



NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY

Nevada Medicaid and Nevada Check Up Provider Contract

This Contract, effective on the date specified on the signature page of this document, between the State of Nevada Division of Health Care Financing and Policy, which includes Nevada Medicaid and Nevada Check Up, (hereinafter called the "Division") and the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the "Provider"), is made pursuant to Title XIX and Title XXI of the Social Security Act, Nevada Revised Statutes, Chapter 422, and state regulations promulgated there under to provide medical, paramedical, home and community based services and/or remedial care and services (hereinafter called "Service(s)") as defined in the Nevada Medicaid Services Manual to eligible Division Recipients (hereinafter called "Recipient(s)"). On its effective date, this Contract supersedes and replaces any existing contracts between the parties related to the provision of health care Services to Recipients.

Section 1. Provider Agrees

- 1.1 To adhere to standards of practice, professional standards and levels of Service as set forth in all applicable local, state and federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Division relating to the Provider's performance under this Contract and to hold harmless, indemnify and defend the Division from all negligent or intentionally detrimental acts of the Provider, its agents and employees.
- 1.2 To provide Services to Recipients without regard to age, sex, race, color, religion, national origin, disability or type of illness or condition. This includes providing Services in accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794). To provide Services in accordance with the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and regulations adopted hereunder contained in 28 C.F.R §§ 36.101 through 36.999, inclusive.
- 1.3 To provide Services in accordance with the terms, conditions and requirements of the Health Insurance Portability and Accountability Act of 1996 as amended and the HITECH Act (HIPAA) and related regulations at 45 CFR 160, 162 and 164.
- 1.4 To obtain and maintain all licenses, permits, certification, registration and authority necessary to do business and render service under this Agreement. Where applicable, the provider shall comply with all laws regarding safety, unemployment insurance and workers compensation. Copies of applicable licensure/certification must be submitted at the time of each license/certification renewal.
- 1.5 To check the List of Excluded Individuals/Entities on the Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors.
- 1.6 To comply with protocols set forth in the Nevada Medicaid Services Manual, the Nevada Check Up Manual and Medicaid Operations Manual, including but not limited to, verifying Recipient eligibility,

obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of provider.

- 1.7 To adhere to the provisions in 1396a(a)(68) of Title 42, United States Code, should the Division notify the provider it has reached the threshold of \$5,000,000 in annual payments from Medicaid; classifying the provider as an “entity”, and making the provider subject to this regulation.
- 1.8 To safeguard all information on applicants and recipients, in accordance with the requirements set forth in 42 CFR 431 subpart F and NRS 422.290. To ensure appropriate security, provider agrees that no processing or storage of Protected Health Information as defined by HIPAA or electronic transactions with the Division will be conducted from outside the geographic limits of the United States.
- 1.9 To exhaust all Administrative remedies, including the QIO-like vendor’s reconsideration and appeal process and the Fair Hearing process described at NRS 422.306, prior to initiating any litigation against the Division.

Section 2. Reimbursement

- 2.1 The Division agrees to provide for payment of Services to the Division-enrolled Provider for all Services properly authorized, timely claimed, and actually and properly rendered by Provider in accordance with federal and state law and the state policies and procedures set forth in the Nevada Medicaid Services Manual, Nevada Check Up Manual and Nevada Medicaid Billing Manual. Other claims are not properly payable Division claims.
- 2.2 The Provider is responsible for the validity and accuracy of claims whether submitted on paper, electronically or through a billing service.
- 2.3 The Provider agrees to pursue the Recipient’s other medical insurance and resources of payment prior to submitting a claim for Services to the Division’s Fiscal Agent. This includes but is not limited to Medicare, private insurance, medical benefits provided by employers and unions, worker compensation and any other third party insurance.
- 2.4 The Provider shall accept payment from the Division as payment in full on behalf of the Recipient, and agrees not to bill, retain or accept payments for any additional amounts except as provided for in item number 2.3 above. The Provider shall immediately repay the Division in full for any claims where the Provider received payment from another party after being paid by the Division.
- 2.5 Upon receipt of notification that the Provider is disqualified through any federal, State and/or Medicaid administrative action, the Provider will not submit claims for payment to the Division for services performed after the disqualification date.
- 2.6 The parties agree that any overpayment or improper payment to a Provider may be immediately deducted from future Division payments to any payee with the Provider’s Tax Identification Number at the discretion of the Division.
- 2.7 Continuation of this Agreement beyond the current biennium is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State Legislature and/or federal sources. The Division may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified

therein) if for any reason the Division's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired.

Section 3. Notices

All written notices or communication shall be deemed to have been given when delivered in person; or, if sent to address on file by first-class United States mail, proper postage prepaid. Provider shall notify the Division and/or Fiscal Agent within five (5) working days of any of the following:

- 3.1 Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest or felony conviction or any criminal charge.
- 3.2 Change in any ownership and control information described in 42 C.F.R. 455 subpart B. Among other information, this will include corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Division Funds.
- 3.3 When there is a change in ownership, the terms and agreements of the original Contract are assumed by the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined. Change in ownership requires full disclosure of the terms of the sale agreement, a new enrollment application and a newly signed Medicaid provider contract.

Section 4. Records

- 4.1 The Division is a covered entity as defined by HIPAA. Accordingly, the Division complies with the HIPAA Privacy Regulations promulgated in 45 CFR 160 and 164. Division health care providers will furnish protected health information about potential or current Division recipients without requiring the individual's authorization in accordance with 45 CFR 164.506 when requested by the Division for treatment, payment or health care operations.
- 4.2 For six years from the date of payment, or longer if required by law, Provider shall maintain adequate medical, financial and administrative records as necessary to fully justify and disclose the extent of service provided to Recipients under this Contract, including the requirements stated in the Nevada Medicaid Services Manual. The Division, its Fiscal Agent, the Medicaid Fraud Control Unit (MFCU), U.S. Department of Health and Human Services' employees, and/or authorized representatives shall be given access to the business or facility and all related Recipient information and records, including claims records, within 14 days from the date the request was made, except in the case of an audit by the Division, its Fiscal Agent, the MFCU, federal employees, and/or authorized representatives in which case such access shall be given at the time of the audit. If requested by the Division, its Fiscal Agent, or the MFCU, the Provider shall provide copies of such records free of charge. The Provider further agrees to give the Division, the authorized representatives and/or the MFCU, access to private interviews with any and all Recipients upon request. It is the Provider's responsibility to obtain any Recipient consent required in order to provide the Division, its Fiscal Agent, the MFCU, federal employees, and/or authorized representatives with requested information and records or copies of records.
- 4.3 Failure to timely submit or failure to retain adequate documentation for services billed to the Division may result in recovery of payments for medical services not adequately documented, and

may result in the termination or suspension of the Provider from participation as a Medicaid Provider.

- 4.4 The Provider agrees to furnish all information as described in 42 CFR Part 455, subpart B, as now in effect or as may be amended, including ownership or control information.
- 4.5 For Facility Providers Only: The Provider agrees to maintain records as are necessary to fully disclose to the Recipient, his/her representative and/or the Division, the management of Recipient trust funds and upon demand transfer to the Recipient, his/her representative and/or the Division the balance of his/her Recipient trust funds held by the Provider. Upon discharge, the Provider agrees to return monies and valuables of the Recipient to him/her or, in the event of the death, to the Recipient's legal representative.

Section 5. Miscellaneous

- 5.1 Both parties mutually agree that the Division Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Contract and is a part hereof as though fully set forth herein.
- 5.2 For Provider Groups Only: Group Provider affirms that it has authority to bind all member Providers to this Contract and that it will provide each member Provider with a copy of this Contract. The Provider Group also agrees to provide the Division with names and proof of current licensure for each member Provider as well as the name(s) of the individual(s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.
- 5.3 For Hospital, Nursing Facility, Hospice, Home Health Agency and Personal Care Service Providers Only: Provider shall provide all Recipients with written information regarding their rights to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives (durable power-of-attorney for health care decisions and declarations).
- 5.4 For Facility Providers Only: Provider shall cooperate in the transfer of Recipients from level to level as prescribed by the attending physician and all pertinent federal and state regulations.
- 5.5 For Providers Not Defined as Covered Entities under HIPAA in 45 CFR 160. Providers who are not required to comply with HIPAA privacy rules must inform the Division in writing and execute a business associate agreement or other appropriate confidentiality agreement concurrent with this Contract to protect and secure the privacy of all Recipients' Protected Health Information in accordance with the HIPAA requirements of 45 CFR 160, 162 and 164.
- 5.6 The Division does not guarantee the Provider will receive any Recipients as clients and the Provider does not obtain any property right or interest in any Division Recipient business by the Contract.
- 5.7 The Division may terminate this Contract with cause at any time with twenty (20) days prior written notice to the Provider.

5.8 The Division may terminate this Contract immediately when the Division receives notification that the Provider no longer meets the professional credential/ licensing requirements, or the enrollment screening criteria described at 42 CFR 455 subpart E.

5.9 It is further expressly understood and agreed that either party to this Contract, may terminate this Contract without cause at any time by 90 days prior written notice to the other party.

The parties agree that all questions pertaining to validity, interpretation and administration of this Contract shall be determined in accordance with the laws of the State of Nevada, regardless of where any Service is performed. The parties consent to the exclusive jurisdiction of the First Judicial District court, Carson City, Nevada for enforcement of this Contract.

Both parties mutually agree that the Provider is an independent contractor and all of the provisions of NRS 333.700 apply.

To continue as a Nevada Medicaid Provider, a new Enrollment Application and Nevada Provider Contract must be submitted 36 months from the date of DHCFP approval on the signature page of this Contract.

By signature below, Provider attests it is a Covered Entity in compliance with the HIPAA privacy rule at 42 CFR 164, or has complied with section 5.5 above.

Provider Signature: _____ Date: _____

Please Print or Type the following:

Provider Name: _____

Provider National Provider Identifier (NPI): _____

Provider Atypical Provider Identifier (API) (if applicable and for use only when resubmitting this contract or re-enrolling): _____

Provider Type: _____

Federal Tax ID Number or Social Security Number: _____

Legal Business Name: _____

Physical/Street Address of the Practice/Business Facility (*cannot be a P.O. Box*):

Nevada Division of Health Care Financing and Policy

Date: _____