the approved authorization;

b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the ISO, and if applicable the appropriate home and community-based waiver case manager. Documentation must include the recipient's name, Medicaid number, and the dates during which the modified service plan will be in effect; and

c. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FASP is completed due to a significant change in the recipient's condition or circumstance.

5. One-Time Service Authorization Request

The recipient's Provider Agency may submit a single-service authorization request, when the recipient requires an extra visit for an unanticipated need(s), such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the services requested and be the designated provider for the current authorization period. The request must be submitted to the QIO-like vendor no later than seven business days after the service is provided. A new FASP is not required in these single-service situations.

6. Mileage Authorization Request

Mileage for travel to and from a recipient's home or for shopping is not reimbursable to ISO providers, except in hardship situations in remote or rural areas of the state, where failure to reimburse mileage expenses would severely limit available providers. Mileage authorization requests must be submitted in advance to the local DHCFP District Office for review and may be approved on a case-by-case basis. If approved, the DHCFP District

Office will notify the QIO-like vendor to issue an authorization number for the approved mileage to the provider.

2603.1E FLEXIBILITY OF SERVICE DELIVERY

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The recipient will determine how to use the weekly authorized hours on an ongoing basis. Any changes that do not increase the total authorized hours can be made, for the recipient's convenience, within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider or PCA.

The following requirements must be met:

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how the total weekly authorized hours will be provided to meet the individual's needs.

2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient's file.

3. Any change to the approved service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how hours and tasks will be provided.

4. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.

5. The ISO provider must follow their established policies and procedures in order to meet recipient requests for changes in service delivery in a timely manner.

6. Written documentation of the contact with the recipient regarding any change to the approved service plan must be maintained in the recipient's file.

2603.1F ELECTRONIC VISIT VERIFICATION (EVV)

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid State Plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own EVV system if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

Provider Agencies must ensure each Personal Care Attendant (PCA) has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION

   A. The EVV system electronically captures:

      1. The type of service performed, based on procedure code;

      2. The individual receiving the service;

      3. The date of the service;

      4. The location where service is provided;

      5. The individual providing the service;

      6. The time the service begins and ends.

   B. The EVV system must utilize one or more of the following:

      1. The agency/PCA's smartphone;

      2. The agency/PCA's tablet;

      3. The recipient's landline telephone;

      4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);

      5. Another GPS-based device as approved by DHCFP.

2. DATA AGGREGATOR OPTION

   A. All Provider Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate form must be approved by the DHCFP before use of system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into data aggregator.

2603.1G CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers completing the FASPs. Physical and occupational therapists who complete the FASPs must be an independent third party and may not be:

1. related by blood or marriage to the individual, or to any paid caregiver of the individual;

2. financially responsible for the individual;

3. empowered to make financial or health-related decisions on behalf of the individual;

4. related by blood or marriage to the Provider who provides PCS to the individual.

The therapist completing the FASP must not have an interest in or employment by a Provider.

Note: To ensure the independence of individuals performing the FASPs, providers are prohibited from contacting the physical or occupational therapists directly.

2603.2 LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

LRI's are individuals who are legally responsible to provide medical support. These individuals include spouses of recipients, legal guardians, and parents of minor recipients, including stepparents, foster parents and adoptive parents. LRI's may not be reimbursed for providing PCS.

If the LRI is not capable of providing the necessary services/supports, he or she must provide verification to the DHCFP's QIO-like vendor, from a physician, that they are not capable of providing the supports due to illness or injury. If not available, verification that they are unavailable due to hours of employment and/or school attendance must be provided. Without this verification, PCS will not be authorized.

Additional verification may be required on a case by case basis.

2603.3 PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to direct their own care may opt to utilize a PCR. This individual is directly involved in the day-to-day care of the recipient, is available to direct care in the home, acts

on behalf of the recipient when the recipient is unable to direct his or her own personal care services and assumes all medical liability associated with directing the recipient's care. A PCR must be a responsible adult.

For the self-directed service delivery model, the PCR is responsible to hire, manage and schedule PCAs, assumes responsibility for training and manages all paperwork functions.

The PCR must:

1. effectuate, as much as possible, the decision the individual would make for himself/herself;

2. accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;

3. give due consideration to all information including the recommendations of other interested and involved parties; embody the guiding principles of self-determination; and

4. understand that provision of services is based upon mutual responsibilities between the PCR and the ISO.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A recipient's paid PCA cannot be the recipient's PCR. The PCR must meet all criteria outlined in Section 2603.9 of this chapter. In addition, this individual must be present for the provision of care on a consistent basis, as well as sign daily records. For this reason, it is not allowable for individuals such as a paid PCA, care coordinator or case manager to assume this role.

The PCR may reside outside the home if frequent contact can be made by the recipient, the ISO, and other care providers. The PCR must be available to the recipient, the ISO and other care providers as necessary to fulfill the regular elements of Section 2603.9 of this chapter.

Additionally, if a change in PCR becomes necessary, a new personal care representative agreement must be completed and kept in the recipient's provider file. Contact the ISO to make the necessary changes and to obtain form(s).

2603.4 SERVICES TO CHILDREN

An LRI of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends or other

available community resources; however, are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid for PCS services. PCS for children with disabilities may be appropriate when there is no legally responsible, available and capable parent or LRI, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable must be provided upon request. In authorizing PCS services to Medicaid eligible children, the FASP factors in the age and developmental level of the child as well as the parent or LRI's availability and capability to provide the child's personal care needs.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are available to children under the age of 21. EPSDT may provide a vehicle for receiving medically necessary services beyond the limitations of the PCS benefit. Services must be deemed medically necessary. Authorization of additional services under EPSDT must take into account the responsibilities of the LRI and age-appropriate service provision as discussed above.

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with an LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to other housekeeping tasks, meal preparation, essential shopping and escort services.

A child's LRI must be present during the provision of services. If the LRI cannot be present during the provision of services, a PCR designated by the LRI, other than the PCA, must be present during the time services are being provided.

All other policies in this chapter apply.

2603.5 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal condition, and the personal care needs exceed the PCS provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of the individual's comprehensive personal care needs to document any needs not met by hospice and which may be provided by the PCA. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting the total personal care needs. PCS provided under hospice will be subtracted from the total authorized PCS hours.

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed program limits and guidelines.

2603.6 RESIDENTIAL SUPPORT SERVICES/SUPPORTED LIVING ARRANGEMENT (SLA)

Recipients on the Home and Community Based Waiver for Individuals with Intellectual Disabilities and receiving residential support services through a SLA may receive State Plan PCS if the services are determined to be medically necessary and are non-duplicative of the residential support services being provided. The FASP will be completed factoring in the residential support services.

2603.7 SELF-DIRECTED (SD) SKILLED SERVICES

SD Skilled Services are skilled services provided to a recipient by an unlicensed personal care assistant. This option is offered by Nevada Medicaid under the authority of NRS 629.091, where a provider of healthcare can authorize an unlicensed personal care assistant to provide certain specific medical, nursing or home health services, subject to a number of conditions. All skilled services that are self-directed and provided by an unlicensed personal care assistant require a doctor's order and prior authorization.

2603.7A PROGRAM ELIGIBILITY CRITERIA

In addition to the requirements listed in Section 2603.1A, the following requirements must be met to be determined eligible for SD Skilled Services:

1. The primary physician has determined the condition of the person with a disability is stable and predictable;

2. The primary physician has determined the procedures involved in providing the services are simple and the performance of such procedures by the personal care assistant does not pose a substantial risk to the person with a disability;

3. A provider of healthcare has determined the personal care assistant has the knowledge, skill and ability to perform the services competently;

4. The PCA agrees with the provider of health care to refer the person with a disability to the primary physician in accordance with NRS 629.091;

5. Services must be provided in the presence of the LRI or PCR if the recipient is unable to direct their own care, as in the case of a minor or a cognitively impaired adult, in accordance with NRS 629.091.

2603.7B INITIATING SD SKILLED SERVICES

The recipient or their PCR indicates interest in the SD Skilled Services Model by contacting their local DHCFP or ADSD Office directly.

1. The local DHCFP or ADSD Office staff provides information to the recipient, the LRI or the PCR about the self-directed services available. If the recipient is interested in self-direction, a list of enrolled Medicaid ISO providers is provided to the recipient to choose and initiate contact with the ISO of his or her choice.

2. The ISO will provide the recipient with the Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C) for completion.

3. The ISO must fax the completed Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C) and all necessary supporting medical documentation specific to the request to the QIO-like vendor for processing.

2603.7C COVERAGE AND LIMITATIONS

1. COVERED SERVICES

SD Skilled Services may be approved for recipients who are chronically ill or disabled who require skilled care to remain at home. The following criteria must be met:

a. The service(s) are medically necessary and required to maintain or improve the recipient's health status;

b. The service(s) performed must be one that a person without a disability usually and customarily would personally perform without the assistance of a provider of health care;

c. The service(s) must be sufficient in amount, duration and scope to reasonably achieve its purpose;

d. The service(s) must have prior authorization.

2. Non-Covered Services

In addition to the non-covered services listed in Section 2603.1C3 reimbursement is not available for:

a. Services provided in a physician's office, clinic or other outpatient setting;

b. SD Skilled Services provided in the absence of an LRI or PCR for those individuals who are not able to direct their own care; or

c. Services normally provided by a legally responsible individual or other willing and capable caregiver.

3. Medical Criteria

Services must be based on supporting documentation provided by the provider of health care that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.

a. The following criteria are used to establish the appropriate complexity of skilled interventions. The DHCFP or its designee makes the final determination regarding the reasonable amount of time for completion of a task based on supporting documentation, standards of practice, and/or a home health evaluation, as indicated.

1. Limited Skilled Interventions - Interventions that when performed in combination would not reasonably exceed four hours per week. Limited skilled interventions include, but are not limited to: obtaining vital signs or weights; nail care; suprapubic catheter care; attaching a colostomy bag on a wafer or other attachment device that already adheres to the skin; weekly bowel care; skin care, or catheter care; application of opsite, duoderm, or similar product to an abrasion or Stage I wound; application of oxygen; monitoring of oxygen saturation levels; nebulizer treatments performed no more frequently than once daily; once a day glucose monitoring; medication set up; administration of non-complex oral medications; suppositories; enemas; subcutaneous or intramuscular injections; eye drops, nose drops, and/or ear drops; application of a medicated patch, or application of a prescription ointment or lotion to fewer than two body parts.

2. Routine Skilled Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed four hours on a weekly basis. Routine skilled interventions include, but are not limited to: bowel care performed more than once a week; daily pulmonary treatments; nebulizer treatments done more than once a day; catheter changes; Stage II to IV wound care; digital stimulation; colostomy care that includes both attaching a colostomy bag on a wafer or other attachment device that already adheres to the skin and changing the wafer or attachment device; multiple straight catheterizations daily; and complex medication administration. Complex medication administration includes, but is not limited to, administration of six or more medications on a different frequency schedule, administration of medications through a feeding tube, and glucose testing and insulin administration occurring more than once a day.

3. Highly Complex Intervention - Intervention that by its inherent complexity combined with the frequency in the recipient's care routine can reasonably be expected to exceed one and one-half or more hours per day to perform. Highly complex interventions may include but are not limited to: tube feedings; special swallow techniques; peritoneal dialysis; Stage III or IV wound care; or care of Stage II to Stage IV wounds in multiple locations. A physician must provide a written rationale for the time requested to perform this intervention.

b. Interventions performed on a monthly frequency are not included in calculating the total number of interventions being performed unless the performance of this task requires two or more hours and a physician has provided a written rationale to explain this request. If authorized, this intervention will equal one routine intervention.

c. Additional major procedures not listed here may be considered in determining the complexity of skilled intervention. The DHCFP's QIO-like vendor, or their designee, should be contacted with information on what the procedure is and the amount of skilled time needed to perform this procedure or task.

d. Clinical Decision Support Guide – See Section 2606. The Clinical Decision Support Guide identifies the benefit limitations for individual recipients based upon supporting documentation provided by the physician that describes the complexity of the recipient's care and the frequency of skilled interventions. Services must be appropriate, reasonable and necessary for the diagnosis and treatment of the recipient's illness or injury within the context of the recipient's unique medical condition and the standard of practice within the community.

The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the clinical decision support guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.

4. Crisis Override

The SD Skilled Services benefit allows, in rare crisis situations, a short-term increase of service hours beyond standard limits. A crisis situation is one that is generally unpredictable and puts the individual at risk of institutionalization without the provision of additional hours.

a. Coverage and Limitations

1. Additional services may be covered up to 20% above program limits.

2. Additional services are limited to one 60-day interval in a three-year period (calendar years).

The provider must contact the DHCFP QIO-like vendor with information in writing regarding the crisis situation and need for additional hours.

2603.7D AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. SD Skilled Services are authorized by the DHCFP's QIO-like vendor. Services must be requested using Code T1019 plus a TF modifier to represent SD Skilled Services If the TF modifier is not requested, reimbursement for SD Skilled Services will not be approved and subsequent claims will be denied.

1. The ISO must fax the completed Authorization Request for Self-Directed Skilled Services Authorization Form (FA-24C) and all necessary supporting medical documentation specific to the request to the QIO-like vendor for processing.

2. The QIO-like vendor reviews the request and supporting documentation utilizing criteria identified in the Clinical Decision Support Guide. The QIO-like vendor will use these criteria to review for medical necessity and utilization control procedures.

3. Prior authorizations are specific to the recipient, a provider, specific services, established quantity of units and for specific dates of service.

4. Prior authorization is not a guarantee of payment for the service; payment is contingent upon passing all edits contained with the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

2603.8 PROVIDER RESPONSIBILITIES

ISO providers shall ensure that services to Medicaid and NCU recipients are provided in accordance to the individual recipient's approved service plan and in accordance with the conditions specified in this chapter and the Medicaid Provider Contract.

Additionally, all ISO providers have the following responsibilities:

1. Certification and/or Licensure

In order to enroll as a Nevada Medicaid ISO provider, all providers must be certified and/or licensed by the DPBH as an ISO or an Agency to Provide Personal Care in the Home and certified as an ISO.

Providers must comply with licensing requirements and maintain an active certification

and/or license at all times.

2. Provider Enrollment

To become a Nevada Medicaid ISO provider, the provider must enroll with the QIO-like vendor as an Intermediary Service Organization (PT 83).

The provider must meet the conditions of participation as stated in the MSM Chapter 100.

The provider must comply with all local, state and federal regulations and applicable statutes, including but not limited to Nevada Revised Statutes Chapters 449 and 629, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA), the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act.

3. Employer of Record

The ISO is the employer of record for the PCAs providing services to a Medicaid recipient who chooses the Self-Directed service delivery model. The ISO shall not serve as the managing employer of the PCA.

4. Electronic Visit Verification (EVV)

Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the PCS provided to Medicaid recipients served by a Medicaid provider.

5. Recipient Education

The ISO may initiate education of the recipient or PCR in the skills required to act as the managing employer and self-direct care. This may include training on how to recruit, interview, select, manage, evaluate, dismiss and direct the PCA in the delivery of authorized services. Education must begin with an accepted recipient referral and continue throughout the duration of the service provision. Verification of recipient education must be maintained in the recipient's file.

6. Personal Care Assistant (PCA) List

The ISO may, upon request, provide a list of PCAs to recipients, their LRI or their PCR. The recipient, their LRI or PCR may reference this list in recruiting potential PCAs.

7. Backup List

The ISO shall maintain and make available to the recipient, their LRI or PCR, on request, a list of qualified PCAs that may be able to provide back-up services. The ISO is not responsible for arranging or ensuring back-up care is provided as this is the responsibility of the recipient, their LRI or PCR.

8. Backup Plan

The ISO may, upon request, assist the recipient in developing a written back-up plan to address personal care service needs in the event that care is interrupted. This may include providing a current list of PCAs available to assist in providing appropriate back-up services. The ISO is responsible for documenting the back-up plan that is developed but is not responsible for arranging or ensuring back-up care is provided, as this is the responsibility of the recipient, their LRI or PCR.

9. Medicaid and Nevada Check Up (NCU) Eligibility

Verification of Medicaid or NCU eligibility on a monthly basis is the responsibility of the ISO.

10. Prior Authorization

The ISO shall obtain prior authorization for services prior to the provision of services. All initial and ongoing services must be prior authorized by the DHCFP's QIO-like vendor. Services which have not been prior authorized will not be reimbursed.

11. Service Initiation

Prior to the start of services, the ISO staff must review and document with the recipient, their LRI or PCR all components of the MSM Chapter 2600 and the following items:

a. The ISO may initiate education of the recipient or PCR in the skills required to act as managing employer and self-direct care. This may include training on how to recruit, interview, select, manage, evaluate, dismiss and direct the PCAs in the delivery of authorized services. Documentation of this must be maintained in the recipient's file.

b. The ISO must review with the recipient, their LRI or PCR the approved service plan, weekly hours, tasks to be provided and EVV requirements and recipient participation.

c. The ISO must review with the recipient, their LRI or PCR his or her responsibility to establish the PCA's schedule and to establish his or her own back-up plan.

d. The ISO provider must review with the recipient, their LRI or PCR the differences between the Agency and the SD Service Delivery Model.

12. PCS Not Permitted

The following are some of the activities that are not within the scope of PCS and are not permitted. This is not an all-inclusive list.

a. Skilled Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials;

b. Increasing and/or decreasing time authorized on the approved service plan;

c. Accepting or carrying keys to the recipient's home;

d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;

e. Making personal long-distance telephone calls from the recipient's home;

f. Performing tasks not identified on the approved service plan;

g. Providing services that maintain an entire household;

h. Loaning, borrowing, or accepting gifts of money or personal items from the recipient;

i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient; and

j. Care of pets, except in the case where the animal is a certified service animal.

13. Supervision

The ISO must review with the recipient, their LRI or PCR, the recipient's approved service plan. This must be done each time a new service plan is approved. The ISO must clarify with the recipient, their LRI or PCR, the recipient's needs and the tasks to be performed.

Documentation of the approved service plan review must be maintained in the recipient's record.

All PCAs must understand the EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system.

14. Provider Liability

Provider liability responsibilities are included in the Medicaid and NCU Provider Contract.

15. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities make a report to a child protective service agency, an aging and disability services agency or law enforcement agency immediately, but in no event later than 24 hours after there is reasonable cause to believe that a child, adult or older person has been abused, neglected, exploited, isolated or abandoned.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults' age 60 and over, the Aging and Disability Services Division (ADSD) accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. For all other individuals (other age groups) contact local law enforcement.

The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

16. Serious Occurrences

The ISO must report all serious occurrences involving the recipient, the PCA, or affecting the provider's ability to deliver services. The Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's ADSD office.

Reportable serious occurrences involving either the recipient or PCA include, but are not limited to the following:

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization or ER visit;

c. Neglect of the recipient;

d. Exploitation;

e. Sexual harassment or sexual abuse;

f. Injuries or falls requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;

i. Death of the recipient;

j. Loss of contact with the recipient for three consecutive scheduled days;

k. Medication errors;

l. Theft;

m. Medical Emergency; or

n. Suicide Threats or Attempts.

17. Health Insurance Portability and Accountability Act (HIPAA), Privacy and Confidentiality

Information on HIPAA, privacy and confidentiality of recipient records and other protected health information is found in MSM Chapter 100.

18. Direct Marketing

Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid PCS recipient or their LRI. All marketing activities conducted must be limited to the general education of the public or health care providers about the benefits of PCS. Such literature may be printed with the company's logo and contact information, however, this literature may not be distributed, unsolicited, to any current or potential Medicaid PCS recipient(s)or their LRI. The provider may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or other cold-call marketing activities.

The provider must ensure that marketing, including plans and materials, are accurate and do not mislead, confuse or defraud current or potential recipients. Statements considered inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

a. the recipient must enroll with the provider in order to obtain benefits or in order not to lose benefits; or

b. the provider is endorsed, certified or licensed by the DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.

19. Records

The provider must maintain medical and financial records, supporting documents, and all other records relating to services provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six years from the date of payment for the specified service.

a. If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims or audit findings have been finally determined.

1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.

2. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period.

b. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records. This includes electronic service delivery records.

20. Documentation Requirements

In addition to all of the above responsibilities, if Self-Directed Skilled Services are provided it is the responsibility of the ISO to ensure all requirements of NRS 629.091 are met in order to receive reimbursement for these services. All required documentation must be made available to the DHCFP or its designee immediately upon request.

In order to ensure the safety and well-being of the recipient, documentation specific to this option is required and must be signed by all applicable individuals as identified on each form and updated annually with any significant change in condition. Documentation must be maintained in the recipient's file.

All service delivery records completed by the PCA must be reviewed. The provider will

only be paid for the hours and tasks which are provided according to the approved service plan and are documented on the service delivery records. This includes electronic service delivery records.

21. Discontinuation of Provider Agreement

a. In the event that a Provider decides to discontinue providing PCS to any of their service areas, the Provider shall:

1. provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and included with the notification;

2. provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation; and

3. continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.

b. In the event that the DHCFP discontinues the contractual relationship with a Provider, for any reason, the Provider shall:

1. within five calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to all their current Medicaid recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and be included in this notification.

2. provide reasonable assistance to recipients in transferring services to another provider.

Providers who fail to satisfactorily meet the requirements discussed above shall be prohibited from participation in a new application for any other PCS provider agreement for a period of not less than one year.

2603.9 RECIPIENT RESPONSIBILITIES AND RIGHTS

1. Recipient Responsibilities

Participation in the SD service delivery option is completely voluntary and failure to comply with any of the responsibilities listed below may result in termination of the recipient's participation in this service delivery option.
The recipient, their LRI or PCR will:

a. notify the provider of changes in Medicaid or NCU eligibility.

b. notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare.

c. notify the provider of changes in medical status, service needs, address and location or in changes of status of legally responsible individual(s) or PCR.

d. treat all staff appropriately.

e. agree to utilize an approved EVV system for the Medicaid services being received from the ISO.

f. confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

g. establish a backup plan in case a PCA is unable to provide services at the scheduled time.

h. not request a PCA to work more than the hours authorized on the approved service plan.

i. not request a PCA to work or clean for non-recipients.

j. not request a PCA to provide services not on the approved service plan.

k. comply with all Medicaid policies and procedures as outlined in the MSM, all relevant chapters, including Chapters 100 and 3300.

l. recruit, interview, select, schedule, direct and dismiss PCAs.

m. develop a backup plan in the event of failure to maintain continuous coverage of regularly scheduled PCAs.

n. Verify services were provided according to the approved service plan and/or doctor's orders by, whenever possible, signing or initialing the PCA documentation of the exact date and time the PCA was in attendance and providing services.

o. inform the PCA of the existence of advance directive documents, if these are available, and provide a copy to the ISO, if appropriate.

p. notify the ISO and the recipient's case manager, if applicable, or the local DHCFP District Office when the recipient, their LRI or PCR no longer wish to self-direct their services and request care be provided through a provider agency.

q. cooperate with the DHCFP or its designee in conducting compliance reviews, investigations or audits.

r. specify any and all specialized training requirements of the PCA and assure that the specified training has been received.

s. obtain re-certification for continued services according to policy. This may require that a FASP and/or a new authorization request for Self-Directed Skilled Services Form be completed.

In addition to the responsibilities identified above, the following requirements are applicable to all recipients that opt to self-direct their Skilled Services.

t. The recipient, LRI and/or PCR are responsible to cooperate fully with the physician and other healthcare providers in order to establish compliance with the requirements set forth in NRS 629.091.

u. When the recipient desires to provide specialized training and is able to state and convey his/her own needs and preferences to the PCA, information must be documented in the recipient's file identifying the specific training the recipient has provided.

v. The authorization request for Self-Directed Skilled Services Form is required and must be completed by a qualified provider for each personal care assistant who will perform the skilled services.

2. Recipient Rights

Every Medicaid and NCU recipient receiving PCS or SD Skilled Services, their LRI or PCR, has the right to:

a. request a change in service delivery model from the Self-Directed model provided through an ISO to the Provider Agency model for their PCS or a Home Health Agency for their skilled services;

b. receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;

c. participate in the development process and receive an explanation of authorized services;

d. receive a copy of the approved service plan;

e. contact the local DHCFP District Office, with questions, complaints, or for additional information;

f. receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;

g. know that all communications and records will be treated confidentially;

h. expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;

i. receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, FASP determinations and the opportunity for fair a hearing;

j. request a change of provider;

k. have access, upon request, to his or her Medicaid recipient files;

l. request a Fair Hearing if there is disagreement with the DHCFP's action(s) to deny, terminate, reduce or suspend services; and

m. receive upon request the telephone number of the Office for Consumer Health Assistance.

2603.10 ESCORT SERVICES

Escort services may be authorized in certain situation for recipients who require a PCA to perform an approved PCS task en route to or while obtaining Medicaid reimbursable services.

2603.10A COVERAGE AND LIMITATIONS

Escort services may be authorized as a separate billable service when all the following conditions

are met:

1. The needed PCS is currently an authorized task on the approved service plan and will be provided during the course of the visit.

2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a physician visit.

3. An LRI is unavailable or incapable of providing the personal care task en route to or during the appointment.

4. Staff at the site of the visit (surgery center, physician's office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) is unable to assist with the needed personal care task.

2603.10B AUTHORIZATION PROCESS

1. The provider must contact the QIO-like vendor for prior authorization for escort services.

2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.

3. A new FASP is not required in this situation.

2603.10C PROVIDER RESPONSIBILITY

1. The provider must verify that all conditions above are met when asking for an escort services authorization.

2. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested. The provider must comply with all other policies in Section 2603.1D of this chapter.

2603.11 TRANSPORTATION

Transportation of the recipient in a provider's vehicle, or the PCA's private vehicle or any other vehicle is not a covered service and is not reimbursable by the DHCFP. Recipients who choose to be transported by the PCA do so at their own risk.

Refer to MSM Chapter 1900, Transportation Services, for requirements of the DHCFP medical transportation program. Medicaid may reimburse for necessary and essential medical

transportation to and from medical providers.

2603.12 REIMBURSEMENT

Medicaid reimbursement is made directly to the Provider Agency for services billed using Service Code T1019 for PCS or T1019TF for SD Skilled. The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following: Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consultant;

A. The cost of criminal background checks and TB testing;

B. Travel time to and between recipients' home;

C. The cost of basic training, in-service requirements and the CPR and First Aid requirement;

D. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

2603.13 IMPROPER BILLING PRACTICES

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual.

Any provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include, but are not limited to:

A. submitting claims for unauthorized visits;

B. submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipient's residence;

C. submitting claims for visits without documentation to support the claims billed.

1. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the recipient's signature, the month, day, year and time in and out of the recipient's home. Providers shall submit or produce such documentation upon request by the DHCFP staff;

D. submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;

E. billing for the full authorized number of units when they exceed the actual amount of service units provided; or submitting claims for PCS provided by an unqualified paid PCA.

F. submitting claims for PCS provided by an unqualified paid PCA.

Any PCS or other provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupments listed in the MSM Chapter 3300. All Medicaid overpayments are subject to recoupment.

Any such action taken against a provider by the DHCFP has no bearing on any criminal liability of the provider.

2603.14 QUALITY ASSURANCE

The DHCFP and/or ADSD may conduct reviews, announced or unannounced, to evaluate the provider's compliance with this chapter and any other regulatory requirement.

These reviews may consist of, but are not limited to, a desk review by the DHCFP and/or ADSD staff and/or an onsite review. Providers must cooperate with the review process. Additionally, reviews may be conducted to verify that providers meet requirements established for each service, to ensure services are being provided and billed for accordingly and that claims for those services are paid in accordance with the State Plan, this chapter and all federal and state regulations.

Reviews may also be conducted to ensure the health and welfare, service satisfaction and freedom of choice of the recipients receiving PCS and/or Skilled Services.

2603.15 ADVERSE ACTIONS

An adverse action refers to a denial, termination, reduction or suspension of an applicant or recipient's request for services or eligibility determination.

For the purposes of this Chapter, the DHCFP or their designee may take adverse action when:

A. the recipient is not eligible for Medicaid;

B. the recipient does not meet the PCS eligibility criteria;

C. the recipient, their LRI or the PCR refuses services or is non-cooperative in the establishment or delivery of services;

D. the recipient, their LRI or the PCR refuses to accept services in accordance with the approved service plan;

E. all or some services are no longer necessary as demonstrated by the FASP;

F. the recipient's needs can be met by an LRI;

G. the recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child;

H. services requested exceed service limits;

I. services requested are non-covered benefits (refer to 2603.1C.3);

J. another agency or program provides or could provide the services.

2604 PCS INDEPENDENT CONTRACTOR (IC) MODEL

An individual may independently contract with the DHCFP to provide SD Skilled Services and PCS in a recipient's residence or in a location outside the home, except as excluded per 1905(a)(24) of the Social Security Act. An individual may only apply to the DHCFP to become a PCS IC when the need and preference for SD Skilled Services exists, where no PCS Agency or ISO is available and when the absence of an IC would constitute a hardship for an eligible recipient. A hardship situation is one in which the recipient is considered to be "at risk."

An application to become an IC with Nevada Medicaid is made through the local DHCFP District Office. Each IC providing PCS must comply with all PCS program criteria. The local DHCFP District Office will inform the potential IC of program criteria, training requirements, etc. The local DHCFP District Office will assist in processing the IC's application which must be submitted to the QIO-like vendor. Once the IC is approved, the local DHCFP District Office will notify the appropriate ADSD case manager who will provide the IC with the recipient's service plan and authorized service hours.

2604.1 COVERAGE AND LIMITATIONS

All of the policies discussed in the Section 2603.1C and 2603.7C of this chapter apply to the IC option.

2604.1A AUTHORIZATION PROCESS

Prior authorization must be obtained before services can be provided. PCS is authorized by the ADSD case manager. The IC shall contact the recipient's ADSD case manager to obtain prior authorization for services.

2604.1B PROVIDER RESPONSIBILITIES

The IC must assist eligible Medicaid recipients with ADLs and IADLs, as identified on the individual recipient's service plan and in accordance with the conditions specified in this Chapter and the Medicaid Provider Contract, as well as SD Skilled Services pursuant to NRS 629.091.

In order to ensure the safety and well-being of the recipient, documentation specific to the SD Skilled Services option of the program is required and must be signed by all applicable individuals as identified on each form, and updated annually and/or with any significant change in condition. Current forms are available upon request from the DHCFP or the QIO-like vendor.

1. Provider Enrollment.

   To become a Nevada Medicaid provider, the IC must enroll with the QIO-like vendor as a PT 58, Specialty 189.

2. Electronic Visit Verification (EVV)

Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the PCS provided to Medicaid recipients served by a Medicaid provider.

3. The following policies apply to the IC option:

a. The IC must verify Medicaid Eligibility monthly.

b. The Provider shall provide PCS in ADLs and IADLs which are medically necessary and approved on the service plan. The services provided must not exceed the PCA scope of services or limitations defined elsewhere in the MSM.

c. The IC must review the recipient's service plan with the recipient or their PCR prior to the initiation of services. The IC shall review all allowable tasks, excluded activities and recipient back up plan. Documentation must be maintained in the recipient's file that this requirement has been met.

d. 24-Hour Accessibility.

The IC should have reasonable phone access either through a cell phone or home telephone for contact by the recipient or PCR. The IC is not required to maintain 24-hour phone accessibility.

e. Backup Mechanism.

The IC has no responsibility to establish a back-up mechanism in the event of an unanticipated, unscheduled absence because this is a recipient or PCR responsibility. The IC must notify the recipient at least two weeks in advance of anticipated time off (vacation, elective surgery etc.).

f. Referral Source Agreement.

The IC has no responsibility to establish a referral source agreement as there are no provider agencies within the immediate geographical area.

g. Administrative Functions

The IC is responsible for complying with all state regulations regarding independent contractors.

h. Service Initiation.

Prior to initiation of services and periodically as needed, the IC must review with the recipient or PCR, the following:

1. Advanced Directive, including their right to make decisions about their health care, and the right to execute a living will or grant power of attorney to another individual. Refer to MSM Chapter 100 for further information.

2. Procedure to be followed when a PCA does not appear at a scheduled visit or when an additional visit is required.

3. The non-covered service/tasks of the PCS program.

4. The procedure and form used to verify PCA attendance.

5. The recipient's service plan or any changes in the service plan, including the following:

   a. Authorized service hours;

   b. PCA's schedule;

   c. PCA's assigned tasks and pertinent care provided by informal supports; and

6. EVV requirements and recipient participation.

i. Supervision

The IC is not required to meet the supervisory requirement of the PCS agency. As an IC the provider is required to perform all PCA services and document all services in an approved EVV system.

j. Training

The IC may be required to obtain training in the following areas, if directed to do so by the recipient.

1. Basic Training - Basic training shall involve community resources, such as public health nurses, home economists, physical therapists and social workers. An outline of content of each subject shall be maintained by the IC.

Basic training shall be a minimum of 16 hours in length. Basic training may include content in the following areas:

a. Orientation to the service plan, community and the DHCFP medical assistance program services;
b. Body mechanics and transfer techniques;

c. Bathing, basic grooming and mobility techniques, including simple non-prescribed range of motion;

d. Personal care skills, including PCS permitted and not permitted (refer to Sections 2603.1C and 2603.8);

e. Care of the home and personal belongings;

f. Infection control, including information on common communicable diseases, blood borne pathogens, infection control procedures, universal precautions and applicable Occupation Safety Hazard Act (OSHA) requirements;

g. Household safety and accident prevention, including information on general household safety and how to prevent accidents, poisoning, fires etc. and minimizing the risk of falls;

h. Food, nutrition and meal preparation, including information on a well-balanced diet, special dietary needs and the proper handling and storage of food;

i. Bowel and bladder care, including routine care associated with toileting, routine maintenance of indwelling catheter drainage system (emptying bag, positioning, etc.), routine care of colostomies (emptying bag, changing bag), signs and symptoms of urinary tract infections and common bowel problems, such as constipation and diarrhea;

j. Skin care, including interventions to prevent pressure sores, (repositioning, use of moisturizers, etc.), routine inspections of skin, and reporting skin redness, discoloration or breakdown to the recipient or caregiver;

k. Health oriented record keeping, including written documentation of services provided and time verification records;

l. Recipient's rights, including confidentiality pursuant to state and federal regulations and consumer rights;

m. Communication skills, including basic listening and verbal communication skills, problem solving and conflict resolution skills, as well as alternative modes of communication techniques for individuals with communication or sensory impairments;

n. Information including overview of aging and disability (sensory, physical and cognitive) regarding changes related to the aging process, sensitivity training towards aged and disabled individuals, recognition of cultural diversity and insights into dealing with behavioral issues;

o. Directives, including information regarding the purpose of an advance directive and implications for the PCA.

k. Records

The IC must maintain medical and financial records, supporting documents, and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State records retention policy, which is currently six years from the date of payment for the specified service.

l. HIPAA, Privacy and Confidentiality

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.

m. Notification of Suspected Abuse or Neglect

Reference Section 2603.8 of this chapter.

2604.1C RECIPIENT RESPONSIBILITIES

All of the policies discussed in the Section 2603.9 of this chapter apply to the IC model.

2605 HEARINGS

Reference MSM Chapter 3100, Hearings, for Medicaid recipient hearing procedures and Medicaid provider hearing procedures.

2606 SELF DIRECTED (SD) SKILLED SERVICES – CLINICAL DECISION SUPPORT GUIDE

Level I	Level II	Level III	Level IV	Level V
Not to exceed four hours a week	Not to exceed10 hours a week	Not to exceed 22 hours a week	Not to exceed 30 hours a week	Not to exceed 40 hours a week
+ Limited skilled interventions	**++One or two routine skilled** interventions, with or without limited skilled interventions.	**Three to five routine skilled** interventions, with or without limited skilled interventions; or	**Four to six routine skilled** interventions, with or without limited skilled interventions; or	**Seven routine skilled** interventions, with or without limited skilled interventions; or
		+++One highly complex skilled and one to two routine skilled intervention(s), with or without limited skilled interventions; or	**One highly complex skilled intervention and three to four routine skilled** intervention(s), with or without limited skilled interventions; or	**One highly complex skilled intervention and five to six routine skilled** interventions, with or without limited skilled interventions; or
		Two complex skilled interventions, with or without limited skilled services.	**Two highly complex skilled** interventions, with either **routine skilled** interventions or limited skilled interventions.	**Two highly complex skilled intervention and two to five routine skilled** interventions, with or without limited skilled interventions; or
				Three highly complex skilled interventions, with or without **additional routine skilled** interventions or limited skilled interventions.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 27, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES Casey Angres (Jan 5, 2023 10:11 PST)
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2700 – CERRITFIED COMMUNITY BEHAVIORAL HEALTH CENTER SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2700 – Certified Community Behavioral Health Centers (CCBHC) are being proposed to the CCBHC MSM with regard to the LEAD CASE MANAGER is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. CCBHC, Managed Care Organization (MCO), or governmental agencies). The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for MCO, it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case manager will coordinate all care with the MCO to ensure there is an elimination of any potential for duplication of services.

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: This proposed change affects all Medicaid-enrolled providers delivering Targeted Case Management Services (TCM). Those Provider Types (PT) include but are not limited to CCBHCs (PT 17, Specialty 188), Targeted Case Management (PT 54), Behavioral Health Outpatient Treatment (PT 14).

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 1, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 19/22 MSM 2700 – Certified Community Behavioral Health Centers	MTL 03/20 MSM 2700 – Certified Community Behavioral Health Centers

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2703.16.K	**Lead Case Manager**	Added clarifying language to the Lead Case Managers in ensuring case management services are not duplicated between TCM and CCBHCs.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER SERVICES

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER SERVICES

2700 INTRODUCTION

Nevada Medicaid reimburses for the Certified Community Behavioral Health CENTER (CCBHC) model for children and adults under a combination of mental health rehabilitation, medical/clinical and institutional authority. The intent of the CCBHC model is to increase access to high quality, coordinated and integrated care that is outcomes-based across the continuum of care. The services must be recommended by a physician or other licensed practitioner of the healing arts working within their scope of practice under state law. Services are provided for the maximum reduction of a physical and mental disability and to restore the recipient to the best possible functioning level. The services are provided in the least restrictive, most normative setting possible and must be delivered in a CCBHC delivery model. The CCBHC provides developmentally appropriate services that are recovery-oriented, person- and family-centered, strengths-based and trauma-informed in a culturally and linguistically competent manner. The CCBHC delivery model ensures recipient participation in shared decision-making regarding their individualized treatment and recovery plans and engages recipients and their families in active participation in their care. The provision of services occurs within community settings, using a welcoming approach that encourages and supports treatment to occur "beyond the four walls" of a traditional treatment setting, increasing availability and accessibility of care.

CCBHCs meet the psychosocial and physical health needs of the recipient through the provision of direct services and through effective case management and care coordination. CCBHCs may collaborate with a Designated Collaborating Organization (DCO) that is an extension of the CCBHC delivery model. This innovative and flexible delivery model provides whole person responsive and preventative care to best meet the needs of the recipient. Services assist recipients to develop, enhance and/or retain behavioral and physical health, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently and begin as soon as clinically possible.

CCBHC providers must ensure that all services are coordinated across the continuum of care and provided under this chapter and according to most recent edition of the relevant Medicaid Services Manuals (MSM) sections to include, but not limited to, Chapters 100, 400, 600, 1700, 1900, 2500, 3400, 3800 and the MSM Addendum. Providers must ensure all services are evidenced-based and accepted as best practices based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Evidenced-Based Practices Guide (reference: https://www.samhsa.gov/ebp-web-guide).

2701 AUTHORITY

In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA) authorizing varying percentages of Federal Financial Participation (FFP) for states that elected to offer medical programs. States must offer the 11 basic required medical services. Two of these are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20). All other mental health and substance abuse services provided in a setting other than an inpatient or outpatient hospital are covered by Medicaid as optional services. Additionally, state Medicaid programs are required to correct or ameliorate defects and physical and mental illnesses and conditions discovered as the result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening for children 21 years or younger, whether or not such services are covered under the state plan (Section 1905(a) of the SSA).

Other authorities include:

- Nevada Medicaid Inpatient Psychiatric and Substance Abuse Policy, Procedures and Requirements. The Joint Commission Restraint and seclusion Standards for Behavioral Health.

  Health and Human Services (HHS) Sections 2701 through 2763, 2791 and 2792 of the Public Health Service (PHS) Act (42 USC 300gg through 300gg–63, 300gg–91 and 300gg–92), as amended.

  (Reference:https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf).

- Section 223(a)(2)(F) of Protecting Access to Medicare Act (PAMA). This demonstration authority has been extended.

- Section 2402(a) of the Patient Protection and Affordable Care Act (ACA).

- Section 2403(a) of the ACA: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.

- Nevada State Plan Section 4.19-A.

- Nevada State Plan Section 3.1-A.

- CMS 2261-P, Centers for Medicare and Medicaid Services (CMS) (Medicaid Program; Coverage for Rehabilitative Services).

2702 DEFINITIONS

The following definitions are listed for the purpose of this demonstration program only and are specific to the CCBHC delivery model. All other relevant definitions can be found in the appropriate MSM Chapter and the MSM Addendum.

A. CARE COORDINATION: Deliberately organizing, facilitating and managing a CCBHC recipient's care. This includes coordinating all behavioral/mental and physical health activities regardless if the care is provided directly by the CCBHC and it's DCO or through referral or other affiliation outside of the CCBHC delivery model. Care coordination includes:

1. Ensuring access to high-quality physical health care (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems and employment opportunities as necessary to facilitate wellness and recovery of the whole person. This may include the use of telehealth services.

2. Having policies and procedures in place that comply with Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 requirements specific to adults and children, and other privacy and confidentiality requirements of state or federal law to facilitate care coordination.

3. Having policies and procedures in place to encourage participation by family members and others important to the recipient to achieve effective care coordination, subject to privacy and confidentiality requirements and recipient consent.

4. Having policies and procedures in place to assist recipients and families of children and adolescents in obtaining appointments and keeping the appointments when there is a referral to a provider outside the CCBHC delivery model, subject to privacy and confidentiality requirements and consistent with the recipient's and their family's preference and need.

B. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC): An entity that meets criteria as established by the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration program and is certified in the State of Nevada by the Division of Public and Behavioral Health's (DPBH) Health Care Quality and Compliance (HCQC) bureau. CCBHCs provide and contract with DCOs that provide services in accordance with the Protecting Access to Medicare Act of 2014 (PAMA) if providing service through this authority and with state plan.

C. CLINICAL SUPERVISOR: A licensed behavioral health professional operating within the scope of their practice under state law who has specific education, experience, training,

credentials and licensure to coordinate and oversee an array of behavioral health services and ensure clinical compliance with the requirements of a CCBHC delivery model. The Clinical Supervisor has administrative and clinical oversight of the program and must ensure that services provided are medically necessary, and clinically, developmentally, culturally and linguistically appropriate, and follow an evidence-based model.

D. CO-OCCURRING BEHAVIORAL HEALTH DISORDER (COD): Recipients with co-occurring disorders are those who currently, or at any time in the past year (12 continuous month period), have had a diagnosable substance use and a mental health disorder that meets the coding and definition criteria specified in the most current International Classification of Diseases (ICD), that has resulted in a functional impairment which substantially interferes with or limits one or more major life activity. This impairment also hinders their ability to function successfully in several areas including social, occupational and/or educational environments, or substantially interferes with or limits them from achieving or maintaining housing, employment, education, relationships or safety.

E. DESIGNATED COLLABORATING ORGANIZATION (DCO): A distinct entity that is not under the direct supervision of a CCBHC, but has a formal contractual relationship with a CCBHC to provide an authorized CCBHC service. The CCBHC must ensure the DCO provides the same quality of care as those required by the CCBHC program. The CCBHC maintains ultimate clinical responsibility for the services provided to CCBHC recipients by the DCO under this agreement. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for the overall coordination of a recipient's care including services provide by the DCO or those to which it refers a recipient.

F. EVIDENCED-BASED PRACTICE (EBP): Services that have specific fidelity measures for proven effectiveness. CCBHCs and DCOs must provide EBP services that meet criteria as best practices and approaches for the purpose of the CCBHC program. The following required EBPs are meant to meet the needs of the broader focus of recipients served throughout their lifespan and set the minimum standard of practice in the application of EBPs. The CCBHC may select more population-specific EBPs listed in the SAMHSAs Evidenced-Based Practices Guide to reflect the unique needs of their communities.

1. Crisis Behavioral Health Services

    a. Collaborative Management and Assessment of Suicidality

    b. Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA/CIWA-Ar)

    c. Clinical Opiate Withdrawal Scale (COWS)

d. Targeted Case Management (TCM)

e. Solution-Focused, Brief Psychotherapy (SFBT)

f. Wellness Recovery Action Plans (WRAP)

2. Screening, Assessment and Diagnostic Services

a. Achenbach Children's Behavioral Checklists

b. Ages and Stages Questionnaire-Social Emotional

c. CRAFIT Screening Test

d. Patient Health Questionnaire-9 (PHQ-9)

e. DSM-5 Level 1 and 2 Cross-Cutting Symptom

f. Child and Adolescent Needs and Strengths (CANS)

g. Children's Uniform Mental Health Assessment (CUMHA)

h. Child and Adolescent Services Intensity Instrument (CASII)

i. Level of Care Utilization System (LOCUS)

j. American Society of Addiction Medicine – Patient Placement Criteria (ASAM)

k. World Health Organization Disability Assessment Scale Version 2 (WHODAS 2.0)

3. Outpatient Mental Health and Substance Use Treatment

a. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

b. Cognitive Behavioral Therapies (CBT) including Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT)

c. Family Check-Up and Everyday Parenting

d. Motivational Interviewing

e. Integrated Dual Diagnosis Treatment; Life Skills Training

f. Illness Management and Recovery (IMR)

g. Medication Management

h. Body Mass Index

i. Metabolic Monitoring with Atypical Antipsychotics

4. Psychiatric Rehabilitation Services

a. Basic Skills Training and Psychosocial Rehabilitation

b. Life Skills Curriculum

c. Assertive Community Treatment

5. Behavior Change and Counseling Risk Factors

a. Screening, Brief Intervention and Referral to Treatment (SBIRT)

b. Nursing Quit-Line

c. Chronic Disease Management

6. Peer Support, Counselor Services and Family Supports

a. Peer Support Services

G. FAMILY-CENTERED: An approach to the planning, delivery and evaluation of care based on active participation and input from a recipient's family and the CCBHC. Family-centered care recognizes families as the ultimate decision-makers for their child, with the child encouraged to gradually take on more and more of the decision-making. Services are culturally, linguistically and developmentally appropriate and youth-guided and not only meet the behavioral, mental, emotional, developmental, physical and social needs of the child, but also support the family's relationship with the child's health care providers.

H. INTENSIVE FAMILY INTERVENTION SERVICES: A comprehensive interdisciplinary array of flexible CCBHC services that are expected to improve or maintain a family system to support the recipient's recovery and functioning level and to prevent an exacerbation of symptoms. Intensive Family Intervention Services provide support to the family to connect them to resources, provide mentoring or coaching and assist them with setting recovery

goals and developing and implementing recovery action plans. These services also help families to solve problems directly related to recovery, including finding sober housing, developing appropriate social interactions, occupying free time, improving job skills or, if needed, assisting the family in traversing criminal or juvenile justice systems.

I. LINGUISTIC COMPETENCE: Meaningful access to services that allow the recipient with Limited English Proficiency (LEP) or language-based disabilities to fully understand and participate in CCBHC services. Linguistic competence includes the use of interpretation/translation services (provided by individuals trained in a medical setting), bilingual providers, auxiliary aids and services that are ADA compliant. Linguistic competence also includes having written forms and signage at the appropriate literacy level for recipients and/or their families and that are available in alternate formats as needed for recipients with disabilities to accommodate functional limitations. CCBHCs and DCOs must also ensure outgoing phone messages/recordings reflect linguistic competence.

J. PEER SUPPORT SPECIALIST: An individual who meets the provider qualifications in MSM Chapter 400 and uses their lived experience of recovery from mental or substance use disorders to deliver Peer Support Services. A Peer Support Specialist is an individual who is currently or was previously diagnosed with a mental and/or behavioral health disorder and who possesses the skills and abilities to work collaboratively with and under the clinical and direct supervision of a CCBHC. A Peer Support Specialist cannot be the legal guardian, spouse or parent.

K. PERSON-CENTERED: Person-centered care involves the recipient to the maximum extent possible and also includes family members, legal guardians, friends, caregivers and others whom the recipient wishes to include. The recipient directs their care and the provider supports the recipient's goals and wishes in their treatment and their health care goals, objectives and approaches used.

L. PERSON-CENTERED PLANNING: An approach that focuses on the recipient's goals, desires, strengths and needs for support in the development of an effective plan for treatment and in the provision of services. Services are individualized in partnership with the recipient served to ensure that they and their families (when appropriate) can select and direct meaningful and informed interventions. Services are matched to treatment needs, are outcome-based and designed to maximize each recipient's independence, capabilities and satisfaction. (Also reference Person-Centered Treatment Planning in the MSM Addendum).

M. PRINCIPAL BEHAVIORAL HEALTH PROVIDER (PBHP): A CCBHC clinician assigned to each recipient. The PBHP must ensure that:

1. Regular contact is maintained with the recipient as clinically indicated and as long as ongoing care is required;

2. A psychiatrist reviews and reconciles the recipient's psychiatric medications on a regular basis;

3. Coordination and development of the treatment plan incorporates input from the recipient (and, when appropriate, the family with the recipient's consent when the recipient possesses adequate decision-making capacity or with the recipient's surrogate decision-maker's consent when the recipient does not have adequate decision-making capacity);

4. Effective communication occurs with the recipient and addresses any of the recipient's problems or concerns about their care. This includes discussion regarding future mental health care for recipients who are at high risk of losing decision-making capacity;

5. For a recipient who lacks the capacity to make a decision about their integrated treatment plan, that the recipient's decision-making capacity is formally assessed and documented; and

6. For a PBHP providing services to a veteran recipient (in the case that the Veterans Health Administration (VHA) has not already assigned a PBHP), the PBHP must also:

   a. Follow the most recent edition of the VHA Handbook; and

   b. Ensure that collaboration occurs with the Veterans Administration (VA) Suicide Prevention Coordinator (SPC) at the nearest VA facility to support the identification of those who have survived suicide attempts and others at high risk, and to ensure that they are provided with increased monitoring and enhanced care.

N. RECOVERY: A process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. CCBHC and DCO providers must utilize SAMHSAs working definition, dimensions and guiding principles of recovery from mental health disorders and substance use disorders in their clinical decisions. Reference http://www.samhsa.gov/ for the latest best practices.

O. RECOVERY-ORIENTED: The recipient's care is designed to promote and sustain their recovery from a behavioral health condition. Services are strengths-based and support the recipient to optimal functioning and community integration.

P. SUBSTANCE USE DISORDER (SUD): An individual with a substance use disorder (SUD) is a person who currently, or at the any time in the past year (12 continuous month period), has had a diagnosable substance use disorder that meets the coding and definition

criteria specified in the most current ICD that has resulted in a functional impairment which substantially interferes with, or limits, one or more major life activity in several areas such as social, occupational or educational.

Q. TRAUMA-INFORMED: An approach to care which "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures and practices, and seeks to actively resist re-traumatization." The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (SAMHSA (2014)).

2703 POLICY

2703.1 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC) DELIVERY MODEL

A. The CCBHC delivery model incorporates the provision of expanded and non-traditional biopsychosocial services in a behavioral health clinic. Services focus on whole person, integrated care and the coordination of quality care for improved health outcomes for recipients with behavioral health disorders. The CCBHC delivery model is designed to increase provider flexibility and improve the responsiveness of services to meet the needs of recipients served.

B. CCBHCs and DCOs must ensure that services are evidenced-based, address multiple domains, are provided in the least restrictive environment, and involve family members, caregivers and informal supports when considered appropriate per the recipient and/or their legal guardian. CCBHC and DCO providers must collaborate and facilitate full participation from the recipient's team members including the recipient and their family (when appropriate), to address the quality and progress of the individualized treatment plan. CCBHCs must continuously work to improve services in order to ensure overall efficacy of the recipient's care.

C. In the case of child recipients, CCBHC and DCO providers must deliver youth-guided and family-driven effective/comprehensive services and monitor child and family outcomes through the utilization of Child and Family Team meetings. CCBHC and DCO providers must also coordinate care for any child recipient under the jurisdiction of a state or county child welfare agency with the relevant agency. The CCBHC must document this specific coordination in the child recipient's medical record.

D. Recipients receiving services from a CCBHC and/or DCO may receive services in conjunction with or independent of other services. Services are based on an on-going review of admission, continuing stay and discharge criteria. All services must be provided according to the Federal requirements of a CCBHC as prescribed by SAMHSA.

2703.2 PROVIDER STANDARDS

CCBHC providers must be certified by the following DPBH bureaus: HCQC and Substance Abuse Prevention and Treatment Agency (SAPTA). CCBHC providers must ensure timely access to integrated, coordinated and responsive care, treatment, interventions and services under an established CCBHC delivery model. This model is based on an integrated system of care that meets the individually assessed biopsychosocial needs of recipients served. The provision of services is based on medical necessity, clinical appropriateness and the emergent, urgent and stabilization needs of each recipient in conjunction with their goals and choices. Individuals must be offered entry into any service needed, regardless of the point of contact. All services must be coordinated

across the continuum of care and provided under this chapter and according to all relevant MSM Chapters and Addendum.

2703.3 GENERAL PROVISIONS

A. CCBHC providers must:

1. Continuously meet HCQC certification criteria;

2. Ensure recipient's rights and freedom to choose providers;

3. Ensure recipients have access to the CCBHC grievance procedures outlined in the certification criteria, including CCBHC services provided by a DCO;

4. Address specific sub-populations within their Medicaid populations. These sub-populations include, but are not limited to, recipients involved in the juvenile/criminal justice systems, children in child welfare, recipients at-risk for hospitalization, recipients transitioning from inpatient stays and recipients with co-morbid chronic health conditions;

5. Assign a PBHP to each recipient;

6. Ensure locations are accessible and recipients have a safe and functional environment;

7. Ensure outpatient clinic hours include night and weekend hours to meet the needs of recipients in crisis. This includes informing recipients of these services and how to access suicide/crisis hotlines and warm lines;

8. Provide outreach and engagement activities to assist recipients and their families in accessing services;

9. Coordinate access to transportation through Nevada Medicaid's non-emergency transportation vendor;

10. Have adequate continuity of operations and disaster plans in place;

11. Maintain records and documentation as required by the CCBHC program to include the monitoring and reporting of the fidelity to selected core EBPs;

12. Submit a cost report at the end of the first year of doing business, or until a rebase is required by the DHCFP;

13. Submit quarterly reports on the CCBHC and State led measures;

14. Submit ad hoc reports as requested;

15. Ensure all DCO services are evidenced-based and there are formal agreements with their DCOs to obtain access to data needed to fulfill the reporting obligations for the CCBHC program;

16. Comply with requests from the Qualified Improvement Organization (QIO)-like vendor; and

17. Comply with the DHCFP's polices and agency review processes.

2703.4 RECIPIENTS IN THE U.S. MILITARY OR VETERANS

A. CCBHCs must ensure services to U.S. Military and Veterans. CCBHCs must ask all recipients inquiring about or requesting services whether they have ever served in the U.S. Military. For those individuals who respond positively, the CCBHC must:

1. Either direct them to care or provide the needed care;

2. Offer assistance enrolling in the VHA programs;

3. Ensure veterans and active duty military receive the required CCBHC services;

4. Assign a PBHP with specific cultural competence in military and veteran's culture to every veteran, unless the VHA has already assigned a PBHP;

5. Provide care and services for veterans that are recovery-oriented, and adhere to the guiding principles of recovery as defined by the VHA and other VHA guidelines;

6. Ensure all staff who work with military or veteran recipients are trained in cultural competence, and specifically military and veteran's culture; and

7. Ensure the individualized treatment plan complies with VHA requirements.

2703.5 STAFF COMPETENCIES

A. CCBHCs and DCOs must ensure staff are competent and capable to provide CCBHC services that are developmentally, culturally and linguistically appropriate as documented by:

1. Written policies and procedures to describe the methods used for assessing the skills and competencies of providers;

2. A list of in-service trainings and educational programs provided that includes documentation of the qualifications of the in-service trainers for each training topic as evidenced by their education, training and experience; and

3. Documentation of the completion of training and demonstration of competencies to provide CCBHC services within each staff's personnel record.

    a. This documentation must include verification to show that each staff has completed the trainings required under the CCBHC program.

2703.6 CARE COORDINATION

A. CCBHCs and DCOs must work on behalf of recipients in the coordination and management of their care to ensure effective outcomes. This includes all providers of behavioral/mental and physical health care and other agencies serving a joint recipient.

CCBHCs must have policies that ensure:

1. Coordination of care for recipients who present to the local emergency department (ED) or who are involved with law enforcement when in a crisis;

2. A reduction in any delays in the initiation of services during and after a recipient has experienced a psychiatric crisis;

3. Coordination with all State of Nevada Department of Health and Human Services programs to maximize benefits to recipients served, eliminate duplication of efforts, streamline processes and improve access to available community supports; and

4. Effective and timely care coordination by having appropriate consents in place that meet HIPAA and 42 CFR Part 2 requirements.

B. To ensure effective and timely care coordination, CCBHCs must also have agreements in place which describe the mutual expectations and responsibilities related to care coordination for each of the following providers unless the service is provided directly by the CCBHC:

1. Federally Qualified Health Centers (FQHCs);

2. Rural Health Clinics (RHCs), when relevant;

3. The recipient's primary care provider and other recipient providers of health care to ensure physical health care needs are addressed;

4. Ambulatory detoxification, medical detoxification, post detoxification step-down services and residential program(s) to include the ability to track the recipient's admission and discharge to these facilities;

5. Emergency departments which includes having protocols for transitioning recipients from emergency departments and other emergency settings to a safe community setting, including the transfer of medical records, prescriptions, active follow-up, a plan for suicide and homicide prevention and safety, where appropriate, and the provision of peer services;

6. Acute-care and psychiatric hospitals, including, outpatient clinics and urgent care centers;

7. Local law enforcement, criminal justice agencies and facilities including drug, mental health, veterans and other specialty courts;

8. Indian Health Services (IHS) and tribal programs;

9. Specialty providers of medications for treatment of opioid and alcohol disorders;

10. Homeless shelters/housing agencies;

11. Employment services systems;

12. Services for children e.g., schools, child welfare agencies, juvenile justice programs, youth regional treatment centers and state licensed and nationally accredited child placement agencies for therapeutic foster care service, when relevant;

13. Services for older adults, such as Aging and Disability Services Division (ADSD);

14. The nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center or other VA facility; and

15. Local human services programs (e.g., domestic violence centers, pastoral services, grief counseling, ACA navigators, food and transportation programs and other social and human services programs as identified by the recipient and/or their family as integral to their stabilization and/or recovery success).

2703.7 ACCESS TO CARE

A. CCBHC and DCO providers must ensure access to high quality behavioral and physical health care. This includes having policies in place that ensure:

1. Services cannot be refused due to the recipient's residence which include protocols to address services for those living out of state;

2. Initial services will not be denied to those who do not live in the CCBHC catchment area (where applicable), including the provision of crisis services and other services, and coordination and follow-up with providers in the recipient's catchment area. Telehealth services may be provided;

3. Services are available for recipients living in the CCBHC catchment area including those residing in remote areas of the CCBHC's location;

   a. An access site (or point) is a location where a CCBHC recipient can receive CCBHC services within the current service area. However, an access point is not intended to provide all of the required services under the CCBHC model.

   b. A CCBHC offering more than four of the required services at this facility would be classified as a "satellite clinic" and would need to be certified as a CCBHC.

4. Communication is made to the public of the availability of CCBHC services; and

5. For access to higher levels of care, CCBHCs must:

   a. Have procedures and services for transitioning recipients from emergency departments and these other settings to CCBHC care, for shortened lag time between assessment and treatment, and for transfer of medical records, prescriptions and active follow-up;

   b. Have provisions for tracking recipients admitted to and discharged from these facilities (unless there is a formal transfer of care from the CCBHC);

   c. Have care coordination agreements for recipients presenting to the facility at risk of harm to themselves or others which includes the coordination of consent for follow-up within 24 hours and continuing until the recipient is linked to services or is assessed as being no longer at risk; and

d. Have in place procedures that make and document reasonable attempts to contact all recipients discharged from these facilities within 24 hours of discharge.

2703.8 HEALTH INFORMATION TECHNOLOGY (HIT)

A. CCBHC providers must have HIT systems in place that:

1. Include Electronic Health Records (EHRs);

2. Capture demographic information, diagnoses and medications lists;

3. Provide clinical decision support;

4. Electronically transmit prescriptions to the pharmacy;

5. Allow reporting on data and quality measures required by the CCBHC program;

6. Allow the system to conduct activities such as population health management, quality improvement, disparity reduction, outreach and research; and

7. If the HIT is newly established, can also send and receive the full common data set for all summary of care records to support capabilities including transitions of care, privacy and security and to meet the *Patient List Creation* criterion (45 CFR 170.314(a)(14)) established by the Office of the National Coordinator (ONC) for ONC's Health IT Certification Program.

2703.9 QUALITY ASSURANCE

A. CCBHCs must have in place a HCQC approved written Continuous Quality Improvement (CQI) Plan. CCBHCs must:

1. Comply with this plan and all other HCQC requirements to ensure on-going quality care;

2. Ensure the plan includes a description of how the public is made aware of the availability of CCBHC services;

3. Submit all required and requested data, quality and fidelity measures reports to comply with the requirements of the CCBHC program timely; and

4. Provide oversight and monitoring of all their DCOs to ensure services provided meet the requirements of the CQI plan; they are enrolled as an Ordering,

Prescribing or Referring (OPR) provider, if relevant; they are compliant with the requirements of this chapter and all relevant MSM Chapters and Addendum; and the DCOs submit all required data reports timely which includes both CCBHC and State led measures.

2703.10 BOARD OF DIRECTORS

A. CCBHCs must operate under established bylaws and have board members that are representatives of the individuals being served in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age and sexual orientation. In terms of representation of behavioral health disorders, CCBHCs must incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders and family members of CCBHC consumers i.e., 51 % of the board are families, consumers or people in recovery from behavioral health conditions to provide meaningful input to the board about the CCBHC's policies, processes and services.

B. CCBHCs must provide the board:

1. An annual financial audit and correction plan with the relevant management letter to address any deficiencies; and

2. The following reports to verify timely access to care:

a. Recipients seeking an appointment for routine needs are provided an initial evaluation within 10 business days of the request;

b. Recipients seeking an appointment for an urgent need are seen and initial evaluation completed within one business day; and

c. Recipients with an emergency or crisis need receive immediate and appropriate action.

2703.11 SUPERVISION STANDARDS

CCBHC providers must ensure all services are provided under medical and clinical supervision as prescribed by this chapter and within CCBHC certification criteria. Non-compliance will result in the DHCFP provider termination and/or suspension without cause.

2703.12 RECIPIENT SATISFACTION OF CARE

CCBHC and DCO providers must demonstrate satisfaction of care by their recipients under the CCBHC delivery model by ensuring this satisfaction is measured and any dissatisfaction is responded to. This includes a satisfaction survey and the review of recipient responses by their

Board of Directors. The review is to be the foundation for opportunities to improve performance by the CCBHC and perception by the recipients.

2703.13 PROVIDER QUALIFICATIONS

A. CCBHC services are provided by qualified individuals in an interdisciplinary treatment team approach. The CCBHC treatment team is comprised of individuals who meet the qualifications of direct care providers under the relevant MSM chapter and who collaborate to provide and coordinate medical, psychosocial, emotional, therapeutic and recovery support services to the recipients served. All direct care providers of CCBHC services must be able to provide services under the CCBHC delivery model and meet the qualification as specified in the relevant MSM chapter.

B. CCBHCs must also ensure all DCO providers are qualified and compliant with the requirements of the CCBHC program, this chapter and all relevant MSM Chapters and the Addendum.

2703.14 TARGET POPULATIONS

The CCBHC target populations are the primary populations of focus. These groups include: COD, Seriously Emotionally Disturbed (SED)/Non-SED, Severely Mentally Ill (SMI)/Non-SMI and SUD. SED/Non-SED and SMI/Non-SMI are defined in the MSM Addendum. COD and SUD are defined above.

2703.15 RECIPIENT ELIGIBILITY

A. Admission Criteria: To be eligible for CCBHC services, a recipient must meet criteria for one of the six target groups.

B. Continuing Stay Criteria: The recipient continues to meet admission criteria and needs restoration for the best possible functioning or is at risk of relapse and a higher level of care.

C. Discharge Criteria: The recipient no longer meets admission and continuing stay criteria; no longer wishes to receive services; or their care has been transferred, the discharge summary has been provided and the coordination of care has been completed with the new provider.

2703.16 SERVICES

This CCBHC program allows for the expansion of existing services and the provision of integrated health care services. CCBHCs must provide the following required services under this program: Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention

services and crisis stabilization; screening, assessment and diagnosis, including risk assessment; patient-centered treatment planning or similar processes, including risk assessment and crisis planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the VHA, including clinical guidelines contained in the "Uniform Mental Health Services Handbook of such Administration." In addition to the required services, CCBHCs are allowed to provide additional services identified on the Allowable Services grid located with the CCBHC billing guide.

CCBHC treatment and services are based on the individually assessed biopsychosocial needs of the recipient and prescribed on a person- and family-centered integrated treatment plan. Services must be provided under the philosophy of recovery and be informed by best practices for working with individuals from diverse cultural and linguistic backgrounds. The treatment plan guides the prescribed treatment and services and must reflect collaboration with and endorsement by the recipient and their family, when appropriate. The treatment plan identifies the recipient's needs, strengths, abilities and preferences and includes the recipient's goal(s) that is expressed in a manner that captures their own words or ideas and, for children, those of their family/caregiver. In addition, the treatment plan must indicate the recipient's advance wishes related to treatment and crisis management or reflects their decision not to discuss those preferences.

CCBHC services are projected to reduce the number of behavioral health emergency room (ER) visits in communities, increase positive outcomes of treatment and reduce the negative impacts of social determinants of health on recovery. Nevada Medicaid reimburses for the following services provided under a CCBHC delivery model in accordance with this chapter, MSM Chapter 100, MSM Addendum and all relevant MSM Chapters. The services describe below include criteria specific to the CCBHC delivery model. Additional requirements are specified in the relevant MSM Chapter and Addendum.

A. CRISIS BEHAVIORAL HEALTH SERVICES:

CCBHCs must provide through an existing state-sanctioned, certified or licensed system or network, rapid crisis response to address immediate needs, triage, stabilization and/or appropriate transfer to a higher level of care. Crisis behavioral health services include but are not limited to:

1. 24-hour mobile crisis to include evaluations, interventions and stabilization;

2. Telephonic crisis services. The CCBHC must ensure, once the emergency has been resolved, the recipient is seen in-person at the next encounter and the initial evaluation is reviewed;

3. Comprehensive suicide assessments and interventions using the Collaborative Management and Assessment of Suicidality to identify and address the immediate safety needs of the recipient;

4. Identifying and managing recipients who may be at-risk of or are currently experiencing withdrawal and determining the level of care needed to safely manage the severity of the withdrawal. When clinically indicated, recipients must be assessed for signs and symptoms of withdrawal using the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA/CIWA-Ar) and the Clinical Opiate Withdrawal Scale (COWS);

5. Ambulatory withdrawal management for recipients who can be managed in the community and coordinated referral for recipients who require higher levels of withdrawal management;

6. Targeted Case Management (TCM), links to community resources to address social determinates of health, such as access to safe housing, food and basic health care. When the TCM provider is working with children and their families, community resources must also be leveraged to provide wrap-around supports to increase family resiliency and reduce the risk of further crisis;

7. Brief, solution-focused interventions to assist recipients and/or their families in finding strength-based ways to address their needs and ameliorate further crisis. These interventions include Solution-Focused, Brief Psychotherapy (SFBT) and the use of Wellness Recovery Action Plans (WRAP) for the development of a crisis plan to support recipients in advocating for their own preferences for care; and/or

8. Care coordination and discharge planning for recipients needing referrals to higher levels of care.

B. SCREENING, ASSESSMENT AND DIAGNOSTIC SERVICES

CCBHCs must appropriately screen, assess and diagnose recipients with behavioral health disorders for their optimal success and to provide the foundation for treatment and services. CCBHCs must also utilize standardized, validated evidenced-based screening and assessment tools with developmentally, culturally and linguistically appropriate measures, and, where appropriate, motivational interviewing techniques.

1. SCREENING

CCBHCs must:

a. Ensure all new recipients receive a preliminary screening and risk

assessment to determine acuity of needs;

b. Upon completion of a screen, provide further diagnostic assessment/ evaluation services when clinically indicated; and

c. Ensure immediate, appropriate action, including any necessary subsequent outpatient follow-up if the screening or other evaluation identifies an emergency or crisis need.

2. ASSESSMENT AND DIAGNOSIS

All CCBHC services must be based on a comprehensive person- and family-centered diagnostic and treatment planning evaluation. This biopsychosocial assessment must be completed with the recipient and in consultation with the primary care provider, if any, within 60 calendar days of the first request for services.

Standardized and evidence-based biopsychosocial assessments help guide the clinician, in collaboration with the recipient and/or their families, to make informed decisions on their treatment and recovery support options. Assessments include aspects of motivational interviewing and treatment matching options and consider a recipient's or family's preferences and stages of treatment engagement. To ensure continuity of care, avoid duplication of services and to reduce frustration on the part of the recipient and/or their family due to repetitious disclosure, the CCBHC must make every effort to obtain and update the most recent comprehensive assessment available.

3. The initial evaluation must include:

a. Preliminary diagnoses and severity rating;

b. Source of referral;

c. Reason for seeking care, as stated by the recipient or other individuals who are significantly involved;

d. Identification of the recipient's immediate clinical needs related to the behavioral health diagnosis(es);

e. List of current prescriptions and over-the-counter medications, as well as other substances the recipient may be taking;

f. Assessment of whether the recipient is a risk to self or others, including

suicide risk factors;

g. Assessment of whether the recipient has other concerns for their safety;

h. Assessment of the need for medical care (with referral and follow-up as required);

i. Determination of whether the recipient presently is or ever has been a member of the U.S. Military;

j. Assessment and documentation of COD, SED/Non-SED, SMI/Non-SMI or SUD status; and in addition;

k. For children, a comprehensive assessment must include:

1. The Children's Uniform Mental Health Assessment (CUMHA) and the Child and Adolescent Service Intensity Instrument (CASII); and

2. Other age appropriate screening and prevention interventions including, where appropriate, assessment of learning disabilities.

l. For adults, the comprehensive assessments must include:

1. Level of Care Utilization System (LOCUS); or

2. American Society of Addiction Medicine-Patient Placement Criteria (ASAM); and

3. World Health Organization Disability Assessment Scale Version 2 (WHODAS 2.0).

C. CHRONIC DISEASE MANAGEMENT: Recipients with chronic health conditions must receive specific documented approaches intended to manage and monitor their disease(s). This includes coordinating care to reduce the impact on their overall physical health care and behavioral health recovery. Chronic disease management includes recipient and/or family education, support and assistance for self-management.

D. INTENSIVE FAMILY INTERVENTION SERVICES: Family-centered and family-driven services that are based on the strengths of the recipient's family and include family support services. The focus of these services is to preserve and empower families by finding solutions that best meet their needs through home-based interventions, education and skills building. These services include assisting families to get their basic needs met (e.g., food, housing, transportation and/or childcare).

E. INTENSIVE COMMUNITY-BASED BEHAVIORAL HEALTH CARE FOR MEMBERS OF THE U.S. MILITARY AND VETERANS: Care that is consistent with the minimum clinical mental health guidelines promulgated by the VHA and the VHA's Uniform Mental Health Services Handbook. These integrated and coordinated care services are provided by the CCBHC to:

1. U.S. Military members located 50 miles are more (or one hour's drive time) from a Military Treatment Facility; and

2. Veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law.

F. PRIMARY CARE SCREENING AND MONITORING SERVICES: Basic preventive health services for recipients to improve overall health outcomes. These services are considered to have high value in the prevention and intervention of preventable health and chronic health conditions and include family planning, vaccinations and well-visits. Primary care services include outpatient primary care screening and monitoring. This service monitors key health indicators and health risks and identifies the need for the coordination of care. CCBHCs must provide, collect, report, monitor and document the following services on the integrated treatment plan:

1. Adult body mass index (BMI) screening and follow-up;

2. Adult major depressive disorder suicide risk assessment;

3. Child and adolescent major depressive disorder suicide risk assessment;

4. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications;

5. Screening for clinical depression and follow-up plan;

6. Tobacco use, screening and cessation intervention;

7. Unhealthy alcohol use, screening and brief counseling; and

8. Weight assessment and counseling for nutrition and physical activity for children and adolescents.

G. OCCUPATIONAL THERAPY: Services provided by an Occupational Therapist licensed in the State that are designed to restore self-care, work and leisure skills to eligible recipients with functional impairments in order to increase their ability to perform tasks of

daily living. Services must meet medical necessity and comply with the requirements of MSM Chapter 1700 – Therapy.

H. PEER SUPPORT SERVICES: Services to improve recipient engagement by providing them support from individuals with lived experience to bring meaningful insights into the journey of recovery.

I. PSYCHIATRIC REHABILITATION: Recovery supports that are rehabilitative in nature and are behavioral health services/interventions designed to engage recipients in regaining skills and abilities necessary to live independent and self-directed lives.

J. SMOKING CESSATION: Evidence-based strategies to assist the recipient in quitting smoking to include referral to the Nevada Tobacco Quit Line and health education classes aimed at providing support information and needed encouragement.

K. TARGETED CASE MANAGEMENT (TCM): Services that assist CCBHC recipients in gaining access to needed medical, social, educational and other support services including housing and transportation needs; however, they do not include the direct delivery of medical, clinical or other services. Components of TCM services include case management assessment, care planning, referral/linkage and monitoring/follow-up.

All TCM services provided must comply with MSM Chapter 2500, Case Management. Target groups for the CCBHC include those listed under MSM Chapter 2500, Non-Seriously Mentally Ill (Non-SMI) Adults, Serious Mental Illness Adult, Non-Severely Emotionally Disturbed (Non-SED Children and Adolescents), Severe Emotional Disturbance (SED) Children and Adolescents

1. LEAD CASE MANAGER is only used if a recipient is included in more than one target group at a given time or is eligible to receive case management services from different programs (i.e. CCBH, MCO, or governmental agencies). The Lead Case Manager coordinates the recipient's care and services with another case manager. The Lead Case Manager is responsible for coordinating the additional case management services, whether or not, chronologically, the Lead Case Manager was the original or the subsequent case manager. When a recipient is eligible for MCO, it is the responsibility of the Lead Case Manager to ensure that the identified MCO is notified of the recipient's participation in targeted case management. The Lead Case Manager will coordinate all care with the MCO to ensure there is an elimination of any potential for duplication of services.

2703.17 DOCUMENTATION REQUIREMENTS

A. CCBHCs must comply with the MSM Chapter 400 documentation requirements and must also document:

1. The medical necessity and clinical appropriateness of services prescribed on an integrated and individualized person- and family-centered treatment plan;

2. The coordination of care for recipients with all providers of behavioral and physical health care and, when relevant, with the VHA;

3. How services are individualized and developmentally, culturally and linguistically competent for each recipient; and

4. The tracking of and response to recipient's accessing higher levels of care which includes discharge planning, implementation and coordination.

2703.18 UTILIZATION MANAGEMENT

A. The CCBHC delivery model expands access to crisis evaluation, ambulatory detoxification services and outpatient stabilization for recipients who are appropriate for such services. For recipients with needs that exceed outpatient treatment, CCBHCs are required to provide coordinated referrals to higher levels of care in the community.

B. The role of the CCBHC includes follow-up after hospitalization for behavioral/mental health issues within seven and 30 days. CCBHCs are required to focus care coordination efforts towards recipients transitioning from inpatient behavioral health care to outpatient community treatment settings.

C. The CCBHC must provide utilization management and oversight of all services performed by a DCO.

2703.19 COVERAGE AND LIMITATIONS

A. Nevada Medicaid reimburses for all CCBHC services listed in this chapter based on the prospective payment system (PPS) rate methodology.

B. The CCBHC is responsible for submission of claims including those on behalf of the DCO. Payments for DCO services will be made directly to the CCBHC.

2703.20 NON-COVERED SERVICES

A. The following services are not covered under the CCBHC program for Nevada Medicaid and Nevada Check Up (NCU):

1. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

2. Therapy for marital problems without a covered, current ICD diagnosis;

3. Therapy for parenting skills without a covered, current ICD diagnosis;

4. Therapy for gambling disorders without a covered, current ICD diagnosis;

5. Custodial services, including room and board;

6. Social model support group services (Peer Support Services are based on a medical model);

7. More than one provider seeing the recipient in the same therapy session; and

8. Respite.

2703.21 PROVIDER RESPONSIBILITIES

A. CCBHCs must ensure recipients are informed of services, choices and their rights and responsibilities prior to the provision of services.

B. Providers are also responsible for:

1. Verifying Medicaid eligibility on a monthly basis.

2. Submitting appropriate billing reflecting accurate procedure and code usage.

2703.22 FEDERALLY QUALIFIED HEALTH CENTERS DUALLY ENROLLED AS A CCBHC

A. FQHCs dually enrolled as a CCBHC should determine the appropriate model to bill medically appropriate rendered services. The FQHC and the CCBHC must have internal policies regarding the appropriate placement for treatment for their respective recipients. Medical necessity and clinical appropriateness as determined by the clinical professionals, under care coordination are required and should be taken into consideration when services overlap both within the FQHC and/or the CCBHC scope of services. This is to determine which encounter (FQHC or CCBHC) is appropriate to request reimbursement. Care

coordination is required to prevent duplicative billing for the same service occurring at the same time.

B. Services that are covered under the CCBHC model are identified on the services grid located in the CCBHC billing guide. Recipients that are accessing services that are primarily CCBHC and not an exclusively FQHC service will bill the CCBHC PPS rate. Services that are primarily FQHC specific and not exclusively CCBHC services will bill the FQHC encounter rate.

C. The Medicaid Surveillance and Utilization Review unit (SUR) will monitor in a retrospective review for any duplication of billing between the two delivery models.

2703.23 RECIPIENT AND/OR FAMILY RESPONSIBILITIES

A. Recipients or their legal guardians (when applicable) must:

1. Participate in the development and implementation of their individualized treatment plan;

2. Inform their Medicaid providers of any changes to their Medicaid eligibility; and

3. Provide their Medicaid card to their service providers.

2703.24 AUTHORIZATION PROCESS

A. Prior Authorizations are not required under the CCBHC model.

B. The CCBHC has the ultimate clinical responsibility for all services including those provided by the DCO and must ensure the medical necessity and clinical appropriateness of the services.

2704 HEARINGS

Please reference MSM Chapter – 3100, Hearings, for hearings procedures.

2704 HEARINGS

Please reference MSM Chapter – 3100, Hearings, for hearings procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 24, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR /Cody L. Phinney/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2800 – SCHOOL HEALTH SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2800 – School Health Services (SHS) are being proposed to remove the Individualized Education Program (IEP) limitations and align the policy with the Centers for Medicare and Medicaid Services' (CMS') State Medicaid Director's Letter (SMD #14-006) which reversed the CMS guidance on reimbursement for services provided free of charge to all students in a school setting.

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: School Health Services (SHS) – Provider Type (PT) 60.

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective March 1, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 15/20 MSM Chapter 2800 – School Health Services	MTL 45/10, 25/08 MSM Chapter 2800 – School Based Child Health Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2800	**Introduction**	Changed the name of services from School Based Child Health Services (SBCHS) to School Health Services (SHS). Added language to allow both Local Education Agencies (LEAs) and State Education Agencies (SEAs) to be able to provide medical services in schools. Removed IEP limitation and

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		replaced it with requirement that services be screening/diagnostic or in a Plan of Care (POC). Removed Individuals with Disabilities Education Act (IDEA) language. Updated Nevada Check Up (NCU) citation.
2801	**Authority**	Removed list of services and replaced it with more general language. Split regulations into Federal and State. Added several Code of Federal Regulations (CFRs) and Nevada Revised Statutes (NRSs). Updated State Plan Amendment (SPA) page(s).
2802	**Definitions**	Added definitions of 504 Accommodation Plan, Activities of Daily Living (ADLs), Applied Behavior Analysis (ABA), Autism Spectrum Disorder (ASD), By or Under Direction Of, Fetal Alcohol Spectrum Disorder (FASD), Individual Family Service Plan (IFSP), Instrumental Activities of Daily Living (IADLs), Legally Responsible Individual (LRI), Medical Necessity, Medical Team Conference (with interdisciplinary team), Personal Care Assistant (PCA), Personal Care Services (PCS), Plan of Care (POC), School Functional Assessment Service Plan (SFASP), Screening and Diagnostic Services, State Education Agency (SEA), Third Party Liability (TPL) and Treatment Services. Removed definitions of Counseling Services, Disability, Multidisciplinary Conference (MDC) replaced by Medical Team Conference, Parent (replaced by LRI), Present Levels of Educational Performance, Progress Monitoring, Related Services, Review and Revision of IEP, Special Education and Support Services. Revised definitions of Assistive Communication Device (ACD), Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Local Education Agency (LEA), and Short-term Objectives/Benchmark.
2803.1	**Policy Overview**	Added POC language. Added the categories Screening and Diagnostic Services, and Treatment Services.
2803.1A	**Screening and Diagnostic Services**	Added new section that refers to Chapter 1500 – Healthy Kids Program services that will now be covered in School Health Services (SHS).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2803.1B	**Treatment Services**	Added new section that includes all SHS except those in Screening and Diagnostic Services.
2803.1C	**Coverage and Limitations**	Previously Section 2803.1A. IEP development meeting changed to medical team conference. Added the language to "Section 2803.1C(3) Covered Services" to make it more inclusive of screening and diagnostic services. Rearranged services to match order they are described later in the chapter. Updated MSM sections referenced. Added screening, diagnostic, and treatment services; mental health and alcohol/substance abuse services (replaced psychological counseling); PCS; ABA services; dental services; optometry services; case management; and services delivered by telehealth to covered services. Added medical necessity and Ordering, Prescribing, Referring (OPR) section to the non-covered services. Removed dental or related services, treatment of obesity, and any examination and laboratory tests for preventable diseases from the non-covered services.
2803.1D	**Provider Responsibility**	Previously Section 2803.1B. Replace "Medical or Treatment Services" section with newly drafted "Ordering, Prescribing and Referring (OPR)" section. Added table to "By or Under the Direction Of" section to clarify who can practice under the direction of another provider. Replaced "Reserved for Future Use" section with newly drafted "Plan of Care (POC)" section. Replaced "Individualized Education Program (IEP)" section with "Medical Team Conference (with Interdisciplinary Team)" section. Removed IEP Assessment/Evaluation and Assessment sections. Added statement that documentation must be completed as appropriate for the service being provided as detailed in the corresponding MSM chapter to the Records section. Made Non-Discrimination section more general and reference back to MSM 100. Added language to the Third Party Liability (TPL) section to state that Pay & Chase will only apply to IEP services. Replaced Parental Notification and Consent section with Katie Beckett Recipients section. Removed parental notification and consent as it is a Family Educational

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Rights and Privacy Act (FERPA) regulation not a Medicaid regulation.
2803.1F	**Authorization Process**	Previously Section 2803.1D. Added language that POC serves as prior authorization. Added reference to the OPR section.
2803.2	**Provider Qualifications**	Licensed replaced with qualified as not all services require a licensed provider.
2803.2A	**Physician, Physician's Assistant, & Advanced Nurse Practitioner Qualification**	Added provider qualifications.
2803.2B	**Mental Health and Substance Abuse Services Qualifications**	Added provider qualifications.
2803.2C	**Nursing Qualifications**	Added provider qualifications.
2803.2D	**Physical Therapy Qualifications**	Added provider qualifications.
2803.2E	**Occupational Therapy Qualifications**	Added provider qualifications.
2803.2F	**Speech Therapy and Audiology Qualifications**	Added provider qualifications.
2803.2G	**PCS Qualifications**	Added provider qualifications.
2803.2H	**Applied Behavior Analysis (ABA) Qualifications**	Added provider qualifications.
2803.2I	**Dental Qualifications**	Added provider qualifications.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2803.2J	**Optometry Qualifications**	Added provider qualifications.
2803.2K	**Case Management Qualifications**	Added provider qualifications.
2803.2L	**Telehealth Qualifications**	Added provider qualifications.
2803.3	**Screening, Diagnostic Services, and Treatment**	Added new section that refers to Chapter 1500 – Healthy Kids Program services that will now be covered in School Health Services (SHS).
2803.3A	**Coverage and Limitations**	Added new section with coverage and limitations of screening, diagnostic and treatment services.
2803.3B	**Covered Services**	Added new section with covered services for screening, diagnostic and treatment services.
2803.3C	**Limitations**	Added new section with limitations for screening, diagnostic and treatment services.
2803.4	**Physician, Physician's Assistant & Advanced Nurse Practitioner Services**	Previously Section 2803.3. Added APRNs.
2803.4A	**Covered Services**	Defined the list of covered services as examples, not an exhaustive list.
2803.4B	**Limitations**	Added new section with limitations for physician, physician's assistant & advanced nurse practitioner services.
2803.5	**Mental Health and Alcohol/Substance Abuse Services**	Renamed section from psychological counseling. Added language to more closely resemble the language in MSM, Chapter 400.
2803.5A	**Covered Services**	Added neuro-cognitive, psychological and mental status testing; mental health therapies; medication management; medication training & support, rehabilitative mental health services; outpatient

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		alcohol and substance abuse services; and medical team conference participation as covered services.
2803.5B	**Limitations**	Added new section with limitations for Mental Health and Alcohol/Substance Abuse Services.
2803.6	**Nursing Services**	Added language that nursing services must be under the order and direction of a physician or APRN. Removed statement that services considered observational or stand-by in nature are not covered.
2803.6A	**Covered Services**	Clarified who Registered Nurses (RNs) may supervise. Changed IEP/IFSP meeting to Medical Team Conference.
2803.6B	**Limitations**	Added new section with limitations for Nursing Services.
2803.7A	**Covered Services**	Changed IEP/IFSP meeting to Medical Team Conference.
2803.7B	**Limitations**	Added new section with limitations for Physical Therapy Services.
2803.8A	**Covered Services**	Changed IEP/IFSP meeting to Medical Team Conference.
2803.8B	**Limitations**	Added new section with limitations for Occupational Therapy Services.
2803.9A	**Covered Services**	Changed IEP/IFSP meeting to Medical Team Conference.
2803.9B	**Limitation**	Added new section with limitations for Speech Therapy and Audiology Services.
2803.10	**Audiological Supplies, Equipment, Medical Supplies and Other Durable Medical Equipment (DME)**	Replaced IEP with POC.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2803.10B	**Limitations**	Added new section with limitations for Audiological Supplies, Equipment, Medical Supplies and other DME.
2803.11	**Personal Care Services (PCS) in School Setting**	Added new section on how PCS can be provided in a school setting.
2803.11A	**Covered Services**	Added new section on what is covered under PCS in a school setting.
2803.11B	**Service Limitations**	Added new section with service limitations for PCS in a school setting.
2803.11C	**Non-Covered Services**	Added new section on non-covered services for PCS in a school setting.
2803.11D	**Authorization Process**	Added new section on authorization process for PCS in a school setting.
2803.11E	**Flexibility of Services Delivery**	Added new section on flexibility of PCS services delivered in a school setting.
2803.11F	**Supervision**	Added new section on supervision of Personal Care Assistant (PCA) providing services in a school setting.
2803.11G	**Records**	Added new section on documentation of PCS services in a school setting.
2803.12	**Applied Behavior Analysis (ABA)**	Added new section on how ABA services can be provided.
2803.12A	**Covered Services**	Added new section on covered services for ABA in a school setting.
2803.12B	**Limitations**	Added new section on limitations of ABA services in a school setting.
2803.13	**Dental**	Added new section on dental services covered in a school setting.
2803.13A	**Covered Services**	Added new section on what dental services are covered in the school setting.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2803.13B	**Limitations**	Added new section on limitations of dental services in a school setting.
2803.14	**Optometry**	Added new section on optometry services provided in a school setting.
2803.14A	**Covered Services**	Added new section on optometry services covered in a school setting.
2803.14B	**Limitations**	Added new section on limitations of optometry services covered in a school setting.
2803.15	**Case Management**	Added new section on case management services provided in a school setting.
2803.15A	**Covered Services**	Added new section on case management services covered in a school setting.
2803.15B	**Limitation**	Added new section on limitations of case management services covered in a school setting.
2803.16	**Telehealth**	Added new section on services provided by telehealth in a school setting.
2803.16A	**Coverage and Limitations**	Added new section on coverage and limitations of telehealth in a school setting.
2804	**Reserved for Future Use**	Added new section for future use.
2805	**Hearings**	Previously section 2804.
2806	**References and Cross References**	Previously section 2805.
2806.1	**Provider Specific Information**	Added MSM, Chapters 1000, 1100, 2500, 3400, and 3700 to the references.
2805.3	**Contracted QIO-Like Vendor and Fiscal Agent**	Removed section.
Attachment A	**Qualified Nevada Medicaid Providers**	Removed section.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

SCHOOL BASED CHILD HEALTH SERVICES

SCHOOL HEALTH SERVICES

2800 INTRODUCTION

School Health Services (SHS) are medical services provided by a Local Education Agency (LEA) or State Education Agency (SEA) for children who attend public schools in Nevada. SHS are provided to Medicaid eligible students. SHS are medically necessary services listed in the student's Plan of Care (POC), and/or preventive services that are coverable under Early Periodic Screening, Diagnostic, and Treatment (EPSDT) as defined in 42 Code of Federal Regulations (CFR) 440.40(b). Services listed in a POC are designed to meet the health needs of a child and work towards the reduction of a physical or mental impairment and restoration of the child to the best possible functional level.

All Medicaid policies and requirements (such as prior authorization (PA), etc.) are the same for Nevada Check Up (NCU) recipients, with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

2801 AUTHORITY

SHS contain an element of early detection and preventive service delivery. EPSDT is a mandatory benefit authorized by 1905(a) and 1903(4)(c) of the Social Security Act.

SHS also contains a rehabilitative element of service delivery. These services are optional benefits under the program and include services authorized in the Nevada Medicaid State Plan.

Federal regulations governing SHS are:

- Social Security Act Section 1903(c)
- Social Security Act Section 1902(a)(30)(A)
- 42 CFR 441.58.c.
- 42 CFR 440.110, 440.130.d and 440.170
- 42 CFR 440.40(b)
- 42 CFR 440 Subpart A
- 42 CFR 447.201
- 42 CFR 431.53
- 42 CFR 435
- 42 CFR 455.410 and 455.440
- 34 CFR 300.154(d)(2)(iv)
- 34 CFR 300.300

State regulations governing SHS are:

- Nevada Administrative Code (NAC) 640A.020
- NAC 640.001 to 006
- State Plan Amendment 3.1-A
- Nevada Revised Statutes (NRS) 603

- NRS 630
- NRS 632
- NRS 633
- NRS 636
- NRS 637
- NRS 637B
- NRS 640
- NRS 640A

2802 DEFINITIONS

504 ACCOMODATION PLAN

A plan developed to ensure that a child who has a disability identified under the law and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.

ACTIVITIES OF DAILY LIVING (ADLs)

Self-care activities routinely performed on a daily basis, such as bathing, dressing, grooming, toileting, transferring, mobility/ambulation and eating.

APPLIED BEHAVIOR ANALYSIS (ABA)

The design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

ASSISTIVE COMMUNICATION DEVICE (ACD)

A Durable Medical Equipment (DME) which helps speech, hearing and verbally impaired individuals communicate.

AUDIOLOGY TESTING

Audiology testing is evaluation/testing performed by an audiologist licensed by the appropriate licensure board of the state to determine extent of hearing impairments that affect the student's ability to access education. Audiology testing includes hearing and/or hearing aid evaluations, hearing aid fitting or reevaluation and audiograms.

AUTISM SPECTRUM DISORDER (ASD)

A group of developmental disabilities that can cause significant social, communication, and behavioral challenges.

BY OR UNDER DIRECTION OF

“By or under the direction of” means that the Medicaid qualified staff providing direction is a licensed practitioner of the healing arts qualified under state law and federal regulations to diagnose and treat individuals with the disability or functional limitations, is operating within their scope of practice defined in Nevada State law, and is supervising each individual’s care.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

A preventive health care program, the goal of which is to provide to Medicaid eligible children under the age of 21 the most effective, preventive health care through the use of periodic examinations, standard vaccinations, diagnostic and treatment services which are medically necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. 42 United States Code (USC) Section 1396.d (a)(4)(B). Nevada's program is named Healthy Kids.

FETAL ALCOHOL SPECTRUM DISORDERS (FASD)

A group of developmental conditions resulting from maternal alcohol use during pregnancy.

FREE APPROPRIATE PUBLIC EDUCATION (FAPE)

A federal statutory requirement that children and youth with disabilities receive a public education appropriate to their needs at no cost to their families.

INDIVIDUAL FAMILY SERVICE PLAN (IFSP)

A plan for special services for young children from birth to three years of age with disabilities. The goals that are put into place within an IFSP are targeted toward the family versus the goals within an Individualized Education Program (IEP) which are targeted specifically towards the student.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

The federal law that mandates that a free and appropriate public education is available to all school-age children with disabilities.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

A written plan for every student receiving special education services that contain information such as the student's special learning needs and the specific education services required for the student. The document is periodically reviewed and updated at least annually.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

Activities related to independent living including meal preparation, laundry, light housekeeping and essential shopping.

LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

Individuals who are legally responsible to provide medical support. These individuals include legal guardians and parents of minor recipients, including stepparents, foster parents, and adoptive parents. LRIs may not be reimbursed for providing Personal Care Services (PCS). For this chapter's purpose LRI does not include the State if the child is a ward of the State and an LRI can be any person, individual acting in the place of a natural or adoptive parent including a grandparent, or other relative with whom the child lives.

LOCAL EDUCATION AGENCY (LEA)

A public board of education or other public authority legally constituted for administrative control or direction of a public elementary or secondary schools in a city, county, township, school district, or for a combination of school districts or counties as are recognized in a state as an administrative agency for its public elementary schools or secondary schools

MEDICAL NECESSITY

Reference Medicaid Services Manual (MSM) Chapter 100 for Nevada's definition of medical necessity.

MEDICAL TEAM CONFERENCE (WITH INTERDISCIPLINARY TEAM)

A conference with an interdisciplinary team to determine a student's need for further testing. The required composition of the team is defined in MSM Section 2803.1D(6) of this Chapter, Provider Responsibility - Medical Team Conference (with Interdisciplinary Team). Other professional staff such as physical therapists, occupational therapists, speech therapists, and behavior analysts, etc. may provide input, as well as audiology, vision, health, education and the student's LRI. As a result of this process, a POC will be established outlining treatment modalities.

PERSONAL CARE ASSISTANT (PCA)

A trained but unlicensed individual who provides PCS to individuals with disabilities and/or conditions which causes them barriers to independently performing ADLs and IADLs.

PERSONAL CARE SERVICES (PCS)

A range of human assistance provided to a student with disabilities and chronic conditions, which enables accomplishment of tasks that they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of direct hands-on assistance or cueing the student to perform the task themselves and related to the performance of ADLs and IADLs.

PLAN OF CARE (POC)

For the purpose of this chapter POC is defined as a medical document developed after an assessment by a qualified health professional acting within their scope of practice. Serves as documentation of medical necessity for all services being provided to the student. Must include all elements outlined in MSM 2803.1D(5) of this chapter.

SCHOOL FUNCTIONAL ASSESSMENT SERVICE PLAN (SFASP)

An assessment tool used by a trained physical or occupational therapist, to complete an in-person assessment, to identify the ability/inability of a student to perform ADLs and IADLs. This assessment identifies a student's unmet needs and provides a mechanism for determining the appropriate amount of PCS hours, based on the student's needs and functional ability. The SFASP also evaluates the environment in which services are provided.

SCREENING AND DIAGNOSTIC SERVICES

A child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated. Assessment of a child's health at regularly scheduled intervals assures that a condition, illness or injury is not developing or present. Screening services provide physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems. Diagnostic services or tests are performed to follow up when a risk is identified.

SHORT-TERM OBJECTIVES/BENCHMARK

A POC must contain a statement of annual goals, including a description of short-term objectives or benchmarks that are measurable and outcome oriented. Goals should be related to the child's unique needs to enable the child with a disability to participate and function in the general curriculum.

STATE EDUCATION AGENCY (SEA)

The State board of education or other agency responsible for the State supervision of public elementary schools and secondary schools.

THIRD PARTY LIABILITY (TPL)

The legal obligation of third parties (ie. any individual, entity or program) that may be liable to pay all or part of the expenditures for medical assistance furnished under a State Medicaid Plan including NCU. By law, all other third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid.

TREATMENT SERVICES

Treatment services are those available to correct or improve diagnosed physical and/or mental illnesses. Treatment must be medically necessary and does not include educational interventions.

2803 POLICY

2803.1 POLICY OVERVIEW

It is the policy of the Division of Health Care Financing and Policy (DHCFP) to support the unique health needs of Medicaid eligible students Medicaid covers School Health Services (SHS) when they are primarily medical and not educational in nature. This chapter establishes a Medicaid provision for medically necessary health care services a LEA/SEA may provide to students.

For a LEA/SEA to receive reimbursement for services through the Medicaid SHS Program, each Medicaid eligible student must have a POC that documents the medical necessity of the service to be provided and/or preventive services that are coverable under EPSDT. This documentation needs to specify the services required to treat the student's identified medical condition(s) as specified in MSM Section 2803.1D of this chapter.

The DHCFP recognizes two categories of services that can be provided in SHS. These categories are:

a. Screening and Diagnostic Services, and

b. Treatment Services.

2803.1A SCREENING AND DIAGNOSTIC SERVICES

LEAs/SEAs are encouraged to provide screening and diagnostic services as defined in MSM Chapter 1500 – Healthy Kids Program. These services can be covered without a POC as long as the screening and diagnostic services:

1. Follow the periodicity schedule as established in the Healthy Kids Program, MSM Chapter 1500;

2. Are determined to be a medically necessary screening when it falls outside the periodicity schedule; and

3. Are documented in medical records with the assessments and significant positive and negative findings, and referrals made for diagnosis, treatment or other medically necessary health services for any conditions identified.

A child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated. Assessment of a child's health at regularly scheduled intervals assures that a condition, illness or injury is not developing or present.

2803.1B TREATMENT SERVICES

Treatment services are those available to correct or improve defects and physical and mental illnesses. Treatment must be medically necessary and does not include educational interventions.

Treatment services must be documented appropriately for the service that is being provided in a POC as described in MSM Section 2803.1D(5) of this chapter, Provider Responsibility – Plan of Care (POC).

2803.1C COVERAGE AND LIMITATIONS

1. PROGRAM ELIGIBILITY CRITERIA

Only those services listed in MSM Sections 2803.3 – Preventive Health Screenings and Treatment through 2803.16 – Telehealth of this chapter are covered benefits.

a. SHS are available for eligible Medicaid and NCU children between three years of age and under the age of 21, in both Fee-for-Service (FFS) and Medicaid Managed Care. SHS for children who are enrolled in Medicaid Managed Care are covered and reimbursed under the FFS Medicaid. The student must be Medicaid eligible when services are provided;

b. The DHCFP does not reimburse for any services considered educational or recreational in nature;

c. Any Medicaid eligible child requiring SHS services may receive these services from the LEA/SEA provided:

1. All SHS relate to a medical diagnosis and are medically necessary;

2. The service performed is within the scope of the profession of the healthcare practitioner performing the service;

3. All services including the scope, amount, frequency and duration of service are documented as part of the child's school record, including the name(s) of the health practitioner(s) actually providing the service(s);

4. The treatment services are a part of the recipient's written POC; or an assessment, evaluation, or screening for the purpose of early identification of health concerns. This documentation must be kept on file with the LEA/SEA. The plan/documentation may be subject to review by authorized DHCFP personnel; and

5. All applicable federal and state Medicaid regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope of provisions.

2. LIMITATIONS

The Nevada Medicaid Program pays for SHS services conforming to accepted methods of diagnosis and treatment directly related to the recipient's diagnosis, symptoms or medical history. Limitations are:

a. Only qualified health care providers will be reimbursed for their participation in the POC development for medical related services concerning each specific discipline. Nevada Medicaid reimbursement for the participation time in the Medical Team Conference is only allowed for medical related services, not educational process and goals.

b. Services are limited to medical and related services described throughout this Chapter and procedure codes listed on the DHCFP website Provider Type (PT) 60 SHS Fee Schedule at http://dhcfp.nv.gov/RatesUnit.htm.

c. Services may not be provided to students under the age of three years old or students age of 21 years and older.

3. COVERED SERVICES

SHS are medically necessary diagnostic, evaluative, and direct medical services to detect, correct, or ameliorate any physical or mental diagnosis that meet the medical needs of Medicaid eligible students. The services are provided by a LEA/SEA to meet the health needs of a student. The services are 1) directed at early detection of a physical or mental health impairment, or 2) the reduction of a physical or mental impairment and restoration of the child to his/her best possible functioning level.

SHS Covered Services include:

a. Screening, diagnostic and treatment services when provided as described in MSM Section 2803.3 of this chapter.

b. Physician services when provided as described in MSM Sections 2803.2A and 2803.4 of this chapter.

c. Mental health and alcohol/substance abuse services when provided as described in MSM Sections 2803.2B and 2803.5 of this chapter.

d. Nursing services when provided as described in MSM Sections 2803.2C and 2803.6 of this chapter.

e. Physical therapy services when provided as described in MSM Sections 2803.2D and 2803.7 of this chapter.

f. Occupational therapy services when provided as described in MSM Sections 2803.2E and 2803.8of this chapter.

g. Speech therapy services when provided as described in MSM Sections 2803.2F and 2803.9 of this chapter.

h. ACD, audiological supplies and disposable medical supplies provided to serve a medical purpose, intervention to maintain or improve the student's health status. Refer to MSM Section 2803.10 of this chapter.

i. PCS when provided as described in MSM Sections 2803.2G and 2803.11 of this chapter.

j. ABA services when provided as described in MSM Sections 2803.2H and 2803.12 of this chapter.

k. Dental services when provided as described in MSM Sections 2803.2I and 2803.13 of this chapter.

l. Optometry services when provided as described in MSM Sections 2803.2J and 2803.14 of this chapter.

m. Case management services when provided as described in MSM Sections 2803.2K and 2803.15 of this chapter.

n. Telehealth services when clinically appropriate and within the health care professional's scope of practice as established by its licensing agency. Refer to MSM Sections 2803.2L and 2803.16 of this chapter.

4. NON-COVERED SERVICES

a. Medical care that does not meet the medical necessity definition in MSM Chapter 100, e.g. health education classes and first aid classes;

b. Evaluation and/or direct medical service performed by providers who do not meet Medicaid provider qualifications;

c. Information furnished by the provider to the recipient over the telephone;

d. Services which are educational, vocational, or career oriented;

e. Speech services involving non-diagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for the child's general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicaid purposes and are not to be covered since they do not require performance by a licensed qualified health care provider;

f. When maximum benefits from any treatment program are reached, the service is no longer covered;

g. Any vaccinations, biological products and other products available free of charge from the State Division of Public and Behavioral Health (DPBH);

h. Any services recreational in nature, including those services provided by an adaptive specialist or assistant;

i. Textbooks or other such items that are educational in nature and do not constitute medical necessity;

j. Transportation of school aged children to and from school, including specialized transportation for Medicaid eligible children on days when they receive Medicaid covered services at school;

k. Covered medical service(s) listed in a POC for those dates of service when the POC has expired; and

l. Covered medical or treatment service(s) which require a referral/prescription (as detailed in MSM Section 2803.1D(3) of this chapter, Provider Responsibility – OPR) from a qualified professional working within their scope of practice pursuant to Nevada State Law and are being provided without the referral or prescription from a qualified professional.

2803.1D PROVIDER RESPONSIBILITY

1. GENERAL INFORMATION

The provider shall furnish screening, diagnostic, and treatment services as medically necessary and identified in the POC.

As a condition of participation in the Nevada Medicaid Program, all service providers must

abide by the policies of the DHCFP, state and federal laws and regulations, including but not limited to, the United States CFRs governing the Medicaid Program, and all state laws and rules governing the Department of Education and the DHCFP. All providers must meet the requirements established for being a Medicaid provider. This includes the LEA/SEA's subcontractors who must meet all qualifications as Nevada Medicaid providers for the services they are providing. Department of Education Certification is not sufficient under federal regulations to meet Medicaid provider requirements.

All staff providing services to recipients under the SHS Program must be qualified as detailed in MSM Section 2803.2 of this chapter (Provider Qualifications) and provide services within their scope of practice.

2. ENROLLMENT PROCEDURES AND REQUIREMENTS

To be enrolled in the Nevada Medicaid Program as a SHS (PT 60), a LEA/SEA must enter into an Inter-Local Agreement, signed by the LEA or SEA and the DHCFP. Participating providers must comply with Medicaid regulations, procedures, and terms of the contract.

The provider must allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit, or utilization review. Refer to the MSM Chapter 100 for medical and fiscal record retention timeframes.

3. ORDERING, PRESCRIBING AND REFERRING (OPR)

In the school setting, if the service being provided is one in which reimbursement is dependent on the presence of an order, prescription or referral, then the claims for those services must comply with the Ordering, Prescribing, and Referring (OPR) requirements found at 42 CFR 455.410 and 455.440. The OPR requirements for services are based on the federal regulations at 42 CFR 440 Subpart A and what the state has defined in the Nevada Medicaid State Plan.

The referral/prescription services must be renewed at least annually and/or when the scope, amount and frequency, or duration of service(s) has changed. A POC that includes the required components of a referral/prescription for a service that has been reviewed and signed by a Medicaid qualified provider operating within their scope of practice pursuant to state law may serve as the referral/prescription for service(s).

For Medicaid to reimburse for services or medical supplies resulting from a practitioner's order, prescription, or referral, the OPR provider must be enrolled in Medicaid. Physicians or other eligible professionals who are already enrolled in Nevada Medicaid as a participating provider and who submit claims to Medicaid are not required to enroll separately as an OPR.

The table below shows each category of service that can be provided in SHS and if that service requires an order or prescription prior to being provided. Additionally, if the service does require an order or prescription, it states what level of professional is able to make that order/prescription.

Service	**Ordering, Prescribing, Referring (OPR) Required**	**Ordering/Referring Qualifications**
Physician Services	No	No OPR requirement
Mental Health and Alcohol/Substance Abuse Services	No	No OPR requirement
Nursing Services	Yes	Physician, M.D.; Osteopath, D.O.; Advanced Practice Registered Nurse (APRN); Physician's Assistant (PA)
Therapies (Physical, Occupational, and Speech)	Yes	Physician, M.D.; Osteopath, D.O.; APRN; PA
Durable Medical Equipment (DME) Disposable Supplies and Supplements	Yes	Physician, M.D.; Osteopath, D.O.; APRN; PA
Audiology Services	No	No OPR requirement
Hearing Aid Dispenser & Related Supplies	Yes	Audiologist; Physician, M.D.; Osteopath, D.O.; APRN; PA
Laboratory Services	Yes	Physician, M.D.; Osteopath, D.O.; APRN; PA
Personal Care Services (PCS)	Yes	Occupational Therapist; Physical Therapist; Physician, M.D.; Osteopath, D.O.; APRN; PA
Applied Behavior Analysis (ABA) services	Yes	Clinical Psychologist; Neuropsychologist; Physician, M.D.; Osteopath, D.O.; APRN; PA
Dental	No	No OPR requirement
Ocular Services	No	No OPR requirement
Case Management	No	No OPR requirement

Treatment services may also be provided by a community-based private practitioner performing within the scope of his/her practice as defined by state law. In providing SHS at a location other than the school campus, the LEA or SEA may contract with community-based licensed health professionals and clinics.

4. BY OR UNDER THE DIRECTION OF

"By or under the direction of" means that the Medicaid qualified staff providing direction is a licensed practitioner of the healing arts qualified under state law and federal regulations to diagnose and treat individuals with a disability or functional limitations and is operating within their scope of practice defined in Nevada State law and is supervising each individual's care.

The supervision must include, at a minimum, face-to-face contact with the individual provider being supervised initially and periodically as needed, prescribing the services provided and reviewing the need for continued services throughout the course of treatment. The Medicaid qualified supervisor must also assume professional responsibility for the services provided and ensure that the services are medically necessary. The Medicaid qualified supervisor must spend as much time as necessary directly supervising the services to ensure the student(s) are receiving services in a safe and efficient manner and in accordance with accepted standards of practice. Documentation must be kept supporting the supervision of services and ongoing involvement in the treatment.

Qualified Nevada Medicaid Providers		
Physician licensed by the Nevada State Board of Medical Examiners or the Nevada State Board of Osteopathic Medical Examiners acting within their scope of practice.	X	
Physician Assistant licensed by the Nevada State Board of Medical Examiners or certification by the Nevada State Board of Osteopathic Medicine to perform medical services supervised by a licensed physician in accordance with professional standards.		X
Advanced Practice Registered Nurse (APRN) licensed by the Nevada State Board of Nursing acting within their scope of practice.	X	
A Registered Nurse (RN) licensed by the Nevada State Board of Nursing acting within their scope of practice.	X (LPNs/CNAs only)	X (M.D., D.O., or APRN)
A licensed Practical Nurse licensed by the Nevada State Board of Nursing. Supervised by a licensed APRN or RN in accordance with professional standards.		X
A Nursing Assistant certified by the Nevada State Board of Nursing. Supervised by a licensed APRN or RN in accordance with professional standards.		X
A Doctorate Degree in Psychology and licensed by the State of Nevada Board of Psychological Examiners acting within their scope of practice.	X	
Psychological Assistants registered with the State of Nevada Board of Psychological Examiners and supervised by a licensed psychologist in accordance with professional standards.		X
Psychological Interns registered with the State of Nevada Board of Psychological Examiners and supervised by a licensed psychologist in accordance with professional standards.		X
Psychological Trainees registered with the State of Nevada Board of Psychological Examiners and supervised by a licensed psychologist in accordance with professional standards.		X
Licensed Clinical Social Workers (LCSW) licensed by the Nevada Board of Examiners for Social Workers acting within their scope of practice.	X	
Licensed Marriage and Family Therapists (LMFT) licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors acting within their scope of practice.	X	
Clinical Professional Counselors (CPC) licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors acting within their scope of practice.	X	

Qualified Nevada Medicaid Providers		
Qualified Mental Health Professionals (QMHPs) as defined in MSM, Chapter 400, excluding Interns, operating within the scope of their practice under state law.	X	
LCSW interns licensed by the Nevada Board of Examiners for Social Workers and supervised by a LCSW, LMFT, CPC, or QMHP acting within their scope of practice.		X
LMFT interns licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors and supervised by a LCSW, LMFT, CPC, or QMHP acting within their scope of practice.		X
CPC intern licensed by the Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors and supervised by a LCSW, LMFT, CPC, or QMHP acting within their scope of practice.		X
Qualified Mental Health Associates (QMHAs) as defined in MSM, Chapter 400, and supervised by a LCSW, LMFT, CPC, or QMHP acting within their scope of practice.		X
Qualified Behavioral Aids (QBAs) as defined in MSM, Chapter 400, and supervised by a LCSW, LMFT, CPC, or QMHP acting within their scope of practice.		X
An Occupational Therapist licensed by the State of Nevada Board of Occupational Therapy acting within their scope of practice.	X	
An Occupational Therapy Assistant certified by the State of Nevada Board of Occupational Board of Therapy. Supervised by a Licensed Occupational Therapist in accordance with professional standards.		X
A Physical Therapist licensed by the State of Nevada Physical Therapy Examiners Board.	X	
A Physical Therapist Assistant licensed by the State of Nevada Physical Therapy Examiners Board. Supervised by a licensed Physical Therapist in accordance with professional standards.		X
Licensed Speech-Language Pathologist by the Nevada Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Board and has Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA).	X	
Licensed Speech-Language Pathologist by the Nevada Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Board with **no** CCC but holds a Master's or doctoral degree from an accredited institution.	X	
Speech-Language Pathologist clinical fellow with a provisional license from the Nevada Speech-Language Pathology, Audiology, and Hearing Aid Dispensing Board and supervised by a licensed Speech-Language Pathologist in accordance with professional standards.		X
Qualified Speech-Language endorsed by the Department of Education as detailed in NAC 391.370 2(a), (c), (d), (e) and supervised by a licensed Speech-Language Pathologist in accordance with professional standards.		X

5. PLAN OF CARE

A POC is a medical document developed after an assessment by a qualified health professional acting within their scope of practice. A POC must meet the following guidelines:

a. The POC must identify a health condition/diagnosis that requires treatment.

b. The POC must identify the type of treatment to be provided and the frequency it will be provided.

c. The POC must identify the short-term objectives of the treatment interventions.

d. The POC must include a time frame for evaluation of progress.

e. Each POC must have a start and end date. Treatment is only authorized during the time period as written in the POC.

f. POCs can be written for no longer than a year.

g. POCs can be reviewed and renewed annually or more often as is medically necessary.

h. IEPs and 504 Accommodation Plans may act as a POC and an additional plan is not required if they meet all requirements of a POC and document medical necessity of the services being provided.

i. Not all POCs are required to be IEPs or 504 Accommodation Plans as LEAs/SEAs may have the need for shorter and less formal plans for lower acuity health conditions.

j. Multiple conditions can be documented in the same POC for a student who has multiple health conditions/diagnoses, however each service is to be documented in a specific service area.

The POC serves as a medical summary of progress documentation. The POC also serves as a PA for services that require PA.

6. MEDICAL TEAM CONFERENCE (WITH INTERDISCIPLINARY TEAM)

A medical team conference with an interdisciplinary team is completed with a team consisting of a minimum of a:

a. Physician, M.D.; Osteopath, D.O.; APRN; PA; or Clinical Psychologist;

b. Registered Nurse; and

c. Special Education Teacher

to determine a student's medical needs. Other professional staff such as physical therapists, occupational therapists, speech therapists, behavior analysts, etc. may provide input, as well as audiology, vision, health, education, and the student's LRI. As a result of this process, a POC will be established outlining treatment modalities. For simplicity, we will refer to this as a Medical Team Conference for the remainder of this MSM Chapter.

7. ELIGIBILITY VERIFICATION

Medicaid recipient eligibility is determined on a monthly basis. Therefore, it is important to verify the student's eligibility on a monthly basis. Payments can only be made for covered services rendered to eligible students. If the student was not eligible on the date the service was rendered, payment will be denied.

Eligibility can be verified by accessing the Automated Response System (ARS) or the Electronic Verification System (EVS) or using Health Insurance Portability Accountability Act (HIPAA) compliant electronic transaction. Refer to our Quality Improvement Organization (QIO)-like vendor's website for additional information.

8. RECORDS

The evaluative and diagnostic services which determine the need for treatment and the POC which defines the treatment needs must be documented as part of the student's medical record at the school, including the name(s) of the health practitioner(s) actually providing the service(s). The written POC must be on file with the participating LEA/SEA.

All medical and financial records which reflect services provided must be maintained by the LEA/SEA and furnished on request to the Department of Health and Human Services (DHHS) or its authorized representative. A LEA/SEA must keep organized and confidential records that detail all student specific information regarding all services rendered for each student receiving ~~of~~ services and retain those records for review.

LEAs/SEAs must maintain appropriate records to document the student's progress in meeting the goals of the treatment. SHS encompasses services from several disciplines, as such all documentation must be completed as appropriate for the service that is being provided as detailed in the MSM Chapter corresponding to the service being provided. Nevada Medicaid reserves the right to review the student's records to assure the treatment is restorative and rehabilitative.

9. NON-DISCRIMINATION

LEAs/SEAs must follow all federal rules and regulations and the DHCFP rules and regulations regarding discrimination against recipients on the basis of protected status(es) as detailed in MSM Chapter 100.

10. THIRD PARTY LIABILITY (TPL)

In 1988, as a result of the Medicare Catastrophic Coverage Act, Medicaid was authorized by Congress to reimburse for IDEA related medically necessary services for eligible children before IDEA funds are used. Medicaid reimbursement is available for those services under Social Security Act, Section 1903(c) to be the primary payer to the other resources as an exception. Federal legislation requires Medicaid to be the primary payer for Medicaid services provided to eligible recipients under IDEA, Children with Special Health Care Needs, Women's Infants and Children (WIC) Program, Title V Programs, Indian Health Services (IHS), or Victims of Crimes Act 1984.

Although Medicaid must pay for services before (or primary to) the U.S. Department of Education (School Districts), it pays secondary to all other sources of payment. As such, Medicaid is referred to as the "payer of last resort."

Medicaid statutory provisions for TPL preclude Medicaid from paying for services provided to Medicaid recipients if another payer (e.g. health insurer or other state or federal programs) is legally liable and responsible for providing and paying for services.

The Medicaid Program is generally the payer of last resort; exceptions to this principle are IEP and related services, Title V, and WIC, as mentioned previously.

Medicaid is required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the Nevada Medicaid State Plan. If a state has determined that probable liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of TPL (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay

and chase"). Nevada Medicaid has elected to pay and chase for SHS found to have TPL for IEP services only.

11. KATIE BECKETT RECIPIENTS

In order for children to remain eligible under the Katie Beckett eligibility category, Medicaid must assure the Centers for Medicare and Medicaid Services (CMS) that the per capita expenditures under this eligibility category will not exceed the per capita expenditures for the institutional level of care under the state plan. LRIs with children eligible under the Katie Beckett category may not want the SHS to be billed to Nevada Medicaid as this may impact the child's eligibility or may result in a cost to the LRI for services outside of the school arena. LRIs with a child eligible under this category are encouraged to work closely with their Medicaid District Office (DO) case manager to assure services do not impact their eligibility status.

12. NOTIFICATION OF SUSPECTED ABUSE/NEGLECT

The DHCFP expects that all Medicaid providers will be in compliance with all laws relating to incidents of abuse, neglect, or exploitation as it relates to students.

2803.1E RECIPIENT RESPONSIBILITIES

The recipient or authorized representative shall:

1. Provide the LEA/SEA with a valid Medicaid card at the LEA's/SEA's request.

2. Provide the LEA/SEA with accurate and current medical information, including diagnosis, attending physician, medication, etc.

3. Notify the LEA/SEA of all insurance information, including the name of other third party insurance coverage.

4. Participate in the Medical Team Conference(s).

5. Every student and their LRI is entitled to receive a statement of students or parent/guardian rights from their LEA/SEA. The student and their LRI should review and sign this document.

2803.1F AUTHORIZATION PROCESS

1. Prior authorizations are not required for any SHS that may be reimbursed for a Medicaid-eligible student even when the MSM chapter referenced for that service requires a prior authorization as the POC serves as the prior authorization. Refer to MSM Section 2803.1C

in this chapter outlining service coverage and limitations. Services must be deemed medically necessary and appropriate as defined in this chapter. The treatment services must be documented as defined in this chapter and substantiated that the services are medically necessary by a signature by a qualified provider working within the scope of their practice. Refer to MSM Section 2803.1D(3) in this chapter for more details on OPR requirements. A referral and signature do not constitute medical necessity. Refer to MSM Chapter 100 for the definition of medical necessity. Proper documentation is required to show the referral/recommendation for services.

As a method of protecting the integrity of the SHS Program, Medicaid will perform retro-review activities on claims data to evaluate medical necessity and billing procedures. Services that have been reimbursed but are shown not to have been documented in the POC and a progress note(s) of the student, as outlined in this chapter, may be subject to recoupment.

Refer to the DHCFP website for billable codes http://dhcfp.nv.gov/RatesUnit.htm. The SHS billing manual PT 60 can be found at our QIO-like vendor's website.

2. MISCELLANEOUS PROVISIONS

a. All payments for SHS are made to the LEA/SEA. Separate payment will not be made to those individual practitioners who rendered the services.

b. The LEA/SEA can submit claims for reimbursement on a monthly basis maintaining adherence to Medicaid's timely filing requirements. Refer to MSM, Chapter 100, Eligibility, Coverage and Limitations.

2803.2 PROVIDER QUALIFICATIONS

In order to be reimbursed by Nevada Medicaid, all SHS must be provided by a qualified health care provider working within their scope of practice under state and federal regulations.

It is the responsibility of the LEA/SEA to assure all billed Medicaid covered services are rendered by the appropriately credentialed providers. Each LEA/SEA must maintain documentation of each rendering practitioner's license, certifications, registration, or credentials to practice in Nevada. All documentation must be available, if requested by state or federal agencies.

2803.2A PHYSICIAN, PHYSICIAN'S ASSISTANT & ADVANCED NURSE PRACTITIONER QUALIFICATIONS

Providers must meet qualifications as detailed in at least one of the following NRS Chapters:

1. NRS Chapter 630 Physicians and Physician Assistants and Practitioners of Respiratory Care, or

2. NRS Chapter 633 Osteopathic Medicine, or

3. NRS Chapter 632 Nursing as an advanced practice registered nurse as detailed in NRS 632.140 through 632.240.

2803.2B MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES QUALIFICATIONS

Providers must meet qualifications as detailed in MSM Chapter 400.

2803.2C NURSING QUALIFICATIONS

Providers must meet qualifications as detailed in NRS Chapter 632 Nursing.

2803.2D PHYSICAL THERAPY QUALIFICATIONS

Providers must meet qualifications as detailed in NRS Chapter 640 Physical Therapy.

2803.2E OCCUPATIONAL THERAPY QUALIFICATIONS

Providers must meet qualifications as detailed in NRS Chapter 640A Occupational Therapy.

2803.2F SPEECH THERAPY AND AUDIOLOGY QUALIFICATIONS

Providers must meet qualifications as detailed in NRS Chapter 637B Audiologists and Speech Pathologist.

2803.2G PCS QUALIFICATIONS

1. PCS Supervisor must meet the following documented minimum qualifications:

   a. Is at least 18 years of age;

   b. Has a high school diploma or its equivalent;

   c. Is responsible and mature and exhibits empathy, listening skills, and other personal qualities which will enable the PCS Supervisor to understand the problems of persons with disabilities;

   d. Has demonstrated the ability to read, write, speak, and understand the English language; and

   e. Meets all qualifications of a Personal Care Assistant (PCA) as detailed below.

2. The PCS Supervisor shall oversee the daily operations of the PCS being delivered in the

school. The PCS Supervisor shall appoint another qualified employee to assume the responsibilities of the PCS Supervisor in the case of their absence. The responsibilities of the PCS Supervisor include, without limitation:

a. Ensuring that all PCAs under their supervision are qualified and properly trained;

b. Ensuring that the initial SFASP of each student is completed and that the PCA to provide the PCS to the student is capable of providing the services necessary to meet those needs;

c. Providing oversight and direction for PCAs as necessary to ensuring that the students receive needed PCS, each PCA must receive at least one hour of direct supervision a year; and

d. Ensure that:

1. Students are not abused, neglected, or exploited by a PCA or another member of the staff of the LEA/SEA; and

2. Suspected cases of abuse, neglect, or exploitation of a student are reported in the manner prescribed in NRS 432B.220.

3. Personal Care Assistant (PCA) must meet the following documented minimum qualifications:

a. Be at least 18 years of age;

b. Maintain records and provide to the DHCFP, upon request, documentation that the PCA is in compliance with the tuberculosis (TB) testing requirements of NAC 441A.375.

c. Be responsible, mature, exhibit empathy, listening skills, and other personal qualities which will enable the PCA to understand the problems of persons with disabilities;

d. Demonstrate the ability to read, write, speak, and communicate effectively in the language of the student receiving the PCS.

e. Demonstrate the ability to meet the needs of the students of the LEA/SEA by having the ability and skills for all tasks listed in the SFASP; and

f. Within the 90 days immediately preceding the date on which the PCA begins providing the services to a student and at least annually thereafter, complete not less than eight hours of training related to providing for the needs of the students of

the LEA/SEA and limitation on the PCS provided by the LEA/SEA. The training must include, without limitation, training concerning:

1. Duties and responsibilities of PCA and the appropriate techniques for providing PCS including the written documentation of PCS provided;

2. Recognizing and responding to emergencies, including, without limitation, fires and medical emergencies;

3. Dealing with the adverse behaviors of the student;

4. Nutrition and hydration, including, without limitation, special diets and meal preparation and service;

5. Bowel and bladder care, including, without limitation, routine care associated with toileting, routine maintenance of an indwelling catheter drainage system such as emptying the bag and positioning of the system, routine care of colostomies such as emptying and changing the colostomy bag, signs and symptoms of urinary tract infections and common bowel problems, including without limitation, constipation and diarrhea;

6. Methods for preventing skin breakdown, contractures and falls;

7. Handwashing and infection control;

8. Basic body mechanics, mobility and techniques for transferring students;

9. The rights of the student and methods to protect the confidentiality of information concerning the student as required by federal and state law and regulations;

10. The special needs of persons with disabilities;

11. Maintenance of a clean and safe environment;

12. Recognizing the signs of child abuse and mandated reporting; and

13. First aid and cardiopulmonary resuscitation (CPR). A certificate in first aid and CPR issued to the PCA by the American Red Cross or an equivalent certificate will be accepted as proof of that training.

14. Communication skills, including without limitation, active listening, problem solving, conflict resolution, and techniques for communicating through alternative modes with persons with communication or sensory

impairments.

g. PCAs must participate in and complete a training program before independently providing PCS to the students of the LEA/SEA. The training program must include an opportunity for the PCA to receive on-the-job instruction provided to students of the LEA/SEA, as long as the PCS Supervisor provides supervision during this instruction to determine whether the PCA is able to provide the PCS successfully and independently to the student.

4. Each PCA at a LEA/SEA must be evaluated and determined to be competent by the LEA/SEA in the required areas of training set forth in MSM Section 2803.2G of this chapter.

5. Each PCA at a LEA/SEA must have evidence of successful completion of a training program that includes the areas of training set forth in MSM Section 2803.2G of this chapter within 90 days immediately preceding the date on which the PCA begins providing PCS to a student.

2803.2H APPLIED BEHAVIOR ANALYSIS (ABA) QUALIFICATIONS

Providers must meet qualifications as detailed in MSM Chapter 3700.

2803.2I DENTAL QUALIFICATIONS

Any dental provider, who undertakes dental treatment, as covered by Nevada Medicaid, must be qualified by training and experience in accordance with the Nevada State Board of Dental Examiners rules and regulations.

All materials and therapeutic agents used or prescribed must meet the minimum specifications of the American Dental Association (ADA).

2803.2J OPTOMETRY QUALIFICATIONS

Providers must meet qualifications as set forth by one of the following and be working within their scope of practice;

1. NRS Chapter 630.375 – Physicians,

2. NRS Chapter 636 – Optometry, or

3. NRS Chapter 637 – Dispensing Opticians.

2803.2K CASE MANAGEMENT QUALIFICATIONS

Providers must meet qualifications as detailed in MSM Chapter 2500.

2803.2L TELEHEALTH QUALIFICATIONS

Services provided via telehealth must be clinically appropriate and within the health care professional's scope of practice as established by its licensing agency.

2803.3 SCREENING AND DIAGNOSTIC SERVICES

Screening and diagnostic services refers to health care that focuses on disease (or injury) prevention. Screening and diagnostic services also assists the provider in identifying a patient's current or possible future health care risks through assessments, lab work, and other diagnostic studies.

LEAs/SEAs are encouraged to provide screening and diagnostic services as defined in MSM Chapter 1500 – Healthy Kids Program.

A child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated. Assessment of a child's health at regularly scheduled intervals assures that a condition, illness, or injury is not developing or present.

2803.3A COVERAGE AND LIMITATIONS

Screening and diagnostic services can be covered without a POC as long as they:

1. Follow the periodicity schedule as established in MSM, Chapter 1500 – Healthy Kids Program;

2. Are determined to be a medically necessary screening when it falls outside the periodicity schedule; and

3. Are documented in medical records with the assessments and significant positive and negative findings, and referrals made for diagnosis, treatment or other medically necessary health services for any conditions that were identified.

2803.3B COVERED SERVICES

1. American Academy of Pediatrics (AAP) recommended screenings and diagnostics as

detailed in MSM Chapter 1500 – Healthy Kids Program.

2. Dental services are outline in MSM Chapter 1000 – Dental. Dental services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition.

3. Vision services are outlined in MSM Chapter 1100 – Ocular Services. Vision services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition.

4. Hearing services are outlined in MSM Chapter 2000 – Audiology. Hearing services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition.

5. Vaccinations are outlined in MSM Chapter 1500 – Healthy Kids Program. Nevada Medicaid will reimburse for appropriate immunizations that are due and administered during the screening visit and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html. Nevada Medicaid will only reimburse for administration fees if the vaccination is available through the DPBH as part of the Vaccines for Children (VFC) Program.

6. Laboratory procedures are outlined in MSM Chapter 800 – Laboratory Services. Nevada Medicaid will reimburse for age-appropriate laboratory procedures performed at intervals in accordance with the Healthy Kids periodicity schedule. These include blood lead level assessment appropriate to age and risk, urinalysis, Tuberculin Skin Test (TST), Sickle-cell, hemoglobin or hematocrit and other tests and procedures that are age-appropriate and medically necessary.

7. Interperiodic Screenings – Healthy Kids screenings are provided to all eligible persons under the age of 21, which may include medically necessary intervals that are outside an established periodicity schedule, also known as interperiodic screenings.

2803.3C LIMITATIONS

Refer to MSM Chapter 1500 – Healthy Kids Program for limitations.

2803.4 PHYSICIAN, PHYSICIAN'S ASSISTANT & ADVANCED NURSE PRACTITIONER SERVICES

Nevada Medicaid reimburses for covered medical services that are reasonable and medically necessary, performed by a physician, APRN or under the personal supervision of a physician and that are within the scope of practice as defined by Nevada State Law. Services must be performed by the physician, APRN or by a licensed professional working under the personal supervision of the physician.

2803.4A COVERED SERVICES

Physician and APRN services may include, but are not limited to:

1. Evaluation and consultations with providers of covered services for diagnostic and preventive services including participation in a multi-disciplinary team assessment;

2. Record review for diagnostic and prescriptive services;

3. Diagnostic and evaluation services to determine a student's medically related condition that results in the student's need for medical services;

4. New and established patient visits as described in MSM Chapter 600 – Physician Services; and

~~4.~~5. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time of POC development for educational processes and goals.

2803.4B LIMITATIONS

Refer to MSM Chapter 600 – Physician Services for limitations.

2803.5 MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

Nevada Medicaid reimburses LEAs/SEAs for community-based mental health services to students under a combination of mental health rehabilitation and medical/clinical authority. The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under Nevada State law for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functioning level.

Mental health rehabilitation assists individuals to develop, enhance and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as

independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically possible.

Alcohol and substance abuse treatment and services are aimed to achieve the mental and physical restoration of alcohol and drug abusers. Medicaid only reimburses LEAs/SEAs for services delivered in an outpatient setting and they must constitute a medical-model service delivery system.

Nevada Medicaid's philosophy assumes that behavioral health services shall be person-centered and/or family driven. All services shall be culturally competent, community supportive, and strength based. The services shall address multiple domains, be in the least restrictive environment, and involve family members, caregivers, and informal supports when considered appropriate per the recipient or legal guardian. Service providers shall collaborate and facilitate full participation from team members including the individual and their family to address the quality and progress of the individualized care plan and tailor services to meet the recipient's need.

2803.5A COVERED SERVICES

The following services are covered when provided as described in MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services:

1. Mental Health Assessments;
2. Neuro-Cognitive, Psychological and Mental Status Testing;
3. Mental Health Therapies;
4. Medication Management;
5. Medication Training and Support;
6. Rehabilitative Mental Health Services;
7. Outpatient Alcohol and Substance Abuse Services; and
8. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time of development for educational processes and goals.

2803.5B LIMITATIONS

1. Mental Health and Alcohol/Substance Abuse Services not listed above in covered services.
2. All limitations listed in MSM Chapter 400 for the related services.

2803.6 NURSING SERVICES

Skilled nursing refers to assessments, judgments, interventions, and evaluation of interventions which require the education, training and experience of a licensed nurse to complete. Services must be based on an assessment and supporting documentation that describes the complexity and intensity of the student's care and the frequency of skilled nursing interventions.

All nursing services must be under the order and direction of a physician or APRN. Skilled nursing services are a covered service when provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the supervision of an RN in accordance with the POC. An LPN may participate in the implementation of the POC for providing care to students under the supervision of a licensed RN, physician or APRN that meet the federal requirements of 42 CFR 440.166. Nursing services are provided to an individual on a direct, one-to-one basis, on site within the school setting.

2803.6A COVERED SERVICES

Nursing services are provided by a licensed RN, or an LPN under the supervision of an RN, or a CNA under the direction and supervision of an RN. RNs, LPNs and CNAs must be licensed by the Nevada State Board of Nursing and acting within their scope of practice. These services may include, but are not limited to:

1. Evaluations and assessments (RN only);
2. Care and maintenance of tracheotomies;
3. Catheterization or catheter care;
4. Oral or tracheal suctioning;
5. Oxygen administration;
6. Prescription medication administration that is part of the POC;
7. Tube feedings;
8. Ventilator Care; or
9. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time of POC development for educational processes and goals. (RN only)

2803.6B LIMITATIONS

1. Nursing services must be provided within the scope of work for the level of licensure of the nurse providing the service(s).

2. Service(s) provided without an OPR from a qualified health professional working within their scope of practice are not eligible for reimbursement.

3. Services not listed on the individual's POC other than services for screening and diagnostics are not eligible for reimbursement.

2803.7 PHYSICAL THERAPY SERVICES

Physical Therapy Services are performed by an appropriately certified or licensed physical therapist who develops a written individual program of treatment. Licensed physical therapist assistants functioning under the supervision of the licensed physical therapist may assist in the delivery of the POC.

Physical Therapy means services prescribed by a physician or other licensed practitioner of the healing arts operating within their scope of practice under Nevada State law and provided to a student by or under the direction of a qualified physical therapist to ameliorate or improve neuromuscular, musculoskeletal and cardiopulmonary disabilities.

Physical therapy evaluation, and treatment includes: assessing, preventing, or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the student receiving treatment.

2803.7A COVERED SERVICES:

1. Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments effecting areas such as tone, coordination, movement, strength and balance;

2. Individual Therapy provided to a student in order to correct or ameliorate the effects of motor delays, disabilities and/or physical impairments;

3. Group Therapy provided to more than one student, but less than seven, simultaneously in order to remediate correct or ameliorate the effects of motor delays, disabilities, and/or physical impairments;

4. Therapeutic exercise, application of heat, cold, water, air, sound, massage, and electricity;

5. Measurements of strength, balance, endurance, range of motion (ROM); and

6. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time POC development for educational processes and goals.

2803.7B LIMITATIONS

Refer to MSM Chapter 1700 – Therapy for limitations.

2803.8 OCCUPATIONAL THERAPY SERVICES

Occupational Therapy is provided by an appropriately licensed occupational therapist who evaluates the student's level of functioning and develops a KPOC. Licensed occupational therapist assistants functioning under the general supervision of the licensed occupational therapist may assist in the delivery of the POC.

Occupational Therapy evaluation and treatment includes: assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation; improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; obtaining and interpreting information; coordinating care and integrating services the student is receiving.

2803.8A COVERED SERVICES

1. Evaluation and diagnosis to determine the extent of a student's disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;

2. Individual Therapy provided to a student to remediate and/or adapt skills necessary to promote the student's ability to function independently;

3. Group Therapy provided to more than one student but less than seven simultaneously to correct or ameliorate and/or adapt skills necessary to promote the students' ability to function independently;

4. Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits;

5. Exercise to enhance functional performance;

6. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time of POC development for educational processes and goals.

2803.8B LIMITATIONS

Refer to MSM Chapter 1700 – Therapy for limitations.

2803.9 SPEECH THERAPY AND AUDIOLOGY SERVICES

Speech, hearing, and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication or the condition of the student must be such that the services required can be safely and effectively performed only by a qualified therapist.

The practice of audiology consists of rendering services for the measurement, testing, appraisal prediction, consultation, counseling, research, or treatment of hearing impairment for the purpose of modifying disorders in communication involving speech, language, and hearing. Audiology services must be performed by a certified and licensed audiologist.

2803.9A COVERED SERVICES

1. Speech and Language evaluation and diagnosis of delays and/or disabilities including, but not limited to, voice, communication, fluency, articulation or language development. Audiological evaluation and diagnosis to determine the presence and extent of hearing impairments that affect the student's educational performance. Audiological evaluations include complete hearing and/or hearing aid evaluation, hearing aid fittings or re-evaluations, and audiograms.

2. Individual Therapy provided to a student in order to correct or ameliorate delays and/or disabilities associated with speech, language, hearing, or communication.

3. Group Therapy provided to one student, but less than seven, simultaneously in order to correct or ameliorate delays and/or disabilities associated with speech, language, hearing, or communication.

4. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time of POC development for educational processes and goals.

2803.9B LIMITATION

Refer to MSM Chapter 1700 – Therapy for limitations.

2803.10 AUDIOLOGICAL SUPPLIES, EQUIPMENT, MEDICAL SUPPLIES AND OTHER DURABLE MEDICAL EQUIPMENT (DME)

The LEA/SEA, as a Medicaid SHS PT 60, may be reimbursed for medically necessary audiology supplies, equipment, and medical supplies when shown to be appropriate to increase, or improve the functional capabilities of individuals with disabilities. Refer to the DHCFP website for list of available Healthcare Common Procedure Coding System (HCPCS) codes: SHS PT 60: Fee Schedule http://dhcfp.nv.gov/RatesUnit.htm.

Such services must be reviewed and recommended by the presence of a signature on either the POC or a prescription by a licensed physician, APRN, or PA providing services within the scope of medicine as defined by Nevada State Law and provided through the POC.

2803.10A COVERED SERVICES

1. Disposable medical supplies are items purchased for use at school or home which are not durable or reusable, such as surgical dressings, disposable syringes, catheters, tracheotomy dressings, urinary tray, etc. SHS PT 60 may dispense audiological supplies, equipment, and medical supplies by their qualified practitioners acting within the scope of their practice under Nevada State Law.

2. DME is considered items such as ACDs (e.g. Speech Generating Devices), wheelchairs, canes, standers, walkers, etc. Medicaid DME Providers are qualified to dispense and receive reimbursement for medically necessary DME, prosthetic, orthotics, and supplies. Some services may require prior authorization.

3. DME, ACDs, audiology supplies, equipment, and medical supplies are for the exclusive use of the student that can be used at school, at home and is the property of the student.

Refer to MSM Chapter 1300 – DME, Disposable Supplies and Supplements for coverage and limitations on DME, prostheses, and disposable medical supplies.

Refer to MSM Chapter 2000 – Audiology Services for coverage and limitations on audiological supplies and equipment.

2803.10B LIMITATIONS

Refer to MSM Chapter 1300 – DME, Disposable Supplies and Supplements; and MSM Chapter 2000 – Audiology Services for limitations.

2803.11 PERSONAL CARE SERVICES (PCS) IN SCHOOL SETTING

PCS include a range of human assistance provided to a student with disabilities and/or chronic conditions, which enables accomplishment of tasks that they would normally do for themselves if

they did not have a disability and/or chronic condition. These services are provided where appropriate, medically necessary, and within service limitations.

Assistance may be in the form of direct hands-on assistance or cueing the student to perform the task themselves and related to the performance of ADLs and IADLs. Services are based on the needs of the student being served, as determined by a SFASP approved by the DHCFP. All services must be performed in accordance with the approved POC. LRIs may not be reimbursed for providing PCS.

2803.11A COVERED SERVICES

1. Assistance with the following ADLs. Services must be directed to the individual student and related to their health and welfare.

    a. Dressing.

    b. Toileting needs including but not limited to routine care of an incontinent student.

    c. Transferring and positioning non-ambulatory student from one stationary position to another, assisting a student out of chair or wheelchair, including adjusting/changing student's position in a chair or wheelchair.

    d. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the student to walk with support of a walker, cane or crutches, or assisting a student to stand up or get his/her wheelchair to begin ambulating.

    e. Eating, including cutting up food. Specialized feeding techniques may not be used.

2. Assistance with the following IADLs is a covered service. Services must be directed to the individual student and related to their health and welfare.

    a. Meal preparation, which includes storing, preparing, and serving food.

2803.11B SERVICE LIMITATIONS

Assistance with the IADLs may only be provided in conjunction with services for ADLs.

2803.11C NON-COVERED SERVICES

Duplicative services are not considered medically necessary and will not be covered by Nevada Medicaid. PCS services must be one-on-one with the PCA and individual student receiving the service. PCAs may not overlap times between students being provided services.

The following are not covered under PCS and are not reimbursable:

1. Instruction, tutoring or guidance in academics.

2. A task that the DHCFP or its designee determines could reasonably be performed by the student.

3. Services normally provided by an LRI.

4. Any tasks not included in the student's approved POC.

5. Services to maintain an entire classroom, such as cleaning areas of the room not used solely by the student.

6. Services provided to someone other than the intended student.

7. Skilled care services requiring the technical or professional skill that State Statute or regulation mandates must be performed by a health care professional licensed or certified by the State of Nevada. Services include, but are not limited to, the following:

    a. Insertion and sterile irrigation of catheters;

    b. Irrigation of a body cavity. This includes both sterile and non-sterile procedures such as ear irrigation, vaginal douches, and enemas;

    c. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;

    d. Administration of injections of fluids into veins, muscles, or skin;

    e. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions or the instillation of prescribed eye drops (as opposed to assisting with self-administered medications);

    f. Physical assessments;

    g. Monitoring vital signs;

    h. Specialized feeding techniques;

    i. Rectal digital stimulation;

    j. Massage;

k. Specialized ROM;

l. Toenail cutting;

m. Medical case management, such as accompanying a student to a physician's office for the purpose of providing or receiving medical information;

n. Any task identified with the Nurse Practice Act as requiring skilled nursing including Certified Nursing Assistant (CNA) services.

8. Companion care, baby-sitting, supervision or social visitation.

9. Care of pets except in cases where the animal is a certified service animal.

10. A task the DHCFP determines is within the scope of services provided to the student as part of an assisted living contract, a supported living arrangement contract, or a foster care agreement.

11. Escort services for social, recreational, or leisure activities.

12. Transportation of the student by the PCA.

13. Any other service not listed under Covered Services in MSM Section 2803.11A of this chapter.

2803.11D AUTHORIZATION PROCESS

A SFASP must be completed prior to the service date of any billable PCS. The SFASP must be completed in person with the student present by a physician, APRN, PA, or trained physical or occupational therapist working within their scope of practice. The SFASP should be added as part of the student's POC.

Students receiving PCS services must be reassessed with a SFASP at least annually. Annual reassessments must be completed in person with the student present by a physician, APRN, PA, or a trained physical or occupational therapist working within their scope of practice.

Significant change in condition or circumstance may cause a need to reassess a student. All reassessments should be completed in person with the student present by a physician, APRN, PA, or a trained physical or occupational therapist working within their scope of practice.

2803.11E FLEXIBILITY OF SERVICES DELIVERY

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the

student, as long as the plan does not alter medical necessity. Any changes that do not increase the total authorized hours can be made, for the student's convenience, within a single week without an additional SFASP.

Backup Mechanism

The provider shall have a written backup mechanism to provide a student with his or her service hours in the absence of a regular PCA due to sickness, vacation or any unscheduled event. The covering individual must be qualified to provide PCS services as outlined in MSM, Section 2803.2G of this chapter.

2803.11F SUPERVISION

PCAs providing PCS to students must have a supervisor available to them during their work hours. Each time a PCA providing PCS to students is assigned to a new student the supervisor must review the SFASP and the student's POC. The supervisor must then clarify the following items with the PCA providing PCS to that student:

1. The needs of the student and tasks to be provided;

2. Any student specific procedures including those which may require on-site orientation;

3. Situations in which the PCA should notify the supervisor.

The supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA providing the PCS.

2803.11G RECORDS

The LEA/SEA must maintain all records relating to PCS provided. The LEA/SEA must retain records for a period pursuant to the State record retention policy, which is currently six years from the date of payment for the specified service.

If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims, or audit findings have been finally determined.

1. The LEA/SEA must maintain all required records for each individual employed to provide PCS regardless of the length of employment.

2. The LEA/SEA must maintain the required record for each student who has been provided services, regardless of the length of the service period.

At a minimum, the LEA/SEA must document the following on all service records:

1. Consistent service delivery within program requirements;

2. Amount of services provided to students;

3. When services were delivered;

4. Documentation attesting to the services provided, and the time spent providing the service signed or initialed by the PCA.

2803.12 APPLIED BEHAVIOR ANALYSIS (ABA)

Medicaid will reimburse for ABA services rendered to Medicaid eligible individuals under the age of 21 years old in accordance with EPSDT coverage authority. The behavior intervention must be medically necessary as defined in MSM Chapter 100, to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of ASD, FASD, or other condition for which ABA is recognized as medically necessary. It must be rendered according to the written orders of the Physician, PA, or an APRN. The treatment regimen must be designed and signed off on by the qualified ABA provider as defined in MSM Chapter 3700 – Applied Behavior Analysis.

All services must be documented as medically necessary and appropriate and must be prescribed on a POC.

2803.12A COVERED SERVICES

Covered services are detailed in MSM Chapter 3700. Covered services include the following services when delivered as detailed in MSM Chapter 3700:

1. Behavioral Screening;

2. Comprehensive Diagnostic Evaluation;

3. Behavioral Assessment;

4. Adaptive Behavioral Treatment Intervention; and

5. Adaptive Behavioral Family Treatment.

2803.12B LIMITATIONS

All limitations listed in MSM Chapter 3700 – Applied Behavior Analysis.

2803.13 DENTAL

Through the EPSDT benefits, individuals under the age of 21 receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention of oral disease, and maintenance of dental health. The EPSDT Program assures children receive the full range of necessary dental services.

The Nevada Medicaid Dental Services Program is designed to provide dental care under the supervision of a licensed provider. Dentist participating in Nevada Medicaid shall provide services in accordance with the rules and regulations of the Nevada Medicaid Dental Program detailed in MSM Chapter 1000 – Dental. Dental care provided in the Nevada Medicaid Program must meet prevailing professional standards for the community-at-large.

2803.13A COVERED SERVICES

Covered services include the following services when delivered as detailed in MSM, Chapter 1000 – Dental:

1. Diagnostic and preventive services;
2. Restorative dentistry services;
3. Endodontic services;
4. Periodontic services;
5. Adjunctive general services; and
6. Fluoride supplements.

2803.13B LIMITATIONS

1. Dental services not listed above in covered services.
2. All limitations listed in MSM Chapter 1000 – Dental.

2803.14 OPTOMETRY

The Nevada Medicaid Ocular Program reimburses for medically necessary ocular services to eligible Medicaid recipients.

2803.14A COVERED SERVICES

Covered services include the following services when delivered as detailed in MSM Chapter 1100 – Ocular Services:

1. Healthy Kids (EPSDT) vision screening;
2. Glasses;
3. Refractive examinations; and
4. Ocular examinations.

2803.14B LIMITATIONS

1. Ocular services not listed above in covered services
2. All limitations listed in MSM Chapter 1100 – Ocular Services.

2803.15 CASE MANAGEMENT

The intent of case management services is to assist eligible students in gaining access to needed medical, social, educational, and other support services including housing and transportation needs. Case management services do not include the direct delivery of medical, clinical, or other direct services. Components of the service include assessment, care planning, referral/linkage, and monitoring/follow-up.

2803.15A COVERED SERVICES

Case Management services are covered for the following target groups when delivered as detailed in MSM Chapter 2500 – Case Management:

1. Children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) as defined in MSM Chapter 2500, and
2. Adults with a Non-Serious Mental Illness (Non-SMI) as defined in MSM Chapter 2500.
3. Medical Team Conference participation time for the development of medical related services in the POC. Payment is excluded for participation time of POC development for educational processes and goals.

2803.15B LIMITATIONS

1. Case management services to target groups not listed above in covered services.

2. All limitations listed in MSM Chapter 2500 – Case Management.

2803.16 TELEHEALTH

Telehealth is the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other medical services. “Telehealth” is defined as the delivery of service from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.

Services provided via telehealth must be clinically appropriate and within the health care professional’s scope of practice as established by its licensing agency.

2803.16A COVERAGE AND LIMITATIONS

Must follow all policies in MSM Chapter 3400 – Telehealth Services.

2804 RESERVED FOR FUTURE USE

2805 HEARINGS

Please reference MSM Chapter 3100 – Hearings, for hearing procedures.

2806 REFERENCES AND CROSS REFERENCES

2806.1 PROVIDER SPECIFIC INFORMATION

Specific information about each PT can be found in the following MSM Chapters and NCU Manual Chapter:

Medicaid Services Manual (MSM):

Chapter 100	Medicaid Program
Chapter 400	Mental Health and Alcohol/Substance Abuse Services
Chapter 600	Physician Services
Chapter 1000	Dental
Chapter 1100	Ocular Services
Chapter 1300	DME, Disposable Supplies and Supplements
Chapter 1500	Healthy Kids Program
Chapter 1700	Therapy
Chapter 2000	Audiology Services
Chapter 2500	Case Management
Chapter 3100	Hearings
Chapter 3300	Program Integrity
Chapter 3400	Telehealth Services
Chapter 3600	Managed Care Organization
Chapter 3700	Applied Behavior Analysis

Nevada Check Up (NCU) Manual:

Chapter 1000	Nevada Check Up Program

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 28, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE *Casey Angres*
Casey Angres (Jun 29, 2022 16:09 PDT)

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2900 – FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2900 – Federally Qualified Health Centers (FQHCs) are being proposed. As a result of the passage of Assembly Bill 190 and Senate Bill 325 during the 81st (2021) Legislative Session, Licensed Pharmacist is being proposed as a new provider type (PT) under the encounter whose services include dispensing of self-administered hormonal contraceptives to any patient, and the prescribing, dispensing, and administration of drugs to prevent the acquisition of human immunodeficiency virus (HIV), as well, as perform certain HIV laboratory tests.

Allow Licensed Marriage and Family Therapists (LMFT) services as part of the behavioral health encounter rate.

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: The proposed change affects all Medicaid-enrolled providers delivering FQHC encounter type of services. Those PTs include but are not limited to: FQHCs (PT 17, specialty 181), Licensed Pharmacist (PT 91) and Licensed Marriage and Family Therapist (PT 14, specialty 306).

Financial Impact on Local Government:

Licensed Pharmacist: There is no anticipated fiscal impact known at this time.

LMFT: An estimated increase in annual aggregate expenditures for LMFT services:

SFY 2022: $93,433
SFY 2023: $852,960

These changes are effective July 1, 2022, pending Centers for Medicare and Medicaid Services (CMS) approval.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 10/22 MSM 2900 – Federally Qualified Health Centers	MTL 01/22; 07/22; 11/21 MSM 2900 – Federally Qualified Health Centers

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2901(B)	**Authority**	Added "NRS Chapter 639 – Pharmacists and Pharmacy" and "NRS 641A – Marriage and Family Therapist and Clinical Professional Counselors."
2903(D)(1)	**Policy**	Added "Licensed Marriage and Family Therapist (LMFT)" and "Licensed Pharmacist."
2903.1(A)(1)	**Coverage and Limitations**	Added "Licensed Pharmacist."
2903.1(B)(1)	**Coverage and Limitations**	Added "LMFT."

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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FEDERALLY QUALIFIED HEALTH CENTERS

2900 INTRODUCTION

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. FQHCs increase access to care, promote quality and cost-effective care, improve patient outcomes, and are uniquely positioned to spread the benefits of community-based care and patient-centered care.

Nevada Medicaid reimburses for medically necessary services provided at FQHCs and follows State and Federal laws pertaining to them.

2901 AUTHORITY

A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (CFR) Part 440, Subpart A – Definitions, Subpart B and Sections 1861, 1929(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Social Security Act (SSA) and Section 4161 of the Omnibus Budget Reconciliation Act of 1990. Physician's services are mandated as a condition of participation in the Medicaid Program Nevada Revised Statute (NRS) 630A.220.

B. The Nevada State Legislature sets forth scopes of practice for licensed professionals in the NRS for the following Specialists:

1. NRS Chapter 449 – Medical Facilities and Other Related Entities;
2. NRS Chapter 630 – Physicians, Physician Assistants, Medical Assistants, Perfusionists and Practitioners of Respiratory Care;
3. NRS Chapter 631 – Dentistry, Dental Hygiene and Dental Therapy;
4. NRS Chapter 632 – Nursing;
5. NRS Chapter 633 – Osteopathic Medicine;
6. NRS Chapter 635 –Podiatric Physicians and Podiatry Hygienists;
7. NRS Chapter 636 – Optometry;
8. NRS Chapter 637 – Dispensing Opticians;
9. NRS Chapter 639 – Pharmacists and Pharmacy;
10. NRS Chapter 640E –Dietitians;
11. NRS Chapter 641 – Psychologists;
12. NRS Chapter 641A- Marriage and Family Therapist and Clinical Professional Counselors;
13. NRS Chapter 641B – Social Workers;
14. NRS Chapter 652 – Medical Laboratories.

2902 RESERVED

2903 POLICY

A. The Division of Health Care Financing and Policy (DHCFP) reimburses FQHCs an outpatient encounter rate. DHCFP reimburses for medically necessary services provided at FQHCs.

B. Encounters must include preventive and/or primary health services and are categorized as:

1. Medical;

2. Mental/Behavioral Health; or

3. Dental.

C. FQHCs that have more than one Service Specific Prospective Payment Systems (SSPPS) rate established may bill for each reimbursable service type once per patient/per day.

1. An FQHC that has one established SSPPS encounter rate, only one reimbursable encounter may be billed per day.

2. An FQHC that has two established SSPPS encounter rates, the FQHC may bill up to two reimbursable encounters per patient per day.

3. An FQHC that has three established SSPPS encounter rates, the FQHC may bill up to three reimbursable encounters per patient per day.

4. For information about Rate Development, Prospective Payment Systems, SSPPS, Change in Scope of Services, and Supplemental Payments, please refer to the Nevada Medicaid State Plan, Attachment 4.19B.

D. For the purposes of reimbursement, an encounter is defined as:

A face-to-face "visit" or an "encounter" between a patient and one or more approved licensed Qualified Health Professional and/or certified provider that takes place on the same day with the same patient for the same service type; this includes multiple contacts with the same provider.

1. Licensed Qualified Health Professionals approved to furnish services included in the outpatient encounter are:

a. Physician or Osteopath;

b. Dentist;

c. Advanced Practice Registered Nurse (APRN);

d. Physician Assistant (PA);

e. Certified Registered Nurse Anesthetist (CRNA);

f. Nurse Midwife (NM);

g. Psychologist;

h. Licensed Clinical Social Worker (LCSW);

i. Registered Dental Hygienist (RDH);

j. Podiatrist;

k. Radiology;

l. Optometrist;

m. Optician;

n. Registered Dietitian (RD);

o. Clinical Laboratory Services;

p. Licensed Pharmacist; and

q. Licensed Marriage and Family Therapist.

2. Certified providers approved to furnish services included in the outpatient encounter are:

a. Community Health Workers (CHW).

b. Doulas.

2903.1 COVERAGE AND LIMITATIONS

A. Medical Encounter(s):

1. May be provided by an employed or contracted Physician or Osteopath, Advanced Practice Registered Nurse (APRN), Physician Assistant (PA), Nurse Midwife (NM), Certified Registered Nurse Anesthetist (CRNA), Podiatrist, Optometrist, Optician, Licensed Pharmacist, Community Health Worker (CHW), Doulas, or

Registered Dietitian (RD) under the FQHCs HRSA approved scope ofservices and the practitioners applicable state regulatory board's scope of practice. Encounters are to be billed as applicable with the FQHC encounter reimbursement methodology.

2. Services may include:

   a. Primary care services medical history, physical examination, assessment of health status, treatment of a variety of conditions amendable to medical management on an ambulatory basis by an approved provider and related supplies;

      1. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;

      2. Integral laboratory and radiology services conducted during the visits are included in the encounter as they are built into the established encounter rate and are not to be billed separately.

   b. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening policy and periodicity recommendations; Refer to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids.

   c. Preventive health services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and education Refer to MSM Chapter 600 – Physicians Services;

   d. Home visits;

   e. Family planning services including contraceptives;

      Up to two times a calendar year, the FQHC may bill for additional reimbursement for family planning education on the same date of service as the encounter. Refer to Billing Guide, Provider Type 17, Specialty 181 for more information.

   f. For women: annual preventive gynecological examination, clinical breast examination, thyroid function test, and maternity care services which includes antepartum, labor and delivery, and postpartum care services;

   g. Vision and hearing screening;

   h. CHW services as defined in MSM Chapter 600 – Physician Services.

   i. Doula services as defined in MSM Chapter 600 – Physician Services.

B. Behavioral/Mental Health Encounter(s):

1. May be provided by employed or contracted Psychiatrist, Psychologist, APRN, PA, LMFT, or LCSW who is authorized to provide mental/behavioral health services by the FQHC under the FQHC's HRSA approved scope of services and the practitioner'sapplicable state regulatory board's scope of practice.

2. Conditions may include behavioral/mental health, and/or substance use disorders including co-occurring disorders. Services may include:

   a. Screening, assessments, diagnosis, and/or treatment.

   b. Treatments may include clinically appropriate evidence-based practices suchas therapy, counseling, and medication management.

   c. Refer to MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services.

C. Dental Encounter(s):

1. Dental encounters are provided by employed or contracted Dentists or RDHs, under FQHCs HRSA approved scope of practices and the practitioner's applicable regulatory boards of practice. Encounters are to be billed as applicable with the FQHC encounter reimbursement methodology.

2. An FQHC may bill a dental encounter for each face-to-face encounter for dental services.

3. Dentures provided by an FQHC are included in the daily encounter rate unlike the denture policy established in MSM Chapter 1000 – Dental.

   a. Medicaid will pay for a maximum of one emergency denture reline and/or a maximum of six adjustments (dental encounters) done not more often than every six months, beginning six months after the date of partial/denture purchase. A prior authorization is not required for relines.

   b. Full denture/partial relines and adjustments required within the first six months are considered prepaid with the Medicaid's dental encounter payment for the prosthetic.

4. The FQHCs in-office records must substantially document the medical need.

5. Refer to MSM Chapter 1000 for all other covered and non-covered dental services.

D. Telehealth

1. An FQHC may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e. consult with specialist). If, for example, the originating site and distant site are two different encounter sites, the originating encounter site must bill the telehealth originating Healthcare Common Procedural Coding System (HCPCS) code and the distant encounter site may bill the encounter code. Refer to MSM Chapter 3400 – Telehealth Services

2903.2 NON-COVERED SERVICES

A. Non-covered services under an FQHC encounter:

1. Group therapy;

2. Eyeglasses;

3. Hearing aids;

4. Durable medical equipment, prosthetic, orthotics and supplies; and

5. Ambulance services.

2903.3 FQHC PHARMACIES

A. FQHC pharmacies who want to bill Medicaid for vaccines administered by pharmacists must do so through point of sale as a Provider Type 28. Refer to MSM Chapter 1200 – Prescribed Drugs.

2903.4 ANCILLARY SERVICES

A. Ancillary services are those services which are an approved Nevada Medicaid State Plan service but are not included within an approved FQHC encounter.

1. Ancillary services may be reimbursed on the same date of service as an encounter by a licensed Qualified Health Professional.

2. The FQHC must enroll within the appropriate provider type and meet all the MSM coverage guidelines for the specific ancillary service.

3. Partial Hospitalization Program (PHP) – As an extension of an FQHC's delivery model, an FQHC may have administrative oversight through a contractual agreement with an organization that provides outpatient PHP services and meets the criteria of a Certified Mental Health Clinic (CMHC). PHP services include a variety of psychiatric treatment modalities designed for recipients with chronic mental illness and/or substance abuse related disorders that require collaborative,

intensive assistance normally found in an inpatient setting. Refer to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services for PHP policy.

2903.5 FQHCs DUALLY ENROLLED AS A CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTER (CCBHC)

A. FQHCs dually enrolled as a CCBHC should determine the appropriate model to bill medically appropriate rendered services. The FQHC and the CCBHC must have internal policies regarding the appropriate placement for treatment for their respective recipients. Medical necessity and clinical appropriateness as determined by the clinical professionals, under care coordination, are required and should be taken into consideration when services overlap both within the FQHC and/or the CCBHC scope of services. This is to determine which encounter (FQHC or CCBHC) is appropriate to request reimbursement. Care coordination is required to prevent duplicative billing for the same service occurring at the same time.

B. Services that are covered under the CCBHC model are identified on the services grid located in the CCBHC billing guide. Recipients that are accessing services that are primarily CCBHC and not an exclusively FQHC service will bill the CCBHC PPS rate. Services that are primarily FQHC specific and not exclusively CCBHC services will bill the FQHC encounter rate.

C. Refer to the MSM Chapter 2700 – Certified Community Behavioral Health Center, and Billing Guide (Provider Type 17, Specialty 188), for guidance related to CCBHC policy and billing.

D. The Medicaid Surveillance and Utilization Review (SUR) unit will monitor in a retrospective review for any duplication of billing between the two delivery models.

2903.6 MEDICAL NECESSITY

A. To receive reimbursement, all services provided must be medically necessary as defined in MSM Chapter 100 – Medicaid Program.

2903.7 PRIOR AUTHORIZATIONS

A. FQHC encounters do not require prior authorizations (PAs). PA requirements indicated in reference to MSM Chapters do not apply when the service is performed as an FQHC encounter. However, the patient file must contain documentation supporting medical necessity of services provided.

B. FQHCs not contracted with a Managed care Organization (MCO), must follow the MCOs prior authorization policy.

C. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific services provided.

For billing instructions for FQHCs, please refer to the Billing Guide for Provider Type 17, Specialty 181.

For Indian Health Programs (IHP) policy, including Tribal FQHCs please refer to MSM Chapter 3000, Indian Health.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 24, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR /Cody L. Phinney/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES CHAPTER 3000 – INDIAN HEALTH

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3000, Section 3003.1 – Health Services are being proposed to allow the opportunity for Tribal or Tribal Organization outpatient health clinics to enroll as Federally Qualified Health Centers (FQHCs). This service model will promote greater access to specialty and related services outside of the four walls of the tribal clinics for Medicaid eligible American Indian/Alaska Native (AI/AN) recipients.

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: Federal, State and Tribal Governmental Agencies.

Financial Impact on Local Government: Unknown at this time.

These changes are effective March 25, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 12/20 MSM Ch 3000 – Indian Health	MTL 22/14 MSM Ch 3000 – Indian Health

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3003.1	**Health Services**	To include new policy for tribal organizations selecting to be recognized as Tribal FQHCs.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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INDIAN HEALTH PROGRAM

3000 INTRODUCTION

Medically necessary (as defined in Medicaid Services Manual (MSM) Chapter 100 (Medicaid Program) services are reimbursable when the services are provided by an Indian Health Program to an eligible American Indian or Alaskan Native (AI/AN) Medicaid or Nevada Check Up recipient. Indian Health Programs may be operated by the Indian Health Service (IHS), Tribal Organization, or an Urban Indian Organization – (I/T/U).

Numerous public laws guide federal and state interactions with tribal governments and AI/ANs. A basic understanding of these laws is essential to help facilitate the collaborative relationship between the Division of Health Care Financing and Policy (DHCFP) and the tribes within the State of Nevada. Below is a brief summation of these laws.

WORCESTER V. GEORGIA (1832): The Supreme Court of the United States held that the federal government, and not state governments, had exclusive "authority over American Indian Affairs".

GENERAL ALLOTMENT ACT OF 1877

The Act authorized the President of the United States to partial reservation lands into general allotments. Federal trust land owned or possessed by an AI/AN may be exempt from Medicaid estate recovery.

SNYDER ACT OF 1921

The Act made the federal government responsible for the health care of AI/ANs.

INDIAN CITIZENSHIP ACT OF 1924

The Act granted AI/ANs dual citizenship.

INDIAN REORGANIZATION ACT OF 1934

The Act reversed the General Allotment Act. The Act reinstated self-governance and returned tribal lands to respective tribal governments.

INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT OF 1975

Prior to this Act, the federal government managed, coordinated, and provided health care services for AI/ANs. The Act authorized tribal governments to establish contracts and compacts with the federal government. In general, tribal governments may plan, conduct and administer their own public programs – to include Indian Health Programs.

INDIAN HEALTH CARE IMPROVEMENT ACT OF 1976

The Act authorized 100% federal reimbursement to states for medical services provided to AI/ANs when provided through the Indian Health Service (IHS) and/or tribal organizations.

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

The Act established:

- Guidelines surrounding the enrollment of AI/ANs in Medicaid Managed Care Organizations (MCO);
- Prohibitions of state Medicaid agencies from charging AI/AN premiums and cost shares for services provided through Indian Health Programs or tribal organizations to AI/ANs;
- Protections of certain properties held by AI/AN from federal or state recovery; and
- Mandates that states seek ongoing advice from Indian Health Programs on issues that are likely to have a direct effect on Indian Health Programs.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Act reauthorized and made permanent the Indian Health Care Improvement Act.

3001 AUTHORITY

- Public Law (PL) 49-43: General Allotment Act of 1877
- PL 67-85: Snyder Act of 1921
- PL 68-175: Indian Citizenship Act of 1924
- PL 73-383: General Allotment Act of 1934
- PL 93-638: Indian Self-Determination and Education Act of 1975
- PL 94-437: Indian Health Care Improvement Act of 1976
- Social Security Act (SSA), Title XIX (Grants to States for Medical Assistance Programs), Chapter 1905 (Definitions), Section (b)
- SSA, Title XIX, Chapter 1911 (Indian Health Service Facilities)
- SSA, Title XIX, Chapter 1916A (State Option for Alternative Premiums and Cost Sharing)
- SSA, Title XIX, Chapter 1917 (Liens, Adjustments and Recoveries, and Transfers of Assets)
- SSA, Title XIX, Chapter 1932 (Provisions Relating to Managed Care)
- United States Code (USC), Title 25 (Indians), Chapter 14 (Miscellaneous), Subchapter II (Indian Self-Determination and Education Assistance)
- USC, Title 25 (Indians), Chapter 18 (Indian Health Care)
- Code of Federal Regulations, Title 42 (Public Health), Chapter IV (Centers for Medicare & Medicaid Services, Department of Health and Human Services), Section 431.110 (Participation by Indians Health Service Facilities)
- Johnson v. McIntosh (1823)
- Worcester v. Georgia (1832)
- United States v. Wheeler (1978)

3002 DEFINITIONS

A. American Indians and Alaskan Natives (AI/AN)

In accordance with 25 USC, Section 1602: "The term [eligible] Indians or Indian, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of Sections 1612 and 1613 of this title, such terms shall mean any individual who:

1. Irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member, or

2. Is an Eskimo or Aleut or other Alaska Native, or

3. Is considered by the Secretary of the Interior to be an Indian for any purpose, or

4. Is determined to be an Indian under regulations promulgated by the Secretary."

B. Children, Eligible

"Any individual who:

1. has not attained 19 years of age;

2. is the natural or adopted child, stepchild, foster child, legal ward or orphan of an eligible Indian; and

3. is not otherwise eligible for health services provided by the Indian Health Service (IHS), shall be eligible for all health services provided by IHS on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age."

C. Indian Descent, Eligible

Indian descendants may be eligible for Indian health services if:

1. They are verifiable descendants of an enrolled tribal member – as established by each tribe;

2. The recipient belongs to an Indian community which may be verified by tribal

record or census number; and

3. The recipient lives within the established contract health service delivery area.

D. Indian Health Programs

Indian Health Programs include the IHS, Tribal Organizations and Urban Indian Organizations (I/T/U):

1. Indian Health Service: IHS is a federal agency within the Department of Health and Human Services (DHHS).

2. Tribal Organizations: Tribal Organizations are operated by tribal governments.

3. Urban Indian Organizations: Urban Indian Organizations are nonprofit organizations.

E. Pregnant Woman, Non-Indian, Non-Spouse, Eligibility

During the period of her pregnancy through postpartum – a non-Indian, non-spouse pregnant woman with an eligible Indian child is eligible for tribal organization health services on the same basis and subject to the same rules that apply to eligible Indians.

F. Sovereignty, Trust Relationship

Federally recognized tribes are sovereign governments. They may establish their own governments, establish tribal membership guidelines and create and enforce their own laws.

G. Tribes, Federally Recognized

Any Indian tribe, band, nation, or other organized group or community, which the Federal government recognizes as eligible for programs and services provided by the United States to AI/AN.

3003 POLICY

It is the policy of the DHCFP to follow State and Federal laws, uphold the tribal-state consultation process, and promote Indian Health Programs (IHP).

3003.1 HEALTH SERVICES

A. The DHCFP reimburses Indian Health Services (IHS), Tribal organizations and Tribal Federally Qualified Health Centers (FQHCs) at an outpatient encounter rate.

1. Encounter visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan. Each healthcare professional is considered an independent (i.e., separate) outpatient encounter.

2. Service Limits: Eligible Indians may receive up to five face-to-face IHS and/or Tribal Organization outpatient encounter/visits per day, per recipient, any provider.

3. Medical Necessity: In order to receive reimbursement, all services must be medically necessary as defined in the Medicaid Services Manual (MSM), Chapter 100 – Medicaid Program.

4. Tribes or Tribal organizations that choose to be recognized as a Tribal FQHC may receive reimbursement for services furnished by an enrolled Medicaid non-IHS/Tribal provider to AI/AN Medicaid recipient's when requested by a Tribal FQHC provider (refer to CMS SHO #16-002). Covered services include those in the Medicaid State Plan.

a. The Tribal FQHC and the offsite non-IHS/Tribal provider must have a written agreement in place that designates that the non-IHS/Tribal provider is a contractual agent furnishing services as part of the Tribal FQHC.

b. The written agreement between the non-IHS/Tribal provider and the Tribal FQHC provider must include:

1. The Tribal FQHC provider makes a specific request for specific services to the non-IHS/Tribal provider;

2. The non-IHS/Tribal provider must send information about the recipients care to the Tribal FQHC;

3. The Tribal FQHC continues to assume responsibility for the recipient's care; and

4. The Tribal FQHC incorporates the recipient's information into their medical record.

c. Both the Tribal FQHC and non-IHS/Tribal provider must be enrolled in Nevada Medicaid.

d. There must be an established relationship between the recipient and the Tribal FQHC provider.

e. The following services are not eligible:

1. Services that are self-requested by the recipient.

2. Services in which the Tribal FQHC does not remain responsible for the recipient's care.

3. Services requested by a non-IHS/Tribal provider.

a. The provider could furnish and bill for services via their own Medicaid provider type but would not be eligible for reimbursement through the Tribal FQHC.

B. Primary Care Provider (PCP)

In accordance with the American Recovery and Reinvestment Act of 2009, the DHCFP supports eligible Indians in selecting an Indian Health Program as their PCP. These recipients may select an Indian Health Program as their PCP, whether they are enrolled in managed care or fee-for-service (FFS). Indian Health Programs that become PCPs for eligible Indians do not have to be, but may be, enrolled with either of the Managed Care Organizations (MCOs). Services which are referred out by PCPs must follow the service limitation and prior authorization requirements set forth by the applicable benefit plan (i.e., managed care or FFS).

C. Managed Care Enrollment

Eligible Indians are exempt from mandatory enrollment in managed care. In situations where Indians voluntarily enroll in managed care, they may access health care services from Indian Health Programs without restriction. Health care services provided to Indians through the IHS and/or tribal organizations may be reimbursed FFS or through the MCO.

D. Prior Authorizations

1. Medically necessary services provided by the IHS and/or Tribal Organizations do not require prior authorization when:

a. The service is provided to an eligible Indian; and

b. The service is provided through IHS or a Tribal Organization.

E. Program Funding

1. Premiums and Cost Sharing

a. Adults – Age 21 and older: Eligible Indians may not be charged premiums or cost shares when they receive medical services through an Indian Health Program.

b. Children – Age 20 and younger: Eligible Indian children may not be charged premiums or cost shares for covered Nevada Medicaid and/or Check Up services – regardless if the services are provided through an Indian Health Program, FFS providers or an MCO.

1. Federal Medical Assistance Percentage (FMAP)

The FMAP for services provided by the IHS or Tribal Organizations to eligible Indians is 100 percent. This percentage does not apply to non-emergency transportation services.

2. The FMAP for medical services provided by Urban Indian Organizations to eligible Indians is the established state percentage.

3. Rates

a. IHS and Tribal Organization Clinics – Provider Type 47 (PT 47): PT 47s are paid the federally established Outpatient Per Visit Rate (i.e., encounter rate). The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.

b. Tribal Organization Inpatient Hospitals – Provider Type 51 (PT 51): PT 51s are paid the federally established Inpatient Hospital Per Diem Rate. The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.

c. IHS Inpatient Hospitals – Provider Type 78 (PT 78): PT 78s are paid the federally established Inpatient Hospital Per

Diem Rate. The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.

F. Facility Licensure and Accreditation

1. IHS and Tribal Organizations:

a. Licensure: Facility licensure is not required.

b. Accreditation: In accordance with the Indian Health Care Improvement Act, to assure nondiscrimination, Indian Health Programs must follow the same provider enrollment criteria as other similar Medicaid provider types. The DHCFP does not require tribal clinics to be accredited.

G. Staff Licensure and Certification

Health care professionals do not have to be licensed in the State of Nevada if:

1. They provide services at an Indian Health Program; and

2. They are currently licensed in another state.

H. Transportation

1. Non-emergency transportation is not a covered IHS benefit. Indian Health Programs may enroll with the DHCFP's Non-Emergency Transportation (NET) broker (see MSM Chapter 1900).

2. Ambulance, Air or Ground – Provider Type 32: While emergency medical transportation is not a covered IHS benefit, qualified Indian Health Programs may enroll as a Provider Type 32 (see MSM Chapter 1900).

3003.2 TRIBAL GOVERNMENTS

A. Consultations

The DHCFP will consult with Tribes and Indian Health Programs on Medicaid State Plan Amendments (SPAs), waiver requests, waiver renewals, demonstration project proposals and/or on matters that relate to Medicaid and Nevada Check Up programs.

1. The notification will describe the purpose of the SPA, waiver request, waiver renewal, demonstration project proposal and/or on matters relating to Medicaid and

Nevada Check Up programs and will include the anticipated impact on Tribal members, Tribes and/or Indian Health Programs.

2. The notification will also describe a method for Tribes and/or Indian Health Programs to provide official written comments and questions within a time-frame that allows adequate time for State analysis, consideration of any issues that are raised and the time for discussion between the State and entities responding to the notification.

3. Tribes and Indian Health Programs will be provided a reasonable amount of time to respond to the notification. Whereof, 30 days is considered reasonable.

4. In all cases where Tribes and/or Indian Health Programs request in-person consultation meetings, the DHCFP will make these meetings available.

5. The tribe-state consultation process allows for an expedited process for notification of policy changes due to budget cuts prior to changes being implemented. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid SPAs, waiver requests and waiver renewals, which fall within this category to have a notification process prior to these documents being submitted to CMS. Due to this, the State is instituting an expedited process which allows for notification to the Tribes and Indian Health Programs of at least one week notice prior to the changes being implemented as agreed upon in the tribe-state consultation process or two weeks prior to the submission of the SPAs, waiver requests and/or waiver renewals, whichever date precedes.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 22, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3100 – HEARINGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3100 – Hearings, are being proposed for consistency with the federal policy language in the Code of Federal Regulations (CFR), Title 42, Chapter IV, 431 Subpart E. Language specifying the circumstances under which a provider can request an expedited fair hearing for a recipient is proposed.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: All provider types are affected by this regulation.

Financial Impact on Local Government: Unknown at this time.

These changes are effective February 23, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/18 Chapter 3100 - Hearings	MTL 20/17 Chapter 3100 - Hearings

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3104.1B.1	**Medicaid Services Expedited Fair Hearing**	Added the words "(only under circumstances described below)"and "Providers may file a request only in cases where the recipient is unable to act on their own behalf, either because of physical incapacity or mental incapacity. Additional documentation may be required to demonstrate the incapacity on a case by case basis."

DIVISION OF HEALTH CARE FINANCING AND POLICY

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HEARINGS

3100 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) (also referred to as the "agency") makes a Fair Hearing process available to any Nevada Medicaid or Nevada Check Up (NCU) recipient who disagrees with: any action resulting in the reduction, suspension, termination, denial or denial-in-part of a Medicaid service; any recipient who makes a request for a service and believes the request was not acted upon with reasonable promptness by the DHCFP and/or the health plan. Also, the DHCFP makes available a Fair Hearing process for any Nursing Facility (NF) resident eviction.

The DHCFP makes available a Fair Hearing process whereby providers may request a hearing for any adverse action taken by the Division or its agents which affects the provider's participation in the Medicaid program, and/or reimbursement for services rendered to eligible Medicaid recipients' recoupment of overpayments or disenrollment.

For purposes of this manual section, Medicaid and NCU are referred to as Medicaid. All Medicaid policies and requirements (such as prior authorization, etc.) are the same for NCU, with the exception of three areas where Medicaid and NCU policies differ as referenced in the NCU Manual, Section 1003.6.

3101 AUTHORITY

The Fair Hearing process for recipients is a mandated service. The citation denoting the right to a hearing is found in 42 Code of Federal Regulations (CFR), §431, Subpart E and 42 CFR 457.1130 and Nevada Revised Statute (NRS) 422.276. Please see CFR §431.244 for exceptions to the Hearing decision due dates. In addition, the citation denoting the appeals procedure for NF and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is found in 42 CFR §431, Subpart D.

The Fair Hearing process for providers is cited at NRS Chapter 422.306 – Hearing to review action taken against provider of services under state plan for Medicaid regulations; appeal of final decision.

3102 RESERVED

3103 POLICY

3103.1 The DHCFP provides the Fair Hearing process pursuant to Sections 3104 and 3105 of this Chapter of the Medicaid Services Manual (MSM).

3104 RECIPIENT FAIR HEARINGS

3104.1 FAIR HEARINGS

3104.1A MEDICAID SERVICES STANDARD FAIR HEARING

1. WHO MAY REQUEST

A recipient or his authorized representative may request a Standard Fair Hearing. A request for a Fair Hearing can be submitted via the internet, telephonically, in person, through other commonly available electronic means and in writing and signed by the recipient or the recipient's authorized representative.

2. DATE OF REQUEST

The date of the request for a Standard Fair Hearing is the date the request is received by the DHCFP office. The request must be received by the DHCFP office within 90 calendar days from the Notice Date, unless a recipient can substantiate "good cause" for not doing so. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

The request for hearing must contain the recipient's name, address, telephone number and Medicaid number as well as the name, telephone number and address of the authorized representative, if applicable.

Recipients enrolled in a Managed Care Organization (MCO) must request a Fair Hearing no later than 120 days from the date on the MCO's Notice of Decision (NOD) (Action).

3. SUBJECT MATTER

The DHCFP must grant an opportunity for a hearing to:

a. a recipient who requests it because his request for services is denied, reduced, suspended or terminated;

b. a recipient who requests it because his request for services is not acted upon with reasonable promptness;

c. a recipient who requests it because he believes the agency or managed health plan has taken an action erroneously;

d. any resident of a nursing facility who believes the facility erroneously determined that he must be transferred or discharged;

e. any recipient who requests it because he believes the State has made an erroneous determination with regard to the Pre-admission Screening and Resident Review (PASRR) as outlined in Section 1917(e)(7) of the Social Security Act;

f. any recipient who is assigned (locked in) to using one pharmacy for all controlled substance prescriptions.

This includes an adverse determination that the recipient does not require specialized services as defined in 42 CFR §431.201, 431.206 and 431.220 as determined by a PASRR.

Pursuant to 42 CFR §483.204, the state will provide a system for a resident of a NF to appeal a notice from the NF of intent to discharge or transfer the resident. Upon receipt of the discharge notice, the resident may request a Fair Hearing via the internet, telephonically, in person, through other commonly available electronic means or by submitting the request to the DHCFP. The DHCFP will inform the Department of Administration of the residents request for a Fair Hearing. The DHCFP does not take an adverse action against the resident; rather the facility takes the action via the discharge. The DHCFP is not a party to the action.

3104.1B MEDICAID SERVICES EXPEDITED FAIR HEARING

1. WHO MAY REQUEST

A recipient, his/her authorized representative or a provider acting on a recipient's behalf (only under circumstances described below) may file for an Expedited Fair Hearing if the clinical documentation shows that the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function. The Expedited Fair Hearing request must be submitted with pertinent medical information that supports the reason for the urgent need of the expedited timeframe. Providers may file a request only in cases where the recipient is unable to act on their own behalf, either because of physical incapacity or mental incapacity. Additional documentation may be required to demonstrate the incapacity on a case by case basis. A request for an Expedited Fair Hearing can be made via the internet, telephonically, in person, through other commonly available electronic means and in writing.

2. DATE OF REQUEST

The date of the request for an Expedited Fair Hearing is the date the request is received by the DHCFP office.

The request for an Expedited Fair Hearing must contain the recipient's name, address, telephone number and Medicaid number, as well as the name, telephone number and address of the authorized representative and/or provider, if applicable, and must include all pertinent medical information that supports the reason for the urgent need of the expedited timeframe.

If the Expedited Hearing request is submitted without pertinent medical information, the Hearing request will be treated as a Standard Fair Hearing request (90-day decision). If the required documentation is submitted after the initial Expedited Hearing request is received, the timeframe for the Expedited Fair Hearing will begin the day the required pertinent medical documentation is received by the DHCFP.

3. SUBJECT MATTER

The DHCFP must grant an opportunity for an Expedited Fair Hearing to:

a. a recipient who requests it because his request for services is denied, reduced, suspended or terminated and the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function;

b. a recipient who requests it because his request for services is not acted upon with reasonable promptness and the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function;

c. a recipient who requests it because he believes the agency or managed health plan has taken an action erroneously and the time permitted for a Standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function; or

d. any resident of a NF who believes the facility erroneously determined that he must be transferred or discharged and the time permitted for a standard Fair Hearing could jeopardize the individual's life, health or ability to attain, maintain or regain maximum function;

This includes an adverse determination that the recipient does not require specialized services as defined in 42 CFR §431.201, 431.206 and 431.220 as determined by a PASRR.

Pursuant to 42 CFR §483.204, the state will provide a system for a resident of a NF to appeal a notice from the NF of intent to discharge or transfer the resident. Upon receipt of the discharge notice, the resident may request an Expedited Fair Hearing over the phone, electronically or in writing by submitting a letter to the DHCFP. The DHCFP will inform the Department of Administration of the resident's request for a Fair Hearing. The DHCFP does not take an adverse action against the resident; rather the facility takes the action via the discharge. The DHCFP is not a party to the action. A decision will be provided within seven working days from when the Hearing request was received.

4. EXCEPTIONS TO EXPEDITED FAIR HEARINGS

a. The agency cannot reach a decision because the recipient, authorized representative and/or provider request the delay.

b. The recipient, authorized representative and/or provider fails to take a required action such as submitting the required documentation.

c. If Medicaid services have been continued at unreduced levels per MSM Section 3104.4(C), the Expedited Fair Hearing process is not applicable and the Fair Hearing request will be treated as a Standard Fair Hearing request.

3104.2 DISPOSITION OF A FAIR HEARING REQUEST

A. DISMISSAL OF A HEARING REQUEST

A Fair Hearing request will be dismissed upon:

1. Withdrawal of a Hearing Request

A recipient may withdraw the request for a hearing at any time before a decision is rendered via phone, written submission or electronically. Notification of the request for withdrawal will be submitted to the Hearing Officer who will dismiss the hearing request. Written confirmation will be sent to the recipient regarding the withdrawal.

2. Abandonment of a Hearing Request

A hearing is considered abandoned and may be dismissed by the Hearing Officer when the recipient fails to appear for a scheduled hearing after having been properly notified. The recipient's request for hearing is considered abandoned unless they submit to the Hearing Officer substantiation for good cause for failing to appear. The Hearing Officer must receive the substantiation within 10 calendar days of the date of the scheduled hearing.

3. Agency Action

Medicaid may reverse its NOD at any time during the hearing process. If a Medicaid reversal occurs, a report shall be submitted by the person conducting the review detailing the reason(s) for the reversal if a Fair Hearing has been calendared. The report must be forwarded to the Hearing Officer within five business days following the reversal decision date or review date if a fair hearing has been scheduled. The Hearing Officer notifies the recipient the request for hearing is dismissed because Medicaid will not take action or has reversed the decision.

B. DENIAL OF A HEARING REQUEST

A hearing need not be granted when:

1. the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients;

2. the request is not received timely;

3. the agency and/or managed health plan has not taken any action affecting the recipient, or made an Adverse Determination, nor denied a request for services or failed to act upon the request within reasonable promptness;

4. a recipient is not Medicaid eligible, except for PASRR determinations; or

5. the primary insurance policy and access (including appeal/hearing process) has not been exhausted. As Medicaid is the payer of last resort, all remedies under other insurance must be exhausted.

3104.3 HEARING NOTIFICATION, SCHEDULING AND LOCATION

A. HEARING PREPARATION MEETING (HPM)

Within 10 calendar days of a request for a Standard Fair Hearing, the DHCFP Hearings Office shall contact the recipient to offer an HPM. The purpose is to provide the recipient an explanation of the action, which is the subject of the hearing request, and attempt to resolve the matter. Every effort is made to reconcile the disagreement without the necessity of a Fair Hearing. The right to a Fair Hearing is not affected by attendance at a HPM. The recipient may allow participation in the HPM by legal counsel, a friend or other spokesperson.

It is important the HPM be held at the earliest possible date, no later than 21 working days after receipt of a hearing request. Rescheduling of an HPM shall be kept to a maximum of two instances, assuring completion within 21 working days.

An HPM shall be conducted telephonically.

B. NOTICE OF A STANDARD FAIR HEARING

The Department of Administration Hearing Officer shall notify all parties by mail as to the time, date and place the hearing has been scheduled. Recipients are given at least 10 calendar days advance notice of the scheduled hearing unless the recipient specifically requests a hearing in a shorter period of time based on an emergency.

At the discretion of the Hearing Officer, a Fair Hearing may be postponed if requested by either party.

If the recipient requests a postponement, the number of days postponed will extend the decision due date by an equal number of days.

C. FAIR HEARINGS BY TELEPHONE

Either party may request the Fair Hearing be conducted telephonically. If a telephone hearing is held, the following procedures apply:

1. The recipient is advised at the time the hearing is scheduled that all other policies and procedures relative to hearings and program requirements still apply.

2. The Hearing Officer may request the DHCFP, the managed health plan and the recipient to provide copies of any evidence or exhibits to be presented during the hearing to the Hearing Officer and the other parties prior to a scheduled telephone hearing. This does not preclude additional information from being presented during the hearing, or if requested, after the close of the hearing.

3. All telephone hearings must be tape recorded by the Hearing Officer over the telephone. This recording is the official record.

All Expedited Fair Hearings are held telephonically due to time constraints.

3104.4 PROGRAM PARTICIPATION PENDING A HEARING DECISION

A. RECOVERY

If Medicaid services are continued until a decision is rendered, such cost of services are subject to recovery by the DHCFP if the agency's action is sustained or the hearing request is withdrawn by the recipient.

B. MAINTAINING MEDICAID SERVICES

If the agency mails the notice as required, and the recipient requests a hearing before the Date of Action, the DHCFP or managed health plan will not terminate or reduce services until a decision is rendered after the hearing unless:

1. the Hearing Officer makes a determination the sole issue is one of Federal or State law or policy and the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision; or

2. the recipient requests in writing that benefits not be continued pending a hearing decision; or

3. the request for hearing is denied or dismissed.

C. REINSTATING MEDICAID SERVICES

1. Discretionary:

When a recipient requests a hearing no more than the 10th calendar day after the Date of Action, the agency may reinstate benefits if requested by the recipient. The reinstated services will continue until a hearing decision is rendered unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

2. Mandatory:

The agency must reinstate and continue services until a decision is rendered after a hearing if:

a. action is taken without the required advance notice;

b. the agency mails the 10-day or 5-day notice as required under 42 CFR §431.211 or 42 CFR §431.214, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:

1. it is determined that the sole issue is one of Federal or State law or policy; and

2. the agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

3104.5 HEARING PARTICIPATION

A. ATTENDANCE

Attendance at a hearing is limited to those directly concerned; namely, the Hearing Officer, recipient(s), and/or their witnesses, counsel or authorized representative(s), interpreter, witnesses and representatives of the DHCFP, and if applicable, representatives from the managed health plan. Counsel for the agency and/or managed health plan may also attend as necessary.

Medicaid assures the availability for recipients, their authorized representatives and witnesses of necessary transportation to and from the hearing.

B. GROUP HEARINGS

A series of recipient requests for a hearing may be consolidated upon agreement of all parties by conducting a single group hearing in cases in which the sole issue involved is one of State and/or Federal law, regulation or policy.

3104.6 PREPARATION/PRESENTATION

A. AGENCY/MANAGED HEALTH PLAN

It is the responsibility of the agency and/or managed health plan representative to be present at the hearing, in person or telephonically, and to provide testimony and/or evidence regarding the agency's and/or managed health plan's action. This includes the organization of oral and written evidence and preparation of a Basis of Action summary substantiating the decision to be presented at the hearing. This summary becomes part of the record at the end of the hearing.

B. RECIPIENT

1. Before the date of the hearing and during the hearing, the recipient may examine and request copies of their own case information. Authorized representatives must provide a current signed release from the recipient to permit release of records. The DHCFP and/or managed health plan will provide the copies free of charge. The recipient shall not have access to confidential information.

2. It is the responsibility of the recipient to provide testimony and/or evidence in support of their position either in person or telephonically. If the hearing involves a legal issue only, the recipient's presence, in person or telephonically, is not necessary. Testimony can be provided by a representative.

   Recipients are allowed to bring witnesses and submit evidence to establish all pertinent facts and circumstances relative to the issue and to present arguments without undue interference. They are also allowed to question or refute any testimony or evidence and confront and cross-examine adverse witnesses. New evidence not previously provided to the DHCFP or managed health plan, but which is believed to have a bearing on the action taken, must be provided to the DHCFP prior to the hearing for evaluation and any necessary action.

3. Recipients are provided a copy of all evidence presented at the hearing by the DHCFP.

3104.7 CONDUCT OF HEARING

A. CONTROL

The Hearing Officer controls the hearing and ensures only relevant issues are considered. Disrespectful language or contemptuous conduct, refusal to comply with directions or continued use of dilatory tactics by any person at the hearing constitutes grounds for immediate exclusion of such person from the hearing by the Hearing Officer and the hearing decision will be based on evidence submitted. The Hearing Officer shall record hearing proceedings. The Hearing Officer's Transcripts of Evidence constitutes the sole official record.

B. OPENING THE HEARING

At the opening of the hearing, the Hearing Officer shall:

1. Introduce their self;

2. Explain the reason for the hearing and the role of the Hearing Officer;

3. Assure all persons in attendance at the hearing are identified by name and purpose of attendance;

4. Advise all persons in attendance that the hearing is being tape-recorded.

C. ADMINISTERING OATHS

Testimony under oath shall be required at the discretion of the Hearing Officer.

D. TESTIMONY AND EVIDENCE

Nevada Rules of Evidence do not apply in the hearing. The Hearing Officer:

1. Excludes irrelevant, immaterial or unduly repetitious evidence;

2. Provides the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and

3. Collects and logs relevant evidence exhibits.

E. CLOSING THE HEARING

At the close of the hearing, the Hearing Officer advises persons in attendance:

1. When a decision is expected to be made;

2. That the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and

3. The parties will be advised in writing by certified mail of the decision.

3104.8 ACTION ON INCORRECT NOTICE OF DECISION (NOD)

A. If, prior to the hearing, it becomes apparent the recipient has received an incorrect NOD for Prior Authorization Request from the DHCFP or the managed health plan, a corrected notice must be sent to the recipient if the proposed action remains unchanged.

B. If, after a hearing has begun, it becomes apparent the recipient received an incorrect NOD for Prior Authorization Request (i.e., the notice quotes incorrect factual and legal reason(s) or omits additional factual and legal reason(s) pertinent to the issue), the Hearing Officer may offer the recipient the choice of either accepting the incorrect notice, with the necessary corrections noted for the record and continuing with the hearing; or setting the hearing to a later date to allow the DHCFP or the managed health plan time to prepare and serve the corrected NOD.

3104.9 SUBMISSION OF ADDITIONAL EVIDENCE

During a hearing, additional evidence related to the hearing issue may be submitted. The Hearing Officer, recipient, the DHCFP or managed health plan may request additional evidence be submitted which is not available at the hearing.

The Hearing Officer shall:

A. Recess the hearing if additional evidence has been submitted, to allow for review by the recipient, the DHCFP or managed health plan; or

B. Continue the hearing to a later date and order further investigation or request either party to review or produce the additional evidence; or

C. Close the hearing, but hold the record open to permit submission of any additional evidence.

3104.10 MEDICAL ISSUES

When the hearing involves medical issues such as those concerning a diagnosis or an examining physician's report, the Hearing Officer may require an additional medical assessment other than that of the person involved in making the original assessment. The request is directed to the

DHCFP or the managed health plan for evaluation and follow-up. Any additional assessment determined to be necessary is obtained at the DHCFP or the managed health plan's expense. The hearing may be held open for a specified length of time pending receipt of such requested information. This additional assessment must be made part of the record.

3104.11 HEARING DECISION

The Hearing Officer's decision must be in writing and comply with Medicaid program policy. The decision is based exclusively on evidence introduced at the hearing. Changed physical or social factors following the DHCFP or managed health plan action being appealed cannot be considered in rendering the hearing decision.

A. BASIS

Decisions by the Hearing Officer shall:

1. Be based exclusively on the evidence introduced at the hearing;

2. Comply with applicable regulations in effect at the time of the agency or managed health plan's action;

3. Summarize the findings of fact;

4. Identify and cite supporting evidence and regulation;

5. Be submitted in written format, to the Deputy Administrator, the DHCFP or designee.

B. APPEAL IS DENIED

Denied decisions are adverse to the recipient. When the appeal is denied, the Hearing Officer will notify the DHCFP or the managed health plan and the recipient of the right to judicial review.

Recipient withdrawals and abandonments are equivalent to a denied appeal. The DHCFP may institute recovery procedures against the recipient to recoup the cost of any services furnished by Medicaid.

C. APPEAL IS SUSTAINED

Sustained decisions are favorable to the recipient. The DHCFP or the managed health plan must take corrective action promptly, retroactive to the date an incorrect action was taken. If appropriate, the agency must provide for admission or readmission of a recipient to a

facility if the hearing decision is favorable to the recipient or if the DHCFP decides in the recipient's favor before the hearing.

D. DECISION DUE DATE

Within 90 calendar days after the date of the request for a hearing has been received by the DHCFP office, the recipient and the Hearings Unit must be notified of the Hearing Officer's decision specifying the factual and legal reasons for the decision and identifying the supporting evidence relied upon to reach the decision. A copy of the decision must be delivered by certified mail to each party and to their attorney or other authorized representative.

The time period for a hearing decision may be extended for a period equal to the total delay if the recipient requests a delay or postponement of the hearing proceedings and waives his right to have a decision rendered within 90 days after the date of the request for a hearing.

Decisions on Expedited Fair Hearing requests will be made expeditiously as the recipient's health condition requires, but no later than three working days after the date the request for a hearing has been received by the DHCFP office.

3104.12 RIGHT TO APPEAL HEARING DECISION

The Decision of the Hearing Officer is final. The Hearing Decision may be appealed by any party, within 90 days after the date on which the written notice of decision is mailed, to the appropriate District Court of the State of Nevada. The day after the mailing is the first day of the 90-day period.

3104.13 HEARING RECORD

A. CONTENT

A hearing record is maintained by the Department of Administration, Hearing Office. The record consists of all papers and requests filed in the proceeding, the transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing, all exhibits received or considered and the Decision letter.

B. RETENTION OF HEARING RECORD

Administrative hearing files and taped recordings must be retained no less than six years from the date the hearing decision was rendered.

If a hearing decision is appealed, the hearing record must be retained until the court action is resolved or the designated retention period, whichever is later.

C. COPYING THE HEARING RECORD

Copies of the Hearing Record are made as follows:

1. The requestor may secure a copy of the recording and/or transcript of a Fair Hearing by written request to the Department of Administration. Please note that the requestor shall be invoiced from the Department of Administration for this service and the requestor is responsible for the payment of these records.

2. An official typed transcription of the recording of the hearing is prepared for the District Court and recipient when a hearing decision is appealed. Within 90 days after the service of the petition for judicial review, the DHCFP or its designee shall transmit to the court the original or a certified copy of the entire record of the proceeding under review, including, without limitation, a transcript of the evidence resulting in the final decision of the Hearing Officer.

   * The requested recording and/or transcript is free of charge to the recipient in the event that the recipient appeals to District Court.

3105 MEDICAID PROVIDER HEARINGS

3105.1 REQUEST FOR A MEDICAID PROVIDER FAIR HEARING

A. WHO MAY REQUEST

A Nevada Medicaid provider may request a Fair Hearing when they disagree with an adverse determination taken against them by the agency, the Quality Improvement Organization (QIO)-like vendor/fiscal agent, managed health plan or other third-party plan or Program Administrator. An adverse determination may include, but is not limited to:

1. an outcome of the Fiscal Agent's provider appeal determination regarding a denied claim;

2. a determination to suspend payment;

3. suspension, sanction, lockout or termination;

4. recoupment of an overpayment; or

5. disenrollment or denied renewal of a provider contract

6. ineligible determination for the Incentive Payment Program for Electronic Health Record (EHR) enrollment.

The provider must exhaust any internal grievance process available through the QIO-like vendor/Fiscal Agent, managed health plan or third-party plan or Program Administrator prior to a DHCFP Fair Hearing.

B. DATE OF REQUEST

The date of request for a hearing is the date the request is received by the DHCFP Hearings Office. A request for a Fair Hearing must be received by the DHCFP Hearings Office within 90 calendar days from the date of the adverse determination notification. When a determination notification provides a specific timeframe in which a Fair Hearing may be requested, the timeframe specified in the notification is the applicable timeframe. When the deadline falls on a weekend or holiday, the deadline is extended to the next working day.

C. REQUEST FOR A FAIR HEARING

A request for a Fair Hearing must be submitted to the DHCFP Hearing Office in writing and must include the provider name, Medicaid provider number, correspondence address,

contact telephone number, the reason(s) why the provider disagrees with the determination and a copy of the determination notification from the agency, Fiscal Agent, managed health plan or third-party plan or Program Administrator. A request for a Fair Hearing must be signed by the provider or the provider's authorized representative.

3105.2 DISPOSITION OF A MEDICAID PROVIDER FAIR HEARING REQUEST

A. DISMISSAL OF A HEARING REQUEST UPON:

1. Withdrawal of a Hearing Request

A provider may withdraw a request for a Fair Hearing at any time before a decision is rendered. A request to withdraw a hearing must be submitted in writing to the Hearing Officer who may dismiss the hearing request.

2. Abandonment of a Hearing Request

A provider hearing is considered abandoned and may be dismissed by the Hearing Officer when the provider fails to appear for a scheduled hearing after having been properly notified. The provider's request for hearing is considered abandoned unless they submit to the Hearing Officer substantiation for good cause for failing to appear. The Hearing Officer must receive the substantiation within 10 calendar days of the date of the scheduled hearing.

3. Agency, Fiscal Agent or Managed Health Plan Action

The agency, Fiscal Agent or managed health plan may reverse its adverse action determination at any time during the hearing process. If a determination reversal occurs, notification of the reversal must be made to the Hearing Officer, if a Fair Hearing had been scheduled. The Hearing Officer notifies the provider the request for hearing is dismissed because Medicaid, the Fiscal Agent or managed health plan will not take the action or has reversed the decision.

B. DENIAL OF A HEARING REQUEST

A hearing need not be granted when:

1. the sole issue is a Federal suspension or ban of regulation at the Federal level affecting providers.

2. the request is not received timely.

3. the provider has not exhausted the Appeal process available through the Fiscal Agent, the managed health plan or a third-party plan administrator.

3105.3 FAIR HEARING NOTIFICATION, SCHEDULING AND LOCATION

A. HEARING PREPARATION MEETING (HPM)

Nevada Medicaid Hearings Office will offer an HPM with the provider to allow an opportunity to have an informal discussion regarding the determination being disputed, and to attempt to resolve the disputed matter. A provider may refuse an HPM if they choose. The right to a Fair Hearing is not affected by attendance at an HPM. A provider may designate participation in the HPM by legal counsel or a representative.

An HPM shall be conducted telephonically.

B. NOTICE OF A FAIR HEARING

The Department of Administration Hearing Officer shall notify all parties by mail as to the date, time and location of the Fair Hearing.

At the discretion of the Hearing Officer, a Fair Hearing may be postponed if requested by either party.

C. HEARINGS BY TELEPHONE

1. A representative of each party must be in attendance at a Provider Fair Hearing.

2. The Hearing Officer may allow testimony from witnesses telephonically.

3. Telephonic testimony is recorded by the Hearing Officer and is part of the official record.

3105.4 HEARING PARTICIPATION

A. ATTENDANCE

Attendance at a hearing is limited to those directly concerned, namely the:

1. Hearing Officer;

2. provider;

3. provider’s witnesses, counsel or authorized representative(s) for the provider;

4. interpreter;

5. witnesses, counsel and representatives of Medicaid; and

6. representatives, counsel and witnesses from the managed health plan.

B. GROUP HEARINGS

At the discretion of the Hearing Officer, a series of provider requests for a hearing may be consolidated by conducting a single group hearing in cases in which the sole issue involved is one of State and/or Federal law, regulation or policy.

3105.5 PREPARATION/PRESENTATION

A. AGENCY/MANAGED HEALTH PLAN

1. It is the responsibility of the agency and/or managed health plan representative to be present at the Fair Hearing, unless permission has been granted prior to the Fair Hearing by the Hearing Officer to participate telephonically.

2. The agency or the managed health plan must provide testimony and/or evidence regarding the agency's and/or managed health plan's action. This includes the organization of oral and written evidence and preparation of a Basis of Action summary substantiating the decision to be presented at the Fair Hearing. This summary becomes part of the record at the conclusion of the Fair Hearing. Witness testimony may be provided telephonically at the discretion of the Hearing Officer.

3. All documents being presented at a Fair Hearing by the agency or managed health plan must be made available to the provider or representative and to the Hearing Officer at least five days prior to the Fair Hearing.

B. PROVIDER

1. It is the responsibility of the provider or representative to be present at the Fair Hearing, unless permission has been granted prior to the Fair Hearing by the Hearing Officer to participate telephonically.

2. Providers must provide testimony and/or evidence in support of their position. Testimony may be provided telephonically at the discretion of the Hearing Officer. Providers may bring witnesses and submit evidence to establish all pertinent facts and circumstances relative to the issue and to present arguments without undue interference. They may also question or refute any testimony or evidence and confront and cross-examine adverse witnesses. New evidence not previously provided to the DHCFP or the managed health plan, but which is believed to have

a bearing on the action taken, must be provided to all parties prior to the hearing for evaluation and any necessary action.

3. All documents being presented at a Fair Hearing by the provider or representative must be made available to the agency or managed health plan and to the Hearing Officer at least five days prior to the Fair Hearing.

3105.6 CONDUCT OF A FAIR HEARING

A. CONTROL

The Hearing Officer controls the hearing and ensures only relevant issues are considered. Disrespectful language or contemptuous conduct, refusal to comply with directions or continued use of dilatory tactics by any person at the hearing constitutes grounds for immediate exclusion of such person from the hearing by the Hearing Officer and the hearing decision will be based on evidence submitted. A recorder shall be used by the hearing officer to record hearing proceedings. The Hearing Officer's Transcripts of Evidence constitutes the sole official record.

B. OPENING THE HEARING

At the opening of the hearing, the Hearing Officer shall:

1. introduce their self;

2. explain the reason for the hearing and the role of the Hearing Officer;

3. assure all persons in attendance at the hearing are identified by name and purpose of attendance; and

4. advise all persons in attendance that the hearing is being recorded.

C. ADMINISTERING OATHS

Testimony under oath shall be required at the discretion of the Hearing Officer.

D. TESTIMONY AND EVIDENCE

Nevada Rules of Evidence do not apply in the hearing. The Hearing Officer shall:

1. exclude irrelevant, immaterial or unduly repetitious evidence;

2. provide the parties an opportunity to present their case, to present witnesses, introduce evidence and cross-examine witnesses and examine evidence; and

3. collect and log relevant evidence exhibits.

E. CLOSING THE HEARING

At the close of the hearing, the Hearing Officer shall advise persons in attendance:

1. when a decision is expected to be made;

2. that the decision will be made based on program policy and exclusively on the testimony and evidence presented at the hearing; and

3. the parties will be advised in writing by certified mail of the decision.

3105.7 ACTION ON INCORRECT DETERMINATION NOTICE

If the agency, fiscal agent or managed health plan recognizes an incorrect or inaccurate determination Notice has been issued, a corrected Amended Notice will be issued by the agency, Fiscal Agent or managed health plan. The action and effective date remain unchanged unless otherwise notified in the Amended Notice.

3105.8 SUBMISSION OF ADDITIONAL EVIDENCE

During a hearing, additional evidence related to the hearing issue may be submitted. The Hearing Officer, provider, the DHCFP or managed health plan may request additional evidence be submitted which is not available at the hearing. The Hearing Officer may:

A. recess the hearing if additional evidence has been submitted, to allow for review by the provider, the DHCFP or managed health plan;

B. continue the hearing to a later date and order further investigation or request either party to review or produce the additional evidence; or

C. close the hearing, but hold the record open to permit submission of any additional evidence.

3105.9 HEARING DECISION

The Hearing Officer's decision must be in writing and comply with Nevada Medicaid or the managed health plan's program policy. The decision is based exclusively on evidence introduced at the hearing.

A. BASIS

Decisions by the Hearing Officer shall:

1. be based exclusively on the evidence introduced at the hearing;

2. comply with applicable regulations in effect at the time of the agency's or managed health plan's action;

3. summarize the findings of fact;

4. identify and cite supporting evidence and regulation; and

5. be submitted in written format, to the Deputy Administrator, Medicaid or designee.

B. APPEAL IS DENIED

Denied decisions are adverse to the provider. When an appeal is denied, the Hearing Officer will notify the DHCFP or the managed health plan and the provider of their right to judicial review.

Provider withdrawals and abandonments are equivalent to a denied appeal. The DHCFP may institute recovery procedures against the provider to recoup the cost of any services furnished.

C. APPEAL IS SUSTAINED

Sustained decisions are favorable to the provider. The DHCFP or the managed health plan must take corrective action promptly, retroactive to the date an incorrect action was taken. If appropriate, the agency must provide for admission or readmission of a recipient to a facility if the hearing decision is favorable to the provider or if the DHCFP decides in the provider's favor before the hearing.

D. DECISION DUE DATE

Within 30 calendar days following the Fair Hearing, or the date the record is closed, whichever is later, the Hearing Officer shall issue a final Decision.

3105.10 RIGHT TO APPEAL HEARING DECISION

Reference NRS 422.306

3105.11 HEARING RECORD

Reference NRS 422.306

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 22, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES,
CHAPTER 3200 – HOSPICE

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3200 – Hospice are being proposed to better coincide with the Code of Federal Regulation (CFR) Title 42 Part 418, Conditions of Participation (COP) updates and to coincide with the Medicare Guidelines Criteria for Non-Cancer Terminal Illnesses. The chapter was also updated to clarify the criteria for pediatric hospice recipients.

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: Provider Type (PT) 64 – Hospice and PT 65 – Hospice, Long Term Care.

Financial Impact on Local Government: None.

These changes are effective February 23, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 05/17 HOSPICE	MTL 02/14, 29/11, 41/10 HOSPICE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1	**HOSPICE SERVICES**	The second sentence was made in to its own paragraph. New language was added in the first paragraph for clarification.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The second paragraph was moved to a new section, Section 3203.1A, “Pediatric Recipients.” The new third and fifth paragraph were moved here from Section 3203.1B, Provider Responsibility. The fourth paragraph is new language. The word "condition" in the sixth paragraph was changed to "illness."
3203.1e	**HOSPICE SERVICES**	This sentence was deleted.
3203.1h	**HOSPICE SERVICES**	The second sentence was deleted due to duplication.
3203.1A	**COVERAGE AND LIMITATIONS**	This section was deleted and renamed “Pediatric Recipients,” with new language.
3203.1B	**PROVIDER RESPONSIBILITY**	This section was deleted. The language from Section 3203.7, “Hospice Coverage and Waiver recipients” was moved here and renamed, “Waiver Recipients.” New language was added related to the pediatric waiver recipient.
3203.1C	**RECIPIENT RESPONSIBILITY**	This section was deleted. The language from Section 3203.8, “Managed Care and Hospice Recipients” was moved here and renamed, “Managed Care Recipients.”
3203.1A.3	**HOSPICE CARE SERVICES**	This was renumbered as Section 3203.2, “Covered Services.” All the language from Section 3203.1A3 was moved to this new section, with the last sentence in item number 3 being deleted for clarification, and item number 4 being deleted for clarification.
3203.1A.4	**LEVEL OF CARE**	This section renumbered as Section 3203.3 and renamed, “Hospice Categories” per CFR language. All language from Section 3203.1A4 was moved and inserted here.
3203.1A.4	**LEVEL OF CARE**	The last paragraph became its own Section 3203.4.
3203.1B	**PROVIDER RESPONSIBILITY**	This section was deleted.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1.C	**RECIPIENT RESPONSIBILITY**	This section was moved to a new Section 3211, "Recipient Responsibility."
3203.2	**NON-HOSPICE SERVICES**	This section was moved and renumbered as Section 3204.
3203.2A	**COVERAGE AND LIMITATIONS**	This section was deleted and the language was moved to Section 3204 for better flow.
3203.2B	**PROVIDER RESPONSIBILITY**	This section was deleted. The language was moved to new Section, 3207, "Election of Hospice Care."
3203.2C	**RECIPIENT RESPONSIBILITY**	This section was deleted and the language was moved to Section 3204 for better flow.
3203.3	**CHANGING THE DESIGNATED HOSPICE**	This section was deleted. The language was moved to new Section 3212, "Changing the Designated Hospice." New language added due to new forms.
3203.4	**REVOKING THE ELECTION OF HOSPICE CARE**	This section was deleted. The language was moved to new Section 3213, "Revoking the Election of Hospice Care." New language added due to new forms.
3203.5	**DISCHARGE OF A RECIPIENT FROM HOSPICE**	The language was moved to new Section 3214, "Discharge of a Recipient from Hospice." New language added due to new forms. This section was renamed, "Hospice Recipients Residing in a Nursing Facility."
3203.6	**HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY**	This section was deleted. The language was moved to a new Section 3203.5, "Hospice Recipients Residing in a Nursing Facility." The first sentence was removed for redundancy. New language was added for clarification.
3203.6A	**COVERAGE AND LIMITATIONS**	This section deleted and language moved to Section 3203.5, "Hospice Recipients Residing in a Nursing Facility."
3203.6B	**PROVIDER RESPONSIBILITIES**	This section deleted and language moved to Section 3203.5B, "Coordination of Services."
3203.6B.2	**NURSING FACILITY SCREENINGS**	This section deleted except for the first sentence which was moved to Section 3203.5, "Hospice Recipients Residing in a Nursing Facility."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.7-3203.7B	**HOSPICE COVERAGE AND WAIVER RECIPIENTS**	This section moved to new Section 3203.1B, "Waiver Recipients."
3203.8	**MANAGED CARE AND HOSPICE RECIPIENTS**	This section moved to new Section 3203.1C, "Managed Care Recipients."
3203.9	**CLINICAL RECORDS**	This section was deleted.
3203.10	**DHCFP REVIEW**	This section was moved to new Section 3203.6, "DHCFP Review." New language was added for clarification.
3203.10A	**PROVIDER RESPONSIBILITY**	This section was moved to new Section 3203.6, "DHCFP Review" for better flow.
3204	**HEARINGS**	This section was moved to new Section 3215, "Hearings" for better flow.
3203.5A	**HOSPICE PLAN OF CARE**	New section.
3203.5B	**COORDINATION OF SERVICES**	New section with new language and retained language.
3203.6	**DHCFP REVIEW**	New section with new language and retained language .
3204	**NON-HOSPICE SERVICES**	New section with new language and retained language.
3205	**CURATIVE SERVICES**	New section with retained language.
3206	**INITIATION OF SERVICES**	New section.
3206.1	**ELIGIBILITY REQUIREMENTS**	New section with new language and retained language.
3206.1A	**CERTIFICATION OF TERMINAL ILLNESS**	New section with retained language and new language.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3206.1B	**HOSPICE PLAN OF CARE (POC)**	New section with retained language and new language.
3207	**ELECTION OF HOSPICE CARE**	New section with retained language and new language.
3207.1	**DURATION OF HOSPICE CARE PERIODS**	New section with retained language and new language.
3208	**COORDINATION OF SERVICES**	New section with retained language and new language.
3209	**DETERMINING TERMINAL STATUS-LOCAL COVERAGE DETERMINATIONS (LCD) - ADULTS**	New section.
3209.1	**NON-CANCER TERMINAL ILLNESSES**	New section.
3209.2	**HOSPICE CRITERIA FOR ADULT CANCER**	New section.
3210	**REASONS FOR DENIAL OF ANY OF THE ABOVE**	New section.
3211	**RECIPIENT RESPONSIBILITY**	New section with retained language.
3212	**CHANGING THE DESIGNATED HOSPICE**	New section with retained language and new language.
3213	**REVOKING THE ELECTION OF HOSPICE CARE**	New section with retained language and new language.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3214	**DISCHARGE OF A RECIPIENT FROM HOSPICE**	New section with retained language and new language.
3215	**HEARINGS**	New section with retained language.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HOSPICE

3200 INTRODUCTION

The Nevada Division of Health Care Financing and Policy (DHCFP) Medicaid Hospice Services program is designed to provide support and comfort for Medicaid eligible recipients who have a terminal illness and have decided to receive end of life care. Covered hospice services address the needs of the individual, their caregivers and their families while maintaining quality of life as a primary focus. The hospice philosophy provides for the physical needs of recipients as well as their emotional and spiritual needs. This care is provided in the recipient's place of residence, which could be a specialized hospice facility, an Intermediate Care Facility (ICF) or in his or her own home. Hospice care incorporates an interdisciplinary team approach which is sensitive to the recipient and family's needs during the final stages of illness, dying and the bereavement period.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000. Refer to Medicaid Services Manual (MSM) Chapter 3600 for Managed Care recipients for differences in Hospice enrollment, claims and payment.

3201 AUTHORITY

Hospice Services are an optional program under the Social Security Act XVIII Sec. 1905.(o)(1)(A), and are governed by The Code of Federal Regulations (CFR) Title 42, Part 418 and Title 42 Part 489.102, Subpart I.

Effective October 1, 1997, the Nevada Revised Statutes (NRS) Chapter 422.304 mandated reimbursement for hospice care under the Medicaid State Plan.

Patient Protection and Affordable Care Act (PPACA) Section 2302.

Health Care and Education Affordability Reconciliation Act of 2010.

3202 RESERVED

3203 POLICY

3203.1 HOSPICE SERVICES

Hospice services must be identified in the established plan of care; maintain a high standard of quality and be reasonable and necessary to palliate or manage the terminal illness and related illnesses. Hospice must include a comprehensive set of services identified and coordinated by an Interdisciplinary Group (IDG) to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill recipient and/or family members, as delineated in a specific recipient plan of care.

All services must be provided in accordance with recognized professional standards of practice and within the limitations and exclusions hereinafter specified, as described in the Centers for Medicare and Medicaid Services (CMS) – State Operations Manual (SOM) and the Code of Federal Regulations (CFR) Title 42, Part 418 which sets forth the Conditions of Participation (COP). The COP is the eligibility, health and safety requirements that all hospices are required to meet. COPs also provide a guide for continuous quality improvement and current standards of practice.

All Nevada Medicaid recipients electing Hospice services, including those with primary insurance such as Medicare or a private insurance, must be enrolled in Nevada Medicaid's Hospice Program regardless of where hospice services are provided.

Nevada Medicaid shall be available to assist hospice providers in coordinating the services and shall require that the other service providers cooperate in these coordination efforts and understand that the hospice provider is the lead case coordinator.

NOTE: Enrollment paperwork for hospice recipients who are pending a Nevada Medicaid eligibility determination should not be submitted until Medicaid benefits have been approved. All enrollment forms must be received by the Quality Improvement Organization (QIO)-like vendor within 60 days of the date of decision of eligibility determination.

Should a terminally ill adult recipient elect to receive hospice care, he or she must waive all rights to Medicaid payments for the duration of the election of hospice care for any Medicaid services that are related to the treatment of the terminal illness for which hospice care was elected or a related illness or that are equivalent to hospice care except for services:

1. Provided (either directly or under arrangement) by the designated hospice;

2. Provided by the individual’s attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services;

3. Provided as room and board by a Nursing Facility (NF) if the individual is a resident, or

4. Provided by a Home and Community-Based Waiver (HCBW) whose services do not duplicate hospice services.

A hospice program may arrange for another individual or entity to furnish services to the hospice's recipients. If services are provided under arrangement, the hospice must meet the following standards:

1. Continuity of Care: The hospice program assures the continuity of recipient/family care in home, outpatient, and inpatient settings;

2. Written Agreement: The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:

   a. Identification of the services to be provided;

   b. A stipulation that services may be provided only with the express authorization of the hospice;

   c. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;

   d. The delineation of the role(s) of the hospice and the contractor in the admission process, recipient/family assessment, and the interdisciplinary group care conferences;

   e. Requirements for documenting services are furnished in accordance with the agreement; and

   f. The qualification of the personnel providing the services.

Professional Management Responsibility:

The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications, and in accordance with the recipient's Plan of Care (POC) and other requirements.

3203.1A PEDIATRIC RECIPIENTS

Recipients under the age of 21 are entitled to concurrent care under the Affordable Care Act (ACA); that is curative care and palliative care at the same time while an eligible recipient of the Medicaid Hospice Program, and shall not constitute a waiver of any rights of the child to be provided with, or to have payment made for services that are related to the treatment of the child's terminal illness. Upon turning 21 years of age, the recipient will no longer have concurrent care benefits and will be

subject to the rules governing adults who have elected Medicaid hospice care. Upon turning 21 years of age, the recipient must sign a Nevada Medicaid Hospice Program Election Notice-Adult (FA-93), continuing in the certification period currently in place.

Pediatric hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with terminal illnesses and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth, planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center.

3203.1B WAIVER RECIPIENTS

As part of the admission procedure it is the responsibility of the hospice agency to obtain information regarding recipient enrollment in HCBW programs.

When a Waiver recipient is enrolled in the hospice program there can be no duplication of hospice covered services, such as PCA services, homemaker services, home health services, respite~~,~~ or companion services. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services.

Pediatric waiver recipients are entitled to continue to receive Waiver services that are related to their terminal illness, but are not covered by the hospice benefit because they are curative not palliative in nature. Close coordination between the hospice agency and the waiver case manager is required to avoid any unnecessary duplication of services.

This also includes all HCBW recipients who have Medicare as their primary insurance and Medicare is paying for the hospice services. The hospice agency must immediately notify the QIO-like vendor of any new hospice admissions who are receiving services through a Medicaid HCBW.

3203.1C MANAGED CARE RECIPIENTS

Managed care participants who elect hospice care must be disenrolled from their managed care program.

1. The hospice is responsible for notifying the QIO-like vendor in such situations.

2. The recipient electing the hospice benefit will then return to Fee-for-Service (FFS) Medicaid.

3. There should be no delay in enrolling managed care recipients in hospice services.

3203.2 COVERED SERVICES

Nursing services, physician services, and drugs and biologicals must be routinely available on a 24-hour basis; all other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions and provide these services in a manner consistent with accepted standards of practice.

The hospice must designate a Registered Nurse (RN) to: coordinate the implementation of the POC; to ensure that the nursing needs of the recipient are met as identified in the recipient's initial assessment, comprehensive assessment, and updated assessments; and coordinate and oversee all services for each recipient.

The following services are included in the hospice reimbursement when consistent with the POC. The services must be provided in accordance with recognized professional standards of practice.

1. Nursing Services: Nursing services must comply with the following: The hospice must provide nursing care and services by or under the supervision of a qualified RN; a qualified RN is one who is authorized to practice as an RN by the Nevada State Board of Nursing or the licensing board in the state in which the RN is employed. Recipient care responsibilities of nursing personnel must be specified.

2. Medical Social Services: Medical Social Services (MSS) must be provided by a qualified social worker, under the direction of a physician. A qualified social worker is a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed to practice social work in the State of Nevada or the state in which the social worker is employed.

3. Physician Services: In addition to palliative care and management of the terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the recipients to the extent these needs are not met by the attending physician.

    a. Reimbursement for physician supervisory and interdisciplinary group services for those physicians employed by the hospice agency is included in the rate paid to the agency.

    b. Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of POCs and services, periodic review and updating of POCs, and contribute to establishment of governing policies.

c. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians, and are not considered hospice services, therefore are not included in the amount subject to the hospice payment limit.

4. Counseling Services: Counseling services are available to both the individual and the family. Counseling includes bereavement counseling, dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice. Bereavement counseling for the client's family and significant others, as identified in the POC, must be provided for up to one year after the recipient's death and is not reimbursable per 42 CFR 418.204.(c).

5. Medical Appliances, Supplies and Pharmaceuticals:

a. Medical supplies include those that are part of the written POC. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the client's terminal illness. Equipment is provided by the hospice for use in the recipient's home while he or she is under hospice care and the reimbursement for this is included in the rates calculated for all levels of hospice care.

b. Drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid hospice program and are to be billed in accordance with the appropriate Medicaid Services Manual (MSM) chapter for those services.

6. Home Health Aide (HHA), Personal Care Aide (PCA) and Homemaker Services: HHA services and homemaker services when provided under the general supervision of an RN. Services may include personal care services and such household services which may be necessary to maintain a safe and sanitary environment in the areas of the home used by the recipient.

7. Physical Therapy (PT), Occupational Therapy (OT), Respiratory Therapy and Speech-Language Pathology Services: PT, OT, respiratory therapy and speech-language pathology when provided for the purpose of symptom control, or to enable the recipient to maintain Activities of Daily Living (ADLs) and basic functional skills.

3203.3 HOSPICE CATEGORIES

1. Routine Home Care: The reimbursement rate for routine home care is made without regard

to the intensity or volume of routine home care services on any specific day.

2. Continuous Home Care:

   a. Continuous home care is only furnished during brief periods of crisis, described as a period in which a recipient requires continuous care to achieve palliation or management of acute medical symptoms, and only as necessary to maintain the terminally ill recipient at home.

   b. Nursing care must be provided by an RN or Licensed Practical Nurse (LPN) and the nurse (RN or LPN) must be providing care for more than half of the period of care. HHA or homemaker services or both may be provided on a continuous basis.

   c. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day.

3. Inpatient Care (Respite or General):

   a. The appropriate inpatient rate (general or respite) is paid depending on the category of care furnished on any day on which the recipient is an inpatient in an approved facility. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the recipient is discharged. For the day of discharge, the appropriate home care rate is paid unless the recipient is deceased; the discharge day is then paid at the general or respite rate.

   b. Inpatient care must be provided by a facility that has a written contract with the hospice. This may be an approved Nursing Facility (NF), hospital or hospice capable of providing inpatient care.

   c. Respite care is short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

   d. Time limited for reimbursement: In a 12-month period the inpatient reimbursement is subject to the following limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid

recipients during that same period. Refer to the 42 CFR 418.302 for further information on the calculation of the inpatient limitation.

3203.4 OPTIONAL CAP ON OVERALL HOSPICE REIMBURSEMENT

The DHCFP may limit overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1st of each year through October 31st of the next year. The total payment made for services furnished to Medicaid beneficiaries during this period is compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.

3203.5 HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY

The hospice recipient residing in a Skilled Nursing Facility (SNF) must not experience any lack of services or personal care because of his or her status as a hospice recipient. The NF must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The recipient has the right to refuse any services.

The NF must continue to still comply with all requirements for participation in Medicare and/or Medicaid for hospice-enrolled Nevada Medicaid residents.

Refer to MSM Chapter 500 for specific guidelines regarding NF pre-admission screenings.

A hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards:

1. Resident eligibility, election and duration of benefits. Recipients receiving hospice services and residing in a SNF, NF or ICF/IID are subject to the Medicaid/Medicare hospice eligibility criteria set out at Title 42 CFR 418.20 through CFR 418.30.

2. Written agreement. The hospice and SNF/NF or ICF/IID must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services. The written agreement must include at least the following:

    a. The manner in which the SNF/NF or ICF/IID and the hospice are to communicate with each other and document such communications to ensure that the needs of recipients are addressed and met 24 hours a day.

    b. A provision that the SNF/NF or ICF/IID immediately notifies the hospice when:

        (1) A significant change in a recipient's physical, mental, social or emotional status occurs;

(2) Clinical complications appear that suggest a need to alter the plan of care;

(3) A need to transfer a recipient from the SNF/NF or ICF/IID, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related illnesses; or

(4) A recipient dies.

c. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

d. An agreement that it is the SNF/NF or ICF/IID responsibility to continue to furnish 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.

e. An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IID resident were in his or her own home.

f. A delineation of the hospice's responsibilities, which include, but are not limited to, the following: Providing medical direction and management of the recipient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related illnesses; and all other hospice services that are necessary for the care of the resident's terminal illness and related illnesses.

g. A provision that the hospice may use the SNF/NF or ICF/IID nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/IID to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice recipient's family in implementing the plan of care.

h. A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of recipient property by anyone unrelated to the hospice to the SNF/NF or ICF/IID administrator within 24 hours of the hospice becoming aware of the alleged violation.

i. A delineation of the responsibilities of the hospice and the SNF/NF or ICF/IID to

provide bereavement services to SNF/NF or ICF/IID staff.

3203.5A HOSPICE PLAN OF CARE

In accordance with Title 42 CFR 418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives. All hospice care provided must be in accordance with this hospice plan of care.

3203.5B COORDINATION OF SERVICES

The hospice must:

1. Designate a member of each interdisciplinary group that is responsible for a recipient who is a resident of a SNF/NF or ICF/IID. The designated interdisciplinary group member is responsible for:

   a. Providing overall coordination of the hospice care of the SNF/NF or ICF/IID resident with SNF/NF or ICF/IID representatives; and

   b. Communicating with SNF/NF or ICF/IID representatives and other health care providers participating in the provision of care for the terminal illness and related illnesses and other illnesses to ensure quality of care for the recipient and family.

2. Ensure that the hospice IDG communicates with the SNF/NF or ICF/IID medical director, the recipient's attending physician and other physicians participating in the provision of care to the recipient as needed to coordinate the hospice care of the hospice recipient with the medical care provided by other physicians.

3. Provide the SNF/NF or ICF/IID with the following information:

   a. The most recent hospice plan of care specific to each recipient;

   b. Hospice election form and any advance directives specific to each recipient;

   c. Physician certification and recertification of the terminal illness specific to each recipient;

   d. Names and contact information for hospice personnel involved in hospice care of each recipient

   e. Instructions on how to access the hospice's 24-hour on-call system;

   f. Hospice medication information specific to each recipient; and

g. Hospice physician and attending physician (if any) orders specific to each recipient.

4. The hospice agency and the NF must have a written agreement under which the hospice is responsible for the professional management of the recipient's hospice care. The NF is responsible to provide room and board to the recipient.

a. Room and board includes:

(1) Performance of personal care services;

(2) Assistance in the ADLs;

(3) Socializing activities;

(4) Administration of medication;

(5) Maintaining the cleanliness of a resident's room; and

(6) Supervising and assisting in the use of Durable Medical Equipment (DME) and prescribed therapies.

3203.6 DHCFP REVIEW

The DHCFP may conduct a review of a hospice provider to ensure appropriateness of care and accuracy of claims. The hospice provider being reviewed must comply with the DHCFP staff on providing all information requested in a timely manner.

The methods of review may include, but are not limited to:

1. On-site visits with recipients and family at their residence;

2. Chart reviews at the hospice agency;

3. Post-payment review of claims data;

4. The DHCFP desk review;

5. On-site review in facilities; and

6. Independent Physician Review for Extended Care.

Medicaid hospice benefits are reserved for terminally ill recipients who have a medical prognosis to live no more than six months if the illness runs its normal course.

When an adult recipient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the recipient continues to receive extended hospice care. Hospice agencies should advise recipients of this requirement and provide The Nevada Medicaid Independent Physician Review for Extended Care form (FA-96) to take with them to each independent review.

Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the recipient does not continue to meet program eligibility requirements.

The following medical professionals may conduct the Independent Physician Review:

1. Physician (MD)

2. Doctor of Osteopathic Medicine (D.O.)

3. Physician's Assistant (PA)

4. Advanced Practice Registered Nurse (APRN)

The Independent Physician Review can occur at a physician's office or at the recipient’s place of residence, whether it be a private home or a nursing facility. The review must be completed no sooner than 30 days before the end of the recipient's 12-month certification period. In cases when the independent physician reviewer claims the recipient should no longer be appropriate for hospice services, the hospice provider will be notified. The hospice physician has seven days to submit a narrative update on the recipient to staff at LTSS for further review. The Independent Physician review is not required for dual-eligible recipients. Due to concurrent care allowed for the pediatric recipient of hospice services, the Independent Physician Review is required for the pediatric hospice recipient who has elected not to pursue curative treatment.

3204 NON-HOSPICE SERVICES

1. Nevada Medicaid recipients continue to be eligible for applicable state benefits for services unrelated to the terminal illness and related conditions for which hospice was elected. Pediatric recipients continue to be eligible for the applicable State benefits for services that are curative in nature and related to the terminal illness for which hospice was elected. The hospice provider is expected to be the lead case coordinator and maintain communication with other services including those listed below:

   a. Personal Care Services (PCS) for Recipients Enrolled in Hospice:

      PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal illness and related conditions, and the personal care needs exceed the personal care services provided under the hospice benefit. If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of an individual's comprehensive personal and skilled care needs. The evaluation will differentiate between personal care needs unrelated to the terminal illness and those needs directly related to hospice, clearly documenting total personal care needs. PCS provided under hospice will be subtracted from total PCS needs to document any personal care needs not met by hospice services and which may be provided by the Personal Care Agency. The PCS provided by a personal care agency to a recipient because of needs unrelated to the terminal illness may not exceed State Plan program limitations. Refer to MSM Chapter 3500 for regulations regarding PCS.

   b. Home Health Agency (HHA) Services for Recipients Enrolled in Hospice:

      HHA Services may be provided for recipients enrolled in hospice when the need for HHA Services is unrelated to the terminal illness and related conditions. The HHA Services provided to a recipient for needs unrelated to the terminal illness may not exceed State Plan program limitations. Refer to MSM Chapter 1400 for HHA Services policy.

   c. Private Duty Nursing (PDN) for Recipients Enrolled in Hospice:

      PDN may be provided for recipients enrolled in hospice when the need for PDN is unrelated to the terminal illness and related conditions. PDN provided to a recipient for needs unrelated to the terminal illness may not exceed State Plan program limitations. Refer to MSM Chapter 900 for PDN policy.

2. Typical services available that are not covered by the hospice benefit but payable by the DHCFP may include, but are not limited to:

   a. Attending physician care (e.g., office visits, hospital visits, etc.);

b. Optometric services;

c. Any services, drugs, equipment or supplies for an illness other than the recipient's terminal illness.

3. The recipient/guardian/agent is responsible for communicating fully with the hospice agency regarding all services unrelated to the terminal illness to ensure continuity of care.

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3205 CURATIVE SERVICES

Neither the hospice nor Nevada Medicaid is responsible for payment for curative services related to an adult's terminal illness.

3206 INITIATION OF SERVICES

3206.1 ELIGIBILITY REQUIREMENTS

All Nevada Medicaid recipients, including those with primary insurance such as Medicare or a private insurance, must be enrolled in Nevada Medicaid's Hospice Program regardless of where hospice services are provided.

NOTE: Enrollment paperwork for hospice recipients who are pending a Nevada Medicaid eligibility determination should not be submitted until Medicaid benefits have been approved. All enrollment forms must be received by the Quality Improvement Organization (QIO)-like vendor within 60 days of the date of decision of eligibility determination.

For the initial election period, the DHCFP requires the following documentation be received by the QIO-like vendor within eight working days of the hospice admission:

1. Nevada Medicaid Hospice Program Election Notice for Adults or a Nevada Medicaid Hospice Program Election Notice for Pediatrics.

2. Nevada Medicaid Hospice Program Physician Certification of Terminal Illness.

3. A face-to-face visit with the recipient within 15 days of admission to Hospice.

4. The hospice Plan of Care.

3206.1A CERTIFICATION OF TERMINAL ILLNESS:

The hospice must obtain written certification of terminal illness, within two calendar days of initiation of services, signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician. If the recipient does not have an attending physician, this must be indicated on the Hospice Medicaid Information Form. If the hospice cannot obtain a written certification within two days, a verbal certification may be obtained within these two days, and a written certification obtained no later than eight days after care is initiated. If these requirements are not met, no payment will be made for days prior to the certification. Both the certification and election of hospice services statement must be in place for payment to commence. Ideally, the dates on the certification statement and the election statement should match, but if they differ, the earliest date will be the date payment will begin.

The certification of terminal illness must meet the following requirements:

1. The recipient must have a face-to-face encounter with any of the following within 15 business days from date of planned admission to Hospice Services. This face-to-face is not for certification of hospice services, but to ensure that recipient has been seen, examined and deemed appropriate for admission to Hospice. This encounter can occur in any setting

prior to Hospice admission:

a. Acute Care hospital

b. Nursing Facility

c. Private residence

d. Medical professional's office

e. Long Term Acute Care (LTACH)

The medical professional will make a note in their progress notes or discharge summaries when in the acute care setting:

The face-to-face may be performed by the following:

a. Physician

b. Doctor of Osteopathic Medicine (DO)

c. Physician Assistant

d. Advanced Practice Registered Nurse (APRN)

2. The Certification of Terminal Illness (CTI) must specify that the recipient's prognosis is terminal and life expectancy is six months or less if the illness runs its normal course.

3. Clinical information and other documentation that supports the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the recipient's eligibility assessment.

4. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and re-certification. The content of the narrative must support the terminal illness diagnosis by adhering to the Local Coverage Determination for Hospice (LCD) Guidelines and the Medicare Non-Cancer and Cancer Diagnosis Determination Guidelines for Hospice (see Section 3209, Determining Terminal Status).

5. Pediatric patients may not meet LCD criteria given that the criteria is largely geared toward adult prognosis and diseases. Hospices providing services to pediatric recipients must

submit clinical narratives describing the signs and symptoms that support the terminal illness and life expectancy prediction of six month or less without taking into account whether the patient is receiving concurrent care services.

3206.1B HOSPICE PLAN OF CARE (POC)

1. All hospice care and services furnished to recipients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the recipient or representative and the primary caregiver in accordance with the recipient's needs if any of them so desire. The hospice must ensure that each recipient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

3207 ELECTION OF HOSPICE CARE

An individual who is a designated Nevada Medicaid recipient, and has been certified as terminally ill, may file a Nevada Medicaid Hospice Election form (FA-92 for adults and FA-93 for pediatrics) with a licensed hospice provider who is contracted with the DHCFP. If the recipient is physically or mentally incapacitated, his or her representative may file a signed hospice election statement which must include the following:

1. Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice;

2. The recipient's or representative's acknowledgment he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;

3. Acknowledgment that certain otherwise covered Medicaid services are waived by the election, except for children under the age of 21;

4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date the election statement was executed and the date certification was made; and

5. The signature of the recipient or representative. In cases where a recipient signs the Hospice Election Statement with an "X", there must be two witnesses to sign next to his/her mark. The witnesses must also indicate relationship to the recipient and daytime phone numbers. Hospice provider representatives, employees or subcontractors cannot sign as witnesses. Verbal elections are prohibited.

The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the QIO-like vendor and prior authorization has been obtained. It is the responsibility of the hospice provider to ensure that prior authorization is obtained for services unrelated to the hospice benefit. Authorization requests for admission to Hospice Services must be submitted as soon as possible, but not more than eight business days following admission. Please note: if the authorization request is submitted after admission, the Hospice Provider is assuming responsibility for program costs if the authorization request is denied. Prior Authorization only approves the existence of medical necessity, not recipient eligibility.

3207.1 DURATION OF HOSPICE CARE PERIODS

1. An eligible recipient may elect to receive hospice care during one or more of the following election periods:

a. An initial 90-day period;

b. A subsequent 90-day period;

c. An unlimited number of subsequent 60-day periods.

2. An eligible recipient may receive an unlimited number of subsequent 60 day periods without a break in care as long as:

a. The recipient is re-certified by the hospice physician;

b. A hospice physician or Nurse Practitioner (NP) has a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the 180th day benefit period recertification and no more than 30 calendar days prior to every subsequent recertification thereafter. These face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.

c. The practitioner certifies that the recipient has a life expectancy of six months or less if the illness runs its normal course;

d. The recipient does not revoke the election of hospice; and

e. The recipient in the care of a hospice remains appropriate for hospice care.

3208 COORDINATION OF SERVICES

The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to:

1. Ensure that the interdisciplinary group maintains responsibility for directing, coordinating and supervising the care and services provided.

2. Ensure that the care and services are provided in accordance with the plan of care.

3. Ensure that the care and services provided are based on all assessments of the recipient and family needs.

4. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

5. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related illnesses.

3209 DETERMINING TERMINAL STATUS – Local Coverage Determinations (LCD) - Adults

Pediatric recipients may not meet LCD criteria given that the criteria is geared toward adult prognosis and diseases. Hospices providing services to pediatric recipients need to ensure all narratives and clinical documentation address all body systems, showing clinical data supporting the recipient's terminally ill status and decline in condition if curative care were no longer being pursued.

3209.1 NON-CANCER TERMINAL ILLNESSES:

1. CMS acknowledges that the primary diagnoses of hospice recipients have shifted from cancers to non-cancer terminal illnesses.

2. CMS clarifies that "debility" and "adult failure to thrive" SHOULD NOT be used as principal hospice diagnoses on the hospice claim form. When reported as a principal diagnosis, these would be considered questionable encounters for hospice care.

3. Claims would be returned to the provider (RTPd) for a more definitive principal diagnosis. "Debility" and "adult failure to thrive" could be listed on the hospice claim as other, additional or coexisting diagnoses. CMS expects providers to code the most definitive, contributory terminal diagnosis in the principal diagnosis field with all other related illnesses in the additional diagnoses fields for hospice claims reporting.

4. All recipients must have a terminal illness with a life expectancy of six months or less if the illness runs its normal course.

    a. Hospice Criteria for Adult Failure to Thrive Syndrome:

        (1) Terminal Illness Description: The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition and disability. The syndrome has been associated with multiple primary illnesses (e.g., infections and malignancies), but always includes two defining clinical elements, namely nutritional impairment and disability. The nutritional impairment and disability associated with the adult failure to thrive syndrome must be severe enough to impact the recipient's short-term survival. The adult failure to thrive syndrome presents as an irreversible progression in the recipient's nutritional impairment/disability despite therapy (i.e., treatment intended to affect the primary illness responsible for the recipient's clinical presentation).

        (2) Criteria for initial certification or recertification: Criteria below must be present at the time of initial certification or re-certification for hospice. An individual is considered to be terminally ill if the individual has a medical

prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. Recipients must meet a) and b) below:

a) The nutritional impairment associated with the adult failure to thrive syndrome must be severe enough to impact a beneficiary's weight. The Body Mass Index (BMI) of beneficiaries electing the Medicaid Hospice Benefit for the adult failure to thrive syndrome must be below 22 kg/m^2 and the recipient must be either declining enteral/parenteral nutritional support or has not responded to such nutritional support.

b) The disability associated with the adult failure to thrive syndrome should be such that the individual is significantly disabled. Significant disability must be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%. Both the recipient's BMI and level of disability should be determined using measurements/observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted prior to the hospice election and will be continued, the BMI and level of disability should be determined using measurements/observations made at the time of the initial certification and at each subsequent recertification. At the time of recertification recumbent measurement(s) - (anthropometry) such as mid-arm circumference in cm may be substituted for BMI with documentation as to why a BMI could not be measured. This information will be subject to review on a case by case basis.

b. Hospice Criteria for Adult HIV Disease:

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. Recipients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria: HIV Disease a) and b) must be present; factors from (3) will add supporting documentation.

a) CD4+ Count less than 25 cells/mcL or persistent viral load greater than 100,000 copies/ml, plus one of the following:

1) CNS lymphoma.

2) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass).

3) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment or treatment refused.

4) Progressive multifocal leukoencephalopathy.

5) Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy.

6) Visceral Kaposi's sarcoma unresponsive to therapy.

7) Renal failure in the absence of dialysis.

8) Cryptosporidium infection.

9) Toxoplasmosis, unresponsive to therapy.

b) Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50.

c) Documentation of the following factors will support eligibility for hospice care:

1) Chronic persistent diarrhea for one year

2) Persistent serum albumin less than 2.5 gm/dl

3) Age greater than 50 years

4) Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease

5) Advanced AIDS dementia complex

6) Toxoplasmosis

7) Congestive heart failure, symptomatic at rest, New York Heart Association (NYHA) classification Stage IV

c. Hospice Criteria for Adult Pulmonary Disease

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. Recipients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less)

if they meet the following criteria. The criteria refer to recipients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease: a) and b) must be present; documentation of c), d) and/or e) will lend supporting documentation:

a) Severe chronic lung disease as documented by both factors below:

1) Recipient with Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicted and disabling dyspnea at rest, poorly responsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue and cough (documentation of Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea and must be provided when performed). If the FEV1 has not been performed, the clinical condition must support an FEV1 less than 30% of predicted.

2) Progression of end stage pulmonary disease as documented by two or more episodes of pneumonia or respiratory failure requiring ventilatory support within the last six months. Alternatively, medical record documentation of serial decrease in FEV1 greater than 40 ml/year for the past two years can be used to demonstrate progression.

b) Hypoxemia at rest on room air, with a current ABG PO2 at or below 59 mm Hg or oxygen saturation at or below 89% taken at rest or hypercapnia, as evidenced by PCO2 greater than or equal to 50 mmHg (these values may be obtained from recent hospital records).

c) Cor pulmonale and right heart failure (RHF) secondary to pulmonary disease (e.g. not secondary to left heart disease or valvulopathy).

d) Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

e) Resting tachycardia greater than 100/min.

d. Hospice Criteria for Adult Alzheimer's Disease, Dementia & Related Disorders:

(1) Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Alzheimer's disease and related disorders are further substantiated with medical documentation of a progressive decline in the Reisburg Functional Assessment Staging (FAST) Scale, within a six-month period of time, prior to the Medicaid hospice election.

Criteria below must be present at the time of initial certification and recertification for hospice. Alzheimer's disease and related disorders may support a prognosis of six months or less under many clinical scenarios. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by co-morbid and/or secondary illnesses. Co-morbid illnesses affecting recipients with Alzheimer's disease are by definition distinct from the Alzheimer's disease itself - examples include coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Secondary illnesses on the other hand are directly related to a primary illness - in the case of Alzheimer's disease examples include delirium and pressure ulcers.

(2) The presence of secondary illnesses is thus considered separately by this policy. Recipients must meet a) and b) below:

a) To be eligible for hospice, the individual must have documentation of a FAST scale level equal to 7 and documentation of at least 4 or 6 sub-stage FAST scale indicators under level 7.

FAST Scale Items:

Stage #1: No difficulty, either subjectively or objectively.

Stage #2: Complains of forgetting location of objects; subjective work difficulties.

Stage #3: Decreased job functioning evident to coworkers; difficulty in traveling to new locations.

Stage #4: Decreased ability to perform complex tasks (e.g., planning dinner for guests; handling finances).

Stage #5: Requires assistance in choosing proper clothing.

Stage #6: Decreased ability to dress, bathe, and toilet independently:

Sub-stage 6a: Difficulty putting clothing on properly.

Sub-stage 6b: Unable to bathe properly; may develop fear of bathing.

Sub-stage 6c: Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly).

Sub-stage 6d: Urinary incontinence.

Sub-stage 6e: Fecal incontinence.

Stage #7: Loss of speech, locomotion and consciousness:

Sub-stage 7a: Ability to speak limited to approximately a half dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.

Sub-stage 7b: All intelligible vocabulary lost (Speech ability limited to the use of a single intelligible word in an average day or in the course of an intensive interview – the person may repeat the word over and over).

Sub-stage 7c: Non-ambulatory (Ambulatory ability lost – cannot walk without personal assistance).

Sub-stage 7d: Unable to sit up independently (Cannot sit up without assistance - e.g., the individual will fall over if there are not lateral rests [arms] on the chair).

Sub-stage 7e: Loss of ability to smile.

Sub-stage 7f: Loss of ability to hold head up independently.

b) Documentation of specific secondary illness(es) related to Alzheimer's Disease must be present, including but not limited to, Contractures, Pressure Ulcers, recurrent UTI, Dysphagia, Aspiration Pneumonia.

e. Hospice Criteria for Adult Stroke and/or Coma

(1) Criteria below must be present at the time of initial certification and recertification for hospice. The medical criteria listed below would support

a terminal prognosis for individuals with a diagnosis of stroke. Recipients must meet a) and b) below:

a) A Palliative Performance Scale (PPS) of less than or equal to 40:

1) Degree of ambulation - Mainly in bed.

2) Activity/extent of disease - not able to do work; extensive disease.

3) Ability to do self-care - Mainly Assistance.

4) Food/fluid intake - Normal to reduced.

5) State of consciousness - Either fully conscious or drowsy/confused.

b) Inability to maintain hydration and caloric intake with any one of the following:

1) Weight loss greater than 10% during previous three months.

2) Weight loss greater than 7.5% in previous six weeks.

3) Serum albumin less than 2.5 gm/dl.

4) Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.

5) Calorie counts documenting inadequate caloric/fluid intake. (Recipient's height and weight - caloric intake is too low to maintain normal BMI or fewer calories than necessary to maintain normal BMI - determine with caloric counts).

6) Dysphagia severe enough to prevent the recipient from receiving food and fluids necessary to sustain life in a recipient who declines or does not receive artificial nutrition and hydration.

c) The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of coma (any etiology).

Comatose recipients with any three of the following on day three or after of coma:

1) Abnormal brain stem response.

2) Absent verbal response.

3) Absent withdrawal response to pain.

4) Increase in serum creatinine greater than 1.5 mg/dl.

f. Hospice Criteria for Adult Amyotrophic Lateral Sclerosis (ALS).

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. ALS tends to progress in a linear fashion over time. The overall rate of decline in each Recipient is fairly constant and predictable, unlike many other non-cancer diseases. No *single* variable deteriorates at a uniform rate in all recipients. Therefore, multiple clinical parameters are required to judge the progression of ALS. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time recipients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist. In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent, ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the recipient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis. Examination by a neurologist within three months of assessment for hospice is required, both to confirm the diagnosis and to assist with prognosis. Recipients will be considered to be in the terminal stage of ALS (life expectancy of six months or less) if they meet the following criteria (must fulfill a), b) or c)):

a) The recipient must demonstrate critically impaired breathing capacity.

Critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

1) Vital capacity (VC) less than 30% of normal.

2) Continuous dyspnea at rest.

3) Hypoxemia at rest on room air, with a current ABG PO2 at or below 59mm Hg or oxygen saturation at or below 89%.

4) Recipient declines artificial ventilation.

b) Recipient must demonstrate both rapid progression of ALS and critical nutritional impairment.

1) Rapid progression of ALS as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

(a) Progression from independent ambulation to wheelchair or bed bound status.

(b) Progression from normal to barely intelligible or unintelligible speech.

(c) Progression from normal to pureed diet.

(d) Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs.

2) Critical nutritional impairment as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

(a) Oral intake of nutrients and fluids insufficient to sustain life.

(b) Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

c) Recipient must demonstrate both rapid progression of ALS and life-threatening complications.

1) Rapid progression of ALS, see b) 1) above.

2) Life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months

preceding initial hospice certification: Upper urinary tract infection (pyelonephritis) and Sepsis.

3) Other medical complications not identified above will be reviewed on a case-by-case basis with appropriate medical justification.

g. Hospice Criteria for Adult Heart Disease

(1) Criteria for initial certification or recertification: Criteria below must be present at the time of initial certification or re-certification for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of heart disease. Medical criteria a) and b) must be present as they are important indications of the severity of heart disease and would thus support a terminal prognosis if met.

a) When the recipient is approved or recertified the recipient is already optimally treated with diuretics and vasodilators, which may include angiotensin converting enzymes (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, or evidence of treatment failure prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, or recipient voluntarily declines treatment, the documentation must be present in the medical records or with lab results and medical records submitted upon request.

b) The recipient has significant symptoms of recurrent congestive heart failure (CHF) at rest, and is classified as a New York Heart Association (NYHA) Class IV:

1) Unable to carry on any physical activity without symptoms.

2) Symptoms are present even at rest.

3) If any physical activity is undertaken, symptoms are increased.

c) Documentation of the following factors may provide additional support for end stage heart disease:

1) Treatment resistant symptomatic supraventricular or ventricular arrhythmias.

2) History of cardiac arrest or resuscitation.

3) History of unexplained syncope.

4) Brain embolism of cardiac origin.

5) Concomitant HIV disease.

6) Documentation of ejection fraction of 20% or less.

7) Angina pectoris, at rest.

h. Hospice Criteria for Adult Liver Disease

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(1) Criteria for initial certification and recertification: Criteria below must be present at the time of initial certification/recertification for hospice. Recipients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria:

a) Documentation of progression with active decline as evidenced by worsening clinical status, symptoms, signs and laboratory results. The recipient's terminal illness must be supported by one or more of the items below:

1) Clinical Status

(a) Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.

2) Documented progressive inanition (II) Symptoms

(a) Dyspnea with increasing respiratory rate.

(b) Nausea/vomiting poorly responsive to treatment.

(c) Diarrhea, intractable.

(d) Pain requiring increasing doses of major analgesics more than briefly.

3) Signs

(a) Ascites.

(b) Edema.

(c) Weakness.

(d) Increasing pCO2 or decreasing pO2 or decreasing SaO2.

(e) Increasing liver function studies.

(f) Progressively decreasing or increasing serum sodium.

4) Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease.

5) Progression to dependence on assistance with additional activities of daily living.

6) History of increasing ER visits, hospitalizations or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

b) End stage liver disease is present and the recipient shows at least one of the following:

1) Change in level of consciousness.

2) Ascites, refractory to treatment or recipient non-complaint.

3) Spontaneous bacterial peritonitis.

4) Hepatorenal syndrome (elevated serum creatinine and BUN with oliguria (<400 ml/day) and urine sodium concentration less than 10 mEq/l.

5) Hepatic encephalopathy, refractory to treatment or recipient non-compliant.

6) Recurrent variceal bleeding, despite intensive therapy.

c) Documentation of the following factors will also support eligibility for hospice care:

1) Progressive malnutrition.

2) Muscle wasting with reduced strength and endurance.

3) Continued active alcoholism (>80 gm ethanol/day).

4) Hepatocellular carcinoma.

5) HBsAg (Hepatitis B) positivity.

6) Hepatitis C refractory to interferon treatment.

i. Hospice Criteria for Adult Renal Disease

When an individual elects Hospice care for end stage renal disease or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a recipient may access both the hospice benefit and ESRD benefit is when the need for dialysis is not related to the patient's terminal illness, or if the pediatric recipient is pursuing concurrent care.

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. Recipients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria:

a) Acute renal failure 1) and 2) must be present:

1) Creatinine clearance less than 10 cc/min (less than 15 cc/min for diabetes).

2) Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetes).

b) Chronic renal failure 1), 2) and 3) must be present:

1) Creatinine clearance less than 10 cc/min (less than 15 cc/min for diabetes).

2) Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetes).

3) Glomerular filtration rate (GFR) less than 30 ml/min.

3209.2 HOSPICE CRITERIA FOR ADULT CANCER

1. Criteria for initial certification or recertification: Criteria below must be present at the time of initial certification or re-certification for hospice. Recipients will be considered to be in the terminal stage of cancer (life expectancy of six months or less) if (a) or (b) below are present:

   a. Documentation of metastasis or final disease stage is required with evidence of progression as documented by worsening clinical status, symptoms, signs and/or laboratory results.

   b. Progression from an earlier stage of disease to metastatic disease with either:

      (1) A continued decline in spite of therapy, that is, aggressive treatment, or

      (2) Recipient declines further disease directed therapy.

3210 REASONS FOR DENIAL OF ANY OF THE ABOVE

1. Recipients not meeting the specific medical criteria in this policy.

2. Absence of supporting documentation of progression or rapid decline.

3. Failure to document terminal status of six months or less if the illness runs its normal course.

4. Recipient is not eligible for full Medicaid benefits.

5. A person who reaches a point of stability and is no longer considered terminally ill must not be recertified for hospice services. The individual must be discharged to traditional Medicaid benefits.

3211 RECIPIENT RESPONSIBILITY

The Medicaid recipient is responsible for signing the election statement to receive hospice care. The election statement may be signed by the recipient's representative.

The recipient is responsible to comply with the POC as established by the hospice interdisciplinary group.

3212 CHANGING THE DESIGNATED HOSPICE

An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

1. The change of the designated hospice is not a revocation of the hospice election for the period in which it was made.

2. To change the designation of hospice agencies, the individual or representative must file, with the hospice agency from which care has been received and with the newly designated hospice, a Nevada Medicaid Hospice Action Form that includes the following:

   a. The name of the hospice from which the individual has received care;

   b. The name of the hospice from which he or she plans to receive care;

   c. The effective date of the transfer of hospice care.

3. The transferring hospice agency files the notice in the medical record and faxes one copy to the receiving hospice and faxes one copy to the QIO-like vendor along with a Hospice Medicaid Information form.

4. The receiving hospice agency must fax an updated Hospice Medicaid Information form, Hospice Ancillary Information form, a signed election statement and a signed copy of the physician's certification of terminal illness to the QIO-like vendor.

5. If a hospice recipient is residing in an NF, the transferring hospice agency is required to submit a copy of the transfer statement to the NF for their records.

3213 REVOKING THE ELECTION OF HOSPICE CARE

An individual or representative may revoke the election of hospice care at any time during an election period.

1. To revoke the election of hospice care, the recipient or representative must file with the hospice a Nevada Medicaid Hospice Action Form to be placed in the medical record that includes the following information:

   a. Signed statement that the recipient or representative revokes the recipient's election for coverage of hospice care for the remainder of that election period with the date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made);

   b. The hospice agency is required to fax the QIO-like vendor the signed copy of the revocation notice and a Medicaid Hospice Information form/Notice of Revocation within 72 hours, once the revocation notice has been signed.

2. If the hospice recipient is residing in an NF, the hospice agency is required to immediately submit to the NF a signed copy of the notice of revocation for their medical records.

3. An individual, upon revocation of the benefit election of hospice care for a particular election period:

   a. Is no longer covered for hospice care for that election period;

   b. Resumes eligibility for all Medicaid covered services as before the election to hospice; and

   c. May at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible to receive.

3214 DISCHARGE OF A RECIPIENT FROM HOSPICE

With adequate documentation explaining cause, a hospice may discharge a recipient.

1. Reasons for discharge may include:

   a. Noncompliance with hospice POC;

   b. Moves out of the hospice's service area or transfers to another hospice;

   c. No longer meets the criteria for hospice;

   d. No longer eligible for Medicaid; or

   e. Request of recipient, or representative.

2. The hospice must have policies in place to address disruptive, abusive or uncooperative behavior, on the part of the recipient or other individuals in the home, to the extent that delivery to the recipient or the ability of the hospice to operate is seriously impaired. The hospice must do the following prior to discharge for cause:

   Advise the recipient that a discharge for cause is being considered.

   a. Make a serious effort to resolve the problem(s) presented by the recipient's behavior or situation;

   b. Ascertain that the recipient's proposed discharge is not due to the recipient's use of necessary services; and

   c. Document the problem(s) and efforts made to resolve the problems(s) and enter this documentation into its medical records.

3. Prior to discharge, the hospice must obtain a written discharge order from the hospice medical director. If a recipient has an attending physician, the physician must be consulted and his/her recommendation or decision must be included in the discharge note.

4. A copy of the signed discharge notice, physician's discharge order and the Nevada Medicaid Hospice Action Form are required to be faxed to the QIO-like vendor within 72 hours of the discharge. A copy is retained in the client's record at the hospice.

5. If the hospice recipient is residing in an NF, the hospice is required to immediately submit a copy of the signed discharge notice to the facility for their records the day the discharge notice has been signed. The hospice agency is required to also verbally inform the NF staff

of the discharge.

3215 HEARINGS

All Medicaid recipients and providers have rights to hearings regarding reimbursement and treatment issues. Please refer to Medicaid Services Manual (MSM) Chapter 3100, Hearings for the hearing process

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 30, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3300 – PROGRAM INTEGRITY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3300 – Program Integrity are being proposed to clarify the authority to implement payment suspensions as outlined in 42 Code of Federal Regulations (CFR) 455.23.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: All Medicaid Providers.

Financial Impact on Local Government: None known at this time.

These changes are effective May 1, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 08/19 MSM Ch 3300 – Program Integrity	MTL 19/07, 07/07 MSM Ch 3300 – Program Integrity

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3302.2	**Administrative Action**	Add: "payment suspensions;" between "status;" and "and."
3303.2B(4)	**Coverage and Limitations**	Add "if payment" in between "to determine" and "has or will be made."
3303.3A(2)	**Coverage and Limitations**	Replace: "The" with "the" before "DHCFP."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3303.3A(2)(1)	**Coverage and Limitations**	Move text regarding the fair hearing process within the section.
3303.3A(4)	**Coverage and Limitations**	Paragraph now reads: "Payment suspensions to the provider. The DHCFP may implement a payment suspension and withhold payments to the provider, in whole or in part, upon determining there is a credible allegation of fraud or willful misrepresentation under the Medicaid or Nevada Check Up programs. The DHCFP may suspend payment without first notifying the provider. The DHCFP will send notice to the provider in accordance with 42 CFR 455.23."
3303.3A(4)(a)	**Coverage and Limitations**	Remove: "Specify the claims affected by the withholding action." Add: "Set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation."
3303.3A(4)(b)	**Coverage and Limitations**	Remove: "withholding action will be." Add: "payment suspension is."
3303.3A(4)(c)	**Coverage and Limitations**	Add: "the payment suspension." Remove: "withholding."
3303.3A(4)(d)	**Coverage and Limitations**	Remove: "Cite the duration of the withholding." Add: "Specify, when applicable, to which type or types of Medicaid claims or business units of a provider are subject to the payment suspension;"
3303.3A(4)(e)	**Coverage and Limitations**	Remove: "and."
3303.3A(4)(t)	**Coverage and Limitations**	Add: "Set forth the applicable State administrative appeals process and corresponding citations to State law; and."

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

PROGRAM INTEGRITY

3300 INTRODUCTION

The Division of Health Care Financing and Policy (DHCFP) is responsible for the fiscal integrity of the Medicaid and Nevada Check Up programs and is committed to a program that identifies and reduces fraud, abuse and improper payments. The DHCFP must ensure Medicaid and Nevada Check Up recipients have access to quality care and claims are paid appropriately and in accordance with state statutes and federal laws and regulations, program policies and billing manuals. The DHCFP has three distinct programs to assist in ensuring the fiscal integrity of the programs it administers: the Surveillance and Utilization Review (SUR) program, the Payment Error Rate Measurement (PERM) program and the Financial and Compliance Audit program.

Surveillance and Utilization Review

Federal regulations require the DHCFP to operate a statewide SUR program to safeguard against unnecessary or inappropriate use of services and prevent excess payments in an efficient, economical and effective manner. The DHCFP has methods in place to: identify, investigate and refer suspected cases of provider and recipient fraud and abuse; methods and processes to review provider over-utilization of services and in the case of managed care providers, under-utilization of services and recover improper payments. The DHCFP will conduct reviews to determine if services were billed in accordance with applicable policies and/or regulations. Providers are selected for review based on complaints, referrals and through the use of fraud detection and other analysis. All providers are at risk for review.

The DHCFP must refer all cases of suspected fraud and abuse, pursuant to Nevada Revised Statutes (NRS) 422.540 to 422.570, to the Office of the Attorney General, Medicaid Fraud Control Unit (MFCU). The MFCU has the primary authority and responsibility to fully investigate and prosecute, for civil and/or criminal action, violations of fraud and abuse in the Medicaid and Nevada Check Up programs.

The Division of Welfare and Supportive Services (DWSS) is responsible for all recipient related Medicaid fraud and abuse, including unlawful acts relating to Medicaid cards. To report any fraudulent activity related to Medicaid recipients contact the Investigations and Recovery Unit within the DWSS or fill out a fraud report on-line at http://welfare.state.nv.us/I&R/ir.htm.

The DHCFP must ensure the exclusion of certain individuals and entities from participation in the Medicaid and Nevada Check Up programs. For the DHCFP policies and applicable state and federal statutes and regulations relating to this process, refer to the Medicaid Services Manual (MSM) Chapter 100.

The DHCFP must ensure all entities receiving payments of $5 million or more from the Medicaid program establish policies for the entity's employees providing detailed information about: the entity's procedures for detecting and preventing fraud, waste and abuse; false claims; civil and

criminal penalties; and whistle blower protections. For the DHCFP policy relating to this provider requirement, refer to MSM Chapter 100.

Payment Error Rate Measurement (PERM)

The Improper Payments Act of 2002 (IPIA) requires the Centers for Medicare and Medicaid Services (CMS) to estimate improper payments in all state Medicaid and State Children's Health Insurance Programs (SCHIP) (Nevada Check Up). CMS must annually calculate and report to Congress the national error rates in each of these programs and the actions it is taking to reduce improper payments in these health care programs. To meet the requirements of the federal mandate, CMS requires each state to undergo a PERM review once every three years. Nevada will be reviewed in federal fiscal year 2008 and every third year thereafter.

PERM reviews consist of a thorough analysis of recipient eligibility, claims processing and medical record or service documentation. Recipient eligibility reviews will be conducted by the DWSS. The claims processing and medical record or service documentation reviews for the mandated PERM program will be conducted by federal contractors.

Financial and Policy Compliance Audits

The DHCFP will conduct regular financial and policy compliance audits of programs and services provided under the Medicaid and Nevada Check Up programs. These audits consist of a thorough review of program policy, claims processing and/or medical or service record documentation.

3301 REGULATORY AUTHORITY

Provider and recipient fraud, abuse and improper payments are regulated by federal law and state statute, specifically, the Social Security Act (SSA), United States Code (USC) (Title 42), Code of Federal Regulation (42 CFR) and the Nevada Revised Statutes (NRS). Specific authorities include, but are not limited to:

Social Security Act (SSA)

A. The penalty for fraud is regulated by Section 1107.

B. Section 1128A outlines civil monetary penalties for acts involving federal health care programs.

C. Section 1128B outlines criminal penalties for acts involving federal health care programs.

D. Section 1902 and Section 2103 govern the amount, duration and scope of medical assistance for Medicaid and Nevada Check Up recipients, respectively.

E. Section 1902(a)(68) describes the requirements for false claims education for entities receiving $5 million in payments from the Medicaid program. Refer to the Deficit Reduction Act of 2005, Section 6032.

F. Section 1903 and Section 2105 govern federal and other payments to states for Medicaid and Nevada Check Up programs, respectively.

G. Section 1903(q) describes the requirements of state MFCU.

H. Sanctions for non-compliance of provisions relating to managed care are regulated by Section 1932.

Code of Federal Regulations (CFR)

A. 42 CFR Part 431, Subpart Q – Requirements for Estimating Improper Payments in Medicaid and SCHIP.

B. 42 CFR 431.54(e) – Regulates recipient lock-in for recipients over utilizing services.

C. 42 CFR 431.54(f) – Regulates restrictions such as provider lock-out or suspension for abuse of the Medicaid program.

D. 42 CFR 455 Subpart A – Describes the requirements of Medicaid Agency Fraud Detection and Investigation Programs.

E. 42 CFR 456 Subpart A – Describes the general provisions for utilization control in state or federal health care programs.

F. 42 CFR 456 Subpart B – Describes the requirements of a statewide Surveillance and Utilization Review control program for all Medicaid services.

G. 42 CFR 457.915-.935 – Pertains to fraud detection and investigation associated with the SCHIP.

H. 42 CFR 1001 – Regulates the mandatory and permissive provider exclusions for state or federal health care programs.

I. 42 CFR 1002 – Includes regulations for state-initiated exclusions from Medicaid programs.

J. 42 CFR 1003 – Provides for the imposition of civil money penalties and other applicable regulations regarding exclusion of individuals or entities from federal or state health care programs.

K. 42 CFR 1005 – Regulates appeals of exclusions, civil money penalties and assessments.

Nevada Revised Statutes (NRS)

A. NRS 193.120-193.150 – Details the types of crimes and punishments associated with fraudulent acts.

B. NRS 228.410 – Established the MFCU, including their duties and powers. The MFCU is responsible for the investigation and prosecution of violations of NRS 422.540-422.570.

C. NRS 357 – Governs false claims submitted to state or local governments.

D. NRS 422.2374 – Details the required cooperation between the DHCFP and the MFCU involving the suspension or exclusion of provider services under Medicaid.

E. NRS 422.305 – Regulates confidentiality of information obtained in investigations of a provider of services for Medicaid.

F. Unlawful acts regarding Medicaid cards are regulated by NRS 422.366-422.369.

G. Unlawful acts; fraud by person authorized to provide care to holder of stolen, forged, expired or revoked card; penalties are regulated by NRS 422.369.

H. NRS 422.410-422.590 – Covers unlawful acts and penalties related to services provided by or through the DHCFP.

3302 DEFINITIONS

Definitions apply to this chapter and do not supersede applicable state or federal law.

3302.1 ABUSE

Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid or Nevada Check Up programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid or Nevada Check Up programs. (42 CFR 455.2)

3302.2 ADMINISTRATIVE ACTION

Administrative Action is an action taken by the DHCFP which includes but is not limited to: the recovery of improper payments; issuance of educational letters; issuance of warning letters; issuance of recoupment/recovery letters; special claims reviews or on-site audits; requests for provider corrective action plans; requests for provider self audits; referral to appropriate civil agencies (licensing bodies); referral to the MFCU; denial of provider applications; suspension and termination of provider status; payment suspensions; and other actions as stated in policy 3303.3A. See the SSA Sections: 1128, 1128A, 1128B, and 1903.

3302.3 FRAUD

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)

3302.4 IMPROPER PAYMENT

An improper payment is any payment that is billed to or paid by the DHCFP that is not in accordance with: The Medicaid or Nevada Check Up policy governing the service provided; fiscal agent billing manuals; contractual requirements; standard record keeping requirements of the provider discipline; and federal law or state statutes. An improper payment can be an overpayment or an underpayment. Improper payments include but are not limited to: improper payments discovered during federal PERM reviews or Financial and Policy Compliance Audits; payments for ineligible recipients; payments for ineligible, non-covered or unauthorized services; duplicate payments; payments for services that were not provided or received; payments for unbundled services when an all-inclusive bundled code should have been billed; payments not in accordance with applicable pricing or rates; data entry errors resulting in incorrect payments; payments where the incorrect procedure code was billed (up-coding); payments over Medicaid allowable amounts; payments for non-medically necessary services; payments where an incorrect number of units were billed; submittal of claims for unauthorized visits; and payments that cannot be substantiated by

appropriate or sufficient medical or service record documentation. Improper payments can also be classified as fraud and/or abuse.

3302.5 KICKBACKS

The offering or receiving of any payments or incentives by/from a provider for referring patients, including illegal cash reimbursements, vacations, merchandise or personal services. (NRS 422.560)

3302.6 OVERPAYMENT/UNDERPAYMENT

This is an amount paid by the DHCFP, to a provider, which is in excess of or less than the amount that is allowable for services furnished under applicable policy, rate or regulation.

3302.7 PERM REVIEW ERRORS

These are payment errors discovered during the course of PERM medical record, processing or eligibility reviews.

3302.8 RECOUPMENT/RECOVERY

Recoupment or recovery is an administrative action by the DHCFP or its fiscal agent to initiate re-payment of an overpayment, with or without advance official notice. Recoupment or recovery can be made by reducing future payments to a provider or by direct reimbursement from the provider.

3302.9 UNBUNDLING

Unbundling is the billing of separate procedure codes rather than one all-inclusive code when an all-inclusive code is required to be billed.

3302.10 UP-CODING

Up-coding is billing using procedure codes that overstate the level or amount of health care or other service provided.

3303 POLICY

3303.1 IDENTIFICATION OF FRAUD, ABUSE AND IMPROPER PAYMENTS

The DHCFP has methods and criteria to identify and track suspected cases of fraud, abuse and/or improper payments. These methods or criteria must not infringe on the legal rights of persons involved; must afford due process of law; and must comply with federal law and state statutes.

3303.1A COVERAGE AND LIMITATIONS

1. The following activities are the responsibility of the DHCFP:

   a. Conduct regular investigations or reviews of claims or other payments to determine if improper payments have been made or fraud and/or abuse has occurred;

   b. Investigate and track referrals from all sources;

   c. Refer suspected fraud and abuse cases to the MFCU in accordance with the Memorandum Of Understanding (MOU) between the DHCFP and the MFCU and state statutes;

   d. Request and/or monitor provider self-audits;

   e. Assist the DHCFP administrative staff, as necessary, in clarification or revision of Medicaid and Nevada Check Up policies to aid in preventing or reducing fraud, abuse and/or improper payments;

   f. Assist with assuring Medicaid recipients receive necessary health or other care services at an appropriate level and quality;

   g. Process and track recoupment or recovery of improper payments or improperly paid claims;

   h. Educate providers about the requirements related to provision of service documentation mandated by the PERM program;

   i. Assist in providing education to providers on proper billing practices;

   j. Assist in assuring provider compliance with the DHCFP program policy, MSM, Medicaid Operations Manual (MOM), provider billing manuals and federal law and state statutes;

   k. Develop and maintain methodologies to verify services reimbursed by the DHCFP were actually furnished to recipients. The DHCFP fiscal agent sends out

approximately 500 notices each month to a random sample of Medicaid and Nevada Check Up recipients receiving services. This is the Verification of Service (VOS) program. Recipients are asked to notify the DHCFP if the services listed were not received. All recipient responses received by the DHCFP are reviewed and if warranted, investigations are conducted;

l. Take all necessary steps to ensure the fiscal integrity and effectiveness of the programs administered by the DHCFP.

2. Fraudulent acts, false claims or abusive billing practices include, but are not limited to:

a. Knowingly and designedly, by any false pretense, false or misleading statement, impersonation or misrepresentation, obtain or attempt to obtain authorization to furnish services, receive payment for services, receive public assistance, money, property or medical care;

b. Submitting a claim or causing a claim to be submitted knowing the claim to be false, in whole or in part, by commission or omission;

c. Make or cause to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission;

d. Make or cause to be made a statement or representation for use by another in obtaining goods or services pursuant to the state plan, knowing the statement or representation to be false, in whole or in part, by commission or omission;

e. Make or cause to be made a statement or representation for use in qualifying as a provider, knowing the statement or representation to be false, in whole or in part, by commission or omission;

f. Concealing or failing to disclose knowledge affecting the initial or continued right to any payment or to secure such payment either in greater quantity than is due or when no such payment is authorized or due;

g. Converting part or all of any payment intended for another person to himself/herself;

h. Soliciting, receiving, offer or pay any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for or to induce any person to make:

1. Referral of an individual to a provider;

2. Purchase, lease, order, arrange for or recommend the purchase, lease or order of any item, service, good or facility for which payment may be made, in whole or part, under the programs operated by the DHCFP;

3. Submit or cause to be submitted bills or requests for payment containing charges or costs that are substantially in excess of customary charges or costs;

i. Submit a false application for provider status;

j. Submitting false information to obtain compensation for services, supplies or equipment the provider is not entitled to from the programs operated by the DHCFP;

k. Submitting repeated claims for services that are not reimbursable by the DHCFP;

l. Submitting repeated claims from which required information is missing or incorrect;

m. Violating any provision in the DHCFP provider agreement (contract between the DHCFP and the provider);

n. Acts which result in termination, suspension or exclusion of the provider from other governmental programs;

o. Any acts which violate professional conduct standards adopted by state medical licensure boards and other medical professional organizations;

p. Submitting a duplicate claim for services or items for which the provider has already received or claimed reimbursement from a source;

q. Submitting a claim for services or items which were not rendered by the provider or were not rendered to an eligible recipient;

r. Submitting a claim for services or items which includes costs or charges which are not related to the cost of the services or items;

s. Except in emergency situations, dispensing, rendering or providing a service or items without a practitioner's written order and the consent of the recipient;

t. Submitting a claim which misrepresents the description of the services, supplies or equipment dispensed or provided, the date of service, the identity of the recipient or of the attending, prescribing, referring or actual provider;

u. Submitting a claim for medically unnecessary services;

v. Coercion of recipients to sign Verification of Service forms for services not provided;

w. Reporting or billing for hours or services when services were not provided to the extent reported or billed;

x. False statements include, but are not limited to:

1. Falsification of medical records;

2. Submitting a bill for a service not provided;

3. Up-coding;

4. Unbundling;

5. Business, fiscal or medical practices which result in unnecessary costs to the programs operated by the DHCFP;

6. Duplicate billing for services, supplies or equipment;

7. Providing medical care, services or equipment which are not medically necessary or which fail to meet professionally recognized standards for health care; and/or

8. Failure to develop and maintain health service records as required by NRS 422.570 and the DHCFP policy.

3. Confidentiality of information.

a. All material gathered during an inquiry of fraud, abuse or improper payment will only be used for the purpose for which it was gathered and will not be distributed to any individual(s) or organization(s), with the exception of MFCU and/or the Office of the Inspector General, the CMS or their sub-contractors.

b. Any information obtained by the DHCFP or the MFCU in an investigation of a provider of services under the State Plan for Medicaid is confidential unless it is

used as evidence at a hearing to enforce the provisions of NRS 422.450 to 422.590 or to review an action by the DHCFP against a provider.

c. Release of information or evidence is done in compliance with published confidentiality and privacy law, rules and regulations. Materials collected by the DHCFP may be of an extremely sensitive nature. All such materials are kept secure.

d. The identity of any person reporting fraud, abuse or improper payments is not disclosed unless mandated by court order or the person agrees to the disclosure of their identity.

The identity of any recipient or applicant receiving assistance is always kept confidential unless disclosure is authorized by the recipient or legally responsible adult.

e. The DHCFP is a covered entity, as defined by the Health Insurance Portability and Accountability Act (HIPAA) regulations (45 CFR Parts 160, 162 and 164), and as such, must comply with all aspects of this federal regulation.

3303.1B PROVIDER RESPONSIBILITY

1. Providers have an obligation to report to the DHCFP any suspicion of fraud or abuse in the DHCFP programs, including fraud or abuse associated with recipients or other providers.

2. Providers must adhere to:

a. The DHCFP policy;

b. Provider services and operations manuals;

c. Fiscal agent billing manuals;

d. All applicable federal law and state statutes; and

e. Any other guidance furnished by the DHCFP or their fiscal agent regarding provider requirements and responsibilities.

3303.1C RECIPIENT RESPONSIBILITY

Recipients have an obligation to report to the DHCFP any suspicion of fraud, abuse or improper payment in the DHCFP programs or concerning the DHCFP recipients or providers.

3303.2 INVESTIGATIONS OF FRAUD, ABUSE OR IMPROPER PAYMENTS

The DHCFP conducts investigations of all suspected cases of fraud, abuse or improper payments. Investigations continue until an appropriate action is taken or the case is closed.

PERM reviews are done in accordance with the requirements mandated by CMS. PERM reviews are completed by CMS or their sub-contractors every three years starting in FY 2008.

Financial and Policy Compliance audits are performed regularly by the DHCFP and follow the standards and guidelines developed by CMS for the PERM reviews.

Suspected fraud or abuse discovered during the course of a PERM review or a Financial and Policy Compliance Audit will be referred to the MFCU for further investigation or action.

3303.2A COVERAGE AND LIMITATIONS

1. An investigation or review is initiated by the DHCFP when questionable practices are identified or the DHCFP receives complaints of suspected fraud, abuse or improper payments.

2. An investigation consists of a thorough review of the complaint or questionable practice and may include: An analysis of the paid claims; review of provider and recipient reports; review of policy and billing manuals; review of applicable rates; review of medical or other service record documentation; and review of appropriate federal law and state statutes.

3. The MFCU of the Attorney General's Office is the single state agency responsible for the investigation and prosecution of violations of NRS 422.540 to 422.570, inclusive (NRS 228.410). All suspected cases of provider fraud and/or abuse are referred to the MFCU in accordance with the MOU between the DHCFP and the MFCU.

4. PERM reviews consist of an analysis of randomly sampled Fee-for-Service (FFS) and managed care claims or line items.

    a. FFS claims or line items will undergo a medical record or service documentation review and a claims processing review.

        1. At a minimum, the following items will be considered PERM Review Errors resulting from medical reviews:

            a. No documentation or insufficient documentation provided within specified timeframes to support the service billed and paid by the DHCFP.

b. Claim billed with incorrect procedure code.

c. Provider billed separate procedure codes when a bundled procedure code should have been used.

d. The number of units billed was incorrect.

e. Service was medically unnecessary.

f. Service or procedure was not in agreement with documented policy.

2. At a minimum, the following items will be considered PERM Review Errors resulting from processing reviews:

a. Duplicate claims billed for same service, same recipient and same date of service.

b. Claim paid for a non-covered service.

c. FFS claim paid although the recipient was enrolled in managed care.

d. Incorrect rate was used to pay the claim.

e. Logical edit issues (e.g. gender and procedure code are incompatible).

f. Data entry errors.

b. Managed care payments will undergo a claims processing review only. The managed care claims reviewed will include monthly capitation payments and condition specific payments such as maternity payments and re-insurance payments. At a minimum, the following items will be considered PERM Review Errors resulting from managed care reviews:

1. Recipient not eligible for enrollment in a Health Maintenance Organization (HMO).

2. Recipient not enrolled in the HMO that received the capitation or other payment.

3. Incorrect capitation or other payment – either the wrong rate cell was used to pay the claim or the rate was not consistent with the rate in the HMO contract.

5. Financial and Policy Compliance Audits may utilize random sampling techniques or may target specific provider types, procedures or services. These audits will utilize the guidelines for PERM reviews addressed in 4. of Section 3303.2A above.

3303.2B PROVIDER RESPONSIBILITY

1. Providers are bound by both federal and state statutes and regulations, the DHCFP policy and the DHCFP provider agreement to cooperate and provide any and all documentation (e.g., medical records, charts, billing information and any other documentation) requested by the DHCFP or other state and/or federal officials or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP.

2. The DHCFP providers are required to keep records sufficient and necessary to establish medical necessity and to fully disclose the basis for the type, extent and level of the services provided to recipients. All services billed to and paid by the DHCFP which cannot be validated by appropriate documentation are subject to recovery.

3. Requested documentation must be provided within timeframes specified by the DHCFP or other state or federal officials.

4. Records, documentation and information must be available regarding any service for which payment has been or will be claimed to determine if payment has or will be made in accordance with applicable federal and state requirements.

5. Providers must make all documentation requested by the DHCFP readily available for review by state and/or federal officials or their authorized agents. Readily available means the records shall be made available at the provider's place of business or, upon written request, forwarded without charge to the state or federal official requesting the documentation.

6. For medical record requests associated with the DHCFP audits or investigations, providers are required to submit documentation to support the claims under review within 15 calendar days after receipt of a letter from the DHCFP requesting such information.

7. For medical record requests associated with the mandated federal PERM reviews, providers are required to submit documentation to support the claim or line item under review within the timeframes specified in the PERM Final Rule (released in the Federal Register on August 31, 2007) or any subsequent policy instruction issued by CMS.

8. All records subject to audit or review must be produced at no cost to the DHCFP.

9. Providers must adhere to both federal and state statutes and regulations and the DHCFP policy concerning the appropriate and adequate documentation of services billed to the DHCFP.

10. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with the DHCFP operations or services manuals and state and federal statutes and regulations.

11. Providers must retain patient records in accordance with state and or federal statutes and regulations or at a minimum for six years from the date of payment for the specified service.

3303.3 ADMINISTRATIVE ACTIONS AND CIVIL AND CRIMINAL PENALTIES

The DHCFP is required and authorized to review identified cases of suspected fraud, abuse and improper payments and impose appropriate actions upon offending parties. The DHCFP is able to impose a variety of Administrative Actions including referral to the MFCU at the Attorney General's Office. The MFCU has the authority to impose civil monetary and other penalties as well as criminally prosecute offenders.

In determining the appropriate action(s) to recommend in a fraud, abuse or improper payment situation, the following will be considered:

A. Recommendations of the MFCU;

B. Action(s) necessary to eliminate fraud or abuse and to recover payments related to the fraud, abuse or improper payment;

C. Seriousness of the offense(s);

D. Number of current and past violations;

E. Provider's willingness to cooperate;

F. Past sanctions applied; and

G. Other available services in the area.

3303.3A COVERAGE AND LIMITATIONS

1. Administrative Actions. The DHCFP is authorized to take Administrative Actions to ensure compliance with program policies, state statutes and federal laws and regulations.

2. In response to the discovery of fraud, abuse or improper payments in the Medicaid and Nevada Check Up programs, the DHCFP may initiate more than one Administrative Action

at one time, if warranted (e.g. issuance of a recoupment/recovery letter and request a corrective action plan). The types of Administrative Actions that may be taken by the DHCFP are as follows:

a. Issuance of educational letters. The DHCFP or the DHCFP fiscal agent may issue an educational letter to a provider if the results of an investigation indicate the provider was only in need of policy or billing clarification and an improper payment did not occur. This action is used primarily when minor billing errors are detected. The provider Fair Hearing process is not available to dispute an educational letter.

b. Issuance of warning letters. The DHCFP may issue a warning letter to a provider if the provider has taken an action which violates or is not in accordance with policy, state statutes, federal laws or regulations or the terms of the provider contract with the DHCFP. Warning letters will be sent by certified mail with a return receipt requested. Warning letters are to assist the provider in rectifying improper billing practices and will give notice to the provider that continuation of the activity in question will result in further action. Warning letters may request submittal of sufficient and appropriate documentation to substantiate claims billed to and paid by the DHCFP. Failure of providers to submit appropriate documentation within timeframes specified by the DHCFP in a warning letter may result in payment recoupments/recovery without additional notice. The provider Fair Hearing process is not available to dispute a warning letter.

c. Issuance of recoupment/recovery letters. The DHCFP may issue a recoupment/recovery letter to a provider if the results of an investigation indicate the provider was improperly paid for one or more services. A recoupment/recovery letter may also be sent after a provider fails to submit sufficient and appropriate documentation within the timeframes requested in a warning letter. Recoupment/recovery letters will be sent by certified mail with a return receipt requested. The letter will notify the provider of the nature of the improper payment, the amount to be recovered and the method of repayment. The provider Fair Hearing process is available to dispute recoupment/recovery letters unless the recoupment/recovery letter was the result of the provider's failure to provide sufficient and necessary information to establish medical necessity and to fully disclose the basis for the type, extent and level of services provided within the timeframes indicated in the letter that requested such information; or the provider's failure to provide sufficient and appropriate documentation within specified timeframes for the mandated federal PERM reviews.

d. Recovery of improper payments. The DHCFP may recover improper payments with or without prior notice to the provider. All improper payments discovered may be recovered by the DHCFP. If documentation sufficient to support the amount billed to or paid by the DHCFP is not provided within the timeframes specified by

the DHCFP, the associated payments for the service are subject to recovery. All improper payments discovered during the course of mandated federal PERM reviews are subject to recovery.

e. Special claims reviews or on-site audits. The DHCFP can perform special claims reviews or on-site audits of any provider billing claims for Medicaid or Nevada Check Up programs. The reviews or audits can be conducted with or without prior notice to the provider under review. The provider Fair Hearing process is not available to dispute special claims reviews or on-site audits.

f. Corrective Action Plan. After the DHCFP conducts an investigation or audit and determines improper payments have been made, the DHCFP may require the provider to complete a Corrective Action Plan (CAP), specifying how, as well as when, the provider expects to achieve compliance. The provider Fair Hearing process is not available to dispute requests for Corrective Action Plans.

g. Provider self audits. The DHCFP may request a provider or group of providers to perform self audits. This action can be taken with or without the discovery of improper payments, or fraud or abusive billing practices. The DHCFP will accept reimbursement for improper payments, discovered during provider self audits, without penalty, if the improper payment was disclosed voluntarily by the provider and the acts that led to the improper payment were not the result of fraudulent conduct on the part of the provider, its employees or agents. Provider self audits do not relieve the provider of any liability for civil or criminal action by the MFCU, if improper payments were the result of fraud or fraudulent acts. The provider Fair Hearing process is not available to dispute requests for provider self audits.

h. Referrals to appropriate civil agencies (licensing bodies). If the DHCFP discovers licensing or other regulatory violations while conducting an investigation or audit, the DHCFP may make referrals to appropriate licensing or governing entities, such as the Nevada Bureau of Licensure and Certification, the federal Office of the Inspector General, the federal Office of Civil Rights or other such governing entities. The provider Fair Hearing process is not available to dispute referrals to civil agencies or licensing bodies.

i. Referrals to the MFCU. The DHCFP is required to refer all suspected cases of fraud and abuse to the MFCU. Providers are never notified about this action.

j. Denials of provider applications. Providers may be denied DHCFP provider status if they are found to be out of compliance with policy, state and/or federal regulations or the terms of the provider contract with the DHCFP. Refer to Chapter 100 of the Medicaid Services Manual for further information.

k. Suspension and termination of provider status. Termination, lock-out suspension, exclusion, non-renewal of the DHCFP provider status are possible actions applied to providers found to be out of compliance with policy, state and/or federal regulations, the terms of the provider contract with the DHCFP, or who commit fraud. Refer to Chapter 100 of the Medicaid Services Manual for further information.

l. Other action. The DHCFP may impose special requirements on providers as a condition of participation. The provider Fair Hearing process is not available to dispute the other actions. The other actions include, but are not limited to:

1. Requirement for all services to be prior authorized to be eligible for reimbursement; and/or

2. Requirement for provider to submit all records or documentation to support the services billed prior to payment.

3. Any administrative action taken by the DHCFP does not eliminate any civil or criminal liability from the provider.

4. Payment suspensions to the provider. The DHCFP may implement a payment suspension and withhold payments to the provider, in whole or in part, upon determining there is a credible allegation of fraud or willful misrepresentation under the Medicaid or Nevada Check Up programs. The DHCFP may suspend payment without first notifying the provider. The DHCFP will send notice to the provider in accordance with 42 CFR 455.23.

The notice to the provider will:

a. Set forth the general allegations as to the nature of the payment suspension action, but need not disclose any specific information concerning an ongoing investigation;

b. State that the payment suspension is for a temporary period;

c. Cite the circumstances under which the payment suspension will be terminated;

d. Specify, when applicable, to which type or types of Medicaid claims or business units of a provider are subject to the payment suspension;

e. Inform the provider of the right to submit written evidence for consideration by the DHCFP;

f. Set forth the applicable State administrative appeals process and corresponding citations to State law; and

g. Cite that payments are being withheld in accordance with 42 CFR 455.23.

5. Repayment Requirements. The DHCFP will determine the repayment method for all overpayments or improper payments to providers. Repayment can be made by either direct reimbursement by the provider or the provider may be allowed to make repayment through deductions from future payments. To be acceptable, repayment through reductions to future payments or direct reimbursement must ensure the total overpayment amount will be repaid to the DHCFP within 60 days from the date the provider was first notified of the improper payment, as required by Section 1903(d)(2)(c) of the SSA. The provider's request for a Fair Hearing does not suspend the provider's obligation to repay the amount of the overpayment.

6. Statute of Limitations. Erroneous billing resulting in a benefit overpayment violates the provider contract and brings the issue within the authority of NRS 11.190 Actions Other Than for the Recovery of Real Property. NRS 11.190.1 states: "Within 6 years: 1(b) an action upon a contract, obligation or liability founded upon an instrument in writing, except those mentioned in the preceding sections of this chapter." This statute gives the DHCFP the authority that unless limited by a specific statute, a recovery action may be commenced within a six year period. Additionally, 31 USC 235-Limitation of Suit provides "Every such civil suit shall be commenced within six years from the commission of the act and not afterward."

7. Civil Monetary and Criminal Penalties

The SSA and the NRS identify certain activities as misdemeanors or felonies and provide for fines and/or imprisonment upon conviction.

a. The MFCU of the Nevada Attorney General's Office can assess civil monetary penalties and criminally prosecute violations of NRS 422.540 to 422.570, inclusive. This includes offenses regarding: false claims; mis-statements or mis-representations; and sale, purchase or lease of goods, service materials or supplies associated with payments under the State Plan for Medicaid or the SCHIP (Nevada Check Up). Providers can be liable at both the state and federal level and prosecuted by both. Additionally, the provider may be excluded from state and federal health care programs based on a conviction.

b. State civil monetary penalties are not less than $5,000 and can equal three times the amount unlawfully obtained in addition to expenses incurred by the State for investigation activities.

c. State criminal penalties, in addition to the civil monetary penalties, range from a gross misdemeanor punishable by imprisonment in the county jail for not more than

one year to a Class D felony punishable by 1 – 4 years in a State prison. (NRS 193.130 to 193.140)

d. In addition to State penalties, there are federal penalties associated with false or fraudulent acts involving federal health care programs. Civil monetary and criminal penalties are sought by the Department of Justice (DOJ) according to Section 1128A and Section 1128B of the SSA. Providers who are convicted by a federal court of willfully defrauding the Medicaid or Nevada Check Up program may be subject to a $25,000 fine or up to five years imprisonment or both.

e. Any action brought pursuant to NRS 422.540 through 422.580, inclusive, must be commenced within four years of discovery by the aggrieved party.

3304 REFERENCES AND CROSS REFERENCES

3304.1 FRAUD, ABUSE OR IMPROPER PAYMENT REFERRALS

A. To report alleged fraud, abuse or improper payment to the DHCFP contact:

Phone: (775) 684-3648
Fax: (775) 684-3643
E-Mail: npi@dhcfp.nv.gov
Mail: Division of Health Care Financing and Policy
Program Integrity Unit
1100 E. William St., Suite 102
Carson City, NV 89701

Provide as much identifying information as possible. Include: provider name, address, phone number and details regarding the allegation or nature of the referral. Explain the basics of who, what, when, where, why and how. Include your name and phone number unless you wish to remain anonymous when calling or writing.

The DHCFP will not provide any information regarding actions taken by the DHCFP or others on any allegations reported, even to the person making the referral or allegation. Once the allegation is received, there will be no further communication with the person making the referral.

B. To Report Medicaid Fraud or Abuse to the Medicaid Fraud Unit in the Attorney's Office:

Phone: (800) 266-8688
Mail: MFCU
100 N. Carson St.
Carson City, NV 89701-4717

C. To report fraud in all federal health care programs, including Medicare, Medicaid and Nevada Check Up contact the Office of Inspector General:

Phone: (800) 447-8477
Fax: (800) 223-8164
TTY: (800) 377-4950
E-Mail: HHSTips@oig.hhs.gov
By Mail: Office of the Inspector General, DHHS
Attn: HOTLINE
330 Independence Ave., S.W.
Washington, DC 20201

The following is the link to the Office of Inspector General (OIG) Hotline website, where there is more information regarding how to make alleged fraud and abuse referrals: http://oig.hhs.gov/hotline.html

3304.2 POLICY REFERENCES

1. For policy information governing services covered under Medicaid and Nevada Check Up programs consult the MSMs located on the DHCFP Website: http://www.dhcfp.nv.gov

2. For billing manuals, web announcements and other information governing services covered under Medicaid and Nevada Check Up programs consult the DHCFP fiscal agent Website: https://nevada.fhsc.com/

3304.3 OTHER CONTACTS

A. DHCFP Fiscal Agent

Provider Enrollment Issues:

First Health Services
Provider Enrollment
PO Box 300412
Reno NV 89520-30412

Provider Claims Issues:

First Health Services
Claims
PO Box 30042
Reno NV 89520-3042

B. DHCFP Administration Office

1100 E. Williams Street, Suite 102
Carson City, NV 89703
Telephone: (775) 684-3600
Toll free (800) 992-0900 Extension 3600

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 31, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres* Casey Angres (Jun 1, 2022 11:13 PDT)
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3400 – TELEHEALTH SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3400 – Telehealth Services are being proposed as a result of the passage of Senate Bill 5 (SB5) in the 81st Nevada Legislative Session removing the restriction of audio-only telehealth services.

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: The following provider types may be affected:

Outpatient Surgery Provider Type (PT 10), Hospital, Inpatient (PT 11), Hospital, Outpatient (PT 12), Psychiatric Hospital, Inpatient (PT 13), Behavioral Health Outpatient Treatment (PT 14), Registered Dieticians (PT 15), Special Clinics (PT 17), Nursing Facility (PT 19), Physician, M.D., Osteopath, D.O. (PT 20), Podiatrist (PT 21), Dentist (PT 22), Advanced Registered Nurses (PT 24), Optometrist (PT 25), Psychologist (PT 26), Radiology & Noninvasive Diagnostic Centers (PT 27), Pharmacy (PT 28), Durable Medical Equipment (DME) (PT 33), Therapy (PT 34), Chiropractor (PT 36), Optician/Optical Business (PT 41), Laboratory Pathology/Clinical (PT 43), End Stage Renal Disease (ESRD) Facility (PT 45), Ambulatory Surgical Centers (ASC) (PT 46), Indian Health Programs (IHP) and Tribal Clinics (PT 47), Indian Health Program Hospital Inpatient (PT 51), Indian Health Program Hospital Outpatient (PT 52), Targeted Case Management (PT 54), Rehabilitation, Specialty and Long Term Acute Care Hospital (PT 56), School Based (PT 60), Residential Treatment Center (RTC) (PT 63), Hospice (PT 64), Hospice Long Term Care (PT 65), Nurse Anesthetist (PT 72), Nurse Midwife (PT 74), Critical Access Hospital Inpatient (PT 75), Audiologist (PT 76), Physician's Assistant (PT 77), Indian Health Program (IHP) Hospital Inpatient (Non-Tribal) (PT 78), IHP Hospital Outpatient (Non-Tribal) (PT 79), Hospital Based ESRD Provider (PT 81), Behavioral Health Rehabilitative Treatment (PT 82), Applied Behavioral Analysis (PT 85), Community Health Workers (PT 89) and Doula (PT 90).

Financial Impact on Local Government: No financial impact is anticipated.

These changes are effective June 1, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 09/22 MSM 3400 – Telehealth Services	MTL 30/15, 22/16, MSM 3400 – Telehealth Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3403	**Telehealth Policy**	Removed "standard telephone" from the list of unacceptable communication technologies and removed "audio-visual communication" as a descriptor.
3403.1	**Telehealth Originating Site**	Added item "B": A provider is not eligible for payment as both the origination and distant site for the same patient, same date of service. Updated item "D" to clarify who may bill a facility fee or an encounter code.
3403.5	**Coverage and Limitations**	Removed item "C" to align with MSM Chapter 400 – Mental Health and Alcohol and Substance Abuse Services; Added item "D" to identify which Behavioral Health services may be delivered via audio-only telehealth.
3403.6	**Non-Covered Services**	Removed "Telephone Calls" and updated language for Behavioral Health Services.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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TELEHEALTH SERVICES

3400 INTRODUCTION

Telehealth is the use of a telecommunications system to substitute for an in-person encounter for professional consultations, office visits, office psychiatry services and a limited number of other medical services.

All providers participating in the Medicaid and Nevada Check Up (NCU) programs must offer services in accordance with the rules and regulations of the Division of Health Care Financing and Policy (DHCFP).

Telehealth services are an optional benefit within DHCFP.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for NCU. For further clarification, please refer to the NCU Manual, Chapter 1000.

3401 AUTHORITY

The State Legislature grants authority to the relevant professional licensure boards to set the standard of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following specialists:

A. NRS – Chapter 449-Hospitals;

B. NRS – Chapter 629-Healing Arts Generally;

C. NRS – Chapter 630-Physicians and Physician Assistants;

D. NRS – Chapter 632-Nursing;

E. NRS – Chapter 633-Osteopathic Medicine; and

F. NRS – Chapter 641-Psychologists, Social Workers.

3402 RESERVED

3403 TELEHEALTH POLICY

The DHCFP reimburses for telehealth services. The originating site must be located within the state. "Telehealth" is defined as the delivery of service from a provider of health care to a patient at a different location through the use of telecommunication technologies, not including facsimile or electronic mail. Services provided via telehealth must be clinically appropriate and within the health care professional's scope of practice as established by its licensing agency. Services provided via telehealth have parity with in-person health care services. Health care professionals must follow the appropriate Medicaid Services Manual (MSM) policy for the specific service they are providing.

A. Photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis or a treatment plan. Dermatologic photographs (e.g., photographs of a skin lesion) may be considered to meet the requirement of a single media format under this instruction.

B. Reimbursement for the DHCFP covered telehealth services must satisfy federal requirements of efficiency, economy and quality of care.

C. All participating providers must adhere to requirements of the Health Insurance Portability and Accountability Act (HIPAA). The DHCFP may not participate in any medium not deemed appropriate for protected health information by the DHCFP's HIPAA Security Officer.

3403.1 TELEHEALTH ORIGINATING SITE

The originating site is defined as the location where a patient is receiving telehealth services from a provider of health care located at a distant site (via a HIPAA-compliant telecommunications system).

A. In order to receive coverage for a telehealth facility fee, the originating site must be an enrolled Medicaid provider.

B. A provider is not eligible for payment as both the originating and distant site for the same patient, same date of service.

C. If a patient is receiving telehealth services at an originating site not enrolled in Medicaid, the originating site is not eligible for a facility fee from the DHCFP. Examples of this include, but are not limited to, cellular devices, home computers, kiosks and tablets.

D. Facilities that are eligible for encounter reimbursement (e.g. Indian Health (IH) programs, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs)) may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e. consult with specialist). If the originating site and distant site are two different encounter sites, the originating site may only bill the telehealth facility fee, and the distant encounter site may bill the encounter code.

3403.2 TELEHEALTH DISTANT SITE

The distant site is defined as the location where a provider of health care is providing telehealth services to a patient located at an originating site. The distant site provider must be an enrolled Medicaid provider.

3403.3 SYNCHRONOUS TELEHEALTH SERVICES

Synchronous telehealth interactions are defined as real-time interactions between a recipient located at an originating site and a health care provider located at a distant site. A provider has direct visualization of the patient.

3403.4 ASYNCHRONOUS TELEHEALTH SERVICES

Asynchronous telehealth services, also known as Store-and-Forward, are defined as the transmission of a patient's medical information from an originating site to the health care provider distant site without the presence of the recipient. The DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees.

3403.5 COVERAGE AND LIMITATIONS

The following coverage and limitations pertain to telehealth services:

A. The medical examination of the patient is under the control of the health care professional at the distant site.

B. While the distant physician or provider may request a telepresenter, a telepresenter is not required as a condition of reimbursement.

C. End Stage Renal Disease (ESRD)

1. ESRD visits must include at least one in-person visit to examine the vascular access site by a provider; however, an interactive audio/video telecommunications system may be used for providing additional visits.

2. Medical records must indicate that at least one of the visits was furnished in-person by a provider. Refer to MSM Chapter 600, Physician Services, for medical coverage requirements.

D. Audio only telehealth for behavioral health delivery is limited to:

1. Targeted Case Management

2. Crisis Intervention Services

3403.6 NON-COVERED SERVICES

A. Images transmitted via facsimile machines (faxes);

B. Text messages;

C. Electronic mail (email); and

D. The following services must be provided in-person and are not considered appropriate services to be provided via telehealth:

1. Basic Skills Training and Psychosocial Rehabilitation services, whether authorized, provided, and billed as stand-alone services or as components of Intensive Outpatient Program, Partial Hospitalization, and Day Treatment must be provided in person;

2. Personal care services provided by a Personal Care Attendant (PCA) as identified in provider qualifications found in MSM Chapter 2600, Intermediary Service Organization and MSM Chapter 3500, Personal Care Services;

3. Home Health Services provided by a Registered Nurse (RN), Physical Therapist (PT), Occupational Therapist, Speech Therapist, Respiratory Therapist, Dietician or Home Health Aide as identified in provider qualifications found in MSM Chapter 1400, Home Health Agency (HHA); and

4. Private Duty Nursing services provided by an RN as identified in provider qualifications found in MSM Chapter 900, Private Duty Nursing.3403.7

3403.7 PRIOR AUTHORIZATION

Telehealth services follow the same prior authorization requirements as services provided in person. Utilization of telehealth services does not require prior authorization, however, individual

services delivered via telehealth may require prior authorization. It is the provider's responsibility to refer to the individual medical coverage policies through the MSM for coverage requirements.

3403.8 HEARINGS

Please reference MSM Chapter 3100, Hearings, for Medicaid recipient hearing procedure.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 24, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3500 – PERSONAL CARE SERVICES PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3500 – Personal Care Services Program are being proposed to add language due to the passage of the 21st Century Cures Act. In December 2016, Congress passed H.R. 34 – 21st Century Cures Act, mandating that all States require the use of an Electronic Visit Verification (EVV) system for all Medicaid-funded personal care services (PCS) that are provided under a state plan or a waiver of the plan, including services provided under Section 1915(c).

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: This proposed change affects all Medicaid-enrolled providers delivering specific personal care services. Those provider types (PT) include but are not limited to: Personal Care Services (PT 30).

Financial Impact on Local Government: Unknown at this time.

These changes are effective September 25, 2019.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 21/19 MSM Ch 3500 – Personal Care Services Program	MTL 20/16 MSM Ch 3500 – Personal Care Services Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3501	**AUTHORITY**	Added 21st Century Cures Act mandate and H.R. 6042 – 115th Congress.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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PERSONAL CARE SERVICES (PCS) PROGRAM

3500 INTRODUCTION

PERSONAL CARE SERVICES (PCS)

The objective of the PCS Program is to assist, support and maintain recipients living independently in their homes. PCS include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables accomplishment of tasks that they would normally do for themselves if they did not have a disability or chronic condition. These services are provided where appropriate, medically necessary and within service limitations. Services may be provided in settings outside the home, including employment sites.

PCS are available to recipients who are not inpatients or residents of a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or institutions for mental disease or other excluded settings.

Nevada Medicaid offers two distinct PCS delivery models: The Provider Agency Model or the Self-Directed Model.

This Medicaid Services Manual (MSM), Chapter 3500, contains Nevada Medicaid's policy for PCS provided through the Provider Agency service delivery model. For policy pertaining to the Self-Directed service delivery model, refer to MSM Chapter 2600.

All providers must be contracted with the Division of Health Care Financing and Policy (DHCFP) in accordance with MSM Chapter 100 and meet certain qualifications and criteria as discussed later in this chapter.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

3501 AUTHORITY

Personal Care Services (PCS) are an optional Medicaid benefit under the Social Security Act (SSA).

Regulatory oversight:

SSA 1905(a) (24)

Title 42, Code of Federal Regulations (CFR), Section 440.167

Nevada State Plan Attachment 3.1-A (26)

21st Century Cures Act, H.R. 34, Section 12006 – 114th Congress

H.R. 6042 – 115th Congress

3502 DEFINITIONS

Program definitions can be found in the MSM Addendum.

3503 POLICY

3503.1 PERSONAL CARE SERVICES (PCS)

PCS provide assistance to support and maintain recipients living independently in their homes. Services may be provided in the home, locations outside the home or wherever the need for the service occurs. Assistance may be in the form of direct hands-on assistance or cueing the individual to perform the task themselves, and related to the performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Services are based on the needs of the recipient being served, as determined by a Functional Assessment Service Plan (FASP) approved by the Division of Health Care Financing and Policy (DHCFP). All services must be performed in accordance with the approved service plan, must be prior authorized and documented in an approved Electronic Visit Verification (EVV) system. The time authorized for services is intended to meet the recipient needs within program limits and guidelines, facilitate effective and efficient service delivery, and to augment unpaid and paid supports currently in place. Services are not intended to replace or substitute services and/or supports currently in place, or to exchange unpaid supports for paid services.

Legally Responsible Individuals (LRIs) may not be reimbursed for providing PCS.

3503.1A ELIGIBILITY CRITERIA

1. The recipient must have ongoing Medicaid or Nevada Check Up (NCU) eligibility for services;

2. The recipient is not in a hospital, Nursing Facility (NF), Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an institution for the mentally ill or a licensed residential facility for groups;

3. The recipient does not have an LRI who is available and capable of providing the necessary care;

4. The recipient or Personal Care Representative (PCR) must be cooperative in establishing the need for the provision of services and comply with the approved service plan;

5. The recipient is capable of making choices about ADLs or has a PCR who assumes this responsibility;

6. PCS must be determined to be medically necessary as defined by the DHCFP or its designee.

3503.1B COVERAGE AND LIMITATIONS

1. Covered Services

a. Assistance with the following ADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare.

1. Bathing/dressing/grooming.

2. Toileting needs and routine care of an incontinent recipient.

3. Transferring and positioning non-ambulatory recipients from one stationary position to another, assisting a recipient out of bed, chair or wheelchair, including adjusting/changing recipient's position in a bed, chair or wheelchair.

4. Mobility/Ambulation, which is the process of moving between locations, including walking or helping the recipient to walk with support of a walker, cane or crutches or assisting a recipient to stand up or get to his/her wheelchair to begin ambulating.

5. Eating, including cutting up food. Specialized feeding techniques may not be used.

b. Assistance with the following IADLs is a covered service when no LRI is available and/or capable of providing the necessary service. Services must be directed to the individual recipient and related to their health and welfare. See the service limitations section of this chapter for specific eligibility criteria to be considered eligible to receive additional time for assistance with IADLs.

1. Meal preparation, which includes storing, preparing and serving food.

2. Laundry, including washing, drying and folding the recipient's personal laundry and linens (sheets, towels, etc.). Ironing is not a covered service.

3. Light housekeeping, which includes changing the recipient's bed linens, dusting or vacuuming the recipient's living area.

4. Essential shopping, which includes shopping for prescribed drugs, medical supplies, groceries and other household items required specifically for the health and nutrition of the recipient.

2. Service Limitations

To be considered eligible to receive additional time for assistance with IADLs, the recipient must be eligible to receive PCS for ADLs and have deficits which directly preclude the individual from completing IADLs. The FASP must demonstrate that the recipient meets the following criteria:

a. The recipient has extensive impairments, Level 2 or higher on the FASP in two or more areas of ADLs; and

b. The recipient has at least one of the deficits listed below:

1. Mobility deficits/impairments of an extensive nature which requires the use of an assistive device, and directly impact the recipient's ability to safely perform household tasks or meal preparation independently;

2. Cognitive deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently;

3. Endurance deficits directly impacting the recipient's ability to complete a task without experiencing substantial physical stressors;

4. Sensory deficits directly impacting the recipient's ability to safely perform household tasks or meal preparation independently.

Assistance with the IADLs may only be provided in conjunction with services for ADLs, and only when no LRI is available and/or capable.

3. Non-Covered Services

Duplicative services are not considered medically necessary and will not be covered by Nevada Medicaid. An inquiry or referral for services does not determine the medical necessity for services.

The following are not covered under PCS and are not reimbursable:

a. A task that the DHCFP or its designee determines could reasonably be performed by the recipient.

b. Services normally provided by an LRI.

c. Any tasks not included on the recipient's approved service plan.

d. Services to maintain an entire household, such as cleaning areas of the house not used solely by the recipient(s).

e. Services provided to someone other than the intended recipient.

f. Skilled care services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State. Services include, but are not limited to, the following:

1. Insertion and sterile irrigation of catheters;

2. Irrigation of any body cavity. This includes both sterile and non-sterile procedures such as ear irrigation, vaginal douches and enemas;

3. Application of dressings involving prescription medications and aseptic techniques, including treatment of moderate or severe skin problems;

4. Administration of injections of fluids into veins, muscles or skin;

5. Administration of medication, including, but not limited to, the insertion of rectal suppositories, the application of prescribed skin lotions or the instillation of prescribed eye drops (as opposed to assisting with self-administered medication);

6. Physical assessments;

7. Monitoring vital signs;

8. Specialized feeding techniques;

9. Rectal digital stimulation;

10. Massage;

11. Specialized range of motion (ROM);

12. Toenail cutting;

13. Medical case management, such as accompanying a recipient to a physician's office for the purpose of providing or receiving medical information;

14. Any task identified within the Nurse Practice Act as requiring skilled nursing, including Certified Nursing Assistant (CNA) services.

g. Chore services.

h. Companion care, baby-sitting, supervision or social visitation.

i. Care of pets except in cases where the animal is a certified service animal.

j. Respite care intended primarily to relieve a member of the recipient's household, a family member or caregiver from the responsibility of caring for the recipient.

k. A task the DHCFP determines is within the scope of services provided to the recipient as part of an assisted living contract, a supported living arrangement contract or a foster care agreement.

l. Escort services for social, recreational or leisure activities.

m. Transportation of the recipient by the Personal Care Attendant (PCA).

n. Any other service not listed under Section 3503.1.B.1.

3503.1C LEGALLY RESPONSIBLE INDIVIDUAL (LRI)

LRIs are individuals who are legally responsible to provide medical support. These individuals include spouses of recipients, legal guardians, and parents of minor recipients, including stepparents, foster parents and adoptive parents. LRIs may not be reimbursed for providing PCS.

If the LRI is not capable of providing the necessary services/supports, he or she must provide verification to the DHCFP's QIO-like vendor, from a physician, that they are not capable of providing the supports due to illness or injury. If not available, verification that they are unavailable due to hours of employment and/or school attendance must be provided. Without this verification, PCS will not be authorized. Additional verification may be required on a case by case basis.

3503.1D PERSONAL CARE REPRESENTATIVE (PCR)

A recipient who is unable to provide direction in the delivery of their own care may opt to utilize a PCR. This individual is directly involved in the day-to-day care of the recipient, is available to direct care in the home, acts on behalf of the recipient when the recipient is unable to direct his or her own personal care services and assumes all medical liability associated with directing the recipient's care. A PCR must be a responsible adult.

The PCR must:

1. Effectuate, as much as possible, the decision the individual would make for himself/herself;

2. Accommodate the individual, to the extent necessary that they can participate as fully as possible in all decisions that affect them;

3. Give due consideration to all information including the recommendations of other interested and involved parties;

4. Understand that provision of services is based upon mutual responsibilities between the PCR and the provider agency.

A PCR is not eligible to receive reimbursement from Medicaid for this activity. A recipient's paid PCA cannot be the recipient's PCR. The PCR must meet all criteria outlined in Section 3503.1I of this chapter. In addition, this individual must be present for the provision of care on a consistent basis, as well as sign daily records. For this reason, it is not allowable for individuals such as a paid PCA, care coordinator or case manager to assume this role.

The PCR may reside outside the home if frequent contact can be made by the recipient, the provider agency and other care providers. The PCR must be available to the recipient, the provider agency and other care providers as necessary to fulfill the regular elements of Section 3503.1I of this chapter.

Additionally, if a change in PCR becomes necessary, a new personal care representative agreement must be completed and kept in the recipient's provider file. Contact the provider agency to make the necessary changes and obtain necessary form(s).

3503.1E AUTHORIZATION PROCESS

PCS authorization requests must be submitted to the QIO-like vendor using the following procedures:

1. Initial Authorization Requests

   The recipient, LRI, PCR or an individual covered under the confidentiality requirements of HIPAA may contact the QIO-like vendor to request PCS. Initial requests may not be made by the PCS Agency provider.

   The QIO-like vendor validates that the recipient meets PCS criteria, and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS.
After completion, the FASP is forwarded to the QIO-like vendor to process.

If the recipient's request for PCS is approved, the QIO-like vendor will issue a prior authorization number to the recipient's chosen PCS Provider Agency.

a. At Risk Recipient Requests

Upon receipt of a request for an initial FASP, the QIO-like vendor will first complete a risk assessment over the phone to identify those recipients for whom PCS are urgent to avoid institutionalization, or for whom the service need is the result of an acute medical condition or loss of a primary caregiver or LRI. The intent of the telephonic risk assessment is to determine if a recipient is at risk of losing or being unable to return to a community setting because of the need for PCS.

When a recipient is determined "at risk," the QIO-like vendor will provide a temporary service authorization.

An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

The selected Provider Agency is notified when a recipient is at risk and agrees, by accepting the case, to initiate needed services within 24 hours of case acceptance. The approved service plan and authorization document are faxed to the provider upon acceptance.

2. Annual Update Authorization Requests

To prevent a break in service, reassessment requests for ongoing services are recommended to be submitted to the QIO-like vendor at least 60 days, but not greater than 90 days, prior to the expiration date of the current authorization. The request must be submitted on the Authorization Request for PCS form (FA-24). The form must include all required recipient and provider information, as well as the units requested and the dates of service for the service interval requested.

The QIO-like vendor validates that the request meets PCS criteria. An enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the PCS Provider Agency submitting the request.

3. Significant Change in Condition or Circumstance Authorization Requests

Requests for reassessment due to significant change in the recipient's condition or circumstances must be submitted to the QIO-like vendor as soon as the significant change is known. A request for reassessment due to a significant change in the recipient's condition or circumstances must be submitted on the Authorization Request for PCS form (FA-24) and must be accompanied by documentation from the recipient's physician or health care provider. Requesting a reassessment does not guarantee an increase in previously approved PCS.

a. Significant change in condition may be demonstrated by, for example, an exacerbation of a previous disabling condition resulting in a hospitalization (within past 14 days) or a physician's visit (within past seven days) or a new diagnosis not expected to resolve within eight weeks.

b. Significant change in circumstances may include such circumstances as absence, illness or death of the primary caregiver or LRI.

c. Significant change in condition or circumstances would result in hospitalization or

other institutional placement if PCS are not reassessed to meet the recipient's change in service needs.

The QIO-like vendor validates that the request meets PCS criteria and if so, an enrolled and trained physical or occupational therapist will then complete an in-home assessment of the recipient's functional abilities.

The physical or occupational therapist contacts the recipient to schedule an appointment for the completion of the FASP. The recipient is responsible for keeping the scheduled appointment.

Taking into account the physical or occupational therapists' clinical judgment, the in-home visit may be followed by an in-clinic visit in order to accurately evaluate the recipient's need for PCS. After completion, the FASP is forwarded to the QIO-like vendor to process.

If the request is approved, the QIO-like vendor will issue a prior authorization number to the PCS Provider Agency submitting the request.

4. Temporary Service Authorization Requests

When the recipient has an unexpected change in condition or circumstance which requires short-term (less than eight weeks) modification of the current authorization, a new FASP is not required.

Such a modification is considered when additional PCS are required for a short time as the result of an acute medical episode or during a post-hospitalization period.

The following procedure must be followed for all short-term modifications of the approved service plan:

a. Documentation must be maintained in the recipient's record of the circumstance(s) that required the short term modification(s) of the approved service plan;

b. Documentation of the short-term modification(s) of the approved service plan must be completed and sent to the Provider Agency, and if applicable, the appropriate home and community-based waiver case manager. Documentation must include the recipient's name, Medicaid number and the dates during which the modified service plan will be in effect; and

c. Upon expiration of the modified service plan, the recipient's original approved service plan is automatically reinstated unless a new FASP is completed due to a significant change in the recipient's condition or circumstance.

5. One-Time Service Authorization Request

   The recipient's Provider Agency may submit a single-service authorization request when the recipient requires an extra visit for an unanticipated need, such as bowel or bladder incontinence. The Provider Agency must document the medical necessity of the service requested and be the designated provider for the current authorization period. The request should be submitted to the QIO-like vendor no later than seven business days after the service is provided. A new FASP is not required in these single-service situations.

6. Mileage Authorization Request

   Mileage for travel to and from a recipient's home or for shopping is not reimbursable to PCS Agency providers, except in hardship situations in remote or rural areas of the state where failure to reimburse mileage expenses would severely limit available PCS Agency providers. Mileage authorization requests must be submitted in advance to the local DHCFP District Office for review and may be approved on a case-by-case basis. If approved, the DHCFP District Office will notify the QIO-like vendor to issue an authorization number for the approved mileage to the provider.

3503.1F FLEXIBILITY OF SERVICES DELIVERY

The total weekly authorized hours for PCS may be combined and tailored to meet the needs of the recipient, as long as the plan does not alter medical necessity. The recipient will determine how to use the weekly authorized hours on an ongoing basis. Any changes that do not increase the total authorized hours can be made, for the recipient's convenience, within a single week without an additional authorization. Flexibility of services may not take place solely for the convenience of the provider or PCA.

The following requirements must be met:

1. Upon receipt of an initial service plan from the QIO-like vendor, the provider must meet with the recipient in person to determine how the total weekly authorized hours will be provided to meet the individual's needs.

2. Written documentation of the contact with the recipient regarding provision of services must be maintained in the recipient's file.

3. Any change to the approved service plan must be discussed between the provider and the recipient. This may be done either in person or via the telephone in order to determine how the hours and tasks will be provided.

4. Changes may be requested on a daily and/or weekly basis when necessary to meet a change in circumstance or condition.

5. The PCS provider must follow their established policies and procedures in order to timely meet recipient requests for changes in service delivery.

6. Written documentation of the contact with the recipient regarding any change to the approved service plan must be maintained in the recipient's file.

3503.1G ELECTRONIC VISIT VERIFICATION (EVV)

The 21st Century Cures Act requires the use of an EVV system to document services that are provided for all personal care services under a Medicaid state plan or waiver program. This mandate requires provider agencies to use an EVV system to record service delivery visit information. Nevada Medicaid utilizes the open-system model, procuring a vendor but also allows agencies to utilize their own EVV system if it meets the 21st Century Cures Act requirements for documentation.

All service information must be recorded in an electronic system that interfaces with either a telephone or an electronic device that generates a timestamp. The provider agency must verify the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. All claims must be supported by an EVV entry into an EVV system prior to claim submission.

Provider Agencies must ensure each personal care attendant (PCA) has a unique identifier (National Provider Identification – NPI) associated with their worker profile in the EVV system.

1. STATE OPTION

   a. The EVV system electronically captures:

      1. The type of service performed, based on procedure code;

      2. The individual receiving the service;

      3. The date of the service;

      4. The location where service is provided;

      5. The individual providing the service;

      6. The time the service begins and ends.

   b. The EVV system must utilize one or more of the following:

      1. The agency/PCA's smartphone;

2. The agency/PCA's tablet;

3. The recipient's landline telephone;

4. The recipient's cellular phone (for Interactive Voice Response (IVR) purposes only);

5. Another GPS-based device as approved by the DHCFP.

2. DATA AGGREGATOR OPTION

a. All Provider Agencies that utilize a different EVV system (as approved by the DHCFP) must comply with all documentation requirements of this chapter and must utilize the data aggregator to report encounter or claim data.

1. Appropriate form must be approved by the DHCFP before use of the system to ensure all data requirements are being collected to meet the 21st Century Cures Act.

2. At a minimum, data uploads must be completed monthly into data aggregator.

3503.1H CONFLICT OF INTEREST STANDARDS

The DHCFP assures the independence of contracted providers completing the FASPs. Physical and occupational therapists who complete the FASPs must be an independent third party and may not be:

1. Related by blood or marriage to the individual or to any paid caregiver of the individual;

2. Financially responsible for the individual;

3. Empowered to make financial or health-related decisions on behalf of the individual;

4. Related by blood or marriage to the Provider who provides PCS to the individual.

The therapist completing the FASP must not have an interest in or employment by a Provider.

Note: To ensure the independence of individuals completing the FASP, providers are prohibited from contacting the physical or occupational therapists directly.

3503.1I PROVIDER RESPONSIBILITIES

PCS providers shall furnish PCAs to assist eligible Medicaid and NCU recipients with ADLs and IADLs, as identified on the individual recipient's approved service plan and in accordance with the conditions specified in this Chapter and the Medicaid Provider Contract.

Additionally, all PCS providers have the following responsibilities:

1. Licensure

   In order to enroll as a Nevada Medicaid PCS Provider, a provider must be licensed by the Division of Public and Behavioral Health (DPBH) as an Agency to Provide Personal Care Services in the Home (personal care agency).

   Providers must comply with licensing requirements and maintain an active certification and/or license at all times.

2. Provider Enrollment

   To become a Nevada Medicaid PCS provider, the provider must enroll with the QIO-like vendor as a Personal Care Services – Provider Agency (PT 30).

3. Electronic Visit Verification (EVV)

   Utilize an EVV system that meets the requirements of the 21st Century Cures Act, to electronically document the personal care services provided to Medicaid recipients served by a Medicaid provider.

4. Time Parameters

   The Provider will implement PCS in a timely manner. The Provider agrees to furnish qualified staff to provide PCS to eligible Medicaid recipients within five working days of an accepted referral and within 24 hours of an accepted referral if the recipient is identified as "at risk" by the DHCFP or its designee.

   PCS providers must meet the conditions of participation as stated in the MSM Chapter 100.

   The Provider must comply with all local, state and federal regulations, and applicable statutes, including, but not limited to, Nevada Revised Statutes Chapter 449, Nevada Administrative Code Chapter 449, the Internal Revenue Service (IRS), Federal Insurance Contributions Act (FICA), Occupational Safety and Health Act (OSHA), the Health Insurance Portability and Accountability Act (HIPAA) and the 21st Century Cures Act.

5. 24-Hour Accessibility

The Provider shall maintain an available telephone line 24 hours per day, seven days per week for recipient contact.

6. Backup Mechanism.

The Provider shall have a backup mechanism to provide a recipient with his or her authorized service hours in the absence of a regular caregiver due to sickness, vacation or any unscheduled event.

7. Referral Source Agreement

The Provider shall maintain, and utilize as necessary, written referral source agreements with other DHCFP contracted PCS-provider agencies to ensure continuity of care and service coverage for any at risk recipients (on a prospective or back- up basis), who cannot be timely served by the Provider in order to reasonably avoid institutionalization or serious injury to the recipient.

8. Prior Authorization

The Provider shall obtain prior authorization prior to providing services. All initial and ongoing services must be prior authorized by the DHCFP's QIO-like vendor. Services which have not been prior authorized will not be reimbursed.

9. Provider Liability

Provider liability responsibilities are included in the Nevada Medicaid and NCU Provider Contract.

10. Direct Marketing

Providers shall not engage in any unsolicited direct marketing practices with any current or potential Medicaid PCS recipient or their LRI. All marketing activities conducted must be limited to the general education of the public or health care providers about the benefits of PCS. Such literature may be printed with the company's logo and contact information, however, this literature may not be distributed, unsolicited, to any current or potential Medicaid PCS recipient(s)/or their LRI. The agency may not, directly or indirectly, engage in door-to-door, telephone, direct mail, email or any other type of cold-call marketing activities.

The agency must ensure that marketing, including plans and materials, are accurate and do not mislead, confuse or defraud current or potential recipients. Statements considered

inaccurate, false or misleading include, but are not limited to, any assertion or statement that:

a. The recipient must enroll with the agency in order to obtain benefits or in order not to lose benefits; or

1. The agency is endorsed, certified or licensed by the DHCFP. Compensation or incentives of any kind which encourage a specific recipient to transfer from one provider to another are strictly prohibited.

11. Medicaid and NCU Eligibility

Verification of Medicaid or NCU eligibility on a monthly basis is the responsibility of the Provider Agency.

12. Service Initiation

Prior to initiation of services and periodically as needed, the supervisory staff must review with the recipient or PCR the following:

a. Advanced Directive, including the right to make decisions about health care, and the right to execute a living will or grant power of attorney to another individual.

Refer to MSM Chapter 100 for further information.

b. The agency's program philosophy and policies including:

1. Hiring and training of PCA staff;

2. Agency responsibilities;

3. Providing recipient assistance;

4. Complaint procedure and resolution protocols;

5. Procedure to be followed if a PCA does not appear at a scheduled visit or when an additional visit is required;

6. Information about flexibility of authorized hours in order to meet recipient needs;

7. Non-covered services under PCS;

8. The requirement that each approved service plan must also be reviewed with the PCA;

9. The procedures and forms used to verify PCA provision of services.

10. EVV requirements and recipient participation.

c. The recipient's approved service plan or any changes in the service plan, including the following:

1. Authorized weekly service hours;

2. PCA's schedule;

3. PCA's assigned tasks and pertinent care provided by informal supports;

4. The recipient's back-up plan.

13. PCS Not Permitted

The Provider is responsible to ensure that all PCAs work within their scope of service and conduct themselves in a professional manner at all times.

The following are some of the activities that are not within the scope of PCS and are not permitted. This is not an all-inclusive list.

a. Skilled Care Services requiring the technical or professional skill that State statute or regulation mandates must be performed by a health care professional licensed or certified by the State, are not permitted to be provided by employees of a PCS Agency. PCS services must never be confused with services of a higher level that must be performed by persons with professional training and credentials.

b. Increasing and/or decreasing time authorized on the approved service plan;

c. Accepting or carrying keys to the recipient's home;

d. Purchasing alcoholic beverages for use by the recipient or others in the home unless prescribed by the recipient's physician;

e. Making personal long-distance telephone calls from the recipient's home;

f. Performing tasks not identified on the approved service plan;

g. Providing services that maintain an entire household;

h. Loaning, borrowing or accepting gifts of money or personal items from the recipient;

i. Accepting or retaining money or gratuities for any reason other than that needed for the purchase of groceries or medications for the recipient;

j. Care of pets except in the case where the animal is a certified service animal.

14. Supervision

A supervisor (or other designated agency representative) must review with the PCA the recipient's approved service plan. This must be done each time a new service plan is approved. Documentation of the approved service plan's review must be maintained in the recipient's record.

The supervisor (or other designated agency representative) must clarify with the PCA the following:

a. The needs of the recipient and tasks to be provided;

b. Any recipient specific procedures including those which may require on-site orientation;

c. Essential observation of the recipient's health;

d. Situations in which the PCA should notify the supervisor.

e. EVV requirements and expectations, including the documentation of all personal care services in an approved EVV system.

The supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks which are provided according to the approved service plan and are documented on the service delivery records.

15. Complaint Procedure

The Provider must investigate and respond in writing to all complaints in a reasonable and prompt manner. The Provider must maintain records that identify the complaint, the date received, the outcome of the investigation and the response(s) to the complaint.

16. Serious Occurrences

The Provider must report all serious occurrences involving the recipient, the PCA, or affecting the provider's ability to deliver services. The Nevada DHCFP Serious Occurrence Report must be completed within 24 hours of discovery and submitted to the local DHCFP District Office. If the recipient is on a Home and Community Based Waiver (HCBW), the notification shall be made directly to the HCBW case manager's Aging and Disability Services (ADSD) office.

Reportable serious occurrences involving either the recipient or PCA include, but are not limited to the following:

a. Suspected physical or verbal abuse;

b. Unplanned hospitalization or ER visit;

c. Neglect of the recipient;

d. Exploitation;

e. Sexual harassment or sexual abuse;

f. Injuries or falls requiring medical intervention;

g. An unsafe working environment;

h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;

i. Death of the recipient;

j. Loss of contact with the recipient for three consecutive scheduled days;

k. Medication errors;

l. Theft;

m. Medical Emergency;

n. Suicide Threats or Attempts.

17. Notification of Suspected Abuse or Neglect

State law requires that persons employed in certain capacities make a report to a child protective service agency, an aging and disability services agency or law enforcement

agency immediately, but in no event later than 24 hours after there is reasonable cause to believe a child, adult or older person has been abused neglected, exploited, isolated or abandoned.

For recipients under the age of 18, the Division of Child and Family Services (DCFS) or the appropriate county agency accepts reports of suspected child abuse and neglect. For adults age 60 and over, the ADSD accepts reports of suspected abuse, neglect or self-neglect, exploitation or isolation. For all other individuals (other age groups) contact local law enforcement.

The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

18. Termination of Services

a. The Provider may terminate services for any of the following reasons:

1. The recipient or other person in the household subjects the PCA to physical or verbal abuse, sexual harassment and/or exposure to the use of illegal substances, illegal situations or threats of physical harm;

2. The recipient is ineligible for Medicaid or NCU services;

3. The recipient requests termination of services;

4. The place of service is considered unsafe for the provision of PCS;

5. The recipient or PCR refuses services offered in accordance with the approved service plan;

6. The recipient or PCR is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms;

7. The recipient no longer meets the PCS eligibility criteria;

8. The provider is no longer able to provide services as authorized;

9. The recipient requires a higher level of services than those provided within the scope of a PCA;

10. The recipient refuses services of a PCA based solely or partly on the basis of race, color, national origin, gender, religion, age, disability (including AIDS and AIDS related conditions), political beliefs or sexual orientation

of the PCA. A Provider's inability to provide services for a specific recipient does not constitute termination or denial from Nevada Medicaid's PCS. The recipient may choose another provider.

b. Notification Requirements – The Provider must notify the recipient and all other appropriate individuals and agencies of the date when services are to be terminated. The DHCFP District Office Care Coordination Unit should be notified by telephone one business day prior to the date services will be terminated. If the recipient is on an HCBW the notification should be made directly to the HCBW case manager's ADSD office.

The Provider must submit written notice, within five working days, advising the DHCFP District Office Care Coordination Unit or the waiver case manager of the effective date of the action of the termination of service, the basis for the action and intervention/resolution(s) attempted prior to terminating services.

The provider is not required to send a written notice if the recipient has chosen to terminate services.

19. Records

a. The provider must maintain medical and financial records, supporting documents and all other records relating to PCS provided. The provider must retain records for a period pursuant to the State record retention policy, which is currently six years from the date of payment for the specified service.

If any litigation, claim or audit is started before the expiration of the retention period provided by the DHCFP, records must be retained until all litigation, claims or audit findings have been finally determined.

1. The Provider must maintain all required records for each PCA employed by the agency, regardless of the length of employment.

2. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period.

b. The PCA's supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. The provider will only be paid for the hours and tasks authorized on the approved service plan, which are clearly documented as being provided on the service delivery records.

20. Health Insurance Portability and Accountability Act (HIPAA), Privacy and Confidentiality

Information on HIPAA, privacy and confidentiality of recipient records and other protected health information is found in MSM Chapter 100.

21. Discontinuation of Provider Agreement

a. In the event that a Provider decides to discontinue providing PCS to any of their service areas, the Provider shall:

1. Provide all current Medicaid recipients with written notice at least 30 calendar days in advance of service discontinuation advising the recipient will need to transfer to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS Providers must be obtained from the QIO-like vendor and included with the notification;

2. Provide the DHCFP with a copy of the written notice of intent to discontinue services, including a list of the affected recipients, at least 30 calendar days in advance of service discontinuation;

3. Continue to provide services through the notice period or until all recipients are receiving services through another Provider, whichever occurs sooner.

b. In the event that the DHCFP discontinues the contractual relationship with a Provider, for any reason, the Provider shall:

1. Within five calendar days of receipt of the DHCFP notification to terminate the contractual relationship, send written notification to all their current Medicaid recipients advising the recipient will need to transfer services to a Medicaid contracted PCS provider. A current list of Medicaid contracted PCS providers must be obtained from the QIO-like vendor and be included in this notification.

2. Provide reasonable assistance to recipients in transferring services to another provider.

Providers who fail to satisfactorily meet the requirements discussed above shall be prohibited from participation in a new application for any other PCS provider agreement for a period of not less than one year.

3503.1J RECIPIENT RESPONSIBILITIES AND RIGHTS

1. Recipient Responsibilities

The recipient must be able to make choices about ADLs, understand the impact of these choices and assume responsibility for the choices. If this is not possible, the recipient must have a PCR willing to assist the recipient in making choices related to the delivery of PCS. If the recipient utilizes a PCR, the recipient and the PCR must understand that the provision of services is based upon mutual responsibilities between the PCR and the PCS Provider.

The recipient or PCR is responsible for reviewing and signing all required documentation related to the PCS. The recipient or PCR will:

a. Notify the provider of changes in Medicaid or NCU eligibility;

b. Notify the provider of current insurance information, including the carrier of other insurance coverage, such as Medicare;

c. Notify the provider of changes in medical status, service needs, address and location or in changes of status of LRI(s) or PCR;

d. Treat all staff appropriately;

e. Agree to utilize an approved EVV system for the Medicaid services being received from the Provider Agency.

f. Confirm services were provided by electronically signing or initialing, as appropriate per service plan, the EVV record that reflects the service rendered. If IVR is utilized, a vocal confirmation is required.

g. Notify the Provider when scheduled visits cannot be kept or services are no longer required;

h. Notify the Provider of missed visits by provider staff;

i. Notify the Provider of unusual occurrences or complaints;

j. Give the Provider a copy of an Advance Directive, if appropriate;

k. Establish a backup plan in case a PCA is unable to provide services at the scheduled time;

l. Not request a PCA to work more than the hours authorized on the approved service plan;

m. Not request a PCA to work or clean for non-recipients;

n. Not request a PCA to provide services not on the approved service plan.

2. Recipient Rights

Every Medicaid and NCU recipient receiving PCS, or their PCR, has the right to:

a. Receive considerate and respectful care that recognizes the inherent worth and dignity of each individual;

b. Participate in the assessment process and receive an explanation of authorized services;

c. Receive a copy of the approved service plan;

d. Contact the local DHCFP District Office with questions, complaints or for additional information;

e. Receive assurance that privacy and confidentiality about one's health, social, domestic and financial circumstances will be maintained pursuant to applicable statutes and regulations;

f. Know that all communications and records will be treated confidentially;

g. Expect all providers, within the limits set by the approved service plan and within program criteria, to respond in good faith to the recipient's reasonable requests for assistance;

h. Receive information upon request regarding the DHCFP's policies and procedures, including information on charges, reimbursements, FASP determinations and the opportunity for a fair hearing;

i. Request a change of provider;

j. Request a change in service delivery method from the Provider Agency model to the Self-Directed model through an Intermediary Service Organization (ISO);

k. Have access, upon request, to his or her Medicaid recipient files;

l. Request a Fair Hearing if there is disagreement with the DHCFP's action(s) to deny, terminate, reduce or suspend services;

m. Receive, upon request, the telephone number of the Office for Consumer Health Assistance.

3503.2 PCS TO CHILDREN

An LRI of a minor child has a duty/obligation to provide the child necessary maintenance, health/medical care, education, supervision and support. Necessary maintenance includes, but is not limited to, the provisions of ADLs and IADLs. Payment will not be made for the routine care, supervision or services normally provided for the child without charge as a matter of course in the usual relationship among members of the nuclear family.

PCS are not a substitute for natural and informal supports provided by family, friends or other available community resources; however, PCS are available to supplement those support systems so the child is able to remain in the home. LRIs may not be reimbursed by Medicaid.

PCS for children with disabilities may be appropriate when there is no legally responsible, available and capable parent or LRI, as defined by the DHCFP, to provide all necessary personal care. Documentation verifying that the recipient's parent or LRI is unavailable or incapable must be provided upon request.

In authorizing PCS services to Medicaid eligible children, the FASP factors in the age and developmental level of the child as well as the parent or LRI's availability and capability to provide the child's personal care needs.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are available to children under the age of 21. EPSDT may provide a vehicle for receiving medically necessary services beyond the limitations of the PCS benefit. Services must be deemed medically necessary. Authorization of additional services under EPSDT must take into account the responsibilities of the LRI and age-appropriate service provision as discussed above.

Housekeeping tasks are limited directly to the provision of PCS, such as cleaning the bathtub/shower after a bath/shower has been given. Time is allocated under the bathing task and is not an additional service. When a recipient lives with an LRI, it is the responsibility of the LRI to perform specific housekeeping tasks, other than those which are incidental to the performance of Personal Care tasks. This includes, but is not limited to, other housekeeping tasks, meal preparation, essential shopping and escort services.

A child's LRI must be present during the provision of services. If the LRI cannot be present during the provision of services, a PCR designated by the LRI, other than the PCA, must be present during the time services are being provided.

All other policies in this chapter apply.

3503.3 PCS FOR RECIPIENTS ENROLLED IN HOSPICE

PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the

terminal condition and the personal care needs exceed the PCS provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of an individual's comprehensive personal care needs to document any needs not met by hospice and which may be provided by the PCA. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting total personal care needs. PCS provided under hospice will be subtracted from the total authorized PCS.

The PCS provided by a PCA to a recipient because of needs unrelated to the terminal condition may not exceed program limits and guidelines.

3503.4 RESIDENTIAL SUPPORT SERVICES/SUPPORTED LIVING ARRANGEMENT (SLA)

Recipients on the Home and Community Based Waiver for Individuals with Intellectual Disabilities and receiving residential support services through a supported living arrangement (SLA) may receive State Plan PCS if the services are determined to be medically necessary and are non-duplicative of the residential support services being provided.

The FASP will be completed factoring in the residential support services.

3503.5 ESCORT SERVICES

Escort services may be authorized in certain situations for recipients who require a PCA to perform an approved PCS task en route to or while obtaining Medicaid reimbursable services.

3503.5A COVERAGE AND LIMITATIONS

Escort services may be authorized as a separate billable service when all the following conditions are met:

1. The needed PCS is currently an authorized task on the approved service plan and will be provided during the course of the visit.

2. The PCS required are an integral part of the visit. Covered personal care tasks would include undressing/dressing, toileting, transferring/positioning, ambulation and eating. For example, transferring a recipient on and off an examination table is an integral part of a physician visit.

3. An LRI is unavailable or incapable of providing the personal care task en route to or during the appointment.

4. Staff at the site of the visit (surgery center, physician's office, clinic setting, outpatient therapy site or other Medicaid reimbursable setting) is unable to assist with the needed personal care task.

3503.5B AUTHORIZATION PROCESS

1. The provider must contact the QIO-like vendor, the ADSD or Waiver for Persons with Physical Disabilities DHCFP case manager, as appropriate, for prior authorization for escort services.

2. Service should be requested as a single service authorization request. The provider must document the medical necessity of the services.

3. A new FASP is not required in this situation.

3503.5C PROVIDER RESPONSIBILITY

A. The provider must verify that all conditions above are met when asking for an escort services authorization.

B. The provider must include all the above information when submitting the prior authorization request, including the date of service and the amount of time requested. The provider must comply with all other policies in Section 3503.1E.

3. All services must be documented and verified in an approved EVV system.

3503.6 TRANSPORTATION

Transportation of the recipient in a provider's vehicle, the PCA's private vehicle or any other vehicle is not a covered service and is not reimbursable by the DHCFP. Recipients who choose to be transported by the PCA do so at their own risk.

Refer to MSM Chapter 1900, Transportation Services, for requirements of the DHCFP medical transportation program. Nevada Medicaid provides necessary and essential medical transportation to and from medical providers.

3503.7 REIMBURSEMENT

Medicaid reimbursement is made directly to the Provider Agency for services billed using Service Code T1019. The reimbursement rate is based on a contracted rate which takes into consideration and includes the costs associated with doing business. Consequently, separate reimbursement is not available for the following:

A. Time spent completing administrative functions such as supervisory visits, scheduling, chart audits, surveys, review of service delivery records and personnel consults;

B. The cost of criminal background checks and TB testing;

C. Travel time to and between recipient's home;

D. The cost of basic training, in-service requirements and the CPR and First Aid requirement; and/or

E. Routine supplies customarily used during the course of visits, including but not limited to non-sterile gloves.

3503.8 IMPROPER BILLING PRACTICES

Providers must bill only for the dates when services were actually provided, in accordance with the appropriate billing manual.

Any Provider found by the State or its agent(s) to have engaged in improper billing practices, without limitations, may be subject to sanctions including recoupment, denial or termination from participation in Nevada Medicaid.

The findings and conclusions of any investigation or audit by the DHCFP shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

Improper billing practices may include, but are not limited to:

A. Submitting claims for unauthorized visits;

B. Submitting claims for services not provided, for example billing a visit when the recipient was not at home but the PCA was at the recipient's residence;

C. Submitting claims for visits without documentation to support the claims billed.

1. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year and exact time in and out of the recipient's home. Providers shall submit or produce such documentation upon request by the DHCFP staff;

D. Submitting claims for unnecessary visits or visits that are in excess of amount, scope and duration necessary to reasonably achieve its purpose;

E. Billing for the full authorized number of units when they exceed the actual amount of service units provided; or

F. Submitting claims for PCS services provided by an unqualified paid PCA.

Any PCS or other provider who improperly bills the DHCFP for services rendered is subject to all administrative and corrective sanctions and recoupments listed in the MSM Chapter 3300. All Medicaid overpayments are subject to recoupment.

Any such action taken against a provider by the DHCFP has no bearing on any criminal liability of the provider.

3503.9 QUALITY ASSURANCE

The DHCFP and/or ADSD may conduct reviews, announced or unannounced, to evaluate the provider's compliance with this chapter and any other regulatory requirements.

These reviews may consist of, but are not limited to, a desk review by the DHCFP and/or ADSD staff and/or an onsite review. Providers must cooperate with the review process. Additionally, reviews may be conducted to verify that providers meet the requirements established for each service, to ensure services are being provided and billed for accordingly, and that claims for those services are paid in accordance with the State Plan, this chapter and all federal and state regulations.

Reviews may also be conducted to ensure the health and welfare, service satisfaction, and freedom of choice of the recipients receiving PCS.

3503.10 ADVERSE ACTIONS

An adverse action refers to a denial, termination, reduction or suspension of an applicant or recipient's request for services or eligibility determination.

For the purposes of this Chapter, the DHCFP or their designee may take adverse action when:

A. The recipient is not eligible for Medicaid;

B. The recipient does not meet the PCS eligibility criteria;

C. The recipient, their PCR or LRI refuses services or is non-cooperative in the establishment or delivery of services;

D. The recipient, their PCR or their LRI refuses to accept services in accordance with the approved service plan;

E. All or some services are no longer necessary as demonstrated by the FASP;

F. The recipient's needs can be met by an LRI;

G. The recipient's parent and/or legal guardian is responsible for the maintenance, health care, education and support of their child;

H. Services requested exceed service limits;

I. Services requested are non-covered benefits (Refer to Section 3503.1B); or

J. Another agency or program provides or could provide the services.

3504 HEARINGS

Reference MSM Chapter 3100, Hearings, for Medicaid recipient hearing procedures and Medicaid provider hearing procedures.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 28, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres* Casey Angres (Mar 7, 2022 08:21 PST)
MANAGER OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3600 – MANAGED CARE ORGANIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3600 – Managed Care Organizations are being proposed to align with the new contracts held with the Managed Care Organizations (MCOs). The proposed changes include revisions and clarification to existing policy related to MCO responsibility and coverage of Certified Community Behavioral Health Centers (CCBHCs); Residential Treatment Centers (RTC); and Population Health program.

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: This proposed change affects all Nevada Medicaid MCOs.

Financial Impact on Local Government: Unknown at this time.

These changes are effective January 29, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/22 MSM Chapter 3600 – Managed Care Organizations	MTL 16/20 MSM Chapter 3600 – Managed Care Organizations

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3600	**INTRODUCTION**	Revised "three" to "four" Health Maintenance Organizations (HMO).
3603.1(A)(10)	**ELIGIBLE GROUPS**	Revised number 10 "TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI)."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.4(B)	**EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS**	Added "medical" to non-emergency transportation (NEMT).
3603.4(D)		Revised "45"days to "180" days. Revised "40th" to "175th" day. Revised "46th" to "181st" day.
3603.4(H)		Deleted the item (Residential Treatment Center (RTC) Limitations).
3603.4(I)		Added language "such as crisis residential services."
3603.4(M)		Revised "45" days to "180" days. Revised "#c" to "#D."
3603.4(O)		Deleted any reference to Seriously Mentally Ill (SMI) I this section. Deleted "Newly Eligibles" and replaced with "and Nevada Check Up recipients."
3603.4(Q)		Deleted language related to Certified Community Behavioral Health Centers (CCBHC) in this section.
3603.5(D)	**SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES**	Added language "FQHCs not contracted with a Contractor must follow the Contractor's Prior Authorization Policy."
3603.5(F)(4)		Added language "Maternity Kick payment will be processed per delivery episode regardless of how many babies are delivered."
3603.5(F)(6)		Revised language to Coordination of Care to align with Code of Federal Regulation (CFR) requirements.
3603.5(G)		Added language to clarify Essential Community Providers (ECP) requirements.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.10	**CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC)**	Added language related to CCBHCs.
3603.11	**RESIDENTIAL TREATMENT CENTER (RTC)**	Added language related to RTC.
3603.12	**CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS**	Added language to clarify services included.
3603.12(a)		Added "or Case Manager."
3603.12(b)		Added "as part of the Utilization Management process."
3603.13	**TRANSPLANTATION OF ORGANS AND TISSUE, AND RELATED IMMUNO-SUPPRESSANT DRUGS**	Revised "$100,000" to "$500,000."
3603.15	**POPULATION HEALTH PROGRAM**	Added section related to Population Health Program.
3603.18(A)(1)	**ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS**	Revised "45" to "180" days.
3603.18(C)		Revised language to clarify reporting on newborn enrollments.
3603.18(C)(1)		Revised language to clarify MCO responsibilities for Medicaid Eligible Newborns.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.18(C)(2)		Revised language to clarify MCO responsibilities for Nevada Check Up (NCU) Newborns.
3603.18(D)(2)		Added language "and outlines in the Medicaid State Plan."
3603.18(F)		Added new section F "Performance Based Auto Assignment."
3603.20(B)	**TRANSITIONING/ TRANSFERRING OF ENROLLEES**	Added language to clarify enrollees changing MCOs or reverting to Fee-for-Service (FFS). Deleted number 12. Added number 17.
3603.20(C)		Added item C section related to Transitions of Child Welfare Involved Children from FFS to an MCO.
3603.21(A)(1)	**INFORMATION REQUIREMENTS**	Added language to the Member Handbook requirements.
3603.21(A)(2)		Added language to the role of Primary Care Physician (PCP).
3603.21(A)(3)		Deleted number 3.
3603.21(A)(4)		Added language "as well as their right to select a Primary Care Site (PCP) that meets their cultural and/or racial preferences."
3603.21(A)(10)		Deleted language related to explanation of procedures for urgent medical situations.
3603.21(A)(11)		Added language related to explanation of procedures for urgent medical situations.
3603.21(A)(12)		Added "and information that a referral is not required in choosing a family planning provider."
3603.21(A)(13)		Added language to clarify that MCOs must notify enrollees when the MCO changes a policy based on moral or religious objectives.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.21(A)(24)		Added language to clarify how to report fraud and abuse.
3603.21(A)(25)		Added number 25 "The transition of care policy and instructions on how to access continued services upon transition to FFS or another MCO." Revised language throughout the section for more clarification on the Member Handbook.
3603.21(B)		Revised item B "Identification of Cards" to "Member Newsletter."
3603.21(E)		Added "calendar" days. Revised "working" to "business" days.
3603.22(A)	**MEDICAL PROVIDER REQUIREMENTS**	Revised language related to PCP or PCS requirements in this section.
3603.22(B)		Added language related to PCP or PCS assignment.
3603.22(B)(2)		Added language to clarify access to PCPs per CFR requirements and removed Nevada Administrative Code (NAC) reference.
3603.22(B)(5)		Added number 5 "Assigning an enrollee to a PCP upon receipt of a claim for services rendered by a PCP to the enrollee."
3603.22(C)(1)		Deleted "The materials used to notify enrollees shall be approved by DHCFP prior to publication and/or distribution."
3603.22(C)(2)		Changed "business" to "calendar" days.
3603.22(C)(3)(B)		Changed "25" to "10" miles.
3603.23	**PROVIDER DIRECTORY**	Revised language to clarify Provider Directory requirements.
3603.24(A)(3)	**NETWORK MAINTENANCE**	Added number 3 "Monitoring of adherence to the network adequacy and timely access standards under the contract and remediation of any deficiencies."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3603.25(B)	**RETRO-CAPITATION AND CAPITATION RECONCILIATION**	Throughout the chapter "Forms and Reporting Guide" is replaced with "MOVE it reporting repository."
3604(A)(1)	**GRIEVANCES, APPEALS AND HEARINGS**	Added language related to enrollee grievances and appeals actions.
3604(A)(3)		Added language related to State Fair Hearings Process.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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MANAGED CARE ORGANIZATION

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3600 INTRODUCTION

In 1992, the Nevada State Department of Human Resources (now called the Department of Health and Human Services (DHHS)) initiated the development of a fully capitated, risk based Managed Care Program. The capitated, risk-based Managed Care Program was implemented under a Section 1915(b) Waiver which established a mandatory Managed Care Program, serving recipients in urban Clark County and Washoe County. The mandatory program became effective on January 1, 1996 and served eligible recipients in the programs that were then known as "Aid to Families with Dependent Children/Aid to Dependent Children (AFDC/ADC)" and related programs as well as the Child Health Assurance Program (CHAP) and other child welfare programs. On April 1, 1997, the voluntary Medicaid Managed Care Program was also implemented in Nevada.

Subsequent to the close of the 1997 Nevada Legislature, the U.S. Congress passed the Balanced Budget Act (BBA) of 1997. Under the BBA, states are given the ability to implement managed care programs without a waiver. This generally simplified approval at the federal level. On October 1, 1998, Nevada's Managed Care Program was approved by the Centers for Medicare and Medicaid Services (CMS), which was formerly known as the Health Care Financing Administration (HCFA) as a state plan amendment.

The State of Nevada Division of Health Care Financing and Policy (DHCFP) oversees the administration of all Medicaid Managed Care Organizations (MCOs) in the state. Nevada Medicaid operates a Fee-for-Service (FFS) and a managed care reimbursement and service delivery system with which to provide covered medically necessary services to its eligible population. MCO contracts are comprehensive risk contracts and are paid a risk-based capitated rate for each eligible, enrollee on a Per-Member, Per-Month (PMPM) basis. These capitated rates are certified to be actuarially sound. There is also a formula for Stop Loss, when costs of inpatient care exceed a threshold during a specified time period; Very Low Birth Weight Newborns (VLBW); and the Primary Care Physician (PCP) enhancements, according to the Patient Protection and Affordable Care Act (ACA) and as approved by CMS.

The mandatory Managed Care Program is currently available to Medicaid and Nevada Check Up (NCU) recipients in urban Clark and Washoe counties. DHCFP may, at a future date, designate other geographical locations as mandatory managed care areas in accordance with Nevada Administrative Code (NAC) 695C.160.

All MCOs must be in compliance with all applicable Nevada Revised Statutes (NRS), NAC, the Code of Federal Regulations (CFR), the United States Code (USC), and the Social Security Act (the Act) which assure program and operational compliance as well as assuring services that are provided to Medicaid and NCU recipients enrolled in an MCO are done so with the same timeliness, amount, duration, and scope as those provided to FFS Medicaid and NCU recipients.

Participating MCOs shall provide to enrolled Medicaid and NCU recipients a benefits package covering inpatient and outpatient hospital care, ambulatory care, physician services, a full range of preventive and primary health care services, and such other services as DHCFP determines to

be in the best interests of the State and eligible recipients to include in benefits package. The MCO is responsible for reimbursing claims of eligible enrollees for services covered under the contract or for each month a capitated payment is made. DHCFP will continue to provide, on a FFS basis, certain services that are not contained in the MCO contracts or the capitated benefits package.

Currently, DHCFP contracts with four Health Maintenance Organizations (HMO) as MCOs and one Prepaid Ambulatory Health Plan (PAHP) as the Dental Benefits Administrator (DBA) for the State of Nevada. Enrollment in an MCO is mandatory for the Family Medical Category (FMC) categories of Temporary Assistance for Needy Families (TANF) (Section 1931) and CHAP (poverty level pregnant women, infants, and children) recipients when there is more than one MCO option from which to choose in a geographic service area. Enrollment in an MCO is mandatory for all NCU recipients when there is at least two MCO options in the recipient's geographic service area. The eligibility and aid code determination functions for Medicaid and NCU applicants and eligible populations are the responsibility of the Division of Welfare and Supportive Services (DWSS). The enrollment function is the responsibility of the Medicaid Management Information System (MMIS).

All Medicaid policies and requirements (such as prior authorization) are the same for NCU, with the exception of the certain areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

3601 AUTHORITY

The rules set forth below are intended to supplement, and not to duplicate, supersede, supplant or replace other requirements that are otherwise generally applicable to Medicaid managed care programs as a matter of federal statute, regulation, or policy, or that are generally applicable to the activities of MCOs and their network providers under applicable laws and regulations. In the event that any rule set forth herein is in conflict with any applicable federal law or regulation, such federal law or regulation shall control. Such other applicable requirements include, but are not limited to:

A. Federal contract and procurement requirements applicable to risk comprehensive contracts with an MCO, as set forth in 42 CFR §438 for MCOs and Primary Care Case Management (PCCM); 42 CFR §434.6 of the general requirements for contracts; 42 CFR §438.6 (c) of the regulations for payments under any risk contracts; 42 CFR §447.362 for payments under any non-risk contracts Section 1903 (m) of the Act, for MCOs and MCO contracts; 45 CFR §74 for procurement of contracts and, Part 2 of the State Medicaid Manual, CMS Publication 45-2;

B. Section 1932, provisions relating to managed care, (including Section (a)(1)(A)) of the Act, 42 United States Code (U.S.C.) 1396(a) governing state plans for medical assistance and 42 CFR 438.10 for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities;

C. MCO licensure and financial solvency requirements, as set forth in Title XIX of the Act, Part 2 of the State Medicaid Manual, CMS Publication 45-2, and the Nevada Revised Statutes (NRS);

D. Independent external quality review requirements, as set forth in Part 2 of the State Medicaid Manual, CMS Publication 45-2, and 42 CFR §438;

E. Restrictions on payments by MCOs of incentives to physicians to restrict or limit services, as set forth in 42 CFR §§417.479(d)-(g) and (i) and §434.70;

F. Composition of enrollment requirements for MCOs, as set forth in 42 CFR §438 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

G. The requirement that MCOs maintain written policies and procedures with respect to Advance Directives (ADs), as set forth in 42 CFR §438, 42 CFR §431.20 and Section 1902(w)(1);

H. Requirements for screening, stabilization, and appropriate transfer of persons with an emergency medical condition, as set forth in the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd and 42 CFR 438;

I. The requirement that certain entities be excluded from participation, as set forth in Section 1128 and Section 1902(p) of the Act and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

J. The requirement of prior CMS approval for risk comprehensive contracts, as set forth in 42 CFR §438 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

K. The requirements of access to and reimbursement for federally qualified health center services, as set forth in Section 4704(b) of the Omnibus Budget Reconciliation Act of 1990 and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

L. Confidentiality and privacy requirements as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

M. The requirement of freedom of choice for family planning services and supplies, as set forth in 42 CFR §431.51 and as defined in Section 1905 (a)(4)(C) and Part 2 of the State Medicaid Manual, CMS Publication 45-2;

N. The Nevada Title XIX and Title XXI State Plans;

O. The requirements to operate as an HMO/MCO in Nevada as set forth in NRS 695C and 695G;

P. The requirements for health information technology under the Health Information Technology for Economic and Clinical Health Act (HITECH);

Q. The 21st Century Cures Act, §12006; and

R. Any other requirements that are imposed as a matter of applicable federal statutes or regulations, or under applicable CMS requirements with respect to Medicaid managed care programs.

These rules are issued pursuant to the provisions of NRS Chapter 422. The Nevada State Department of Health and Human Services (DHHS), acting through the Nevada Division of Health Care Financing and Policy (DHCFP) has been designated as the single state agency responsible for administering the Nevada Medicaid program under delegated federal authority pursuant to 42 CFR 431. Accordingly, to the extent that any other state agency rules are in conflict with these rules, the rules set forth herein shall control.

3602 RESERVED

3603 POLICY

3603.1 ELIGIBLE GROUPS

A. Mandatory Managed Care Program Enrollees:

The State of Nevada Managed Care Program requires the mandatory enrollment of recipients found eligible for Medicaid program coverage under specific categories under the FMC when there are two or more MCOs in the geographic service area. These specific categories include the following:

1. TANF;
2. Two parent TANF;
3. TANF – Related Medical Only;
4. TANF – Post Medical (pursuant to Section 1925 of the Act;
5. TANF – Transitional Medical (under Section 1925 of the Act);
6. TANF Related (Sneede vs. Kizer);
7. CHAP;
8. Aged-out Foster Care (Young adults who have “aged out” of foster care); and
9. New Medicaid Newly Eligibles, defined as childless adults ages 19 – 64, and the expanded parent and caretakers ages 19 – 64, who are made eligible as part of the Patient Protection and Affordable Care Act (PPACA) expansion population and who are receiving the Alternative Benefit Plan.
10. TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI);

In addition, the mandatory enrollment of recipients found eligible for Medicaid program coverage include the following categories when there are two or more MCOs in the geographic service:

11. Children’s Health Insurance Program, NCU.

B. Ineligible Managed Care Program Enrollees:

The State of Nevada Managed Care Program makes ineligible the following Medicaid recipients from enrollment in managed care:

1. Recipients who are eligible for Medicare;

2. Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI;

3. Children under the age of 19 years who are eligible under Section 1902(e)(3) of the Act;

4. Children under the age of 19 years who are foster care or other out-of-the-home placement;

5. Children under the age of 19 years who are receiving foster care or adoption assistance under Title IV-E; and

6. Recipients with comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased from another organization or agency which cannot be billed by an MCO are exempt from mandatory enrollment.

C. Voluntarily Enrolled Managed Care Program Enrollees:

The State of Nevada Managed Care Program allows that although the following Medicaid recipients are exempt from mandatory enrollment, they are allowed to voluntarily enroll in an MCO if they choose:

1. American Indians and Alaskan Natives (AI/AN) who are members of federally recognized tribes except when the MCO is the Indian Health Service (IHS); or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the IHS;

2. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs (also known as Children with Special Health Care Needs – CSHCN);

3. TANF and CHAP adults diagnosed as Seriously Mentally Ill (SMI); and

4. TANF and CHAP children diagnosed as Severely Emotionally Disturbed (SED).

3603.2 GEOGRAPHIC AREA

The State assures individuals will have a choice of at least two MCOs for the Medicaid Managed Care enrollees in each geographic area. When fewer than two MCOs are available for choice in the geographic areas listed, enrollment in Managed Care will be voluntary.

3603.3 COVERED SERVICES

No enrollee shall receive fewer services in Managed Care than they would receive in the current Nevada Medicaid/NCU State Plans, except as contracted or for excluded services noted in Section 3603.4 below.

Any new services added or deleted from the Medicaid benefit package will be analyzed for inclusion or exclusion in the MCO benefit package.

3603.4 EXCLUDED SERVICES AND/OR COVERAGE LIMITATIONS

The following services are either excluded as an MCO covered benefit or have coverage limitations. Exclusions and limitations are identified as follows:

A. All services provided at IHS Facilities and Tribal Clinics

AI/AN may access and receive covered medically necessary services at IHS facilities and Tribal Clinics. If an AI/AN voluntarily enrolls with an MCO and seeks covered services from the IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by the IHS. If treatment is recommended by the IHS and the enrollee seeks the recommended treatment through the MCO, the MCO must either provide the service or must document why the service is not medically necessary. The documentation may be reviewed by DHCFP or other reviewers. The MCO is required to coordinate all services with IHS. If an AI/AN recipient elects to disenroll from the MCO, the disenrollment will commence no later than the first day of the next administrative month and the services will then be reimbursed by FFS.

B. Non-Emergency Medical Transportation (NEMT)

A contracted MCO will authorize and arrange for all medically necessary non-emergency medical transportation. The MCO must verify medical appointments upon request by DHCFP or their designee.

C. Ground Emergency Medical Transportation (GEMT)

GEMT Services are available to eligible managed care enrollees; however, the services are reimbursed under FFS pursuant to the MSM Chapter 1900. The MCO is not responsible for payment of any GEMT service received by an enrollee. The GEMT provider will submit their claims directly to DHCFP's Fiscal Agent and will be paid by DHCFP through the Medicaid FFS fee schedule. The MCO is responsible for ensuring referral and coordination of care for GEMT services.

D. All Nursing Facility stays over 180 days

The MCO is required to cover the first 180 days of a Nursing Facility admission, pursuant to the MSM. The MCO is also required to collect any patient liability (pursuant to 42 CFR §435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify DHCFP by the 175th day of any nursing facility stay expected to exceed 180 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 181st day of the facility stay.

E. Swing bed stays in acute hospitals over 45 days

The MCO is required to cover the first 45 days of a swing bed admission pursuant to the MSM. The MCO is also required to collect any patient liability (pursuant to 42 CFR 435.725) for each month a capitated payment is received, pursuant to the MSM. The MCO shall notify DHCFP by the 40th day of any swing bed stay expected to exceed 45 days. The enrollee will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.

F. School Health Services (SHS)

DHCFP has provider contracts with several school districts to provide Early Periodic Screening, Diagnostic, and Treatment (EPSDT) medically necessary covered services to eligible Title XIX Medicaid and Title XXI NCU recipients. School Based Health Clinics are separate and distinct from SHS.

The school districts can provide, through school district employees or contract personnel, medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school districts' provider contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document why the services are not medically necessary. The documentation may be reviewed by DHCFP or its designees. Title XIX Medicaid and Title XXI NCU eligible children are not limited to receiving health services through the school districts. Services may be obtained through the MCO rather than the school district, if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

G. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID)

Residents of ICF/ID facilities are not eligible for enrollment with the MCO. If a recipient is admitted to an ICF/ID after MCO enrollment, the recipient will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.

H. Hospice Services

Recipients who are receiving Hospice Services are not eligible for enrollment with the MCO. Hospice Services are an optional program under Title XVIII Section 1905(o)(1)(A) of the Act and are governed by 42 CFR §418 and §489.102(I). Once admitted into hospice care, Medicaid recipients will be disenrolled immediately. NCU recipients will not be disenrolled. However, payment for NCU Hospice Services will be billed as FFS. It is the responsibility of the MCOs to provide reimbursement for all ancillary services until properly disenrolled from managed care.

I. Inpatient Hospital Services

MCOs may provide Inpatient Hospital Services, to mandatory enrollees within an alternative inpatient setting, which is licensed by the State of Nevada, in lieu of services such as crisis residential services in an inpatient hospital. The alternative inpatient setting must be a lower cost than the traditional inpatient setting.

J. Adult Day Health Care (ADHC)

ADHC services for eligible managed care recipients are covered under FFS pursuant to the MSM Chapter 1800. The MCO is responsible for ensuring referral and coordination of care for ADHC services. The MCO must ensure that recipients who are receiving ADHC services are receiving all medically necessary services covered in the managed care benefit package.

K. Habilitation Services

Habilitation services for eligible managed care enrollees who have a traumatic brain injury (TBI) or acquired brain injury (ABI) are covered under FFS pursuant to the MSM Chapter 1800.

L. Home and Community Based Waiver (HCBW) Services

Recipients who are receiving HCBW Services are not eligible for enrollment with the MCO. If a recipient is made eligible for HCBW Services after MCO enrollment, the recipient will be disenrolled and the HCBW Services will be reimbursed through FFS.

M. All Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments are performed by the State's Fiscal Agent.

Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the recipient is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 180 days of admission (see #D above).

N. Pharmacy Drug Limitations

Zolgensma® is a high-cost gene therapy drug used to treat children less than two years old with spinal muscular atrophy (SMA). Recipients receiving this drug will not be disenrolled from managed care; however, payment for the drug will be carved out and FFS should be billed.

O. SED/SMI

The MCO must ensure enrollees who are referred for evaluation for SED/SMI or who have been determined SED/SMI by the health plan are obtaining the medically necessary evaluations by an in-network provider and that enrollees are transitioned, as necessary, to another provider in order to obtain their mental health services if such services are not available within the network. The MCO is required to notify DHCFP if a Title XIX Medicaid recipient elects to disenroll from the MCO following the determination of SED and forward the enrollee's medical records to the provider from whom the enrollee will receive the covered mental health services. However, in the event the Medicaid enrollee who has received such a determination chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care. Enrollees who receive either an SED or SMI determination must be redetermined at least annually.

The MCO is required to adhere to the MSM Chapter(s) 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Such services include but are not limited to: case management; lab work; prescription drugs; acute in-patient; and, other ancillary medical and mental health services required by the plan of treatment. Title XIX Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED. Title XXI, NCU recipients must remain enrolled with the MCO who is responsible for on-going patient care. If a Title XIX eligible recipient elects to disenroll from the MCO following a determination of SED, the disenrollment will commence the first day of the next administrative month and the services will then be reimbursed by FFS.

Nevada Medicaid and Nevada Check Up recipients cannot opt out of managed care, where available, based on a determination of SMI.

3603.5 SPECIAL REQUIREMENTS FOR SELECTED COVERED SERVICES

A. Out-of-Network Providers

When it is necessary for enrollees to obtain services from out-of-network providers (e.g., the enrollee needs to see a specialist for which the MCO has no such specialist in its network) the MCO must:

1. Coordinate with out-of-network providers with respect to payment;

2. Offer the opportunity to the out-of-network provider to become part of the network; and,

3. Negotiate a contract to determine the rate prior to services being rendered.

B. Emergency Services

The MCO must cover and pay for emergency services regardless of whether the provider who furnished the services has a contract with the MCO. The MCO must pay the out-of-network provider for emergency services applying the "prudent layperson" definition according to the Emergency Medical Treatment and Labor Act (EMTALA) of an emergency, rendered at a rate limited to the amount that would have been paid if the service had been provided under FFS, unless a lower amount is mutually agreed to between the MCO and the party(ies) rendering service. Pursuant to 1932 (b)(2)(D) of the Act, a non-contracting provider of emergency services must accept as payment in full no more than it would receive if the services were provided under FFS. This rule applies whether the non-contracting provider is within the State or outside of the State in which the managed care entity has a contract.

No prior or post-authorization can be required for emergency care provided by network or out-of-network providers. The MCO may not deny payment for treatment obtained when the enrollee has an emergency medical condition and seeks emergency services, applying the "prudent layperson" definition of an emergency; this includes the prohibition against denying payment in those instances in which the absence of immediate medical attention would not have resulted in placing the health of the enrollee in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily part or organ. The MCO may not deny payment for emergency services treatment when a representative of the MCO instructs the enrollee to seek emergency services care. Final determination of coverage and payment must be made taking into account the presenting symptoms rather than the final diagnosis.

Pursuant to 42 CFR §438.114, the MCO may not limit what constitutes an emergency medical condition as defined in this section on the basis of lists of diagnoses or symptoms nor refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's PCP, MCO, or DHCFP of the enrollee's screening and treatment within ten calendar days of the presentation for emergency services.

An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The attending physician or the provider actually treating the enrollee is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO.

C. Post-Stabilization Services

The MCO is financially responsible for:

1. Post-stabilization services obtained within or outside the network that are pre-approved by a network provider or the MCO representative;

2. Post-stabilization services obtained within or outside the network that are not pre-approved by a network provider or other organization representative, but administered to maintain the enrollee's stabilized condition within one hour of a request to the MCO for pre-approval of further post-stabilization care services;

3. Post-stabilization care services obtained within or outside the network that are not pre-approved by a network provider or other MCO representative but administered to maintain, improve, or resolve the enrollee's stabilized condition if the MCO does not respond to a request for pre-approval within one hour or the MCO cannot be contacted or the MCO and the treating physician cannot reach an agreement concerning the enrollee's care and a network provider or other organization representative is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the enrollee until a network physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.

   Pursuant to 42 CFR §422.113(c)(3), the MCO's financial responsibility for post-stabilization care it has not pre-approved ends when a network physician with privileges at the treating hospital assumes responsibility for the enrollee's care or a network physician assumes responsibility for the enrollee's care through transfer or the MCO and the treating physician reach an agreement concerning the enrollee's care or the enrollee is discharged.

D. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)

The MCO must pay for services provided by an FQHC or an RHC. MCOs may enter into contracts with FQHCs or RHCs, provided that payments must be at least equal to the amount paid other providers for similar services and no lower than the FFS rates. If the MCO does not have a contract with an FQHC or RHC, the MCO must pay at a rate equivalent to that paid by DHCFP FFS reimbursement schedule, regardless of whether the FQHC or RHC is in or out of network. This does not apply to out-of- network providers of emergency services. See Section 3603.5(B). The MCO must make a good faith effort to negotiate a contract with these providers. The MCO must report to DHCFP payments and visits made to FQHCs and/or RHCs. FQHCs not contracted with a Contractor must follow the Contractor's Prior Authorization Policy.

E. Out-Of-State Providers

When it is necessary for recipients to obtain services from an Out-Of-State (OOS) provider, the MCO must negotiate a contract to determine the rate prior to services being rendered. The MCO must inform the OOS provider to accept the MCO's reimbursement as payment

in full. The only exception is for Third-Party Liability (TPL). The OOS provider must not bill, accept or retain payments from Medicaid or NCU recipients. OOS providers of emergency services must accept as payment in full no more than it would receive if the services were provided under FFS, pursuant to §1932(b)(2)(D) of the Act.

F. Obstetrical/GYN Services

1. Care Coordination for Certain Pregnant Women

The MCO is responsible for the identification and medical management of women identified as having a risk of preterm birth or poor pregnancy outcome.

A pregnancy is defined as "high risk" when there is a likelihood of an adverse outcome to the woman and/or her baby that is greater than the incidence of that outcome in the general pregnant population.

It is the responsibility of the MCO to assess the risk status of all enrolled pregnant women.

Subsequently, the MCO is responsible for providing medical case management to all enrolled women who have been identified as having a high-risk pregnancy.

The MCO is also responsible for referring enrolled pregnant women identified with specified social needs to the DWSS. The DWSS staff is available to provide information regarding available community support programs to enrollees identified as experiencing any of the specified high-risk social issues. DHCFP District Office staff is available to assist in limited care coordination.

2. Obstetrical Global Payment

Length of time that the pregnant woman is enrolled in the health plan is not a determining factor in payment to the obstetrician. Payment to the delivering obstetrician for a normal routine pregnancy shall be based upon the services and number of visits provided by the obstetrician to the pregnant woman through the course of her pregnancy. Payments are determined by Current Procedural Terminology (CPT) codes submitted by the provider. The MCO must provide separate payment for covered medically necessary services required as a result of a non-routine pregnancy.

A Global Payment will be paid to the delivering obstetrician, regardless of network affiliation, when the enrollee has been seen seven or more times. If the obstetrician has seen the enrollee less than seven times, the obstetrician will be paid according to the FFS reimbursement schedule.

a. Network Providers

For all cases, the MCO must have policies and procedures in place for transitioning the Medicaid or NCU eligible pregnant recipient to a network provider.

b. Non-network Providers

The MCO may reimburse a non-network provider at a negotiated rate less than the FFS rates established for pregnancy-related CPT codes.

c. New Enrollees within the Last Trimester of Pregnancy

A pregnant woman who is enrolled with the MCO within the last trimester of pregnancy must be allowed to remain in the care of a non-network provider, if she so chooses. The MCO must have policies and procedures for this allowance.

d. Prior Authorization (PA)

The MCO's PA policies and procedures must be consistent with the provision of prenatal care in accordance with community standards of practice. DHCFP, at its discretion, may require removal of the prior authorization requirement for various procedures based on reported approval data and any other relevant information. The MCO is required to provide written notification to all affected network providers within 30 days of end of reported quarter regarding the elimination of the prior authorization requirement.

Under no circumstance will visits not covered by Medicaid or NCU be applied toward the minimum number of visits required for a global payment.

3. Certified Nurse Midwife Services

The MCO must make certified nurse midwife services available to enrollees, if such services are available in the MCO's service area. If the MCO does not have a contract for said services, the MCO must pay the certified nurse midwife provider according to DHCFP FFS reimbursement schedule for services rendered to the enrollee.

4. Maternity Kick Payment (aka Supplemental Omnibus Reconciliation Act (SOBRA) payment)

The MCO will receive a maternity kick payment from DHCFP to cover the maternity costs of any birth, still born, or miscarriage occurring in the third trimester of pregnancy for which an obstetrical payment has been made and there is an accompanying provider claim for the delivery. The third trimester commences

at 27 weeks of gestation. Maternity kick payments will be generated upon submission of encounter data confirming the delivery. Maternity Kick payment will be processed per delivery episode regardless of how many babies are delivered.

The maternity kick payment is intended to offset most of the costs to the health plans for costs associated specifically with the covered delivery of a child, including prenatal and postpartum care. Ante partum care is included in the capitation rate paid for the mother. Costs of care for the newborn are included in the capitation rate.

DHCFP will not pay a SOBRA payment in a situation where there is no accompanying provider claim for the delivery.

5. Family Planning Services

Federal regulations grant the right to any enrollee of child-bearing age to receive family planning services from any qualified provider, even if the provider is not part of the MCO's provider network. The MCO may not require family planning services to be prior authorized. Family planning services are provided to enrollees who want to control family size or prevent unwanted pregnancies. Family planning services may include education, counseling, physical examinations, birth control devices, supplies and Norplant.

Pursuant to the MSM Chapter 600, tubal ligations and vasectomies are a covered benefit for recipients 21 years of age or older. In accordance with federal regulations, the recipient must fill out a consent form at least 30 days prior to the procedure. The physician is required to send the consent form to the Fiscal Agent with the initial claim. Tubal ligations and vasectomies to permanently prevent conception are not covered for any recipient under the age of 21 or any recipient who is adjudged mentally incompetent or is institutionalized.

The MCO must, at a minimum, pay qualified out-of-network providers for family planning services rendered to its enrollees at the FFS rate paid by DHCFP. The MCO will be responsible for coordinating and documenting out-of-network family planning services provided to its recipients and the amounts paid for such services.

6. Coordination of Care

Pursuant to 42 CFR §§438.208(b)(2, 3, and 4) the MCO is required to implement procedures to coordinate services it may provide to the enrollee with the services the enrollee may receive from any other vendor or entity, including dental, pharmacy, or through FFS. Upon request or notification of need, the MCO is required to communicate with other vendors or entities serving the enrollee the results of its identification and assessment of that enrollee's needs to ensure services are not duplicated. The MCO must implement procedures to ensure that in

the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR §160 and §164 (HIPAA). The MCO case managers will be responsible for coordinating services with appropriate non-Medicaid programs. This coordination includes referral of potentially eligible enrollees, including women with high-risk pregnancies, to appropriate community resources and social service programs. The MCO case managers will also be responsible for coordinating the transition of services for those enrollees transferring to or from FFS, another MCO, and/or the State-designated Health Insurance Exchange (HIX).

7. Freestanding Obstetric/Birth Centers

Section 2301 of the ACA requires coverage of services furnished at freestanding birth centers. The MCO is required to provide services at freestanding obstetric/birth centers.

A freestanding birth center is described as a health facility that is not a hospital or physician's office, where childbirth is planned to occur away from the pregnant woman's residence. The birth center must be in compliance with applicable state licensure and nationally recognized accreditation organization requirements for the provision of prenatal care, labor, delivery and postpartum care. "Obstetric Center", Nevada's legal term for birth center, complies with Section 2301 of the ACA birth center requirements related to the health and safety of recipients provided services by licensed birth centers.

DHCFP birth center coverage and reimbursement is limited to medically necessary childbirth services which use natural childbirth procedures for labor, delivery, postpartum care and immediate newborn care. Birth center coverage and reimbursement are limited to women admitted to a birth center in accordance with adequate prenatal care, prospect for a normal uncomplicated birth defined by criteria established by the American College of Obstetricians and Gynecologists and by reasonable generally accepted clinical standards for maternal and fetal health. Prior authorization is not required.

Refer to the Maternity Care section of the MSM Chapter 600 – Physician Services, for comprehensive maternity care coverage provided by physicians and/or nurse midwives. Refer to Attachment A, Policy #02-01, of the MSM Chapter 200 for comprehensive birth center covered services and provider requirements.

G. Essential Community Providers (ECP)

As defined by the ACA and Section 340(B)(a)(4) of the Public Health Service Act, ECPs are providers that have historically provided services to underserved populations and demonstrate a commitment to serve low income, underserved populations who make up a significant portion of its patient population or, in the case of a sole community provider,

serves underserved patients within its clinical capability; and (b) waives charges or charges for services on a modified sliding fee scale based on income and does not restrict access or services because of a patient's financial limitations. The MCOs must make a good faith effort to negotiate a contract with the ECPs who are located in the plan's geographic service area, including but not limited to those identified in the managed care contract. The State has identified ECPs that may not meet the aforementioned requirements but are critical to ensuring access to Covered Services in the Contractor's Provider Network. The Health Resources and Services Administration (HRSA) provides a non-exclusive list of ECPs; however, DHCFP reserves the right to modify this list at any time.

3603.6 ADDITIONAL PREVENTIVE SERVICES

The MCO is encouraged to offer additional preventive or cost-effective services to enrolled recipients, if the services do not increase the cost to the State.

3603.7 DENTAL SERVICES

Dental services are included in the benefit package for those mandatorily enrolled in a Managed Care geographic area. A contracted PAHP will be responsible for all covered medically necessary dental services pursuant to the MSM Chapter 1000, the NCU State Plan and the State Plan, Section 3.1-A.

3603.8 PRIVATE DUTY NURSING

Private duty nursing services (42 CFR §440.80) are included in the MCO package for recipients who require more individual and continuous care. These services are provided:

A. By a Registered Nurse (RN) or a Licensed Practical nurse (LPN);

B. Under the directions of the recipient's physician; and

C. In the recipient's home, or any setting where normal life activities occur.

For additional information, reference the MSM Chapter 900.

3603.9 PHARMACY SERVICES

Pharmacy services are included in the MCO benefit package. The MCO may design its own pharmacy formulary based on clinical guidelines. Medications not covered in the MCO's formulary must be available through a non-formulary request process based on physician certification and justification of medical necessity. Pharmacy coverage benefits are based on the Medicaid/NCU State Plan.

The MCO may use generic substitutions unless the physician/dentist justifies the medical necessity of the brand name pharmaceutical.

The MCO must have a policy for transitioning a recipient's prescriptions from FFS, another MCO or the HIX, to the MCO, vendor or HIX. The MCO will not be allowed to terminate a current prescription without first conducting a medical examination of the recipient. The MCO then must document why a drug is not medically necessary, if a current prescription is terminated.

DHCFP shall approve the MCO's formulary prior to implementation. The MSM Chapter 1200 stipulates the conditions with which a prescriber must comply to certify that a specific brand of medication is medically necessary for a particular patient. The physician should document in the patient's medical record the need for the brand name product in place of the generic form. The procedure of the certification must comply with the following: certification must be in the physician's own handwriting; and, certification must be written directly on the prescription blank and a phrase indicating the need for a specific brand is required (an example would be "Brand Medically Necessary"). Substitution of generic drugs prescribed by brand name must also comply with NRS 639.2583.

The MCO will report all claims billed for drugs that were acquired through the 340B drug pricing program using standard identifiers as defined by DHCFP so they can be properly excluded from federal drug rebates. Entities that are identified on the HRSA website as 340B providers must be excluded from rebate invoicing.

The MCO must operate a drug utilization review program for covered outpatient drugs that includes prospective drug review, retrospective drug use review, application of standards and an education program in compliance with the requirements described in Section 1927(g) of the Act and 42 CFR part 456, subpart K.

Pursuant to Sec. 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT ACT) the MCOs are required to have a constructed or designed claims review, process, or program as outlined in the Managed Care contract.

3603.10 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC)

Services furnished in a CCBHC are available to eligible Managed Care enrollees. The MCO must pay CCBHCs no less than the approved rates in the Medicaid State Plan. The required Prospective Payment System (PPS) reimbursement for CCBHCs will be accounted for in the Capitation Payments. The quality incentive payment will be calculated by the State and distributed through the MCOs after the value of the incentive payment for each contract year is known.

3603.11. RESIDENTIAL TREATMENT CENTER (RTC)

The MCO is responsible for reimbursement of all RTC charges including admission, bed day rate and ancillary services.

3603.12 CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) AND MENTAL HEALTH SERVICES FOR ADULTS

The MCO benefit package must include certain services for members with special health care needs, including CSHCN, Early Intervention, and mental health services for adults for which the MCO must reimburse certain types of providers with whom formal contracts may not be in place and coordinate these services with other services in the MCO benefit package.

The MCO must implement mechanisms to assess each enrollee, identified to the MCO as an individual with special health care needs, in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

The MCO must produce a treatment plan for enrollees with special health care needs who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be:

A. Developed by the enrollee's PCP or Case Manager with enrollee participation, and in consultation with any specialists caring for the enrollee;

B. Approved by the MCO, as part of the Utilization Management process, in a timely manner, if approval is required by the MCO; and,

C. In accordance with any applicable State quality assurance and utilization review standards.

For children with special health care needs who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow these enrollees access to a specialist, through a standing referral or an approved number of visits, as appropriate for the enrollee's condition and identified needs.

The MCO is required to adhere to the MSM Chapters 400 and 2500 for all SED and SMI referrals and determinations and must reimburse providers of these services pursuant to the referenced MSM Chapters. Medicaid eligible recipients have the option of disenrolling from the MCO, if determined to be SED or SMI, with the exception of the Nevada Medicaid Newly Eligible childless adults ages 19 – 64 and the expanded parent and caretakers ages 19 - 64. Title XXI NCU recipients must remain enrolled with the MCO who is responsible for ongoing patient care.

3603.13 TRANSPLANTATION OF ORGANS AND TISSUE, AND RELATED IMMUNO-SUPPRESSANT DRUGS

These services are covered, with limitations, when medically necessary. Coverage limitations for these services are defined in the Medicaid State Plan. DHCFP via its Medicaid State Plan Attachment 3.1.E covers corneal, kidney, liver and bone marrow transplants and associated fees for adults. For children up to age 21 any medically necessary transplant that is not experimental

will be covered. The MCO may claim transplant case reimbursement from DHCFP for in-patient medical expenses above the threshold of $500,000 in a one-year period (State Fiscal Year). 75% of the expenses above $500,000 are reimbursed to the health plan.

At the discretion of DHCFP administration, an enrollee may be assigned to another MCO at any time and DHCFP may reimburse the MCO for claims and waive stop loss. DHCFP may also assign an otherwise FFS child to the MCO for care management. The MCO will be expected to administer these FFS payments with no added markup.

3603.14 TARGETED CASE MANAGEMENT (TCM)

TCM has a specific meaning for Nevada Medicaid and NCU. TCM, as defined by the MSM Addendum, is carved out of the managed care contracts. Case management, which differs from TCM, is required from the contracted MCO.

3603.15 POPULATION HEALTH PROGRAM

The MCO must establish a Population Health program that establishes population health goals and targeted annual improvements that are aligned with the State's Quality Strategy. The MCO's Population Health program must align the efforts and resources of the MCO's Care Management programs (i.e., disease management, Care Coordination, Case Management, and programs that address social determinants of health and racial and ethnic disparities in health care), Quality Management, and the Contractor's value based contracting strategies to achieve population health improvements.

3603.16 IMMUNIZATIONS

The MCO shall require its network providers to enroll in the Vaccines for Children Program (VFC) which is administered by the Nevada Division of Public and Behavioral Health (DPBH). Providers licensed by the state to prescribe vaccines may request to be enrolled in the DPBH's VFC Program. The immunization program will review and approve provider enrollment requests. The MCO shall require VFC enrolled providers to cooperate with the DPBH for purposes of performing orientation and monitoring activities regarding the VFC Program requirements.

Upon successful enrollment in the VFC Program, providers may request state supplied vaccine to be administered to enrollees through 18 years of age in accordance with the most current Advisory Committee on Immunization Practices (ACIP) schedule and/or recommendation and following the VFC program requirements as defined in the VFC Provider Enrollment Agreement.

The MCOs shall require VFC enrolled network providers to participate in the DPBH's Immunization Registry to ensure DHCFP's goal to fully immunize children up to the age of two years. The MCO shall provide appropriate technical support in instances where the provider does not have the capability to meet these requirements. The MCO must work with the DPBH to interface directly with the Immunization Registry.

3603.17 EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

The MCO is required to cover EPSDT screenings of its enrollees under the age of 21 years. The screening must meet the EPSDT requirements found in the MSM as well as Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act, and 42 CFR §441.50 through §441.62. The MCO must cover all interperiodic screening on behalf of eligible enrollees, as defined in the MSM.

Medically necessary screening, diagnostic and treatment services identified in an EPSDT periodic or interperiodic screening must be provided to eligible children under the age of 21 years if the service is listed in 42 U.S.C. § 1396 d(a). The MCO is responsible for reimbursement of all medically necessary services under EPSDT whether or not the service is in the Medicaid/NCU State Plans. The MCO is responsible for coverage of the oral examination component of the EPSDT physical exam and referral to a dental provider, as per the dental periodicity schedule or when medically necessary. The MCO is responsible for the coordination of care in order to ensure all medically necessary coverage is being provided under EPSDT.

The services which need to be provided through the MCO include, but are not limited to the following in accordance with 1905(r) of the Act and the MSM:

A. Screening services which include a comprehensive health and developmental history (including assessment of both physical and mental health development);

B. A comprehensive, unclothed physical exam;

C. Age appropriate immunizations (according to current American Committee On Immunization Practices – ACIP - schedule);

D. Laboratory tests (including blood lead level assessment appropriate to age and risk as directed by current federal requirements);

E. Health education;

F. Vision services;

G. Dental services;

H. Hearing services; and,

I. Such other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid/NCU State Plan.

The MCO is not required to provide any items or services which are determined to be unsafe or ineffective, or which are considered experimental. Appropriate limits may be placed on EPSDT services based on medical necessity.

The MCO is required to provide information and perform outreach activities to eligible enrollees for EPSDT services. These efforts may be reviewed and audited by DHCFP or its designee.

3603.18 ENROLLMENT AND DISENROLLMENT REQUIREMENTS AND LIMITATIONS

A. Eligibility and Disenrollment

The eligibility and enrollment functions are the responsibility of DHCFP and the DWSS. The MCO shall accept each recipient who is enrolled in or assigned to the MCO by DHCFP and/or its enrollment sections and/or for whom a capitation payment has been made or will be made by DHCFP to the MCO. The first date a Medicaid or NCU eligible recipient will be enrolled is not earlier than the applicable date in the MCO's specified contract.

The MCO must accept recipients eligible for enrollment in the order in which they apply without restriction, up to the limits set under the contract. The MCO acknowledges that enrollment is mandatory except in the case of voluntary enrollment that meet the conditions set forth in 42 CFR §438.50(a). The MCO will not, on the basis of health status or need for health services, discriminate against recipients eligible to enroll. The MCO will not deny the enrollment nor discriminate against any Medicaid or NCU recipients eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color or national origin. If the recipient was previously disenrolled from the MCO as the result of a grievance filed by the MCO, the recipient will not be re-enrolled with the MCO unless the recipient wins an appeal of the disenrollment. The recipient may be enrolled with another MCO.

The State reserves the right to recover pro-rated capitation whenever the MCO's responsibility to pay medical claims ends in mid-month. A situation where a mid-month capitation recovery may occur includes, but is not limited to:

1. Enrollee is in a nursing facility over 180 days;
2. Enrollee is in an acute hospital swing bed over 45 days;
3. Enrollee is placed in an out of home placement;
4. Medicaid enrollee is placed in a hospice;
5. Enrollees enters an ICF/ID;
6. Enrollee enters a Home and Community Based Services (HCBS) Waiver Program.

The MCO is not financially responsible for any services rendered during a period of retroactive eligibility except in the specific situation(s) described in this Chapter. The MCO is responsible for services rendered during a period of retroactive enrollment in situations where errors committed by DHCFP or the DWSS, though corrected upon discovery, have caused an individual to not be properly and timely enrolled with the MCO. In such cases, the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. OOS providers in these circumstances will be paid according to a negotiated rate between the MCO and the OOS provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date. DHCFP is responsible for payment of applicable capitation for the retroactive coverage. As described in Section 3603.15(C)(1), the MCO is responsible for Medicaid newborns effective the first day of the month in which the infant was born.

The MCO must notify a recipient that any change in status, including family size and residence, must be immediately reported by the recipient to the DWSS eligibility worker.

B. Enrollment of Pregnant Women

The eligibility of Medicaid applicants is determined by the DWSS. The DWSS notifies the state's Fiscal Agent who enrolls the applicant. Letters are sent to the new recipients requiring them to select an MCO or an MCO will be automatically assigned. The MCO will be notified of the pregnant woman's choice by the State's Fiscal Agent. The MCO shall be responsible for all covered medically necessary obstetrical services and pregnancy related care commencing on the date of enrollment.

C. Enrollment of Newborns

The MCO must have written policies and procedures for newborns of enrollees. The MCO is required to report births electronically on a weekly basis to the State's fiscal agent. The MCO will be responsible for all covered medically necessary services included in the MCO benefit package to the qualified newborn.

Enrollment requirements for newborns are as follows:

1. Medicaid Eligible Newborns

The MCO is responsible for Medicaid newborns as of the date of birth, provided the mother was actively enrolled or retroactively enrolled at the date of birth.

In situations where it is determined that eligibility decisions were made that caused incorrect enrollment decisions, the MMIS may be corrected to show correct enrollment and all payments due the MCO reconciled accordingly. In such cases,

the MCO shall only be obligated to pay for such services that would have been authorized by the MCO had the individual been enrolled at the time of such services. For in-state providers in these circumstances, the MCO shall pay the providers for such services only in the amounts that would have been paid to a contracted provider in the applicable specialty. OOS providers in these circumstances will be paid according to a negotiated rate between the MCO and the OOS provider. The timeframe to make such corrections will be limited to 180 days from the incorrect enrollment date.

2. NCU Newborns

The head of household or mother must notify the MCO and NCU of the pregnancy prior to and within 14 calendar days following the delivery in order to qualify to receive coverage from the date of birth. If the family of the newborn is an NCU family currently receiving coverage from the MCO for a sibling of the newborn, the newborn is qualified to receive coverage from the date of birth, and is eligible for NCU, the MCO will receive a Capitation Payment and provide coverage for the month of birth. The MCO will also receive a Capitation Payment and provide coverage for all subsequent months that the child remains enrolled with the MCO. If notification is not received as required herein, the newborn will be enrolled as of the first day of the next administrative month from the date of notification.

If the mother has other health insurance coverage that provides for 30 calendar days of coverage of the newborn and she has other children enrolled in NCU, the newborn will be enrolled in the MCO as of the first day of the next administrative month.

D. Auto Assignment Process

For Medicaid recipients who do not select an MCO, DHCFP will assign the recipient to an MCO based upon federally required enrollment default criteria that include:

1. The maintenance of existing provider individual relationships or relationships with traditional Medicaid providers; and

2. Distributing the recipients among the contracted MCOs based upon an algorithm developed by DHCFP and outlined in the Medicaid State Plan when maintaining such relationships is not possible.

E. Automatic Re-enrollment

Enrollees disenrolled solely due to the loss of Medicaid or NCU eligibility will be auto assigned to their last known MCO upon re-entry within 60 days of disenrollment and if that MCO remains under contract. Should the MCO no longer be under contract, enrollee(s)

will make a selection during redetermination at DWSS or be assigned to an alternate MCO. After assignment, enrollee(s) have an additional 90 days in which to exercise the option of selecting an alternative MCO.

F. Performance Based Auto Assignment

Member auto assignment after December 31, 2023, will be based on MCO performance on selected quality measures with preference given to high performing MCOs. Measure domains intended for auto assignment during contract year 2024 are 1) MCO performance in maternal and child health outcomes, and 2) reduction in inappropriate hospitalizations during contract year 2022. DHCFP has the sole authority for determining the methodology and criteria used for the auto assignment of members and can change the algorithm at any time with appropriate notice to the MCOs.

G. Disenrollment Requirements and Limitations

1. Disenrollment at the Request of the Enrollee

Enrollees eligible in the 90-day "right to change" period may request disenrollment from the MCO without cause at any time during this period. The enrollee is required to notify DHCFP Fiscal Agent by mail of his/her decision to disenroll and, if he/she is a mandatory recipient, as defined by the mandatory managed care geographical areas of urban Clark or Washoe County, will be assigned to an alternate MCO. The effective date of change in the MCO will be based on the monthly administrative cutoff date but not later than the first day of the second month following the month in which the enrollee makes the request to disenroll. After the first 90 days of enrollment, the enrollee will be locked into an MCO until the next open enrollment period. There will be one open enrollment period annually. If the enrollee wishes to disenroll at any time during the lock-in period, they must contact the appropriate MCO and provide good cause for doing so. The MCO will determine good cause as defined in 42 CFR §438.56.

NCU enrollees may request disenrollment from the MCO without cause during the first 90 days of enrollment. The enrollee is required to contact the NCU office if they request disenrollment from the MCO and they are a mandatory enrollee, must select an alternate MCO. After the first 90 days of enrollment, the enrollee will be locked into an MCO for the remainder of the current open enrollment period. There will be one open enrollment period annually. If the enrollee wishes to disenroll at any time during the 12-month lock-in period, they must contact the appropriate MCO and provide good cause for doing so. The MCO will determine if it is good cause as defined by 42 CFR §438.56(d)(2).

2. Disenrollment at the Request of the MCO

The MCO may request disenrollment of an enrollee if the enrollee has been seen by at least three of the MCO's PCPs and each PCP provides a written statement to DHCFP confirming their inability to treat the enrollee due to the enrollee's serious behavioral non-compliance or disruptive behavior. In addition, the MCO must confirm the enrollee has been referred to the MCO's Enrollee Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem. The MCO may also request disenrollment of an enrollee if the MCO can provide documentation the enrollee has, on at least three separate occasions, demonstrated serious behavioral non-compliance or disruptive behavior toward the MCO's or subcontractor's staff. Prior approval by DHCFP of an MCO's request for the enrollee's disenrollment is required. If approval is granted, the enrollee will be given notice by the MCO that disenrollment will occur effective the first day of the next month following administrative cut off.

The MCO may request disenrollment of an enrollee for a combination of PCP and MCO serious, behavioral non-compliance or disruptive behavior by an enrollee for a total of at least three separate instances. The same documentation and procedure apply as in the separate PCP or MCO instances. Prior approval from DHCFP is required for these disenrollments.

DHCFP reserves the right to review and act upon the MCO's request for disenrollment without the enrollee exhibiting the serious, behavioral non-compliance or disruptive behavior three times. DHCFP will make a determination on such a request within five days. If approval is granted, the enrollee will be given notice by the MCO that disenrollment will occur effective the first day of the next month following administrative cut off.

The MCO may not request disenrollment of an enrollee for any of the following reasons:

a. An adverse change in the enrollee's health status;

b. Pre-existing medical condition;

c. The enrollee's utilization of medical services;

d. Diminished mental capacity;

e. Uncooperative or disruptive behavior resulting from his/her special needs (except when continued enrollment of such an enrollee seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees);

f. An enrollee's attempt to exercise his/her grievance or appeal rights; or,

g. Based on the enrollee's national origin, creed, color, sex, religion, age, pursuant to DHCFP Managed Care contract and applicable CFRs.

Pursuant to 42 CFR 438.56(b)(3) in those circumstances in which the MCO requests disenrollment of an enrollee, the MCO must provide DHCFP with written assurances that it is not requesting disenrollment for any reason(s) other than those permitted under DHCFP Managed Care contract.

3. Disenrollment Pursuant to a finding of SED or SMI Status:
See Section 3603.4(p).

H. Enrollment, Disenrollment and Other Updates

The MCO must have written policies and procedures for receiving monthly updates from DHCFP of recipients enrolled in, and disenrolled from, the MCO, and other updates pertaining to these recipients. The updates will include those newly enrolled with the MCO. The MCO must incorporate these updates into its management information system.

I. Provider Enrollment Roster Notification

The MCO must establish and implement a mechanism to inform each PCP about any new MCO enrollees assigned to the PCP on at least a monthly basis. Written or electronic notice to each PCP regarding patient rosters effective for each month must be provided to the network provider within five business days of the MCO receiving the Benefit Enrollment and Maintenance (834) file from DHCFP.

3603.19 CHANGE IN AN ENROLLEE'S STATUS

Within seven calendar days of becoming aware of any changes in an enrollee's status, including changes in family size and residence, the MCO must electronically report the change(s) to DHCFP.

3603.20 TRANSITIONING/TRANSFERRING OF ENROLLEES

A. Transitioning Recipients into MCOs
The MCO will be responsible for enrollees as soon as they are enrolled and the MCO is aware of the enrollee in treatment. The MCO must have policies and procedures for transitioning enrollees currently receiving services in the FFS program into the MCO's plan.

The MCO must have policies and procedures including, without limitation, the following to ensure an enrollee's smooth transition from FFS to the MCO:

1. Enrollees with medical conditions such as:

   a. Pregnancy (especially if high risk);

   b. Major organ or tissue transplantation services in process;

   c. Chronic illness;

   d. Terminal illness; and/or,

   e. Intractable pain.

2. Enrollees who, at the time of enrollment, are receiving:

   a. Chemotherapy and/or radiation therapy;

   b. Significant outpatient treatment or dialysis;

   c. Prescription medications or durable medical equipment (DME); and/or,

   d. Other services not included in the Medicaid/NCU State Plans but covered by Medicaid under EPSDT for children.

3. Enrollees who at enrollment:

   a. Are scheduled for inpatient surgery(ies);

   b. Are currently in the hospital;

   c. Have prior authorization for procedures and/or therapies for dates after their enrollment; and/or,

   d. Have post-surgical follow-up visits scheduled after their enrollment.

B. Transferring Enrollees Between MCOs

It may be necessary to transfer an enrollee from one MCO to another or to FFS for a variety of reasons. When notified by DHCFP that an enrollee has been transferred to another plan or to FFS, the MCO must have written policies and procedures for transferring/receiving relevant patient information, medical records and other pertinent materials to the other plan or current FFS provider. Prior to transferring an enrollee, the MCO (via their subcontractors when requested by the MCO) within 5 calendar days or as medical needs dictate must send the receiving MCO or provider information regarding the enrollee's condition. This information shall include the name of the assigned PCP, as well as the following information, without limitation, as to whether the enrollee is:

1. Hospitalized;
2. Pregnant;
3. Receiving dialysis;
4. Chronically ill (e.g., diabetic, hemophilic);
5. Receiving significant outpatient treatment and/or medications, and/or pending payment authorization request for evaluation or treatment;
6. On an apnea monitor;
7. Receiving behavioral or mental health services;
8. Receiving Nevada early intervention services in accordance with an Individualized Family Service Plan (IFSP), which provides a case manager who assists in developing a plan to transition the child to the next service delivery system. For most children this would be the school district and services are provided for the child through an IEP.
9. Involved in, or pending authorization for, major organ or tissue transplantation;
10. Scheduled for surgery or post-surgical follow-up on a date subsequent to transition;
11. Scheduled for prior authorized procedures and/or therapies on a date subsequent to transition;
12. Referred to a Specialist(s);
13. Receiving substance abuse treatment;
14. Receiving prescription medications;
15. Receiving DME or currently using rental equipment;
16. Currently experiencing health problems;
17. Receiving case management (including the case manager's name and phone number); or
18. Receiving Long Term Services and Supports, such as but not limited to, Personal Care Services and/or Home Health.

When an enrollee changes MCOs or reverts to FFS while hospitalized, the transferring MCO shall notify the receiving MCO, the receiving provider(s) providing direct care (if

the Member changes Contractors or transitions to FFS), or DHCFP Quality Improvement Organization (QIO-like vendor). The notification process must occur as soon as the transition is known to the MCO.

An enrollee may need to be transitioned between Medicaid and the HIX, due to changes in eligibility. When notified that an enrollee is eligible for HIX coverage or other non-exchange coverage to include individual and employer-based coverage or Medicare, the MCO must have written policies and procedures in place to notify any insurance carrier or plan of relevant patient information. This must be done in compliance with HIPAA and other privacy laws.

C. Transitions of Child Welfare Involved Children from FFS to an MCO

For children that received Medicaid benefits through the FFS system while in the custody of the Child Welfare system (e.g., foster care, juvenile justice) that become eligible for and enroll in the managed care program, the following requirements for continuity of care apply:

1. For a period of no less than 12 months from the date of enrollment with an MCO, the member must maintain full access to the Providers and level of services that were received while in FFS.

2. Any service Providers affiliated with or employed by the State or County Child Welfare system that treated the member prior to the transition to managed care must be under a single case agreement or part of the MCO's Network. Regardless of such Provider's status with the MCO, such Providers must be reimbursed no less than FFS reimbursement under the Medicaid State Plan.

3603.21 INFORMATION REQUIREMENTS

The MCO must have written information about its services and access to services available upon request to enrollees and potential enrollees. This written information must also be available in the prevalent non-English languages, as determined by the State, in its particular geographic service area. "Prevalent" is determined as the primary language spoken by 1,000 or 5% (whichever is less) of the MCO's members. The MCO must make free, oral interpretation services available to each enrollee and potential enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

The MCO is required to notify all enrollees and potential enrollees that oral interpretation services are available for any language and written information is available in English and all prevalent non-English languages. The MCO must notify all enrollees and potential enrollees how to access this information.

The MCO's written material must use an easily understandable format. The MCO must also develop appropriate alternative methods for communicating with visually and hearing-impaired

enrollees and accommodating physically disabled recipients in accordance with the revised regulations of the Americans with Disabilities Act of 1990 (ADA), ADA Amendments Act of 2008, and Section 504 of the Rehabilitation Act of 1973. All enrollees and potential enrollees must be informed that this information is available in alternative formats and how to access those formats. The MCO will be responsible for effectively informing Title XIX Medicaid enrollees who are eligible for EPSDT services.

If the MCO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover to the State with its application for a Medicaid contract and whenever it adopts the policy during the term of the contract. The information provided must be consistent with the provisions of 42 CFR 438.10 and must be provided to potential enrollees before and during enrollment.

Such information must also be provided within 90 days after adopting the policy with respect to any particular service.

A. Member Handbook

The MCO must provide all enrollees with a Member Handbook. The handbook must be written at no higher than an eighth-grade reading level and must conspicuously state the following in bold print:

"This Handbook is not a certificate of insurance and shall not be construed or interpreted as evidence of insurance coverage between the MCO and the Enrollee."

The MCO must submit the Member Handbook to DHCFP before it is published and/or distributed. DHCFP will review the handbook and has the sole authority to approve or disapprove the handbook and the MCO's policies and procedures therein. The MCO must agree to make modifications in handbook language if requested to do so in order to comply with the requirements as described above or as required by CMS or State law. In addition, the MCO must maintain documentation that the handbook is updated at least once per year. These annual updates must be submitted to DHCFP before publication and/or distribution. The MCO must furnish the handbook to all recipients within five business days of receiving notice of the recipient's enrollment and must notify all enrollees of their right to request and obtain this information at least once per year or upon request. The MCO will also publish the Member Handbook on the MCO's internet website upon contract implementation and will update the website, as needed, to keep the Member Handbook current. The MCO shall issue updates to the Member Handbook, 30 days before the intended effective date, as described in 42 CFR §438.10(f)(4), when there are material changes that will affect access to services and information about the Managed Care Program.

At a minimum the information enumerated below must be included in the handbook:

1. An explanation of benefits and how to obtain benefits, including out-of-plan benefits, and how to access them; the address and toll-free telephone number of the MCO's member services, medical management or any other office or facility providing services directly to enrollees; and the days that the office or facility is open, and services are available;

2. The role of the PCP and a description of how the Member will receive confirmation of their selection of a PCP, if a PCP was designated at the time of enrollment;

3. Any restrictions on the enrollee's freedom of choice among network providers;

4. Procedures for changing a PCP as well as their right to select a PCP that meets their cultural and/or racial preferences;

5. Enrollee rights and protections as specified in 42 CFR §438.100;

6. The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;

7. Procedures for obtaining benefits, including authorization requirements;

8. The extent to which, and how, enrollees may obtain benefits, including family planning services, from out-of-network providers;

9. Procedures for disenrollment;

10. The extent to which, and how, after hours and emergency coverage are provided including: what constitutes an emergency medical condition, emergency and post stabilization services with reference to the definitions in 42 CFR §438.114; the fact that prior authorization is not required for emergency services; the process and procedures for obtaining emergency services, including the 911-telephone system or its local equivalent; the locations of any emergency settings and other locations at which providers and hospitals furnish emergency and post stabilization services under the contract; the fact that, subject to regulatory limitations, the enrollee has a right to use any hospital or other setting for emergency care;

11. Explanation of procedures for urgent medical situations and how to utilize services, including the member services telephone number; clear definitions of urgent care; and how to use non-emergency medical transportation;

12. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's PCP, including explanation of authorization procedures and information that a referral is not required in choosing a family planning provider;

13. How and where to access any benefits that are available under the Medicaid/NCU State plans but are not covered under the contract, including any cost sharing, and how transportation is provided.
For a counseling or referral service that the MCO does not cover because of moral or religious objections, the MCO need not provide the information on how or where to obtain the service. The MCO must notify enrollees when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objectives at least 30 calendar days prior to the effective date of the policy for any particular service. The MCO must also notify the State regarding services that meet this criterion and, in those instances, the State must provide the information on where and how to obtain the service;

14. Procedures for accessing emergency and non-emergency services when the recipient is in and out of the MCO service area;

15. Information on grievance, appeals, and fair hearing procedures and information as specified in 42 CFR §438.10(g);

16. Information on procedures for recommending changes in policies and services;

17. The MCO must provide adult enrollees with written information on Advance Directives (AD) policies and include a description of applicable State law. This information must reflect changes in State law as soon as possible but no later than 90 days after the change. The MCO must ensure that a signed copy of DHCFP's "Acknowledgment of Patient Information on Advance Directives" form is included in the recipient's medical record. (A sample form is available online at http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives/);

18. To the extent available, quality and performance indicators, including enrollee satisfaction;

19. The MCO is also required to provide, to the enrollee upon request, information on the structure and operation of the MCO and information about physician incentive plans as set forth in 42 CFR §438.6(h);

20. The Member Handbook must include a distinct section for eligible recipients which explains the EPSDT program and includes a list of all the services available to children; a statement that services are free and a telephone number which the enrollee can call to receive assistance in scheduling an appointment;

21. Information regarding prescription coverage;

22. Notification of the enrollee's responsibility to report any on-going care corresponding to a plan of care at the time of enrollment and their right to continue that treatment under the MCO on a transitional basis;

23. Notification of the enrollee's responsibility to report any third-party payment service to the MCO and the importance of doing so; and

24. The transition of care policy and instructions on how to access continued services upon transition to FFS or another MCO.

The MCO must give each enrollee written notice of any significant change, as defined by the State, in any of the enumerations noted above. The MCO must issue updates to the Member Handbook 30 calendar days before the intended effective date, as described in 42 CFR 438.10(f)(4), when there are material changes that will affect access to services and information about the managed care program. The MCO will provide notification when a change directly affects the ongoing care of Members.

The MCO shall also provide such notices in its semi-annual recipient newsletters and shall maintain documentation verifying handbook updates.

The MCO must give written notice of termination of a network provider within 15 days after receipt or issuance of the termination notice. This notice shall be provided to each enrollee who received his/her primary care from, or was seen on a regular basis by, the terminated provider.

B. Member Newsletter

The MCO must publish a newsletter for enrollees at least twice per year. The newsletter will focus on topics of interest to enrollees and must adhere to the requirements for written enrollee materials in Section 3603.18. The MCO must provide a copy of all newsletters to the State. Additionally, these newsletters must be published on the MCO's website.

C. Identification Cards

The MCO may choose to issue an identification card to enrollees. The identification card must clearly state that the card does not constitute evidence of insurance coverage or eligibility. The card may include the following information: enrollee's billing number; the MCO's name and member services department telephone number; and date of issue. The MCO must educate its network providers regarding the card issued to enrollees. The MCO may, at its discretion, include a unique member identification number on the card. The MCO must annotate on the card that the number is to be used by its network providers only.

D. Information for Potential Enrollees

The MCO must provide information regarding contracted MCOs to potential enrollees pursuant to CFR §438.10. The information is to be furnished at the time the potential enrollee first becomes eligible to voluntarily enroll, or is first required to enroll, in managed care and, at that time, must be provided within a timeframe which enables the potential

enrollee to use the information in choosing among available MCOs. The required information for potential enrollees will be provided to the MCO by DHCFP and will include:

1. General information about the basic features of managed care, including which populations are excluded, subject to mandatory enrollment, or free to enroll voluntarily in the program, and the responsibilities for coordination of enrollee care;

2. Information specific to each MCO operating in a potential enrollee's service area and a summary of the following information:

   a. Benefits covered;

   b. Service area;

   c. Names, locations, telephone numbers of and non-English languages spoken by current network providers, and including identification of providers that are not accepting new patients;

   d. Information on PCPs, specialists, and hospitals;

   e. To the extent available, quality and performance indicators, including enrollee satisfaction; and,

   f. Benefits that are available under the Medicaid/NCU State Plans but are not covered under the contract, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided. For a counseling or referral service that the MCO does not cover because of moral or religious objections, the State will provide information about where and how to obtain the service.

   The State is responsible for providing more detailed information to potential enrollees upon request.

E. Medical Records

Complete medical records shall be maintained by the MCO's network providers, for each enrollee in accordance with 42 CFR §438.416. The records shall be available for review by duly authorized representatives of the State and CMS upon request of the State, CMS and other federal agencies.

The MCO shall have written policies and procedures to maintain the confidentiality of all medical records; provide accessibility and availability of medical records; ensure adequate record keeping and record review processes. Not more than ten calendar days after

submitting a request, the State shall have access to an enrollee's medical record, whether electronic or paper, and has the right to obtain copies at the MCO's expense.

The recipient's medical record is the property of the provider who generates the record. The MCO shall assist the enrollee or the parent/legal guardian of the enrollee in obtaining a copy of the enrollee's medical records, upon written request, from the provider. Records shall be furnished in a timely manner upon receipt of such a request but not more than 30 calendar days from the date of request. Each enrollee or parent/legal guardian of the enrollee is entitled to one free copy of the requested medical records. The fee for additional copies shall not exceed the actual cost of time and materials used to compile copy and furnish such records.

When an enrollee changes primary care providers and/or health plans, the MCO's network provider must forward all medical records in their possession to the new provider within 10 business days from receipt of the request.

3603.22 MEDICAL PROVIDER REQUIREMENTS

A. PCP or Primary Care Site (PCS)

The MCO shall allow each enrollee the freedom to choose from among its participating PCPs and change PCPs as requested.

Each enrollee must be assigned to a PCP or PCS, within five business days of the effective date of enrollment. Enrollees with disabilities must be given 30 calendar days to select a PCP.

Enrollees with disabilities, chronic conditions, or complex conditions must be allowed to select a Specialist as their PCP and any Specialist can be a PCP based on Medically Necessary conditions. Enrollees must also be allowed to select a State-operated clinic as their PCP. If a Specialist is chosen as a PCP, the Provider should be reported as a Specialist. The Specialist does not count as both a PCP and Specialist for reporting purposes.

If the enrollee desires, the MCO shall allow him or her to remain with his or her existing PCP if the PCP is part of the MCO's network.

B. Assignment of a PCP or PCS

The MCO shall ensure that enrollees receive information about where they can receive care during the time period between enrollment and PCP selection/assignment. The MCO shall notify the enrollee of his or her assigned PCP within five business days of assignment.

If an enrollee does not choose a PCP, the MCO shall match enrollees with PCPs by one or more of the following criteria:

1. Assigning enrollees to a network provider from whom they have previously received services, if the information is available;

2. Designating a PCP or PCS who is geographically accessible to the enrollee per 42CFR §438.68 and the Time and Distance requirements for PCPs outlined in the managed care contract;

3. Assigning all children within a single family to the same PCP;

4. Assigning a CSHCN to a practitioner experienced in treating that condition, if the MCO knows of the condition; and/or

5. Assigning an enrollee to a PCP upon receipt of a claim for services rendered by a PCP to the enrollee.

C. Changing a PCP or PCS

1. An enrollee may change a PCP or PCS for any reason. The MCO shall notify enrollee of procedures for changing PCPs.

2. In cases where a PCP has been terminated, the MCO must notify enrollees in writing and allow enrollees to select another primary care provider or make a re-assignment within 15 calendar days of the termination effective date and must provide for urgent care for enrollees until re-assignment.

3. The MCO may initiate a PCP or PCS change for an enrollee under the following circumstances:

   a. Specialized care is required for an acute or chronic condition;

   b. The enrollee's residence has changed such that distance to the PCP is greater than 10 miles. Such change will be made only with the consent of the enrollee;

   c. The PCP ceases to participate in the MCO's network; or,

   d. Legal action has been taken against the PCP which excludes provider participation.

   The enrollee will be given the right to select another PCP or PCS within the MCO network.

4. The MCO shall document the number of requests to change PCPs and the reasons for such requests.

3603.23 PROVIDER DIRECTORY

The MCO will publish its provider directory for all geographic service areas in machine readable, online and paper formats upon contract implementation. The MCO will update the paper directory quarterly (if a mobile-enabled provider directory is available) or otherwise monthly, and update the electronic directory on the website no later than 30 calendar days after the Contractor receives updated provider information. The MCO will provide DHCFP with the most current provider directory upon contract award for each geographic service area. Thereafter, the MCO will provide monthly electronic updates (including additions/deletions to the network) to DHCFP.

3603.24 NETWORK MAINTENANCE

A. Maintenance of the network includes, but is not limited to:

1. Initial and ongoing credentialing;

2. Adding, deleting, and periodic contract renewal;

3. Monitoring of adherence to the network adequacy and timely access standards under the contract and remediation of any deficiencies;

4. Provider education; and,

5. Discipline/termination

B. The MCO must have written policies and procedures for monitoring its network providers, and for disciplining those who are found to be out of compliance with the MCO's medical management standards.

C. The MCO must take appropriate action related to dual FFS and managed care network providers, as follows:

1. Upon the MCO's awareness of any disciplinary action, sanction taken against a network provider, or any suspected provider fraud or abuse, the MCO shall immediately inform DHCFP.

2. If the MCO is notified that the Office of the Inspector General (OIG), DHCFP or another state, federal or local agency has taken an action or imposed a sanction against a network provider, the MCO shall review the provider's performance related to DHCFP Managed Care Contract and take any action or impose any sanction, including disenrollment from the MCO's Provider Network.

3603.25 RETRO-CAPITATION AND CAPITATION RECONCILIATION

Capitation payments are subject to several types of error. Most often, a capitation payment error is introduced due to an inaccuracy in eligibility or enrollment status. Some errors are corrected automatically by the MMIS, others by manual financial transaction. Depending upon the nature of the error in a particular instance, capitation may be paid or recovered from the MCO. Capitation is also reconciled periodically, typically for a three-month period.

A. Errors automatically corrected by the MMIS

The MMIS automatically adjusts up to three months of capitation for newborns when updated DWSS eligibility data for the current month also includes previously unreported eligibility.

In those instances where an eligibility agent has corrected an estimated date of birth forward in time, the MMIS automatically recovers the incorrectly paid capitation.

Should an error extend beyond three months, the instance must be researched and corrected manually by financial transaction.

B. Errors Corrected Manually by Financial Transaction

The MCO, in order to recover unpaid capitation, is required to submit such instances on a periodic basis via the process described in the Contract (MOVEit reporting repository).

The Supplemental Reimbursement unit reconciles and authorizes payment of these retro-capitation payment requests on a quarterly basis with sufficient lag time (typically three months) to allow automated MMIS corrections to occur.

The Supplemental Reimbursement unit also reconciles and authorizes capitation recovery in instances where it is discovered that capitation has been incorrectly paid. This may occur on either a periodic or per-instance basis.

C. Reconciliation of Capitation Payments

The Supplemental Reimbursement unit determines the validity of retro-capitation requests or may use an appropriate sample for a large number of payment requests.

3603.26 THIRD-PARTY LIABILITY (TPL) AND SUBROGATION

For DHCFP's contracts with the MCOs, TPL refers to any individual, entity (e.g., insurance company) or program (e.g., Medicare) including group health plans, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 (29 USC and 1167 (1)) service benefits plans and Section 6035 of the Deficit Reduction Act of 2005 that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State (Medicaid) Plan. TPL also

includes the Coordination of Benefits (COB) cost avoidance and COB recovery. Under Section 1902(a)(25) of the Act, DHCFP is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid and NCU recipient.

For DHCFP's contracts with MCOs, subrogation is the principle under which an insurer that has paid a loss under an insurance policy is entitled to all the rights and remedies belonging to the insured against a third party with respect to any loss covered by the policy.

The MCO shall act as the State's authorized agent for the limited purpose of TPL collection, within the limitation of the Fair Debt Collection Practices Act, 15 USC § 1692, of all TPL pursuant to 42 CFR § 433.135 et seq and 42 CFR 433.147. The MCO's capitated payments include an offset in the rates for these collections. The MCO shall vigorously pursue billing prior resources and report their TPL and subrogation collection results to DHCFP quarterly, as these amounts are considered part of their capitation.

MCOs are required to secure signed acknowledgements from enrollees or their authorized representative for any prior resources (Medicare, worker's compensation, private insurance, and similar resources). The MCO must pursue TPL in accordance with 42 CFR §433.139. The MCO must also determine if casualty claims are filed and recover costs through subrogation on behalf of both Medicaid and NCU enrollees. The MCO is responsible for not only pursuing third party resources that it identifies but also for pursuing third-party resources identified and communicated to the MCO by DHCFP. All information on the third party, including collections and collection attempts, are to be reported to DHCFP (including circumstances under which the third-party refuses to pay) as instructed in the State's MOVEit reporting repository.

DHCFP will monitor and evaluate the MCO's TPL and subrogation collection reports to validate collection activities and results. The MCO will then be expected to meet or exceed baseline target collections as determined by DHCFP and its actuaries. If the MCO does not meet or exceed baseline TPL and subrogation collections, DHCFP will conduct a review to determine if there is a legitimate reason. If there is no legitimate reason as determined by DHCFP, the difference between baseline and actual collections will be deducted from the MCO's costs before the data is used to set future rates. DHCFP will prospectively adjust capitation rates downward to account for expected TPL collections.

The MCO is required to obtain TPL information independently of DHCFP for the purpose of avoiding claim payments or recovering payments made from liable third parties. TPL recovery may be incorporated into the capitated rate development by DHCFP and its actuary. The MCO has 365 days from claim paid date to recover the TPL payment; after 365 days, the MCO forfeits the right to recovery to the State unless the MCO can provide evidence that the recovery effort is active and/or in dispute.

3603.27 PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES

Pursuant to Section 6505 of the ACA, which amends Section 1902(a) of the Act, the MCO shall not provide any payments for items or services provided under the Medicaid/NCU State Plans or under a waiver to any financial institution or entity located outside of the United States (U.S.).

Payments for items or services provided under the Medicaid/NCU State Plans to financial institutions or entities such as provider bank accounts or business agents located outside of the U.S. are prohibited by this provision. Further, this Section prohibits payments to telemedicine providers located outside of the U.S. Additionally; payments to pharmacies located outside of the U.S. are not permitted.

Any payments for items or services provided under the Medicaid/NCU State Plan or under a waiver to any financial institution or entity located outside of the U.S. may be recovered by the State from the MCO.

For purposes of implementing this provision, Section 1101(a) (2) of the Act defines the term "United States" when used in a geographical sense, to mean the "States." Section 1101(a)(1) of the Act defines the term "State" to include the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, when used under Title XIX.

The phrase, "items or services provided under the Medicaid/NCU State Plans or under a waiver" refers to medical assistance for which the State claims Federal funding under Section 1903(a) of the Act. Tasks that support the administration of the Medicaid/NCU State Plan that may require payments to financial institutions or entities located outside of the U.S. are not prohibited under this statute. For example, payments for outsourcing information processing related to Plan administration or outsourcing call centers related to enrollment or claims adjudication are not prohibited under this statute.

3603.28 MANAGEMENT INFORMATION SYSTEM (MIS)

A. The MCO shall operate the MIS capable of maintaining, providing, documenting, and retaining information sufficient to substantiate and report MCO's compliance with the contract requirements. The MCOs must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for the MCO's requirement.

B. The MCO shall have an MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The MCO shall provide DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data from network providers. The MCO shall submit its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations.

C. The MCO shall have internal procedures to ensure that data reported to DHCFP are valid and to test validity and consistency on a regular basis.

D. Eligibility Data

1. The MCO enrollment system shall be capable of linking records for the same enrollee that are associated with different Medicaid and/or NCU identification numbers; e.g., recipients who are re-enrolled and assigned new numbers.

2. At the time of service, the MCO or its subcontractors shall verify every enrollee's eligibility through the current electronic verification system (EVS).

3. The MCO shall update its eligibility database whenever enrollees change names, phone numbers, and/or addresses, and shall notify DHCFP of such changes.

4. The MCO shall notify DHCFP of any enrollees for whom accurate addresses or current locations cannot be determined and shall document the action that has been taken to locate the enrollees. The MCO shall immediately notify DHCFP of the births and known deaths of all enrollees.

E. Encounter and Claims Records

1. The encounter data reporting system should be designed to assure aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities. The MCO shall use a standardized methodology capable of supporting CMS reporting categories for collecting service event data and costs associated with each category of service.

2. The MCO shall collect and submit service specific encounter data in the appropriate CMS 1500, UB04 and the appropriate ADA Dental Claim format or an alternative format if prior approved by DHCFP. The data shall be submitted in accordance with the requirements set forth by the American National Standards Institute (ANSI), Accredited Standards Committee (ASC), Electronic Data Interchange (EDI) standards in current use and in the State's MOVEit reporting repository of the current DHCFP Managed Care Contract. The data shall include all services reimbursed by Medicaid.

F. EPSDT Tracking System

The MCO shall operate a system that tracks EPSDT activities for each enrolled Medicaid eligible child by name and Medicaid identification number. The system shall allow the MCO to report annually on the CMS 416 reporting form. This system shall be enhanced, if needed, to meet any other reporting requirements instituted by CMS or DHCFP.

3603.29 REPORTING

Adequate data reporting capabilities are critical to the ability of CMS and DHCFP to effectively evaluate DHCFP's Managed Care Programs. The success of the Managed Care Program is based on the belief that recipients will have better access to care, including preventive services, and will experience improved health status, outcomes, and satisfaction with the health care delivery system. To measure the program's accomplishments in each of these areas, the MCO must provide DHCFP and/or its contractors with uniform utilization, cost, quality assurance, and recipient satisfaction and grievance/appeal data on a regular basis. It must also cooperate with DHCFP in carrying out data validation steps.

The MCO is required to certify the data including, but not limited to, all documents specified by the State as required in the Reporting Guide of the current DHCFP Managed Care Contract, enrollment information, encounter data, and other information contained in contract proposals, as provided in 42 CFR §438.606. The data must be certified by the MCO's Chief Executive Officer (CEO), the MCO's Chief Financial Officer (CFO) or an individual who has delegated authority to sign for, and who reports directly to, the MCO's CEO or CFO. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data**.**

The MCO must meet all reporting requirements and timeframes as required in the Reporting Guide of the current DHCFP Managed Care Contract unless otherwise agreed to in writing by both parties. Failure to meet all reporting requirements and timeframes as contractually required and all attachments thereto may be considered to be in default or breach of said contract.

A. Encounter Reporting

Contracted MCOs must submit encounter data for all recipients and all claims paid and denied in accordance with current ANSI, ASC, EDI standards and requirements in the Reporting Guide of the current DHCFP Managed Care Contract, to include any revisions or additions which contain information regarding encounter data, including DHCFP's media and file format requirements, liquidated damages and submittal timeframes. The MCO must assist DHCFP in its validation of encounter data.

B. Summary Utilization Reporting

The contracted MCO shall produce reports using the Healthcare Effectiveness Data and Information Set (HEDIS), as specified in the current DHCFP Managed Care Contract. The MCO must submit these reports to DHCFP in a timely manner pursuant to contract requirements in addition to the other reports required by this contract.

C. Dispute Resolution Reporting

Contracted MCOs must provide DHCFP with monthly reports documenting the number and types of provider disputes, enrollee grievances, appeals and fair hearing requests

received. Reports must be submitted within 45 business days after close of the quarter to which they apply.

These reports are to include, but not be limited to, the total number of enrollee grievances, the total number of notices provided to enrollees, the total number of enrollee and appeals requests, and provider disputes filed, including reporting of all subcontractor's enrollee grievances, notices, appeals and provider disputes. The reports must identify the enrollee grievance or appeal issue, or provider dispute received; and verify the resolution timeframe for enrollee grievances and appeals and provider disputes.

Comprehensive enrollee grievance and appeal information, fair hearing requests, and provider dispute information, including, but not limited to, specific outcomes, shall be retained for each occurrence for review by DHCFP.

D. Quality Assurance Reporting

Studies will be performed by the MCOs pursuant to guidelines established jointly by the MCOs, DHCFP, and the External Quality Review Organization (EQRO) as well as those identified in the current DHCFP Managed Care Contract. In addition, the MCO must provide outcome-based clinical reports and management reports as may be requested by DHCFP. Should the MCO fail to provide such reports in a timely manner, DHCFP may require the MCO to submit a Plan of Correction (POC) to address contractual requirements regarding timely reporting submissions.

E. Enrollee Satisfaction Reporting

Each MCO must collect and submit to DHCFP a statistically valid uniform data set measuring enrollee satisfaction prior to the third quarter of each contract year, unless the requirement is waived by DHCFP due to an EQRO performed survey. This may be done in conjunction with the MCO's own satisfaction survey. DHCFP may request a specific sample, and/or survey tool, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

Survey results must be disclosed to the State, and, upon State's or enrollee's request, disclosed to enrollees.

F. Financial Reporting

The MCO must meet the financial reporting requirements set forth in the State's MOVEit reporting repository of the current DHCFP Managed Care Contract including any revisions or additions to the document.

G. Fraud and Abuse Reporting

The MCO must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. These arrangements or procedures must include the following:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;

2. The designation of a compliance officer and a compliance committee that are accountable to senior management;

3. Effective training and education for the compliance officer and the organization's employees and subcontractors;

4. Effective lines of communication between the compliance officer and the organization's employees and the rights of employees to be protected as whistleblowers must be included in any employee handbook;

5. Enforcement of standards through well-publicized disciplinary guidelines;

6. Provision for internal monitoring and auditing;

7. Provision for prompt response to detected offenses and for the development of corrective action initiatives relating to the MCO's contract; and

8. Instructions and details of how to report Fraud and Abuse in the Member Handbook.

The MCO and its subcontractors must provide immediate notification to DHCFP regarding all suspected recipient and provider fraud and abuse.

Upon the MCO's awareness of any disciplinary action or sanction taken against a network provider or any suspected fraud or abuse, the MCO shall immediately inform DHCFP.

These reporting requirements shall be included in all MCO subcontracts.

H. Other Reporting

The MCO shall be required to comply with additional reporting requirements upon the request of DHCFP. Additional reporting requirements may be imposed on the MCO if DHCFP identifies any area of concern with regard to a particular aspect of the MCO's performance under the current DHCFP Managed Care Contract. Such reporting would provide DHCFP with the information necessary to better assess the MCO's performance.

3603.30 INFORMATION SYSTEMS AND TECHNICAL REQUIREMENTS

A. The MCO will be required to provide compatible data in DHCFP prescribed format for the following functions:

1. Enrollment;
2. Eligibility;
3. Provider Network Data;
4. PCP Assignment;
5. Electronic Visit Verification (EVV);
6. Claims Payment; and
7. Encounter Data.

The MCO must provide an interface with all applicable systems to provide DHCFP, providers and recipients access to appropriate data.

B. Current Environment – A description of the current functional requirements for the following systems can be found in the current MMIS Contract and supporting documentation located at DHCFP.

1. Enrollment;
2. Eligibility;
3. Provider Network Data;
4. PCP Assignment;
5. Claims Payment; and
6. Encounter Data.

C. The MCO must provide encounter data report files in prescribed data fields to DHCFP's encounter data processing agent on a monthly basis. DHCFP will provide the required data fields and data transfer instructions upon execution of the contract.

D. The MCO is required to provide encounter data from all providers. It is the MCO's responsibility to require this data and enforce the requirement from their providers.

3603.31 SANCTIONS

Pursuant to 42 CFR §438.726, the State has developed a plan to monitor MCO actions and failures to act as specified in Subpart I, 42 CFR §438 and to implement provisions of this subpart. The State will monitor MCO activities to validate:

A. the extent to which the MCO provides the covered medically necessary services required under the contract with the State;

B. the imposition of any cost sharing;

C. the basis of disenrollment or refusal to enroll a recipient;

D. the accuracy of information furnished by the MCO to CMS or the State and its designees;

E. the accuracy of information furnished to an enrollee, potential enrollee, or health care provider;

F. compliance with physician incentive plans as required in DHCFP Managed Care Contract;

G. prior approval of marketing materials and the accuracy of information provided therein; and

H. compliance with Sections 1903(m) and 1932 of the Act.

The State's monitoring activities include contract requirements including, but are not limited to, enrollee and provider satisfaction surveys, review and confirmation of all financial reports and encounter data, the collection of enrollment and disenrollment reporting data, State prior approval of all MCO policies/procedures as well as all marketing materials proposed by the MCO for distribution, and review and approval of all base provider contracts. If the State determines the MCO violates any prohibition listed in 42 CFR §438.700, the State will provide written notice to CMS of any imposition of sanctions or remedies taken against the MCO pursuant to 42 CFR §438.724(b).

The State will implement provisions of this Subpart through remedies under DHCFP Managed Care Contract, which include:

I. civil penalties in the amounts specified in 42 CFR §438.704;

J. appointment of temporary management for the MCO as provided in 42 CFR §438.706;

K. granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;

L. suspensions of all new enrollments, including default enrollment, after the effective date of the sanction;

M. suspension of payment for enrollees enrolled after the effective date of the sanction until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or

N. any additional sanctions allowed under State statute or State regulations that address areas of non-compliance specified in 42 CFR §438.700 as well as additional areas of non-compliance. Additional sanctions may include liquidated damages and imposition of plans of correction in addition to its remedies at law.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 28, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER /Jessica Kemmerer/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3700 – APPLIED BEHAVIORAL ANALYSIS (ABA)

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3700, Applied Behavioral Analysis (ABA) are being proposed to incorporate the findings from Senate Bill 174 from Legislative Session 2019 and Senate Bill 96 from Legislative Session 2021. These chapter changes will include provider types permitted to bill ABA as well as the documentation required for treatment notes.

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. Structural changes were made to the chapter including renumbering and re-arranging of sections. Section 3704.4(E)-(G) – subsections were added.

Entities Financially Affected:

This proposed change affects all Medicaid-enrolled providers delivering ABA services. Those provider types include, and are limited to:

PT 85 Specialty 310 - Licensed Behavioral Analyst (LBA) specialty
PT 85 Specialty 311 - Psychologist specialty
PT 85 Specialty 312 - Licensed Assistant Behavioral Analyst (LaBA) specialty
PT 85 Specialty 314 - Registered Behavioral Technician (RBT) specialty
PT 60 – School Health Services
PT 47 – Indian Health Services/Tribal Clinics/Tribal FQHCs

Financial Impact on Local Government: There is no estimated financial impact to Local Government based on these changes.

These changes are effective January 1, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 14/21 CHAPTER 3700 – Applied Behavioral Analysis (ABA)	MTL 01/20 CHAPTER 3700 – Applied Behavioral Analysis (ABA)

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3704.4E-F	**Provider Responsibility**	Policy clarification of allowed providers.
3704.4G		Documentation requirements.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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APPLIED BEHAVIOR ANALYSIS

3700 INTRODUCTION

Applied Behavior Analysis (ABA) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. ABA is a behavior intervention model based on reliable evidence-based practices focusing on targeted skills in all areas of development. The Division of Health Care Financing and Policy (DHCFP) utilizes the Center for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and Behavior Analyst Certification Board (BACB) "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.)" as guiding principles for this policy.

All DHCFP policies and requirements (such as prior authorizations, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000 are the same for NCU.

All DHCFP policies and requirements for Outpatient Physical, Occupational, Speech and Maintenance Therapy are listed in the Medicaid Services Manual (MSM) Chapter 1700. Chapter 3700 specifically covers ABA services; for other Medicaid services, coverage, limitations and provider responsibilities the specific MSM needs to be referenced.

3701 AUTHORITY

A. A comprehensive array of preventive, diagnostic and treatment services are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21, including children with Autism Spectrum Disorder (ASD), Fetal Alcohol Spectrum Disorder (FASD) or other condition for which ABA is recognized as medically necessary.

1. ABA is an evidence-based behavior intervention meeting the provision of the law as defined in the following:

   a. Social Security Act (SSA) 1905(a) and (r);

   b. 42 Code of Federal Regulation (CFR), Subpart B, 441.50-441.62;

   c. Nevada Revised Statute (NRS) Chapter 437 describes persons deemed to practice ABA services; and

   d. Nevada Medicaid State Plan describes the amount, duration and scope of ABA services provided to the categorically needy.

3702 DEFINITIONS

A. ABA is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

B. Autism Spectrum Disorders (ASD) are a group of developmental disabilities that can cause significant social, communication and behavioral challenges.

C. FASD are a group of developmental conditions resulting from maternal alcohol use during pregnancy.

D. Other conditions, as referenced in this policy, are defined as any developmental condition in which ABA is recognized as a medically necessary treatment.

3703 RESERVED

3704 POLICY

3704.1 APPLIED BEHAVIOR ANALYSIS POLICY

Medicaid will reimburse for ABA rendered to Medicaid eligible individuals under age 21 years old in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage authority. The behavior intervention must be medically necessary (reference MSM Chapter 100) to develop, maintain or restore to the maximum extent practical the functions of an individual with a diagnosis of ASD, FASD or other condition for which ABA is recognized as medically necessary. It must be rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner Registered Nurse (APRN). The treatment regimen must be designed and signed off on by the qualified ABA provider.

The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment or in the recipient's home.

All services must be documented as medically necessary and appropriate and must be prescribed on an individualized treatment plan.

3704.2 COVERAGE AND LIMITATIONS

3704.2A COVERED SERVICES

1. There are two types of ABA treatment delivery models recognized by the DHCFP, Focused and Comprehensive. Based upon the Behavior Analyst Certification Board (BACB), Inc. (2014) within each of the two delivery models there are key characteristics which must be demonstrated throughout the assessment and treatment. These characteristics include:

    a. Comprehensive assessment that describes specific levels of baseline behaviors when establishing treatment goals.

    b. Establishing small units of behavior which builds towards larger changes in functioning in improved health and levels of independence.

    c. Understanding the current function and behaviors targeted for treatment.

    d. Use of individualized and detailed behavior analytic treatment.

    e. Ongoing and frequent direct assessment, analysis and adjustments to the treatment plan by a Behavior Analyst by observations and objective data analysis.

    f. Use of treatment protocols that are implemented repeatedly, frequently and consistently across all environments.

g. Direct support and training of family members and other involved qualified professionals.

h. Supervision and management by a licensed provider with expertise and formal training in ABA for treatment of ASD. "Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2014) (2nd ed.)". https://www.bacb.com/team-view/applied-behavior-analysis-treatment-of-autism-spectrum-disorder-practice-guidelines-for-healthcare-funders-and-managers-2nd-ed/

2. Focused Delivery Model

a. Focused ABA is treatment directly provided to the individual for a limited number of specific behavioral targets.

1. The appropriate target behaviors are prioritized. When prioritizing multiple target areas, the following behaviors are considered:

a. Behaviors that may threaten the health and safety of themselves or others; and

b. Absence of developmentally appropriate adaptive, social or functional skills.

2. Treatment may be delivered in individual or small group format.

3. Comprehensive Delivery Model

a. Comprehensive ABA is treatment provided to the individual for a multiple number of targets across domains of functioning including cognitive, communicative, social and emotional.

1. The behavior disorders may include co-occurring disorders such as aggression, self-injury and other dangerous disorders.

2. Treatment hours are increased and decreased as recipient responds to treatment goals.

3. Treatment is intensive and initially provided in a structured therapy setting. As recipient progresses towards treatment goals the setting may be expanded to alternative environments such as group settings.

4. Services covered within the ABA delivery models

a. Behavioral Screening – A brief systematic process to determine developmental delays and disabilities during regular well-child doctor visits. Screens must be a nationally accepted Developmental Screen. A recommended list of screens may be found at: http://www.medicalhomeinfo.org/downloads/pdfs/DPIPscreeningtoolgrid.pdf. Refer to MSM Chapter 600 for coverage of developmental screens.

b. Comprehensive Evaluations – Is the further review and diagnosis of the child's behavior and development. Coverage of this service is found within MSM Chapter 600.

c. Behavioral Assessment – A comprehensive assessment is an individualized examination which establishes the presence or absence of developmental delays and/or disabilities and determines the recipient's readiness for change and identifies the strengths or problem areas that may affect the recipient's treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

d. Adaptive Behavioral Treatment Intervention – Is the systematic use of behavioral techniques and intervention procedures to include intensive direction instruction by the interventionist and family training and support.

e. Adaptive Behavioral Family Treatment – The training in behavioral techniques to be incorporated into daily routines of the child and ensure consistency in the intervention approach. The training should be extensive and ongoing and include regular consultation with the qualified professional. The training is broken down into two components:

1. Family Treatment with the child present – Is training that includes the parent/guardian or authorized representative in behavioral techniques during the behavior intervention with the child.

2. Family Treatment without the child present – Is training in behavioral techniques provided to the parent/guardian or authorized representative without the child present. The training may be for the review of prior adaptive behavioral treatment sessions to break down the exhibited behavior and training techniques.

5. The coverage of ABA services requires the following medical coverage criteria to be met:

a. The recipient must be zero to under 21 years of age;

b. Have an established supporting diagnosis of ASD, FASD or other condition for which ABA is recognized as medically necessary.

c. The individual exhibits excesses and/or deficits of behavior that impedes access to age appropriate home or community activities (examples include, but are not limited to aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

d. ABA services are rendered in accordance with the individual's treatment plan with realistic and obtainable treatment goals to address the behavioral dysfunction;

e. Treatment may vary in intensity and duration based on clinical standards. Approval of fewer hours than recommended/supported in clinical literature requires justification based on objective findings in the medical records;

f. A reasonable expectation on the part of the treating healthcare professional that the individual will improve, or maintain to the maximum extent practical functional gains with behavior intervention services;

g. The treatment plan must be based on evidence-based assessment criteria and the individual's test results;

h. Behavioral assessments which are previously performed at the Local Education Agency (LEA) must be utilized and not duplicatively billed under the DHCFP if current (within six months) and clinically appropriate; and

i. Services must be prior authorized.

6. Services may be delivered in an individual or group (two to eight individuals) treatment session.

7. Services may be delivered in the natural setting (i.e. home and community-based settings, including clinics).

8. Individuals with Disabilities Education Act (IDEA) related services:

a. Part C, Early Intervention ages zero up to three – Services identified on an Individualized Family Services Plan (IFSP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under "provider qualifications" for ABA service. These providers must directly bill the DHCFP.

b. Part B, Special Education and related services ages three up to 21 years old – Services identified on an Individual Educational Plan (IEP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as

outlined under "provider qualifications" for ABA services. These providers must directly bill the DHCFP.

3704.2B PRIOR AUTHORIZATION REQUIREMENTS

1. Behavioral screens do not require prior authorization.

2. Behavioral initial assessment and re-assessments do not require prior authorization. Assessments are limited to one in every 180 days or unless prior authorized.

3. Adaptive Behavioral Treatment (individual and group) requires prior authorization from the Quality Improvement Organization (QIO)-like vendor.

4. Adaptive Family Behavioral training (individual and group) requires prior authorization from the QIO-like vendor.

5. ABA services identified through an IEP. When an IEP is issued by the school system, the IEP must accompany a request for ABA services and coordination of services is expected.

6. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both) of the current authorization, the provider is responsible for the submittal of a new prior authorization request.

3704.2C NON-COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.

2. Services used to reimburse a parent/guardian for participation in the treatment plan.

3. Services rendered by the parent/guardian.

4. Services that are duplicative services under an IFSP or an IEP.

5. Treatment whose purpose is vocationally or recreationally based.

6. Services, supplies or procedures performed in a non-conventional setting including but not limited to Resorts, Spas and Camps.

7. Custodial services:

   a. For the purpose of these provisions, custodial care:

      1. Shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs) such as bathing, dressing, eating, and maintaining personal hygiene and safety;

2. Is provided primarily for maintaining the recipient's or anyone else's safety; and

3. Could be provided by persons without professional skills or training.

8. Services not authorized by the QIO-like vendor if an authorization is required according to policy.

9. Respite services.

10. Child--care services.

11. Services for education.

12. Equine therapy.

13. Hippotherapy.

14. Phone consultation services.

15. Care coordination and treatment planning billed independently of direct service.

16. ABA services cannot be reimbursed on the same day as Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR) as defined in MSM Chapter 400.

3704.3 PROVIDER QUALIFICATIONS

A. In order to be recognized and reimbursed as an ABA provider by the DHCFP, the provider must be one of the following:

1. Licensure as a Physician by the Nevada State Board of Medical Examiners acting within their scope of practice (NRS 630.630, 630.165, 630.195, 633 Nevada Administrative Code (NAC) 630.080), and 42 CFR §440.50.

2. A Psychologist licensed under by the Board of Psychological Examiners (NRS 641.170.3) and acting within their scope of practice.

3. A qualified Behavior Analyst is an individual who has earned a master's degree level and/or doctorate from an accredited college or university in a field of social science or special education and holds a current certificate as a Board--Certified Behavior Analyst (BCBA and BCBA-D) by the BACB, Inc., and licensed by the Nevada State Board of Applied Behavior Analysis under NRS 437.205 .

4. A qualified Assistant Behavior Analyst is an individual who has earned a bachelor's degree from an accredited college or university in a field of social science or special education and holds a current certification as a Board--Certified Assistant Behavior

Analyst (BCaBA) by the BACB, Inc., and licensed by the Nevada State Board of Applied Behavior Analysis under NRS 437.205 and acting within their scope of practice under the direction of a physician, psychologist, BCBA-D or BCBA.

5. A Registered Behavior Technician (RBT) is an individual who has earned a high school diploma or equivalent, completed training and testing as approved and credentialed by the BACB, Inc., registered by the Nevada Stated Board of Applied Behavior Analysis under NRS 437.205 and acting within the scope of practice under direction of a physician, psychologist, BCBA-D, BCBA or BCaBA.

3704.3A SUPERVISION STANDARDS

Clinical Supervision as established by NRS 437.050, which includes: program development, ongoing assessment and treatment oversight, report writing, demonstration with the individual, observation, interventionist and parent/guardian training/education and oversight of transition and discharge plans. All supervision must be overseen by a Licensed Psychologist, BCBA-D or BCBA who has experience in the treatment of autism, although the actual supervision may be provided by a BCaBA at their direction. The amount of supervision must be responsive to individual needs and within the general standards of care and may temporarily increase to meet the individual needs at a specific period in treatment.

3704.4 PROVIDER RESPONSIBILITY

A. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.

B. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.

C. Ensure services are consistent with applicable professional standards and guidelines relating to the practice of ABA as well as state Medicaid laws and regulations and state licensure laws and regulations.

D. Ensure caseload size is within the professional standards and guidelines relating to the practice of ABA.

E. Provider Type (PT) 85 groups may not be linked with any other provider types. The group NPI must be unique to the group.

F. PT 60 - School Health Services (SHS), PT 85 ABA and PT 47 Indian Health Services/Tribal Clinics/Tribal FQHCs are the only provider types permitted to bill for ABA services.

1. Providers that may enroll, link, and provide services under these PTs are limited to the following:

   PT 85 Specialty 310 - Licensed Behavioral Analyst (LBA) specialty
   PT 85 Specialty 311 - Psychologist specialty
   PT 85 Specialty 312 - Licensed Assistant Behavioral Analyst (LaBA) specialty
   PT 85 Specialty 314 - Registered Behavioral Technician (RBT) specialty
   PT 60 - School Health Services (SHS)
   PT 47 Indian Health Services/Tribal Clinics/Tribal FQHCs

G. Progress Notes: Progress notes for all ABA services are written documentation of treatment services, or services coordination provided to the recipient pursuant to the Treatment Plan, which describes the progress, or lack of progress, towards the goals and objectives of the Treatment Plan. Progress notes must be available upon request for review and investigation of claims.

1. All progress notes documented with the intent of submitting a billable Medicaid ABA service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope, frequency and duration of the services(s) provided as well as the identity of the provider of the service(s).

2. A Progress Note is required for each day the services were delivered, must be legible and must include the following information:

   a. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated.

   b. The place of service.

   c. The date the service was delivered.

   d. The actual beginning and ending times the service was delivered.

   e. The name of the provider who delivered the service.

   f. The credentials of the person who delivered the service.

   g. The signature of the provider who delivered the service.

3704.5 PARENT/GUARDIAN RESPONSIBILITY

A. The parent/guardian when applicable must:

1. Be present during all provider training and supervisory visits that occur during home-based services. A parent/guardian may designate an authorized representative, who is 18 years of age or older, to participate in the parent/guardian's absence during home-based services.

2. Participate in discussions during supervisory visits and training.

3. Participate in training by demonstrating taught skills to support generalization of skills to the home and community environment.

4. Sign the treatment plan indicating an understanding and agreement of the plan.

5. Participate in treatment hours.

6. Keep scheduled appointments.

7. Inform provider within 24 hours if the appointment needs to be rescheduled.

3704.6 TREATMENT PLAN

A. All ABA services must be provided under a treatment plan developed and approved by a licensed psychologist, BCBA-D or BCBA, supported by a BCaBA where applicable. The licensed psychologist, BCBA-D or BCBA trains the BCaBA and RBT to implement assessment and intervention protocols with the individual and provides training and instruction to the parent/guardian and caregiver as necessary to support the implementation of the ABA treatment plan. The licensed psychologist, BCBA-D or BCBA is responsible for all aspects of clinical direction, supervision, and case management.

B. ABA services shall be rendered in accordance with the individual's treatment plan that is reviewed no less than every six months by a licensed psychologist, BCBA-D, or BCBA. All treatment plans are based on documentation of medical necessity for specific treatment goals to address specific behavior targets based on the appropriate treatment model. The treatment plan shall include:

1. Goals derived from the functional assessment and/or skill assessment that occur prior to initiation of treatment, and relating to the core deficit derived from the assessment;

2. Specific and measurable objectives to address each skill deficit and behavioral excess goal:

   a. Delineate the baseline levels of target behaviors;

   b. Identify short, intermediate and long-term goals and objectives that are behaviorally defined;

c. Criteria that will be used to measure achievement of behavioral objectives; and
d. Target dates for when each goal will be mastered.

3. Interventions consistent with ABA techniques;

4. Specific treatment, intervention including amount, scope, duration and anticipated provider(s) of the services;

5. Training and supervision to enable the BCaBAs and RBTs to implement assessment and treatment protocols;

6. Care coordination involving the parent/guardian, community, school and behavior health and/or medical providers who are concurrently providing services. Care coordination must include parent/guardian's documented consent;

7. Parent/guardian training, support and participation;

8. Parent/guardian or designated authorized representative responsibility to be physically present and observant during intervention process occurring in the home;

9. Parent/guardian signature; and

10. Discharge criteria to include requirements of discharge, anticipated discharge date, next level of care and coordination of other services.

3704.7 DISCHARGE PLAN

A. All ABA services must include discharge criteria as a written component of the treatment plan at the initiation of services and updated throughout the treatment process; involving a gradual step down in services. Discharge planning should include the details of monitoring and follow up for the individual.

1. Discharge planning should occur when:

a. The individual has achieved treatment goals; or

b. The individual no longer meets the diagnostic criteria for ASD; or

c. The individual does not demonstrate progress towards goals for successive authorization periods; or

d. The parent/guardian requests to discontinue services; or

e. The parent/guardian and provider are unable to reconcile concerns in treatment planning and delivery.

2. Discharge plan must identify:
   a. The anticipated duration of the overall services;

   b. Discharge criteria;

   c. Required aftercare services;

   d. The identified agency(ies) or Independent Provider(s) to provide the aftercare services; and

   e. A plan for assisting the recipient in accessing these services.

B. A discharge summary is written documentation of the last service contact with the recipient, the diagnosis at admission and termination and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, towards treatment goals and objectives, as documented in the ABA treatment plan. The discharge summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 30, 2023

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES *Casey Angres* Casey Angres (Jun 20, 2023 15:11 PDT)
CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3800 – MEDICATION ASSISTED TREATMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3800 – Medication Assisted Treatment (MAT) are being proposed to align with the Consolidated Appropriations Act of 2023 signed into law on December 29, 2022, which eliminated the "DATA-Waiver Program." The Act removes the federal requirement for practitioners to obtain a Data-Waiver (X-Waiver) to prescribe medications such as buprenorphine, a Schedule III controlled substance, for the treatment of opioid use disorder (OUD).

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: This proposed change affects all Medicaid-enrolled providers delivering MAT. Those provider types (PTs) include, but are not limited to: Physician, M.D., Osteopath, D.O. (PT 20), Advance Practice Registered Nurse (PT 24), Nurse Midwife (PT 74), Physician's Assistant (PT 77), Certified Community Behavioral Health Center (CCBHC) (PT 17, Specialty 188), and Substance Abuse Agency Model (SAAM) (PT 17, Specialty 215).

Financial Impact on Local Government: Unknown at this time.

These changes are effective May 31, 2023.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 07/23 MSM Chapter 3800 – Medication Assisted Treatment	MTL 17/20; 12/21 MSM Chapter 3800 – Medication Assisted Treatment

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3800	**Introduction**	Added clarifying language to the definition of medication-assisted treatment; updated language

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		regarding Drug Enforcement Administration (DEA) license.
3801	**Authority**	Removed DATA 2000 related language and patient limit requirements.
3802	**Coverage and Limitations**	Removed DATA 2000 related language, patient limit requirements, and provider training requirements.
3804	**Phases of Care**	Updated Treatment Agreement language; removed language contradictory to the harm reduction model.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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MEDICATION ASSISTED TREATMENT

3800 INTRODUCTION

Medication-Assisted Treatment (MAT), otherwise known as medications for opioid use disorder, (MOUD), is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Nevada Medicaid acknowledges that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery. National and state guidelines suggest MAT should be managed as an elective treatment and include signed, informed consent. This policy addresses the requirements for providers who are providing outpatient addiction treatment services for Opioid Use Disorder (OUD) in an office-based opioid treatment setting that is not a certified Opioid Treatment Program (OTP). The use of buprenorphine as a MAT medication is specifically outlined in this policy. For other medications that can be used to treat other diagnoses, review Medicaid Services Manual (MSM) Chapter 1200, Prescribed Drugs.

Buprenorphine is an opioid partial agonist/antagonist that is Food and Drug Administration (FDA) approved for the treatment of opioid dependence by physicians in an office-based setting. It is a Schedule III controlled substance and requires that physicians obtain a Drug Enforcement Administration (DEA) license to prescribe it for office-based treatment of opioid dependence. The optimal length of treatment with buprenorphine has not been established, but research studies strongly support better outcomes with maintenance treatment. Many successful patients are treated with buprenorphine indefinitely to prevent relapse to opioid use.

Medication of choice is buprenorphine/naloxone for non-pregnant patients and buprenorphine single ingredient for pregnant patients (see MSM Chapter 1200, Prescribed Drugs). For the remainder of this chapter, both forms will be referred to as buprenorphine.

Nevada Medicaid pays for medically necessary MAT services for eligible Medicaid recipients with the diagnosis of OUD as defined by either the current edition of the Diagnostic and Statistical Manual of Mental Disorders or the current edition of the International Classification of Diseases, and who meet the predetermined criteria. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. See MSM Chapter 100, Medicaid Program.

3801 AUTHORITY

A. The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act promotes increased access to SUD/OUD treatment and recovery services by increasing the number of providers eligible to provide some level of SUD services. In response to the SUPPORT Act, Nevada has developed a comprehensive Medication Assisted Treatment strategy.

B. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (CFR) Part 440, Subpart A – Definitions, Subpart B and Sections 1929 (a), 1902 (e), 1905 (a), 1905 (p), 1915, 1920, and 1925 of the Act. Physician's services are mandated as a condition of participation in the Medicaid Program Nevada Revised Statute (NRS) 630A.220.

C. The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

1. Section 330 of the Public Health Service (PHS) Act;
2. NRS Chapter 629 - Healing Arts Generally;
3. NRS Chapter 632 - Nursing;
4. NRS Chapter 630 - Physicians and Physician Assistants and Practitioners of Respiratory Care General Provisions;
5. NRS Chapter 633 - Osteopathic Medicine;
6. Section 1861 of the Social Security Act;
7. Section 1905 of the Social Security Act;

3802 COVERAGE AND LIMITATIONS

Requirements for eligible providers to prescribe buprenorphine as treatment for opioid dependence:

A. Must have a DEA license to prescribe medication.

B. Eligible providers include the following:

1. Physician, M.D., Osteopath, D.O. (PT 20)
2. Advance Practice Registered Nurse (PT 24)
3. Physician's Assistant (PT 77)
4. Nurse Midwife (PT 74)

C. Providers must satisfy the following criteria:

1. Follow all policies and guidelines related to their individual provider type per MSM Chapter 600, Physician Services.
2. Have the capacity to provide or to refer patients for necessary ancillary services, such as psychosocial therapy.

3803 SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT)

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care, hospitals, and other community-based settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

The screener will identify patients in need for more intensive treatment such as the MAT program. If SBIRT was completed by a provider other than the MAT provider, the MAT provider shall obtain the SBIRT documentation. An authorization of release shall be obtained from the patient prior to obtaining the SBIRT documentation.

3804 PHASES OF CARE

Treatment with buprenorphine can be divided into the following stages: assessment (comprehensive medical evaluation, comprehensive psychosocial assessment), induction (transition from other opioid[s] to buprenorphine), stabilization, and maintenance.

A. Assessment Stage

1. Prior to commencing MAT, and in addition to ensuring that any patient has a comprehensive medical evaluation, the provider shall assess the patient and diagnose and document an opioid use disorder as defined by either the current edition of the Diagnostic and Statistical Manual of Mental Disorders, or the current edition of the International Classification of Diseases.

   The physician will make a determination on the individual's suitability for MAT. During this assessment process, the patient will receive a complete medical evaluation, education about the MAT process and a consent to treatment form. Providers shall arrange for services that are well-organized and accessible, minimizing the number of separate trips required for the patient to receive MAT program services.

2. Prior to commencing MAT, the provider shall either conduct an intake examination that includes any relevant physical and laboratory tests or refer the patient to a medical professional who can perform such an examination. Necessary laboratory tests may include, but are not limited to, urine drug screening, complete blood count, liver function tests, testing for tuberculosis, hepatitis, HIV, sexually transmitted diseases/infections, and pregnancy testing for women of childbearing age.

   The first clinical priority shall be given to identifying and making appropriate referral for any urgent or emergent medical or psychiatric problem(s), including drug-related impairment or overdose. The psychosocial assessment shall be completed before the third patient visit to the provider prescribing or dispensing MAT. The psychosocial assessment must include documentation supporting ASAM criteria with the dimensions and levels of care. The psychosocial assessment must be completed by:

   a. Psychiatrist;

   b. Physician certified by the American Board of Addiction Medicine;

   c. Advance Practice Registered Nurse with a specialty in psychiatry;

   d. Physician Assistant with a specialty in psychiatry;

   e. Licensed Clinical Social Worker;

f. Psychologist;

g. Licensed Marriage and Family Therapist;

h. Licensed Clinical Professional Counselor;

i. Licensed Clinical Alcohol and Drug Counselor;

j. Licensed Alcohol and Drug Counselor; or

k. Certified Alcohol and Drug Counselor.

If the prescribing provider (as listed in section 3802.B) is not certified in one of these disciplines, then the patient shall be referred for the psychosocial assessment during the initial visit. Following completion of the psychosocial assessment, the patient shall be offered or referred to behavioral health services based on the individual's needs. When referring a patient for behavioral health services, the individual providing these services must follow the guidelines listed in MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services. The psychosocial assessment must be completed before the third patient visit to the provider prescribing or dispensing MAT and shall be documented in the patient's record. Each provider shall maintain a referral and consultative relationship with a variety of providers who are proficient in providing primary and specialty medical services and consultation services for patients receiving MAT.

A provider may not deny or discontinue MAT based solely on a patient's decision not to follow a recommendation to seek counseling or other behavioral interventions unless the patient is otherwise non-compliant with program expectations. Harm reduction is a set of practical strategies and ideas aimed at reducing the public health risks associated with drug use. Harm reduction calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs, and the communities in which they live, in order to assist them in reducing harm. One of the most common forms of harm reduction is MAT for people who are addicted to opioids. Providers will consider how to incorporate harm reduction strategies into the patient's treatment and make recommendations to the prescribing provider. Refusal of services by patient must be documented in treatment plan and progress notes.

3. Prior to treating a patient with buprenorphine, a provider shall:

a. Obtain voluntary, written, informed consent to treatment from each patient and confirm the patient has no specific contraindication for buprenorphine treatment.

b. Obtain a treatment agreement outlining the responsibilities and expectations of the prescribing provider and the patient.

c. Treatment Agreement must document patient decisions for the following:

1. Patient agrees to refrain from opioid use prior to the scheduled date of induction for the indicated timeframe deemed appropriate by the clinician based on acuity of patient.

2. Patient agrees to participate in all components of MAT program.

3. Patient will attend all appointments as scheduled.

4. Patient agrees to participate in therapy sessions weekly or as clinically appropriate.

5. Patient agrees to complete random and/or scheduled lab testing as clinically appropriate.

6. Patient agrees to comply with all medications as prescribed.

d. Treatment Agreement must document patient receiving the following provider education:

1. MAT provider will educate the patient of risks of use of alcohol and other drugs while receiving buprenorphine treatment.

2. MAT provider shall provide 24-hour emergency hotline to patient as additional support after normal business hours.

3. MAT provider shall offer patient with referrals to community resources as needed.

4. MAT provider will educate the patient of buprenorphine for use of opioid treatment.

5. MAT provider will educate the patient of withdrawal symptoms related the opioid use.

e. Make reasonable efforts to obtain releases of information for any health care providers or others important for the coordination of care to the extent allowed by Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR, Part 2.

f. Ensure the current medical evaluation (with lab testing results) is included in the patient's medical record prior to or shortly after the patient is started on the medication.

B. Induction Phase

The Induction Phase is the medically monitored startup of buprenorphine treatment performed in a qualified physician's office using approved buprenorphine products. The medication is administered when a person with an opioid dependency has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal. It is important to note that buprenorphine can bring on acute withdrawal for patients who are not in the early stages of withdrawal and who have other opioids in their bloodstream.

Following initiation, buprenorphine dose will be titrated to alleviate symptoms. To be effective, buprenorphine dose must be sufficient to enable patients to discontinue illicit opioid use. The provider will make the clinical decision as to whether the patient needs to be seen for two or three consecutive days as part of the induction process. At the onset of induction phase, patients must be seen frequently until they are determined to be stable.

A MAT provider is responsible for evaluating and monitoring the patient during the induction phase. The Clinical Opiate Withdrawal Scale or other approved tool shall be completed during each visit or until symptoms are noted as absent. Stabilization Phase

The Stabilization Phase begins after a patient has discontinued or greatly reduced their misuse of the problem drug, no longer has cravings, and experiences few, if any, side effects. The buprenorphine dose may need to be adjusted during this phase. Because of the long-acting agent of buprenorphine, once patients have been stabilized, they can sometimes switch to alternate-day dosing instead of dosing every day.

The stabilization period lasts several weeks following induction. Patients will receive a limited supply of medication during stabilization and return for regular follow-up which is defined as clinically appropriate for the first month.

The MAT team shall conduct therapy sessions (individual or group) with the patient as clinically appropriate. The MAT team shall refer the patient to individual or group therapy if not offered by the MAT provider.

C. Maintenance Phase

The Maintenance Phase occurs when a patient is doing well on a steady dose of buprenorphine. The length of time of the maintenance phase is tailored to each patient and could be indefinite. People can engage in further treatment—with or without MAT—to prevent a possible relapse.

Buprenorphine maintenance may continue indefinitely for most patients; unless there is a compelling reason to stop, due to the high rate of relapse when buprenorphine is discontinued. Concurrent and psychosocial support is an important part of treatment. Periodic psychosocial assessment and laboratory testing is indicated throughout treatment.

3805 PRIOR AUTHORIZATION

There are no prior authorization requirements for the initiation and maintenance MAT services as listed in this policy. An individual must meet the medical necessity criteria of MAT services as documented in the patient's medical record.

3806 NON-COVERED SERVICES

Buprenorphine prescription for any other reason than OUD.

3807 HEARINGS

Please reference MSM Chapter 3100, for Hearings process and policy.

3807 HEARINGS

Please reference MSM Chapter 3100, for Hearings process and policy.

~~3900 INTRODUCTION~~

~~The Home and Community-Based Waiver for Assisted Living (AL Waiver) recognizes that many individuals at risk of being placed in hospitals or nursing facilities can be cared for in their homes or communities, preserving independence and ties to family and friends at a cost no higher than that of institutional care.~~

~~Division of Health Care Financing and Policy's (DHCFP) AL Waiver originated in 2006. The provision of the AL Waiver services is based on the identified needs of the waiver recipient. Every biennium, the service needs and the funded slot needs of the AL Waiver are reviewed by the Aging and Disability Services Division (ADSD) and the DHCFP, and presented to the Nevada State Legislature for approval. The state of Nevada is committed to the goal of providing the elderly with the opportunity to remain in a community setting in lieu of institutionalization and to be self-sufficient. The state of Nevada also understands that people who are elderly are able to lead satisfying and productive lives when appropriate services and supports are provided.~~

~~3901 AUTHORITY~~

~~Section 1915(c) of the Social Security Act permits states to waive certain Medicaid statutory requirements in order to offer an array of home and community-based services that an individual requires to remain in a community setting and avoid institutionalization. The Home and Community-Based Waiver for Assisted Living (AL Waiver) is an optional program approved by the Centers for Medicare and Medicaid Services (CMS). The AL Waiver is designed to provide Medicaid State Plan services and certain extended Medicaid covered services unique to this waiver to eligible Medicaid waiver recipients. The goal is to allow recipients to live in a community setting when appropriate.~~

~~Nevada has the flexibility to design the AL Waiver and select the mix of Home and Community-Based Waiver (HCBW) services that best meet the goal to keep people in the community. Such flexibility is predicated on administrative and legislative support as well as federal approval.~~

~~Statutes and Regulations:~~

- ~~Social Security Act: 1915(c) (Home and Community-Based Waiver)~~
- ~~Social Security Act: 1916(e) (No denial for inability to share costs)~~
- ~~Social Security Act: 1902(w) (Eligibility)~~
- ~~Omnibus Budget Reconciliation Act of 1987~~
- ~~Balanced Budget Act of 1997~~
- ~~Health Insurance Portability and Accountability Act of 1996 (HIPAA)~~
- ~~State Medicaid Manual, Section 4440 (Home and Community-Based Waiver, Scope, and Purpose~~
- ~~Title 42 Code of Federal Regulations (CFR) Part 431, Subpart B (General Administrative Requirements)~~
- ~~Title 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Recipients)~~
- ~~Title 42 CFR 440.40~~
- ~~Title 42 CFR 440.169 (Case Management Services)~~
- ~~Title 42, CFR Part 441, Subparts G and H (Home and Community-Based Services: Waiver Requirements; Home and Community-Based Services Waivers for Individuals Age 65 or Older: Waiver Requirements)~~

- ~~Title 42 CFR 441.305(a) (Replacement of Recipients in Approved Waiver Programs)~~

- ~~Title 42 CFR 489, Subpart I (Advance Directives)~~

- ~~Title 42 CFR 440.155 (Nursing Facility Services)~~

- ~~Nevada's Home and Community-based AL Waiver Control Number 0452~~

- ~~Nevada Revised Statutes (NRS) Chapters 200 (Crimes Against the Person); 232 (Department of Health and Human Services); 319 (Assistance to Finance Housing); 422, (Health Care Financing and Policy); 427A (Services to Aging Persons); 439 (Fund for a Healthy Nevada); 449 (Medical and Other Related Facilities); 616A (Industrial Insurance Administration); 629 (Healing Arts Generally)~~

- ~~Nevada Administrative Code (NAC) Chapters 427A (Services to Aging Persons), 449 (Medical and Other Related Facilities); 441A.375 (Tuberculosis)~~

~~3902 RESERVED~~

~~3903 POLICY~~

~~The Home and Community-Based Waiver (HCBW) for Assisted Living (AL Waiver) waives certain statutory requirements and offers HCBW services to all recipients enrolled in this waiver to assist them to remain in the community.~~

~~Division of Health Care Financing and Policy (DHCFP) must provide assurance to Centers for Medicare and Medicaid Services (CMS) that the state's total expenditures for HCBW services and other Medicaid State Plan services for all recipients will not exceed, in any waiver year, 100 percent of the amount that would be incurred by Medicaid for all these recipients in an institutional setting in the absence of the waiver. DHCFP must also document that there are safeguards in place to protect the health and welfare of recipients.~~

~~3903.1 ADMINISTRATIVE CASE MANAGEMENT ACTIVITIES~~

~~Administrative case management activities are performed by the Aging and Disability Services Division (ADSD) case managers and refer to data collection for eligibility verification, Level of Care (LOC) evaluation, Plan of Care (POC) development, and other case management activities that are not identified on the POC.~~

~~3903.1A COVERAGE AND LIMITATIONS~~

~~1. Intake referral;~~

~~2. Facilitating Medicaid eligibility, which may include assistance with the Medical Assistance to the Aged, Blind and Disabled (MAABD) application, obtaining documents required for eligibility determination;~~

~~3. Provision of the written POC document to the Assisted Living provider;~~

~~4. Complete prior authorization form prior to submission to Medicaid Management Information Systems (MMIS);~~

~~5. Determine cost effectiveness of waiver services for each applicant;~~

~~6. Monitor Assisted Living providers to assure compliance with the AL Waiver provider goals and provision of services;~~

~~7. Preliminary and ongoing assessments, evaluations and completion of forms required for service eligibility:~~

~~a. Complete recipient's reassessment of the LOC, functional status and needs addressed by the POC annually or more often as needed. The recipient must also be reassessed when there is a significant change in his/her condition which influences eligibility. The reassessment should be conducted during a face-to-face visit.~~

~~b. The POC identifies the waiver services as well as other ongoing community support services that the recipient needs in order to live successfully in the community. The POC must reflect the recipient's service needs and include both waiver and non-waiver services in place at the time of POC completion, along with informal supports that are necessary to address those needs.~~

~~8. Arrange for the relocation of the recipient, if necessary, when an alternative placement is requested or needed;~~

~~9. Issuance of Notices of Actions (NOA) to DHCFP Central Office Waiver Unit staff, to issue a Notice of Decision (NOD) when a waiver application is denied;~~

~~10. Outreach activities to educate recipients or potential recipients on how to enter into care through a Medicaid program;~~

~~11. Documentation for case files prior to recipient eligibility;~~

~~12. Case closure activities when the recipient's waiver eligibility is terminated; and~~

~~13. If the POC is approved by the applicant/recipient and the case manager, but the applicant/recipient's signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the applicant/recipient. Case managers must document the applicant/recipient's verbal approval in the case notes and obtain the applicant/recipient signature on the POC as soon as possible.~~

~~3903.1B ADMINISTRATIVE CASE MANAGEMENT PROVIDER RESPONSIBILITIES~~

~~1. Possess current licensure as a social worker or associate in Social Work from the Nevada Board of Examiners for Social Workers, or meet the criteria for licensure as a social worker but currently licensed in another capacity which qualifies for exemption per NRS 641.040, or who has licensure as a Registered Nurse from the Nevada State Board of Nursing.~~

~~2. Have, or be supervised by someone who has one year of experience working with seniors in a home-based environment.~~

~~3. Conform to Health Insurance Portability and Accountability Act (HIPAA) of 1996 requirements.~~

~~3903.1C ADMINISTRATIVE CASE MANAGEMENT RECIPIENT RESPONSIBILITIES~~

~~The applicant/recipient will cooperate in the assessment/reassessment process as well as participate in the development and review of the POC. The applicant/recipient or his/her legally responsible individual or authorized representative must sign the POC.~~

~~3903.2 ELIGIBILITY CRITERIA~~

~~Recipients must meet and maintain all criteria to be eligible during the period of time the recipients receive services under the auspices of the AL Waiver.~~

~~Eligibility for the AL Waiver is determined by the combined efforts of the DHCFP, ADSD, and the Division of Welfare and Supportive Services (DWSS). These three state agencies collaboratively determine eligibility.~~

~~A. Applicants must be 65 years of age or older.~~

~~B. Applicant/recipient must meet and maintain a level of care category for admission to a nursing facility. If the AL Waiver services or other supports were not available, the applicant/recipient would require imminent placement in a nursing facility (within 30 days). The administrative case manager assesses a LOC according to the guidelines specified in Medicaid Services Manual Chapter 500.~~

~~C. Applicants/recipients must demonstrate a continued need for the AL Waiver services to prevent placement in a nursing facility or other institutional setting. Utilization by the applicant/recipient of Medicaid State Plan services only is not in itself sufficient to support the eligibility of the applicant/recipient for AL Waiver services.~~

~~D. Applicants who are currently in an acute care facility, a nursing facility, in another HCBW, or in the community may be evaluated for the AL Waiver services.~~

~~E. Financial eligibility for Medicaid benefits is determined by DWSS.~~

~~F. Recipients must be Medicaid eligible each month in which AL Waiver services are provided.~~

~~G. DHCFP Central Office Waiver Unit reviews and authorizes all waiver applications prior to the start of service provision.~~

~~H. Services cannot be provided nor be reimbursed by DHCFP until and unless the applicant is found eligible in all three determination areas, as established by ADSD, DHCFP, and DWSS.~~

~~3903.2A COVERAGE AND LIMITATIONS~~

~~1. Services are offered to eligible applicants who, without waiver services, would require institutional care provided in a hospital or nursing facility within 30 days or less.~~

~~2. Recipients on this waiver must maintain Medicaid eligibility requirements.~~

~~3. The AL Waiver is limited by legislative authority to a specific number of recipients who can be served through the waiver per year (slots). When all waiver slots are filled, a wait list is utilized to prioritize applicants who have been screened for waiver eligibility.~~

~~4. The Wait List is managed based on priority, slot availability, available budget authority, and date the waiver application is received by ADSD.~~

~~Applicants who, at the time of application, are in a nursing facility or an acute care setting will be prioritized and processed before those applicants placed on the Wait List by date of application. This priority facilitates the provision of services in the most integrated setting appropriate to the needs of the applicant.~~

~~5. Waiver services may not be provided while a recipient is an inpatient of any institution.~~

~~6. Applicants must require the provision of one waiver service at least monthly to be determined eligible for the AL Waiver.~~

~~7. Recipients of the AL Waiver who are enrolled or elect to enroll in a hospice program may be eligible to remain on the waiver if they require waiver services to remain in the community. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services. Refer to Medicaid Services Manual (MSM) Chapter 3200 for additional information on hospice services.~~

~~8. If an applicant is determined eligible for more than one HCBW program, the individual cannot receive services under two or more programs at the same time. The applicant must choose one HCBW program and receive services provided by that program.~~

~~3903.2B PROVIDER RESPONSIBILITIES~~

~~1. All waiver service providers, including case managers, are responsible for verifying the Medicaid and the AL Waiver eligibility monthly.~~

~~2. Providers are responsible for maintaining all required provider qualifications per DHCFP and ADSD policy.~~

~~3. Providers are responsible for assuring prior authorization is established prior to initiating services.~~

~~3903.2C RECIPIENT RESPONSIBILITIES~~

~~Recipients/applicants must meet and maintain all eligibility criteria to be eligible for and to remain on the AL Waiver.~~

~~3903.3 AL WAIVER SERVICES~~

~~DHCFP determines which services will be offered under the AL Waiver. Providers and recipients must agree to comply with the requirements for service provision.~~

~~3903.3A COVERAGE AND LIMITATIONS~~

~~**Under this waiver, the following services are provided as necessary to avoid institutionalization:**~~

~~1. Direct Service Case Management:~~

~~Direct service case management is a service which assists individuals who receive waiver services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational services regardless of the funding source for the services to which access is gained.~~

~~2. Augmented Personal Care Services:~~

~~Augmented Personal Care Services provided by Assisted Living Facilities include assistance with basic self care and activities of daily living (ADL), homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised. This care is over and above the mandatory service provision required by regulation for residential facilities for groups. There are three levels of augmented personal care based on the recipient's functional status.~~

~~3903.3B ALL PROVIDER RESPONSIBILITIES~~

~~1. All providers may only provide services identified in the recipient's POC. For those services requiring prior authorization, a prior authorization must be obtained before service provision.~~

~~2. Payment for services will be based on the level of care and the specific tasks identified on the POC.~~
~~3. Payments will not be made for services provided by a recipient's legally responsible individual.~~

~~4. Providers must have a file for each recipient. In the recipient's file, the provider must have a copy of the current POC and maintain daily records, fully documenting the scope and frequency of services as specified on the POC. The daily record is documentation completed by a provider, indicating the scope and frequency of services provided. The documentation will include the recipient's initials daily with a full signature of the~~

~~recipient on each record. If the recipient is unable to provide a signature due to cognitive and/or physical limitations, this will be clearly documented in the recipient file. The provider will initial after the daily services are delivered, with a full signature of the provider on each daily record. Providers may use electronic signatures on the daily record documentation, but using an electronic signature does not remove the provider's responsibility for providing accurate and verifiable documentation indicating the scope and frequency of the services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Periodically, the DHCFP Central Office staff may request this documentation to compare it to billings submitted. These records must be maintained by the provider for at least six years after the date the claim is paid.~~

~~5. Criminal Background Checks:~~

~~All agency personnel, including owners, officers, administrators, managers, employees and consultants must undergo State and Federal Bureau of Investigation (FBI) background check upon licensure as a provider and then at a minimum of every five (5) years thereafter to ensure no convictions of applicable offenses have been incurred and the safety of recipients is not compromised.~~

~~a. The DHCFP policy requires all waiver providers have State and Federal criminal history background checks completed. The DHCFP fiscal agent will not enroll any provider agency whose owner or operator has been convicted of a felony under State or Federal law for any offense which the DHCFP determines is inconsistent with the best interest of recipients. Additional information may be found in MSM Chapter 100, Section 102.2.~~

~~b. Criminal background checks must be conducted through the Nevada Department of Public Safety (DPS). Agencies do not have to have a DPS account. Individuals may request their own personal criminal history directly from DPS and the FBI and must have the results sent directly to the employer. Information and instructions may be found on the DPS website at: http://nvrepository.state.nv.us/criminal/forms/PersonalNevadaCriminalHistory.pdf~~

~~c. The employer is responsible for reviewing the results of employee criminal background checks and maintaining the results within the employee's personnel records. Continued employment is at the sole discretion of the servicing agency. However, the DHCFP has determined certain felonies and misdemeanors to be inconsistent with the best interests of recipients. The employer should gather information regarding the circumstances surrounding the conviction when considering ongoing employment and have this documented in the employee's personnel file. These convictions include (not all inclusive):~~

~~1. murder, voluntary manslaughter or mayhem;~~

~~2. assault with intent to kill or to commit sexual assault or mayhem;~~

~~3. sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;~~

~~4. abuse or neglect of a child or contributory delinquency;~~

~~5. a violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of the NRS;~~

~~6. a violation of any provision of NRS 200.700 through 200.760;~~

~~7. criminal neglect of a patient as defined in NRS 200.495;~~

~~8. any offense involving fraud, theft, embezzlement, burglary, robbery, fraudulent conversion or misappropriation of property;~~

~~9. any felony involving the use of a firearm or other deadly weapon;~~

~~10. abuse, neglect, exploitation or isolation of older persons;~~

~~11. kidnapping, false imprisonment or involuntary servitude;~~

~~12. any offense involving assault or battery, domestic or otherwise;~~

~~13. conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a provider contract is issued;~~

~~14. conduct or practice that is detrimental to the health or safety of the occupants or employees of the facility or agency; or~~
~~15. any other offense that may be inconsistent with the best interests of all recipients.~~

~~d. Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. An "undecided" result is not acceptable. If an employee believes that the information provided as a result of the criminal background check is incorrect, the individual must immediately inform the employing agency in writing. Information regarding challenging a disqualification is found on the DPS website at: http://dps.nv.gov under Records and Technology.~~

~~Providers are required to initiate diligent and effective follow up for results of background checks within 90 days of submission of prints and continue until results are received. This is particularly important when an "undecided" result is received. Documentation must be maintained in the employee's personnel file and submitted to the DHCFP upon request.~~

~~6. Serious Occurrence Report (SOR):~~

~~Providers must report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the ADSD case manager by telephone/fax within 24 hours of discovery. A completed Serious~~

~~Occurrence Report (SOR) form must be made within five (5) working days and maintained in the agency's recipient record.~~

~~Serious occurrences/incidents include, but are not limited to the following:~~

~~a. Suspected physical or verbal abuse;~~

~~b. Unplanned hospitalization;~~

~~c. Neglect of recipient;~~

~~d. Exploitation;~~

~~e. Sexual harassment or sexual abuse;~~

~~f. Injuries requiring medical intervention;~~

~~g. An unsafe working environment;~~

~~h. Any event which is reported to Child or Elder Protective Services or law enforcement agencies;~~

~~i. Death of the recipient during the provision of services;~~

~~j. Medication error;~~

~~k. Loss of contact with the recipient for three consecutive scheduled days.~~

~~The State of Nevada has established mandatory reporting requirements of suspected incidents of elder abuse. Refer to Section 3904.1 regarding elder abuse and neglect.~~

~~7. Aging and Disability Services Division (ADSD):~~

~~Maintains compliance with the Interlocal Agreement with DHCFP to operate the AL Waiver.~~

~~8. Assisted Living Providers:~~

~~a. Providers are responsible for maintaining certification, including the use of tax credits, as an assisted living facility in accordance with the provisions of NRS 319.147.~~

~~b. Training:~~

~~1. Assisted Living providers must arrange training for employees who have direct contact with the AL Waiver recipients. Assisted Living staff providing direct care and support to residents will be trained in the functional care skills needed to care for each recipient. Training will include, but not be limited to, techniques such as transfers, mobility, positioning, use of special equipment, identification of signs of distress, First Aid and cardiopulmonary resuscitation (CPR).~~

~~2. Within 60 days of employment, the Assisted Living staff must receive not less than 4 hours of training related to the care of the residents. Additionally, Assisted Living staff must receive annually not less than eight (8) hours of training related to providing for the needs of the residents of the Assisted Living facility.~~

~~3. If an Assisted Living staff assists a resident of the Assisted Living facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must receive training in medication administration/management. The training must include not less than three (3) hours of instruction in medication administration/management. The caregiver must receive such training at least every three (3) years, and must provide the facility with the documentation that the training requirements were satisfactorily met.~~

~~For more information regarding qualifications and training for caregivers in a residential/assisted living facility, refer to NAC 449.196.~~

~~c. Interpersonal and communication skills and appropriate attitudes for working effectively with recipients including: understanding care goals; respecting recipient's rights and needs; respect for age, cultural and ethnic differences; recognizing family relationships; respecting personal property; ethics in dealing with the recipient, family and other providers; handling conflicts and complaints and other topics that are pertinent.~~

~~d. Assisted Living staff providing direct care and support to recipients must: be at least 18 years of age, be responsible, mature, and have the personal qualities enabling him or her to understand the problems of the aged and disabled; demonstrate the ability to read, write, speak and understand the English language; possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the Assisted Living facility; and must be knowledgeable about the use of any prosthetic devices or dental, vision, or hearing aids that the recipient is using.~~

~~e. Tuberculosis Testing:~~

~~Providers are responsible for ensuring that their employees complete either a QuantiFERON® TB Gold blood test (QFT-G) or a two step (TB) Tuberculin skin test prior to initiation of services for the AL Waiver recipients. Thereafter, each employee must receive a QFT-G blood test or a one step TB skin test annually, prior to the expiration of the initial test. If the employee has a documented history of a positive QFT-G or TB skin test (+10 mm induration or larger), the employee must have clearance by a chest X-ray prior to initiation of services for the AL Waiver recipients.~~

~~If the employee has been medically cleared after a documented history of a positive QFT-G or TB skin test which was 10 mm or larger and then by chest X-ray, the employee must have documentation annually which demonstrates no signs or symptoms of active tuberculosis. The annual screening for signs and symptoms must address each of the following areas of concern and must be administered by a qualified health care provider.~~

~~1. Has had a cough for more than 3 weeks;~~

~~2. Has a cough which is productive;~~

~~3. Has blood in his sputum;~~

~~4. Has a fever which is not associated with a cold, flu or other apparent illness;~~

~~5. Is experiencing night sweats;~~

~~6. Is experiencing unexplained weight loss; or~~

~~7. Has been in close contact with a person who has active tuberculosis.~~

~~Annual screening for signs and symptoms of active disease must be completed prior to the one year anniversary of the last screening. Documentation of the annual screening and the results must be maintained in the employee's file.~~

~~Documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test, signed by the physician or his/her designee, stating the date of the test, the date the test was read, and the results, and maintained in the employee's file. Any lapse in the required timelines above results in non-compliance with this section.~~

~~3903.3C RECIPIENT RESPONSIBILITIES~~

~~The recipient or the recipient's authorized representative will:~~

~~1. Notify the Assisted Living provider and case manager of any change in Medicaid eligibility;~~

~~2. Notify the provider and case manager of current insurance information, including the name of the insurance coverage, such as Medicare;~~

~~3. Notify the provider and case manager of changes in medical status, service needs, address or location changes, and/or any change in status of legally responsible individual or authorized representative;~~

~~4. Treat all staff and providers appropriately;~~

~~5. Notify the provider and/or case manager of any unusual occurrences or complaints regarding delivery of services, specific staff, or to request a change in caregiver or provider agency;~~

~~6. Complete, sign and submit all required forms;~~

~~7. Not request any provider to perform services not outlined and authorized in the POC; and~~

~~8. Furnish the provider with a copy of any existing advance directives.~~

~~3903.4 DIRECT SERVICE CASE MANAGEMENT~~

~~3903.4A COVERAGE AND LIMITATIONS~~

~~Direct service case management is provided to eligible recipients in the AL Waiver when case management is identified as a service on the POC. The recipient has a choice of direct service case management provided by ADSD staff, an agency or an independent private provider, who are enrolled as Medicaid providers with the QIO-like vendor. These services include:~~

~~1. Identification of resources and assisting recipients in locating and gaining access to waiver services, as well as medical, social, educational and other services regardless of the funding source;~~

~~2. Monitoring the overall provision and quality of care of waiver services, in order to protect the health, welfare and safety of the recipient, and to determine that the POC goals are being met;~~

~~3. Making certain that the recipient retains freedom of choice in the provision of services;~~

~~4. Notifying all affected providers of changes in the recipient's medical status, services' needs, address and location or changes on the status of legally responsible individual or authorized representative;~~

~~5. Notifying all affected providers of any unusual occurrence or change in the recipient's health status;~~

~~6. Notifying all affected providers of any recipient complaints regarding delivery of service or specific provider staff;~~

~~7. Notifying all affected providers if a recipient requests a change in the provider staff or provider agency;~~

~~8. Coordination of multiple service/providers;~~

~~9. Case Managers must provide recipients with an appropriate amount of case management services to ensure the recipient is safe and receives sufficient services. Case management is considered an "as needed" service. The case manager is to have monthly contact with each recipient or recipient's authorized representative or legally responsible individual at least 15 minutes per recipient, per month. The amount of case management services billed to the DHCFP must be adequately documented and substantiated by the case manger's notes. This may be a telephone contact;~~

~~10. There must be a face to face contact in the place of residence where services are provided to each recipient at least every three months or more often if the recipient has indicated a significant change in his or her health care status or if he or she is concerned about health or safety issues. When a recipient service needs increase due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The POC does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days;~~

~~11. During the monthly contact, the case manager assesses the recipient's satisfaction with services and determines if there are any issues with the service provision. The case manager also assesses the need for any changes in services or providers and determines whether the services are promoting the goal(s) stated on the POC, and communicates this information to the ADSD administrative case manager.~~

~~3903.4B DIRECT SERVICE CASE MANAGEMENT PROVIDER RESPONSIBILITIES~~

~~In addition to all provider responsibilities listed on Section 3903.3B:~~

~~1. Providers must meet and maintain the minimum qualifications per the State of Nevada Board of Examiners for Social Workers and the Nevada Board of Nursing for Registered Nurses.~~

~~2. Providers must have the ability to conduct home visits. If applicable, Provider Agency must have a business license as required by city, county or state government.~~

~~3. Case managers must have one year of experience working with seniors in a home based environment. The case manager does not have to have this experience if the agency supervisor or administrator who supervises the case manager meets these qualifications.~~

~~4. Provide evidence to DHCFP of a State/FBI criminal history background check.~~

~~5. Conform to HIPAA of 1996 requirements.~~

~~3903.4C RECIPIENT RESPONSIBILITIES~~

~~**1.** Each recipient and/or his or her authorized representative must cooperate with the implementation of services and the implementation of the POC.~~

~~2. Each recipient is to comply with the rules and regulations of the:~~

~~a. Assisted Living facility;~~

~~b. ADSD;~~

~~c. DWSS;~~

~~d. DHCFP; and~~

~~e. AL Waiver.~~

~~3903.5 AUGMENTED PERSONAL CARE SERVICES~~

~~3903.5A COVERAGE AND LIMITATIONS~~

~~1. Augmented personal care services provided in an AL facility include assistance with the basic self-care and ADLs, homemaker, chore, companion services, medication oversight (to the extent permitted under state law), therapeutic social and recreational programming, and services which will ensure that the residents of the facility are safe, secure, and adequately supervised.~~

~~2. The AL facility provides 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides supervision, safety and security.~~

~~3. Other individuals or agencies may also furnish care directly, or under arrangement with the assisted living facility, but the care provided by these other entities supplements that provided by the assisted living facility and does not supplant it. The AL facility is the only entity that can enroll as a Medicaid provider and bill for the AL Waiver services.~~

~~4. There are three levels of augmented personal care. The level provided is based on the recipient's functional needs to ensure his or her health, safety and welfare in the assisted living facility. Qualified administrative case managers determine the service level and prior authorization for services as an administrative function.~~

~~a. Level One - Provides supervision and cueing to monitor the quality and completion of basic self-care and activities of daily living. Some basic self-care services may require minimal hands-on assistance. This is not a skilled level service, so the ability of the recipient to swallow must be intact. This service level provides laundry services once a week, basic weekly homemaking, assistance with grocery shopping, and community access. This service also provides access to social and recreational programs. This service provides indirect supervision when direct care tasks are not being completed.~~

~~b. Level Two - Provides minimal physical assistance with completion of basic self-care and activities of daily living. Some basic self-care may require a moderate level of assistance. This service level provides laundry services twice a week if needed, daily assistance with homemaking related to self-care, assistance with grocery shopping, and community access. This service provides once daily assistance with in-apartment meal preparation if requested. This service also provides access to and physical assistance with social and recreational programs, and provides indirect supervision with regularly scheduled checks when direct care tasks are not being completed.~~

~~c. Level Three - Provides moderate physical assistance with all basic self-care needs. Some basic self-care may require a maximal level of assistance. This service includes assistance with feeding, if needed. This is not a skilled level service, so the recipient's ability to swallow must be intact. This service level provides laundry service, including changing of linens daily if needed. It includes daily homemaking for clean up after basic self-care tasks and weekly homemaking for general cleaning. This service provides completion of or assistance with grocery shopping and community access. If requested, this service provides up to twice daily assistance with in-apartment meal preparation, access to and physical assistance with social and recreational programs, and direct supervision or safety systems to ensure participant safety when supervision is not direct.~~

~~5. Federal Financial Participation (FFP) is unavailable to subsidize the cost of room and board.~~

~~3903.5B AUGMENTED PERSONAL CARE SERVICES PROVIDER RESPONSIBILITIES~~

~~In addition to provider responsibilities listed in Section 3903.3B:~~

~~1. Maintain licensure and standards as outlined by the Health Division, HCQC under NRS 449.037 (Adoption of Standards, Qualifications and other Regulations).~~

~~2. Maintain certification from the Department of Business and Industry, Nevada Housing Division.~~

~~3. An AL provider may not impose additional fees on the recipient for services covered by Medicaid.~~

~~a. Before authorizing a recipient to move into the facility, the facility must make a full written disclosure to the recipient, regarding what services of personalized care will be available to the recipient and the amount that will be charged for those services throughout the resident's stay at the facility.~~

~~b. The assisted living environment must evidence a setting that provides:~~

~~c. The residents of the facility reside in their own living units which:~~

~~1. contain private toilet facilities;~~

~~2. contain a sleeping area or bedroom;~~

~~3. include a kitchenette; and~~

~~4. are shared with another occupant only upon consent of both occupants.~~

~~d. The facility provides personalized care to the residents of the facility and the general approach to operating the facility incorporates these core principles:~~

~~1. The facility is designed to create a residential environment that actively supports and promotes each resident's quality of life and right to privacy;~~

~~2. The facility is committed to offering high-quality supportive services that are developed by the facility in collaboration with the resident to meet the resident's individual needs;~~

~~3. The facility provides a variety of creative and innovative services that emphasize the particular needs of each individual resident and his personal choice of lifestyle;~~
~~4. The operation of the facility and its interaction with its residents supports, to the maximum extent possible, each resident's need for autonomy and the right to make decisions regarding his or her own life;~~

~~5. The operation of the facility is designed to foster a social climate that allows the resident to develop and maintain personal relationships with fellow residents and with persons in the general community;~~

~~6. The facility is designed to minimize and is operated in a manner which minimizes the need for its residents to move out of the facility as their respective physical and mental conditions change over time; and~~

~~7. The facility is operated in such a manner as to foster a culture that provides a high-quality environment for the residents, their families, the staff, any volunteers and the community at large.~~

~~e. The assisted living provider must:~~

~~1. Notify the case manager within three working days when the recipient states that he or she wishes to leave the facility;~~
~~2. Participate with the case manager in discharge planning;~~

~~3. Notify the case manager within one working day if the recipient's living arrangements or eligibility status has changed or if there has been a change in his or her health status that could affect his or her health, safety or welfare;~~

~~4. Notify ADSD of any occurrence pertaining to a waiver recipient that could affect his or her health, safety or welfare;~~

~~5. Notify ADSD of any recipient complaints regarding delivery of service or specific Assisted Living facility staff;~~

~~6. Provide ADSD with at least a 30-day notice before discharging a recipient unless the recipient's condition deteriorates and warrants immediate discharge;~~

~~7. Be responsible for any claims submitted or payment received on the recipient's behalf; such claims shall be made under penalties of perjury. Any false claims, statement or documents, or concealment of material facts may be prosecuted under applicable federal or state laws;~~

~~8. Provide care to a newly placed recipient for a minimum of thirty (30) days unless the recipient's condition deteriorates and warrants immediate discharge;~~

~~9. Conduct business in such a way that the recipient retains freedom of choice;~~

~~10. Comply with rules and regulations for providers as set forth in Medicaid Services Manual Chapter 100;~~

~~11. Provide assisted living services to AL Waiver eligible recipients in accordance with the recipient's POC, the rate, program limitations and procedures of the DHCFP;~~

~~12. Not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the AL Waiver except by written consent of the recipient, his or her authorized representative or legally responsible individual;~~

~~13. Have sufficient number of caregivers present at the facility to conduct activities and provide care and protective supervision for the residents;~~
~~14. Provide at least one caregiver on the premises of the facility if one or more residents are present;~~

~~15. Not use Medicaid waiver funds to pay for the recipient's room and board. The recipient's income is to be used to cover room and board costs;~~

~~16. Comply with Medicaid regulations in accepting Medicaid payment as payment in full for services rendered, and not contacting the recipient or members of the recipient's family for additional sums related to those services. (MSM Chapter 100);~~

~~17. Not bill for services when the recipient is not in the facility or is in suspended status with the AL Waiver ; and~~

~~18. Comply with ADSD Assisted Living provider qualifications and standards per Appendix C-1/C-3: "Provider specification for Service" of the approved waiver.~~

~~3903.5C RECIPIENT RESPONSIBILITIES~~

~~1. Recipients are to cooperate with the AL facility in the delivery of services.~~

~~2. Recipients are to report any problems with the delivery of AL services to the AL facility administrator and the case manager.~~

~~3903.6 INTAKE PROCEDURES~~

~~ADSD has developed procedures to ensure fair and adequate access to the AL Waiver services.~~

~~3903.6A COVERAGE AND LIMITATIONS~~

~~1. Slot Provision:~~

~~a. The allocation of waiver slots is maintained by ADSD Central Office, with sub-lists maintained at each local ADSD office. ADSD determines the number of slots allocated to each local ADSD office.~~

~~b. If an AL Waiver recipient voluntarily or involuntary terminates from the waiver and then at a later date wants to reapply for the waiver, the following will be taken into consideration:~~

~~1. If the termination took place 90 days or less prior to the request for reinstatement, the recipient will be reinstated on the AL Waiver providing:~~

~~a. The request is within the same waiver year.~~

~~b. The recipient meets all requirements for waiver eligibility.~~

~~2. If the termination took place in a prior waiver year, the following is taken into consideration for reinstatement onto the AL Waiver:~~

~~a. Slot availability;~~

~~b. Emergent need; and~~

~~c. The recipient meets all waiver eligibility requirements.~~

~~If the recipient is eligible for reauthorization of waiver services, the administrative case manager will forward all necessary forms to the DHCFP Central Office Waiver Unit for approval. Recipients must cooperate with the reauthorization process.~~

~~2. Referral To AL Waiver:~~

~~a. A referral or inquiry for the waiver may be made by a potential applicant or by another party on behalf of the potential applicant by contacting any ADSD office.~~

~~b. If the applicant is not currently a Medicaid recipient, information is provided regarding the Medicaid eligibility process.~~

~~c. Even if the applicant does not appear to meet the functional eligibility criteria for the AL Waiver, he or she must be informed of the right to continue the Medicaid application process through DWSS and, if still deemed ineligible, the right to a fair hearing through DWSS.~~

~~3. Wait List:~~

~~a. If the case manager informs ADSD that the applicant appears to meet functional eligibility criteria and no waiver slots are available, the applicant is placed on the AL Waiver Wait List.~~
~~b. At the time of Wait List placement, applicants are notified by ADSD of other options that may be available, such as other HCBW services.~~

~~c. If it has been determined that no slot is expected to be available within the 90 day determination period, ADSD will notify DHCFP Central Office Waiver Unit to deny the application due to no slot available and send out a NOD stating the reason for the denial. The applicant will remain on the waiting list.~~

~~4. Waiver Slots Available:~~

~~Once a waiver slot is available, the applicant is allowed the right to choose waiver services in lieu of placement in a nursing facility. If the applicant or authorized representative or legally responsible individual prefers placement in a nursing facility, the case manager will assist the applicant in arranging for nursing facility placement. The applicant has the right to request a hearing if not given a choice between AL Waiver services and nursing facility placement.~~

~~5. Effective Date For AL Waiver Services:~~

~~The effective date for AL Waiver service approval is the completion date of all the required forms in the application packet, the Assisted Living facility move-in date, or the Medicaid eligibility date, whichever date is last. If the applicant is in an institution, the effective date cannot be before the date of discharge from the institution.~~

~~6. AL Waiver Per Capita Expenditures:~~

~~DHCFP must assure CMS that the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the institutional level of care under the Medicaid State Plan that would have been made in that fiscal year, had the waiver not been granted.~~

~~3903.6B DENIAL OF AL WAIVER APPLICATION~~

~~Basis of denial for waiver services:~~

~~1. The applicant is under the age of 65 years.~~

~~2. The applicant does not meet the level of care criteria for nursing facility placement, i.e. the applicant would not require nursing facility placement if AL Waiver services were not available.~~

~~3. The applicant has withdrawn his or her request for waiver services.~~

~~4. The applicant fails to cooperate with his or her case manager in establishing the POC or verifying eligibility for waiver services.~~

~~5. The applicant fails to cooperate with his or her administrative case manager or assisted living service provider in implementing the POC.~~
~~6. The case manager, ADSD, DHCFP, or DWSS has lost contact with the applicant.~~

~~7. The applicant fails to show a need for AL Waiver services.~~

~~8. The applicant has moved out of state.~~

~~9. Another agency or program will provide the services.~~

~~10. ADSD has filled the number of slots allocated to the AL Waiver. The applicant will be placed on the waiver wait list and will be contacted when a slot is available.~~

~~11. There is no Assisted Living facility where the applicant can be placed appropriately and safely. The applicant will be referred to other services.~~

~~12. The applicant is in an institution (e.g. hospital, nursing facility, ICF/MR) and discharge within 45 days is not anticipated.~~

~~13. The applicant has been placed in an Assisted Living facility that does not have a provider agreement with the DHCFP.~~

~~14. The applicant chooses to remain at home.~~

~~When an application for waiver services is denied, the case manager will send a Notice of Action (NOA) to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the applicant or the applicant's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been denied and the reason for the denial.~~

~~3903.6C SUSPENDED WAIVER SERVICES~~

~~1. If it is likely the recipient will be eligible again for waiver services within the next 60 days (for example, if a recipient is admitted to a hospital or nursing facility), a recipient's case is suspended and not closed.~~

~~2. An Assisted Living facility is not paid for services on the days that a recipient's case is suspended.~~

~~3. If at the end of 45 days the recipient has not been removed from suspended status, the case is closed and the recipient is removed from the waiver.~~

~~When waiver services are suspended, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been suspended and the reason for the suspension.~~

~~4. Release From Suspended Waiver Services:~~

~~If a recipient has been released from the hospital or nursing facility before 60 days of suspension of waiver services, within five working days, the administrative case manager must:~~

~~a. Complete a new LOC assessment if there has been a significant change in the recipient's condition;~~

~~b. Complete a reassessment if there has been a significant change in the recipient's condition or status;~~

~~c. Complete a new POC if there has been a change in medical, social or waiver services expected to last longer than 30 days.~~

~~d. ADSD will coordinate with the case manager and contact the Assisted Living facility to reestablish services.~~

~~3903.6D REDUCTION OF WAIVER SERVICES~~

~~A waiver service or services are reduced when:~~

~~1. The recipient no longer needs the previously provided level of waiver service(s).~~

~~2. The recipient's support system is providing the service(s).~~

~~3. The recipient has failed to cooperate with the case manager or the Assisted Living provider in establishing and/or implementing the POC, implementing waiver service(s) or verifying eligibility for waiver service(s).~~

~~4. The recipient has requested a reduction in service(s).~~

~~5. The recipient's ability to perform activities of daily living has improved.~~

~~6. Another agency or program will provide the service(s).~~

~~When waiver services are reduced, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that waiver services have been reduced and the reason for the service reduction.~~

~~3903.6E TERMINATION OF AL WAIVER SERVICES~~

~~A recipient will be terminated from the AL Waiver services if:~~

~~1. The recipient does not meet the level of care criteria for nursing facility placement;~~

~~2. The recipient would not require nursing facility placement if home and community-based services were not available;~~

~~3. The recipient has requested termination of waiver services;~~

~~4. The recipient fails to cooperate with the case manager or the Assisted Living provider in establishing and/or implementing waiver services;~~

~~5. The recipient's swallowing ability is not intact and requires skilled service for safe feeding/nutrition;~~

~~6. The recipient fails to show a need for the AL Waiver services;~~

~~7. The recipient has moved out of state;~~

~~8. Another agency or program will provide the services;~~

~~9. The recipient has been placed in an Assisted Living facility that is not a Medicaid provider;~~

~~10. The recipient chooses to return to independent community living;~~

~~11. The recipient does not qualify for the AL Waiver services because of institutionalization (e.g. hospital, nursing facility, correctional, ICF/MR), and discharge within 60 days is not anticipated at this time; and~~

12. The case manager, ADSD, DHCFP or DWSS has lost contact with the recipient.

When waiver services are terminated, the case manager will send a NOA to the DHCFP Central Office Waiver Unit. The DHCFP Central Office Waiver Unit will then send a NOD to the recipient or the recipient's authorized representative or legally responsible individual, via the DHCFP Hearings Unit, informing them that the waiver services have been terminated and the reason for the termination.

When a termination of waiver services is due to the death of a recipient, any agency receiving this information will notify appropriate agencies of the date of death. No NOD is sent.

3903.7 BILLING PROCEDURES

The State assures that claims for payment of waiver services are made only when an individual is Medicaid eligible, when the service is included in the approved POC or Service Plan, and prior authorization is in place when indicated.

3903.7A COVERAGE AND LIMITATIONS

All providers (Provider Type 59) for the AL Waiver must submit claim forms to DHCFP's Fiscal Agent. Claims must meet the requirements in the CMS-1500 Claim Form. Claims must be complete and accurate. Incomplete or inaccurate claims will be returned to the provider by DHCFP's fiscal agent. If the wrong form is submitted it will also be returned to the provider by DHCFP's fiscal agent.

3903.7B PROVIDER RESPONSIBILITIES

In addition to the provider responsibilities listed in Section 3903.3B:

1. Providers must refer to the QIO-like vendor Provider Billing Procedure Manual for detailed instructions for completing the CMS-1500 form.

2. Providers must maintain documentation to support claims billed for a minimum of 6 years from the date of service.

3903.8 ADVANCE DIRECTIVES

Section 1902(w) of the Social Security Act requires licensed agencies providing personal care services to give their clients information about their decision-making rights about health care, declarations (living wills), and durable powers of attorney for health care decisions. Refer to MSM Chapter 100.

~~3903.9 DHCFP ANNUAL REVIEW~~

~~DHCFP has in place a formal system in which an annual review of all AL Waiver service providers is conducted, assuring the health and welfare of the individuals served by AL Waiver service providers, the recipient's satisfaction with services, and the cost effectiveness of these services.~~

~~The review:~~

~~a. Provides CMS annually with information on the impact of the waiver on the type, amount, and cost of services provided under the AL Waiver and the Medicaid State Plan. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of the recipients served on the waiver;~~

~~b. Assures financial accountability for funds expended for home and community-based services;~~

~~c. Evaluates all provider standards are continuously met, and the POC are reviewed to assure that the services furnished are consistent with the documented needs of the recipients;~~

~~d. Evaluates the recipient's satisfaction with the AL Waiver services; and~~

~~e. Further assures that all problems identified by the review will be addressed in an appropriate and timely manner, consistent with the severity and nature of any deficiencies.~~

~~3903.9A PROVIDER RESPONSIBILITIES~~

~~Providers must cooperate with DHCFP's annual review process.~~

~~3903.9B RECIPIENT RESPONSIBILITIES~~

~~Recipients and/or legally responsible individual must cooperate with DHCFP's annual review process.~~

~~3904 APPEALS AND HEARINGS~~

~~Refer to MSM, Chapter 3100, for specific instructions regarding notice and recipient hearings.~~

~~3904.1 ELDER ABUSE~~

~~All members of the ADSD staff, waiver services case managers, and employees of the Assisted Living facility are mandatory reporters of suspected elder abuse. NRS 200.5093 states that anyone "who, in his professional or occupational capacity, knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated…" must report the abuse, exploitation, neglect (including self-neglect) or isolation to the Elder Rights Unit of the ADSD, the local police department or the county's protective services unit in Clark County (if the suspected action occurred in Clark County). This applies to all employees of the ADSD. This report must be made as soon as possible, but no later than 24 hours after the Division employee knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated. NRS 200.5093(1)(b).~~

~~a. For the purposes of elder protective services, abuse means willful:~~

~~1. Infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;~~

~~2. Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person.~~

~~b. Neglect means the failure of:~~

~~1. A person who has assumed legal responsibility or a contractual obligation for caring for an older person, or who has voluntarily assumed responsibility for his or her care, to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person, or~~

~~2. An older person to provide for his or her own needs because he or she is unable to do so. (NRS 200.5091-200.50995 et seq.)~~

~~c. Exploitation means any act taken by a person who has the trust and confidence of an older person or any use of the power of attorney or guardianship of an older person to obtain control, through deception, intimidation or undue influence, over the older person's money, assets, or property with the intention of permanently depriving the older person of the ownership, use, benefit or possession of his or her money, assets or property. As used in this subsection, undue influence does not include the normal influence that one member of a family has over another. (NRS 200.5091-200.50995 et seq.)~~

~~d. Isolation means willfully, maliciously and intentionally preventing an older person from having contact with another person by:~~

~~1. Intentionally preventing the older person from receiving his or her visitors, mail or telephone calls, including, without limitation, communicating to a person who comes to visit the older person or a person who telephones the older person that the older person is not present or does not want to meet with or talk to the visitor or caller, knowing that the statement is false, contrary to the express wishes of the older person and intended to prevent the older person from having contact with the visitor; or,~~

~~2. Physically restraining the older person to prevent the older person from meeting with a person who comes to visit.~~

~~The term does not include an act intended to protect the property or physical or mental welfare of the older person or an act performed pursuant to the instructions of a physician who is treating the older person. (NRS 200.5091-200.50995)~~

~~It is Division policy that any life-threatening elder abuse must be reported by Division staff to the Elder Rights Unit immediately, either by telephone, in person, or in writing.~~

~~Any person making a good faith report of suspected elder abuse is immune from civil or criminal liability for reporting. (NRS 200.5096)~~

~~NRS 200.5093 (9) provides that anyone who knowingly and willfully violates the mandatory reporting law is guilty of a misdemeanor.~~

~~Recipient safeguards include initiation of investigation by local law enforcement and/or Elder Protective agency, provision of protective services to the older person if they are able and willing to accept them. If the person who is reported to have abused, neglected, exploited or isolated an older person or a vulnerable person is the holder of a license or certificate issued pursuant to chapters 449, 630 to 641B, inclusive, or 654 of NRS, information contained in the report must be submitted to the board that issued the license.~~

~~Any employee of the ADSD who knows or should have known that an elderly person is being abused, neglected, exploited or isolated and does not report this to the Elder Rights Unit, Clark County Protective Services (if the suspected action occurred in Clark County), or to law enforcement is subject to disciplinary action, including possible termination. Additionally, the licensing board for any professional employee who fails to report suspected elder abuse would be notified.~~

~~The HCQC also receives complaints regarding the facilities they license. ADSD staff receives training regarding the role of the HCQC and how to make appropriate referrals for investigation when events occur that may be considered licensing infractions.~~

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 26, 2021

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JESSICA KEMMERER, HIPAA PRIVACY AND CIVIL RIGHTS OFFICER /Jessica Kemmerer/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 4000 – 1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 4000 – 1915(i) Home and Community Based Services State Plan Option Intensive In-Home Services and Crisis Stabilization are being proposed being proposed to include an additional care coordination model, Safety Assessment Family Evaluation (SAFE), to be utilized by the local county agencies when evaluating individuals to be eligible for these services.

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: This proposed change affects all Medicaid-enrolled providers delivering Intensive In-Home Supports and Services and Crisis Stabilization Services. Those provider types include but are not limited to Specialized Foster Care Services – Provider Type 86.

Financial Impact on Local Government: The financial impact on local government is unknown at this time.

These changes are effective January 27, 2021.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 04/21 1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION	MTL New 1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates

4003.1A	**NEEDS BASED ELIGIBILITY CRITERIA**	Replace Case Manager/Wraparound Facilitator with Care Coordinator
4003.3F(1)(d)	**DOCUMENTATION STANDARDS**	Moved to d. from e.
4003.3F(1)(e)		Added additional care coordination model, SAFE
4003.3F(1)(f)		Added additional clarifying language to define Care Coordinator
4003.3F(1)(g)		Moved to g. from d.
4003.3F(1)(h)		Replace CM and WF with Care Coordinator
4003.3F(2)(a)	**PERSON CENTERED PLAN OF CARE**	Replace CM/WF with Care Coordinator
4003.3F(2)(d)		Replace CM/WF with Care Coordinator
4003.3G(1)	**RECIPIENT RESPONSIBILITIES**	Replace CM/WF with Care Coordinator
4003.3G(2)		Replace CM/WF with Care Coordinator
4003.3G(4)		Replace CM/WF with Care Coordinator
4003.3G(5)		Replace CM/WF with Care Coordinator
4003.3G(7)		Replace CM/WF with Care Coordinator

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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1915(i) HCBS STATE PLAN OPTION INTENSIVE IN-HOME SERVICES AND CRISIS STABILIZATION

4000 INTRODUCTION

Under Section 1915(i) of the Social Security Act (SSA) states can provide Home and Community-Based Services (HCBS) to individuals who require less than institutional level of care and therefore would otherwise not be eligible for such services through a 1915(c) HCBS Waiver.

Specifically, Section 1915(i) of the Act allows the Nevada Division of Health Care Financing and Policy (DHCFP) to provide State Plan HCBS similar to that of a 1915(c) HCBS Waiver using a needs-based eligibility criterion rather than an institutional level of care criteria. Additionally, a 1915(i) HCBS State Plan Option has no cost neutrality requirement as required under a 1915(c) HCBS Waiver. This significant distinction affords the Nevada DHCFP the opportunity to offer HCBS to recipients whose needs are substantial but are not severe enough to qualify them for institutional or waiver services.

4001 AUTHORITY

Section 6086 of the Deficit Reduction Act, added Section 1915(i) to the SSA, allowing states the option to offer home and community-based services previously only available through a traditional 1915(c) Waiver.

Statutes and Regulations:

- Social Security Act: 1915(i) (1)(a) through (j)
- Code of Federal Regulations (CFR)
    - 42 CFR 441.710 State Plan Home and Community-Based Services under Section 1915(i)(1) of the Act
    - 42 CFR 441.715 Needs-Based Criteria and Evaluation
    - 42 CFR 441.720 Independent Assessment
    - 42 CFR 441.725 Person-Centered Service Plan
    - 42 CFR 441.730 Provider Qualifications
- Nevada Revised Statutes (NRS) Chapter 424
- Nevada Administrative Code (NAC) Chapter 424

4002 RESERVED

4003 POLICY

4003.1 NEEDS BASED ELIGIBILITY CRITERIA

The DHCFP 1915(i) Home and Community-Based Services (HCBS) State Plan Option utilizes a needs-based criteria to evaluate and reevaluate whether an individual is eligible for services. The criteria considers the individual's support needs and risk factors.

Children/youth must need minimum requirements to be considered for 1915(i) services:

A. Impaired Functioning & Service Intensity: The Care Coordinator and Child and Family Team (CFT) will use a comprehensive biopsychosocial assessment and the level of care decision support tools the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination; and must demonstrate a minimum CASII or ECSII level of 1; and

B. Other Community Alternatives: The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the Division of Child and Family Services (DCFS) or its designee as evidenced by at least one of the following risk factors:

1. At risk of higher level of care placement due to recent placement disruption within the past six months;

2. Current placement in emergency shelter or congregate care due to behavioral and mental health needs;

3. In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or

4. At risk of higher level of care placement because prior less restrictive placements or interventions, such as traditional family foster care and/or community treatment services, have not been successful.

4003.2 COVERAGE AND LIMITATIONS

A. PROGRAM ELIGIBILITY

1. A youth must meet and maintain Medicaid eligibility.

2. Youth must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit through age 19.

3. Youth must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

4. A youth must meet the needs-based eligibility requirements.

5. The youth must reside in the Nevada licensed specialized foster home-based setting not considered an institutional level setting.

B. COVERED SERVICES

1. Intensive In-Home Supports and Services

2. Crisis Stabilization Services

C. NON-COVERED SERVICES

The following services are not covered benefits under 1915(i) HCBS State Plan option and are therefore not reimbursable:

1. Services rendered to a youth who is not eligible for Nevada Medicaid.

2. Services rendered to a youth who no longer meets the needs-based eligibility criteria.

3. Services rendered to a youth who is no longer in the Nevada licensed specialized foster home-based setting but is institutionalized (hospital, residential treatment center, or detained/incarcerated).

4. Services rendered to an individual over the age of 19.

5. Services rendered to an individual over the age of 18 and not enrolled in high school.

6. Services rendered to a youth for which the State of Nevada or county child welfare jurisdiction; Clark County Department of Family Services (CCDFS), Washoe County Human Services Agency (WCHSA) is no longer the legal custodian and who are no longer admitted in the specialized foster care program.

7. Services rendered to a youth that does not have a Diagnostic and Statistical Manual of Mental Disorders (DMS-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

4003.3 PROVIDER RESPONSIBILITIES

A. PROVIDER QUALIFICATION

In addition to this chapter, providers must also comply with rules and regulations for providers as set forth in the MSM Chapter 100. Each 1915(i) service outlines specific provider qualifications which must be adhered to in order to render that 1915(i) service.

B. MEDICAID ELIGIBILITY

All providers must verify each month continued Medicaid eligibility for each recipient. This can be accomplished by utilizing the electronic verification system (EVS) or contacting the eligibility staff at the welfare office hotline. Verification of Medicaid eligibility is the sole responsibility of the provider.

C. HIPAA, PRIVACY, AND CONFIDENTIALITY

Refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records, and other Protected Health Information (PHI).

D. NOTIFICATION OF SUSPECTED ABUSE OR NEGLECT

State law requires that persons employed in certain capacities must make a report to the appropriate agency immediately, but in no event later than 24 hours after there is reason to suspect abuse or neglect. The DHCFP expects that all providers be in compliance with the intent of all applicable laws.

E. SERIOUS OCCURRENCE REPORT (SOR)

Child welfare jurisdictions and agencies shall adhere to the requirements of NAC 424.476 in reporting any serious incident, accident, or injury to a child involving a foster home, or a child in a foster home to the licensing authority and any caseworker assigned to the child. Jurisdictions/agencies should refer to NAC 424.476 in determining specific incidents, accidents, and injuries that must be reported.

F. DOCUMENTATION STANDARDS

1. Assessment

   a. There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

   b. Based on the independent assessment, there is a person-centered plan of care for each individual determined to be eligible for the State plan HCBS benefit. The person-centered plan of care is developed using a person-

centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered plan of care meets federal requirements at 42 CFR §441.725(b).

c. The person-centered plan of care is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly and at the request of the individual.

d. All Wraparound Facilitators (WF) will be required to be certified by the DCFS as a WF utilizing the standards of the National Wraparound Implementation Center. All Care Managers (CM) will be required to be trained by the DCFS in the FOCUS model utilizing the standards of the National Wraparound Implementation Center.

e. All Case Workers (CW) will be trained in the Safety Assessment Family Evaluation (SAFE) model by local county agencies.

f. The term Care Coordinator will be used to encompass either the Child Welfare agency Case Worker or the DCFS Care Manager/Wraparound Facilitator.

g. The Care Coordinators must be independent of the Specialized Foster Care Agency.

h. All Care Coordinators will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS). Recipients will receive services of CW, CM, or WF based on level of need.

2. Person-centered Plan of Care (POC)

a. The development of the person-centered POC will focus on a strengths and needs-driven approach that provides intensive care management in a team setting using a Child and Family Team (CFT) approach. The CFT team includes the Care Coordinator, child or youth, caregiver(s), support persons identified by the family (paid and unpaid), and service providers, including the youth's treating clinician as available.

b. The process is designed to promote youth and parent involvement as active members of the CFT. The goals of CFT meetings are to manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a team approach to address needs. Youth and parent/guardian involvement is essential in the assessment of: safety;

strengths; medical, social, behavioral, educational and cultural needs; skill building; family/caregiver supports and services; and goals.

c. The Care Coordinator will utilize assessments to create the person-centered POC for children and families. The plan will include needs, outcomes, and strategies that are:

1. Specific. The CFT, including the family should know exactly what must be completed or changed and why.

2. Measurable. Everyone should know when the needs have been met. Outcomes will be measurable to the extent that they are behaviorally based and written in clear and understandable language.

3. Achievable. The CFT and family should be able to meet the identified needs in a designated time period given the resources that are accessible and available to support change.

d. The person-centered POC will include detailed service plans for applicable 1915(i) services. The CFT shall develop the initial POC, which will be documented by the Care Coordinator. The Care Coordinator will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance to timeframes as listed in DCFS policy.

3. Progress Notes: Progress notes for all Behavioral Health services including Rehabilitative Mental Health (RMH) and Outpatient Mental Health services are the written documentation of treatment services, or service coordination provided to the recipient pursuant to the Treatment Plan, which describes the progress, or lack of progress towards the goals and objectives of the Treatment Plan.

a. All progress notes documented with the intent of submitting a billable Medicaid behavioral health service claim must be documented in a manner that is sufficient to support the claim and billing of the services provided and must further document the amount, scope, and duration of the service(s) provided as well as identify the provider of the service(s).

b. A Progress Note is required for each day the service was delivered, must be legible and must include the following information:

1. The name of the individual receiving the service(s). If the services are in a group setting, it must be indicated;

2. The place of service;

3. The date the service was delivered;

4. The actual beginning and ending times the service was delivered;

5. The name of the provider who delivered the service;

6. The credentials of the person who delivered the service;

7. The signature of the provider who delivered the service;

8. The goals and objectives that were discussed and provided during the time the services were provided; and

9. A statement assessing the recipient's progress towards attaining the identified treatment goals and objectives requested by the treatment team.

c. Temporary, but clinically necessary, services do not require an alteration of the treatment plan; however, these types of services, and why they are required, must be identified in a progress note. The note must follow all requirements for progress notes as stated within this section.

G. RECIPIENT RESPONSIBILITIES

Individuals receiving 1915(i) services are entitled to their privacy, to be treated with respect and be free from coercion and restraint.

The recipient or the custodian of the child will:

1. Notify the provider(s) and Care Coordinator of a change in Medicaid eligibility.

2. Notify the provider(s) and Care Coordinator of changes in medical status, service needs, or changes of status of designated representative.

3. Initial and/or sign the provider service documentation logs as applicable, verifying services were rendered unless otherwise unable to perform this task due to cognitive and/or physical limitations.

4. Notify the Care Coordinator if services are no longer requested or required.

5. Notify the provider(s) and the Care Coordinator of unusual occurrences, complaints regarding delivery of services or specific staff.

6. Not request a provider(s) to perform services not authorized in the plan of care.

7. Contact the Care Coordinator to request a change of provider.

4003.4 INTENSIVE IN-HOME SERVICES

4003.4A COVERAGE AND LIMITATIONS

1. Evidence-based interventions that target emotional, cognitive, and behavioral functioning within a variety of actual and/or simulated social settings. Activities and environments are designed to foster the acquisition of skills, building positive social behavior, and interpersonal competence. Services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with needed behavioral and physical health services and supports in the participant's person-centered services and support plans.

2. Regular support and technical assistance to the treatment parents in their implementation of the POC and with regard to other responsibilities they undertake. The fundamental components of technical assistance are the design or revision of in-home treatment strategies including proactive goal setting and planning, the provision of ongoing child-specific skills training, and the problem-solving during home visits.

3. Assessing behavioral problems and the functions of these problems and related skill deficits and assets, including identifying primary and other important caregiver skill deficits and assets related to the youth's behaviors and the interactions that motivate, maintain or improve behavior.

4. The amount, frequency, and duration of this service is based on the participant's assessed needs and documented in the approved POC. Eligible setting includes the child's home.

    a. Service Limitations: Intensive In-Home Services and Supports Without Coaching – Provided in-home by the treatment foster parent(s). Maximum of two hours per day, seven days a week.

5. Service Limitations: Intensive In-Home Services and Supports with Coaching – Provided in-home by a trained coach supporting the treatment foster parent(s) to deliver evidence-based interventions to fidelity. Maximum of one hour per week. Intensive In-Home services cannot be reimbursed if billed on the same date of service as Psychosocial Rehabilitation (PSR) and Basic Skills Training (BST).

4003.4B PROVIDER QUALIFICATIONS

1. Intensive Home-based provider/individual

    a. Individuals must be trained in State evidence-based model through the DCFS.

    b. Must meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP MSM, Chapter 100.

    c. Must meet all Conditions of Participation in MSM Chapter 100.

2. Specialized Foster Care Agency

   a. Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.

   b. Agencies must be certified in State evidence-based model through the DCFS.

   c. Agencies must meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP MSM, Chapter 100.

   d. Agencies must meet all Conditions of Participation in MSM 102.1.

   e. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.

3. Child Welfare Jurisdiction

   a. Meet licensure requirements pursuant to the DHCFP MSM.

   b. Must be certified in State evidence-based model through the DCFS.

   c. Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP MSM, Chapters 100 and 400.

   d. The individual providing the coaching will meet the requirements determined through the DCFS.

4003.4C NON-COVERED SERVICES

Intensive In-Home services do not include (from CMS 2261-P):

1. Intensive In-Home services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

2. Custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training, and/or other intrinsic parenting and/or care giver responsibilities;

3. Maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of intensive in-home goals and objectives, impromptu non-crisis interventions, and routine daily therapeutic milieus;

4. Case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage, and monitoring and follow-up;

5. Habilitative services; Services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

6. Cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

7. Transportation: Transporting recipients to and from medical and other appointments/services;

8. Educational, vocational, or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem, and services intrinsically provided through the Individuals with Disabilities Education Improvement Act (IDEA);

9. Inmates of public institutions: To include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent;

10. Room and board: Includes housing, food, non-medical transportation, and other miscellaneous expenses, as defined below:

    a. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs, and insurance), utilities (gas, electricity, fuel, telephone, and water), and housing furnishings and equipment (furniture, floor coverings, major appliances, and small appliances);

    b. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

    c. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs, and insurance;

    d. Miscellaneous expenses include clothing, personal care items, entertainment, and reading materials;

    e. Administrative costs associated with room and board;

11. Non-medical programs: Intrinsic benefits and/or administrative elements of non- medical programs, such as foster care, therapeutic foster care, child welfare, education, childcare, vocational and prevocational training, housing, parole and probation, and juvenile justice;

12. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

13. Any type of psychotherapy services;

14. Respite care;

15. Recreational activities: Recreational activities not focused on rehabilitative outcomes;

16. Personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives;

4003.5 CRISIS STABILIZATION SERVICES

Crisis Stabilization services are short-term, outcome-oriented, and of higher intensity than other behavioral interventions that are designed to provide interventions focused on developing effective behavioral management strategies to secure participant and family/caregiver's health and safety following a crisis. These services may only be delivered in an individual, one-to-one session and are available in the child's home. The service is short-term designed to achieve community stabilization through psychoeducation, crisis stabilization, and crisis resolution support. The service is of high intensity with the intent to develop effective behavioral strategies that will be maintained and help the child to sustain the behavioral strategies long-term.

4003.5A COVERAGE AND LIMITATIONS

1. The amount, frequency and duration of this service is based on the participant's assessed needs and documented in the approved POC.

2. This service is not subject to Prior Authorization requirements.

3. Crisis Stabilization services may only be delivered in an individual, one-to-one session and are available in the child/youth's home.

4. The maximum number of service hours per day is four hours for up to 40 hours per month. Post authorization request required beyond 40 hours. Additional units of services may be authorized by the DHCFP or designee on post authorization review.

4003.5B PROVIDER QUALIFICATIONS

1. Specialized Foster Care Agency

   a. Pursuant to NRS 424, an application for a license to operate a foster care agency must be in a form prescribed by the Division and submitted to the appropriate licensing authority.

   b. Foster Care Agency providers must be enrolled as a Foster Care Provider Agency through the DHCFP's fiscal agent and meet all required standards listed in the DHCFP MSM.

c. Agencies must meet all applicable standards listed in NAC 424 and NRS 424.

2. Child Welfare Jurisdiction

1. Meet licensure requirements pursuant to the DHCFP MSM.

2. Meet all requirements to enroll and maintain status as an approved Medicaid provider, pursuant to the DHCFP MSM, Chapters 100 and 400.

4003.5C NON-COVERED SERVICES

Crisis Stabilization services do not include:

1. When a youth's behavior no longer requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;

2. When a youth no longer presents a moderate risk of danger to themselves and others;

3. When a youth's behavior becomes manageable and no longer requires stabilization; Crisis stabilization services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

4. Custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training, and/or other intrinsic parenting and/or care giver responsibilities;

5. Maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of crisis stabilization goals and objectives, impromptu non-crisis interventions, and routine daily therapeutic milieus;

6. Case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage, and monitoring and follow-up;

7. Habilitative services;

8. Services provided to individuals with a primary diagnosis of intellectual disabilities and related conditions (unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

9. Cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

10. Transportation: Transporting recipients to and from medical and other appointments/services;

11. Educational, vocational, or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem, and services intrinsically provided through the IDEA;

12. Inmates of public institutions: To include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent;

13. Room and board: Including housing, food, non-medical transportation, and other miscellaneous expenses, as defined below:

    a. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs, and insurance), utilities (gas, electricity, fuel, telephone, and water), and housing furnishings and equipment (furniture, floor coverings, major appliances, and small appliances);

    b. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

    c. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs, and insurance; Miscellaneous expenses include clothing, personal care items, entertainment, and reading materials;

    d. Administrative costs associated with room and board;

14. Non-medical programs: Intrinsic benefits and/or administrative elements of non- medical programs, such as foster care, therapeutic foster care, child welfare, education, childcare, vocational and prevocational training, housing, parole and probation, and juvenile justice;

15. Services under this chapter for a recipient who does not have a covered, current ICD diagnosis;

16. Any type of psychotherapy services;

17. Respite care;

18. Recreational activities: Recreational activities not focused on rehabilitative outcomes;

19. Personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives

4004 PRIOR AUTHORIZATION

There are no prior authorization requirements for Intensive In-Home services. The service limitations for Intensive In-home services are listed above. There are no prior authorization requirements for Crisis Stabilization services. The service limitations for Crisis Stabilization services are listed above. Additional units of services may be authorized by DHCFP or designee on post authorization review**.**

4005 HEARINGS

Please reference MSM, Chapter 3100, for Hearings process and policy.