

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-A
Page 9a

G. Transplants

1. Basic Data Sources for Rate Development

- a. 2014 Milliman Research Report – U.S. Organ and Tissue Transplant and Cost Estimate.
- b. 2013 The Lewin Group Study – Cost Benefit Analysis of Corneal Transplant.

2. Rate Conversion

- a. Hospital Services will be reimbursed at 35% of the Hospital Billed Charges for each transplant procedure as listed in the 2014 Milliman Study.
- b. Procurement will be reimbursed at 100% of the Procurement charges for each transplant procedure as listed in the 2014 Milliman Study with the exception of Cornea procurement. Cornea procurement will be reimbursed at 100% of the Procurement charges as listed in the 2013 The Lewin Group Study.

For hospitals with accredited transplant programs, Nevada Medicaid will pay the lower of 1) billed charges; or 2) an all-inclusive fixed fee for the entire admission period (from admission date to discharge date). Organ procurement is a separate reimbursable charge, over and above the facility inpatient component of the transplant service. Organ procurement is reimbursed the lower 1) billed charges; or 2) the maximum reimbursement set forth below.

The maximum reimbursement rate for organ transplant procedures and procurement are:

Organ	Hospital Services	Procurement
Liver	\$83,700 \$139,685	\$34,300 \$95,000
Kidney	\$30,600 \$41,860	\$27,500 \$84,400
Tissue		
Bone Marrow - Autologous	\$44,190 \$74,305	\$10,800 \$10,700
Bone Marrow - Allogeneic Related	\$97,020 \$167,860	\$10,800 \$55,700
Bone Marrow - Allogeneic Unrelated	\$136,080 \$167,860	\$10,800 \$55,700
Cornea	\$5,490 \$7,000	\$0 \$2,500

Commencing July 1, ~~2009-2016~~ and annually thereafter, the amounts listed above shall be adjusted for inflation using the Consumer Price Index for Inpatient Services; BLS Series CUUR0000SS5702.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-A

Page 15a

1. The updated CAH Medical/Surgery interim rate will be calculated by dividing the total Title XIX program inpatient costs by the total program inpatient days as reported in the immediate prior years' Medicare/Medicaid cost report as filed.
2. If Title XIX data reported in the immediate prior years' Medicare/Medicaid cost report is not sufficient to calculate the adjusted CAH Medical/Surgery interim rate, the CAH Medical/Surgery interim rate will default to the Medical/Surgery rate paid to general acute care hospitals for the same service. This applies only to Critical Access Hospitals that have an existing CAH Medical/Surgery interim rate for the prior year.
3. Maternity, newborn, **Psychiatric/Substance Abuse** and administrative days will be reimbursed at the rate paid to general acute care hospitals for the same in-patient services.
4. Critical Access Hospitals that do not have a CAH Medical/Surgery interim rate for the prior year based on the methodology in Paragraph VII.B.3, will be assigned either the prior years' Total Medicare inpatient per diem rate if available or the rate paid to general acute care hospitals for the same Medical/Surgery level of services until such time as the CAH Medical/Surgery interim rate can be updated according to the methodology detailed in Paragraphs VII.B.2 and VII.B.3.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with paragraph VI above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-B

Page 1c

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 rates for respiratory, cardiovascular, hemic, lymphatic, mediastinum and diaphragm related surgical codes (30000 - 39999).
 - 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.
 - 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 Medicaid 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 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nevada

Attachment 4.19-B

Page 1d

6. Medical care and any other type of remedial care provided by licensed practitioners:

- a. Payment for services billed by a Podiatrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
 1. Surgical codes will be reimbursed at 74% of the Medicare facility rate
 2. Radiology codes will be reimbursed at 88% of the Medicare facility rate
 3. Medicine codes and Evaluation and Management codes will be reimbursed at 66% of the Medicare non-facility rate. Vaccine Products will be reimbursed at 85% of the Medicare non-facility rate.
 4. When codes 90465-90468, 90471-90474, 99381-99385 and 99391-99395 are used for EPSDT services, the reimbursement will be 85% of the Medicare non-facility rate.
- b. Payment for services billed by an Optometrist will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or 85% of the Medicare non-facility rate. See also 12.d.,
- c. Payment for services billed by a Chiropractor will be calculated using the April 1, 2002 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2002 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
 1. Medicine codes and Evaluation and Management codes will be reimbursed at 70% of the Medicare non-facility rate
 2. Radiology codes will be reimbursed at 32% of the Medicare facility rate.
- d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife 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. Payment will be the lower of billed charges, or the amounts specified below:
 1. Surgical codes will be reimbursed at 59% of the Medicare facility rate.
 - ~~1.2.~~ **Radiology codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.**
 - ~~2.3.~~ Medicine codes and Evaluation and Management codes will be reimbursed at 63% of the Medicare non-facility rate.
 - ~~3.4.~~ Obstetrical service codes will be reimbursed at 75% of the Medicare non-facility rate.
 - ~~4.5.~~ When codes 90465-90468, 90471-90474, 99381-99385 and 99391-99395 are used for EPSDT services, the reimbursement will be 72% of the Medicare non-facility rate.