

- 6.b. Optometrist services require prior authorization from the Nevada Medicaid Office. Refractions are limited to one in 24 months except for those required as a result of an EPSDT examination.
- 6.c. Chiropractor services are limited to individuals under the age of 21 and referred as a result of a Healthy Kids (EPSDT) screening.
- 6.d. Other practitioner services

Physician Assistants' services are limited to the same extent as are physicians' services.

~~Certified Advanced Practice~~ Registered Nurses' ~~Practitioners'~~ services are limited to the same extent as are physicians' services.

Psychologists' Services must be prior authorized by the Medicaid Office on Form NMO-3 and normally are limited to 24 one-hour individual therapy visits per year. Any limitation of services for children under age 21 will be exceeded based on medical necessity for EPSDT services.

Community Paramedicine services:

1. The Division of Health Care Financing and Policy (DHCFP) provides coverage for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services (Emergency Medical Technician, Advanced Emergency Medical Technician, Paramedic, or Community Paramedic) fill patient care gaps in a local health care system and prevent duplication of services while improving the healthcare experience for the recipient. Prevention of unnecessary ambulance responses, emergency room visits, and hospital admissions and readmissions can result in cost reductions for the DHCFP.
2. Services must be part of the care plan ordered by the recipient's primary care provider. The primary care provider consults with the ambulance service's Medical Director to ensure there is no duplication of services.
 - A) The following services are covered under the supervision of the Medical Director:
 - a. Evaluation/health assessment.
 - b. Chronic disease prevention, monitoring and education.
 - c. Medication compliance.
 - d. Immunizations and vaccinations.
 - e. Laboratory specimen collection and point of care lab tests.
 - f. Hospital discharge follow-up care.
 - g. Minor medical procedures and treatments within their scope of practice as approved by the Community Paramedicine agency's Medical Director.
 - h. A home safety assessment.
 - i. Telehealth originating site.

B) The following are non-covered services:

- a. Travel time.
- b. Mileage.
- c. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital.
- d. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code.
- e. Duplication of services.
- f. Personal care services.

7. Home health care services

Services: As regulated under 42 CFR 484, 42 CFR 440.70 and other applicable state and federal law or regulation.

Home health services are provided to a recipient at his place of residence, certified by a physician and provided under a physician approved Plan of Care. The provider must be enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home. Home health services include the following services and items:

- a. Physical therapy.
(Reference section 11 “a” of Attachment 3.1-A)
- b. Occupational therapy.
(Reference section 11 “b” of Attachment 3.1-A)
- c. Speech therapy.
(Reference section 11 “c” of Attachment 3.1-A)
- d. Family planning education.

Home health agencies employ registered nurses to provide post partum home visiting services to Medicaid eligible women.

Provider Qualifications:

(Reference section 7 “e” of Attachment 3.1-A)

- e. Skilled nursing services (RN/LPN visits)