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

   a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at ~~95~~99.75% of the Medicare facility rate.

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

   b. Radiology Codes 70000 – 79999 will be reimbursed at 10~~05~~% of the Medicare facility rate. Effective ~~February 15, 2012~~January 1, 2024, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 10.25%.

   c. Medicine Codes 90000 – 99199 will be reimbursed at 8~~5~~9.25% of the Medicare non-facility rate.

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

      ~~6. When Community Health Worker (CHW) services are provided under the supervision of a Physician, the following applies:~~
      ~~Effective for dates of service on or after February 1, 2022, payment for services will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor or the first year the applicable code appears on the Medicare fee schedule, whichever is later. Payment will be the lower of billed charges, or the amounts specified below:~~
      ~~a. Medicine Codes 90000 – 99199 will be reimbursed at 60% of the Medicare non-facility rate.~~

   d. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 99.75~~04.50~~% of the Medicare non-facility rate ~~effective July 1, 2015 through June 30, 2016. Effective July 1, 2016 Evaluation and Management Codes 99201 – 99499 will be reimbursed at 95% of the Medicare non-facility rate~~.

   e. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 9~~5~~9.75% of the Medicare non-facility rate.

   f. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by ~~the CMS 2013~~ an anesthesia conversion factor of $2~~23.57~~70. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.

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

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's physician fee schedule rates were set as of January 1, 2024, ~~October 1, 2017 and CHW rates were set as of February 1, 2022~~ and are effective for services provided on or after those dates. All rates are published on our website:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/