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- 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.
- A. 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.

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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;

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- 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

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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.

3. 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.
4. 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).

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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

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- 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;

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- 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;
  - d. Kidney – allotransplantation/autotransplantation; and
  - e. Liver – transplantation for children (under age 21) with extrahepatic biliary atresia or for children or adults with any other form of end-stage liver disease. Coverage is not provided with a malignancy extending beyond the margins of the liver or those with persistent viremia.
5. Prior authorization is required for bone marrow, kidney, and liver transplants from Medicaid’s contracted QIO-like vendor.
6. A transplant procedure shall only be approved upon a determination that it is a

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medically necessary treatment by showing that:

- a. The procedure is not experimental and/or investigational based on Title 42, Code of Federal Regulations (CFR), Chapter IV (Health Care Financing Administration) and Title 21, CFR, Chapter I FDA;
- b. The procedure meets appropriate Medicare criteria;
- c. The procedure is generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is proposed, or there is authoritative evidence that attests to the proposed procedures safety and effectiveness; and
- d. If the authorization request is for chemotherapy to be used as a preparatory therapy for transplants, an approval does not guarantee authorization for any harvesting or transplant that may be part of the treatment regimen. A separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out of state.

603.11 SERVICES IN THE ACUTE HOSPITAL SETTING

- A. Admissions to acute care hospitals both in and out of state are limited to those authorized by Medicaid's QIO-like vendor as medically necessary and meeting Medicaid benefit criteria.
- B. Physicians may admit without prior approval only in the following situations:
  1. An emergency (defined in MSM Chapter 100);
  2. Obstetrical labor and delivery; or
  3. Direct Admission from doctor's office.
- C. All other hospital admissions both in-state and out-of-state must be prior authorized by the QIO-like vendor. Payment will not be made to the facility or to the admitting physician, attending physician, consulting physician, anesthesiologist, or assisting surgeons denied by the QIO-like vendor admissions.
- D. Attending physicians are responsible for ordering and obtaining prior authorization for all transfers from the acute hospital to all other facilities.