MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Alcohol/Substance Abuse Services are being proposed to clarify requirements for case management services and referring providers to MSM Chapter 2500 – Case Management, for further clarification of definitions, service requirements, service limitations, provider qualifications and documentation requirements. This is not a change to policy and is only providing further clarification.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective April 15, 2016.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29937 MSM 400 - MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES	MTL 21/15 MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.4	**Outpatient Mental Health Services**	Added language to refer providers to MSM Chapter 2500 for further clarification of case management services.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates

4. Interns/Psychological Assistants

The following are also considered QMHPs:

a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).

b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

Reimbursement for Interns/Psychological Assistants is based upon the rate of a QMHP, which includes the clinical and direct supervision of services by a licensed supervisor.

403.4 OUTPATIENT MENTAL HEALTH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. For case management services, refer to Medicaid Services Manual, Chapter 2500 for Non-SED and Non-SMI definitions, service requirements, service limitations, provider qualifications and documentation requirements.

a. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental Health Screen.

1. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.

2. Comprehensive Assessment – A comprehensive, evaluation of a recipient's history and functioning which, combined with clinical judgment, is to include a covered, current ICD diagnosis and a summary of identified rehabilitative

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TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

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SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Alcohol/Substance Abuse Services are being proposed to clarify requirements for the Behavioral Health Community Network (BHCN) providers to identify and measure specific domains of quality and care and the requirements for the BHCN Quality Assurance (QA) program and report.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective May 1, 2016.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29936 MSM 400 - MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES	MTL 21/15 MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.2.B.6	**Provider Standards**	Removed previous language and replaced with specific requirements for the BHCN QA Plan and identifies domains of care and clarified what is to be reported on.

5. Work on behalf of recipient's in their care to ensure effective care coordination within the state system of care among other community mental health providers and other agencies servicing a joint recipient;

6. ~~Have a developed, i~~Implement~~ed~~ and maintain~~ed~~ a Quality Assurance (QA) program~~,~~ which ~~includes:~~ continually assesses quality measures and seeks to improve services on an ongoing basis. A QA program description must be submitted upon enrollment and updated annually on the anniversary of the BHCN enrollment month. The BHCN's QA program description and report must include the following:

   a. A list of behavioral health services and evidence based practices that the BHCN provides to recipients.

      i. Identify the goals and objectives of the services and methods which will be used to restore recipient's highest level of functioning.

   b. An organization chart that outlines the BHCN's supervisory structure and the employees and positions within the agency. The organizational chart must identify the medical supervisor, clinical supervisor(s), direct supervisor(s), affiliated qualified mental health professional(s) and qualified mental health associate(s) including names and National Provider Identifier (NPI) numbers for each.

   c. Document how clinical and supervisory trainings are conducted and how they support standards to ensure compliance with regulations prescribed within MSM Chapter 400. Provide a brief description of material covered, date, frequency and duration of training, location, names of employees that attended, and the name of the instructor.

   d. Demonstration of Effectiveness of Care, Access/Availability of Care, and Satisfaction of Care. The BHCN must adhere to the QIO-like vendor's Billing Manual for further instructions concerning the required Quality Measures below. The following quality measures are required:

      i. Effectiveness of Care:

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1. Identify the percentage of recipients demonstrating stable or improved functioning.

2. Develop assessment tool to review Treatment and/or Rehabilitation Plans and report results of assessment.

ii. Access and Availability to Care:

~~6.~~

1. Measure timeliness of appointment scheduling between initial contact and rendered face to face services.

~~ii.~~iii. Satisfaction of Care:

1. Conduct a recipient and/or family satisfaction survey(s) and provide results.

2. Submit a detail grievance policy and procedure.

e. The DHCFP may require the BHCN to submit a DHCFP approved Corrective Action Plan (CAP) if the BHCN's QA report has adverse findings. The BHCN's CAP shall contain the following and must be provided within 30 days from date of notice:

i. The type(s) of corrective action to be taken for improvement;

ii. The goals of the corrective action;

iii. The time-table for action;

iv. The identified changes in processes, structure, internal/external education;

v. The type of follow-up monitoring, evaluation and improvement.

f. QA Programs must be individualized to the BHCN delivery model and services provided. Duplication of QA documentation between BHCNs may be cause for rejection without review.

~~b. An organization chart showing lines of authority, including medical, clinical and direct supervision and responsibility for services;~~

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~~c. Documentation of staff qualifications, licensures and documented competencies;~~

~~d. Written position descriptions for all staff providing mental health services;~~

~~e. Documentation of staff training;~~

~~f. Philosophy and support for use of selected program clinical practices;~~

~~g. Accounting methods that reflect Medicaid billing standards;~~

~~h. A written QA plan containing:~~

~~1. Identified aspects of qualify of care which supports person and family-centered practice;~~

~~2. Indicators and clinical criteria to continually and systematically monitor these aspects of quality care;~~

~~3. Established markers, which indicate problems or opportunities to improve care;~~

~~4. Identified action to correct problems and improve substandard care;~~

~~5. Tools to assess the effectiveness of the actions taken; and~~

~~6. A process to submit an annual QA report to the DHCFP/Department of Health and Human Services (DHHS).~~

Failure to submit QA Program documentation or failure to meet standards of the QA Program and/or Corrective Action Plan (CAP) as required in MSM 403.B.6 within designated timeframes will result in the imposition of sanctions including, but not limited to, partial suspension and/or termination of the BHCN provider contract. Further clarification of the QA Program requirements may be found in the Billing Manual.

A BHCN that is accredited through the Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF) or Council of Accreditation (COA) ~~accredited~~ may substitute a copy of the documented QA ~~processes and plan~~ program and report required for the certification in lieu of the requirements of 403.2B.6~~.g~~. Accreditation must be specific to a BHCN delivery model.

C. Recipient and Family Participation and Responsibilities

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April 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – PHYSICIANS SERVICES, ATTACHMENT A, #6-04

BACKGROUND AND EXPLANATION

A revision to Medicaid Services Manual (MSM) Chapter 600, Physicians Services, Attachment A, #6-04 Intrathecal Baclofen (ITB) Therapy is being proposed to align with current billing procedures. Current policy incorrectly states that no prior authorization is required for ITB Therapy; however, prior authorization is required.

These changes are effective upon approval at Public Hearing.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29838 Physician Services, Attachment A, #6-04	MTL 25/15 Physician Services, Attachment A, #6-04

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Attachment A, #6-04, ITB Therapy	**B**	Policy incorrectly states that a prior authorization is not required for ITB therapy, but a prior authorization is required. We are changing policy to align with our billing requirements.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates

A. DESCRIPTION/POLICY

FDA approved Intrathecal Baclofen (ITB) Therapy ~~(ITB)~~ is a Nevada Medicaid covered benefit for recipients with severe spasticity of spinal cord origin, [(e.g. Multiple Sclerosis (MS), Spinal Cord Injury (SCI)], or spasticity of cerebral origin, [e.g., Cerebral Palsy (CP), and Brain Injury (BI)]~~)~~, who are unresponsive to oral Baclofen therapy or who have Intolerable Central Nervous System (CNS) side effects.

B. PRIOR AUTHORIZATION IS ~~NOT~~ REQUIRED

C. COVERAGE AND LIMITATIONS

1. Coverage of treatment will be restricted to recipients with the following indicators:

   a. Spasticity due to ~~CP or BI~~ spinal cord origin or spasticity of cerebral origin. ~~(i~~If spasticity is result of BI, the injury must have occurred over one year prior to be considered for ITB therapy;

   b. Severe spasticity (as defined by a score of 3 or more on the Ashworth Scale) in the extremities for a duration of six months or longer;

   c. Recipients with increased tone that significantly interferes with movement and/or care;

   d. Spasm score of 2 or more; documentation to include pre and post testing of strength, ~~D~~degree of muscle tone, and frequency of spasm (Spasm Scale not applicable to CP recipients as spasms are not a frequent symptom in these recipients);

   e. Recipient is four years or older and has sufficient body mass to support the infusion pump;

   f. Documented six-weeks or more of failed oral antispasmodic drug therapy at the maximum dose. Recipient is refractory to oral Baclofen, or has intolerable side effects;

   g. Recipient has adequate cerebrospinal fluid flow as determined by myelogram or other studies;

   h. Recipient has no known allergy to Baclofen;

   i. Documentation of a favorable response to a trial dose of ITB prior to pump implantation. If recipient requires a second and/or third trial dose of ITB, documentation needs to include videotape of the recipient's arm and leg range of motion to assess spasticity and muscle tone before and after increased test doses of ITB. Recipients who do not respond to a 100-mcg intrathecal bolus of medication are not candidates for an implanted pump for chronic infusion therapy. Recipient must be free of infection at the time of the trial dose;

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j. Recipient, family, and physicians should agree on treatment goals. Recipient, family and caregivers should be motivated to achieve the treatment goals and be committed to meet the follow-up care requirements;

k. Recipient must be free of systemic infection and/or infection at the implantation site at the time of surgery;

l. Benefit coverage includes up to three trial doses of ITB, surgical implantation of the device, and follow-up physician office visits for dose adjustments and pump refills.

2. Documentation in the recipient's medical record should include what the expected functional outcomes and improvements in quality of life are for the recipient post procedure, e.g., increased independence, ease of caretaking activities, decreased pain, increased ADL's, and improved communication. Also, document why the recipient is not a candidate for Botox injections.

3. Reimbursement for recipients with low muscle tone (often described as floppy muscles), chorea (uncontrollable, small jerky types of movements of toes and fingers), or athetosis (involuntary movements of face, arms or trunk) are not a Nevada Medicaid benefit.

D. COVERED CODES

For a list of covered procedure and diagnostic codes, please see the billing manual.

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TRANSMITTAL LETTER

April 11, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1300 – DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1300 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies are being proposed as follows:

- Clarifying Provider responsibilities to address mobility equipment proper use and modifications were made to the Mobility Assessment Form.
- Clarifying the requirements and allowable documentation on orders/scripts, revised language to indicate "rental only" modifying used equipment option policy as NV Medicaid hasn't ever reimbursed for equipment used by other recipients.
- Addition of non-covered items electric implantable osteogenesis stimulators, travel, activity, or corner chairs, feeder seats and floor sitters.
- Policies for hospital beds were revised and oximeter policy changed to allow purchase rather than just rental.
- Added definition of "current" as being within the last 60 days for specific equipment to spell out timeframes for the provider.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective May 1, 2016.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29790 CHAPTER 1300 – DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES	MTL 27/15 CHAPTER 1300 – DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.1.A.9	**General Information**	Updated web link for rates location.
1303.1.A.10	**General Information**	Added "access to" a same item for non reimbursement.
1303.1.B.8	**Provider Responsibility**	Added the provider is responsible to teach how to care for, use, maintain, and how not to use the equipment.
03.2.A.1.a	**Orders/ Prescriptions**	Clarified orders/scripts need to be relevant to the face-to face and it is required to be with the treating physician and clearly documented.
1303.2.A.1.b.1	**Verbal Orders**	Corrected the web link to DME MAC Noridian
1303.2.A.2	**Detailed Product Description**	Clarified usual and customary (UCC) to manufacturer's invoice of cost and that warranty information can be documented by the physician.
1303.3	**Rental and Purchase Option**	Added a manufacturer's invoice is required when NV Medicaid has not assigned a rate.
1303.3.a.4.a, b, c, d	**Rent-to-Purchase Option**	Removed UCC and whichever is less verbiage and reworded to clarify rental only option and removed UCC adding if no rate assigned a manufacturer's invoice is needed. Added modifier verbiage for RR and NU to locate when an item is rental only.
1303.3.a.5.a	**Rental Only option**	Reworded for clarification.
1303.3.b.2, a, c	**Purchase Used Equipment Option**	Changed Used to Rental for clarity of equipment options and reworded a and c.
1303.4.A.2	**Review Consideration**	Updated web link to Noridian.
1303.4.A.5.d, C	**DMEPOS Specific Prior Authorization Forms**	Added the clinical assessment section of the Mobility Assessment Form must be completed by the treating physician. Corrected web links.
1303.4.A.6.a	**Denied Prior Authorization Requests**	Reworded language and added sections clarifying process of when a prior authorization is denied what the recipient can do.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.4.B.2	**Coverage and Limitations**	Updated web link.
1303.5.A.2.e	**Delivery Method 2. Suppliers utilizing a delivery/shipping service to deliver items**	Clarified NV Medicaid does not reimburse for shipping/delivery to an out of state provider and will only reimburse for Medicare covered supplies for a Medicare covered recipient.
1303.9.A	**DME at Institutional Facility (IF)**	Added reference to nursing facility MSM Chapter 500 Nursing Facilities.
Appendix A.1	**Non-Covered**	Added travel, activity, or corner chairs, feeder seats and floor sitters.
Appendix A.2	**Non-Covered**	Updated web link to DHCFP rates for DMEPOS.
Appendix B, page 1	**Forms and Documentation, Misc policy statements**	Added to determine pricing, a MSRP will not be accepted. Reworded for rental only items and added reimbursement will not be made if item is provided before PA is approved.
Appendix B, page 4	**Beds and Accessories**	Separated types of beds clarifying policy requirements and requiring manufacturer's cost invoice for beds without a rate. Added note for type of beds not covered and why.
Appendix B	**Forms and Documentation**	Added throughout Manufacturer's cost invoice required for items without a rate.
Appendix B, Diabetic Services, page 18, and 20	**Forms and Documentation and Qualifications**	Clarified current is defined as within last 60 days.
Appendix B, Mobility Assistive Equipment	**Forms and Documentation Requirements**	Added Nevada Medicaid assigned rate and removed Usual and Customary Charge for clarification of pricing.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix B, Orthotic and prosthetic Devices, TLSO/LSO	**Misc Policy Statements**	Note added regarding low back pain and brace therapy not being of a benefit and not recommended.
Appendix B, Osteogenesis Devices	**Misc Policy Statements**	Clarified rental calculations and added Electric Implantable devices are not covered.
Appendix B, Pneumatic Compression devices and Pregnancy Related	**Misc Policy Statements**	Added notes as rental items only.
Appendix B, Respiratory, Apnea	**Misc Policy Statements**	Removed references to time limits, prior authorizations, and specific HCPCs. Note added regarding rental calculation towards purchase price.
Appendix, Respiratory, BiPAP and CPAP	**Misc Policy Statements**	Added replacement requires proof of compliance or medical necessity.
Appendix B, Respiratory, High Frequency	**Misc Policy Statements**	Note added stating non reimbursement for item when provided prior to PA approval.
Appendix B, Respiratory Services, Oximeter	**Misc Policy Statements**	Condensed Qualification for all recipients, removed verbiage regarding short and long term, added manufacturer's invoice if no rate and rental calculation for purchase, clarified recertification eligibility, opened policy for purchase, clarified requirement for additional features and plan for training.

1302 DEFINITIONS

ANKLE-FOOT ORTHOSES

Ankle-foot orthoses extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish them from foot orthotics, which are shoe inserts that do not extend above the ankle.

CUSTOM FABRICATED ORTHOSIS

A ~~C~~custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, parts, etc. It involves substantial work such as cutting, bending, molding, sewing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

DISPOSABLE MEDICAL SUPPLIES

Disposable medical supplies are those items which are not reusable, and are primarily and customarily used to serve a medical purpose, and generally are not useful to a person in the absence of an illness or injury.

DURABLE MEDICAL EQUIPMENT (DME)

DME is defined as equipment which can withstand repeated use, and is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

DURABLE MEDICAL EQUIPMENT MEDICARE ADMINISTRATIVE CONTRACTOR (DME MAC)

The Centers for Medicare and Medicaid Services (CMS) utilize four insurance companies to process durable medical equipment, prosthetic, orthotic, and disposable medical supply claims for Medicare in four distinct jurisdictions. Nevada is in Jurisdiction D. This was formerly referred to as Durable Medical Equipment Regional Carrier (DMERC).

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

Aggregate term used under the Medicare program and by some Medicaid programs, which incorporates all durable medical equipment, prosthetics, orthotics, and disposable medical supplies. The acronym is pronounced “demipose”.

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MEDICAL DOCUMENTATION

For the purposes of obtaining DMEPOS through Nevada Medicaid and Nevada Check Up (NCU), medical documentation used to support medical necessity is part of a medical record which is completed, signed and dated by a licensed medical professional. Clinical reports or assessments required to support medical necessity must be from a licensed/certified professional performing within their scope of practice. Information used as medical documentation cannot be compiled or composed by the recipient, their relatives or representatives.

MISUSE

To use in a manner in which an item is not intended, excessive use, or to use incorrectly.

MOLDED TO PATIENT MODEL ORTHOSIS

A molded-to-patient-model orthosis is a particular type of custom fabricated orthosis in which an impression of the specific body part is made (by means of a plaster cast, CAD-CAM technology, etc.) and this impression is then used to make a positive model (of plaster or other material) of the body part. The orthosis is then molded on this positive model.

ORTHOSIS

An orthosis (brace) is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. An orthosis can be either prefabricated or custom-fabricated.

PREFABRICATED ORTHOSIS

A ~~P~~pre-fabricated orthosis is one which is manufactured in quantity without a specific patient in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

PROSTHETIC DEVICES

Prosthetic devices are replacement, corrective, or supportive devices prescribed by a physician (or other licensed practitioner of the healing arts within the scope of his practice as defined by state law) to:

a. Artificially replace a missing portion of the body;

b. Prevent or correct physical deformity or malfunction; or

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1303 POLICY

1303.1 DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTIC DEVICES, DISPOSABLE MEDICAL SUPPLIES (DMEPOS) PROGRAM

A. GENERAL INFORMATION

1. DMEPOS Program coverage areas include parenteral and enteral nutrition (PEN), medical foods and oxygen and oxygen equipment; all of which must meet the definition of durable medical equipment, a prosthetic device, an orthotic device, or disposable medical supply.

2. Durable Medical Equipment (DME) of a medical nature, needed as a result of a medical condition, and which lasts a considerable time without significant deterioration and appropriate for use within the home, is covered by the Division of Health Care Financing and Policy (DHCFP) and Nevada Check Up (NCU) for eligible recipients. New ~~E~~equipment, repairs, or replacement requires medical documentation and ~~is~~are subject to limitations of model, cost and frequency, which are deemed reasonable by the program.

3. Disposable medical supplies are covered by the DHCFP and NCU for eligible recipients only if they are necessary for the treatment of a medical condition and would not generally be useful to a person in the absence of an illness, disability or injury.

4. All DMEPOS products and services must be medically necessary, safe and appropriate for the course and severity of the condition, using the least costly and equally effective alternative to meet the recipient's medical needs.

5. Deluxe equipment will not be authorized when it is determined that a standard model will meet the basic medical needs of the recipient. The recipient must have a medical need for each component of the item(s) requested. This includes accessory items and features not included in the standard models of the product.

6. Equipment which the program determines is principally for education or rehabilitation will not be approved.

7. Refer to Appendix A of this Chapter for non-covered services, and for special coverage considerations that are based on medical necessity outside of the DMEPOS Program or that is considered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Healthy Kids Program.

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8. Refer to Appendix B of this Chapter, for Coverage and Limitation Policies regarding specific coverage information, qualifications, documentation requirements, and miscellaneous information.

9. Refer to the Provider Type 33 DMEPOS Fee Schedule for specific item coverage under the DMEPOS program. Access http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain~~http://dhcfp.nv.gov/Ratesunit.htm~~.

10. The DHCFP does not reimburse for items that are the same or similar to items that the recipient has already acquired~~,~~ or has access to such as, but not limited to, back-up equipment, unless allowed in the specific policy for that item. Duplicate items intended to be used within the same span of time are not considered medically necessary.

11. Individuals deemed eligible for Nevada Medicaid or NCU and who have ownership of existing equipment from any prior resource must continue using that equipment. Existing equipment, regardless of who purchased it, must be identified, including the estimated date of purchase or age of equipment, and medical documentation showing evidence of need for replacement. All documentation must be submitted with a prior authorization request.

12. Some items not covered under the DMEPOS Program may be covered under other Medicaid programs such as Pharmacy, Audiology, or Ocular programs. Additional resources may be available through other agencies or through waiver programs for items not covered under the DMEPOS Program or by the Medicaid State Plan.

B. PROVIDER RESPONSIBILITY

1. All DMEPOS providers must be licensed through the Nevada State Board of Pharmacy (BOP) as a Medical Device, Equipment, and Gases (MDEG) supplier, with the exception of a pharmacy that has a Nevada State Board of Pharmacy license and provides DMEPOS. Once licensed, providers must maintain compliance with all Nevada BOP licensing requirements. Reference Medicaid Services Manual (MSM) Chapter 100 – Medicaid Program for further information on enrollment and provider responsibilities. Also refer to the Enrollment Checklist posted on the following website at: https://www.medicaid.nv.gov.

2. Suppliers of products covered under the Medicare Part B program are required to be enrolled in the Medicare Part B program in order to provide those services to Medicare and Medicaid dually eligible recipients. This includes obtaining and

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maintaining the Centers of Medicare and Medicaid Services (CMS) required accreditation and surety bond.

3. Potential providers who are not enrolled with the Medicare Part B program and who will not be supplying products covered under the Medicare Part B program to individuals eligible for Medicare are required to provide a statement on/with their application that requests a waiver of the requirements for Medicare Part B enrollment. This statement must indicate that they do not service Medicare-eligible individuals and include a listing of the products they plan to supply.

4. A Medicaid-contracted DMEPOS provider may be reimbursed for services rendered to Medicaid eligible recipients when provided in accordance with established policies, guidelines and timeframes.

5. The provider is responsible for ensuring the equipment is appropriate for the recipient and the recipient's residence prior to billing the DHCFP.

6. The provider is responsible for providing a manufacturer's invoice of cost for certain items, where no rate has been established.

7. The DMEPOS provider must comply with additional requirements as specified throughout this Chapter and its Appendices, Medicaid Services Manual (MSM) Chapter 100, the Provider Type (PT) 33 DMEPOS Fee Schedule, the Provider Billing Manual, and DMEPOS Billing Guidelines.

8. The provider is responsible to teach the recipient, caregivers, or authorized representative(s) about the operation, proper use, maintenance requirements, and any unacceptable use of the medical equipment.

C. RECIPIENT RESPONSIBILITY

The eligible Nevada Medicaid or NCU recipient and/or their authorized representative will:

1. Make and keep appointments necessary for securing medical services/equipment;

2. Present current verification of Nevada Medicaid or NCU eligibility;

3. Present any forms or identification necessary to utilize other health insurance coverage;

4. Contact and return to the provider of services/equipment for any necessary adjustment within the time allotted for such adjustments;

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5. Maintain the equipment provided by routinely cleaning and caring for the devices according to user information and supplier's guidance. Provide safe, secure storage for item(s) when not in use to protect item(s) from loss or theft;

6. Not misuse, abuse or neglect purchased or rented item(s) in a way that renders the item(s) unsafe or non-usable;

7. Return all rented equipment to the DMEPOS provider when no longer being used, or upon the DME provider's request. Failure to return rented equipment could result in a recipient's financial responsibility for the retail price of the rented equipment, even if the equipment is lost/stolen, the recipient has moved, or they are no longer eligible for Nevada Medicaid/NCU.

8. Comply with additional requirements as specified throughout this Chapter and its Appendices and MSM Chapter 100.

1303.2 DOCUMENTATION REQUIREMENTS

A. Supplier/provider records must substantiate the medical necessity for all DMEPOS items dispensed to recipients. The following describes the requirements for specific types of documentation associated with DMEPOS.

1. ORDERS / PRESCRIPTIONS

a. All DME items, Prosthetics, Orthotics, or Disposable Supplies (POS) dispensed must have an order/prescription from the treating physician or practitioner, (To determine included practitioners, refer to MSM, Chapter 600 – Physician's Services), such as a Physician's Assistant (PA), or Advanced Practitioner of Nursing (APN), when within their scope of practice and in accordance with federal and state laws governing that entity, prior to dispensing the item.

In accordance with the Patient Protection and Affordable Care Act (PPACA) (The Affordable Care Act) of 2010 (Public Law 111-148), all orders for DMEPOS items, whether verbal or written, must be incidental/relevant to the~~a~~ treating physician-documented face-to-face encounter between the recipient and the prescribing physician/practitioner (as allowed by The Act) within 30 days prior to the start date of the order/script. The encounter must be clearly documented and relevant to the need for the prescribed DMEPOS.

Refer to Appendix B of this Chapter for additional order requirements on specific products.

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General standards of care/practice mandate that if an order is not clear, a clarification of the order must be obtained from the ordering practitioner prior to acting on it.

b. Verbal Orders:

1. Verbal orders from the prescribing physician/practitioner may be accepted for DMEPOS items that do not require prior authorization by the DHCFP (except when Medicare is primary and Medicaid co-payment will be requested, and Medicare requires a written order for that item prior to delivery). Refer online to the DME MAC Jurisdiction D Supplier Manual, Chapter 3 – Documentation Requirements, for a current listing of those items at: https://med/noridianmedicare.com/web/jddme/education/supplier-manual ~~https://www.noridianmedicare.com/dme/news/manual/chapter3.html~~

2. The verbal dispensing order must include:

   a. A description of the item;

   b. The recipient's name;

   c. The physician's name;

   d. The start date and length of need of the order; and

   e. Additional information sufficient to allow appropriate dispensing of the item.

3. Suppliers must maintain written documentation of the verbal order and, if the verbal order is used for dispensing the item, the supplier must obtain a detailed written order prior to billing the DHCFP.

c. Written Orders:

1. Written orders are acceptable for all transactions involving 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.

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6. prescriber must review the detailed description and personally indicate agreement by signing and dating the order.

7. Medical necessity information (such as the most current appropriate diagnosis code(s) (ICD) diagnosis code, narrative description of the recipient's condition, abilities, and limitations) is not in itself considered to be part of the order although it may be put on the same document as the order.

d. New Orders Are Required When:

1. There is a change in the order of a specific DMEPOS item;

2. There is a change in the resident's condition that warrants a change in the order, a change in the treating physician/practitioner, or DMEPOS supplier;

3. An item is replaced for any reason; or

4. An ongoing unchanged order continues to be medically necessary one year after the original order (orders are only valid for up to one year, unless documented with a shorter length of time).

2. DETAILED PRODUCT DESCRIPTION

The detailed product description must contain the Healthcare Common Procedure Coding System (HCPCS) code, manufacturer, make and model, and the provider's/supplier's invoice of cost ~~usual and customary charge~~ for each item supplied. The warranty information must also be included. This may be completed by the provider/supplier but can~~must~~ also be documented~~signed and dated~~ by the physician.

3. PROOF OF DELIVERY (POD)

A POD is a supplier's delivery receipt, which is dated and timed.

NOTE: Item(s) ordered must be delivered within 120 days of the date of the order.

4. ADDITIONAL MISCELLANEOUS MEDICAL RECORDS

The recipient's medical records must contain sufficient documentation of the recipient's medical condition to substantiate the necessity for the type and

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quantity of items ordered and the frequency of the use or replacement. The information must include the recipient's diagnosis and other pertinent information, including but not limited to: duration of recipient's condition, clinical course (deteriorating or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The records must 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.

5. ADVANCED DETERMINATION OF MEDICARE COVERAGE (ADMC)

When Medicare is the primary payer, for all items requiring an ADMC (refer online to the DME MAC Jurisdiction D, Supplier Manual, Chapter 9). The ADMC determination must be submitted to the Quality Improvement Organization (QIO)-like vendor at the same time the prior authorization is submitted.

B. PROVIDER RESPONSIBILITY

1. The provider must obtain the required documentation in a timely manner as described under each section listed previously.

2. The provider must maintain records at the physical location of their business for each item billed to, and paid by, the DHCFP 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.

3. The provider must maintain records in a readily accessible location and, for audit and investigation purposes, to make available upon request by Medicaid staff or its contractors, all supporting information related to prior authorizations, dispensed items, and/or paid clams for DMEPOS items.

1303.3 RENTAL AND PURCHASE OPTIONS

Items identified in the DMEPOS Fee Schedule with an RR modifier for rental and an NU modifier for purchase option may require prior authorization to determine if the recipient's needs justify rental or purchase based on the item prescribed, the individual's anticipated length of need and prognosis (as determined by the prescriber) and cost effectiveness to the DHCFP and NCU. If a Nevada Medicaid rate has not been assigned, a manufacturer's invoice of cost is required to be submitted with the prior authorization (PA) request or claim, if a PA is not ~~a~~already required for that item.

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a. RENTAL

1. In addition to all other requirements and qualifications for specific products, if the DMEPOS Fee Schedule allows a rental option, a device may be rented when:

   a. the anticipated length of need (per physician's/practitioner's order) is short term (six months or less) and rental would be more cost effective than purchase;

   b. a temporary trial period is required for the item according to Medicaid's policy;

   c. the item is only available as a rental per the DMEPOS Fee Schedule; or

   d. a temporary rental is needed while a recipient-owned like item is being repaired.

2. During a rental period, rental rates include all supplies and accessories necessary to render the equipment useable and safe, delivery and set up services, education and training for recipient and family, routine maintenance and servicing (such as testing, cleaning, regulating and checking equipment), repairs, non-routine maintenance and servicing (such as breaking down sealed components and performing tests which require specialized equipment and skills of a technician), and replacement of items. These services are the responsibility of the owner, the DMEPOS supplier.

3. Throughout any rental period, there must be an active physician's/practitioner's order for ongoing use, the prior authorization effective dates are still applicable, and there is a continued medical need for the item. The DMEPOS supplier must contact the recipient or their representative within five business days prior to each billing cycle to verify the rented item is still medically necessary, in working condition, and being used by the recipient (contact does not include system generated correspondence). Verification must be documented and maintained in the DMEPOS supplier's records and be accessible for audits.

4. Rent-to-Purchase Option:

   a. The DHCFP allows rental of certain DMEPOS items up to the ~~provider's Usual and Customary Charge (UCC) for purchase, or the~~ maximum Medicaid allowable purchase price of the item.~~; whichever is less.~~

   b. Only certain equipment, as specifically defined by Medicaid, will be rental only.~~Unless the item is identified by Nevada Medicaid as a rental only,~~

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~~o~~Once the total cumulative ~~rental~~ payments have reached the ~~lower of UCC or~~ maximum Medicaid allowable purchase rate, then the item is considered purchased in full and recipient-owned.

c. The provider shall automatically transfer the title for the equipment to the recipient. Providers are not to submit prior authorizations to transfer titles. Providers are also not to submit prior authorizations coded as a purchase after the ~~lower of UCC or~~ Medicaid allowable purchase rate is reached. No rental or purchase payments will be made for the remaining reasonable useful lifetime of the device (usually not less than five years (60 months)). The provider's records must include the date the title was transferred to the recipient.

d. When an item was new at the time of issuance, and it is later determined the recipient will need the item long term, rental payments will be applied toward the total purchase rate (~~either the provider's UCC or~~ the Medicaid allowableor if no Medicaid rate exists, the manufacturer's invoice of cost). Refer to "Purchase Used Equipment Option" in Section 1303.

e. Equipment that was not new at the time of issuance, such as items from the provider/supplier rental fleet, supplied as a temporary short term rental item must be replaced with new equipment as soon as it is identified the recipient will need the device long term (no later than in the sixth month of rental). Payments made on rental fleet-type items will not be applied to the purchase price of a new item. Purchase or transfer of titles to recipients when the used equipment is from a rental fleet is not allowed.

f. For this option, non-routine maintenance and servicing or repairs may be covered for service dates after the item is owned by the recipient; no sooner than the month following the last rental month.

5. Rental Only Option:

a. Only specific equipment ~~Certain items are~~will be identified by Nevada Medicaid as a rental only. For these items, a monthly rental will be allowed as long as the recipient continues to meet all qualifications and requirements, and the recipient continues to use the device.

b. For this option, the DMEPOS supplier retains ownership of the equipment, regardless of the length of rental. As the owner, the DMEPOS supplier is responsible to ensure the equipment remains in safe working condition for the reasonable useful lifetime of the device. The rental rates include all

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c. supplies and accessories, repairs including routine and non-routine maintenance and servicing, and replacement of items when needed.

b. PURCHASE

1. Purchase New Equipment Option:

a. Certain products are identified by Nevada Medicaid in the DMEPOS Fee Schedule with a purchase option for new equipment, or can only be purchased, such as disposable supplies and custom-made items which can only be used by that recipient. These will be considered for purchase when, in addition to all other requirements and qualifications for a specific item/device:

1. the anticipated length of need (per physician's order) is long term (more than six months); and

2. the provider will be supplying a new device/item to the recipient; or

3. the item is only available for purchase.

2. Purchase ~~Used~~ Rental Equipment Option:

a. ~~Certain~~ Nevada Medicaid identifies specific products ~~are identified by Nevada Medicaid with a~~for purchase ~~option for used equipment. W~~when an item was new at the time it was dispensed to a recipient for rental purposes, and prior to billing the third month of rental, it is determined the item will be needed indefinitely, the DHCFP may purchase the item for the recipient for ongoing use. The DHCFP does not purchase used equipment from the provider's inventory of rental items used for re-issuance to same or multiple persons over time (rental fleets, etc.).

b. The DHCFP will only purchase ~~used~~ equipment when, in addition to all other requirements and qualifications for the item:

1. the recipient meets the criteria for purchase of new equipment;

2. the item was new when placed in the recipient's use and has been used for less than three months; and

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3. the item is currently being used by the same recipient during a trial period and it has been determined the length of need will now be indefinite.

c. A prior authorization must be submitted to request purchase of a ~~used~~ rented piece of equipment~~item,~~ with all supportive medical documentation to show the date the item was initially issued to the recipient and that the recipient continues to have an ongoing need for the item.

1303.4 PRIOR AUTHORIZATION

A. Prior authorization is a review conducted by the Quality Improvement Organization (QIO)-like vendor's medical professionals who review the prior authorization form and any additional information submitted to evaluate medical necessity, appropriateness, location of service, and compliance with the DHCFP's policy, prior to delivery of service. Reference the MSM, Chapter 100 and the general Billing Manual for detailed information on prior authorizations and Medicaid eligibility for all providers at: http://www.medicaid.nv.gov/providers/BillingInfo.aspx.

1. Submission:

a. Prior authorizations must be completed and submitted by a current Medicaid provider (requestor), and the approval must be received, prior to delivery of services. The exception to this is if the recipient is determined eligible for Medicaid retroactively or if number four of this section applies.

b. A prior authorization is required for most durable medical equipment, prosthetics, orthotics, and oxygen.

c. A Medicaid provider may submit the prior authorization electronically using the QIO-like vendor's on-line prior authorization system or may fax or mail the prior authorization to the QIO-like vendor. For more information, refer to the prior authorization section posted at: https://www.medicaid.nv.gov.

d. Requestors must submit a prior authorization with the most appropriate HCPCS code available and may not unbundle items included in the HCPCS code description. If an item has a designated code available, the miscellaneous code cannot be used. Providers may contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor, or the DME MAC for guidance on correct coding.

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e. Documentation requirements are the same regardless of which mode of submission is used (e.g. the on-line prior authorization system, faxed, or mailed). Documentation submitted for consideration of the request must include the physician's order and must clearly support coverage qualifications and recipient's medical need for the equipment. Failure to provide all of the supporting medical documentation in its entirety, and within the required timeframes, will result in a denial of the prior authorization request, regardless of mode of submission.

f. Unless otherwise stated in policy, a prior authorization may be submitted to request authorization to exceed established quantity limitations when the medical documentation supports medical necessity for the increased quantity or frequency.

2. Review Consideration:

a. In addition to the specifications mentioned previously, for reviewing the prior authorization, products and services must be medically necessary, safe and appropriate for the course and severity of the condition using the least costly equally effective alternative to meet the recipient's needs.

b. The recipient must have a medical need for, and the requested item must be suitable for use within the home. Consideration will also be based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: attending school, work, and shopping. This information must be included in the supportive documentation submitted with the prior authorization.

c. For durable medical equipment, prosthetics, orthotics, and disposable medical supplies and appliances where coverage and limitation policies have not been established within this Chapter or its Appendices, the DHCFP may defer to DME MAC Jurisdiction D, Local Coverage Determination (LCD) and policy articles for coverage and limitation criteria. These can be accessed at: https://med.noridianmedicare.com/web/jddme~~http://www.noridianmedicare.com/dme~~. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply and must be necessary to meet the medical needs of the recipient, and must be part of the prescribing physician's/practitioner's Plan of Care (POC).

d. The DHCFP has the option of requesting an Independent Medical Evaluation (IME) to determine the recipient's limitations and abilities to support medical necessity.

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3. Prior Authorization Requirements for Third Party Liability (TPL) and Medicare Crossovers:

   a. Refer to MSM, Chapter 100, for more information on TPL, and Medicare Crossovers and the requirements for securing prior authorizations.

4. Prior Authorization Emergency Situations:

   a. In an emergency situation, when an order is received by the supplier after the QIO-like vendor working hours or over weekends or State holidays, dispensing of a 72-hour supply of those DMEPOS items that require prior authorization will be allowed only when:

      1. A delay of 24 hours of treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others; and

      2. The treating physician/practitioner indicates the most current appropriate diagnosis code(s)/ICD code on the prescription that supports the use of the emergency policy.

   b. The provider/supplier must submit the prior authorization the next business day with all required supportive documentation. The documentation must include proof of the date and time the order was received by the supplier and documentation to support both 1303.4(a.)(1.) and (2.).

5. DMEPOS Specific Prior Authorization Forms:

   All forms must be completed and submitted by a current Medicaid provider. Forms used must be the most current version.

   a. All Forms and Form Release Memorandums or instructions may be accessed at the DHCFP's website: http://dhcfp.nv.gov/~~https://dhcfp.nv.gov/index/htm~~. The instructions provide detailed guidance on form completion requirements.

   b. Specific DME prior authorization forms are found on the QIO-like vendor's website: https://www.medicaid.nv.gov/providers/forms/forms.aspx. All DMEPOS items that require prior authorization must be requested on these forms and submitted electronically, by fax or by mail to the QIO-like vendor for approval.

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c. Usage Evaluation – For Continuing Use of Bi-Level and Continuous Positive Airway Pressure (BIPAP and CPAP) Devices use the form, found on the QIO-like vendor's website. This form may be completed and submitted for continuing usage of BIPAP or CPAP devices.

d. Mobility Assessment for Mobility Devices, Wheelchair Accessories and Seating Systems, form found on the QIO-like vendor's website. This form must be submitted for all mobility devices, wheelchair accessories and seating systems. The Clinical Assessment must be completed and signed by the treating physician.

6. Denied Prior Authorization Requests:

a. There are various processing levels associated with prior authorization requests which do not support medical necessity. These may include, but are not limited to: a contact to the provider by the QIO-like vendor, a system generated technical denial, a system generated denial or reduction of services, a provider-requested reconsideration, a provider-requested peer-to-peer review with the physician. For additional~~specific~~ information on the below time limits and an explanation of each, refer to the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/billinginfo.aspx.

~~b.~~1. If a prior authorization request is denied or reduced, the provider and recipient will be sent a Notice of Decision (NOD) with a citation/reason to provide a general explanation of the denial.

A. The provider may request a peer-to-peer review within 10 days of the date of decision via phone contact to ~~a~~the fiscal agent.

~~c.~~B. The provider may request consideration of the denial by submitting additional medical documentation ~~supportive information~~ and requesting a ~~"R~~reconsideration~~"~~ in writing via fax within 30 days of denial.

~~d.~~C. If a reconsideration is not appropriate or is also denied, the recipient may be entitled to request a~~n appeal or~~ hearing within 90 days from the date of decision. Refer to MSM Chapter 3100 – Hearings.

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B. COVERAGE AND LIMITATIONS

1. Coverage and limitations are explained throughout this Chapter, including its appendices. Appendix B details coverage qualifications, prior authorization documentation requirements, and limitations for specific items.

2. Refer to the Nevada Medicaid Provider Type 33 – DME Fee Schedule posted at:http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/ ~~http://dhcfp.nv.gov/RatesUnit.htm~~ for covered services. The Fee Schedule identifies covered services/items (listed in alpha-numeric order according to HCPCS code), and rates. Codes are updated yearly. Codes not included in the fee schedule after the yearly update are considered non-covered.

C. PROVIDER RESPONSIBILITY

1. The requesting DME provider (supplier) and the prescribing physician/practitioner must work collaboratively to accurately and timely complete and submit prior authorization requests, including all supportive documentation in order to ensure the item(s) being requested is/are the most appropriate to meet the recipient's medical needs. This must be done prior to dispensing any DMEPOS item requiring a prior authorization. Refer to the prior authorization section of the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/BillingInfo.aspx https://www.medicaid.nv.gov/providers/ billinginfo.aspx for detailed information on form completion and submission/transmission of prior authorization requests.

2. In the event additional information is requested by the QIO-like vendor, the provider should submit the requested information within established time limits, and/or review the notice of decision to determine the reason for denial, make any necessary corrections, continue to work collaboratively with the prescribing physician/practitioner to obtain medical justification, and/or when appropriate, request a reconsideration by providing additional supportive information to justify the medical need for the equipment. Refer to the general Billing Manual for all providers for details on denied requests.

D. RECIPIENT RESPONSIBILITY

1. The recipient and/or their representative must accurately represent their needs in relationship to obtaining medical equipment.

2. The recipient must attend appointments with Physical Therapy (PT), Occupational Therapy (OT), and/or physician/ practitioners for the purpose of evaluation for DMEPOS, and with DME providers for adjustments and servicing of equipment.

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a. An acceptable delivery/shipping service receipt POD includes the supplier's shipping invoice (Bill of Lading (BOL or BL)).

b. The supplier's BOL must include the recipient's name, quantity, detailed description of the item(s) delivered, brand name, make and model, serial number (if applicable), date and time of delivery/shipment, and delivery service package identification number associated with recipient's package(s).

c. The POD must reference the recipient's package(s), delivery address, and the corresponding package identification number given by the delivery service.

d. Without the POD that identifies each individual package with a unique identification number and delivery address, the item will be denied and any overpayment will be recouped.

e. Nevada Medicaid only reimburses out-of-state providers for mail order supplies for a recipient who is on Medicare and the supply is Medicare covered. Nevada Medicaid does not reimburse for shipping or delivery service costs.

1303.6 REPAIR, REPLACEMENT AND WARRANTY OF EQUIPMENT

A. REPAIR

1. Repair means to fix or mend a non-functioning part of equipment and to return damaged or worn equipment back to a safe operating condition. Repair of an item may be appropriate when the anticipated lifetime of the base equipment (usually not less than five years) has not been exceeded and repair of the item is more cost effective than replacement.

2. Reimbursement to the provider may be made for repairs of recipient-owned medically necessary equipment. Medical documentation by the prescribing practitioner must be submitted to support the recipient's ongoing medical necessity for the item needing repair. Additionally the prior authorization must substantiate the absence of misuse, negligence, malicious involvement or wrongful disposition on the part of the recipient, their legal representative, or their caregivers. It must indicate the equipment was being used appropriately in a manner prescribed or recommended. The prior authorization and claim must include HCPCS modifier RB for all DMEPOS parts furnished as part of the repair.

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business days of the loss. The prior authorization must substantiate the absence of negligence and/or malicious involvement on the part of the recipient, their legal representative or their caregiver, and that the equipment was being used appropriately. The prior authorization and claim must include HCPCS modifier code RA for all DMEPOS provided as a replacement. Nevada Medicaid and NCU are payers of last resource and would be secondary to any insurance claim/reimbursement. Reference MSM Chapter 100 – Medicaid Program.

2. Replacement of any recipient-owned item, regardless of how it was originally acquired, requires a new physician's/practitioner's order and the recipient must meet current qualifications for the item. Any assessment(s) necessary to support medical necessity must have been completed within six months of the date of request.

3. Lost or stolen DMEPOS resulting from failure to maintain possession or properly secure the item is not covered by Nevada Medicaid or NCU.

C. WARRANTY

1. The purchase of many items includes a product warranty by the manufacturer and/or the DMEPOS provider. Any service (item or labor) covered by warranty cannot be billed to Nevada Medicaid or NCU, the recipient, or their representative.

2. The requesting provider must obtain verification that any repairs or replacement items being requested are not covered under the existing warranty. This documentation must be submitted with the prior authorization.

1303.7 SECTION RESERVED FOR FUTURE USE

1303.8 SECTION RESERVED FOR FUTURE USE

1303.9 DME AT INSTITUTIONAL FACILITY (IF)

A. The DHCFP's hospital and nursing facility rates for an inpatient stay are all inclusive and cover all items needed by the patient during the length of stay. Refer to MSM Chapter 500 Nursing Facilities for information on nursing facility policy. This includes all:

1. Disposable supplies;

2. Wound care supplies;

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APPENDIX A

NON-COVERED SERVICES

1. The Division of Health Care Financing and Policy's (DHCFP's) Durable Medical Equipment, Prosthetics, Orthotics, and Disposable Supplies (DMEPOS) program does not cover the following items as they either do not meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supplies; or are not considered primarily medical in nature. This list is not all-inclusive and may be revised periodically:

- **Equipment used for physical fitness or personal recreation, such as but not limited to:**
  Bicycles/tricycles
  Electronic devices primarily designed for entertainment
  Exercise equipment
  Hot tubs or Jacuzzis
  Personal computers
  Playground equipment (swings, jungle gyms, tunnels, parachutes, obstacle courses)
  Printers
  Pulse tachometers
  Swimming equipment (such as earplugs)
  Tape recorders
  Tennis/gym shoes
  Video recorders or DVD players

- **Personal care or hygiene products, such as but not limited to:**
  Car Seats
  Dental care supplies (toothbrushes, toothpaste, dental floss and toothettes)
  Disposable gloves (non-sterile and sterile)
  Disposable wipes (includes baby wipes and attends-type wash cloths)
  Enuresis or bed-wetting alarms
  Feeder seats
  Feeding instruments – tableware and/or baby bottles
  First aid products
  Floor sitters
  Foam cushion pads
  Food - table foods (with exception of medical foods as defined in Appendix B)
  Glasses (magnifying or reading)
  Heat and massage aids
  Ice packs (disposable)
  Massage devices
  Medical alert bracelets/jewelry
  Menses products
  Scales (bathroom, kitchen, food, or diet)

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Strollers (exception: pediatric wheelchair type classified as a medical device by SADMERC, with a HCPCS code)
Thermometers and covers
Travel, activity, or corner chairs

- **Household items, such as but not limited to:**
  Air conditioners (includes swamp coolers)
  Appliances (microwave, cutting boards or other adaptive equipment for cooking, cleaning, etc.)
  Food blenders
  Furniture
  High chairs
  Humidifiers or dehumidifiers (room type or central)
  Lift chairs
  Orthopedic mattresses
  Overbed tables
  Safety/Canopy Beds
  Telephones (and related items: answering machines, telephone alert systems, or telephone arms)
  Vaporizers
  Waterbeds

- **Household equipment and supplies/Home or Vehicle modification equipment, such as but not limited to:**
  Ceiling fans
  Elevators
  Home security systems
  Intercom monitors
  Medical alert systems
  Motorized lifts for vehicle
  Power door openers
  Ramps or wheelchair ramps
  Trays
  Stair lifts
  Switches

- **Environmental products such as but not limited to:**
  Air filters
  Conditioners
  Hypoallergenic bedding and linens
  Purifiers

- **Miscellaneous:**
  Erectile Dysfunction equipment and supplies

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2. The DHCFP has the authority to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396 (a) (17)) based on such criteria as medical necessity or utilization control (42 CFR 440.230 (d)). The DHCFP has an approved list of covered DMEPOS items. The Provider Type 33 – DMEPOS Fee Schedule is available on the DHCFP website at:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/~~https://dhcfp.nv.gov/ratesunit.htm~~.

   a. The DHCFP is required to have a process and criteria for seeking modifications or exceptions to established coverage policies. This process is available to recipients on a case-by-case basis for DMEPOS items excluded from the DMEPOS Fee Schedule. Because a provider prescribes, orders, and/or recommends a service or supply does not, of itself, make it an eligible benefit.

   b. Consideration will be made on a case-by-case basis using the following criteria:

      1. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply as defined in Section 1302 – the Addendum Medicaid Services Manual (MSM) Definitions;

      2. The prescribing physician/practitioner must submit supporting documentation identifying the individual's specific medical needs that meet the standard definition of medical necessity as defined in MSM Chapter 100 (e.g. physical assessment indicating the limitations to be ameliorated by the use of the item(s), peer review documentation indicating this is an accepted standard of care within Nevada's medical community); and

      3. The prescribing physician/practitioner must document that other items have been used and were found ineffective. The requested item(s) must be the most cost-effective alternative, medically necessary service, provided at the most appropriate level to meet the medical needs of the recipient, that it is reasonable and accessible to the recipient.

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Policy: INTRODUCTION AND GENERAL INFORMATION

Introduction

1. Appendix B is a supplement to the main body of Chapter 1300 and provides: specific coverage qualifications, forms and documentation requirements, and miscellaneous policies related to specific items of durable medical equipment, prosthetic devices, orthotic devices, or disposable medical supplies (DMEPOS).
2. For DMEPOS where coverage and limitations have not been addressed in this Chapter, its Appendices, or the DMEPOS Fee Schedule, the Division of Health Care Financing and Policy (DHCFP) may defer to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction D, Local Coverage Determinations (LCD) and Policy Articles for coverage and limitations information. This information is available at https://www.noridianmedicare.com.

QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
1. Qualifications identified for each specific item listed within this Appendix must all be met for coverage by the DHCFP. 2. If all qualifications are not met, refer to Appendix A for other possible coverage options.	1. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional form completion requirements are found in the Form Release Memorandums or Instructions on the QIO-like vendor's website at: http://www.medicaid.nv.gov/providers/forms/forms.aspx 2. All documentation, reports, evaluations and testing must support medical necessity as specified under the Qualifications section. Requirements must be met for each specific item listed within this Appendix and as specified for that item. a. Physician's/Practitioner's Order/Prescription. b. Prior authorization form (when indicated) - Durable Medical Equipment Prior Authorization Forms are available on the QIO-like vendor's website at the above link. There are specific forms for certain items of DMEPOS. Refer to policies to determine if a specific form is required. Prior authorization is required to exceed program limitations. c. All services provided in an institutional facility require a prior authorization. d. Detailed Product Description. e. Proof of Delivery. f. Additional Miscellaneous Medical Records. g. Manufacturer's Invoice of cost (to determine pricing) for certain items, ~~especially~~ where the DHCFP rate has not been established. A Manufactures Suggested Retail Price invoice will not be accepted.	Refer to the main body of Chapter 1300 for general DMEPOS policies. 1. For all items, documentation must support all criteria in the Qualifications section, as specified in each category. 2. Providers must submit an approved prior authorization and claim using the most appropriate available HCPCS code and may not unbundle items included in the HCPCS code description. 3. Rented devices are to be considered purchased by the DHCFP once the purchase price has been reached. The exception to this is when the item is ~~only~~ deemed as a rental only by the DHCFP.~~available as a rental.~~ Refer to main body of Chapter 1300 and the DMEPOS Fee Schedule. 4. Inclusion of a HCPCS code in this Appendix is not an indication of coverage. Refer to the DMEPOS Fee Schedule and Appendix A. ~~4.~~5. The DHCFP will not reimburse providers who supply DMEPOS prior to PA approval except in certain situations, such as retro eligibility.

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Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
~~**Manual Beds**~~ ~~**Semi-Electric Beds**~~ ~~**Full-Electric Beds**~~ **Height Hospital Bed**	Medical evidence/documentation showing: 1. Recipient requires positioning of the body in ways not feasible with an ordinary bed due to a medical condition lasting at least one month; 2. Alleviation of pain due to positioning of the body in ways not feasible with an ordinary bed; 3. Elevation of the head more than 30 degrees due to a medical condition, i.e.: Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), aspiration problems.~~; or~~ ~~4. Requires frequent or immediate change in positioning.~~	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. An Invoice of Cost if there is no rate established by the DHCFP.	**NOTE:** **Total electric hospital beds** are non covered; the electric height adjustment feature is a convenience feature. **Safety beds/Enclosure Beds/Canopy** are primarily intended for prevention of injury and use is not primarily medical in nature. Per policy, medically necessary services and supplies are medically needed to diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability. Although these beds may prevent injury, they are not considered **care or treatment** of disease or injury, and are therefore not considered medically necessary.
Variable Height Hospital Bed (Manual)	Recipient meets the criteria for Fixed Height Bed and requires a bed height different than a fixed height bed to permit transfers to chair, wheelchair or standing position.		
Semi-Electric Hospital Bed	Recipient meets the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.		
Heavy Duty Extra Wide Hospital Bed	Recipient meets the criteria for a fixed height hospital bed and the recipient's weight is more than 350 pounds, but does not exceed 600 pounds.		
Extra Heavy Duty Hospital Bed	Recipient meets the criteria for a hospital bed and the recipient's weight exceeds 600 pounds.		

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Policy: BEDS (HOSPITAL) AND ACCESSORIES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Trapeze Bars	1. Medical evidence/documentation recipient needs assistance to sit up due to respiratory conditions, change body positions, or to assist in transfers in/out of bed.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	
Lifts and Lift Slings	1. Medical evidence/documentation showing the recipient requires more than one person in assisting in transfers from bed/bath, bed/commode, or bed/chair. 2. Must have an environment able to accommodate equipment. 3. Capable caregiver to assist with transfers.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Group 1 Support Surfaces	Recipient must meet the following criteria: 1. Completely immobile (recipient cannot make changes in body position without assistance); 2. Limited mobility (recipient cannot independently make changes in body position significant enough to alleviate pressure); or 3. Any stage pressure ulcer on the trunk or pelvis; and a) At least one of the following: i) Impaired nutritional status; ii) Fecal or urinary incontinence; iii) Altered sensory perception; iv) Compromised circulatory status.	1. Prescription and/or MD signed PA Form. 2. Medical documentation supporting qualifying factors.	Product needs to be adequate enough to prevent the recipient from bottoming out.

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Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Pressure Pad For Mattress: Non-Powered Pressure Reducing Mattress Overlays	(E0185) Gel/gel-like mattress overlay, with gel layer 2 inches or greater (E0197) Air mattress overlay interconnected air cells having a cell height of 3 inches or greater that are inflated with an air pump. (E0198) Water mattress overlay with a filled height of 3 inches or greater. (E0199) Foam mattress overlay with base thickness of 2 inches or greater and a peak height of 3 inches or greater if it is a convoluted overlay (egg-crate) or an overall height of at least 3 inches if it is a non-convoluted overlay. Foam with a density and other qualities that provide adequate pressure reduction, and durable waterproof cover. 1. Recipient must meet group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	
Non-Powered Pressure Reducing Mattress	(E0184) Foam height of 5 inches or greater, and foam with a density and other qualities that provide adequate pressure reduction, and can be placed directly on a hospital bed frame. (E0186, E0187, E0196) Air, water or gel mattress, height of 5 inches or greater of the air, water or gel layer (retrospectively), and durable, waterproof cover and can be placed directly on a hospital bed frame. 1. Recipient must meet group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	

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Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Powered Pressure Reducing Mattress Overlay Systems	(E0181, E0182, A4640) Alternating pressure or low air loss systems; Air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 2.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for APP overlays) and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out. Recipient must meet group 1 support surfaces criteria for qualification.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Group 2 Support Surfaces	Recipient must meet the following criteria: 1. Multiple stage II pressure ulcers located on the trunk or pelvis; 2. Recipient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface. a. Treatment includes patient/caregiver education, regular assessment by a licensed healthcare practitioner, appropriate turning and positioning, appropriate wound care, appropriate management of moisture/incontinence, nutritional assessment and intervention consistent with the overall plan of care; and 3. Ulcers have worsened or remained the same over the past month; OR 4. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis; OR 5. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	

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Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Group 2 Support Surfaces**	within the past 60 days); and 6. Recipient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).		
Powered Pressure Reducing Mattress	(E0277) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear. Can be placed directly on a hospital bed frame. (E0193) Describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all the characteristics previously defined. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Non-Powered Pressure Reducing Mattress Overlay	(E0371) Height and design of individual cells which provide significantly more pressure reduction than a group 1 overlay and prevents bottoming out, and total height of 3 inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 surfaces. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	

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Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Powered Pressure Reducing Mattress Overlay	(E0372) Low air loss, powered flotation without low air loss, or alternating pressure which is characterized by all of the following: Air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay, and inflated cell height of the air cells through which air is being circulated is 3.5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out, and surface designed to reduce friction and shear. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Advanced Non-Powered Pressure Reducing Mattress	(E0373) Height and design of individual cells which provide significantly more pressure reduction than a group 1 mattress and prevents bottoming out, and total height of 5 inches or greater, and surface designed to reduce friction and shear, and documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for group 2 support surfaces, and can be placed directly on a hospital bed frame. 1. Recipient must meet criteria for Group 2 support surfaces.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A manufacturer's Invoice of cost if there is no rate established by the DHCFP.	

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Policy: BEDS (HOSPITAL) AND ACCESSORIES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Group 3 Air-fluidized Bed	(E0194) Device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid. 1. Recipient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure sore; 2. Is bedridden or chair bound as a result of severely limited mobility; 3. In the absence of an air fluidized bed, the recipient would require institutionalization; 4. Ordered in writing by recipient's attending physician after comprehensive assessment and evaluation after completion of conservative treatment. Evaluation performed within one month prior to indication of therapy with air fluidized bed; 5. Conservative treatment must have been at least one month in duration without progression toward wound healing. Treatment should include: a. Frequent repositioning of recipient (usually every 2 hours); b. Use of group 2 support surface; c. Necessary treatment to resolve any wound infection; d. Optimization of nutrition status to promote wound healing; e. Debridement by any means, including wet-to-dry gauze dressings to remove devitalized tissue from the wound bed; f. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering while the wound heals;	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	

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Policy: COMMUNICATION DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Speech Generating Device (SGD)**		h. For a subsequent upgrade to a previously issued SGD, documentation must support the medical necessity regarding the functional benefit to the recipient of the upgrade compared to the initially provided SGD. i. SLP evaluations and recommendations should consider recipient's needs both at present and over the useful lifespan of the device being recommended. 6. Prior authorizations for synthesized speech output SGDs and digitized speech output SGDs with dynamic displays must include the software required for operation of the device. Any requests for supplemental software for a synthesized speech output SGD must be established as specifically medically necessary. 7. Prior authorizations for digitized speech output SGDs with static displays must identify the symbol set that will be used to operate the device. 8. For all products and accessories, the Manufacturer's Invoice of cost which includes: name of product, make, model, HCPCS code, and cost.	quantity and frequency limitations. Refer to section 1303.6 for policy regarding lost, stolen, or damaged equipment. 8. Reimbursement for codes E2500, E2502, E2504, E2506, E2508 and E2510 is intended to include all applicable software programs (whether they are on the device when shipped by the manufacturer or added by the supplier prior to delivery) necessary to render the device operational, batteries, battery chargers and AC adapters, and a carrying case. These items may not be billed separately at the time of initial issuance. 9. Non-integrated keyboards provided with an SGD are not separately reimbursable. 10. One symbol set may be billed separately using code E2599. <u>Device Descriptions</u>: 1. Digitized speech devices, sometimes referred to as devices with "whole message" speech output, utilize words or phrases that have been recorded by an individual other than the SGD user for playback upon command of the SGD user. 2. Synthesized speech devices translate a user's input into device-generated speech. Users of synthesized speech SGDs are not limited to pre-recorded messages but rather can independently create messages as their communication needs dictate. 3. Devices that have the capability to generate both digitized and synthesized speech are coded as E2508 or E2510, depending on the method of synthesized

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Policy: COMMUNICATION DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Speech Generating Software Programs for Personal Computer (PC) or Personal Digital Assistant (PDA) (E2511)	1. All of the previously described qualifications for a Speech Generating Device are met; and 2. The recipient currently owns the PC or PDA to which the software will be applied to enable the device to function as a Speech Generating Device (SGD).	1. As previously described for SGD. ~~1.~~2. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	1. Installation of the software program or technical support that enables a recipient-owned laptop computer, desktop computer or PDA to function as an SGD is included in the cost of the software program, therefore is not separately reimbursable. 2. Medically necessary upgrades to speech generating devices and/or software programs may be reimbursed 60 months after the month of initial issuance of the device. 3. Repairs to, or replacement of recipient-owned equipment (PC and PDA) is not reimbursable.
Access Device (E2599) *(such as, but not limited to: optical head pointers, joysticks, switches and scanning devices)*	1. All of the previously described qualifications for a Speech Generating Device (SGD) are met; and 2. The access device has been determined to be medically necessary.	1. Documentation by a licensed medical professional, such as a physician, speech-language pathologist, or physical therapist, which supports the medical necessity for the requested access device. ~~1.~~2. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	1. An access device enables the selection of letters, words or symbols via direct or indirect selection techniques. 2. Any components such as software programs, interfaces, cables, adapters, interconnects or switches necessary for the access device to interface with the SGD should be included in the charge for the access device itself and is therefore not separately reimbursable.
Electronic Components (E2599)	1. All of the previously described qualifications for a Speech Generating Device (SGD) are met; and 2. The electronic components are necessary to allow the SGD to be operated by the drive control interface of a power wheelchair.	1. Documentation must include that the recipient requires the use of a power wheelchair, and must address the recipient's ability to operate the SGD from the power wheelchair. ~~1.~~2. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	

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Policy: DIABETIC SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
External Ambulatory Infusion Pump, Insulin (E0784)	Covered ICD codes: Diabetes Mellitus Gestational Diabetes All of the following conditions must be met: 1. Fasting serum C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method or as an alternative must be beta cell autoantibody positive. 2. Recipient has completed a comprehensive diabetic education program within the last year. 3. Recipient is motivated to achieve and maintain improved glycemic control. 4. Recipient has been on a program of multiple daily injections of insulin (e.g., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to request for the insulin pump. 5. Documented frequency of glucose self-testing is an average of at least 4 times per day during the 2 months prior to starting the insulin pump. 6. Glycosylated hemoglobin level (HbA1C) > 7.0% In addition, one or more of the following indications must be present: 1. History of recurring hypoglycemia; 2. Wide fluctuations in blood glucose before mealtime (e.g., preprandial blood glucose level commonly exceeds 140 mg/dl; 3. Dawn phenomenon with fasting blood sugars frequently >200 ml/dl;	1. A prescription from a physician who manages recipients with insulin pumps and who works closely with a team including nurses, diabetes educators, and dietitians. 2. Prior authorization is required for the insulin pump with all of the following documentation: a. Certification of Diabetic Education Class with first time request. b. Signed statement from the physician acknowledging medical necessity and the following: 1. Recipient is motivated to achieve and maintain improved glycolic control, indicated by showing documented finger sticks (at least 4 times per day) with multiple injections. 2. Recipient has been on a program of multiple injections of insulin (at least 3 times per day) with frequent self-adjustment of insulin doses at least 6 months prior to initiation of the insulin pump. 3. Cognitive ability to operate pump and calculate insulin dosages. 3. Qualifying lab results per qualifications. 4. Physician current history and physical including one or more of the additional indications listed in the qualification column. 5. Documentation requirements for recipients using the insulin pump prior to Medicaid eligibility requires a PA with the following documentation: a. A ~~current~~ HbA1C level (within last 60 days). b. Signed narrative from the physician documenting the recipient's compliance	1. External ambulatory infusion pump recipients with Gestational Diabetes whom do not meet conditions 1 through 6 but do meet qualifications under Gestational Diabetes approval of the insulin pump will be on a rental basis until the end of the pregnancy. 2. Insulin Pump-related Supplies through the DMEPOS program: E0784 - External Ambulatory Infusion pump, Insulin A4230 - Infusion set for external pump, non-needle cannula type A4231 - Infusion set for external pump, needle type A4232 - Syringe with needle for external insulin pump, sterile, 3cc

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Policy: DIABETIC SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **External Ambulatory Infusion Pump, Insulin (E0784)**	4. Extreme insulin sensitivity; or 5. Gestational diabetes or when pregnancy occurs or is anticipated within 3 months in a previously diagnosed diabetic with ANY of the following indications: a. Erratic blood sugars in spite of maximal recipient compliance and split dosing; or b. Other evidence that adequate control is not being achieved. Qualifications for recipients on the external ambulatory infusion pump prior to Medicaid eligibility: 1. ~~Current~~A Glycosylated hemoglobin level (HbA1C) within the last 60 days. 2. Recipient has been compliant with using the insulin pump and has the ability of self-adjusting the insulin pump according to glucose levels.	and ability to self adjust the insulin pump according to glucose levels. ~~c.~~6. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	
Diabetic Equipment and Supplies		1. Physician's/Practitioner's Order / Prescription	1. Diabetic shoes, fitting, and Modification A5500 – A5507, A5512 – A5513 2. Diabetic equipment and supplies, such as Glucometers, Test strips, Lancet Device and Lancets, Insulin syringes for self-injection are not covered under the DHCFP's DME program. These supplies are covered under the DHCFP's pharmacy program and must be billed through the Point of Sale (POS). Refer to MSM Chapter 1200, Pharmacy Services.

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Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
MAE General Information ***(pertains to all items in this policy section)***	The qualifications identified in this "general information" section must all be met for any items included in this policy section. Each specific item may also have additional qualifications listed further in this appendix that must be met. Items may be covered if all of the following qualifications are met: 1. The recipient has a mobility limitation that significantly impairs his/her ability to participate in one or more Mobility-Related Activities of Daily Living (MRADL) performed in the home and in each of the environments the recipient is likely to encounter in their daily routines, such as but not limited to: attending school, work, and shopping. The MRADLs to be considered in this and all other statements in this policy are: toileting, grooming, bathing, dressing, eating, and transferring. **Note:** A mobility limitation is one that: a. Prevents the recipient from accomplishing the MRADL entirely; b. Places the recipient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or c. Prevents the recipient from completing the mobility-related Activities of Daily Living (ADL) within a reasonable time frame. 2. All required assessments, evaluations, and physician/practitioner's orders as indicated throughout this section were completed within the required time limits.	The forms and specifications as described in this "general information" section pertain to all MAE items. Refer to the Documentation section and/or the Prior Authorization section in Chapter 1300 for detailed requirements for each type of form. Additional completion requirements are found in the Form Release Memorandums/ Instructions for the Division's forms on the following website: https://www.medicaid.nv.gov/providers/forms/forms.aspx Each specific item may also have additional form requirements and specifications listed further that must be met. 1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization, forms found on the QIO-like vendor's website (when indicated) refer to the DMEPOS Fee Schedule to determine need for a prior authorization for each item. **Note**: For items that require prior authorization and have a Nevada Medicaid assigned rate ~~or Usual and Customary Charge (UCC)~~ of less than $500.00, use the DME Prior Authorization, Form FH-1; for items with a Nevada Medicaid assigned rate ~~or UCC~~ of $500.00 or more, the Mobility Assessment and Prior Authorization Form, FA-1B is required. 3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP. ~~3.~~4. Detailed Product Description. ~~4.~~5. Proof of Delivery. ~~5.~~6. Additional Miscellaneous Medical Records.	Refer to the main body of MSM Chapter 1300 for general DMEPOS policies. The comments/ policy statements identified in this "general information" section pertain to all MAE items. 1. For all MAE items, documentation must support all criteria in the Qualifications section, as specified in each category. a. All rented mobility devices are to be considered purchased by the DHCFP once the purchase price is reached. b. Providers must submit prior authorization and claim with the most appropriate HCPCS code and may not unbundle items included in the HCPCS code description. c. Inclusion of a HCPCS code in this policy section is not an indication of coverage. Refer to the DMEPOS Fee Schedule. d. The recipient must have a medical need within the home for the requested item. In addition, consideration will include: 1. recipient's medical needs; 2. use of the item; and 3. the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: a. attending school; b. work; and c. shopping. This information must be included in the

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Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Walkers** **Walker Accessories**	sufficiently resolved with use of a walker. 2. In addition to #1 and #2 in the MAE General Information Qualification section and #1 of this section, a heavy duty walker may be covered if the recipient's weight is greater than 300 pounds.		be billed separately with the initial purchase.
Gait Trainers	1. ~~Authorization will be given for recipients under 18 years of age~~ EPSDT only. 2. ~~And as a~~ Mobility Assistive Device for moderate to maximum support for walking~~only~~. 3. Functional mobility deficit cannot be resolved using a walker~~Recipient is unable to utilize a standard or reverse walker as a result of truncal weakness, spasticity and/or balance issues~~.	1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization documenting recipient's inability to utilize a standard or reverse walker and how the gait trainer will meet the recipient's needs. 3. Must demonstrate the capability of independently walking with the use of a gait trainer. ~~2.~~4. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	~~1.~~ Note: Rehab equipment and physical/occupational therapy equipment for home use is not covered.~~Not allowed if used as rehab equipment.~~
Wheelchairs *(pertains to all wheelchair types – manual and power)*	1. In addition to the MAE General Qualification section, a wheelchair may be covered if the recipient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane(s), crutches, or a walker; and 2. The recipient meets the specific qualifications listed further in this section for the type of wheelchair being requested. 3. The recipient must have a medical need for, and the requested item must be suitable for use in the home, in accordance with 42 CFR 440.70(b)(3). Consideration for prior authorization is also based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines.	All from MAE General Qualification section; and 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and in MSM Chapter 1300. 2. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	1. Medicaid allows only one wheelchair at a time. Backup chairs are denied as not medically necessary. 2. For all Medicare/Medicaid dual eligible recipients, Medicaid is payer of last resort. Therefore, any MAE that qualifies as an Advanced Determination of Medicare Coverage (ADMC) item must be submitted to Medicare prior to requesting approval by Medicaid. After the ADMC decision is received from Medicare, provider/supplier must submit a copy of the ADMC written decision by Medicare with the prior authorization. 3. Reimbursement for all wheelchair

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Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Group 4 PWC "Any Power Option"**	a Group 1, Group 2, or Group 3 PWC with the same power option being requested for the Group 4 PWC. 2. The recipient must have additional medical needs and mobility limitations that cannot be accommodated by an appropriately configured Group 1, 2, or 3 PWC.	recipient's medical needs.	
Group 5 Pediatric PWC "Single Power Option"	1. Same as Group 2 Single Power Option qualifications; and 2. The recipient is expected to grow in height.		
Wheelchair Options, Accessories, and Seating Systems	1. Options and accessories for wheelchairs may be covered if: a. The recipient meets the wheelchair qualifications as indicated previously, and has either a manual or power wheelchair; b. The device is an appropriate option/accessory for the type of chair the individual has; c. The option/accessory itself is medically necessary, as determined through the Mobility Assessment, form found on the QIO-like vendor's website; d. When the option/accessory is not a required component of the mobility device at the time of initial dispensing; e. The option/accessory is not covered under an existing warranty; and f. As indicated for each specific item listed further in this section. 2. All wheelchair seating system items in this category may be covered if: a. The recipient meets the wheelchair qualifications as indicated above, and has either a manual or power wheelchair;	For all items under this heading: all from General Information section above; and 1. Mobility Assessment, form found on the QIO-like vendor's website (refer to detailed requirements in Form Instructions at: https://www.medicaid.nv.gov/providers/forms/forms.aspx and MSM Chapter 1300 - Prior Authorization section. ~~1.~~2. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	See also General Information; Coverage and Limitations; and Non-covered Services: 1. An option/accessory that is beneficial primarily in allowing the recipient to perform leisure or recreational activities. 2. Electronic interface used to control lights or other electrical devices is not primarily medical in nature. 3. Power seat elevation feature and power standing feature are not primarily medical in nature. 4. Non-medically necessary power wheelchair features including but not limited to: stair climbing (A9270), electronic balance (A9270), ability to balance on two wheels (A9270), remote operation (A9270), an attendant control (E2331) provided in addition to a patient-operated drive control system.

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Policy: NUTRITIONAL SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Parenteral Nutrition	1. Total Parenteral Nutrition (TPN) is covered for a recipient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the recipient's general condition. Permanence does not require a determination that there is no possibility that the recipient's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. 2. The recipient must have: a. A condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients; or b. Disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the gastrointestinal (GI) system.	1. Physician's/Practitioner's Order / Prescription 2. All TPN services require prior authorization. Medical coverage will be determined by the DHCFP QIO-like vendor. 3. A new authorization would be required when: a. Nutrients billed with a different code are ordered; b. The number of days per week administered is increased or decreased; or c. Parenteral nutrition services are resumed when they are not required for two consecutive months. 4. There must be objective evidence supporting the clinical diagnosis.	1. Parenteral nutrition will be denied as non-covered in situations involving temporary impairments.
Infusion Pumps Equipment and Supplies: (B9004 and B9006)	1. Infusion pumps (B9004 and B9006) are covered for recipients in whom parenteral nutrition is covered.	1. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	1. Only one pump (stationary or portable) will be covered at any one time. Additional pumps will be denied as not medically necessary.
Supply Kit, (B4220 or B4222) Administration Kit	1. If the coverage requirements for parenteral nutrition are met, one supply kit (B4220 or B4222) and one administration kit will be covered for each day that parenteral nutrition is administered, if such kits are medically necessary and used.		

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Policy: NUTRITIONAL SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Enteral Nutrition	1. Enteral equipment and supplies are a Medicaid program benefit that requires a prior authorization. The following diagnoses and conditions are acceptable for medical coverage, based on severity and the QIO-like vendor determination: a. AIDS wasting syndrome (as indicated by a weight loss of 20 pounds or 10% of reference weight); b. Carcinoma of gastrointestinal tract; c. Disease of pancreas; d. Dysphagia; e. Failure to thrive; f. Fistulas of the gastrointestinal tract; g. Gastrostomy tube, artificial opening status; h. Gastrostomy tube, attention to artificial opening; i. Inborn errors of metabolism; j. Inflammatory bowel disease; k. Intestinal malabsorption; l. Malabsorption; m. Malnutrition; n. Necrotizing enterocolitis; o. Noninfectious gastroenteritis and colitis; p. Pancreatitis and pancreatic insufficiency; q. Radiation or chemotherapeutic enteropathy; r. Short bowel syndrome; and/or s. Vascular disease of the small bowel. 2. As a non-allergenic source of food in infants when all (e.g., soy base formulas) other food formulas are not tolerated; or 3. Other medical conditions with appropriate medical justification.	1. Physician's/Practitioner's Order/Prescription. 2. Prior authorization when indicated. ~~2.~~3. A Manufacturer's Invoice of cost if there is no rate established by the DHCFP.	1. Non-covered nutritional supplies and products: a. Enteral nutrition will be denied as non-covered in situations involving temporary impairments. b. Enteral nutrition is non-covered for recipients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc. c. Enteral nutrition products that are administered orally and related supplies are non-covered. d. Baby food and other regular grocery products that can be blenderized and used with the enteral system will be denied as non-covered. 2. Nutritional supplements carved out from institutional per diem if clinical coverage criteria are met.

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Policy: ORTHOTIC AND PROSTHETIC DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Orthotics** **Ankle-Foot Orthoses (AFO)** **Knee-Ankle-Foot Orthoses (KAFO)**	lacks normal anatomical integrity or anthropometric proportions.		
Thoracic-Lumbar-Sacral Orthoses (TLSO) **Lumbar-Sacral Orthoses (LSO)**	1. TLSO or LSO are covered when it is ordered for one of the following indications: a. To reduce pain by restricting mobility of the trunk; b. To facilitate healing following an injury to the spine or related soft tissue; c. To facilitate healing following a surgical procedure on the spine or related soft tissue; or d. To otherwise support weak spinal muscles and/or a deformed spine.		Note: The use of a LSO or TLSO brace for patients with chronic low back pain is not recommended because there is no pertinent medical evidence of any long-term benefit or evidence that brace therapy is effective in the treatment of patients with chronic (> 6 months) low back pain.

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Policy: OSTEOGENESIS STIMULATOR DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Osteogenesis Stimulator ***(Non-spinal Noninvasive Electrical)***	Device may be covered if: 1. Non-union of a long bone fracture after six months have elapsed without healing of the fracture; 2. Failed fusion of a joint, other than in the spine, where a minimum of nine months have elapsed since the last surgery; or 3. Congenital pseudarthrosis	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Rental for 20-week intervals, additional authorization will be considered with medical justification. 2. Electric Implantable and Ultrasonic Osteogenic Stimulators are non-covered Medicaid services.
Osteogenesis Stimulator ***(Spinal Noninvasive Electrical)***	Device may be covered if: 1. Failed spinal fusion where a minimum of nine months have elapsed since the last surgery; 2. Following a multilevel spinal fusion surgery involving three or more vertebrae; or 3. Following spinal fusion surgery where there is a history of a previously failed spinal fusion.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Rental for 20-week intervals, additional authorization will be considered with medical justification. 2. Electric Implantable and Ultrasonic Osteogenic Stimulators are non-covered Medicaid services.

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Policy: PNEUMATIC COMPRESSION DEVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Pneumatic Compression Devices ***(used for lymphedema)***	1. One or more limbs involved; and 2. Radical surgical procedure with removal of regional groups of lymph nodes (after radical mastectomy); or 3. Post radiation fibrosis; 4. Spread of malignant tumors to regional lymph nodes with lymphatic obstruction; 5. Scarring of lymphatic channels, 6. Onset of puberty (Milroy's disease); or 7. Congenital anomalies; and 8. Must be treatment of last resort with documented evidence that elevation and custom fabricated gradient pressure stockings or sleeves are ineffective; and 9. Continuous oversight by treating physician (including instruction, treatment plan, fracture and duration of use ongoing monitoring and evaluation).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	Note: Rental only.

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Policy: PREGNANCY-RELATED EQUIPMENT

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Home-Based (outpatient) Terbutaline Infusion Pump Therapy	Terbutaline infusion pump therapy is a covered benefit when the following conditions are met: 1. The recipient is at high risk for preterm labor and delivery based on one or a combination of factors: a. Current diagnosis of preterm labor with uterine contractions of four or more per hour and progressive cervical change; b. Cervical dilatation is less than four centimeters; c. History of preterm labor/delivery with previous pregnancies. 2. The recipient is currently or has recently been under treatment to prevent preterm labor with a combination of the following methods: a. Bed rest or restricted activity; b. Oral tocolytic therapy (document ineffectiveness); c. Increased office visits or phone contact for counseling; d. Hospitalization. 3. Appropriate alternative treatment has been tried and was not successful or was contraindicated. 4. Physician states recipient is capable of complying with home Terbutaline infusion pump therapy. 5. Recipient is not less than 20 weeks gestation or more than 37 weeks gestation. 6. Fetus is alive and well with an estimated weight of less than 2,500 grams. 7. Costs associated with Terbutaline infusion pump therapy do not exceed $240/day.	1. Physician's/Practitioner's Order/Prescription. 2. Requires a prior authorization. 3. Medical records from physician must be submitted to substantiate all qualifications. 4. Prior authorization will not be processed without medical records to substantiate request.	Note: Rental only.

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Policy: PREGNANCY-RELATED EQUIPMENT

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Home Uterine Activity Monitor	1. Recipient has a current diagnosis of pre-term labor and a history of previous pre-term labor/delivery with pregnancies. 2. Records from physician showing pre-term labor with uterine contractions of four or more per hour and progressive cervical changes. 3. Cervical dilation is less than four centimeters. 4. Recipient is ordered on bed rest or restricted activities. 5. Tocolytic therapy initiated (oral, subcutaneous, or intravenous route). 6. Documentation will show there is an increase in physician/patient contact due to pre-term labor symptoms. 7. The recipient is, in the opinion of the physician, capable of complying with the home monitoring program. 8. Recipient is not less than 24 weeks gestation or more than 37 weeks gestation.	1. Prescription and/or MD signed Prior Authorization Form. 2. Prior Authorization Note: Prior authorization submitted more than ten days after onset of service may be denied. 3. Medical documentation supporting qualifying factors	1. Reimbursement only for days of documented telephone contact between recipient/physician and monitoring device. Note: Rental only.

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Apnea Monitor	1. One year qualification for at least one of: a. Prematurity (gestational age must be listed on CMS 1500); b. Substantially small for gestational age; c. HX of maternal alcohol abuse; d. HX of maternal narcotics abuse; and/or e. HX of maternal hallucinogenic agent abuse. 2. Six month qualification for at least one of: a. Gastro-esophageal reflux; b. Abnormal pneumogram indicating desaturating apnea; c. Periodic respirations; d. Significant bradycardia or tachycardia of unknown or specified origin; e. Congenital heart defect; f. Bronchopulmonary dysplasia or newborn respiratory distress; g. Respiratory distress; h. Family history of SIDS (siblings only); i. Respiratory Syncytial Virus (RSV); j. Apparent Life Threatening Episode (ALTE) with subsequent visits to physician or emergency room; k. Laryngeotracheal malacia; l. Tracheal stenosis; and/or m. Swallowing abnormality.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Program limit to one year for diagnoses including prematurity and maternal substance abuse. 2. Other diagnoses limited to six months. ~~3. Beyond stated time limit requires prior authorization with medical justification.~~ ~~4. Original prior authorization not required for ICD codes listed under qualifications. Other diagnoses require prior authorization.~~ ~~5. Reference DMEPOS PT 33 Fee Schedule for quantity limits.~~ ~~6.~~3. An Apnea Monitor is a non-reimbursable service in conjunction with ~~an E0463 or E0464a~~ pressure ventilator, with pressure control pressure support, and flow triggering features.

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Bi-Level Positive Airway Pressure (BiPAP) Device **BiPAP 'S' (E0470) (without back up)** **BiPAP 'ST' (E0471) (with back up rate)** **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	1. For an E0470 or E0471 Respiratory Assist Device (RAD) to be covered, the treating physician must fully document in the recipient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc. A RAD (E0470, E0471) used to administer Noninvasive Positive Pressure Respiratory Assistance (NPPRA) therapy is covered for those recipients with clinical disorder groups characterized as (Group I) restrictive thoracic disorders (e.g., progressive neuromuscular diseases or severe thoracic cage abnormalities), (Group II) severe chronic obstructive pulmonary disease (COPD), (Group III) central sleep apnea (CSA), or (Group IV) obstructive sleep apnea (OSA) (E0470 only) and who also meet the following criteria: <u>Group I: Restrictive Thoracic Disorders:</u> a. There is documentation in the recipient's medical record of a progressive neuromuscular disease (e.g., amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (e.g., post-thoracoplasty for TB); and b. An arterial blood gas PaCO2 , done while awake and breathing the recipient's usual FIO2 is > 45 mm Hg; or c. Sleep oximetry demonstrates oxygen saturation < 88% for at least five continuous minutes, done while breathing the recipient's usual FIO2; or	1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Sleep Study (Diagnostic and Titrated sleep studies). 3. Medical documentation supporting qualifying factors. ~~4. Manufacturer's Invoice (purchased equipment).~~ 4. Refer to specific documentation requirements specified in the Qualifications section for each scenario. 5. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP.	1. The initial rental will be for three months. 2. Further approval requires: a. A letter of compliance from the recipient; or b. A completed form found on the QIO-like vendor's website; or c. Follow up notes from physician documenting compliance with the BiPAP; or d. A readout/printout from the BiPAP supplier documenting regular usage of the BiPAP. ~~d.~~3. BiPAP replacement requires proof of compliance or medical necessity. Note: The BiPAP will be rented until the purchase price is reached; this includes the initial three month rental period.

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **BiPAP 'ST' (E0471)** ***(with back up rate)***	d. For a progressive neuromuscular disease (**only**), maximal inspiratory pressure is < 60 cm H20 or forced vital capacity is < 50% predicted; and e. Chronic O~~o~~bstructive P~~p~~ulmonary D~~d~~isease (COPD) does not contribute significantly to the recipient's pulmonary limitation. 3. If all previously described criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for recipients within this group of conditions for the first three months of NPPRA therapy (see continued coverage after the initial three months). If all of the previously described criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary. <u>Group II: Severe COPD</u>: a. An arterial blood gas $PaCO_2$ done while awake and breathing the recipient's usual FIO_2 is $\geq$ 52 mm Hg; and b. Sleep oximetry demonstrates oxygen saturation $\leq$ 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the recipient's usual FIO_2 (whichever is higher); c. An arterial blood gas $PaCO_2$, done while awake and breathing the recipient's usual FIO_2, is $\geq$ 52 mm Hg; and d. Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out.		

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **Bi-Level Positive Airway Pressure (BiPAP) Device** **BiPAP 'S' (E0470)** ***(without back up)*** **BiPAP 'ST' (E0471)** ***(with back up rate)***	cannot be made, it will be denied as not medically necessary.		
Continuous Positive Airway Pressure Device **CPAP (E0601)**	1. A single level continuous positive airway pressure (CPAP) device (E0601) is covered if the recipient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (a or b): a. The AHI is ≥ 15 events per hour; or b. The AHI is from 5 to 14 events per hour with documented symptoms of: 1. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or 2. Hypertension, ischemic heart disease, or history of stroke. Note: The AHI must be calculated based on a minimum of 2 hours of recorded sleep and must be calculated using actual recorded hours of sleep (e.g., the AHI may not be an extrapolated or a projected calculation). 2. Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 31st day but no later than 91 days after initiating therapy, the supplier ascertain from either the recipient or the treating physician that the recipient is continuing to use the CPAP device. Continued	1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Sleep Study (Diagnostic and Titrated sleep studies). 3. Medical documentation supporting qualifying factors. 4. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP.~~(purchased equipment).~~ 5. Refer to specific documentation requirements specified in the Qualifications section for each scenario.	1. The initial rental will be for three months. 2. Further approval requires: a. letter of compliance from the recipient; or b. a completed form found on the QIO-like vendor's website; or c. follow up notes from physician documenting compliance with the CPAP; or d. a readout/printout from the CPAP supplier documenting regular usage of the CPAP. 3. CPAP replacement requires proof of compliance or medical necessity. Note: The CPAP will be rented until the purchase price is reached; this includes the initial three month rental period.

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483) **(Rental and the initial purchase includes hose and vest)** **Replacement Items:** **High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)** **High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)**	FDA-approved high frequency chest compression (HFCC) device (vest coupled to a pneumatic compressor) is a covered benefit for recipients who meet all of the following qualifications: 1. Documented medical justification for the need and length of time the HFCC system will be utilized; and 2. Recipient must have one of the following diagnoses which causes excessive, tenacious secretions and impairs ability to clear secretions: a. Cystic fibrosis; b. Chronic bronchiectasis; or c. Chronic neuromuscular disorder with prior history of pneumonia or other significant worsening of pulmonary functioning; 3. Well-documented failure of other methods, or inability to use other airway clearance therapies including chest physical therapy (CPT), flutter valve, etc. to adequately mobilize retained secretions; 4. Documentation of physician's treatment plan that includes external manipulation of the thorax at least daily to release retained secretions; 5. Documented evidence that recipient is having difficulty with secretion clearance, or presence of atelectasis caused by mucus plugging confirmed by high resolution, spiral, or standard CT scan; 6. Age greater than 2 years; and 7. Recipient and caregiver cannot adequately perform the needed bronchial drainage treatment (such as having more than one child requiring CPT or a valid medical reason that prohibits the CPT).	1. Physician's order/prescription. 2. Completed prior authorization form. 3. Physician's assessment to include the diagnosis for treatment. Clearly defined medical need for airway clearance as evidenced by retained secretions, prior history of pneumonia or other significant worsening pulmonary function, presence of atelectasis caused by mucus plugging by report. 4. Documented failure of CPT, type used, frequency, duration of use and outcomes. 5. Current medications, route of administration, dosage, and frequency. 6. Diagnostic studies such as high resolution, spiral, or standard CT scan. 7. Number of times per day recipient requires CPT. 8. Age of recipient. 9. Identify primary caregiver and the caregiver availability. 10. The prescribing physician will need to submit periodic follow-up reports. ~~10.~~11. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP.	1. Disease conditions such as: cystic fibrosis (CF), bronchiectasis, and immotile cilia syndrome can lead to abnormal airway clearance which is a source of increased sputum production, often purulent and tenacious; chest physiotherapy (CPT) becomes necessary. In conditions such as CF, excessive tenacious secretions necessitate routine CPT to prevent airway obstruction leading to secondary infection, the principal cause of morbidity and mortality. 2. The standard method of CPT is manual percussion and postural drainage. In the home setting, CPT is administered to the recipient by a trained adult one to three times a day for 20 - 30 minutes per session. 3. FDA approved HFCC (oscillating devices) have been utilized as an alternative to conventional manual chest physical therapy to promote the clearance of respiratory secretions in patients with impaired ability to cough or otherwise expel them on their own. 4. For purchase to be considered, a three month trial period on a rental basis is required. After the trial period and receipt of the follow up documentation showing evidence of compliance and effectiveness, the HFCC device may be approved for purchase. 5. The QIO-like vendor will provide authorization to include the 61st through 120 days if medically necessary. **Not Medically Necessary**

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
(continued) **High Frequency Chest Wall Oscillation Air-Pulse Generator System (E0483)** **(Rental and the initial purchase includes hose and vest)** **Replacement Items:** **High Frequency Chest Wall Oscillation Systems Vest, for the use with recipient owned equipment (A7025)** **High Frequency Chest Wall Oscillation System Hose, for use with recipient owned equipment (A7026)**			n. coagulopathy; and/or o. complaint of significant chest wall pain. ~~o.~~ Note: DHCFP will not reimburse providers when items are provided prior to PA approval.
Humidifiers and Supplies	1. Medical evidence/documentation recipient is a new start or compliant with current positive airway pressure therapy. 2. Sleep study or equipment fitting documentation showing recommended type and sizing. 3. Quantity limited to reimbursable guidelines.	1. Prescription and/or MD signed Prior Authorization Form 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 fee schedule.

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Oximeter ~~Rental~~: E0445-~~RR~~ device for measuring blood oxygen levels, non-invasive **Accessories: Oxygen probe (A4606) for use with continuous oximeter device, replacement**	1. The DHCFP covers ~~short term[1] and long term[2]~~ Pulse Oximetry in the home as medically necessary when one of the following criteria is met~~ under the appropriate corresponding age requirements~~: a. Any age determination: 1. Recipient is dependent on both a ventilator and supplemental oxygen; 2. Recipient has a tracheostomy and is oxygen dependent; or 3. Recipient is on supplemental oxygen and weaning is in process. ~~3.~~4. Recipient is discharged from inpatient stay for pulmonary diagnosis. ~~b. A pediatric recipient must meet one of the following criteria:~~ ~~1. Infants with chronic lung disorder (e.g., bronchopulmonary dysplasia); or~~ ~~2. Premature infant on active therapy for apnea.~~ ~~[1] less than 30 days~~ ~~[2] greater than 30 d[ay]s~~	1. Prescription by physician; 2. Prior authorization; and 3. Documentation by the physician of recipient's medical condition, which documents the need for in-home use of an oximeter, finger or continuous models, duration of use,~~ plans for training/instructions of family, caregiver,~~ and~~/or recipient~~ responses for decreased O_2~~; and~~. ~~3.~~4. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP. **Recertification of Prior Authorization:** 1. Recertification is ~~required~~allowed until the recipient no longer meets criteria,~~ or~~ the device is removed from the home, or purchase price has been met; and 2. Physician progress notes/narratives to substantiate the continued need to use the oximeter for decreased O_2 saturations. Allowable notations to include family, recipient and/or caregivers responses.	~~1. Approval of Oximeter will be on a rental basis only; purchase of equipment is non-reimbursable.~~ ~~2.~~1. Initial approval may be for 30-90 days.~~; unless initial documentation supports long term use then approval will be up to six months.~~ ~~3.~~2. Approval for a Continuous Oximeter model requires medical necessity for all additional features i.e.: pulse, Alarm, O2 Stats, etc.~~prior authorization recertification request will be for up to six months.~~ 3. Oximeter testing is not a reimbursable service for DME providers. 4. Requires plans for training/instructions of family/caregiver.
Oxygen (O_2): Concentrators Portables Regulators O_2 Carts **Oxygen Supplies: Tubing Cannulas O_2 Masks Humidifiers**	1. Arterial blood gases or an ear oximetry reporting: a. PO_2 Level of 60 mmHG or less on room air; or b. 80 mmHG or less on O_2; or c. O_2 saturation (sat) level of 89% or less; and d. Medical Necessity; e. Must list conditions of study (rest, sleeping, exercising, room air, on oxygen). 2. CHILDREN: 92% or less room air saturation, at rest. 3. O_2 sats must be performed within 60 days of requested dates of service.	1. Prescription and/or MD signed Prior Authorization/CMN Form. 2. Oximetry spot check or overnight tape results 3. Medical documentation supporting qualifying factors.	1. Oximetry test must be performed by a physician or qualified laboratory. O_2 saturations (sats) will not be accepted from an oxygen supplier. 2. Liquid oxygen and related equipment are non-covered Medicaid services unless recipient does not have electrical utilities at residence. Reimbursement will be only for stationary at the same rate as concentrator.

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Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Respirometers	1. Medical evidence/documentation supporting a related diagnosis for equipment.		
Suction Pumps	1. Recipients who have difficulty raising and clearing secretions due to: a. Cancer or surgery of the throat or mouth; b. Dysfunction of the swallowing muscles; c. Unconsciousness or obtunded state; or d. Tracheostomy (V44.0).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 Fee Schedule for quantity limits.
Ventilators	1. Medical evidence/documentation supporting a related diagnosis for equipment (e.g., tracheostomy).	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors. 3. Manufacturer's Invoice of cost is required when no rate is established by the DHCFP..	1. Medical Supplier must keep back up inventory available for rented equipment in emergent situations. Reimbursement for a back up ventilator provided in the recipient's home will only be allowed if it is medically prohibitive for a provider to respond in an emergent situation such as a recipient being on 24 hour ventilation support.

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MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

April 14, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Medicaid Services Manual (MSM) Chapter 1200, Prescribed Drugs, Section 1203 will be revised and reorganized. Obsolete policy will be deleted. Some information that is already found in other sources such as MSM Chapter 100, MSM Chapter 3300, in the NRS will be deleted. Information related to claims submission will be moved from Section 1203 to the Nevada Medicaid and Nevada Check Up Pharmacy Manual.

Regarding the Preferred Drug List Exception Criteria, the Continuity of Care clause will be revised to include all psychotropic medications not just antidepressants. Under Immunizations, the language under the Human Papillomavirus (HPV) is being revised to include males for both quadrivalent and bivalent HPV vaccines. Policy is being clarified that hospital-based ESRD facilities, hospice providers and facilities that bill by encounter will be added to the outpatient drug delivery model.

Revisions to Appendix A of MSM Chapter 1200, Prescribed Drugs were made to reflect approved actions by the Drug Use Review (DUR) Board at the September 3, 2015 and the November 5, 2015 meetings.

The DUR Board is a requirement of the Social Security Act to identify and reduce fraud, abuse, overuse, and medically unnecessary care. The DUR Board also works to minimize drug interactions, drug-induced illness, and undesirable drug reactions in recipients.

Revised and new prior authorization criteria were approved by the DUR Board on September 3, 2015. Prior authorization criteria were revised for Psychotropic Medications for Children and Adolescents; Kalydeco® (ivacaftor); Anti-fungal Onychomyosis agents; and Sedative Hypnotics. New prior authorization criteria were approved for Corlanor® (ivabradine).

Revised and new prior authorization criteria were approved by the DUR Board on November 5, 2015. Prior authorization criteria were revised for Immunomodulator Drugs, adding Arcalyst® (rilonacept), Cosentyx® (secukinumab) and Ilaris® (canakinumab) to the current criteria. New prior authorization criteria were approved for Orkambi® (lumacaftor/invacaftor); Invega

Trinza® (paliperidone palmitate); Praluent® (alirocumab); Entresto® (sacubitril/valsartan); Technivie® (ombitasvir/paritaprevir/ritonavir); and Daklinza® (daclatasvir).

Throughout the Chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized. Renumbering and re-arranging of sections was necessary.

These changes are effective April 15, 2016.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL CHAPTER 1200 – PRESCRIBED DRUGS	MTL 26/15 CHAPTER 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1200	**INTRODUCTION**	Delete "0.5" from line two.
1201	**AUTHORITY**	Moved second paragraph under 1202.D to 1202.C second paragraph. Revised language for NRS 422. Deleted "amended by AB 384". Changed "Drug Utilization Review" to "Drug Use Review."
1203	POLICY	Section title change from "POLICY" to "PHARMACEUTICAL POLICY." Revised the language from "Nevada Medicaid" to "The Division of Health Care Financing and Policy (DHCFP)." Added language regarding legend and non-legend drugs. Added practitioners and scope of their practice, and added requirement for pharmaceuticals to be in compliance with the Board of Pharmacy regulations.
1203.1	**POLICY**	Section 1203.1 "PHARMACEUTICALS" language moved to Section 1203.
1203.1A	**COVERAGE AND LIMITATIONS**	Changed "COVERAGE AND LIMITATIONS" to Section 1204 "COVERED SERVICES."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1A.1	**COVERAGE AND LIMITATIONS**	Deleted language regarding pharmaceuticals requiring a written prescription, and dispensing per manufacturer's guidelines. Added language that drugs are subject to prior authorization and quantity limits.
1203.1A.1.a		Language regarding tamper-resistant prescriptions is being moved to Section 1215 (no changes in language). Added language referencing the Social Security Act and the Federal Food, Drug and Cosmetic Act and appropriate compendia sources for pharmaceuticals. Added language that pharmaceuticals must be manufactured by companies participating in the Federal Drug Rebate Program.
1203.1A.1.b		Federal Drug Rebate information is being moved to Section 1204 Covered Services. Referenced Appendix A for specific coverage and limitations.
1203.1A.1.c		PREFERRED DRUG LIST is being moved to Section 1209. Revised with clarifying language.
1203.1A.1.c.1-4 and 6-7		Language regarding the Preferred Drug List (PDL) and the 76th Special Session is being moved to Section 1209.
1203.1A.1.c.5		Deleted language regarding the Drug Use Review Board and the PDL as this language is a function of the Board and is found in NRS 422.403(3) and therefore is not a specific DHCFP policy.
1203.1A.1.d		Language regarding a medically accepted indication is being moved under COVERED SERVICES 1204.
1203.1A.1.e		Language regarding family planning has been deleted.
1203.1A.2		Standard Preferred Drug List Exception Criteria is being moved to Section 1210.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1A.2.a.7	**COVERAGE AND LIMITATIONS**	The Continuity of Care clause is being revised to include all psychotropic medications (not just antidepressants). Language regarding Continuity of Care is being moved to Section 1210.
1203.1A.3		The Section labeled as "Excluded" is being moved to Section 1205 and being changed to "NONCOVERED SERVICES." The language "Nevada Medicaid Drug Rebate Program" is being changed to the "DHCFP."
1203.1A.4		Refills are being moved to Section 1207.
1203.1A.5		Early Refills are being moved to Section 1207.
1203.1A.6.a-d		Quantity of medication is being moved to Section 1207, and changed to "Maintenance Medications." The language regarding 34 day supply is being deleted as it is found under Early Refills.
1203.1A.7.a-d		Emergency supply of is being moved to Section 1208. Section 1203.1.A.7.a Clarifying language is being added to "in an emergency." Language is deleted because the Call Center is open 24/7.
1203.1A.8		The section on Nevada Check Up is being deleted as the same language is found in MSM Chapter 100.
1203.1A.9.c		Immunizations are being moved to Section 1214. Section 1203.1.A.9.c Language under the Human Papillomavirus (HPV) is being revised to include males for both quadrivalent, nonavalent and bivalent HPV vaccines.
1203.1B.1	**PROVIDER RESPONSIBILITY**	Deleted language for Out-of-State Provider information as it is found in MSM Chapter 100.
1203.1B.1.a.1-2		Deleted language regarding the maintenance of medical records as it is found in MSM Chapter 100 and Chapter 3300.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1B.2	**PROVIDER RESPONSIBILITY**	Deleted language for "Utilization Control."
1203.1B.2.a		Pro-DUR language moved to Section 1212.C.
1203.1B.2.b		"Retro Drug Utilization Review" moved to Section 1212.B.
1203.1B.2.c		Drug Utilization Review moved to Section 1212.A. "Drug Utilization Review" changed to "Drug Use Review."
1203.1B.2.d		Deleted information regarding eligibility as it is found in MSM Chapter 100.
1203.1B.2.e		Lock-In Program moved to Section 1213. No language changes.
1203.1B.3		"Generic Substitution" is being changed to "GENERIC SUBSTITION/BRAND CERTIFICATION" and is being moved to 1206.
1203.1B.3.d		"Brand and generic" was added to the clause regarding substituting the least expensive drugs.
1203.1B.4		Prescriber Brand Certification is being moved to 1206.
1203.1C.1	**SERVICE DELIVERY MODEL**	"Institutional Settings" is being changed to "INSTITUTIONAL DELIVERY MODELS" and moved to Section 1217.
1203.1C.1.a		Added clarifying language that inpatient pharmaceutical services billed through MMIS are not reimbursed separately. Moved to Section 1217.
1203.1C.1.b		Long Term Care (LTC) moved to Section 1217.
1203.1C.1.b.1		Nursing Facilities (NF) moved to Section 1217.
1203.1C.1.b.2		ICF/MR changed to Intermediate Care for Individuals with Intellectual Disabilities (ICF/IIR). Moved to Section 1217.b.2.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1C.2	**SERVICE DELIVERY MODEL**	Deleted "Service Delivery Model" and replaced with Section 1216, "OUTPATIENT DELIVERY MODELS." Clarifying language regarding reimbursement methodology sources (Pharmacy Billing Manual) and MMIS is being revised and moved under Outpatient Delivery Models Section 1216.a. Clarifying language on policy/billing resource for providers.
1203.1C.2.a.1-4		Moved retail pharmacies, home infusion therapy, NVPAD, hospital based outpatient clinics and ESRD (hospital based) to Section 1216. Deleted Provider Type 37 language referenced the Pharmacy Billing Manual for IV therapy billing. Replaced "Physician administered drugs" with NVPAD.
1203.1C.2.a.5		Under End Stage Renal Disease, deleted "Facilities" added "hospital-based or stand alone" and moved to Section 1217.
1203.1C.2.b		Moved covered outpatient drugs that are not reimbursed separately to Section 1216.b. Added language for outpatient facilities/clinics that bill by encounter. Added language regarding coverage of outpatient hospice drugs.
1203.1C.3		Disposable supplies moved to Section 1217.c.
1203.1C.4		Unit Dose (Repackage and Re-stock) Repackage moved to 1217.d.
1203.1C.5		Coordination of Benefits moved to Pharmacy Billing Manual.
1203.1C.6		Non-participating Health Maintenance Organization (HMO) Providers moved to the Pharmacy Billing Manual.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1C.7	**SERVICE DELIVERY MODEL**	Pharmacy Billing Process moved to the Pharmacy Billing Manual.
1203.7C.8		The State Maximum Allowable Cost (SMAC) moved to Section 1211.
1203.1D	**AUTHORIZATION PROCEDURES**	AUTHORIZATION PROCEDURES moved to the Pharmacy Billing Manual.
1203.12.a-d	**INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37**	Deleted "INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37" for nonuse. Intravenous (IV) Therapy moved to the Pharmacy Billing Manual.
Appendix A Section H	**ANTI-FUNGAL ONCYCHOMYCOSIS (LAMISIL®. SPORANOX®. PENLAC®)**	Revised the Last Reviewed date to September 3, 2015. Added the standard notification regarding agents are subject to prior authorizations and/or quantity limitations based on Section 1927 of the Social Security Act. Deleted redundant language regarding subject to prior authorization. Changed to Section I.
Appendix A Section I.1.a		Added language regarding approval requires US FDA approval.
Appendix A Section I.1.c1-5		Moved listed criteria: pain which limits activity, disease is iatrogenically-induced, associated with immuosuppression, diabetes or significant peripheral vascular compromise to Section I.1.b.1-5.
Appendix A Section I.1.c.		Added language that requires the length of therapy to be appropriate based on the agent and location of infection. Deleted language regarding positive KOH stain.
Appendix A Section I.1.d.1-2		Listed the drug and agent specific criteria Terbinafine: no pre-existing liver disease; Itraconazole: no heart failure and no ventricular dysfunction. Added oral granules and Onmel: documentation why terbinafine or itraconazole can't be used. Deleted Length of Authorization.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section I.1.	**ANTI-FUNGAL ONCYCHOMYCOSIS (LAMISIL®. SPORANOX®. PENLAC®)**	Added Section I.1.e. Topical dosage forms: documentation why ciclopirox 8% solution, terbinafine, or itraconazole can't be used.
Appendix A Section I.1		Added Section I.1.f. Added language regarding Onmel tablets.
Appendix A Section I.2		Added language regarding Prior Authorizations will be based on the appropriate use.
Appendix A Section L	**IMMUNOMODULATOR DRUGS**	Revised the Last Reviewed date to November 5, 2015. Added Arcalyst®, Cosentyx® and Ilaris® to the list of drugs.
Appendix A Section L.1.a		Added a list of the requirements for all recipients. Added language regarding no approvals to be given for the use of more than one biologic at a time. Added language that each request must meet diagnosis-specific criteria.
Appendix A Section L.1.a	**Rheumatoid Arthritis (RA)**	Renumbered Rheumatoid Arthritis as Section L.1.b. Added the age requirement, 18 years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.b	**Psoriatic Arthritis**	Renumbered Psoriatic Arthritis as Section L.1.c. Added the age requirement, 18 years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.c	**Ankylosing Spondylitis**	Renumbered Ankylosing Spondylitis as Section L.1.d. Added the age requirement, 18 years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section L.1.d.	**Juvenile Rheumatoid Arthritis/Idiopathic Arthritis**	Renumbered Juvenile Rheumatoid Arthritis/Idiopathic Arthritis as Section L.1.e. Added language that the age of the recipient and the drug used is appropriate. Added age requirement for abatacept as six years of age or older. Added age requirement for adalimumab, canakinumab, etancercept, and tocilizumab as two years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.e	**Plaque Psoriasis**	Renumbered Plaque Psoriasis as Section L.1.f. Added the age requirement, 18 years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.f	**Crohn's Disease**	Renumbered Crohn's Disease as Section L.1.g. Added language that the age of the recipient and the drug used is appropriate. Added age requirement for adalimumab, ainfliximab as six years of age or older. Added language that for all others (drugs) the age requirement is 18 years of age or older. Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.g	**Ulcerative Colitis**	Renumbered Ulcerative Colitis as Section L.1.h. Added language that the age of the recipient and the drug used is appropriate. Added language adding an age requirement for infliximab as six years of age or older and all others 18 years of age or older.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Deleted language regarding tuberculin test and an active infection. This language is now in Section 1.a.
Appendix A Section L.1.i	**Cryopyrin-Associated Periodic Syndromes (CAPS)**	Added new criteria for Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflammatory Sydromes (FCAS) and Muckle-Wells Syndrome (MWS).
Appendix A Section L.1.j	**Neonatal-Onset Multisystem Inflammatory Disease**	Added new diagnosis requirement for Cryopyrin-Associated Periodic Syndromes (CAPS); Neonatal-Onset Multisystem Inflammatory Disease (NOMID). Deleted language regarding one biologic at a time as it is now in Section 1.a.
Appendix A Section N	**Psychotropic Medications for Children and Adolescents**	Revised the Last Reviewed date to September 3, 2015. Added the standard notification regarding agents are subject to prior authorizations and/or quantity limitations based on Section 1927 of the Social Security Act.
Appendix A Section N.1		Replaced language on the drugs are subject to prior authorization and criteria must be meet and documented. Revised the first paragraph, adding therapeutic classes, medication combinations and poly-pharmacy. Changed the psychotropic class Lithium Preparations to Mood Stabilizers. Added a new section for children under 18 years of age. Added clarifying language for physician monitoring to include and/or prescriber. Added “any psychotropic” medications.
Appendix A Section N.1.c		Regarding language for initial treatment, added “have not received any doses previously.” Regarding continuing therapy though unstable added “has had a dose change in the last three months.” Added and/or prescriber throughout this paragraph.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section N.1.c.1-6		Revised definition for poly-pharmacy. Deleted language regarding three or more psychotropic medication is to be avoided. Added that each psychotropic medication must independently treat a specific diagnosis. Deleted paragraph regarding multiple-drug therapy.
Appendix A Section N.1.d		Added language regarding requirements for recipients under six years of age such as a medically accepted indication as established by the FDA or peer-reviewed literature.
Appendix A Section N.1.e.1-2		Revised Continuity of Care to allow mental health inpatient recipients under 18 years of age, who have been discharged, six months to establish outpatient mental health services before requiring a prior authorization for applicable medications. A six month allowance will also be granted for recipients under 18 years of age stable on psychotropic medications before Medicaid coverage.
Appendix A Section N.2		Revised exceptions to criteria to include anticonvulsants, ADD/ADHD and Abilify. Added clarifying language regarding a certain diagnosis codes on the prescription will bypass the prior authorization requirement in the POS system. Deleted Abilify bypass prior authorization requirement.
Appendix A Section N.3		Deleted previous Prior Authorization criteria. Added Prior Authorization Guidelines.
Appendix A Section V	**Anti-Insomnia Agents (Sedative Hypnotics)**	Revised the Therapeutic Class and Last Reviewed Date to September 3, 2015. Added language that Section N also has sedative/hypnotic criteria when prescribed for a psychotropic indication.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added Coverage and Limitations, to include criteria must be met and documented, and FDA approved diagnosis. For the drug Hetlioz® (tasimelteon) it requires a diagnosis of non-24 hour sleep-wake disorder. All other agents require a diagnosis of insomnia. Added Prior Authorization Guidelines.
Appendix A Section LL **Appendix A Section LL.1.c**	**Kalydeco® (ivacaftor)**	Revised the Last Reviewed date to September 3, 2015. Changed recipient age from six to two years of age or older. Added additional gene mutations to the list of covered gene mutations.
Appendix A Section DDD	**Corlanor® (ivabradine)**	Added new drug, new criteria. Added Therapeutic Class, Date Reviewed by the DUR Board as September 3, 2015. Added standard disclaimer that Corlanor® is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. New Criteria includes, a diagnosis of chronic heart failure, left ventricular ejection fraction $\leq$ 35%, resting heart rate $\geq$ 70 bpm, the recipient is 18 years of age or older, the prescriber is a cardiologist, the recipient has a normal sinus rhythm, and the recipient is on a tolerated dose of a beta-blocker or has a contraindication to a beta-blocker. Added Prior Authorization Guidelines including language that approvals will be based on appropriate use of agents.
Appendix A Section EEE	**Paluent® (alirocumab)**	Added new drug, new criteria Added Therapeutic Class, Date Reviewed by the DUR

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Board as September 3, 2015. Added standard disclaimer that Praluent® is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Initial request criteria includes a list of required qualifying cardiac diagnoses, prescribed by a cardiologist, recipient must be on a low-fat diet. Recipient must meet one of the following conditions, an inadequate response to a high intensity or moderate intensity statin, has received add-on therapy with exetimibe, has had the LDL-C after therapy, and statin therapy will be continued with PCSK-9 therapy. Added recertification criteria, the recipient is adherent to PCSK-9 inhibitor therapy, adherent to statin therapy, has a contraindication to statin therapy, continuing on a low-fat diet, and has achieved a reduction in the LDL-C level. Added Prior Authorization Guidelines, initial request will be for six months and recertification will be for one year.
Appendix A Section FFF	**Invega Trinza® (paliperidone palmitate)**	Added new drug, new criteria. Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015. Added standard disclaimer that Invega Trinza® is subject to prior authorization and quantity limitations. Added Coverage and Limitation which must be met and documents. Added the recipient must have a diagnosis of schizophrenia, stabilized on a once-monthly paliperidon palmate injection for at least four months, be 18 years of age or older, and the requested dose is for one injection every three months.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix A Section GGG	**Technivie® (ombitasvir/paritaprevir/ ritonavir)**	Added Prior Authorization Guidelines. Approvals will be for one year. Added new drug, new criteria. Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015. Added standard disclaimer that Technivie® (amitasvir/paritaprevir/ritonavir) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient must have a diagnosis of chronic Hepatitis C, Genotype F4, is eight years of age or older, does not have cirrhosis, does not have moderate or severe hepatic impairment, the requested dose is two Technivie® tablets daily, the duration of treatment must not exceed 12 weeks, treatment naïve and treatment experienced recipients must also use ribavirin in combination unless they cannot take or tolerate ribavirin. Added Prior Authorization Guidelines. Approvals will be for 12 weeks.
Appendix A Section HHH	**Orkambi® (Ilumacaftor/ivacaftor)**	Added new drug, new criteria. Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015. Added standard disclaimer that Orkambi® (lumacaftor/ivacaftor) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient has a diagnosis of cystic fibrosis, is 12 years of age or older, is homozygous for the F508del mutation in the CFTR gene, the requested dose is two tablets every 12 hours, or one tablet every 12 hours with severe hepatic impairment.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added Prior Authorization Guidelines. Approvals will be for one year.
Appendix A Section III	**Daklinza® (daclatasvir)**	Added new drug, new criteria. Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015. Added standard disclaimer that Dalinza® (daclatasvir) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient has a diagnosis of Hepatitis C, genotype 3, is 18 years of age or older, has not had a liver transplant, the requested agent will be used in combination with Sovaldi®, the recipient is not on a CYP3A inducer, the recipient does not have cirrhosis, the requested dose of Daklinza® is 60 mg daily, or 30 mg daily with a concomitant strong CYP3A inhibitor, or 90 mg daily with a concomitant moderate CYP3A, usage is based on peer-reviewed literature, the requested duration of treatment is 12 weeks. Added Prior Authorization Guidelines. Approvals will be for 12 weeks.
Appendix A Section JJJ	**Enteresto® (sacubitril/valsartan)**	Added new drug, new criteria. Added Therapeutic Class, Date Reviewed by the DUR Board as November 5, 2015. Added standard disclaimer that Enteresto® (sacubitril/valsartan) is subject to prior authorization and quantity limitations. Added Coverage and Limitations which must be met and documented. Added the recipient has a diagnosis of chronic heart failure, has a reduced left ventricular ejection fraction, is 18 years of age or older, the prescriber is a cardiologist, the recipient has had a trial of ACE or ARB, the recipient will not concurrently receive and ACE inhibitor, is on an individualized dose of a beta-blocker,

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Entresto® will be given twice daily with a maximum dose of 97/103 mg. Added Prior Authorization Guidelines. Approvals will be for one year.
Appendix A	**BLOOD GLUCOSE TESTING**	Paragraph two: Deleted language requiring a diagnosis and that diagnosis to be kept on the premises for 37 months. Paragraph five: Added language regarding a diagnosis on the prescription is only required for newly diagnosed or transitioning recipients. Paragraph six: Deleted as this will be move to the billing manual.

1200 INTRODUCTION

The Nevada Medicaid Pharmacy Services program pays for medically necessary prescription services for eligible Medicaid recipients under the care of the prescribing practitioner. Such ~~0.5~~ services shall maintain a high standard of quality and shall be provided within the limitations and exclusions hereinafter specified.

All providers participating in the Medicaid program must furnish services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Services.

This Chapter describes covered services, service limitations, and general reimbursement methodology.

This manual obsoletes all previous policy and procedure manuals, bulletins and policy news.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

1201 AUTHORITY

~~A.~~ The Code of Federal Regulations (CFR), Title 42, Public Health, Chapter IV Center for Medicare and Medicaid Services (CMS), Subchapter C Medical Assistance Programs, Parts 430 through 456, states prescription drug coverage is an optional service under Title XIX.

~~B.~~ The Omnibus Budget Reconciliation Act (OBRA) of 1989 mandates additional preventive health care services for infants, children and young adults (newborn through age 20) eligible for Medicaid. These mandates provide that children and adolescents under age 21 receive follow-up services for a medically necessary condition discovered in a screening examination Early Preventative Screening and Diagnostic Testing (EPSDT) see Medicaid Services Manual (MSM) Chapter 1500; this includes prescription services.

~~C.~~ CFR Title 42 and Section 1927 of the Social Security Act, require states to provide for a Drug ~~Utilization~~ Use Review (DUR) program for covered outpatient drugs in order to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results (Social Security Administration (SSA), Title 19, (g)(1)(A)).

The Social Security Act requires the establishment of a DUR board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of program beneficiaries.

~~D.~~ Section 1927 of the Social Security Act allows a state to require a prior authorization on any covered outpatient drug, providing the prior authorization program complies with the requirements outlined in the act.

~~The Social Security Act requires the establishment of a DUR board to monitor therapeutic appropriateness, use of generic products, overutilization and underutilization of drugs and quality of care consistent with protecting the health of program beneficiaries~~.

~~E.~~ ~~Chapter 422 of Nevada Revised Statute (NRS) amended by AB 384 to~~ The Nevada Revised Statute (NRS) 422.401 through 422.406 requires the Department of Health and Human Services (DHHS) to:

1. develop a list of preferred prescription drugs;

2. manage prescription drug use through the use of prior authorization and step therapy; and

3. create the Pharmacy and Therapeutics Committee.

~~F.~~ U.S. Troop Readiness, Veteran's Health Care, Katrina Recovery and Iraq Accountability Appropriations Act 2007, Section 7002(b) of the act requires 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.

~~G.~~ The Deficit Reduction Act of 2005 requires Fee-for-Service (FFS) State Medicaid programs to capture and report National Drug Codes (NDC) for outpatient drugs in order for the state to receive federal financial participation.

1203~~2~~ PHARMACEUTICAL POLICY

~~Nevada Medicaid~~ The Division of Health Care Financing and Policy (DHCFP) reimburses pharmacies and practitioners for legend (prescription~~s~~) and non-legend (over the counter) pharmaceuticals, dispensed or administered to ~~each~~ Medicaid recipient~~s,~~. ~~with a maximum of a 34 day supply. Maintenance medications have a maximum of 100 day supply~~ All prescribers must have a license as a healthcare practitioner, such as a physician, doctor of osteopathy, advanced practitioner of nursing, etc., keeping within the scope of their practice. The DHCFP requires that pharmaceuticals are written, dispensed and prescribed in accordance with the Nevada State Board of Pharmacy regulations and enforcement.

~~1203.1 PHARMACEUTICALS~~

~~All legend and non-legend pharmaceuticals must be prescribed by a licensed physician, podiatrist, osteopath, dentist, Advanced Practitioner of Nursing (APN), or physician's assistant within the scope of their practice.~~

1203.1A12041203 COVERAGE AND LIMITATIONSCOVERED SERVICES

1. Covered

The Nevada Medicaid Drug program will pay for the following prescribed pharmaceuticals with a written prescription, dispensed per the manufacturer's guidelines, and may be subject to restrictions (such as prior authorization, quantity limitations etc):

A. Drugs are subject to prior authorization and/or quantity limits, and the following:

200 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. Refer to Medicaid Services Manual (MSM) Addendum for more information on tamper-resistant prescription pads.

1. Section 1927(d)(1)(B)(i) of the Social Security Act allows Medicaid to restrict coverage for an outpatient drug if the prescribed drug is not for a medically accepted indication. Section 1927(k)(6) defines a medically accepted indication as any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia:

a. American Hospital Formulary Service Drug Information,

b. United States Pharmacopeia,

c. DRUGEX Information System, or

d. Peer-Reviewed Medical Literature.

2012. Legend and non-legend pPharmaceuticals must be manufactured by companies participating in the fFederal Medicaid Drug Rebate Program, not on the excluded list (see below).

202 Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Pharmacy and Therapeutics (P&T) Committee. Reference Medicaid Operations Manual (MOM) Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug classes reviewed by the P&T Committee require prior authorization, unless exempt under Nevada Revised Statute (NRS)

or federal law, or excluded through recommendations of the P&T Committee or excluded by the Division of Health Care Financing and Policy (DHCFP).

a. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan are available under prior authorization guidelines until the P&T Committee reviews the product or evidence.

1. Existing pharmaceutical products for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan, are available under prior authorization guidelines until the P&T Committee can review the new evidence.

2. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.

3. If the P&T Committee determines that there are no significant differences between drugs within specific classes based on clinical efficacy and safety, DHCFP or its Quality Improvement Organization (QIO) like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.

4. The Drug Utilization Review (DUR) Board shall not be required to develop, review or approve prior authorization policies necessary for the operations of the PDL.

6. Due to the 76th Special Session and in accordance with Senate Bill (SB) 4, every therapeutic prescription drug that is classified as an anticonvulsant medication or antidiabetic medication that was covered by the Medicaid program on June 30, 2010 must be included on the PDL as a preferred drug. If a therapeutic prescription drug that is included on the list of preferred prescription drugs is prescribed for a clinical indication other than the indication for which it was approved as of June 30, 2010, the Committee shall review the new clinical indication for that drug in accordance with Section 1203 of this chapter.

1. Due to the 76th Special Session and in accordance with SB 4, the P&T Committee must prefer atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness, anticonvulsant medications and antidiabetic medications for a patient who is receiving services pursuant to Medicaid if the patient:

~~a. was prescribed the prescription drug on or before June 30, 2010, and takes the prescription drug continuously, as prescribed, on and after that date; and~~

~~b. maintains continuous eligibility for Medicaid.~~

~~a. Pharmaceuticals prescribed for a medically accepted indication.~~

~~e. Family planning items such as diaphragms, condoms, foams and jellies.~~

Reference Appendix A for coverage and limitations of medications with special criteria.

~~2. Standard Preferred Drug List Exception Criteria~~

~~Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.~~

~~a. Coverage and Limitations~~

~~1. Allergy to all preferred medications within the same class;~~

~~2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;~~

~~3. History of unacceptable/toxic side effects to all preferred medications within the same class;~~

~~4. Therapeutic failure of two preferred medications within the same class.~~

~~5. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication;~~

~~6. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a Food and Drug Administration (FDA) approved indication;~~

~~7. Antidepressant Medication – Continuity of Care.~~

~~Recipients discharged from acute mental health facilities on a non-preferred antidepressant will be allowed to continue on that drug for up to 90 days following discharge. After 90 days, the recipient must meet one of the above five PDL Exception Criteria; or~~

~~8. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications the recipient demonstrated therapeutic failure on one preferred agent.~~

~~b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms/aspx~~

1204 NON COVERED SERVICES

3. Excluded

The Nevada Medicaid Drug Rebate program DHCFP will not reimburse for the following pharmaceuticals:

a. Agents used for weight loss.

b. Agents used to promote fertility.

c. Agents used for cosmetic purposes or hair growth.

d. Yohimbine.

e. Drug Efficacy Study and Implementation (DESI) list "Less than Effective Drugs": In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is Identical, Related or Similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

This includes pharmaceuticals designated "ineffective" or "less than effective" (including identical, related or similar drugs) by the FDA as to substance or diagnosis for which prescribed.

f. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

g. Agents used for impotence/erectile dysfunction.

1205 ~~1206~~ GENERIC SUBSTITUTION/BRAND CERTIFICATION

A. Generic Substitution

Per NRS Chapter 639, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

1. is less expensive than the drug prescribed by brand name;

2. is biologically equivalent to the drug prescribed by brand name;

3. has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and

4. is the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him/her for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her (brand or generic).

B. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies 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 for certification must comply with the following:

1. The certification must be in the physician's own handwriting.

2. Certification must be written directly on the prescription blank.

3. The phrase "Dispense as written" is required on the face of the prescription. For electronically transmitted prescriptions "Dispense as written" must be noted. Not acceptable: A printed box on the prescription blank check by the prescriber to indicate "brand necessary" or a handwritten statement transferred to a rubber stamp and then stamped on the prescription.

4. A prior authorization is required to override generic substitution.

5. Certification is not required if~~s~~ a generic is not manufactured.

6. 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.

1206 1207 REFILLS
4. Refills

A. A refill is a prescription subject to the limitations below:

1. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to the Nevada State Board of Pharmacy guidelines, Nevada Administrative Code (NAC) Chapter 639.

2. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. If a prescription is for a 34-day supply, a consistent refill would be filled in 30 days; an inconsistent refill date would be filled in 20 days from the original fill.

3. Lost Medications. 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. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications only. See Quantity of Medication in this chapter for more information on maintenance medications.

B. 5.Early Refills

1. Nevada Medicaid only pays for up to a 34 day supply of medications (100 day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the non-controlled substance prescription, and 90% of the controlled substance prescription, is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

2. In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill. This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

3. Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

6. Quantity of medication

The maximum quantity of medication per prescription payable by the Medicaid program is a 34 day supply. Exceptions are allowed for maintenance medications.

C. Maintenance Medication

The maximum quantity of medication per prescription payable for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid may be a 100-day supply.

The following drug categories are considered maintenance medications:

1. Antianginals;
2. Antiarrhythmics;
3. Anticonvulsants;
4. Antidiabetics;
5. Antihypertensives;
6. Cardiac Glycosides;
7. Diuretics;
8. Thyroid preparations;
9. Estrogens;
10. Progesterone; and
11. Oral/Topical Contraceptives.

a. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)

b. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

~~c. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day supply.~~

~~The following drug categories are considered maintenance medications:~~

~~1. Antianginals;~~

~~2. Antiarrhythmics;~~

~~3. Anticonvulsants;~~

~~4. Antidiabetics;~~

~~5. Antihypertensives;~~

~~6. Cardiac Glycosides;~~

~~7. Diuretics;~~

~~8. Thyroid preparations;~~

~~9. Estrogens;~~

~~10. Progesterone; and~~

~~11. Oral/Topical Contraceptives.~~

1207~~8~~ EMERGENCY SUPPLY OF MEDICATION

~~7. Emergency supply of medication~~

A. In an emergency situation, ~~after QIO-like vendor working hours and weekends,~~ dispensing of up to a 96 hour supply those covered outpatient drugs that require prior authorization will be allowed.

B. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization.

C. The physician must indicate the diagnosis on the prescription (preferably with an International Classification of Disease (ICD)) code to support the use of the emergency policy.

D. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor, to obtain a verbal verification number.

~~8. Nevada Check Up (NCU)~~

~~All coverage and limitation policies and rules, including any prior authorization requirements, outlined in this chapter apply to NCU recipients as well as Nevada Medicaid Fee-for-Service (FFS) recipients. There are NO exceptions~~.

~~9. Immunizations~~

~~Nevada Medicaid recognizes the importance of preventative health care through vaccines and immunizations. Unless otherwise stated in this chapter, immunizations are covered without prior authorization. Reference Appendix A of this chapter.~~

~~a. Childhood Immunizations: All childhood immunizations are covered without prior authorization under the Healthy Kids Program. Refer to MSM Chapter 1500, Healthy Kids Program, for more information on childhood immunizations.~~

~~b. Adult Immunizations: Adult immunizations such as tetanus, flu vaccine, and pneumococcal vaccine are covered without prior authorization. For a list of covered adult immunizations, please reference the Physician's Fee Schedule under "Professional Rates" at: http://www.dhcfp.nv.gov/RatesUnit.htm~~

~~c. Human Papillomavirus (HPV) Vaccine: The quadrivalent HPV vaccine (for both males and females) is available to Medicaid eligibles age 19 years through 26 years, based on the US FDA approved indications. The bivalent HPV vaccine for~~

~~ages 19-26 years is also available to Medicaid eligible females only. These may be accessed by following the link: http://www.fda.gov/cber/products/gardasil.htm The HPV vaccines are available through the state Health Division as part of the Vaccines for Children (VFC) program for eligible females and males age nine through 18 years. Please refer to MSM Chapter 1500, for more information on the VFC program.~~

~~d. Pharmacies may administer childhood and adult vaccines/immunizations.~~

~~1. Pharmacies must adhere to all Nevada State Board of Pharmacy (BOP) regulations regarding vaccine/immunization administration including certification to administer as documented in NAC Chapter 639.~~

~~2. Pharmacies must receive childhood immunizations through the VFC Program. The DHCFP or Nevada Medicaid and NCU do not reimburse for vaccines included in the VFC Program.~~

~~3. Covered immunizations not included in the VFC Program will be reimbursable per the Nevada Medicaid and NCU Pharmacy Manual.~~

~~4. If the pharmacist administers the immunization, the dispensing fee will not be reimbursed. An administration fee is paid instead.~~

1208~~9~~ PREFERRED DRUG LIST

Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Pharmacy and Therapeutics (P&T) Committee. Reference the Medicaid Operations Manual (MOM) Chapter 200 for the P&T bylaws. Pharmaceuticals not on the PDL, but within drug classes reviewed by the P&T Committee require prior authorization, unless exempt under Nevada Revised Statute (NRS) or federal law, or excluded through recommendations of the P&T Committee or excluded by the Division of Health Care Financing and Policy (DHCFP)

a. New pharmaceutical products not within the reviewed PDL drug classes, and not excluded under the state plan are covered but are still subject to clinical prior authorizations and quantity limits.

b. Existing pharmaceutical products within reviewed PDL drug classes, for which there is new clinical evidence supporting its inclusion on the PDL, and are not excluded under the state plan, are available under the Standard Preferred Drug List Exception Criteria prior authorization until the P&T Committee can review the new evidence.

c. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.

d. If the P&T Committee determines that there are no significant differences between drugs within specific classes based on clinical efficacy and safety, the DHCFP or its Quality Improvement Organization (QIO)-like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.

e. Due to the 76th Special Session in accordance with Senate Bill (SB) 4, every therapeutic prescription drug that is classified as an anticonvulsant medicationor antidiabetic medication that was covered by the Medicaid program on June 30, 2010 prescription drug that is included on the list of preferred prescription drugs is prescribed for a clinical indication other than the indication for which it was approved as of June 30, 2010, the P&T Committee shall review the new clinical indication for that drug in accordance with Section 1203 of this chapter.

f. Due to the 76th Special Session and in accordance with SB 4, the P&T Committee must prefer atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness, anticonvulsant medications and antidiabetic medications for a patient who is receiving services pursuant to Medicaid if the patient:

1. was prescribed the prescription drug on or before June 30, 2010, and takes the prescription drug continuously, as prescribed, on and after that date; and

2. maintains continuous eligibility for Medicaid.

1209~~10~~ STANDARD PREFERRED DRUG LIST EXCEPTION CRITERIA

Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.

a. Coverage and Limitations

1. Allergy to all preferred medications within the same class;

2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;

3. History of unacceptable/toxic side effects to all preferred medications within the same class;

4. Therapeutic failure of two preferred medications within the same class.

5. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication;

6. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a Food and Drug Administration (FDA)-approved indication;

7. ~~Antidepressant~~Psychotropic Medication – Continuity of Care.

   Recipients discharged from ~~acute mental health facilities~~ an institution on ~~a~~ non-preferred ~~antidepressant~~psychotropic medication(s) will be allowed to ~~continue~~remain on ~~that~~their drug(s) for up to ~~90 days following discharge. After 90 days, the recipient must meet one of the above five PDL Exception Criteria; or~~six months to allow the recipient time to establish outpatient mental health services.

8. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications the recipient demonstrated therapeutic failure on one preferred agent.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms/aspx

12210~~1~~ ~~State Maximum Allowable Cost~~ STATE MAXIMUM ALLOWABLE COST (SMAC)

a. SMAC is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the DHCFP, or ~~Fiscal Agent~~their QIO-like vendor.

1. The DHCFP ~~Fiscal Agent~~QIO-like vendor will perform ongoing market analysis to monitor pricing patterns and product availability.

2. The DHCFP ~~Fiscal Agent~~QIO-like vendor will perform monthly updates of the drugs subject to the SMAC.

3. All drugs subject to the SMAC and updates will be posted on the following website: http://www.medicaid.nv.gov/providers/rx/MACinfo.aspx

b. Providers may appeal the current SMAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.

1. The pharmacy must contact the ~~Fiscal Agent~~QIO-like vendor technical call center to initiate the appeal.

2. Information needed to make a decision will include NDC number, manufacturer, drug name, strength, and price paid. A faxed copy of the actual invoice for the drug may be requested.

3. Inquiries not resolved by the technical call center are forwarded to the ~~Fiscal Agent's~~QIO-like vendor's SMAC Coordinator for investigation and resolution.

4. If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to:

a. adjust SMAC pricing for the particular claim being appealed; and

b. make changes to the SMAC pricing file.

5. Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

~~1203.1B PROVIDER RESPONSIBILITY~~

~~1. For information on In-State and Out-Of-State Provider Participation refer to MSM Chapter 100.~~

~~a. The pharmaceutical provider will maintain records for all prescriptions dispensed to eligible recipients as may be required.~~

~~1. The provider will allow, upon request of proper representative, access to all records that pertain to Medicaid recipients for fiscal review, audit or utilization review.~~

~~2. All fiscal records are to be maintained for a period of six years or as specified in federal regulation.~~

~~2. Utilization Control~~

~~a. Prospective (Concurrent) Drug Utilization Review (Pro-DUR)~~

~~Pro-DUR functions will be carried out via the Point of Sale (POS) Systems.~~

~~1. Pro-DUR edits apply to POS claims and paper Uniform Claim Form (UCF) claims.~~

~~2. Long Term Care (LTC) claims are subject to all Pro-DUR edits that apply to retail.~~

~~3. Providers may submit override codes using the National Council for Prescription Drug Programs (NCPDP) standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.~~

~~4. No long term prior authorizations are issued, codes must be entered each time errors occur. Reference the Nevada Medicaid and NCU Pharmacy Manual (Pharmacy Manual) for more information on the current Pro-DUR edits and override procedures.~~

~~5. All drugs may be subject to quantity limitations. Refer to the Nevada Medicaid and NCU Pharmacy Manual for established quantity limits.~~

~~b. Retro Drug Utilization Review (DUR)~~

~~Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.~~

1211~~2~~ DRUG USE REVIEW

A. ~~c~~.Drug ~~Utilization~~ Use Review (DUR)

1. Nevada Medicaid policy and federal law allows the state appointed DUR Board to conduct review of the information compiled about individual ~~clients~~recipients and providers and allows the DUR Board to educate Medicaid providers about the changes in drug therapeutics. Educational programs may include information such as drug interactions between medications that physicians have prescribed for the ~~clients~~ recipients and medications they are prescribing that are unnecessarily expensive. In this case, educational efforts will be directed to help providers improve their efficiency in the allocation of the finite resources available for Medicaid ~~clients~~recipients.

2. Refer to the Medicaid Operations Manual (MOM), Chapter 200 Board and Committees and Advisory Committees for more information on the DUR Board.

~~d.~~ ~~Eligibility~~

~~Please refer to MSM Chapter 100 for information on Medicaid eligibility, eligibility verification and the Eligibility Verification System (EVS).~~

B. Retro Drug Utilization Review (DUR)

Both recipient and provider profiles (i.e. claim payments) are reviewed to identify patterns of excess. Verification of receipt of services is ongoing on a sample basis. Providers may be audited on site.

C. ~~a.~~Prospective (Concurrent) Drug ~~Utilization~~Use Review (Pro-DUR)

Pro-DUR functions will be carried out via the Point of Sale (POS) Systems.

~~a.~~1. Pro-DUR edits apply to POS claims and paper Uniform Claim Form (UCF) claims.

~~b.~~2. Long Term Care (LTC) claims are subject to all Pro-DUR edits that apply to retail.

~~c.~~3. Providers may submit override codes using the National Council for Prescription Drug Programs (NCPDP) standard interactive DUR codes. Override codes may be submitted on the initial claim. A denied claim does not have to be on file.

~~d.~~4. No long term prior authorizations are issued, codes must be entered each time errors occur. Reference the Nevada Medicaid and NCU Pharmacy Manual (Pharmacy Manual) for more information on the current Pro-DUR edits and override procedures.

5. All drugs may be subject to quantity limitations. Refer to the Nevada Medicaid and NCU Pharmacy Manual for established quantity limits.

1212~~3~~ LOCK–IN PROGRAM

~~a. Lock-in Program:~~ When a recipient has shown patterns of abuse/misuse of Nevada Medicaid benefits, or the DHCFP has determined that the recipient requires close medical management, the recipient may be "locked-in" to a specific pharmacy and/or provider. This means that Medicaid will only pay for controlled substance prescriptions/medical services at a single pharmacy/provider.

a. Criteria that is evaluated by the DHCFP when determining if a recipient should be locked in to a specific pharmacy begins with the number of controlled substance prescriptions filled in 60 days.

If the recipient has filled ten or more controlled substance prescriptions in the past 60 day period (includes controlled substance pharmaceuticals given in the emergency room) then the clinical review continues with the following criteria:

1. The recipient has utilized more than one pharmacy in the past 60 day period;

2. The recipient has utilized more than three physicians in the past 60 day period;

3. The recipient has utilized the emergency room(s) for receiving controlled substances;

4. The recipient has been diagnosed with a drug dependency related condition;

5. The dispensed quantity per prescription of controlled substances appears excessive by the clinical review team; or

6. The recipient has other noted drug seeking behaviors(s).

b. The POS system will not allow another pharmacy to bill for controlled substance prescriptions, and a message will be given at the time of service to notify the pharmacy that the recipient is locked-in. Any non-controlled substance prescriptions can be filled at any pharmacy.

c. Recipients who are locked-in to one pharmacy can change their locked-in pharmacy at any time by contacting their Medicaid District Office.

d. Pharmacies may call the Technical Call Center for an override to the locked-in pharmacy if:

~~a.~~1. The locked-in pharmacy is out of stock.

b.2. The locked-in pharmacy is closed.

c.3. The recipient is out of town and cannot access the locked-in pharmacy.

3. Generic Substitution

Per NRS Chapter 639, if the practitioner has not indicated that generic substitution is prohibited, the pharmacy provider must dispense, in substitution, another drug which is available to him if the other drug:

a. is less expensive than the drug prescribed by brand name;

b. is biologically equivalent to the drug prescribed by brand name;

c. has the same active ingredient or ingredient of the same strength, quantity and form of dosage as the drug prescribed by brand name; and

d. is of the same generic type as the drug prescribed by brand name the least expensive of the drugs that are available to him for substitution.

The pharmacy provider shall substitute the least expensive of the drugs available to him/her for substitution.

5. Prescriber Brand Certification

Upper Limit cost limitations specified in this Chapter will not apply when a prescriber certifies 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 for certification must comply with the following:

a. The certification must be in the physician's own handwriting.

b. Certification must be written directly on the prescription blank.

c. The phrase "Dispense as written" is required on the face of the prescription. 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. A prior authorization is required to override genetic substitution.

~~d. Certification is not required if a generic is not manufactured.~~

~~e. 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.~~

9.12134 ImmunizationsIMMUNIZATIONS

Nevada Medicaid recognizes the importance of preventative health care through vaccines and immunizations. Unless otherwise stated in this chapter, immunizations are covered without prior authorization. Reference Appendix A of this chapter.

d.a. Childhood Immunizations: All childhood immunizations are covered without prior authorization under the Healthy Kids Program. Refer to MSM Chapter 1500, Healthy Kids Program, for more information on childhood immunizations.

e.b. Adult Immunizations: Adult immunizations such as tetanus, flu vaccine, and pneumococcal vaccine are covered without prior authorization. For a list of covered adult immunizations, please reference the Physician's Fee Schedule under "Professional Rates" at: http://www.dhcfp.nv.gov/RatesUnit.htm http://dhcfp.nv.gov/Resources/Rates/RatesMain/

f.c. Human Papillomavirus (HPV) Vaccine: The quadrivalent HPV vaccine (for both males and females)non9-avalent and the bivalent HPV vaccine isare available to male and female Medicaid eligibles, age 19 years through 26 years, based on the US FDA approved indications. The bivalent HPV vaccine for ages 19-26 years is also available to Medicaid eligible females only.These may be accessed by following the link: http://www.fda.gov/cber/products/gardasil.htm The HPV vaccines are available through the state Health DivisionNevada Division of Public and Behavioral Health as part of the Vaccines for Children (VFC) program for eligible females and males age nine through 18 years. Please refer to MSM Chapter 1500, for more information on the VFC program.

d. Pharmacies may administer childhood and adult vaccines/immunizations.

1. Pharmacies must adhere to all Nevada State Board of Pharmacy (BOP) regulations regarding vaccine/immunization administration including certification to administer as documented in NAC Chapter 639.

2. Pharmacies must receive childhood immunizations through the VFC Program. The DHCFP or Nevada Medicaid and Nevada Check Up (NCU) do not reimburse for vaccines included in the VFC Program.

3. Covered immunizations not included in the VFC Program will be reimbursable per the Nevada Medicaid and NCU Pharmacy Manual.

4. If the pharmacist administers the immunization, the dispensing fee will not be reimbursed. An administration fee is paid instead.

1214~~5~~ TAMPER RESISTANT PRESCRIPTION PADS

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. Refer to Medicaid Services Manual (MSM) Addendum for more information on tamper-resistant prescription pads.

1203.1C156 SERVICE DELIVERY MODELOUTPATIENT DELIVERY MODELS

For the rate and reimbursement methodology for the administration rates see MSM Chapter 700, Rates.; For POS claims refer to the Pharmacy Manual, and for Medicaid Management Information System (MMIS) claims refer to the Nevada Medicaid and NCU Billing Manual (Billing Manual). For the Medicaid Program, see MSM Chapter 100, for Fiscal Integrity see MSM Chapter 3300. For Medicaid Management Information System (MMIS) claims refer to the Billing Manual for Nevada Medicaid. For Point of Sale (POS) and physician-administered (NVPAD) claims refer to the Pharmacy Manual.

2. Outpatient Pharmaceuticals

a. Covered outpatient drugs that are billed reimbursed separately from medical services, in accordance with Section 1927 of the Social Security Administration (SSA).

1. Retail pharmacies, (billed through POS).

2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics, (billed through POS). Refer to the Intravenous (IV) Therapy Provider Type 37 Section of this chapter.Refer to the Pharmacy Billing Manual for the information on HIT billing.

3. Physician administered drugs, NVPAD, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate National Drug Code (NDC) and NDC quantity. The administration of the drug is billed using the appropriate Current Procedural Terminology (CPT) code (billed through MMIS).

4. Hospital based outpatient clinics, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

5. End Stage Renal Disease (ESRD) (hospital-based or stand alone), Facilities, any administered drugs not included in the Prospective Payment System (PPS) Rate are to be billed using the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS). Drugs included in the PPS Rate as documented in the CMS Manual System, Publication # 100-04, Medicare Claims Processing, Transmittal 2134 will deny if billed separately.

b. Covered outpatient drugs that are not reimbursed separately in accordance with 1927(k)(2) of the SSA.

1. Ambulatory Surgical Centers (ASC)/Hospital-Based Ambulatory Infusion Centers, all pharmacy services are included in the facility rate. Pharmacy charges may not be billed separately~~,~~ .The facility rate is ~~(~~billed through MMIS~~)~~.

2. Emergency Rooms, all pharmacy services are included in the Emergency Room charges. “Take home” medications are also included in the ~~facility rate~~facility rate and may not be billed separately, (billed through MMIS).

3. Outpatient facilities/clinics that are paid per encounter, cannot bill separately for pharmaceuticals when drugs are included in their encounter rate.

4. Hospice (outpatient) reimbursement for drugs related to the documented terminal illness and palliative (symptom relief) are to be covered by the hospice and will not be reimbursed by the DHCFP. Refer to MSM Chapter 3200, Hospice, for more information.

1216 7 INSTITUTIONAL DELIVERY MODELS

7. Institutional settings

a. Inpatient Mmedical/Ssurgical, Sspecialty, and Ppsychiatric Hhospitals, inpatient hospice facilities, etc:— Institutional pharmaceutical delivery models are defined by the Social security Act Section 1927(k)(2) as covered outpatient drugs that are not reimbursed separately from the institutional service. All pharmacy services are included in the daily per diem rate for inpatient services, which are billed through MMIS and are not reimbursed separately.

b. Long Term Care (LTC)

1. Nursing Facilities (NF) – Legend pharmaceutical services are excluded from the daily per diem facility rate. This includes compound prescriptions and Total Parental Nutrition (TPN) solution and additives. Legend pharmaceuticals are billed directly by a licensed pharmacy through POS. Non-legend pharmaceuticals are not separately reimbursable.

2. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Individuals with Intellectual Disabilities (ICFs/IID) – Legend and non-legend pharmaceuticals are excluded from the facility rate. Pharmaceuticals are billed directly by a licensed pharmacy through POS.

3. Hospice Services in NFs, all drugs related to the documented terminal illness and palliative (symptom relief) services are to be covered by the hospice and will not be reimbursed by the DHCFP. Refer to MSM Chapter 3200, Hospice, for more information.

2. Outpatient Pharmaceuticals

a. Covered outpatient drugs that are billed separately from medical services, in accordance with Section 1927 of the Social Security Administration (SSA).

1. Retail pharmacies, (billed through POS).

2. Home Infusion Therapy (HIT)/Free Standing Infusion Clinics, (billed through POS). Refer to the Intravenous (IV) Therapy Provider Type 37 Section of this chapter.

3. Physician administered drugs, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate National

Drug Code (NDC) and NDC quantity. The administration of the drug is billed using the appropriate Current Procedural Terminology (CPT) code(billed through MMIS).

4. Hospital based outpatient clinics, all pharmacy charges are billed separately. The administered drug is to be billed utilizing the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS).

5. End Stage Renal Disease (ESRD) Facilities, any administered drugs not included in the Prospective Payment System (PPS) Rate are to be billed using the appropriate NDC and NDC quantity. The administration of the drug is billed using the appropriate CPT code, (billed through MMIS). Drugs included in the PPS Rate as documented in the CMS Manual System, Publication # 100-04, Medicare Claims Processing, Transmittal 2134 will deny if billed separately.

b. Covered outpatient drugs that are not reimbursed separately in accordance with 1927(k)(2) of the SSA.

2. Ambulatory Surgical Centers (ASC)/Hospital-Based Ambulatory Infusion Centers, all pharmacy services are included in the facility rate. Pharmacy charges may not be billed separately, (billed through MMIS).

3. Emergency Rooms, all pharmacy services are included in the Emergency Room charges. "Take home" medications are also included in the facility rate and may not be billed separately, (billed through MMIS).

c. 3.Disposable Medical Supplies

Please refer to MSM Chapter 1300, Durable Medical Equipment (DME) for instructions on billing and any applicable limitations for these items.

d. 4.Unit Dose (Repackage and Re-Stock) Repackage

1. Nevada Medicaid provides reimbursement incentives for LTC providers who repackage non-unit dose pharmaceuticals; An additional $0.43 per claim is given on pharmaceuticals that are repackaged for unit dose dispensing. Pharmaceuticals that First Data Bank classifies as unit dose products are not covered for this policy.

2. This incentive is available only to pharmacies supplying long-term care inpatients. The pharmacy provider must apply to the QIO-like Vendor Pharmacy Department to enroll in this incentive program.

~~1.~~3. In accordance with the CMS, State Medicaid Director Letter (SMDL) 06-005, repackaging of pharmaceuticals must be in compliance with the Nevada State Board of Pharmacy. In addition, NFs must properly credit the Medicaid program for the return of unused prescription medicines upon discontinuance of the prescription or transfer, discharge or death of a Medicaid beneficiary. This is to assure there is no double billing of the medication.

~~5. Coordination of Benefits (COB)~~

~~On-line COB (cost avoidance) is part of the Nevada Medicaid POS system.~~

~~a. If Nevada Medicaid is the recipient's secondary carrier, claims for COB will be accepted.~~

~~b. Nevada Medicaid is always the payer of last resort.~~

~~c. Other coverage will be identified by the presence of other carrier information on the recipient eligibility file.~~

~~d. If the recipient shows other coverage, the claim will be denied. The POS system will return a unique client-identified carrier code identifying the other carrier, the recipient's policy number and the carrier name in the additional message filed. It is possible that a recipient may have more than one active other carrier; in that case, the returned code will be from the first carrier, subsequent codes will be returned until fully exhausted. Providers will be required to submit this code OTHER PAYER ID (#340-7C) field as part of the override process.~~

~~e. Even if "no other insurance" is indicated on the eligibility file, the claim will be processed as a TPL claim if the pharmacy submits.~~

~~f. If other insurance is indicated on the eligibility file, the claim will be processed as a TPL regardless of what TPL codes the pharmacy submits.~~

~~g. In all cases, the Nevada Medicaid "allowed amount" will be used when calculating payment. In some cases, this may result in a "0" payment, when the insurance carrier pays more than the Medicaid "allowable amount".~~

~~h. In order to facilitate the TPL/COB process, Nevada Medicaid will allow providers to override "days supply limits" and/or "Drug Requires PA" conditions by entering a value of "5" (exemption from prescription limits) in the PA/MC CODE field (NCPCP #416DG) if there are no prior authorization requirements on these drugs from the primary insurer.~~

~~6. Non-participating Health Maintenance Organization (HMO) Providers~~

~~a. Recipients, who have Medicaid and HMO coverage, including Medicare HMOs, must seek treatment and services through their preferred provider network or HMO. Nevada Medicaid is not liable to pay for HMO covered services if the recipient elects to seek treatment from a provider not authorized by the HMO. Unless the provider is an authorized provider of a recipient's health plan, the recipient should be referred to the plan for covered treatment, or the provider should contact the HMO for treatment authorization. Refer to MSM Chapter 3600, Managed Care Organizations (MCO), or MSM Chapter 100, Medicaid Program, for more information.~~

~~b. Exceptions to Medicaid liability policy are:~~

~~1. The service(s) is/are a non-covered benefit of the HMO plan;~~

~~2. The service is an emergency and a participating provider is more than 25 miles away;~~

~~3. The service is for family planning;~~

~~4. The recipient resides outside the service area of the HMO; or~~

~~5. The recipient's HMO coverage has been exhausted.~~

~~7. Pharmacy Billing Process~~

~~a. NCPDP Standard Billing Units~~

~~Nevada Medicaid reimburses for outpatient pharmaceuticals according to NCPDP "Billing Unit Standard Format" guidelines. The standard provides for the billing of pharmaceuticals in one of three billing units for all drug products. These units are "each", "milliliter (ml)", and "gram (g)". The following guidelines are to be used when billing Nevada Medicaid for pharmaceuticals:~~

~~Tablets, Capsules, Suppositories, Pre-filled Syringes: must be billed by "each" or by "mls". For example, if 30 tablets of Metformin are dispensed, the quantity will be 30.~~

~~Liquids, Liquid Orals, Suspensions, Solutions, Opthalmic/Otic Solutions: must be billed by milliliters (mls). For example, if 560ml of guiafenesin is dispensed, the quantity entered will be 560.~~

~~PLEASE NOTE:~~

~~Ounces must be converted to ml (1 ounce = 30ml).~~
~~Liters must be converted to ml (1L = 1000ml).~~
~~Ointments, Bulk Powders: must be billed by grams. For example, if a two ounce tube of oxiconazole nitrate is dispensed, the quantity entered will be 60.~~

~~PLEASE NOTE:~~

~~Ounces must be converted to grams (1 ounce = 30g, ½ ounce = 15g).~~

~~Oral Contraceptives/Therapy packs: must be billed per "each" tablet dispensed, not the number of packages. For example, Ortho Tri-Cyclen is a 28-day dial pack, the quantity entered will be 28.~~

~~Transdermal Patches/Powder Packets: must be billed per "each" patch/packet dispensed, regardless of whether they are pre-packaged in a box or come in individual pouches/packets. For example, Catapress-TTS comes in a box of four patches. If two of these boxes are dispensed, the quantity entered will be eight.~~

~~Inhalers and Aerosols: must be billed as either grams or ml, as specified by the manufacturer on the labeling. For example a 90mcg(microgram)/inh Albuterol Inhaler has a total of 17gm in the canister. If one of these is dispensed, 17 will be quantity entered.~~

~~Topical Products: must be billed as either grams or ml, as specified by the manufacturer on the labeling.~~

~~PLEASE NOTE: Ounces must be converted to grams or ml~~.

~~1 ounce = 30ml~~
~~1 ounce = 30g~~

Reconstitutables (oral, otic, ophthalmic): must be billed per ml that are/will be in the bottle after reconstitution according to the manufacturer's instructions.

Liquid Injectables (vials, ampoules): must be billed by milliliters (ml). For example, if a 10ml vial of Novolin 70/30 is dispensed, the quantity entered will be 10.

Powdered Injectables (vials): must be billed by "each" vial given per dose. For example if the recipient receives Ampicillin 1g every six hours for one week, the quantity entered will be 1, as only one vial is used per dose (assuming a 1gm vial is used), and the # of doses entered will be 28 (4 per day x 7 days).

PLEASE NOTE: If the product is supplied with a diluent, the quantity entered is only the number of powdered vials dispensed, the diluent is not factored in.

Intravenous Solutions: must be billed in ml administered per dose. For example, if a recipient receives 250ml of Normal Saline four times per day, the quantity entered will be 250, as that is the quantity per dose.

Blood Derived Products: products may vary in potency from batch to batch. Anithemophilic products must be billed as the number of antihemophilic units dispensed (each). Prolastin must similarly be billed as the number of milligrams dispensed (each).

Kits: defined as products with a least two different or discreet items (excluding diluents, applicators and activation devices) in the same package, intended for dispensing as a unit. Kits carry only a single NDC. Kits are intended to be dispensed as a unit and should be billed as a unit of each kit dispensed (each).

For further information, refer to the NCPDP Billing Unit Standard Format Official Release.

b. Provider Numbers

The state National Association of Boards of Pharmacy (NABP) provider number is to be used and entered when billing online using the POS system or when using the UCF.

8. State Maximum Allowable Cost (SMAC)

a. SMAC is the upper reimbursement limit for multi-source outpatient pharmaceuticals established by the DHCFP, or Fiscal Agent.

1. The DHCFP Fiscal Agent will perform ongoing market analysis to monitor pricing patterns and product availability.

2. The DHCFP Fiscal Agent will perform monthly updates of the drugs subject to the SMAC.

3. All drugs subject to the SMAC and updates will be posted on the following website: http://www.medicaid.nv.gov/providers/rx/MACinfo.aspx

b. Providers may appeal the current SMAC for a pharmaceutical product if a provider determines that a particular multi-source drug is not available at the current SMAC reimbursement.

1. The pharmacy must contact the Fiscal Agent technical call center to initiate the appeal.

2. Information needed to make a decision will include NDC number, manufacturer, drug name, strength, and price paid. A faxed copy of the actual invoice for the drug may be requested.

3. Inquiries not resolved by the technical call center are forwarded to the Fiscal Agent's SMAC Coordinator for investigation and resolution.

4. If it is determined the SMAC is negatively impacting access to care for recipients, the SMAC Coordinator has the authority to:

a. adjust SMAC pricing for the particular claim being appealed; and

b. make changes to the SMAC pricing file.

5. Appeals will be responded to within three working days of the referral to the SMAC Coordinator.

1203.1D AUTHORIZATION PROCEDURES

Prior Authorization Requests: Physician's may request payment for exceptions to program limitations and medications requiring prior authorization by forwarding a prior authorization request to the QIO-like vendor. Prior authorization requests may be done via phone, fax or internet. Refer to the Pharmacy Manual for more information.

1. When requesting a prior authorization, providers must:

a. Provide all relevant diagnoses.

b. List all routine essential drugs being prescribed.

400 The requesting physician will be advised of the decision within 24 hours of receipt. A facsimile signature stamp is acceptable on faxed prior authorization requests.

d. Unless otherwise indicated by the QIO-like vendor, the prior authorization is for no more than one 34-day supply of prescription for each authorized drug per month.

2. Prior Authorization Protocols

a. Alternate media (e.g. paper/UCF claims) are subject to all prior authorization types.

LTC claims, regardless of the media type, are subject to all prior authorization types. Note that the POS system does not require a "Prior Authorization Number" to be entered on a paper or electronic claim; the only requirement is that the prior authorization record is activated in the system prior to the claim submission. The approved prior authorization will be in the POS system and will be active for all pharmacies using the POS system, unless the recipient is "locked in" to a particular pharmacy for abuse/misuse reasons.

b. A prior authorization will typically be required to be requested and entered prior to the dispensing of the medication, however there may be situations in which an authorization request is considered after the fact (e.g. retroactive eligibility).

c. For clinical prior authorizations in which a Clinical Call Center Prior Authorization Unit pharmacist or pharmacy technician requests information from the prescribing physician, the prior authorization will deny if the doctor does not respond to a request for information within three working days.

d. The Nevada Medicaid QIO-like vendor will send all denial of service letters.

e. For any prior authorization requests that are denied due to criteria not being met, the recipient (only) may appeal the decision. Reference MSM Chapter 3100 for the hearings process.

f. Standard protocols for "Emergency" or "72-96 Hour Fill" type of overrides will be used.

~~1203.2 INTRAVENOUS (IV) THERAPY PROVIDER TYPE 37~~

~~The purpose of IV therapy is to sustain life, reduce or eliminate infections, replace or provide necessary chemicals to maintain electrolyte balance or provide blood product or hemotherapeutics. IV therapy and treatment should only be used when the Medicaid recipient cannot use oral medications.~~

~~a. Billing Guidelines~~

~~IV therapy is billed through the pharmacy POS system using the multi-ingredient functionality. A 37 provider number is required (Home Infusion Therapy Provider). The paper Multi-ingredient UCF may also be used if an exception is granted by the Division. Drug coverage edits and prior authorization edits will be performed at the individual ingredient level.~~

~~The billing units used should be the NCPDP standards of "each", milliliters (ml) or grams(g). Please refer to section 1203.1(D)(8) of this Chapter for complete explanation of these standards.~~

~~For specific instructions related to billing via the POS system, refer to the Nevada Medicaid QIO-like pharmacy vendor.~~

~~b. Dispensing Fees~~

~~A daily dispensing fee of $22.40 will be applied to IV therapy claims for outpatient antibiotic therapy. For recipients in LTC, a daily dispensing fee of $16.80 will be applied to the claim. This will be multiplied by the number of days the therapy was provided.~~

~~c. Supplies~~

~~Supplies for IV therapy, Enteral Nutrition and TPN are billed through the DME program (under Provider Type 33). Please refer to MSM Chapter 1300, DME, Disposable Supplies and Supplements, for instructions on billing and any applicable limitations on these items.~~

~~d. Long Term Care (LTC)~~

~~1. Non-Billable Items~~

~~IV hydration therapy of standard fluids without additives (e.g., antibiotics, potassium, and heparin) as well as supplies only associated with IV therapy,~~

~~Enteral Nutrition, and TPN administration are included in Nevada Medicaid's LTC/NF rate and may not be billed as a separate charge.~~

~~2. Billable Items~~

~~IV Drugs/TPN for recipients in LTC facilities may be billed as a separate charge. Please refer to MSM Chapter 500 (Nursing Facilities) for further information on items which may be billed separately to Nevada Medicaid.~~

12~~0~~417~~8~~ HEARINGS

~~1204.1~~ Please reference Nevada Medicaid Services Manual (MSM), Chapter 3100 for the Medicaid Hearings process.

DRUGS REQUIRING PRIOR AUTHORIZATION AND/OR QUANTITY LIMITATIONS 4

A

ABSTRAL® (Fentanyl Citrate Sublingual Tablet) 18
ACTIQ® (Fentanyl Citrate Transmucosal Lozenge) 18
AGENTS USED FOR THE TREATMENT OF ATTENTION DEFICIT DISORDER (ADD)/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) 7
AMPYRA® (Dalfampridine) 50
ANDROGEL®, ANDRODERM®, TESTIM® (testosterone gel and transdermal system) 51
ANTIEMETICS – SEROTONIN RECEPTOR ANTAGONIST 42
ANTI-FUNGAL ONCYCHOMYCOSIS (Lamisil®, Sporanox®, Penlac®) 21
ANTI-HEPATITIS AGENTS – PROTEASE INHIBITOR AGENTS 55
ANTI-MIGRAINE MEDICATIONS (Triptans) 37
ANTIRETROVIRALS 93
AUVI-Q (epinephrine injection device) 75

B

BERINERT® (C1 Esterase Inhibitor) 60
BLOOD GLUCOSE TESTING 94
BRILINTA® (Ticagrelor) 65
Buprenorphine (SUBUTEX®) 48
Buprenorphine/Naloxone (SUBOXONE®) 48
BYDUREON® (Exenatide Extended-Release) 62
BYETTA® (Exenatide) 62

C

CESAMET® (Nabilone) 70
CINRYZE® (C1 Esterase Inhibitor) 60
CORLANOR® (ivabradine) .....
COLCHICINE (Colcrys®) 52
COLONY STIMULATING FACTORS 73
COX-2 INHIBITORS 5
CYMBALTA® (Duloxetine) 45

D

DAKLINZA® (daclatasvir) .....
DALIRESP® (Roflumilast) 59

E

EFFIENT® (Prasugrel) 65
ENTRESTO® (sacubitril/valsartan) .....

F

FENTORA® (Fentanyl Citrate Buccal Tablet) 18
FIRAZYR® (Icatibant) 60
FORTEO® (Teriparatide) 69

G

GENOTROPIN® (Somatropin) 10
GROWTH HORMONE 10

H

HARVONI® (ledipasvir/sofosbuvir) 79
HEMATOPOIETIC/HEMATINIC AGENTS 19
HEREDITARY ANGIOEDEMA AGENTS 60
HORMONES 91
HUMATROPE® (Somatropin) 10

I

IMMEDIATE-RELEASE FENTANYL PRODUCTS 18
IMMUNOMODULATOR DRUGS 24
INCIVEK® (Telaprevir) 56
INHALED ANTICHOLINERGIC AGENTS 41
INVEGA TRINZA® (paliperidone palmitate) .....

K

KALBITOR® (Ecallantide) 60
KALYDECO® (Ivacaftor) 63

L

LAZANDA® (Fentanyl Citrate Nasal Spray) 18
LEUKINE® (Sargramostim) 73
LIDODERM 5% PATCHES® 32
LONG ACTING NARCOTICS 35

M

MAKENA™ 54
MARINOL® (Dronabinol) 70
MEDICATIONS FOR THE TREATMENT OF ACNE 78
MEDICATIONS WITH GENDER/AGE EDITS 90

N

NATROBA® (Spinosad) 64
NEULASTA® (Pegfilgrastim) 73
NEUPOGEN® (Filgrastim) 74
NORDITROPIN® (Somatropin) 10
NUTROPIN® (Somatropin) 10

O

OLYSIO® (Simeprevir) 56
OMNITROPE® (Somatropin) 10
OMONTYS® (Peginesatide) 72
ONSOLIS® (Fentanyl Citrate Buccal Film) 18
ORKAMBI® (lumacaftor/ivacaftor) .....
ORAL/TOPICAL CONTRACEPTIVES 90
OVER-THE-COUNTER MEDICATIONS 15

P

PLATELET INHIBITORS 65
PRALUENT® (alirocumab) .....
PRAMLINITIDE INJECTION (Symlin®) 22
PRENATAL VITAMINS 90

PROLIA® (Denosumab) 67
PROTON PUMP INHIBITORS (PPI's) 4
PSYCHOTROPIC MEDICATIONS FOR CHILDREN AND ADOLESCENTS 29

R

RAYOS® (prednisone delayed-release) 88
REGRANEX® 23

S

SAIZEN® (Somatropin) 10
SAVELLA® (Milnacipran) 47
SEDATIVE HYPNOTICS 40
SEROSTIM® (Somatropin) 13
SOVALDI® 76
SUBSYS®(Fentanyl Sublingual Spray) 18
SYNAGIS®(palivizumaub) 43

T

TECHNIVIE® (ombitasvir/paritaprevir/ritonavir) .....
TEV-TROPIN®(Somatropin) 10
THROMB ININHIBITORS 53
TOBACCO CESSATION PRODUCTS 38
TOPICALIMMUNOMODULATORS 28
TORADOL (Ketorolac Tromethamine) TABLETS 36
TRANSDERMAL FENTANYL 16

V

VICTOZA®(Liraglutide) 62
VICTRELIS®(Boceprevir) 57
VIEKIRA PAK®(dasabuvir-ombitasvir-paritaprevir-ritonavir) 82
VIMOVO®(naproxen/esomeprazolemagnesium), Duexis® (ibuprofen/famotidine) 86
VITAMIN WITH FLOURIDE 92
VIVITROL® (naltrexone) 84

X

XARTEMIS (oxycodone and acetaminophen)82
XOLAIR® (Omalizumab) 33
XOPENEX®(Levalbuterol) 39
XYREM® (sodium oxybate), Provigil® (modafinil), Nuvigil® (armodafinil) 85

Z

ZORBTIVE®(Somatropin) 13

All drugs in Appendix A may be subject Quantity Limitations.
Check the Nevada Medicaid and Nevada Check Up Pharmacy Manual for a listing of the exact Quantity Limitation.

~~H.~~I. Anti-Fungal Oncychomycosis (Lamisil®, Sporanox®, Penlac®)

Therapeutic Class: Antifungal Agents
Last Reviewed by the DUR: ~~June 3, 2010~~September 3, 2015

~~Anti-Fungal Onchomycosis are subject to prior authorization:~~
Anti-Fungal Onychomycosis Agents are subject to prior authorization and quantity limitations based on the Application of Standard in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Authorization will be given if the following criteria are met and documented:

a. ~~Do not authorize itraconazole if recipient has evidence of ventricular dysfunction~~The agent is U.S. Food and Drug Administration (FDA) approved for the treatment of oncychomcosis (tinea unguium).

b. ~~Do not authorize terbinafine if recipient has pre-existing liver disease.~~And one of the following:

1. The recipient is experiencing pain which limits normal activity, or

2. The recipient's disease is iatrogenically-induced, or

3. The recipient's disease is associated with immunosupression, or

4. The recipient has diabetes, or

5. The recipient has significant peripheral vascular compromise.

c. ~~Positive KOH stain, positive PAS stain or positive fungal culture and any of the following:~~And the requested length of therapy is appropriate, based on the agent and infection location.

~~1. Recipient experiencing pain which limits normal activity;~~

~~2. Recipient has an iatrogenically-induced or disease associated immunosuppression;~~

~~3. Recipient has diabetes; or~~

~~4. Recipient has significant peripheral vascular compromise.~~

d. ~~Length of Authorization~~And the drug and/or formulation-specific criteria is met:

1. ~~Lamisil® tablets & Sporanox® tablets Fingernail: six weeks – Toenail: 12 weeks~~Terbinafine: no pre-existing liver disease.

2. ~~Penlac® liquids Initial: three months~~Itraconazole: The recipient does not have a diagnosis of heart failure and there is no evidence of ventricular dysfunction.

3. Oral granules dosage form: clinical rationale documenting why the recipient cannot or should not use terbinafine tablets or itraconazole capsules.

e. Topical dosage forms:

1. Inadequate response after an appropriate length of therapy with ciclopirox 8% solution or an adverse reaction or contraindication to ciclopirox 8% solution, and

2. Inadequate response after an appropriate length of therapy to either terbinafine tablets or itraconazole tablets or an adverse reaction or a contraindication to terbinafine tablets or itraconazole capsules or a clinical rationale why the recipient cannot use terbinafine tablets or itraconazole tablets.

f. Onmel (itraconazole) tablets: Clinical rationale documenting why the recipient cannot or should not use terbinafine tablets or itraconazole capsules.

2. Prior Authorization Guidelines

a. The extent of Prior Authorization approvals will be based on the appropriate use for the individual agents.

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

L. Immunomodulator Drugs

Therapeutic Class: Immunomodulators
Last Reviewed by the DUR Board: ~~January 22, 2015~~November 5, 2015

Actemra® (tocilizumab)	Ilaris® (canakinumab)
Amevive® (alefacept)	Kineret® (ankinra)
Arcalyst® (rilonacept)	Orencia® (abatacept)
Cimzia® (certolizumab pegol)	Remicade® (infliximab)
Consentyx® (secukinumab)	Simponi® (golimumab)
Enbrel® (etanercept)	Simponi® ARIA™ (golimumab)
Entyvio® (vedolizumab)	Stelara® (ustekinumab)
Humira® (adalimumab)	Xeljanz® (tofacitinib)

Immunomodulator Drugs are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. For all recipients:

1. The recipient has had a negative tuberculin test, and

2. The recipient does not have an active infection or a history of recurring infections, and

3. The approval will not be given for the use of more than one biologic at a time (combination therapy), and

4. Each request meets the appropriate diagnosis-specific criteria (b-j).

b. Rheumatoid Arthritis (RA):

1. The recipient has a diagnosis of moderately to severely active RA; and

2. The recipient is 18 years of age or older; and

3. The recipient has had a rheumatology consultation, including the date of the visit; and one of the following:

~~3. The recipient has had a negative tuberculin test; and~~

~~4. The recipient does not have an active infection or a history of recurring infections; and~~

a. ~~5.~~The recipient has had RA for ≤ six months (early RA) and has high disease activity; and an inadequate or adverse reaction ~~of~~to a disease modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline and sulfasalazine); or

b. ~~6.~~The recipient has had RA for ≥ six months (intermediate or long-term disease duration) and has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline or sulfasalazine); or

c. ~~7.~~The recipient has had RA for ≥ six months (intermediate or long-term disease duration) and has high disease activity.

~~b~~c. Psoriatic Arthritis:

1. The recipient has a diagnosis of moderate or severe psoriatic arthritis; and

1. The recipient is 18 years of age or older, and

2. The recipient has had a rheumatology consultation including the date of the visit or a dermatology consultation including the date of the visit; and

~~3~~4. The recipient had an inadequate response to any one nonsteroidal anti-inflammatory drug (NSAID) or a contraindication to treatment with an NSAID or to any one of the following DMARDs (methotrexate, leflunomide, cyclosporine or sulfasalazine)~~; and~~.

~~4. The recipient has had a negative tuberculin test; and~~

~~5. The recipient does not have active infection or a history of recurring infections.~~

~~c~~d. Ankylosing Spondylitis:

1. The recipient has a diagnosis of ankylosing spondylitis; and

2. The recipient is 18 years of age or older; and

3. has had an inadequate response to NSAIDs; and

~~1.~~4. The recipient has had an inadequate response to any one of the DMARDs: (methotrexate, hydroxychloroquine, sulfasalzine, leflunomide, minocycline)~~; and~~.

~~4. The recipient has had a negative tuberculin test; and~~

~~5. The recipient does not have an active infection or a history of recurring infections.~~

e. ~~d.~~Juvenile Rheumatoid Arthritis/Juvenile Idiopathic Arthritis:

1. The recipient has a diagnosis of moderately or severely active juvenile RA; and

2. The recipient is at ~~least two years of ageat~~ an appropriate age, based on the ~~requrestedrequested~~ agent~~;~~, and:

   a. Abatacept: Six years of age or older.

   b. Adalimumab, canakinumab, etanercept, tocilizumab: Two years of age or older.

3. The recipient has at least five swollen joints; and

4. The recipient has three or more joints with limitation of motion and pain, tenderness or both; and

5. The recipient has had an inadequate response to one DMARD~~; and~~.

~~6. The recipient has had a negative tuberculin test; and~~

~~7. The recipient does not have an active infection or a history of recurring infections.~~

f. ~~e.~~ Plaque Psoriasis:

1. The recipient has a diagnosis of chronic, moderate to severe plaque psoriasis; and

2. The recipient is 18 years of age or older; and

3. The agent is prescribed by a dermatologist; and

4. ~~3.~~The recipient has failed to adequately respond to a topical agent; and

5. ~~4.~~The recipient has failed to adequately respond to at least one oral treatment~~; and~~.

~~5. The recipient has had a negative tuberculin test; and~~

~~6. The recipient does not have an active infection or a history of recurring infections.~~

g. ~~f~~.Crohn's Disease:

1. The recipient has a diagnosis of moderate to severe Crohn's Disease; and

2. The recipient is at an appropriate age, based on the requested agent:

a. Adalimumab, infliximab: Six years of age or older,

b. All others: 18 years of age or older; and

3. The recipient has failed to adequately respond to conventional therapy (e.g. sulfasalzine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide); or

4. ~~3~~The recipient has fistulizing Crohn's D~~d~~isease~~, and;~~.

~~4. The recipient has a negative tuberculin test; and~~

~~5. The recipient does not have an active infection or a history of recurring infections.~~

h. ~~g.~~Ulcerative Colitis:

1. The recipient has a diagnosis of moderate to severe ulcerative colitis; and

2. The recipient is at an appropriate age, based on the ~~requreste~~requested agent:

a. Infliximab: Six years of age or older.

b. All others: 18 years of age or older; and

~~1.~~3. The recipient has failed to adequately respond to one or more of the following standard therapies:

a. Corticosteroids;

b. 5-aminosalicylic acid agents;

~~B.~~c. Immunosuppresants; and/or

~~C.~~d. Thiopurines~~; and~~.

~~3. The recipient has a negative tuberculin test; and~~

~~4. The recipient does not have an active infection or history of recurring infections.~~

i. Cryopyrin-Associated Periodic Syndromes (CAPS): Familial Cold Autoinflamatory Syndromes (FCAS) or Muckle-Wells Syndrome (MWS):

1. The recipient has a diagnosis of FCAS or MWS,

2. The recipient is at an appropriate age, based on the requested agent:

a. Canakinumab: Four years of age or older.

b. Rilonacept: 12 years of age or older.

j. Cryopyrin-Associated Periodic Syndromes (CAPS): Neonatal-Onset Multisystem Inflammatory Disease (NOMID):

1. The recipient has a diagnosis of NOMID.

~~2. Approval will not be given for the use of more than one biologic at a time (combination therapy).~~

3. Prior Authorization Guidelines

~~Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx~~

Prior authorization approval will be for one year.

Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

N. Psychotropic Medications for Children and Adolescents

Therapeutic Class: Psychotropic Agents
Last Reviewed by the DUR Board: ~~July 26, 2012~~September 3, 2015

Psychotropic medications for children and adolescents are subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer~~e~~ to the Nevada Medicaid and Check Up Pharmacy Manual for billing information.

Authorization will be given if the following criteria are met and documented.

1. Coverage and Limitations

~~Nevada Medicaid has adopted the following practice standards to strengthen treatment outcomes for our children and adolescents.~~The Division of Health Care Financing and Policy (DHCFP) requires prior authorization approval for children and adolescents for the psychotropic therapeutic classes below and medication combinations considered to be poly-pharmacy. The DHCFP has adopted the following practice standards to strengthen treatment outcomes for our children and adolescents.

a. The psychotropic therapeutic classes subject to this policy are:

1. Antipsychotics

2. Antidepressants

3. Mood Stabilizers (including lithium and anticonvulsants used for behavioral health indications.)

4. Sedative hypnotics

5. Antianxiety agents

b. For all children under 18 years of age, the following must be documented in the medical record for authorization.

~~These practices include:~~

~~D.~~1. For psychotropic medications in this age group, when possible, be prescribed by or in consultation with a child psychiatrist.

~~E.~~2. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy.

~~F.~~3. Physician and/or prescriber monitoring is required while the recipient is utilizing ~~the~~any psychotropic medication.

~~G.~~a. For recipients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable ~~on the medication therapy~~(has had a dose change in the last three months), medical documentation must support a monthly or more frequent visit with the~~ prescribing practitioner~~ physician and/or prescriber. If the recipient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber.

~~H.~~b. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.

c. ~~Prescribing more than one medication from the same class or prescribing three or more psychotropic medications from different drug classes is to be avoided.~~ Each ~~pharmaceutical prescribed~~ psychotropic medication prescribed must be independently treating a specific ~~condition~~ symptom and/or ~~(~~diagnosis~~)~~. ~~To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatments of medication side effects must be documented. Recipients must fail a trial of a single medication within the same class before treatment with multiple agents in the same class will be considered. This will be demonstrated by medical attestation by the treating physician.~~

1. Poly-pharmacy (intra-class) is defined as more than one drug within the same therapeutic class within a 60 day time period.

   a. Prior authorization approval is required for two or more drugs in the same therapeutic class within a 60 day period.

2. Poly-pharmacy (inter-class) is defined as more than one drug across different therapeutic classes within a 60 day time period.

   a. Prior authorization approval is required for four or more drugs across all psychotropic therapeutic classes listed in this policy within a 60 day time period.

3. Approval for poly-pharmacy may be given in situations where the requested medication(s) will be used for cross tapering and situations where the recipient will be discontinuing the previously prescribed agent. A 30 day cross-taper will be allowed.

4. Approval for poly-pharmacy may be given for a medication to augment the effect of another psychotropic medication as long as the purpose of the

poly-pharmacy is clearly documented in the recipient's medical record and each agent is supported by individual authorizations.

5. The recipient must have a trial of each individual medication alone. The reasons for an inadequate response must be documented in the medical record

6. For intra-class and inter-class poly-pharmacy, all psychotropic medication must be utilized for a medically accepted indication as established by the Food and Drug Administration (FDA), and/or peer reviewed literature.

d. For children under six years of age, in addition to the Coverage and Limitation requirements, all psychotropic medications require a prior authorization approval and must be utilized for a medically accepted indication as established by the FDA and/or peer-reviewed literature.

e. Continuity of Care. In an effort to improve recipient safety and quality of care:

1. For recipients under 18 years of age, who have been discharged from an institutional facility, they will be allowed to remain on their discharge medication regimen for up to six months to allow the recipient time to establish outpatient mental health services. The initial prior authorization after discharge must document the name of the discharge institution and the date of discharge.

2. For all other recipients under the age of 18, a six month prior authorization will be granted to cover current medication(s) when it is documented that the recipient has been started and stabilized. This will allow the recipient time to establish services if necessary and to transition to medication(s) per Nevada Medicaid policy.

~~1. Nevada Medicaid requires prior authorization for all psychotropic medications for recipients less than 18 years of age. Therapeutic classes subject to prior authorization for this age group include:~~

~~a. Antianxiety Agents;~~

~~b. Anticonvulsants;~~

~~c. Antidepressants;~~

~~d. Lithium Preparations;~~

~~e. Sedatives; and~~

~~b. Antipsychotics.~~

2. Exceptions to this ~~policy are~~criteria for Anticonvulsants, ADD/ADHD medications, and Abilify:

   a. ~~g.~~ Treatment for seizure disorders with anticonvulsants are not subject to this policy. The ICD Codes for Epilepsy~~,~~ and/or Convulsions~~ and Convulsions in Newborn will be approved. These ICD codes written on the prescription and on the claim will bypass the prior authorization requirement in the pharmacy POS or~~ will bypass the prior authorization requirement at the pharmacy POS if the correct ICD Code is written on the prescription and transmitted on the claim. Or the prior authorization requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system.

   b. ~~h.~~ The current policy for treatment of ADD/ADHD is to be followed. Refer to this Chapter's Appendix A.

   c. ~~i. For treatment with Abilify, if an ICD code for autistic disorder is written on the prescription and transmitted on the claim it will bypass the prior authorization requirement in the pharmacy POS system.~~

~~3. Prior Authorization Criteria~~

   ~~a. Each medication prescribed must be independently treating a specific condition (diagnosis).~~

   ~~b. To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatment of side effects must be documented.~~

   ~~c. Recipients must fail a trial of a single medication within the same class before treatment with multiple agents in the same class will be considered.~~

   ~~d. Physician monitoring is required while the recipient is utilizing the medication(s).~~

      ~~1. For recipients who are in initial treatment or are unstable on the medication therapy, medical documentation must support a monthly or more frequent visit with the prescribing practitioner. If the recipient was discharged from an institution on the medication, the follow up visit(s) can be with their treating physician.~~

      ~~2. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.~~

   ~~1. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy~~.

3. Prior Authorization Guidelines

Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

V. Anti-Insomnia Agents (Sedative Hypnotics)

Therapeutic Class: Anxiolytics, Sedatives and Hypnotics
Last Reviewed by the DUR Board: September 3, 2015

See Section N of this Appendix for criteria for Sedatives and Hypnotics when prescribed for a psychotropic indication.

Sedatives Hypnotics are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented.

a. A food and Drug Administration (FDA) approved diagnosis:

1. Hetlioz® (tasimelteon):

2. A diagnosis of non-24-hour sleep-wake disorder, or

b. All other agents:

1. A diagnosis of insomnia.

2. Prior Authorization Guidelines

a. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms/aspx

LL. Kalydeco® (ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent
Last Reviewed by the DUR Board: ~~July 2, 2014~~September 3, 2015

Kalydeco® (ivacaftor) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. The recipient is ~~six~~two years of age or older; and

   b. The recipient has a diagnosis of cystic fibrosis; and

   c. There is documentation that the recipient has had an FDA-approved cystic fibrosis mutation test confirming the presence of one of the following gene mutations: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N or S549R~~ gene mutationys~~.

2. Prior Authorization Guidelines

   a. Prior authorization approval will be for one year.

   b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

DDD. Corlanor® (ivabradine)

Therapeutic Class: Cardiovascular Agent
Last Reviewed by the DUR Board: September 3, 2015

Corlanor® (ivabradine) are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations:

   Approval will be given if the following criteria are met and documented:

   a. A diagnosis of chronic heart failure, and

   b. A left ventricular ejection fraction (LVEF) ≤ 35%, and

   c. A resting heart rate ≥ 70 bpm, and

   d. The recipient is ≥ 18 years of age, and

   e. The prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted regarding the diagnosis and treatment recommendations, and

   f. The recipient is in a normal sinus rhythm, and

   g. The recipient is on a maximally tolerated dose of a beta-blocker or the recipient has a contraindication to beta-blocker use.

2. Prior Authorization Guidelines:

   a. The extent of prior authorization approvals will be based on the appropriate use for the individual agents.

   b. Prior Authorization form~~as~~ are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

EEE. Praluent® (alirocumab)

Therapeutic Class: Antilepemic Agent, PCSK9 Inhibitor Agent
Last Reviewed by the DUR Board: November 5, 2015

Parulent® (alirocumab) is subject to prior authorization and quantity limitation based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented.

a. Initial Request (the recipient must meet all criteria (1-4))

1. The recipient has a diagnosis of heterozygous familial hypercholesterolemia (HeFH). Or the recipient has clinical atherosclerotic cardiovascular disease and requires additional lowering of LDL-C (defined as acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin);

2. The agent is prescribed by or in consultation with a cardiologist or lipied specialist;

3. The agent will be used as an adjunct to a low-fat diet and exercise; and

4. The recipient must meet the criteria for one of the following responses (a-d):

a. The recipient has had an inadequate response to high intensity statin therapy defined by all of the following:

1. The recipient has received therapy with atorvastatin ≥ 40 mg or rosuvastatin ≥ 20 mg for at least the past three months;

2. The recipient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past three months or the recipient has a contraindication to ezetimibe therapy;

3. The LDL-C after therapy for at least the past three months was ≥ 100mg/dL (HeFH) for ≥ 70 mg/dL (clinical atherosclerotic cardiovascular disease); and

4. The statin therapy will be continued with PCSK-9 therapy.

b. Or, the recipient has had an inadequate response to moderate intensity statin therapy defined as all of the following:

1. The recipient has had an intolerance or contraindication to high intensity statin therapy; and

2. The recipient has received therapy with:

a. atorvastatin 10 to 20 mg,

b. rosuvastatin 5 to 10 mg, or

c. simvastatin > 20 mg, or

d. pravastatin >40 mg, or

e. lovastatin 40 mg, or

f. fluvastatin XL 80 mg, or

g. fluvastatin 40 mg twice daily, or

h. pitavastatin > 2 mg

for at least the past three months; and

3. The recipient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past three months or the recipient has a contraindication to ezetimibe therapy;

4. The LDL-C after therapy for at least the past three months was ≥ 100/mg/dL (HeFH or ≥70 mg /dL (clinical atherosclerotic cardiovascular disease); and

5. Statin therapy will be continued with PCSK-9 therapy.

c. Or, the recipient experienced an adverse reaction to at least two statins, the statins and adverse reactions must be documented in the recipient's medical record.

d. Or the recipient has a labeled contraindication to all statins, the contraindication is documented in the recipient's medical record.

2. Recertification Request (The recipient must meet all criteria (1-4)).

a. The recipient has been adherent with PCSK-9 inhibitor therapy;

b. The recipient has been adherent with statin therapy or the recipient has a labeled contraindication to statin therapy;

c. The recipient is continuing a low-fat diet and exercise regimen; and

d. The recipient has achieved a reduction in LDL-C level.

3. Prior Authorization Guidelines:

a. Prior ~~Authorizaiton~~Authorization approvals will be for:

1. Initial request: six months

2. Recertification request: one year

b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

FFF. Invega Trinza® (paliperidone palmitate)

Therapeutic Class: Second Generation (Atypical) Antipsychotic
Las Reviewed by the DUR Board: November 5, 2015

Invega Trinza® (paliperidone palmitate) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented.

   a. The recipient has a diagnosis of schizophrenia;

   b. The recipient has been stabilized on once-monthly paliperidone palmitrate injection (Invega Sustenna®) for at least four months with the two most recent doses of the once-monthly injection being the same strength;

   c. The recipient is 18 years of age or older; and

   d. The requested dose is one injection every three months.

2. Prior Authorization Guidelines:

   a. Prior Authorization approvals will be for one year.

   b. Prior Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

GGG. Technivie® (ombitasvir/paritaprevir/ritonavir)

Therapeutic Class: Plymerase Inhibitors/Combination Products
Last Reviewed by the DUR Board: November 5, 2015

Tchnivie® (ombitasvir/paritaprevir/ritonavir) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The recipient has a diagnosis of chronic hepatitis C, genotype F4, and

b. The recipient is eight years of age or older, and

c. The recipient does not have cirrhosis (Metavir score F4), and

d. The recipient does not have moderate or severe hepatic impairment (Child-Pugh grad~~e~~e B or C), and

e. The requested do~~es~~se is t~~ow~~wo Technivie® tablets daily, and

f. The total duration of therapy does not exceed 12 weeks, and

g. For treatment –naïve recipients:

1. Technivie® will be used in combination with ri~~a~~bavirin, or

2. Technivie® will be used without ribavirin. There is documentation that the recipient cannot take or cannot tolerate ribavirin.

h. Or for treatment-experienced recipients:

1. Technivie® will be used in combination with ribavirin.

2. Prior Authorization Guidelines:

a. Prior ~~Authorizaton~~Authorization approvals will be for 12 weeks.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

HHH. Orkambi® (lumacaftor/ivacaftor)

Therapeutic Class: Cystic Fibrosis Agent
Last Reviewed by the DUR Board: November 5, 2015

Orkambi® (lumacaftor/ivacaftor) is subject to prior ~~authorizauton~~authorization based on the ~~Apllication~~Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

   Approval will be given if the following criteria are met and documented:

   a. The recipient has a diagnosis of cystic fibrosis, and

   b. The recipient is 12 years of age or older, and

   c. The recipient is homozygous for the F508del mutation in the CFTR gene, and

   d. The requested dose is two tablets every 12 hours, or

   e. The requested dose is one table every 12 hours in the presence of severe hepatic impairment.

2. Prior ~~Authorizaiton~~Authorization Guidelines:

   a. Prior Authorization approvals will be for one year.

   b. Prior ~~Authorizaiton~~Authorization forms are available at: http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

III. Daklinza® (daclatasvir)

Therapeutic Class: Anti-hepatitis Agents
Last Reviewed by the DUR Board: November 5, 2015

Dalinza® (daclatasvir) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented:

a. The recipient has a diagnosis of hepatitis C genotype 3, and

b. The recipient is 18 years of age or older, and

c. The recipient has not had a liver transplant, and

d. The requested agent will be used in combination with Sovaldi, and

e. The recipient is not a strong CYP3A inducer, and

f. The recipient does not have cirrhosis (Metavir score F4), and one of the following:

a. The requested dose of Daklinza® is 60 mg (one tablet) daily, or

b. The requested dose of Daklinza® is 30 mg (one tablet) daily and the recipient is receiving a concomitant strong CYP3A inhibitor; or

c. The requested dose of Daklinza® is 90 mg (one 30 mg tablet and one 60 mg tablet) daily and the recipient is receiving a concomitant moderate CYP3A inducer. Medical necessity of continued use of the moderate CYP3A inducer during Daklinza® therapy must be provided; and

g. Usage is based on current clinical peer-reviewed literature, and

h. The requested length of therapy is 12 weeks.

2. Prior Authorization Guidelines:

a. Prior Authorization approval will be for 12 weeks.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

JJJ. Entresto® (sacubitril/valsartan)

Therapeutic Class: Angiotension II Receptor Blocker
Last Reviewed by the DUR Board: November 5, 2015

Entresto® (sacubitril/valsartan) is subject to prior authorization based on the Application of Standards in Section 1927 of the Social Security Act (SSA) and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented.

a. The recipient has a diagnosis of chronic heart failure NYHA Class II to IV;

b. The recipient has reduced left ventricular ejection fraction (LVEF);

c. The recipient is 18 years of age or older;

d. The prescriber is a cardiologist or there is documentation in the recipient's medical record that a cardiologist has been consulted;

e. The recipient has had a trial of an ACE of an ARB for at least four weeks prior to the initiation of therapy;

f. The recipient will not concurrently receive an ACE inhibitor;

g. The recipient is on an individualized dose of a beta blocker or the recipient has a contraindication to beta blocker use; and

h. Entresto® will be give twice daily with a maximum dose of 97/103 mg.

2. Prior Authorization Guidelines:

a. Prior ~~Authorizaiton~~Authorization approval will be for one year.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

4. BLOOD GLUCOSE TESTING

Nevada Medicaid and NCU participate in a Diabetic Supply Procurement Program. This program allows for the State to receive additional rebates for diabetic monitors and test strips. Effective March 1, 2009, diabetic monitors and test strips are covered for Nevada Medicaid and NCU from preferred manufacturers. Preferred manufacturers are listed in the pharmacy billing manual. This policy does not negatively impact freedom of choice for recipients. The providers billing for the service will continue to be all willing enrolled pharmacies.

Blood glucose monitors and testing supplies for home use are subject to quantity limitations. A ~~written~~ prescription ~~with a diagnosis is required and must be kept on the premise of the provider for 37 months~~is required. A recipient or their caregiver must specifically request refills of glucose supplies before they are dispensed. The provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if a recipient has "authorized" in advance.

For all items in excess of the limitations, a prior authorization must be obtained from the Nevada Medicaid QIO-like vendor.

Blood Glucose monitors with special features (e.g. voice synthesizers) require a prior authorization. For special blood glucose monitors, ~~the recipient must be legally blind. A~~ a diagnosis, and a statement from the physician ~~of visual~~ documenting the impairment, and manufacturers' invoice ~~in~~of cost is required with ~~the~~a prior authorization.

ICD codes for Diabetes Mellitus Diabetes, gestational (in pregnancy) ~~will be covered. No coverage will be provided for any other ICD code~~are only required for newly diagnosed diabetics who are receiving diabetic prescription medication, a glucometer or test strips for the first time, or for recipients who are new to Medicaid or transitioning from an MCO. For recipients with an ongoing diagnosis of diabetes and a history of Nevada Medicaid paid claims for diabetic prescriptions no ICD code is required.

~~Blood glucose monitors and related supplies are billed on the National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) or on-line through the Point of Sale (POS) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is Wholesale Acquisition Cost (WAC) plus 8% and handling and dispensing fee of $1.54 per prescription.~~