PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
      i. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes ~~01967 – 01969~~ 01953 and 01996 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
      ix. Prescribed drugs (Page 3, Paragraph 12a).
      x. Outpatient laboratory and pathology services (Page 1a, Paragraph 3).
      xi. Dental services (CDT Codes, Page 2c, Paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (Page 2, Paragraph 7c); and disposable supplies (Page 2, Paragraph 7d).

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient hospital fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

b. (This paragraph intentionally left blank.)

5. Payments for services billed by Physicians using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

   a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 95% of the Medicare facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Surgical Codes 10000 – 58999 and 60000 – 69999.

   b. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.

   c. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Procedure Codes 93000 – 93350.

   d. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate effective July 1, 2015 through June 30, 2016. Effective July 1, 2016 Evaluation and Management Codes 99201 – 99499 will be reimbursed at 95% of the Medicare non-facility rate.

   e. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 95% of the Medicare non-facility rate.

   f. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes ~~01967 – 01969~~ 01953 and 01996 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.

   g. Medicine Codes 90281 – 90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

      Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's physician fee schedule rates were set as of October 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

e. Payment for community paramedicine services will be ~~calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be~~ the lower of billed charges or the amounts specified below:

1. The following Medicine codes and Evaluation and Management codes will be reimbursed at 63% of the Medicare non-facility rate: 90460, 90471 – 90474, 99341 – 99345, 99347 – 99350. The Medicare non-facility rate will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor.

f. Payment for services billed by a Nurse Anesthetist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges or the amounts specified below:

1. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes ~~01967 – 01969~~ 01953 and 01996 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
2. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
3. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

~~b.~~g. Payment for services billed by a Psychologist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility-based rate.
2. Vaccine Products require a NDC and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.
3. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility-based rate.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. Podiatrist, Optometrist, Chiropractor, Nurse Anesthetist and Psychologist fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

7. Telehealth Services

Telehealth is the delivery of services from a provider of health care to a patient at a different location, through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.

a. The originating site provider will be paid a telehealth originating site facility fee per completed transmission. Payment for an originating site facility fee will be reimbursed at the rate established in the CY 2012 Medicare Physician Fee Schedule.
b. The distant site provider is paid the current applicable Nevada Medicaid fee for the telehealth service provided. Instructions for submitting billing claims may be found on the Nevada Medicaid website: https://www.medicaid.nv.gov/providers/BillingInfo.aspx.
c. A provider will not be eligible for payment as both the originating and distant site for the same patient, same date of service.
d. Fee schedule rates are the same for both governmental and private providers. The Nevada Medicaid fee schedules may be found on the following website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/