MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 21, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600, PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600, Physician Services, are being proposed to include coverage for genital reconstruction surgery for Medicaid recipients with diagnosis of gender dysphoria. Services will expand to include genital reconstruction surgical procedures, based on medical necessity.

Renumbering and re-arranging of this section was necessary.

Entities Financially Affected: Provider Type (PT) 20 Physician, MD, Osteopath, PT 24 Advanced Practice Registered Nurse, PT 77 Physicians Assistant.

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective January 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 31444 PHYSICIAN SERVICES	MTL 25/15, 14/16 PHYSICIAN SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.10.F.3.k	Physician Services in Outpatient Setting	Removed language related to transsexual surgery or sex reassignment surgery and all ancillary services including the use of pharmaceuticals, deemed as experimental.
607	Transgender Services	Added new language describing for gender reassignment services.
607.1	Coverage and Limitations	Added new language clarifying coverage including Hormone Therapy, Genital Reconstruction Surgery, and Mental Health Therapy.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
607.1A	Hormone Therapy	Added new language reference to MSM Chapter 1200, Prescription Drugs.
607.1B	Genital Reconstruction Surgery	Added new language describing genital reconstruction surgery coverage for transgender recipients based on medical necessity and gender dysphoria diagnosis.
607.1C	Mental Health Services	Added new language reference to MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services, for services and prior authorization requirements.
607.1D	Non-Covered Services	Added new language describing non-covered services for transgender recipients.
607.1E	Documentation Requirements	Added new language describing recipient requirements and appropriate documentation in the recipient's medical record.

603.9 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and CRNAs are based on the Centers for Medicare and Medicaid Services (CMS) base units.

A. Each service is assigned a base unit which reflects the complexity of the service and includes work provided before and after reportable anesthesia time. The base units also cover usual preoperative and post-operative visits, administering fluids and blood that are part of the anesthesia care, and monitoring procedures.

B. Time for anesthesia procedures begins when the anesthesiologist begins to prepare the recipient for the induction of anesthesia and ends when the anesthesiologist/CRNA is no longer in personal attendance, and the recipient is placed under postoperative supervision.

C. All anesthesia services are reported by use of the anesthesia five-digit procedure codes. Nevada Medicaid does not reimburse separately for physical status modifiers or qualifying circumstances.

D. Using the CPT/ASA codes, providers must indicate on the claim the following:

1. Type of surgery;

2. Length of time;

3. Diagnosis;

4. Report general anesthesia and continuous epidural analgesia for obstetrical deliveries using the appropriate CPT codes; and

5. Unusual forms of monitoring and/or special circumstances rendered by the anesthesiologist/CRNA are billed separately using the appropriate CPT code. Special circumstances include but are not limited to nasotracheal/bronchial catheter aspiration, intra-arterial, central venous and Swan-Ganz lines, transesophageal echocardiography, and ventilation assistance.

603.10 PHYSICIAN SERVICES IN OUTPATIENT SETTING

A. Outpatient hospital based clinic services include non-emergency care provided in the emergency room, outpatient therapy department/burn center, observation area, and any established outpatient clinic sites. Visits should be coded using the appropriate Evaluation/Management (E/M) CPT code (e.g. office visit/observation/etc.) on a CMS-1500 billing form. Do not use emergency visit codes.

Services requiring prior authorization include the following:

1. Hyperbaric Oxygen Therapy for chronic conditions (reference Appendix for Coverage and Criteria);

2. Bariatric surgery for Morbid Obesity;

3. Cochlear implants (See MSM Chapter 2000 – Audiology Services);

4. Diabetes training exceeding 10 hours;

5. Vagus nerve stimulation; and

6. Services requiring authorization per Ambulatory Surgical Center (ASC) list.

B. Emergency Room Policy

The DHCFP uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services are defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the recipient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious function of any bodily organ or part." The threat to life or health of the recipient necessitates the use of the most accessible hospital or facility available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

1. Prior authorization will not be required for admission to a hospital as a result of a direct, same day admission from a physician's office and/or the emergency department. The requirement to meet acute care criteria is dependent upon the QIO-like vendor's determination. The QIO-like vendor will continue to review and perform the retrospective authorization for these admissions based upon approved criteria. Prior authorization is still required for all other inpatient admissions.

2. Direct physical attendance by a physician is required in emergency situations. The visit will not be considered an emergency unless the physician's entries into the record include his or her signature, the diagnosis, and documentation that he or she examined the recipient. Attendance of a physician's assistant does not substitute for the attendance of a physician in an emergency situation.

3. Physician's telephone or standing orders, or both, without direct physical attendance does not support emergency treatment.

4. Reimbursement for physician directed emergency care and/or advanced life support rendered by a physician located in a hospital emergency or critical care department, engaged in two-way voice communication with the ambulance or rescue personnel outside the hospital is not covered by Medicaid.

5. Services deemed non-emergency and not reimbursable at the emergency room level of payment are:

   a. Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition;

   b. Refusal to comply with currently ordered procedures or treatments;

   c. The recipient had previously been treated for the same condition without worsening signs or symptoms of the condition;

   d. Scheduled visit to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion;

   e. Visits made to receive a "tetanus" injection in the absence of other emergency conditions;

   f. The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition;

   g. Medical clearance/screenings for psychological or temporary detention ordered admissions; and

   h. Diagnostic x-ray, diagnostic laboratory, and other diagnostic tests provided as a hospital outpatient service are limited to physician ordered tests considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body member. For coverage and limitations, reference MSM Chapter 300 for Radiology and Diagnostic Services and MSM Chapter 800 for Laboratory Services.

C. Therapy Services (OT, PT, RT, ST)

Occupational, Physical, Respiratory and Speech Therapy services provided in the hospital outpatient setting are subject to the same prior authorization and therapy limitations found in the MSM, Chapter 1700 – Therapy.

D. Observation Services Provided by The Physician

1. Observation services are provided by the hospital and supervising physician to recipients held but not admitted into an acute hospital bed for observation. Consistent with federal Medicare regulations, the DHCFP reimburses hospital "observation status" for a period up to, but no more than 48 hours.

2. Observation services are conducted by the hospital to evaluate a recipient's condition or to assess the need for inpatient admission. It is not necessary that the recipient be located in a designated observation area such as a separate unit in the
3. hospital, or in the emergency room in order for the physician to bill using the observation care CPT codes, but the recipient's observation status must be clear.

4. If observation status reaches 48 hours, the physician must make a decision to:

   a. Send the recipient home;

   b. Obtain authorization from the QIO-like vendor to admit into the acute hospital; or

   c. Keep the recipient on observation status with the understanding neither the physician nor the hospital will be reimbursed for any services beyond the 48 hours.

5. The physician must write an order for observation status, and/or an observation stay that will rollover to an inpatient admission status.

   See MSM Chapter 200 for policy specific to the facility's responsibility for a recipient in "observation status."

E. End Stage Renal Disease (ESRD) Outpatient Hospital/Free-Standing Facilities. The term "end-stage renal disease" means the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

1. Treatment of ESRD in a physician-based (i.e. hospital outpatient) or independently operated ESRD facility certified by Medicare is a Medicaid covered benefit. Medicaid is secondary coverage to Medicare for ESRD treatment except in rare

cases when the recipient is not eligible for Medicare benefits. In those cases, private insurance and/or Medicaid is the primary coverage

2. ESRD Services, including hemodialysis, peritoneal dialysis, and other miscellaneous dialysis procedures are Medicaid covered benefits without prior authorization.

3. If an established recipient in Nevada needs to travel out of state, the physician or the facility must initiate contact and make financial arrangements with the out of state facility before submitting a prior authorization request to the QIO-like vendor. The request must include dates of service and the negotiated rate. (This rate cannot exceed Medicare's reimbursement for that facility).

4. Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are covered services for hemodialysis and Continuous Ambulatory Peritoneal Dialysis (CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.

5. Reference Attachment A, Policy #6-09 for ESRD Coverage.

F. Ambulatory Centers (ASC) Facility and Non-Facility Based

Surgical procedures provided in an ambulatory surgical facility refers to freestanding or hospital-based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients who do not generally require extended lengths of stay or extensive recovery or convalescent time.

Outpatient surgical procedures designated as acceptable to be performed in a physician's office/outpatient clinic, ambulatory surgery center or outpatient hospital facility are listed on the QIO-like vendor's website. For questions regarding authorization, the physician should contact the QIO-like vendor.

1. Prior authorization is not required when:

   a. Procedures listed are to be done in the suggested setting or a setting which is a lower level than suggested;

   b. Procedures are part of the emergency/clinic visit; and

c. If the recipient is a QMB the procedure is covered first by Medicare, and Medicaid reimburses the co-insurance and deductible, up to the Medicaid allowable.

2. Prior authorization is required from the QIO-like vendor when:

a. Procedures are performed in a higher level facility than it is listed in the ASC surgical list (e.g., done in an ASC but listed for the office);

b. Procedures on the list are designated for prior authorization;

c. Designated podiatry procedures; and

d. The service is an out-of-state service, and requires a prior authorization if that same service was performed in-state.

3. Surgical procedures deemed experimental, not well established or not approved by Medicare or Medicaid are not covered and will not be reimbursed for payment. Below is a list of definitive non-covered services.

a. Cosmetic Surgery: The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the recipient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or the improvement of a malformed body member, to restore or improve function, which coincidentally services some cosmetic purpose. Examples of procedures which do not meet the exception to the exclusion are facelift/wrinkle removal (rhytidectomy), nose hump correction, moon-face, routine circumcision, etc.;

b. Fabric wrapping of abdominal aneurysm;

c. Intestinal bypass surgery for treatment of obesity;

d. Transvenous (catheter) pulmonary embolectomy;

e. Extracranial-Intracranial (EC-IC) Arterial bypass when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries;

f. Breast reconstruction for cosmetic reasons, however breast reconstruction following removal of a breast for any medical reason may be covered;

g. Stereotactic cingulotomy as a means of psychosurgery to modify or alter disturbances of behavior, thought content, or mood that are not responsive to other conventional modes of therapy, or for which no organic pathological cause can be demonstrated by established methods;

h. Radial keratotomy and keratoplasty to treat refractive defects. Keratoplasty that treats specific lesions of the cornea is not considered cosmetic and may be covered;

i. Implants not approved by the FDA; Partial ventriculectomy, also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery;

j. Gastric balloon for the treatment of obesity;

~~k. Transsexual surgery, also known as sex reassignment surgery or intersex surgery and all ancillary services including the use of pharmaceuticals;~~

~~l.~~k. Cochleostomy with neurovascular transplant for Meniere's Disease;

~~m.~~l. Surgical procedures to control obesity other than bariatric for morbid obesity with significant comorbidities. See Appendix A for policy limitations; and

~~n.~~m. Organ transplantation and associated fees are a limited benefit for Nevada Medicaid recipients.

4. The following organ transplants, when deemed the principal form of treatment are covered:

a. Bone Marrow/Stem Cell – allogeneic and autologous;

b. Noncovered conditions for bone marrow/stem cell:

1. Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma;

2. Autologous stem cell transplantation is not covered as treatment for acute leukemia not in remission, chronic granulocytic leukemia, solid tumors (other than neuroblastoma) and tandem transplantation for recipients with multiple myeloma;

c. Corneal – allograft/homograft;

607 GENDER REASSIGNMENT SERVICES

Transgender Services include treatment for gender dysphoria (GD), formerly known as gender identity disorder (GID). Treatment of GD is a DHCFP covered benefit, including both hormonal and surgical modalities, and psychotherapy, based on medical necessity. Genital reconstruction surgery (GRS) describes a number of surgical procedure options for the treatment of GD.

According to the World Professional Association for Transgender Health (WPATH), the organization that promotes the standards of health care for transsexual, transgender, and gender nonconforming individuals, through the articulation of Standards of Care (SOC), gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).

607.1 COVERAGE AND LIMITATIONS

A. Hormone Therapy

1. Hormone therapy is covered for treatment of GD based on medical necessity; refer to MSM Chapter 1200, Prescribed Drugs, for services and prior authorization requirements.

B. Genital Reconstruction Surgery

1. Genital reconstruction surgery is covered for recipients that are sufficiently physically fit and meet eligibility criteria under Nevada and federal laws.

2. Prior authorization is required for all genital reconstruction surgery procedures.

3. To qualify for surgery, the recipient must be 18 years of age or older.

4. Male-to-Female (MTF) recipient, surgical procedures may include:

   a. breast/chest surgery; mammoplasty

   b. genital surgery; orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy

5. Female-to-Male (FTM) recipient, surgical procedures may include:

   a. breast/chest surgery; mastectomy

   b. genital surgery; hysterectomy/salpingo-oophorectomy, phalloplasty,

vaginectomy, vulvectomy, scrotoplasty

6. Augmentation mammoplasty for MTF recipients is a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy.

7. All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization. Refer to MSM Chapter 600, Section 603.4B for information regarding sterilization services.

8. Refer to the Documentation Requirements section below for additional criteria.

C. Mental Health Services

1. Mental health services are covered for treatment of GD based on medical necessity; refer to MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services for services and prior authorization requirements.

D. Non-Covered Services

1. Payment will not be made for the following services and procedures:

a. cryopreservation, storage, and thawing of reproductive tissue, and all related services and costs;

b. reversal of genital and/or breast surgery;

c. reversal of surgery to revise secondary sex characteristics;

d. reversal of any procedure resulting in sterilization;

e. cosmetic surgery and procedures including:

i. neck tightening or removal of redundant skin;

ii. breast, brow, face or forehead lifts;

iii. chondrolaryngoplasty (commonly known as tracheal shave);

iv. electrolysis;

v. facial bone reconstruction, reduction or sculpturing, including jaw shortening and rhinoplasty;

vi. calf, cheek, chin, nose or pectoral implants;

vii. collagen injections;

viii. drugs to promote hair growth or loss;

ix. hair transplantation;

x. lip reduction or enhancement;

xi. liposuction;

xii. thyroid chondroplasty; and

xiii. voice therapy, voice lessons or voice modification surgery.

E. Documentation Requirements

1. The recipient must have:

a. persistent and well-documented case of GD;

b. capacity to make a fully informed decision and give consent for treatment. According to the American Medical Association (AMA) Journal of Ethics, in health care, informed consent refers to the process whereby the patient and the health care practitioner engage in a dialogue about a proposed medical treatment's nature, consequences, harms, benefits, risks and alternatives. Informed consent is a fundamental principle of health care.

c. comprehensive mental health evaluation provided in accordance with Version 7 of the WPATH SOC; and

d. prior to beginning stages of surgery, obtained authentic letters from two qualified licensed health care professionals who have independently assessed the recipient and are referring the recipient for surgery. The two letters must be authenticated and signed by:

i. a licensed psychiatrist or psychologist that the recipient has an established and ongoing relationship; and

ii. a licensed psychiatrist, psychologist or physician, working within the scope of their license that has only had an evaluation role with the recipient.

iii. Together, the letters must establish the recipient have:

a. a persistent and well-documented case of GD;

b. received hormone therapy appropriate to the recipient's gender goals, which shall be for a minimum of 12 months in the case of a recipient seeking genital reconstruction surgery, unless such therapy is medically contraindicated or the recipient is otherwise unable to take hormones;

c. lived for 12 months in a gender role congruent with the recipient's gender identity without reversion to the original gender, and has received mental health counseling, as deemed medically necessary during that time; and

d. significant medical or mental health concerns reasonably well-controlled; and capacity to make a fully informed decision and consent to the treatment.

iv. When a recipient has previously had one or more initial surgical procedures outlined in this chapter, the recipient is not required to provide referral letters to continue additional surgical procedures, at discretion of the surgeon. The surgeon must ensure this is clearly documented in the recipient's medical record.

2. Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization (PA) is required.

~~607~~609 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM) - 3100 for hearings procedures.