STATE OF NEVADA
MEDICAID HEALTH INFORMATION TECHNOLOGY REGULATORY INVENTORY

A report to:
Nevada Department of Health and Human Services
Office of Health Information Technology

Prepared by:
Leslie Hamner

November 15, 2010

This report has been prepared to assist the Nevada Division of Health Care Financing and Policy (DHCFP) and Department of Health and Human Services (DHHS) Office of Health Information Technology (OHIT) as they implement the provisions of the American Recovery and Reinvestment Act of 2009 related to Medicaid health information technology activities, and coordinate its health information efforts with the broader health information technology changes being made throughout the State. This report includes the provisions of state law and regulation in Nevada which relate to Medicaid and health information, and complements the State of Nevada Health Information Technology Regulatory and Policy Inventory prepared on August 23, 2010. That report includes an Appendix A which contains a complete list of the existing provisions of NRS related to health information, including various provisions of NRS which pertain to Medicaid. These provisions are summarized below and the text of these Medicaid provisions is included as Appendix A at the end of this report. In addition, this report includes a summary of the provisions of the Nevada Medicaid State Plan and the Nevada Medicaid Manuals which relate to health information.

Nevada Revised Statutes Sections Related to Medicaid and Health Information

Most of the provisions of law governing Medicaid are located in state rules and regulations adopted by the DHCFP (State Medicaid Agency) or in federal law. Therefore, there are not many provisions of NRS governing Medicaid, and even fewer provisions which specifically address health information and Medicaid. These provisions will not necessarily need to be amended as a result of the health information changes being made to the Medicaid program, but they should be considered as technological changes are made. Chapter 422 of NRS which governs DHCFP contains a few provisions which address health information.

First, there is a prohibition on publishing, disclosing or using, permitting or causing to be published, disclosed or used, any confidential information pertaining to a recipient of assistance under the provisions of chapter 422 of NRS except for purposes directly connected with the administration of that chapter. In addition, it is illegal for a person, upon submitting a claim for or upon receiving payment for goods or services pursuant to the State Plan for Medicaid, to intentionally fail to maintain certain records for at least 5 years after the date on which payment was received. Finally, chapter 422 of NRS requires each application or report submitted to participate as a provider, each report stating income or expense upon which rates of payment are or may be based, and each invoice for payment for goods or services provided to a recipient to include a statement that all matters stated therein are true and accurate. Each such application, report or invoice must be signed under penalty of perjury by a natural person who is either the provider or a person authorized to act for the provider.

In addition to the provisions of NRS contained in chapter 422 of NRS, there are three additional provisions of NRS related to Medicaid and health information which are located in various other chapters of NRS. First, the provisions of NRS related to the electronic transmission of health information provide that a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt

out of having his or her individually identifiable health information disclosed electronically. In addition, each provider of health care is required to make the health care records of a patient available for physical inspection by an investigator for the Attorney General or a grand jury investigating an alleged crime involving Medicaid fraud. Finally, while personal information related to a communicable disease is generally confidential medical information, that information may be disclosed to the DHHS if the person about whom the disclosure is made has been diagnosed as having AIDS and is a recipient of or an applicant for Medicaid.

Nevada Medicaid State Plan Provisions Related to Health Information

Various sections of the Nevada Medicaid State Plan (Plan) contain provisions related to health information. Some of these provisions require providers of health care to maintain certain records and include certain information in medical records. These provisions will most likely not need to be changed as a result of Medicaid Health Information Technology (HIT) activities because the providers will still need to maintain the records although the records may be in a different format. The provisions included in the Plan are general enough that they most likely work as Medicaid expands its use of HIT. First, on page 6b of Attachment 3.1-A, each mental health rehabilitation service must be identified on a written rehabilitation plan which is also called a treatment plan. Providers of such services are required to maintain case records, and components of the rehabilitation plan and case records must be consistent with the federal rehabilitation regulations. In addition, pursuant to page 1 of Supplement 1 to Attachment 3.1-A, providers of targeted case management services are required to maintain case records in accordance with Medicaid policy. The Plan sets forth certain information that must be contained in these records. Page 16 of Supplement 1 to Attachment 3.1-A requires qualified targeted case management services provider agencies to have the capacity to document and maintain individual case records in accordance with State and Federal Requirements. Page 18 of Attachment 3.1-F requires a primary care provider to maintain a copy of a child's Individual Education Plan in his or her medical record under certain circumstances. Page 8 of Attachment 3.1-G concerning home and community based services provides that for habilitation services, the State includes within the record of each individual an explanation that certain services are not included in habilitation services. Finally, Section 4.13 requires certain facilities, programs, plans and insurers to document in an individual's medical record whether or not the individual has executed an advance directive.

Other provisions set forth in the Plan require certain information to be accessible to or to be provided to certain providers. These provisions will most likely not need to be changed as a result of Medicaid HIT activities because the information will still need to be accessible and provided regardless of its format. Page 16 of Supplement 1 to Attachment 3.1-A requires qualified targeted case management services provider agencies to have full access to all relevant records concerning the child's needs for services including records of the Nevada District Family and Juvenile Courts. In addition, page 17 of Attachment 3.1-F provides that if a Native American voluntarily enrolls with a managed care organization and seeks covered services from Indian Health

Service (IHS), the managed care organization should request and receive medical records regarding those covered services/treatments provided by IHS. Page 20 of Attachment 3.1-F requires a managed care organization to forward the medical records of an enrollee who elects to disenroll with the managed care organization after the determination of severely emotionally disturbed or seriously mentally ill to the provider from whom the enrollee will receive the covered mental health services. Page 22 of Attachment 3.1-G provides that each independent assessment of individuals determined to be eligible for home and community based services is based on, among other factors, an examination of the individual's relevant medical records. Section 4.19 provides that the Medicaid agency assures appropriate audits of records when payment is based on costs of services or on a fee plus costs of materials. Finally, Attachment 4.40-A requires a survey and certification agency that is part of the education program concerning nursing facilities to promote resident and client review of nursing facility records which are maintained within the certification agency. These records contain the last three years of compliance with licensing/certification requirements by the nursing facility and reflect a nursing facility's ability to meet the needs of the residents.

In addition, various provisions set forth in the Plan concern the maintenance of records. These provisions will also probably not need to be changed as a result of Medicaid HIT activity. Page 29 of Attachment 3.1-G provides that written copies or electronic facsimiles of service plans for home and community based services are maintained for a minimum period of three years as required by 45 C.F.R. § 74.53. Attachment 4.11-A provides that: (1) the construction standards for facilities include the area of medical records; (2) the operational standards for intermediate care facilities include records; (3) the operational standards for facilities for the mentally retarded or persons with developmental disabilities include records; (4) the operational standards for mental health facilities include contents of medical records; (5) the operational standards for hospitals, facilities for long term care, nursing homes, and extended care facilities include medical records; and (6) the standards for facilities for care of adults during the day include records and written assessments of clients.

Finally, Section 4.3 of the Plan addresses the confidentiality of records. This section states that under NRS 422.290, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the Plan. This section will likely not need to be changed to accommodate Medicaid HIT activity.

Nevada Medicaid Manuals Provisions Related to Health Information

1. Medicaid Operations Manual

Various provisions of the Medicaid Operations Manual concern health information. These provisions are summarized below, and should be carefully considered to ensure that they are consistent with Medicaid HIT activities and with any HIT legislation enacted during the 2011 Session of the Nevada Legislature.

Some of these provisions require certain information to be written or to be signed. These provisions may need to be modified to ensure that they apply to electronic records and signatures. Section 103.13 provides that in determining whether undue hardship exists such that the State will waive enforcement of an estate recovery claim, the State will consider a doctor's written verification of a medical condition that compromises the applicant's ability to repay the Medicaid claim. Pursuant to Section 600 and Section 603.1(c) concerning the Katie Beckett Eligibility Option, a physician must sign a statement indicating that it is safe and appropriate for a child to receive services in the home. In addition, Section 603.2(b) concerning the Katie Beckett Eligibility Option, requires DHCFP staff to facilitate the collection of medical records to forward to the physician consultant and review team for disability determinations and redeterminations.

Other provisions of the Medicaid Operations Manual concern the confidentiality of information. These provisions may not need to be changed as a result of changes in health information technology as any information that is currently confidential will remain confidential. Section 203.1G states that materials provided to members of a Board, Committee, or Advisory Committee appointed to serve in support of DHCFP programs because of their membership are considered public documents unless specifically protected from disclosure by contract or statute as a trade secret, or they constitute other confidential material. In addition, Section 803.15 concerning Nevada Check Up Plus and Section 903.8 concerning the Nevada HIFA Pregnancy Program provide that all information related to applicants is private and will not be shared with any person other than a person to whom the applicant has provided appropriate legal written permission to receive such information. These provisions state that both programs comply with HIPAA requirements in relation to the privacy of medical information. Confidential information concerning both programs may be shared within the Department of Health and Human Services without a formal release and with other qualified agencies in compliance with HIPAA regulations. Information concerning either program presented at a hearing or case review and constituting the basis of a decision will be open to examination by the applicant and a designated representative. The provisions governing the HIFA Pregnancy Program state that medical providers will not disclose information concerning the care or services given to participants except as specifically allowed by state and federal laws and regulations.

The provisions of the Medicaid Operations Manual governing the Drug Use Review Board (DUR Board) also contain several provisions related to health information. Section 203.3B(1)(b) requires the DUR Board to recommend guidelines governing written predetermined standards that pharmacies not using an electronic claims management system must use in conducting prospective DUR. This section may need to be changed if in the future pharmacies are required to use an electronic claims management system. In addition, Section 203.3B(4)(B) requires the DUR Board to make recommendations as to which interventions would most effectively lead to improvement in the quality of drug therapy. This section also provides that possible interventions include written, oral or electronic reminders containing patient-specific or drug specific, or both, information and suggested changes in prescribing or dispensing practices,

communicated in accordance with HIPAA. This section may need to be changed at some time in the future if only electronic reminders become appropriate.

Finally, various provisions of the Medicaid Operations Manual governing the disability determination program address medical records. These provisions seem general enough that they would not need to be changed as a result of any health information technology policy or statutory changes. Sections 1003.1(a)(2) and (3) provide that DHCFP is responsible for requesting and receiving necessary medical evidence from the applicant's acceptable medical sources and assisting the applicant in obtaining his or her medical reports when the applicant has given the District Office permission to do so. The terms medical evidence and acceptable medical source are explained in Sections 1003.1B and 1003.1C. Section 1003.1D provides that in cases where the medical evidence provided by the individual's medical sources is insufficient to determine disability, the disability team's medical or psychological consultant may request more information from the individual's treating source. Section 1003.2(c)(2) provides that in the case of deceased applicants, medical records may be used which document the four day pre death existence of the diagnosis/condition when the chronological information is absent from the death certificate.

2. Medicaid Services Manual

The Nevada Medicaid Services Manual (Manual) contains multiple references to medical records. These references can be grouped into the following categories: (1) the use of medical records; (2) information included in medical records; (3) maintenance of medical records; and (4) confidentiality of medical records. These sections dealing with medical records are summarized below. Most of the provisions governing medical records seem to be general enough that they will not need to be amended to accommodate changes in electronic health technology, but they should be carefully considered as Medicaid makes HIT changes and as any HIT legislation is enacted during the 2011 Session of the Nevada Legislature. Various provisions of the Manual deal with prescriptions. These provisions are summarized below and should be carefully considered to determine which provisions need to be amended to accommodate electronic prescriptions.

In addition, the Manual contains references to records and other documents that must be signed. These sections are also summarized below, and must be carefully considered as the use of electronic health technology becomes mandatory under certain circumstances to ensure that the required signatures can be created, stored and transmitted electronically. Similarly, other provisions of the Manual require certain reports and records concerning patients to be written. These provisions must be closely examined to ensure that they are consistent with electronic health technology and to ensure that any writing requirements can be satisfied electronically. Finally, the Manual contains a few references to the use of fax machines which should be considered to determine whether the electronic transmission of information should either be added to the transmittal of information by fax or should replace the transmittal of information by fax.

A. Medical Records

(1) Use of Medical Records

Section 101.1A requires a level of care assessment to establish needs-based criteria to qualify for Home and Community-Based Services to be based in part on an examination of the individual's medical records. Section 103.2(a) requires a provider to submit a request for prior authorization with a complete medical record to the Quality Improvement Organization-like vendor (QIO-like vendor) under certain circumstances. Section 106.3A(2)(c)(3) states that Medicaid providers may, as a condition of participation, be required to submit medical records with all claims.

Section 201.1A(1)(a) provides that admission to a hospital is certified by the QIO-like vendor based on supporting documentation available in the medical record. Section 201.1A(1)(d) provides that the role of the QIO-like vendor is to determine whether an admission was medically necessary based on the medical record documentation, not to determine physician intent to admit. Section 203.3C(1)(c) concerning admission to swing-beds involving Medicaid eligible recipients and retrospective and retroactive eligibility review and certification provides that if medically necessary as evidenced by swing-bed criterion being met, the QIO-like vendor issues a certification within 30 calendar days of receipt of the complete medical record (for retrospective cases), and both complete medical record and eligibility verification documentation (for retroactive eligible cases). That section also requires certain swing-bed medical record documentation to be submitted to the QIO-like vendor with a request for interim certification.

Sections 303.1B(2), 303.7B(2), 303.8A and 303.8B(2) concerning radiology services require a provider to allow, upon the request of proper representatives of DHCFP, access to all records which pertain to Medicaid or SCHIP recipients for regular review, audit, or utilization review.

Section 403.8B requires residential treatment centers to ensure that all pertinent medical records and post discharge plans to ensure coordination of and continuity or care are provided to the legal representative upon discharge of a Medicaid-eligible recipient. Section 403.9B(2) requires a provider to 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. Section 403.10D(4)(c) provides that upon a request for a retrospective review, the medical record must be submitted to the QIO-like vendor within 30 days from the date of the eligibility determination. The provider must present to state and federal reviewers the active medical record.

Section 503.2B(1) requires a nursing facility to present to state and federal reviewers the active medical record containing the applicable proof of Level I, and when indicated, Level II screenings completed prior to admission and the most recent screenings if the individual experienced a significant change in his/her physical/mental condition. Section 503.13B requires a nursing facility to provide copies of the recipient's medical record to

those responsible for post-discharge care including a copy of his or her Advance Directive (declaration/living will and/or durable power of health care decision). In addition, to transfer any Medicaid recipient from one nursing facility to another, the transferring facility must document the transfer in the recipient's medical record.

Section 503.16 provides that in order to validate that Medicaid reimbursement to nursing facilities is accurate and appropriate, a periodic review of Minimum Data Set (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. Section 503.16A provides that Case Mix and MDS Verification reviews at nursing facilities consist of a comparison of medical record documentation and the coding reported on the MDS. Section 503.16B(6) requires a nursing facility to prepare in advance and provide to review staff at the beginning of the entrance meeting: (1) the active medical records selected for review; and (2) thinned/purged files and records maintained by the facility in various workbooks which contain information that supports the coding of the MDS'.

Section 1203.1B(1)(b) states that a pharmaceutical provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.

Appendix B to Chapter 1300 provides that for home-based terbutaline infusion pump therapy, medical records from a physician must be submitted to substantiate all qualifications and prior authorization will not be processed without medical records to substantiate the request.

Section 1403.1C(2)(e) provides that a patient of a home health agency has the right to access information in his own record upon written request.

Section 1703.1B(4) states that a provider will allow, upon request of proper representatives of DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.

Section 1803.1D(1) provides that when an individual becomes eligible for Medicaid during the course of treatment or after services were provided, an adult day care provider may request a retro-eligible authorization by submitting the required form accompanied by the medical record including the physician's orders, care plan and progress notes.

Section 2003.1A states that a provider of audiology services will allow, upon request of proper representatives of DHCFP, access to all records which pertain to Medicaid or Nevada Check Up recipients for regular review, audit or utilization review.

Section 2502.10A requires a case manager to make available to Nevada Medicaid or the QIO-like vendor, upon request, copies of the medical records, progress notes, care plan, case record or summary documents which reflect the ongoing need for case management services and support any additional services requested.

Section 3300 provides that Payment Error Rate Measurement 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 Division of Welfare and Supportive Services. The claims processing and medical record or service documentation reviews for the mandated Payment Error Rate Measurement program will be conducted by federal contractors. The financial and policy compliance audits of programs and services provided under the Medicaid and Nevada Check Up programs consist of a thorough review of program policy, claims processing and/or medical or service record documentation. Section 3303.1A(2)(x) provides that false statements include, but are not limited to falsification of medical records and failure to develop and maintain health service records as required by NRS 422.570 and DHCFP policy. Section 3303.2A(2) provides that an investigation may include a review of medical or other service record documentation. Section 3303.2A(4) provides that Fee-For-Service claims or line items will undergo a medical record or service documentation review and a claims processing review.

Section 3303.2B states that providers are bound by both federal and state statutes and regulations, 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 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 DHCFP. In addition, 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. Records, documentation and information must be available regarding any service for which payment has been or will be claimed to determine [whether payment] has or will be made in accordance with applicable federal and state requirements. Providers must make all documentation requested by 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. For medical record requests associated with 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 DHCFP requesting such information. 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. All records subject to audit or review must be produced at no cost to DHCFP. Providers are required to keep patient records that adhere to basic standards of practice and in accordance with DHCFP operations or services manuals and state and federal statutes and regulations. 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. Section 3303.3A(2)(l) provides that DHCFP may impose special requirements on providers as a condition of participation, including the requirement for providers to submit all records or documentation to support the services billed prior to payment.

Section 3503.10 states that DHCFP conducts provider reviews, both announced and unannounced, to examine providers of personal care services programs' records for compliance with personal care service program requirements, procedures and policies.

Section 3603.4(a) provides that if a Native American voluntarily enrolls with a managed care organization and seeks covered services from Indian Health Service, the managed care organization should request and receive medical records regarding those covered services/treatments provided by Indian Health Service. Section 3603.4(m) provides that a managed care organization is required to notify DHCFP if a Title XIX Medicaid recipient elects to disenroll from the managed care organization following the determination of Severe Emotional Disturbance/Serious Mental Illness and forward the enrollee's medical records to the provider from whom the enrollee will receive the covered mental health services. Section 3603.17(B) provides that when notified by DHCFP that an enrollee has been transferred to another plan or to fee-for-service, the managed care organization must have written policies and procedures for transferring/receiving relevant patient information, medical records and other pertinent materials to the other plan or current fee-for-service provider. Section 3603.24(D)(1) requires the managed care organization enrollment system to be capable of linking records for the same enrolled recipient that are associated with different Medicaid and/or Nevada Check-Up identification numbers; e.g., recipients who are re-enrolled and assigned new numbers. Section 3604(a)(3) provides that the process for appeals requires that the enrollee and his/her representative is provided the opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other document and records considered during the appeals process. In addition, the managed care organization is required to maintain records of grievances and appeals, which the State will review as part of the State's quality strategy.

(2) Information Included in Medical Records

Section 103.7A(2) requires service providers to document in an individual's medical records whether or not the individual has an advanced directive.

Section 203.1A(3) requires certain information concerning absences from an acute hospital or Medical Rehabilitation Specialty Hospital to be documented in a recipient's medical record. Section 203.1B(12) concerning discharge planning in hospitals requires significant contacts with family, the recipient, or ancillary personnel to be documented in the medical record, including a description of the recipient's understanding of his or her condition.

Section 303.1A(7) concerning radiology services requires documentation to be available in the clinical record to support the reasonable and necessary indications for all testing. Sections 303.1B(3), 303.7B(3) and 303.8B(3) also concerning radiology services require evidence to support medical necessity for the procedures to be clearly documented in the clinical record. Section 303.6A(2) requires documentation supporting the reasonableness and necessity for certain radiology procedures to be in a patient's record.

Section 403.4(3)(b) requires participation in group therapy to be documented on the clinical record. Section 403.9B(3)(b) requires each Medicare and Medicaid hospital provider to document in an individual's medical record whether the individual has an advance directive. Section 403.10A(2) provides that prior to inpatient admission, the referring or admitting physician must document discussing the three "amenable to treatment" issues with the recipient, including the recipient's response to each. This documentation must be part of the recipient's inpatient hospital record. Section 403.12A(7) provides that medical records should include recipient symptoms, physical findings, and diagnosis to document the medical necessity of performing electroconvulsive therapy.

Section 503.1B provides that at a minimum, a medical record of a nursing facility must contain sufficient information to identify the recipient, a record of the recipient's assessments, the plan of care and services ordered and provided the results of Pre-Admission Screening and Resident Review (PASRR) screenings, the results of Level of Care (LOC) Assessment screening, and progress notes. The record must also contain relevant documentation to support the Minimum Data Set (MDS) coding. Section 503.2B(5) authorizes the Division of Mental Health and Developmental Services staff to contact a nursing facility to document each on-site visit and care conference in the active medical record (indicating progress or lack of progress with the specialized services prescribed). Section 503 provides that medical records of nursing homes must verify that ventilator support is required for a minimum of 6 hours within a 24 hour period. The medical records must also include the date the recipient was placed on the ventilator. Section 503.16B(9) requires a nursing facility provider to maintain documentation supporting the current MDS in the active medical record.

Section 603.1A requires a physician to document medical services in the appropriate medical records for a recipient before submitting claims for services rendered. Section 603.2(a) provides that a request for a physician consult may be documented in the patient's medical record by either the consulting or requesting physician 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 physician or appropriate source. Section 603.2(b)(2) requires documentation in a patient's medical record to support the level of service and/or the medical acuity which requires more frequent physician visits. Section 603.4(c) requires a prenatal patient's record to clearly identify all high risk factors and ultrasound findings under certain circumstances. Section 603.13(A) provides that a certification for Intermediate Care Facility/Mentally Retarded (ICF/MR) care 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 as the first order in the physician's orders. Attachment A to Chapter 600, Policy #6-02, requires a patient's medical record to include a comprehensive wound history that includes certain information. In addition, the education required to be provide to recipients by physicians should be documented in the recipient's medical record. Attachment A to Chapter 600, Policy #6-03, requires documentation supporting the reasonableness and necessity of outpatient hospital based hyperbaric oxygen therapy to

be in the recipient's medical record. Attachment A to Chapter 600, Policy #6-04 provides that documentation in a recipient's medical record should include what the expected functional outcomes and improvements in quality of life are for a recipient after receiving intrathecal baclofen therapy. Attachment A to Chapter 600, Policy #6-06, requires documentation supporting the medial necessity of vagus nerve stimulation to be in a recipient's medical record. This Policy also requires the medical record to indicate changes/alterations in medications prescribed for the treatment of a recipient's condition. Attachment A to Chapter 600, Policy #6-07, requires documentation supporting the reasonableness and necessity of gastric bypass surgery to be in the recipient's medical record.

Section 903.1B(10) concerning private duty nursing provides that a signed, dated copy of a patient's bill of rights will be included in a patient's medical record. Section 903.1B(11)(c) requires a home health agency to document in an individual's medical record whether or not the individual has executed an Advance Directive.

Section 1003.4(a) governing dental services requires providers' in-office records to verify x-rays, periodontal charting, and diagnoses documenting the need for these procedures. Section 1003.6 requires dentists' in-office records to substantiate the emergency for the purposes of Medicaid post-payment utilization review and control. Section 1003.6(a)(2) requires the dentist's office records to substantiate the recipient's medical necessity. Payment for the examination and x-rays may be withdrawn if post-payment reviews of in-office records do not substantiate the medical necessity. Section 1003.6(a)(7) requires a provider's in-office records to substantially document the medical emergency need for the purpose of payment for an emergency denture reline. Section 1003.6(b)(2) requires a provider to 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.

Appendix A to Chapter 1200 requires certain information to be documented in the medical record of a recipient of an agent used for the treatment of Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder.

Section 1303.2(A) requires supplier/provider records to substantiate the medical necessity for all durable medical equipment, prosthetics, orthotics and supply items dispensed to recipients. Section 1303.2(A)(4) requires a provider's recipient medical records to 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 records may 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. Appendix B to Chapter 1300 of NRS requires documentation to be included in the medical record of a recipient of disposable incontinent supplies. Appendix B to Chapter 1300 also provides that for parenteral nutrition services, if the judgment of the attending physician, substantiated in the medical record, is that the

condition is of long and indefinite duration, the test of permanence is considered met. Appendix B to Chapter 1300 also provides that for certain respiratory assist devices to be covered, the treating physician must fully document in the patient's medical record symptoms characteristic of sleep-associated hypoventilation. For restrictive thoracic disorders, there must be documentation in the recipient's medical record of a progressive neuromuscular disease. For continued coverage of certain devices, 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. Appendix B to Chapter 1300 also requires the reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an metered dose inhaler to be documented in the recipient's medical record.

Section 1403.1B(8) provides that a signed and dated statement acknowledging receipt of the patient's Bill of Rights will be included in a patient of a home health agency's medical record.

Section 1503.3A(2) provides that Nevada Medicaid will reimburse separately for developmental screenings, provided that a valid, standardized developmental screening tool has been utilized and entered in the child's health care record. Section 1503.3B concerning the Healthy Kids Program provides that medical records should document the assessments and significant positive and negative findings. In addition, medical records should contain certain information specific to early and periodic screening, diagnostic and treatment services screening services.

Section 1603.1A(1)(d) provides that a 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. Section 1603.1B(6) provides that within 30 days of admission to an intermediate care facility for the mentally retarded, certain assessments and evaluation must be entered in the resident's record. Section 1603.1B(11) requires a case record to document that the Interdisciplinary Team has reviewed the assessments and determined which need updating. Section 1603.2B(1) also requires a case record to show that the Interdisciplinary Team has reviewed all assessments and determined which need updating. If the Interdisciplinary Team finds the objectives are appropriate and do not need revising, they must so note in the case records. 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. Section 1603.2B(2) requires a case record to show that the Interdisciplinary Team has reviewed all assessments and determined which need updating. Section 1603.2B(3) provides that if the Interdisciplinary Team finds that the objectives are appropriate and do not need revising, it must be noted in the case record. In addition, the case record must show that the Interdisciplinary Team has reviewed all assessments and determined which need updating. Section 1603.6A(2)(e) provides that if a recipient of intermediate care services for the mentally retarded is to be either transferred or discharged, the facility must have documentation in the resident's record that the resident was transferred or discharged for good cause. Section 1603.6A(5) provides that 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. The

pharmacist must maintain for each resident a record of all prescription and non-prescription medications dispensed including quantities and frequency of refills.

Section 1703.1A(4) concerning group therapy provides that documentation in the medical record is expected to be available on each Medicaid recipient in the group session.

Section 2003.2B(2) requires additional hearing evaluations outside the normal program guidelines to be prior authorized. The audiologist must keep a copy of the referral and test results in the recipient's medical record. Section 2003.3A(6) requires a provider of audiology services to maintain a hearing aid warranty in the recipient's medical record.

Sections 2102.7 and 2103.2B(1)(i) provide that the daily service record is documentation completed by a provider of home and community-based services for persons with mental retardation and related conditions, indicating the type of service provided and the time spent. The documentation will include the recipient's initials with a full signature of the recipient at the bottom of each daily record. If the recipient is unable to perform this task due to intellectual and/or physical limitations, this will be clearly documented in the Individual Support Plan (ISP). The direct service will initial after the daily services are delivered, with a full signature of the direct service staff at the bottom of each daily record. Section 2103.2B(4)(b) provides that if a prospective service provider is exempted from required training, 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.

Sections 2201 and 2203.3B(1)(i) provide that the Daily Record is documentation completed by a provider of home and community-based services for the frail elderly, indicating the scope and frequency of the service 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 services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 2203.3B(3)(b) provides that if a prospective service provider is exempted from required training, 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.

Sections 2302 and 2303.3G(2) provide that the Daily Record is documentation completed by a provider of home and community-based services for persons with physical disabilities, indicating the type of service provided and the time spent. 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 Personal Care Attendant will initial after the daily services are delivered, with a full

signature of the Personal Care Attendant 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 of services provided and the time spent providing those services. Section 2303.3B(2)(b)(7)(2) provides that if a prospective service provider is exempted from required training, 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.

Section 2403.1B(3)(b)(2)(b) concerning comprehensive outpatient rehabilitation services provides that the decisions made during team conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the clinical record and made available upon request. Section 2403.1B(3)(b)(2)(d) provides that for all re-admissions over 3 consecutive business days, each rehabilitation treatment team member must re-evaluate the recipient's functional status and record the findings in the recipient's medical record.

Section 2602 provides that the Daily Record is documentation by a provider of intermediary services, indicating the type of service provided and the time spent. The documentation includes 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 intellectual and/or physical limitations, this will be clearly documented in the recipient file. The Personal Care Attendant will initial after the daily services are delivered, with a full signature of the Personal Care Attendant 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 of services provided and the time spent providing those services. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.

Sections 2702 and 2703.3B(1)(e) provide that the Daily Record is documentation completed by a provider of home and community-based waiver services for the elderly in adult residential care, 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 indicating the scope and frequency of services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 2703.3B(1)(m) provides that a completed serious occurrence report form must be made within five working days and maintained in the recipient's record.

Section 3203.3(c) provides that if an individual or representative is changing the designation of the particular hospice from which hospice care will be received, the

transferring hospice agency must file a notice in the medical record. Section 3203.3(e) provides that if a hospice recipient is residing in a nursing facility, the transferring hospice agency must submit a copy of the transfer statement to the nursing facility for their records. Section 3203.4 provides that to revoke the election of hospice care, the recipient or representative must file with the hospice a statement to be placed in the medical record that includes certain information. In addition, if the hospice recipient is residing in a nursing facility, the hospice agency is required to immediately submit to the nursing facility a signed copy of the notice of revocation for their medical records. Section 3203.5 provides that a copy of the signed discharge notice and the Hospice Medicaid Information form/Notice Discharge 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. If the hospice recipient is residing in a nursing facility 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 nursing facility staff of the discharge.

Section 3502 provides that the daily record is documentation completed by a provider of personal care services, indicating the type of service provided and the time spent. 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 intellectual and/or physical limitations, this will be clearly documented in the recipient file. The personal care assistant (PCA) will initial after the daily services are delivered, with a full signature of the PCA 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 of services provided and the time spent providing those services. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 3503.1B(16) provides that Documentation of the PCA's orientation to the approved service plan must be maintained in the recipient's record. The supervisor (or other designated agency representative) must review and approve all service delivery records completed by the PCA. Section 3503.1E(3)(c) provides that for all short-term modifications of an approved service plan, documentation must be maintained in the recipient's record of the circumstances that required the short term modification(s) of the approved service plan, and documentation must be maintained in the recipient's record that the recipient participated in the development of the modified service plan, including date and method of contact with the recipient.

Section 3603.4(3) provides that a copy of a child's individual education plan will be sent to the child's Primary Care Physician within the managed health care plan, and maintained in the enrollee's medical record. Section 3603.9 provides that a physician should document in the patient's medical record the need for the brand name product in place of the generic form. Section 3603.18(a)(18) provides that a managed care organization 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.

Sections 3902 and 3903.3B(4) provide that the Daily Record is documentation completed by a provider of home and community-based services for assisted living, indicating the scope and frequency of the service 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 services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.

(3) Maintenance of Medical Records

Section 105.1(K) requires a provider to keep any records necessary to disclose the extent of services the provider furnishes to recipients and to provide these records, upon request, to the Medicaid agency, the Secretary of Health and Human Services, or the state Medial Fraud Control Unit.

Section 402.7 requires clinical supervisors of mental and behavioral health services to assure that an up to date case record is maintained on a recipient. Section 403.2(1)(f) requires all providers to maintain required records and documentation. Section 403.6B(1) requires case records to be maintained on recipients receiving rehabilitation mental health services and sets forth the information which must be included in such records. Section 403.9B requires a medical record to be maintained for each recipient of inpatient mental health services and sets forth the items which must be included in the record.

Section 503.1B(7) requires nursing facilities to maintain records on each recipient in accordance with accepted professional standards and practices. Recipient records must be complete, accurately documented, organized and readily available. Section 503.2B concerning nursing facilities requires a provider to maintain a copy of the Level I Identification screening and/or determination letter completed prior to admission, in the resident's active medical record. In addition to the Level I completed prior to admission, the provider must maintain the most recently completed Level I Identification screening and/or determination letter in the resident's active medical record. The provider must maintain, when applicable, the PASRR Level II determination letter completed prior to admission in the resident's active medical record. In addition to the Level II completed prior to admission, the provider must retain the most current PASRR Level II (RR) determination letter in the active medical record. Documentation of specialized services provided or arranged for, and the resident's response to such services must remain in the active medical record as long as the resident is recommended to receive specialized services. This documentation must be available for state and federal reviewers.

Section 903.1B(15) requires a provider of private duty nursing services to 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.

Section 1203.1B(1)(b) provides that the pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.

Section 1303.2(B) requires a provider to maintain records at the physical location of their business for each item billed to, and paid by, Nevada Medicaid 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. The provider must maintain records in a readily accessible location and, for audit and investigation purposes, and make available upon request by Medicaid staff or its contractors, all supporting information related to prior authorizations, dispensed items, and/or paid clams for durable medical equipment, prosthetics, orthotics, and supplies items.

Section 1403.1B requires a provider of home health agency services to 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.

Section 1703.1B(3) requires therapy providers to maintain patient treatment records and physician's orders for a period of six calendar years.

Section 1803.1B(6) requires an adult day health care facility to maintain records on recipients including daily progress notes. The facility must maintain an accurate record of the recipient's attendance.

Section 2603.1B(25) requires a provider to maintain medical and financial records, supporting documents, and all other records relating to personal care services provided. Section 2603.3B(1)(o) requires an independent contractor to maintain medical and financial records, supporting documents, and all other records relating to personal care services provided.

Section 2803.1B(10) concerning school based child health services requires all medical and financial records which reflect services provided to be maintained by the school district and furnished on request to the Department of Health and Human Services or its authorized representative. A school, as a provider, must keep organized and confidential

records that detail all recipient specific information regarding all specific services provided for each individual recipient of services and retain those records for review.
School based child health services providers must maintain appropriate records to document the recipient's progress in meeting the goals of the therapy. Nevada Medicaid reserves the right to review the recipient's records to assure the therapy is restorative and rehabilitative.

Section 3203.8A provides that in accordance with accepted principles of practice, a hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. Each clinical record is a comprehensive compilation of information. The record includes all services whether furnished directly or under arrangements made by the hospice. The hospice must safeguard the clinical record against loss, destruction, and unauthorized use.

Section 3503.1B(23) requires a provider of personal care services to maintain medical and financial records, supporting documents, and all other records relating to personal care services 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 DHCFP, records must be retained until all litigation,
claims, or audit findings have been finally determined. The Provider must maintain all required records for each personal care assistant (PCA) employed by the agency, regardless of the length of employment. The Provider must maintain the required record for each recipient who has been provided services, regardless of length of the service period. At a minimum, the Provider must document the following on all service records: (1) Consistent service delivery within program requirements; (2)Amount of services provided to recipients; (3) When services were delivered; and (4) A daily record form signed or initialed by the PCA and the recipient.

Section 3602 provides that a recipient’s medical record is maintained at a primary care site location.

(4) Confidentiality of Medical Records

Section 103.5 states that Federal and state regulations (including the Health Insurance Portability and Accountability Act of 1996 (HIPAA of 1996)0 restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the Medicaid program. In accordance with HIPAA, 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. 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 Health and Human Services 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 options.

Section 103.5A provides that 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. This section also provides that 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. Information may be released to the Federal Department of Health and Human Services for purposes directly related to the furtherance of any of the Medicaid programs. The HIPAA 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.). 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). 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.

Section 403.2(1)(e) requires all providers to comply with recipient confidentiality laws and HIPAA. Section 403.6A requires qualified behavioral aides to maintain recipient confidentiality.

Attachment B to Chapter 600, Sterilization Consent Form, states that "I also consent to the release of this form and other medical records about the operation to representatives of the Department of Health and Human Services, or employees of programs or projects funded by the Department but only for determining if Federal laws were observed." Attachment H to Chapter 600, Certification Statement for Abortion due to Sexual Assault (Rape) or Incest, states "I certify that the above statement is true and I understand that all medical records relating to this abortion must be provided to representatives of Nevada Medicaid upon request."

Section 903.1B(8) requires a private duty nursing provider to 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 HIPAA Privacy Regulations (45 CFR 160) must comply with the applicable Privacy Regulations contained in 45 CFR 160 and

164 for recipient health information. Section 903.1C(A)(5) provides that a recipient of private duty nursing services has the right to access information in his own record upon written request. Section 903.1C(A)(4) provides that a recipient of private duty nursing services has the right to confidentiality with regard to information about his health, social and financial circumstances and about what takes place in his home.

Section 1403.1C(2)(d) provides that a patient of a home health agency has the right to confidentiality with regard to information about his health, social and financial circumstances, and about what takes place in his home.

Section 1803.1B(7) states that an adult day health care facility is required to comply with applicable state and federal laws, rules and regulations regarding privacy and protection of an individual's health information.

Section 1903.1E provides that the provider of transportation services must ensure the confidentiality of recipient medical records and other information, such as the health, social, domestic and financial circumstances learned or obtained in providing services to recipients.

Section 2103.16A(3)(a)(iv) concerning home and community based services for persons with mental retardation and related conditions provides that an Authorization for Release of Information form is needed for all waiver recipients. This form provides written consent for the Division of Mental Health and Developmental Services (MHDS) to release information about the recipient to others. The applicant and/or an authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form. The MHDS service coordinator will inform the applicant and/or an authorized representative that, pursuant to NRS 232.357, the Divisions within the Nevada Department of Health and Human Services may share confidential information without a signed Authorization for Release of Information.

Section 2203.3B(1)(n) states refer to MSM Chapter 100 for information on HIPAA, privacy and confidentiality of recipient records and other protected health information.

Section 2403.1C(4) concerning comprehensive outpatient rehabilitation services provides that in accordance HIPAA, 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.

Section 2603.1B(22) and 2603.3B(1)(p) concerning intermediary service organizations states refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other protected health information.

Section 2703.5B(2) requires an adult residential care provider to not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the home and community-based waiver for the elderly in adult residential care except by written consent of the recipient, his or her authorized or legal representative or family. Section 2703.7A(3)(a)(3) provides that an authorization for Release of Information form is needed for all waiver applicants/recipients. It provides written consent for the Aging and Disability Services Division to release information about the applicant/recipient to others. The applicant/recipient and/or authorized representative must understand and agree that personal information may be shared with providers of services and others as specified on the form.

Section 3303.1A(3) provides that 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 the Medicaid Fraud Control Unit (MFCU) and/or the Office of the Inspector General, the Centers for Medicare and Medicaid Services or their sub-contractors. Any information obtained by 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 DHCFP against a provider. Release of information or evidence is done in compliance with published confidentiality and privacy law, rules and regulations. Materials collected by DHCFP may be of an extremely sensitive nature. All such materials are kept secure. 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. DHCFP is a covered entity, as defined by the HIPAA regulations (45 CFR Parts 160, 162 and 164), and as such, must comply with all aspects of this federal regulation.

Section 3503.1B(24) states refer to MSM Chapter 100 for information on HIPAA, privacy, and confidentiality of recipient records and other protected health information.

Section 3601(l) provides that managed care organizations must follow the confidentiality and privacy requirements as set forth in 42 CFR Parts 160 and 164. Section 3603.5(F)(6) provides that a managed care organization 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. Section 3603.24(B) provides that a managed care organization shall have a management information system capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The managed care organization shall provide DHCFP with aggregate performance and outcome data, as well as its policies for transmission of data from network providers. The managed care organization shall submit

its work plan or readiness survey assessing its ability to comply with HIPAA mandates in preparation for the standards and regulations

Section 3903.5B(3)(e)(12) requires an assisted living provider to not use or disclose any information concerning a recipient for any purpose not directly connected with the administration of the assisted living waiver except by written consent of the recipient, his or her authorized representative or legally responsible individual.

B. Prescriptions

Section 702.9 states that the Federal Upper Limit for multi-source drugs for which an upper limit has been set does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient, and the statement "brand medically necessary" appears on the face of the prescription. Section 1003.13(b) states that a dentist should write, “Result of Healthy Kids” or “Result of EPSDT” on a prescription for fluoride. The recipient must present the prescription with a Nevada Medicaid card to a Medicaid participating pharmacy provider. Providers must verify eligibility prior to service.

Section 1203.1B(4) provides that a physician should document in a patient’s medical record the need for the brand name medication in place of the generic form. The certification must be in the physician's own handwriting. Certification must be written directly on the prescription blank. The phrase “Dispense as written” is required on the face of the prescription n. 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. 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.

Section 1201(6) notes that the U.S. Troop Readiness, Veteran’s Health Care, Katrina Recovery and Iraq Accountability Appropriations Act 2007, Section 7002(b), provides that Medicaid outpatient drugs (defined in Section 1927(k)(2) of the Social Security Act) will be reimbursable only if non-electronic written prescriptions are executed on a tamper-resistant prescription pad. Section 1203.1A(1)(a) states that 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. Section 1202.31 provides that a tamper-resistant prescription pad must contain all of the following three characteristics: (1) One or more industry-recognized feature(s) designed to prevent unauthorized copying of a complete or blank prescription form; (2) One or more industry-recognized feature(s) designed to prevent the erasure or modification of information written on the prescription by the prescriber; and (3) One or more industry-recognized feature(s) designed to prevent the use of counterfeit prescription forms. Section 1203.1A(1) states that the Nevada Medicaid Drug program

will pay for certain prescribed pharmaceuticals with a written prescription and may be subject to restrictions. Section 1203.1A(3)(c) states that 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. Section 1203.1E(1)(c) provides that a facsimile signature stamp is acceptable on faxed prior authorization requests. Appendix A to Chapter 1200 provides that a written prescription with a diagnosis is required for blood glucose monitors and testing supplies for home use to be a covered Medicaid benefit. The written prescription must be kept on the premise of the provider for 37 months. Appendix A to Chapter 1200 provides that for the treatment of HIV/AIDS wasting or cachexia there must be documented involuntary weight loss greater than 10% pre-illness baseline or a body mass index of <20KG/M2 (weight and diagnosis must be confirmed by faxed chart notes).

Section 3603.9 provides that a managed care organization (MCO) must have a policy for transitioning a recipient's prescriptions from fee-for-service, or another MCO, to the MCO. 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 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").

C. Signatures Required

Section 101.3B concerning child welfare recipients provides that 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. 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.

Section 104(5) requires a provider under certain circumstances to inform the recipient, or responsible adult, 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 adult, has been informed. Section 105.2C(1)(d) requires a provider who is requesting an appeal of a denied claim to provide an original signed paper claim that may be used for processing should the appeal be approved. Section 105.3(2) provides that 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.

Section 203.1A(1)(c) provides that for those instances in which the admission order was written 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 must be contained in the accepting facility's record. Section 203.1A(1)(d) requires physician orders for admission to be written at the time of admission or during the hospital stay and provides that they are only valid if they are signed by the physician. Verbal and telephone orders written by other allied personnel must be co-signed by the physician.

Section 303.7A(4) requires a licensed physician to review and sign reports of diagnostic testing facilities for sleep disorders.

Sections 402.34(4)(d) and (k) require a written rehabilitation plan to be signed by the individual responsible for developing the plan and to document that the individual, the individual's family (if the individual is a minor), or a representative signed the plan. Section 402.34(6)(i) requires a rehabilitation plan to include certain signatures. Section 403.6B(1)(b) requires case records of rehabilitative mental health services to include the signature of the person who provided the rehabilitative mental health services. Section 403.7A provides that initial office and clinical visits for psychological evaluation and testing require a signed referral. Section 403.8A(6)(a)(7) provides that prior authorization and a certificate of need signed by a physician is required for payment under certain circumstances. Section 403.8C(1)(b) provides that a certification of need required for admission to a residential treatment center must be signed by a physician. Section 403.9A(1)(9)(1) requires a verbal order for admission for inpatient mental health services to be countersigned later by the same physician. Section 403.9A(1)(c) concerning inpatient mental health services provides that 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. Section 403.9A(1)(d) requires a hospital to submit a physician's order which is signed by a physician. Section 403.9A(1)(e) requires a new admissions order to be issued and signed by a physician when a recipient is admitted to inpatient status post discharge from an observation stay.

Section 503.1B provides that all entries in a medical record of a nursing facility must be signed and dated with the professional title of the author. Section 503.16B(6) requires a nursing facility to prepare in advance and provide to review staff at the beginning of the entrance meeting: copies of the selected minimum data sets (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.

Section 603.4B provides that for a hysterectomy performed during a period of retroactive eligibility, in order for payment to be made, either the physician informed the woman before the operation the procedure would make her sterile and the recipient and the

physician signed the written statement, or the woman met one of the exceptions provided in the physician's statement. Section 603.4(b)(2)(j) provides that for a fetal non-stress test to be covered, the provider's signature must be included in the final interpretation. Section 603.4B(2)(a) provides that reimbursement is available for an induced abortion to save the life of the mother only when a physician 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. Section 603.4B(3) provides that all hysterectomy certifications must have an original signature of the physician certifying the forms. A stamp or initial by billing staff is not acceptable. This section also provides that 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 Acknowledgment of Receipt of Hysterectomy Information Form. Section 603.4B(3)(e) provides that for a hysterectomy performed during a period of retroactive eligibility, in order for payment to be made, the physician must submit a written statement certifying that one of two conditions was met. If the physician informed the woman before the operation the procedure would make her sterile, the recipient and the physician must sign the written statement. Section 603.10(B)(2) provides that a 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. Section 603.13(A) provides that a certification for Intermediate Care Facility/Mentally Retarded care 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 as the first order in the physician's orders.

Section 903.1A(3) requires private duty nursing services to be provided under the direction of a physician and according to a signed plan of care. Section 903.1B(3) requires a provider of private duty nursing services to provide private duty nursing services initiated by a physician's order and designated in 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 home health agency services that will be provided, the frequency of the services, and the projected time frame necessary to provide such services. Section 903.1B(10) concerning private duty nursing provides that a signed, dated copy of a patient's bill of rights will be included in a patient's medical record. Section 903.1C requires the recipient or personal representative to sign the private duty nursing visit forms to document the hours and the services that were provided. Section 903.1C(A) provides that a recipient or personal representative is entitled to receive a statement of "Recipient Rights" from their provider. The recipient should review and sign this document.

Section 1003.6(b)(3) requires a recipient to sign and date a delivery receipt to verify that the dentures/partials were received and are accepted and/or acceptable. Section 1003.9(c)(6) provides that for orthodontia approvals, a dental consultant will sign the returned request form and indicate the "Total amount" shown on the form. Section

1003.16 requires dental providers to 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.

Section 1303.2(A)(1)(c) provides that all written orders must, at a minimum: (1) Clearly specify the start date of the order; (2) Include the length of need; (3) Be sufficiently detailed, including all options or additional features that are needed to meet the recipient's needs. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number; and (4) Be signed and dated by the treating physician/practitioner. Section 1303.2(A)(1)(c)(3)(c) provides that custom-fabricated items must be clearly indicated on the written order that has been signed and dated by the prescribing physician/practitioner. Section 1303.2(A)(1)(c)(5) states that someone other than the physician may complete the detailed description of the item. However, the ordering physician/practitioner must review the detailed description and personally indicate agreement by signing and dating the order. Section 1303.2(A)(2) states that a detailed product description may be completed by the provider/supplier but must also be signed and dated by the physician. Section 1303.2(A)(2) states that the detailed product description must contain the Healthcare Common Procedure Coding System (HCPCS) code, manufacturer, make and model, and the provider's/supplier's usual and customary charge for each item supplied. The warranty information must also be included. This may be completed by the provider/supplier but must also be signed and dated by the physician. Section 1303.2(B)(2) requires a provider to maintain records at the physical location of their business for each item billed to, and paid by, Nevada Medicaid 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. Appendix B to Chapter 1300 provides that an order for a power mobility device or power wheelchair must contain a physician or practitioner's signature. Appendix B also requires for external ambulatory infusion pump, insulin, a signed statement from the physician acknowledging medical necessity and a signed narrative from the physician documenting the recipient's compliance and ability to self adjust the insulin pump. For medical foods for inborn errors of metabolism, Appendix B requires a prescription signed by the requesting physician specializing in the treatment of metabolic conditions for requested "medical foods." For certain bi-level positive airway pressure devices, Appendix B requires a signed and dated statement completed by the treating physician declaring that the recipient is compliantly using the device and is benefiting or not benefiting from its use.

Section 1403.1A requires home health agency services to be provided under a plan of care signed by the physician. Section 1403.1B(4) provides that the plan of care is a written set of medical orders signed by the physician which certify the specific home health agency services that will be provided, the frequency of the services, and the projected time frame necessary to provide such services. Section 1403.1B(8) provides that a signed and dated statement acknowledging receipt of the patient's Bill of Rights will be included in a patient of a home health agency's medical record. Section 1403.1C requires a recipient of home health agency services or a personal representative to sign

the home health agency visit form to verify services were provided. Section 1403.1(2) requires a recipient of home health agency services to review and sign a statement acknowledging receipt of a statement of "Patient's Rights" from the provider.

Section 1603.1A(1)(d) provides that a certification must refer to the need for the Intermediate Care Facility for the Mentally Retarded (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. Section 1603.1B(4) provides that 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. Section 1603.1D(4) requires attachments for the Annual Continued Stay Payment Review Packets to include the most recent annual Interdisciplinary Team (IDT) review with signatures and titles of the participants, and the Physician's signed recertification of continued need for ICF/MR level of care. Section 1603.3B(3) requires authorization for an out-of-state placement to include 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.

Section 1803.1B(6) requires entries made in a recipient of adult day health care service's file to be signed and dated by the employee making the entry. In addition, the physician's orders must be signed and dated. Telephone orders must be initialed by the Registered Nurse upon receipt and signed by the physician within 10 days of the date of the order.

Section 1904.2(E) requires the parent or legally responsible individual to sign a consent and release of liability form before a minor child is transported under certain circumstances.

Sections 2102.7 and 2103.2B(1)(i) provide that the daily service record is documentation completed by a provider of home and community-based services for persons with mental retardation and related conditions, indicating the type of service provided and the time spent. The documentation will include the recipient's initials with a full signature of the recipient at the bottom of each daily record. If the recipient is unable to perform this task due to intellectual and/or physical limitations, this will be clearly documented in the Individual Support Plan (ISP). The direct service will initial after the daily services are delivered, with a full signature of the direct service staff at the bottom of each daily record. Sections 2103.16A(7) and 2104.6A(1) require all forms to be complete with signature and dates where required.

Sections 2201 and 2203.3B(1)(i) provide that the Daily Record is documentation completed by a provider of home and community-based services for the frail elderly, indicating the scope and frequency of the service 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 services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 2201 provides that the statement of understanding is the form used to inform applicants of their right to choose between the home and community-based services waiver for the frail elderly or placement in a nursing facility, as well as their right to file a grievance. The form must be signed by the applicant or the applicant's authorized representative if the applicant is not capable to sign the document. Section 2203.1A(3)(c) provides that if services documented on a Plan of Care are approved by the recipient and the case manager and the recipient's signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval form the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient's signature on the Plan of Care as soon as possible. Section 2203.3C(14) requires each recipient or recipient's authorized representative to complete, sign and submit all required forms on a timely basis. Sections 2203.12A(3)(a)(9) and 2204.6A(1)(e) require all forms to be complete with signatures and dates as appropriate. Section 2203.14 requires each applicant to be provided information on Advance Directives and also requires the signed form to be kept in each applicant's file. Sections 2204.3(d) and 2204.5(d) provide that an applicant or applicant's authorized representative's signature is necessary for all required paperwork. Section 2204.4(j) provides that a recipient may be terminated from the waiver or the waiver wait list if the recipient has signed fraudulent documentation on one or more of the provider time sheets and/or forms.

Sections 2302, 2303.3G and 2303.3B(2)(b)(12)(b) provide that the Daily Record is documentation completed by a provider of home and community-based services for persons with physical disabilities, indicating the type of service provided and the time spent. 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 Personal Care Attendant will initial after the daily services are delivered, with a full signature of the Personal Care Attendant 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 of services provided and the time spent providing those services. Sections 2303.1A(3)(c) and 2303.1C(4) provide that if services documented on a Plan of Care are approved by the recipient and the case manager and the recipient's signature cannot be obtained due to extenuating circumstances, services can commence with verbal approval from the recipient. Case managers must document the recipient's verbal approval in the case notes and obtain the recipient signature on the Plan of Care as soon as possible. Section 2303.3B(2)(e) provides that 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. Sections 2303.3C(14) and 2304.2 require a recipient or the recipient's authorized representative to sign all required forms. Section 2303.14A(4)(a)(7) requires all forms to be complete with signature and dates when required. Sections 2304.1C(4), 2304.1D(5) and 2304.1E(4) provide that the recipient's or the recipient's authorized representative's signature is necessary for all required paperwork.

Section 2403.1A(2)(d)(1)(a) concerning the provision of cognitive rehabilitation as a component of a comprehensive rehabilitation program for the severely neurologically impaired individual provides that the services must be directly and specifically related to an active written plan of care/treatment plan signed by the primary care physician after any needed consultation with a clinical psychologist, or physician experienced in working with the neurologically impaired. Section 2403.1B(3)(a) concerning comprehensive outpatient rehabilitation services provides that the initial evaluation must contain certain information and be signed by the treating physician to be considered for authorization. Section 2403.1B(3)(b)(2)(d) requires a review of a plan of care to be signed and dated.

Section 2602 provides that the Daily Record is documentation by a provider of intermediary services, indicating the type of service provided and the time spent. The documentation includes 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 intellectual and/or physical limitations, this will be clearly documented in the recipient file. The Personal Care Attendant will initial after the daily services are delivered, with a full signature of the Personal Care Attendant 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 of services provided and the time spent providing those services. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 2603.1B(5) provides that 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 Personal Care Assistant's file. Section 2603.2B provides that in order to ensure the safety and well-being of the recipient, documentation specific to the self-directed skilled services option is required and must be signed by all applicable individuals as identified on each form, updated annually and/or with any significant change in condition, and maintained in the recipient's file. Section 2603.3B provides that documentation specific to the Self-Directed 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.

Sections 2702 and 2703.3B(1)(e) provide that the Daily Record is documentation completed by a provider of home and community-based waiver services for the elderly in adult residential care, 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 indicating the scope and frequency of services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file.

Section 2702 provides that a statement of understanding form informing applicants/recipients of their rights concerning the home and community-based waiver for the elderly in adult residential care must be signed by the applicant/recipient or the applicant/recipient's authorized representative if he or she is not capable of signing the document. Section 2703.1A(3)(c) provides that if services documented on a Plan of Care are approved by the recipient of home and community-based waiver for the elderly in adult residential care services, and the recipient's signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the recipient.

Section 2703.3B(1)(n) concerning home and community-based waiver for the elderly in adult residential care provides that documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test and be signed by the physician or his/her designee. Section 2703.3C(7) requires a recipient or recipient's authorized representative to complete, sign and submit all required forms, and initial and sign the daily record to verify that services were provided. Section 2704.5(c) provides that the recipient's or the recipient's authorized representative's signature is necessary on all required paperwork.

Section 2803.1A(1)(c)(4) provides that any Medicaid eligible child requiring school based child health services may receive these services from the local school district provided the treatment services are a part of the recipient's written individualized education program (IEP) on file with the local school district. The plan may be subject to review by authorized DHCFP personnel, and must include the signature by the school-based or family designated physician, Advanced Practitioner of Nursing (APN) or Physician's Assistant substantiating that the treatment services are medically necessary services. Section 2803.1B(3) provides that an IEP 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). Section 2803.1D(1) provides that the treatment services must be documented through the IEP and substantiated that the services are medically necessary by a signature by the school based or family designated physician, APN or Physician's Assistant. A referral and signature do not constitute medical necessity. Section 2803.9 provides that audiological supplies, equipment and medical supplies must be reviewed and recommended by the presence of a signature on either the IEP or a prescription by a licensed physician, APN or Physician's Assistant

providing services within the scope of medicine as defined by state law and provided through the IEP.

Section 3203 provides that an election period is a time period for which hospice care may be provided when elected by a recipient and the recipient is deemed appropriate as evidenced by a certification of terminal illness signed by an attending physician and/or a hospice physician. An election statement is a signed statement by a terminally ill recipient or his or her representative indicating the election of hospice care and filed by the individual with a particular hospice which maintains the certification statement. A recipient who elects to discontinue hospice care must sign a statement indicating his/her desire to discontinue hospice care. Section 3203.1B(1)(c) provides that for the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification of terminal illness signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician. In addition, a signed hospice election statement must be provided. The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the QIO-like vendor. Section 3203.1C provides that 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. Section 3203.3(c) provides that an individual or representative may change the designation of the particular hospice from which hospice care will be received and 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. Section 3203.4 provides that to revoke the election of hospice care, the recipient or representative must file with the hospice a statement to be placed in the medical record that includes the following information: (1) A signed statement that the individual or representative revokes the individual's election for coverage of hospice care for the remainder of that election period with the date that the revocation is to be effective; and (2) The hospice agency is required to fax to 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. If the hospice recipient is residing in a nursing facility, the hospice agency is required to immediately submit to the nursing facility a signed copy of the notice of revocation for their medical records. Section 3203.5 provides that with adequate documentation explaining cause, a hospice may discharge a recipient. A copy of the signed discharge notice and the Hospice Medicaid Information form/Notice Discharge are required to be faxed to the QIO-like vendor within 72 hours of the discharge. If the hospice recipient is residing in a nursing facility 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. Section 3203.8A provides that entries into a clinical record are made and signed by the person providing the services.

Section 3502 provides that the daily record is documentation completed by a provider of personal care services, indicating the type of service provided and the time spent. 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 intellectual and/or physical limitations, this will be clearly documented in the recipient file. The personal care assistant (PCA) will initial after the daily services are delivered, with a full signature of the PCA 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 of services provided and the time spent providing those services. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 3503.1B(4) provides that 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 PCA's file. Section 3503.1B(18) states that a certificate must include the date of the training, the number of hours completed for each individual class, the training topic, and trainer signature. Section 3503.1B(22)(a) provides that a provider of personal care services may terminate services if the recipient or personal care representative is non-cooperative in the establishment or delivery of services, including the refusal to sign required forms. Section 3503.1B(23)(b)(4) requires a provider of personal care services to document on all service records a daily record form signed or initialed by the PCA and the recipient, attesting to the services provided and the time spent providing the service. Section 3503.1C provides that the recipient or personal care representative is responsible for reviewing and signing all required documentation related to the personal care services. The recipient or personal care representative will verify services were provided by, whenever possible, signing or initialing the PCA daily record to document the exact date and time the PCA was in attendance and providing services. Section 3503.1C provides that the recipient should review and sign the Recipient's Rights statement. Section 3503.1E(7)(c) provides that 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.

Section 3603.18(a)(18) provides that a managed care organization 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. Section 3603.23 provides that managed care organizations are required to secure signed acknowledgements from enrolled Medicaid recipients or their authorized representative for any prior resources (Medicare, private insurance, etc.). Section 3604(a)(2)(l) provides that a managed care organization must give notice by the date of the action for a signed written enrollee statement requesting termination or giving information requiring termination or reduction of services (where the enrollee understands that this must be the result of supplying that information).

Sections 3902 and 3903.3B(4) provide that the Daily Record is documentation completed by a provider of home and community-based services for assisted living, indicating the scope and frequency of the service 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 services provided. If a provider elects to use electronic signatures, they must have weekly printouts of the daily record in the recipient's file. Section 3902 provides that a statement of understanding form informing applicants/recipients of their rights concerning the home and community-based waiver for assisted living must be signed by the applicant/recipient or the applicant/recipient's authorized representative if he or she is not capable of signing the document. Section 3903.1A(13) provides that if services documented on a Plan of Care are approved by the applicant/recipient of home and community-based waiver for assisted living services, and the applicant/recipient's signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the recipient. Case managers must obtain the applicant/recipient signature on the plan of care as soon as possible. Section 3903.1C provides that an applicant/recipient or his/her legally responsible individual or authorized representative must sign the plan of care. Section 3903.3B(8)(e) concerning home and community-based waiver for assisted living provides that documentation of TB testing must be issued by a medical facility or licensed medical professional qualified to administer the test and be signed by the physician or his/her designee. Section 3903.3C(6) requires a recipient or recipient's authorized representative to complete, sign and submit all required forms.

D. Required to be in Writing

Section 101.1B requires a service provider to obtain a written statement confirming that a recipient of Home and Community Based Services was offered a choice of providers. Sections 103.3 and 103.3A(1) require all changes in ownership, address, or addition or removal or practitioners, or any other information pertinent to the receipt of Medicaid funds to be reported in writing and signed by the practitioner or the owner or administrator. Section 103.6(3) provides that 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. Section 103.7A(1) requires hospitals, nursing facilities, home health agencies, Personal Care Attendant providers, and hospices to maintain written policies and procedures concerning advance directives, and provide certain written information to all adult individuals (age 18 or older) upon admission or service delivery concerning advance directives.

Section 203.1A(1) contains multiple references to physicians writing orders. Sections 203.1A(2)(g)(4) and 203.1B(11)(b) contain a similar reference. Sections 203.1A(2) and 203.1B(11)(c) require a physician and other personnel involved in the care of a recipient to establish a written plan of care for each applicant or recipient before admission to any in-state or out-of-state acute inpatient hospital or before authorization of payment. Section 202.3A(1) requiring transfer of certain recipients to the next closest hospital or

nursing facility provides that exceptions may be made to the "next closest hospital or nursing facility" requirement only if the hospital documents, in writing, the recipient's and/or family's objection to the recipient having to leave the hospital and rural community, and why.

Section 300 concerning radiology services provides that diagnostic studies are rendered according to the written orders of the Physician, Physician's Assistant, or an Advanced Practitioner of Nursing, and must be directly related to the presenting symptoms.

Section 402.7 requires clinical supervisors of mental and behavioral health services to assure that 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. The definitions set forth in sections 402.13, 402.14, 402.16, 402.20, 402.26, 402.30, 402.31, 402.34 and 402.39 all contain references to information being written. Section 403.2(2) requires Behavioral Health Community Network providers to: (1) have written policies and procedures to ensure the medical appropriateness of the services provided; (2) operate under medical supervision and ensure medical 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; and (5) have a developed, implemented and maintained quality assurance program, which includes written position descriptions for all staff providing mental health services and a written quality assurance plan.

Sections 403.4(1)(d) and (e) require a psychiatric diagnostic interview and psychological assessment to conclude with a written report which contains a DSM 5-axial diagnosis and treatment recommendations. Section 403.6B(1) requires the assessing qualified mental health provider to approve a written Rehabilitation Plan. Section 403.8C(9)(c) provides that 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. Section 403.9A(1)(a)(1) requires a physician to issue a written order for admission or provide a verbal order for admission, which is later countersigned by the same physician. Section 403.9B(2)(b) requires the medical record for each recipient to include a written, individualized treatment plan to address the problems documented during the intake evaluation. Section 403.9B(3) requires all Medicare and Medicaid hospital providers to provide written information to all adult (age 18 and older) patients upon admission concerning 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. Section 403.9C(2) provides that during the time of the initial authorization the psychiatric assessment, discharge plan, and written treatment plan, with the attending physician's involvement, must be initiated. Section 403.12A(2)(c) requires

informed written consent by custodial parents or guardians for recipients under 16 years of age undergoing electroconvulsive therapy.

Section 503.7A provides that the absence of a Medicaid recipient from a nursing 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. Sections 503.8B and 503.8C provide that if a Medicaid recipient requests a nursing facility to manage their personal funds, the facility must obtain prior written authorization from the recipient. Section 503.8C also provides that 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. Section 503.11C requires a recipient of nursing facility services to provide written authorization to the provider and nursing facility if purchasing services and supplies not covered in the per diem. Section 503.13B provides that to transfer any Medicaid recipient from one facility to another, the transferring facility must: (1) obtain the physician's written order for transfer; and (2) obtain written consent from the recipient, his/her family and/or guardian. That section also provides that if a nursing facility intends to discharge a resident, they must provide to the resident/legal representative with a 30 day written notice and include the name and address of the person to whom the resident/legal representative may appeal the discharge. Section 503.18B(1)(3) provides that to request approval for out-of-state placement, the in-state nursing facility provider must submit the following documentation to Nevada Medicaid, Out-of-State Coordinator: a 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. The written statement must also include the understanding that burial and funeral arrangements must be made outside of Medicaid intervention. Documentation must show that every effort was made to purchase/obtain a burial policy if the individual does not have funeral or burial coverage.

Section 603.2(a) provides that a physician consultant's opinion and any services that are ordered or performed must be communicated by written report to the requesting physician or appropriate source. Section 603.2(e) provides that a physician is responsible for writing orders for certain services provided by home health agencies. Section 603.4B(3)(a) states that 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 Acknowledgment of Receipt of Hysterectomy Information Form. Section 603.4B(3)(c) provides that in an emergency hysterectomy, the physician who performs the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. Section 603.4B(3)(d) provides that a physician who performs a hysterectomy on a woman who is already sterile, the physician must certify 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. Section 603.4B(3)(e) provides that for a hysterectomy performed during a period of retroactive eligibility, in order for payment to be made, the physician must submit a written statement certifying that one of two conditions was met. Section 603.10(D)(4) provides that for observation services are provided by the hospital and supervising physician to recipients held but not admitted into an acute hospital bed for observation, the physician must write an order for observation status, and/or an observation stay that will rollover to an inpatient admission status. Attachment A to Chapter 600, Policy #6-06, provides that for vagus nerve stimulation to be covered, it must 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)).

Section 702.9 states that the Federal Upper Limit for multi-source drugs for which an upper limit has been set does not apply if a physician certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient, and the statement "brand medically necessary" appears on the face of the prescription.

Section 903.1B requires a provider of private duty nursing services to furnish qualified registered nurses and licensed practical nurses, under the supervision of a registered nurse to assist eligible Medicaid recipients with complex skilled nursing tasks as identified in the physician's written plan of care. Section 903.1B(5) requires a provider of private duty nursing services to inform a recipient orally and in writing of certain information concerning third party liability. Section 903.1B(8) prohibits a provider of private duty nursing services from releasing information related to recipients without written consent from the recipient or the recipient's legal representative, except as required by law. Section 903.1B(10) provides that a recipient has the right to be notified in writing of his rights and obligations before treatment is begun. Home health agencies must provide each patient and family with a written copy of the bill of rights. Section 903.1B(11) also requires home health agencies to provide written information to recipients at the onset of service concerning an individual's right under Nevada state law, NRS 449.540 to 449.690, to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate Advance Directives. Section 903.1B(14)(c) requires a provider of private duty nursing services to provide at least 5 calendar days advance written notice to recipients when PDN services are terminated for certain reasons. Section 903.1B(14)(d) provides that if services are to be cancelled the provider should submit written documentation within five working days.
The provider will send a written notice which advises the Nevada Medicaid Central Office 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. Section 903.1C(A)(5) states that a recipient of private duty nursing services has the right to access information in his own record upon written request. Section 903.2D provides that a provider of private duty nursing services 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 3 working days after the verbal request.

Section 1003.6(a)(7) provides that dentists should call or write to the fiscal agent to ensure a denture reline is not being done within six months of the date of the last reline or new denture purchase. Section 1003.7(b) states that if denture identification is impractical for another reason, the provider's written explanation will be evaluated by the Medicaid Dental Consultant for approval and exceptional processing. Section 1003.9(c)(10) allows orthodontic providers to discontinue treatment due to poor recipient compliance, returning any unused prorated expenditures to Medicaid with a written explanation for the Medicaid fiscal agent's records. Section 1003.13(b) states that a dentist should write, "Result of Healthy Kids" or "Result of EPSDT" on a prescription for fluoride Section 1003.16 requires dental providers to 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. Section 1003.18 (B)(1)(b) requires a provider to write "Hospital Admission" at the top of the Examination and Treatment Plan box of the claim form for inpatient hospitalization for a dental procedure. Section 1003.18(2) concerning outpatient dental services requires the provider to write, "Outpatient Facility Services" at the top of the Examination and Treatment Plan box of the claim form.

Section 1303.2(A)(1)(c) provides that written orders are acceptable for all transactions involving durable medical equipment, prosthetics, orthotics and supplies (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. All written orders must, at a minimum: (1) Clearly specify the start date of the order; (2) Include the length of need; (3) Be sufficiently detailed, including all options or additional features that are needed to meet the recipient's needs. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number; and (4) Be signed and dated by the treating physician/practitioner. Section 1303.4(b)(3) states that a recipient and/or representative must provide the written order/prescription from the physician/practitioner. Appendix B to Chapter 1300 requires devices employing the circulation of filtered air through silicone coated ceramic beads creating characteristics of fluid to be ordered in writing by a recipient's attending physician. Appendix B to Chapter 1300 also requires certain recipients using speech generating devices to have a formal written evaluation of their cognitive and communication abilities. Appendix B provides that for disposable incontinent supplies, the physician's order must contain certain information.

Section 1403.1B requires a provider of home health agency services to 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). Section 1403.1B(4) provides that the POC is a written set of medical orders signed by the physician which certify the specific home health agency services that will be provided, the frequency of the services, and the projected time frame

necessary to provide such services. Section 1403.1B(8) provides that a recipient of home health agency services has the right to be notified in writing of his rights and obligations before treatment is begun. Home health agencies must provide each patient and family with a written copy of the recipient's bill of rights.

Section 1503.3B(3) concerning the Healthy Kids Program states that medical records specific to EPSDT screening services should contain documentation of medical contraindication or a written statement from a parent or a guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations. Section 1503.5B provides that a dated written referral for diagnostic testing must be given to the recipient or parents or forwarded to the referral service provider.

Section 1603.3A(5) provides that the individual (and family or custodial agency if applicable) must agree in writing to an out-of-state placement in an intermediate care facility for the mentally retarded. Section 1603.7A(4) states that 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.

Section 1700 provides that therapy must be rendered according to the written orders of the physician, physician's assistant, or an advanced practitioner of nursing. Section 1702.1 defines speech pathologist as a person who engages in the practice of speech pathology in accordance with NRS 637B to provide services under a written plan of treatment prescribed by a physician, PA or APN. Section 1702.11 provides that the practice of respiratory care includes carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practitioner of nursing relating to respiratory care. Section 1703.1 provides that a written individualized plan addressing the documented disabilities needs to include the frequency, modalities and goals of the planned treatment. Section 1703.1A(1) provides that to be a covered therapy service for Nevada Medicaid, the services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified therapist and must be reasonable and medically necessary to the treatment of the individual's illness or injury.

Section 1803.1B(4) requires a physician to provide a written order for admission to an adult day health care facility. Section 1803.1B(5) requires a written assessment of a recipient's physical, emotional and mental status.

Section 1903.1E prohibits a provider of transportation services from releasing 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. Section 1904.3(E) provides that neither the non emergency transportation 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.

Section 2003.1B requires a recipient of audiology services to be informed in writing before receiving services that he or she will be responsible for payment.

Section 2103.2B(4)(b) provides that if a prospective service provider is exempted from required training, 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. Section 2103.16A(3)(a)(iv) concerning home and community based services for persons with mental retardation and related conditions provides that an Authorization for Release of Information form is needed for all waiver recipients. This form provides written consent for MHDS to release information about the recipient to others.

Section 2203.3B(3)(b) provides that if a prospective service provider is exempted from required training, 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. An Authorization for Release of Information form is needed for all waiver applicants and provides written consent for the Aging and Disability Services Division to release information about the applicant to others.

Section 2303.2A(2)(b)(2) provides that a written assessment will be conducted for each waiver applicant including the individual's abilities to perform Activities of Daily Living, the individual's medical and social needs, the individual's support system and all other services received. Section 2303.3B(2)(b)(7)(2) provides that if a prospective service provider is exempted from required training, 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.

Sections 2403.1A(2)(c)(2), 2403.1A(2)(d)(1)(a) and 2403.1A(2)(d)(2)(a) concerning comprehensive outpatient rehabilitation provides that the services shall be directly and specifically related to an active written plan of care/treatment plan. Section 2403.3A(1)(e) requires a recipient to have a viable written discharge plan. Section 2403.3A(5)(a) requires all rehabilitative services to be part of, and specifically related to, an active treatment program prescribed by a physician experienced in rehabilitation and be a part of a written plan of care/treatment plan that the physician reviews periodically, but not less than every 30 days.

Section 2603.2A(3) concerning intermediary service organizations provides that a physician must provide a written rationale for the time requested to perform a certain intervention. Section 2603.6 provides that reviews of intermediary service organizations will consist of but are not limited to, a pre-audit review of information to be submitted to DHCFP review staff prior to an onsite visit, an onsite review to evaluate the providers' compliance with this chapter, Chapter 3500, Chapter 100, and other regulatory requirements, and include a post-review conference and written report.

Section 2703.3B(1)(m) requires all service providers of home and community-based waiver services for the elderly in adult residential care to provide the appropriate waiver

case manager with written notification of serious occurrences involving the recipient, the employee, or issues affecting the Provider's ability to deliver services.

Section 3203.1B(1)(c) provides that for the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification of terminal illness signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician. Section 3203.1B(2) requires a written plan of care to be established and maintained for each individual admitted to a hospice program

Section 3303.1A(2)(s) provides that fraudulent acts include, except in emergency situations, dispensing, rendering or providing a service or items without a practitioner's written order and the consent of the recipient.

Section 3503.1 provides that all services must be performed in accordance with a written service plan approved by DHCFP, or its designee, developed in conjunction with the recipient or their representative, and based on the needs of the recipient being served as determined by a functional assessment. Section 3503.1B(20) requires a provider of personal care services to provide the local DHCFP District Office Care Coordination Unit with written notification of serious occurrences involving the recipient, the personal care assistant, or affecting the Provider's ability to deliver services.

Section 3601(g) requires managed care organizations (MCOs) to maintain written policies and procedures with respect to advance directives, as set forth in 42 CFR 438 and Section 1902(w)(1). Section 3603.5(F)(2)(d) requires a managed care organization 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. Section 3603.9 provides that a physician should document in a 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"). Section 3603.15 provides that a managed care organization may request disenrollment of a recipient if the recipient has been seen by at least three of the MCO's primary care provider and each primary care provider 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. Section 3603.15 also provides that 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 the DHCFP Managed Care contract. In addition, section 3603.15 requires a managed care organization to 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. Section 3603.15 provides that written or electronic notice to each primary care provider regarding patient rosters effective for each month must be provided to the provider within five business days of the MCO receiving the recipient file

from the enrollment sections. Section 3603.17(B) provides that when notified by DHCFP that an enrollee has been transferred to another plan or to fee-for-service, 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 fee-for-service provider. Section 3603.18 requires a managed care organization to have written information about its services and access to services available upon request to enrollees and potential enrollees. Section 3603.18(a)(18) requires a managed care organization to provide adult enrollees with written information on advance directives policies and include a description of applicable State law. Section 3603.18(a) requires a managed care organization to give each enrollee written notice of any significant change, as defined by the State, in any of the enumerations required to be included in the handbook. Section 3603.18(a) also requires each managed care organization to give written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice. Section 3603.19(C) provides that in cases where a primary care provider has been terminated, the MCO must notify enrolled recipients in writing and allow recipients to select another primary care provider, or make a re-assignment within 15 business days of the termination effective date. Section 3604(a) provides that an enrollee may file for an MCO appeal or grievance either orally or in writing.

E. Use of Facsimile

Section 1403.1D(1) provides that Home Health Agency services may be authorized after providers fax a completed Home Health Prior Authorization form to Nevada Medicaid's QIO-like vendor. The QIO-like vendor will fax the authorization to the requesting provider with the authorization number.

Section 2203.3B(1)(m) requires providers to report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the Aging and Disability Services Division case manager by telephone/fax within 24 hours of discovery.

Section 2303.3B(2)(c) provides that the DHCFP DO Case Manager must be notified of serious occurrences by telephone/fax within 24 hours of discovery.

Section 2703.7A(1) provides that a referral or inquiry for a home and community-based waiver for the elderly in adult residential care may be made or initiated by phone, mail, fax, in person or by another party on behalf of the potential applicant.

Section 3903.3B(6) requires providers of home and community-based waiver for assisted living services to report any recipient incidents, or issues regarding the provider/employee's ability to deliver services to the Aging and Disability Services Division case manager by telephone/fax within 24 hours of discovery.

Section 3203.3(c) provides that a transferring hospice agency must file a notice to change the designation of the particular hospice from which hospice care will be received and fax one copy to the receiving hospice and fax one copy to the QIO-like vendor along with a

Hospice Medicaid Information form. In addition, 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. Section 3203.4(a)(2) provides that a hospice agency is required to fax to the QIO-like vendor the signed copy of a revocation notice and a Medicaid Hospice Information form/Notice of Revocation within 72 hours, once the revocation notice has been signed. Section 3203.5(b) provides that a copy of a signed discharge notice and the Hospice Medicaid Information form/Notice Discharge are required to be faxed to the QIO-like vendor within 72 hours of a discharge.

Section 3503.1B(20) requires the DHCFP District Office Care Coordination Unit to be notified of serious occurrences involving the recipient, the personal care assistant, or affecting the provider's ability to deliver services by fax within 24 hours of discovery. Section 3503.1E(1)(b) provides that the approved service plan and authorization document are faxed to the provider upon acceptance when a recipient is at risk.

3. Nevada Check Up Manual

Two provisions of the Nevada Check Up Manual concern medical records information. These provisions are summarized below, and should be carefully considered to ensure that they are consistent with Medicaid Health Information Technology (HIT) activities and with any HIT legislation enacted during the 2011 Session of the Nevada Legislature.

Section 1003.1D of the Nevada Check Up Manual requires providers to keep any records necessary to disclose the extent of services furnished to participants and produce these records, upon request, to authorized personnel of the State. Section 1003.15 of the Nevada Check Up Manual provides that all information related to a family's application for Nevada Check Up is private, and that Nevada Check Up complies with HIPAA requirements in relation to the privacy of medical information. This section also provides that medical information received on a recipient will not be shared with anyone, including the participant and designated representative, except that information presented at a hearing and constituting the basis of a decision is open to examination by the participant's guardian or designated representative. If the participant or representative requests information regarding a medical condition, the physician providing the care must be consulted. Medical information may be shared within the Department of Health and Human Services without a formal release. Any other agency wishing copies of medical information must submit a release, signed by the legal guardian of the participant, stating what information is requested. Finally, medical providers will not disclose information concerning the care or services given to participants except as specifically allowed by state and federal laws and regulations.

Appendix A

NRS Sections Related to Medicaid and Health Information

Chapter 422 of NRS

NRS 422.510: "Records" means medical, professional or business records relating to the treatment or care of a recipient, or to a good or a service provided to a recipient, or to rates paid for such a good or a service, and records required to be kept by the [State] Plan [for Medicaid].

NRS 422.290 1. To restrict the use or disclosure of any information concerning applicants for and recipients of public assistance or assistance pursuant to the Children's Health Insurance Program to purposes directly connected to the administration of this chapter, and to provide safeguards therefor, under the applicable provisions of the Social Security Act, the Division shall establish and enforce reasonable regulations governing the custody, use and preservation of any records, files and communications filed with the Division.

2. If, pursuant to a specific statute or a regulation of the Division, names and addresses of, or information concerning, applicants for and recipients of assistance, including, without limitation, assistance pursuant to the Children's Health Insurance Program, are furnished to or held by any other agency or department of government, such agency or department of government is bound by the regulations of the Division prohibiting the publication of lists and records thereof or their use for purposes not directly connected with the administration of this chapter.

3. Except for purposes directly connected with the administration of this chapter, no person may publish, disclose or use, or permit or cause to be published, disclosed or used, any confidential information pertaining to a recipient of assistance, including, without limitation, a recipient of assistance pursuant to the Children's Health Insurance Program, under the provisions of this chapter.

NRS 422.550: 1. Each application or report submitted to participate as a provider, each report stating income or expense upon which rates of payment are or may be based, and each invoice for payment for goods or services provided to a recipient must contain a statement that all matters stated therein are true and accurate, signed by a natural person who is the provider or is authorized to act for the provider, under the pains and penalties of perjury.

2. A person is guilty of perjury which is a category D felony and shall be punished as provided in NRS 193.130 if the person signs or submits, or causes to be signed or submitted, such a statement, knowing that the application, report or invoice contains information which is false, in whole or in part, by commission or by omission.

3. For the purposes of this section, a person who signs on behalf of a provider is presumed to have the authorization of the provider and to be acting at the direction of the provider.

NRS 422.570: 1. A person is guilty of a gross misdemeanor if, upon submitting a claim for or upon receiving payment for goods or services pursuant to the [State] Plan, [for Medicaid] the person intentionally fails to maintain such records as are necessary to disclose fully the nature of the goods or services for which a claim was submitted or payment was received, or such records as are necessary to disclose fully all income and expenditures upon which rates of payment were based, for at least 5 years after the date on which payment was received.

2. A person who intentionally destroys such records within 5 years after the date payment was received is guilty of a category D felony and shall be punished as provided in NRS 193.130.

Miscellaneous Chapters of NRS

NRS 439.538: 1. If a covered entity transmits electronically individually identifiable health information in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, which govern the electronic transmission of such information, the covered entity is, for purposes of the electronic transmission, exempt from any state law that contains more stringent requirements or provisions concerning the privacy or confidentiality of individually identifiable health information.

2. A covered entity that makes individually identifiable health information available electronically pursuant to subsection 1 shall allow any person to opt out of having his or her individually identifiable health information disclosed electronically to other covered entities, except:

(a) As required by the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

(b) As otherwise required by a state law.

(c) That a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically.

3. As used in this section:

(a) "Covered entity" has the meaning ascribed to it in 45 C.F.R. § 160.103.

(b) "Individually identifiable health information" has the meaning ascribed to it in 45 C.F.R. § 160.103.

NRS 629.061: 1. Each provider of health care shall make the health care records of a patient available for physical inspection by:

(a) The patient or a representative with written authorization from the patient;

(b) The personal representative of the estate of a deceased patient;

(c) Any trustee of a living trust created by a deceased patient;

(d) The parent or guardian of a deceased patient who died before reaching the age of majority;

(e) An investigator for the Attorney General or a grand jury investigating an alleged violation of NRS 200.495, 200.5091 to 200.50995, inclusive, or 422.540 to 422.570, inclusive;

(f) An investigator for the Attorney General investigating an alleged violation of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive, or any fraud in the administration of chapter 616A, 616B, 616C, 616D or 617 of NRS or in the provision of benefits for industrial insurance; or

(g) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.

The records must be made available at a place within the depository convenient for physical inspection, and inspection must be permitted at all reasonable office hours and for a reasonable length of time. If the records are located outside this State, the provider shall make any records requested pursuant to this section available in this State for inspection within 10 working days after the request.

2. Except as otherwise provided in subsection 3, the provider of health care shall also furnish a copy of the records to each person described in subsection 1 who requests it and pays the actual cost of postage, if any, the costs of making the copy, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of X-ray photographs and other health care records produced by similar processes. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy.

3. The provider of health care shall also furnish a copy of any records that are necessary to support a claim or appeal under any provision of the Social Security Act, 42 U.S.C. §§ 301 et seq., or under any federal or state financial needs-based benefit program, without charge, to a patient, or a representative with written authorization from the patient, who requests it, if the request is accompanied by documentation of the claim or appeal. A copying fee, not to exceed 60 cents per page for photocopies and a reasonable cost for copies of X-ray photographs and other health care records produced by similar processes, may be charged by the provider of health care for furnishing a second copy of the records to support the same claim or appeal. No administrative fee or additional service fee of any kind may be charged for furnishing such a copy. The provider of health care shall furnish the copy of the records requested pursuant to this subsection within 30 days after the date of receipt of the request, and the provider of health care shall not deny the furnishing of a copy of the records pursuant to this subsection solely because the patient is unable to pay the fees established in this subsection.

4. Each person who owns or operates an ambulance in this State shall make the records regarding a sick or injured patient available for physical inspection by:

(a) The patient or a representative with written authorization from the patient;

(b) The personal representative of the estate of a deceased patient;

(c) Any trustee of a living trust created by a deceased patient;

(d) The parent or guardian of a deceased patient who died before reaching the age of majority; or

(e) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law.

The records must be made available at a place within the depository convenient for physical inspection, and inspection must be permitted at all reasonable office hours and for a reasonable length of time. The person who owns or operates an ambulance shall also furnish a copy of the records to each person described in this subsection who requests it and pays the actual cost of postage, if any, and the costs of making the copy, not to

exceed 60 cents per page for photocopies. No administrative fee or additional service fee of any kind may be charged for furnishing a copy of the records.

5. Records made available to a representative or investigator must not be used at any public hearing unless:

(a) The patient named in the records has consented in writing to their use; or

(b) Appropriate procedures are utilized to protect the identity of the patient from public disclosure.

6. Subsection 5 does not prohibit:

(a) A state licensing board from providing to a provider of health care or owner or operator of an ambulance against whom a complaint or written allegation has been filed, or to his or her attorney, information on the identity of a patient whose records may be used in a public hearing relating to the complaint or allegation, but the provider of health care or owner or operator of an ambulance and the attorney shall keep the information confidential.

(b) The Attorney General from using health care records in the course of a civil or criminal action against the patient or provider of health care.

7. A provider of health care or owner or operator of an ambulance and his or her agents and employees are immune from any civil action for any disclosures made in accordance with the provisions of this section or any consequential damages.

8. For the purposes of this section:

(a) "Guardian" means a person who has qualified as the guardian of a minor pursuant to testamentary or judicial appointment, but does not include a guardian ad litem.

(b) "Living trust" means an inter vivos trust created by a natural person:

(1) Which was revocable by the person during the lifetime of the person; and

(2) Who was one of the beneficiaries of the trust during the lifetime of the person.

(c) "Parent" means a natural or adoptive parent whose parental rights have not been terminated.

(d) "Personal representative" has the meaning ascribed to it in NRS 132.265.

NRS 441A.220: <u>All information of a personal nature about any person provided by any other person reporting a case or suspected case of a communicable disease, or by any person who has a communicable disease, or as determined by investigation of the health authority, is confidential medical information and must not be disclosed to any person under any circumstances, including pursuant to any subpoena, search warrant or discovery proceeding, except</u>:

1. As otherwise provided in NRS 439.538.

2. For statistical purposes, provided that the identity of the person is not discernible from the information disclosed.

3. In a prosecution for a violation of this chapter.

4. In a proceeding for an injunction brought pursuant to this chapter.

5. In reporting the actual or suspected abuse or neglect of a child or elderly person.

6. To any person who has a medical need to know the information for his or her own protection or for the well-being of a patient or dependent person, as determined by the health authority in accordance with regulations of the Board.

7. If the person who is the subject of the information consents in writing to the disclosure.

8. Pursuant to subsection 4 of NRS 441A.320 or NRS 629.069.

9. If the disclosure is made to the Department of Health and Human Services and the person about whom the disclosure is made has been diagnosed as having acquired immunodeficiency syndrome or an illness related to the human immunodeficiency virus and is a recipient of or an applicant for Medicaid.

10. To a firefighter, police officer or person providing emergency medical services if the Board has determined that the information relates to a communicable disease significantly related to that occupation. The information must be disclosed in the manner prescribed by the Board.

11. If the disclosure is authorized or required by NRS 239.0115 or another specific statute.