PROPOSED REGULATION OF

THE STATE BOARD OF HEALTH

LCB File No. R039-97

EXPLANATION – Matter in *italics* is new; matter in brackets **[ ]** is material to be omitted.

AUTHORITY: §§2, 6-9, 18, NRS 442.190; §§3, 12-15, 17, 19, NRS 442.140; §4, NRS 449.037 and 449.087; §5, NRS 233B.050, 449.037 and 449.087; §§10, 11, NRS 233B.050 and 442.190; §16, NRS 233B.050 and 442.140.

Section 1. Chapter 442 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this regulation.

Sec. 2. *"Bureau" means the bureau of family health services of the health division of the department of human resources.*

Sec. 3. *"Bureau" means the bureau of family health services of the health division of the department of human resources.*

Sec. 4. NAC 442.501 is hereby amended to read as follows:

442.501 The division may deny, suspend or revoke the right of a hospital to provide level II or level III care for neonates for the failure of the hospital to:

1. Comply with the provisions of NAC 442.250 to 442.570, inclusive; **[**and**]** *or*

2. Pay the costs associated with an inspection made by a site-inspection team.

Sec. 5. NAC 442.511 is hereby amended to read as follows:

442.511 1. The division shall give a hospital written notice *in the manner prescribed in chapter 439 of NAC* before it:

(a) Denies an application of a hospital to provide intensive care for neonates;

(b) Revokes its approval of a hospital to provide intensive care for neonates; or

(c) **[**Orders the hospital to cease and desist providing**]** *Suspends its approval of a hospital to provide* intensive care for neonates.

2. A hospital may **[**submit a written request for a hearing to the administrator of the division within 15 days after receiving the notice required pursuant to subsection 1.

3. The hearing must be held within 30 days after the request is received by the administrator.

4. The administrator shall appoint a hearing officer who shall submit his recommendations in writing to the administrator within 10 working days after the hearing ends.

5. The administrator shall consider:

(a) The findings of the site-inspection team;

(b) The evidence presented at the hearing; and

(c) The recommendation of the hearing officer.

6. The administrator shall advise the hospital of any action the division will take regarding the hospital's provision of intensive care for neonates within 30 days after receipt of the hearing officer's recommendations.**]** *appeal any decision made by the division pursuant to subsection 1 in the manner prescribed in chapter 439 of NAC.*

Sec. 6. NAC 442.600 is hereby amended to read as follows:

442.600 As used in NAC 442.600 to 442.780, inclusive, unless the context otherwise requires, the words and terms defined in NAC 442.602 to 442.708, inclusive, *and section 2 of this regulation,* have the meanings ascribed to them in those sections.

Sec. 7. NAC 442.610 is hereby amended to read as follows:

442.610 "Agreement" means a contract or memorandum of understanding between the **[**program**]** *health division* and a provider which defines the type of medical services a provider will provide to clients and the method by which the program will reimburse the provider.

Sec. 8. NAC 442.690 is hereby amended to read as follows:

442.690 "Physician" means a provider who:

1. Is licensed by the state where he practices;

2. Is certified by or eligible to take an examination for certification from the appropriate American specialty board;

3. Has a memorandum of understanding with the **[**program;**]** *health division;* and

4. Has an agreement with Medicaid to provide medical services.

Sec. 9. NAC 442.715 is hereby amended to read as follows:

442.715 1. To provide medical services to clients, physicians and other regular providers of medical services to the program must have executed an agreement with the **[**program,**]** *health division,* except that providers who provide medical services one time or on a sporadic basis are not required to have executed an agreement. The agreement must **[**require a**]** *:*

(a) Require a physician or other provider of medical services to accept the **[**state fee schedule as the basis of**]** *rates of* reimbursement *set forth in NAC 442.751* for the **[**professional services , and require**]** *provision of medical services or orthotic and prosthetic devices; and*

(b) Provide that families will not be billed by the provider for the remaining balance unless [a] cost sharing has been established.

2. Providers of medical services must receive authorization before delivery of service [in order] to be eligible for reimbursement for medical services, except in cases of emergency. Oral authorization for care must be followed by written authorization. Authorizations for services provided during the hours when the offices of the [health division] *bureau* are closed may be issued retroactively if:

(a) The client meets the eligibility requirements of the program set forth in NAC 442.710; and

(b) The health division is notified by the physician, hospital or other provider of services within 72 hours after the services [were] *are* provided.

3. A physician must certify the anticipated outcome of the services requested at the time he requests prior authorization.

4. Medical treatment authorized for payment must directly relate to the primary diagnosis or diagnoses for which the applicant was accepted into the program.

5. The following services covered by the primary physician's authorization do not require separate prior authorization:

(a) Ambulance, if required by the authorized physician.

(b) Anesthesiologists or anesthetists. The authorized physician is responsible for notifying the anesthetists that the person is a client of the program and that the fees of the program prevail. The anesthetist must bill the insurance carrier or other third-party payer and the program directly. The client's household must not be billed for charges in excess of those allowed by the program.

(c) Assistant surgeon. The authorized physician is responsible for notifying the assistant surgeon that the person is a client of the program and that the fees of the program prevail. The assistant surgeon must bill the insurance carrier or other third-party payer and the program directly. The client's household must not be billed for charges in excess of those allowed by the program.

Sec. 10. NAC 442.725 is hereby amended to read as follows:

442.725 1. Except as otherwise provided in subsection 2, an applicant's eligibility for participation in the program begins:

(a) On the date on which the applicant contacts *a person designated by the administrator to determine eligibility for receipt of medical services pursuant to* the program;

(b) On the date on which a medical facility notifies *a person designated by the administrator to determine eligibility for receipt of medical services pursuant to* the program regarding the applicant; or

(c) Within 72 hours after admission to a medical facility if the applicant was admitted on a weekend,

if, within 30 days after that date, the applicant submits an application to *a person designated by the administrator to determine eligibility for receipt of medical services pursuant to* the program.

2. If an applicant submits an application after the 30-day limit, the applicant's date of eligibility will be the date on which the applicant completed the application.

3. Incomplete applications must be completed within 15 working days after the initial application is submitted to retain the effective date of the initial application.

4. An applicant or a client shall submit an updated application:

(a) Annually; or

(b) When there is a substantial change in the income, expenses or composition of his household.

Sec. 11. NAC 442.765 is hereby amended to read as follows:

442.765 [The] *A person designated by the administrator to determine eligibility for receipt of medical services pursuant to the* program will terminate the eligibility of a client for the following reasons:

1. The client reaches the limitation on age set forth in NAC 442.710.

2. The client has achieved maximum alleviation or rehabilitation of his eligible medical condition.

3. The client's condition has remained static for 1 year.

4. The income of the client's household no longer meets the requirements for financial eligibility set forth in NAC 442.710.

5. The client's family chooses [to no longer] *not to continue to* participate in the program.

6. Failure by the client to cooperate in carrying out recommended treatment or to apply for third-party assistance.

7. A lack of money for the program or from cost sharing for the continuation of the medical services required by the client.

8. Denial of other third-party coverage based on failure to cooperate.

9. Misrepresentation of material facts in the application.

Sec. 12. NAC 442.775 is hereby amended to read as follows:

442.775 1. [If a provider disagrees with a decision made by the case specialist not to pay a claim, the] *A person designated by the administrator to determine eligibility for receipt of*

medical services pursuant to the program shall determine whether to pay a claim for medical services furnished by a provider.

2. If the person designated by the administrator determines that the claim will not be paid, he shall notify the provider, in writing, of the reason why the claim will not be paid.

3. The provider may [seek] *request a* review of the decision [by the manager and request a medical review.

2.] *denying payment of the claim.*

4. The provider must [make the request in writing] *submit a written request to the bureau* within 30 days after [the program notifies him that it denied] *he receives notice that* the claim [.

3. The medical staff that performs the medical review must submit a written report to the manager within 30 days after the date on which the provider requested the medical review. The manager must make] *has been denied.*

5. If the bureau receives a request for a review pursuant to subsection 4, it shall issue a *written* decision [within 30 days] and notify the provider *, in writing ,* of [the report and findings of the medical review and the final decision.

4.] *its decision.*

6. The provider may appeal the decision of the [manager] *bureau* in the manner prescribed in [NAC 442.780.] *chapter 439 of NAC.*

Sec. 13. NAC 442.780 is hereby amended to read as follows:

442.780 1. If [the program] *a person designated by the administrator to determine eligibility for receipt of medical services pursuant to the program* determines that an applicant for medical services does not meet the requirements for eligibility, or that a client receiving medical services no longer meets those requirements,

[it must advise] *he shall notify* the applicant or client in writing of the reason [that] *why the* medical services will not be provided.

2. The applicant or client may request a [hearing on the program's denial of services.

3. The request for a hearing must be in writing setting forth any factual or legal basis for reconsideration and must be submitted within 15 days after notification of the program's denial of services.

4. The person denied services will be afforded a hearing before a hearing officer appointed by the administrator. The hearing must be held within 30 days after the request for it has been received by the health division. The hearing officer must provide his recommendation to the administrator within 10 days after completion of the hearing.

5. The administrator will consider the hearing officer's recommendation and will advise the appellant of his decision on the appeal within 30 days after receipt of the hearing officer's recommendation.] *review of the denial of medical services by submitting a written request to the bureau within 30 days after he receives notice of that denial.*

3. If the bureau receives a request for a review pursuant to subsection 2, it shall issue a written decision and notify the applicant or client, in writing, of its decision.

4. The applicant or client may appeal the decision of the bureau in the manner prescribed in chapter 439 of NAC.

Sec. 14. NAC 442.800 is hereby amended to read as follows:

442.800 As used in NAC 442.800 to 442.838, inclusive, the words and terms defined in NAC 442.802 to 442.818, inclusive, *and section 3 of this regulation,* have the meanings ascribed to them in those sections.

Sec. 15. NAC 442.818 is hereby amended to read as follows:

442.818 “Provider” means a dentist [able] *who is entitled* to receive reimbursement for providing dental services to clients through an agreement with the [program] *health division* pursuant to NAC 442.828.

Sec. 16. NAC 442.824 is hereby amended to read as follows:

442.824 1. [If the health division] *If a person designated by the administrator to determine eligibility for receipt of dental services pursuant to the program* determines that a child who has submitted an application is eligible to receive dental services through the program, [the health division] *he* shall certify that the applicant is eligible to receive [such] *those* services and notify the applicant of the certification.

2. Each client must be financially recertified annually or when there is a substantial change in the income of his family, whichever occurs first.

Sec. 17. NAC 442.826 is hereby amended to read as follows:

442.826 1. [If the health division] *If a person designated by the administrator to determine eligibility for receipt of dental services pursuant to the program* determines that an applicant for the program does not meet the requirements for eligibility, or that a client no longer meets those requirements, [it shall advise] *he shall notify* the applicant or client in writing of the reason [that] *why* coverage through the program will not be provided.

2. An applicant or client who has been denied coverage pursuant to subsection 1 may request a [hearing regarding the denial of coverage.

3. A request for a hearing must:

(a) Be in writing;

(b) Set forth any factual or legal basis for reconsideration; and

(c) Be submitted within 30 days after notification of the denial of coverage.

4. If a proper request for a hearing is made pursuant to subsection 3, a hearing must be held before a person on the staff of the health division appointed by the administrator. The hearing must be held within 60 days after the request has been received by the health division. The appointed person on the staff of the health division shall provide his recommendation to the administrator within 10 days after the completion of the hearing.

5. The administrator shall consider that recommendation, make a decision on the hearing and notify the applicant or client of that decision within 60 days after receipt of the recommendation.**]** *review of the denial of coverage by submitting a written request to the bureau within 30 days after he receives notice of the denial of coverage.*

3. If the bureau receives a request for a review pursuant to subsection 2, it shall issue a written decision and notify the applicant or client, in writing, of its decision.

4. The applicant or client may appeal the decision of the bureau in the manner prescribed in chapter 439 of NAC.

Sec. 18. NAC 442.834 is hereby amended to read as follows:

442.834 1. A person **[**on the staff of the health division**]** designated by the administrator *to determine eligibility for receipt of dental services pursuant to the program* shall determine whether to pay a claim for reimbursement made by a provider. All dental services must have authorization pursuant to NAC 442.828 before payment may be made for **[**them.**]** *those services.* Reimbursement for allowable dental services must be at Medicaid rates established semiannually by the **[**welfare division of the**]** department of human resources.

2. If the **[**designated person on the staff of the health division decides not to pay a claim, the provider is entitled to a review of the decision at a hearing before the director of the program for

maternal and child health of the health division. A request for the hearing must be made within 60 days from the time that the provider is notified of the denial.

3. After the hearing, the director shall make findings and a final decision regarding the claim and shall notify the provider of the findings and decision within 60 days from the time the request for a hearing was made.**]** *person designated by the administrator determines that a claim for reimbursement will not be paid, he shall notify the provider, in writing, of the reason why the claim will not be paid.*

3. The provider may request a review of the denial of the claim by submitting a written request to the bureau within 30 days after he receives notice that the claim will not be paid.

4. If the bureau receives a request for a review pursuant to subsection 3, it shall issue a written decision and notify the provider, in writing, of its decision.

5. The provider may appeal the decision of the bureau in the manner prescribed in chapter 439 of NAC.

Sec. 19. NRS 442.668 is hereby repealed.

TEXT OF REPEALED SECTION

442.668 "Manager" defined. "Manager" means the manager of the bureau of family health services of the health division.