a. When medical care is unavailable for Nevada recipients residing near state borders (catchments areas) the contiguous out-of-state physician/clinic is considered the Primary Care Physician (PCP). All in-state benefits and/or limitations apply.

b. All service physicians must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. (See MSM Chapter 100.)

5. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The EPSDT program provides preventative health care to recipients (from birth through age 20 years) eligible for medical assistance. The purpose of the EPSDT program is the prevention of health problems through early detection, diagnosis, and treatment. The required screening components for an EPSDT examination are to be completed according to the time frames on a periodicity schedule that was adopted by the American Academy of Pediatrics and the DHCFP. See MSM Chapter 1500, Healthy Kids.

603.2 PHYSICIAN OFFICE SERVICES

Covered services are those medically necessary services when the physician either examines the patient in person or is able to visualize some aspect of the recipient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of X-rays, electrocardiogram (ECG) and electroencephalogram (EEG) tapes, tissue samples, etc.

Telehealth services are also covered services under the DHCFP. See MSM Chapter 3400 for the complete coverage and limitations for Telehealth.

A. Consultation Services

A consultation is a type of evaluation and management service provided by a physician and requested by another physician or appropriate source, to either recommend care for a specific condition or problem or determine whether to accept responsibility for ongoing management of the patient's entire care. A consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that are ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or appropriate source. When a consultant follows up on a patient on a regular basis, or assumes an aspect of care on an ongoing basis, the consultant becomes a manager or co-manager of care and submits claims using the appropriate hospital or office codes.

1. When the same consultant sees the same patient during subsequent admissions, the physician is expected to bill the lower level codes based on the medical records.

2. A confirmatory consultation initiated by a patient and/or their family without a physician request is a covered benefit. Usually, requested second opinions concerning the need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) third opinion will be covered if the first two opinions disagree.

B. New and Established Patients

1. The following visits are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility:

   a. Minimal to low level visits - Most patients should not require more than nine office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a three-month period. No prior authorization is required.

   b. Moderate visits - Generally, most patients should not require more than 12 office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a 12-month calendar year. No prior authorization is required.

   c. High severity visits - Generally, most patients should not require more than two office or other outpatient visits at this level by the same physician or by physicians of the same or similar specialties in a 12-month period. Any exception to the limit requires prior authorization.

2. Documentation in the patient's medical record must support the level of service and/or the medical acuity which requires more frequent visits and the resultant coding. Documentation must be submitted to Medicaid upon request. A review of requested reports may result in payment denial and a further review by Medicaid's Surveillance and Utilization Review (SUR) subsystem.

3. Medicaid does not reimburse physicians for telephone calls between physicians and patients (including those in which the physician gives advice or instructions to or on behalf of a patient) except documented psychiatric treatment in crisis intervention (e.g. threatened suicide).

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4. New patient procedure codes are not payable for services previously provided by the same physician or another physician of the same group practice, within the past three years.

5. Some of the procedures or services listed in the Current Procedural Terminology (CPT) code book are commonly carried out as an integral component of a total service or procedure and have been identified by the inclusion of the term "separate procedure". Do not report a designated "separate procedure" in addition to the code for the total procedure or service of which it is considered an integral component. A designated "separate procedure" can be reported if it is carried out independently or is considered to be unrelated or distinct from other procedures/services provided at the same time.

6. Physical therapy administered by a Physical Therapist (PT) on staff or under contract in the physician's office requires a prior authorization before rendering service.

   If the physician bills for physical therapy, the physician, not the PT, must have provided the service.

   A physician may bill an office visit in addition to physical therapy, on the same day in the following circumstances:

   a. A new patient examination which results in physical therapy on the same day;

   b. An established patient with a new problem or diagnosis; and/or

   c. An established patient with an unrelated problem or diagnosis.

   Reference MSM Chapter 1700 for physical therapy coverage and limitations.

7. Physician administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200 for coverage and limitations.

8. Non-Covered Physician services

   a. Investigational or experimental procedures not approved by the Food and Drug Administration (FDA).

   b. Reimbursement for clinical trials and investigational studies.

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c. Temporomandibular Joint (TMJ) related services (see MSM Chapter 1000 - Dental).

A. Referrals

When a prior authorization is required for either in-state or out-of-state services, the referring physicians are responsible for obtaining a prior authorization from the QIO-like vendor. If out-of-state services are medically necessary, the recipient must go to the nearest out-of-state provider for services not provided in-state. It is also the responsibility of the referring physician to obtain the authorization for a recipient to be transferred from one facility to another, either in-state or out-of-state.

B. Hospice

Physicians are responsible for obtaining prior authorization for all services not related to the morbidity that qualifies the recipient for Hospice. Physicians should contact Hospice to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200 for coverage and limitations.

C. Home Health Agency (HHA)

HHA services provide periodic nursing care along with skilled and non-skilled services under the direction of a qualified physician. The physician is responsible for writing the orders and participating in the development of the plan of care. Reference MSM Chapter 1400 for coverage and limitations.

D. Laboratory

Reference MSM Chapter 800 for coverage and limitations for laboratory services.

E. Diagnostic Testing

Reference MSM Chapter 300 for coverage and limitations for diagnostic services.

F. Vaccinations

Vaccinations are a covered benefit for Nevada Medicaid recipients.

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

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2. Adult vaccinations: Adult vaccinations such as tetanus, flu vaccine and pneumococcal vaccine are covered without prior authorization. Refer to MSM Chapter 1200, Prescribed Drugs, for more information on adult vaccinations.

603.2A AUTHORIZATION PROCESS

Certain physician services require prior authorization. There is no prior authorization requirement for allergy testing, allergy injections or for medically necessary minor office procedures unless specifically noted in this chapter. Contact the QIO-like vendor for prior authorization information.

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603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, delivery, and postpartum care provided by a physician and/or a nurse midwife. For women who are eligible for pregnancy-related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the month in which the 60th day falls. She is eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21, and eligible for pregnancy only, are not entitled to EPSDT services.

It is the responsibility of the treating physician to employ a care coordination mechanism to facilitate the identification and treatment of high risk pregnancies. "High Risk" is defined as a probability of an adverse outcome to the woman and/or her baby greater than the average occurrence in the general population.

For those females enrolled in a managed care program, the Managed Care Organization (MCO) physicians are responsible for making referrals for early intervention and case management activities on behalf of those women. Communication and coordination between the physicians, service physicians, and MCO staff is critical to promoting optimal birth outcomes.

A. Stages of Maternity Care

1. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery totaling approximately 13 routine visits. Any other visits or services within this time period for non-routine maternity care should be coded separately. Antepartum care is not a covered benefit for illegal non-U.S. citizens.

2. Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without an episiotomy/forceps), or cesarean delivery. Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the CPT Medicine and Evaluation and Management Services section in addition to codes for maternity care.

   a. In accordance with standard regulations, vaginal deliveries with a hospital stay of three days or less and cesarean-section deliveries with a hospital stay of four days or less do not require prior authorization. Reference MSM Chapter 200 for inpatient coverage and limitations.

   b. Non-Medically Elective Deliveries

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1. Reimbursement for Avoidable Cesarean Section

To make certain that cesarean sections are being performed only in cases of medical necessity, the DHCFP will reimburse physicians for performing cesarean sections only in instances that are medically necessary and not for the convenience of the provider or patient. Elective cesarean sections must be prior authorized and will be reimbursed at the vaginal delivery rate.

2. Early Induction of Labor (EIOL)

The American Congress of Obstetricians and Gynecologists (ACOG) issued a Revision of Labor Induction Guidelines in July 2009, citing, "The rate of labor induction in the US has more than doubled since 1990. In 2006, more than 22% (roughly one out of every five) of all pregnant women had their labor induced." The revision further states, "… the ACOG recommendations say the gestational age of the fetus should be determined to be at least 39 weeks or that fetal lung maturity must be established before induction."

Research shows that early elective induction (<39 weeks gestation) has no medical benefit and may be associated with risks to both the mother and infant. Based upon these recommendations, the DHCFP will require prior authorization for hospital admissions for EIOL prior to 39 weeks to determine medical necessity.

The DHCFP encourages providers to review the toolkit compiled by The March of Dimes, The California Maternity Quality Care Collaborative, and The California Department of Public Health, Maternal, Child and Adolescent Health Division. The aim of the toolkit is to offer guidance and support to Obstetrician/Gynecologist (OB/GYN) providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

3. Progesterone therapy to prevent preterm birth

Preterm birth is determined when a baby is born prior to 37 weeks of pregnancy. Women who have a history of preterm birth are at greater risk of future preterm births. Progesterone therapy is a hormone therapy designed to prevent the onset of preterm birth.

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Nevada Medicaid covers services related to the prevention of preterm birth. Progesterone therapies are initiated between 16 and 20 weeks of pregnancy, with weekly injections until 37 weeks.

Please see billing guide for specific coverage and limitations.

c. Physician responsibilities for the initial newborn examination and subsequent care until discharge includes the following:

1. The initial physical examination done in the delivery room is a rapid screening for life threatening anomalies that may require immediate billable attention.

2. Complete physical examination is done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized. This examination is billable.

3. Brief examinations should be performed daily until discharge. On day of discharge, physician may bill either the brief examination or discharge day code, not both.

4. Routine circumcision of a newborn male is a Medicaid benefit for males up to one year of age. For males older than one year of age, a prior authorization is required to support medical necessity.

5. If a newborn is discharged less than 24 hours after delivery, Medicaid will reimburse newborn follow-up visits in the physician's office up to four days post delivery.

6. In accordance with Nevada Revised Statute (NRS) 442.540, all newborns must receive hearing screenings. This testing and interpretation is included in the facilities per diem rate.

3. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery. Women, who are eligible for Medicaid on the last day of their pregnancy, remain eligible for all pregnancy related and postpartum medical assistance including family planning education and services for 60 days immediately following the last day of pregnancy. Pregnancy related only eligible women are not covered for any Medicaid benefits not directly related to their pregnancy.

4. Reimbursement: If a physician provides all or part of the antepartum and/or postpartum care, but does not perform delivery due to termination of the pregnancy or referral to another physician, reimbursement is based upon the antepartum and postpartum care CPT codes. A global payment will be paid to the delivering obstetrician, when the pregnant woman has been seen seven or more times by the delivering obstetrician. If the obstetrician has seen the pregnant woman less than seven times with or without delivery, the obstetrician will be paid according to the Fee-for-Service (FFS) visit schedule using the appropriate CPT codes. For MCO exceptions to the global payment please refer to MSM Chapter 3600. Please refer to MSM Chapter 700 – Rates and Cost Containment for more information.

B. Maternal Diagnostic Testing

1. Fetal Non-Stress testing (NST) is the primary means of fetal surveillance for most conditions that place the fetus at high risk for placental insufficiency. The test is classified as reactive if, during a 20- minute period, at least two accelerations of the fetal heart rate are present, each at least 15 beats above the baseline rate and lasting at least 15 seconds. The test is non-reactive if fewer than two such accelerations are present in a 45-minute period.

2. There is a difference in placing a patient on a monitor to see if she is contracting, versus performing a complete NST. Therefore, when billing for an NST, the following must be included in the final interpretation:

   a. patient name;

   b. date of service;

   c. gestational age;

   d. diagnosis;

   e. indication for test;

   f. interpretation;

   g. fetal heart rate baseline;

   h. periodic changes;

   i. recommended follow up; and

   j. provider signature

3. Medicaid recognizes the following NST schedule (presuming fetal viability has been reached):

Diagnosis	Testing interval
Prior stillbirth	Weekly (starting at 32-35 weeks)
Maternal medical conditions:	Weekly at 32-35 weeks (earlier if indicated), then twice weekly
Insulin-dependent diabetes	Weekly (starting at 32-35 weeks or when indicated)
Hypertension	Weekly (starting at 32-35 weeks or when indicated)
Renal disease	Weekly (starting at 32-35 weeks or when indicated)
Collagen vascular disease	
Obstetric complications:	
Premature rupture of membranes	At admission to hospital
Preeclampsia	Twice weekly if stable
Discordant twins	Twice weekly
Intrauterine growth retardation	Twice weekly
Postdates pregnancy	Twice weekly from 41.5 weeks
Fetal abnormalities:	
Diminished movement	As needed
Decreased amniotic fluid volume	Twice weekly
Labor	As needed

4. Home uterine activity monitoring service may be ordered for a recipient who has a current diagnosis of pre-term labor and a history of pre-term labor/delivery with previous pregnancies. Reference Nevada Medicaid's Durable Medical Equipment (DME) Coverage and Limitation Guidelines (MSM Chapter 1300).

C. Maternal/Fetal Diagnostic Studies

Obstetrical ultrasound of a pregnant uterus is a covered benefit of Nevada Medicaid when it is determined to be medically necessary. Ultrasound for the purpose of sex determination is not a covered benefit. Per CPT guidelines, an obstetrical ultrasound includes determination of the number of gestational sacs and fetuses, gestational sac/fetal structure, qualitative assessment of amniotic fluid volume/gestational sac shape, and examination of the maternal uterus and adnexa. The patient's record must clearly identify all high risk factors and ultrasound findings.

A first trimester ultrasound may be covered to confirm viability of the pregnancy, to rule out multiple births and better define the Estimated Date of Confinement (EDC).

One second trimester ultrasound with detailed anatomic examination is considered medically necessary per pregnancy to evaluate the fetus for known or suspected fetal anatomic abnormalities.

It is policy to perform ultrasound with detailed fetal anatomic study only on those pregnancies identified as being at risk for structural defects (e.g. advanced maternal age, prior anomalous fetus, medication exposure, diabetes, etc.).

The use of a second ultrasound in the third trimester for screening purposes is not covered. Subsequent ultrasounds, including biophysical profiles should clearly identify the findings from the previous abnormal scan and explain the high-risk situation which makes repeated scans medically necessary. The patient's record must clearly identify all high risk factors and ultrasound findings.

For a list of maternal/fetal diagnostic codes, please refer to the billing manual.

NOTE: The use of the diagnosis of "Supervision of High Risk Pregnancy" or "Unspecified Complications of Pregnancy" without identifying the specific high risk or complication will result in non-payment.

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.

B. 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.

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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

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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. Cochleostomy with neurovascular transplant for Meniere's Disease;

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

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

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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

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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 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

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604 COMMUNITY PARAMEDICINE SERVICES

The Division of Health Care Financing and Policy (DHCFP) reimburses for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services 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.

604.1 COMMUNITY PARAMEDICINE PROVIDER QUALIFICATIONS

A. The following Nevada-licensed providers may provide community paramedicine services for Nevada Medicaid recipients:

1. Emergency Medical Technician (EMT);

2. Advanced Emergency Technician (AEMT);

3. Paramedic~~; or~~

~~4. Community Paramedic.~~

B. Required endorsement:

1. Community paramedicine endorsement from the Nevada Division of Public and Behavioral Health, Office of Emergency Medical Services; or

2. Community paramedicine endorsement from the Southern Nevada Health District's Board of Health.

C. Must be enrolled as a Nevada Medicaid provider and employed by a permitted Emergency Medical System (EMS) agency.

D. Must possess a scope of service agreement, based upon the provider's skills, with the Medical Director of the EMS agency under which they are employed.

1. The Medical Director of the EMS agency providing community paramedicine services must be enrolled as a Nevada Medicaid Provider.

604.2 COVERAGE AND LIMITATIONS

Community paramedicine services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed primary care provider (PCP), including a physician

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(MD/DO), an advanced practice registered nurse (APRN) or physician's assistant (PA) following an appropriate assessment. The PCP must consult with the EMS agency service's medical director to coordinate the care plan with all local community health providers and the local public health agencies, including home health and waiver services, to avoid duplication of services to the recipient~~. If a fee-for-service recipient requires more than five visits in the home during a three-month period, they will be referred to the Care Management Organization (CMO) by the EMS agency.~~

A. The following services can be provided within a community paramedicine provider's scope of practice as part of a community paramedicine visit when requested in a primary care provider's care plan:

1. Evaluation/health assessment;
2. Chronic disease prevention, monitoring and education;
3. Medication compliance;
4. ~~Immunizations and v~~Vaccinations;
5. Laboratory specimen collection and point of care lab tests;
6. Hospital discharge follow-up care;
7. Minor medical procedures and treatments within their scope of practice as approved by the EMS agency's medical director;
8. A home safety assessment; and
9. Telehealth originating site.

B. Non-covered services:

1. Travel time;
2. Mileage;
3. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital;
4. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code;

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5. Duplicated services; and

6. Personal Care Services.

C. For a list of covered procedure and diagnosis codes, please refer to the billing manual.

D. Prior authorization is not required for community paramedicine services.

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606 ~~PREVENTITIVE~~ PREVENTIVE HEALTH SERVICES

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a patient's current or possible future health care risks through assessments, lab work and other diagnostic studies. The U.S. Preventive Services Task Force (USPSTF) is an independent volunteer panel of national experts in prevention and evidence-based medicine authorized by the U.S. Congress. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. Each recommendation has a letter grade (an A, B, C, D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service.

606.1 COVERED SERVICES

Nevada Medicaid reimburses for preventive health ~~medicine~~ services for men, women, and children as recommended by the ~~U.S. Preventive Services Task Force (~~USPSTF~~)~~ A and B ~~R~~recommendations. For the most current list of reimbursable preventive services, please see the USPSTF A and B recommendations located at https://www.uspreventiveservicestaskforce.org/.

Family planning related preventive health services as recommended by the USPSTF are a covered benefit.

~~USPSTF A and B Recommendations~~

606.~~21~~ ~~PRIOR AUTHORIZATION~~NON-COVERED SERVICES

~~A. No prior authorization is required.~~ Preventive health services not cataloged or that do not have a current status as either an A or B recommendation by the USPSTF are not covered.

606.~~32~~ ~~COVERAGE AND LIMITATIONS~~ PRIOR AUTHORIZATIONS (PA)

PAs are not required for preventive health services that coincide with the USPSTF A and B recommendations.

606.4 BILLING REQUIREMENTS

Most preventive health services may be performed as part of an office visit, hospital visit, or global fee and may not be billed separately. Please see the Preventive Services Billing Guide or the USPSTF website.

~~A. The following preventive health services are covered by Nevada Medicaid for women:~~

~~Topic~~	~~Description~~

~~Abnormal blood glucose and Type 2 diabetes mellitus: screening~~	~~The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.~~
~~Alcohol misuse counseling*~~	~~The USPSTF recommends clinicians screen adults age 18 years or older, including pregnant women, for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.~~
~~Anemia screening: pregnant women~~	~~The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.~~
~~Aspirin to prevent CVD: women~~	~~The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.~~
~~Bacteriuria screening: pregnant women~~	~~The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.~~

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~~Topic~~	~~Description~~
~~BRCA risk assessment and genetic counseling/testing*~~	~~The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.~~
~~Breast cancer preventive medication~~	~~The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.~~
~~Breast cancer screening~~	~~The USPSTF recommends biennial screening mammography for women aged 50-74.~~
~~Breastfeeding counseling*~~	~~The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.~~
~~Cervical cancer screening~~	~~The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.~~
~~Chlamydial infection screening: non-pregnant women~~	~~The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.~~
~~Chlamydial infection screening: pregnant women~~	~~The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.~~
~~Cholesterol abnormalities screening: women 45 and older~~	~~The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.~~
~~Cholesterol abnormalities screening: women younger than 45~~	~~The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.~~
~~Colorectal cancer screening~~	~~The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.~~

~~Topic~~	~~Description~~
~~Depression screening: adults*~~	~~The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to assure accurate diagnosis, effective treatment, and appropriate follow-up.~~
~~Diabetes screening~~	~~The USPSTF recommends screening abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.~~
~~Folic acid supplementation~~	~~The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.~~
~~Gestational diabetes mellitus screening~~	~~The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant woman after 24 weeks' gestation.~~
~~Gonorrhea screening: women~~	~~The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).~~
~~Healthy diet counseling*~~	~~The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.~~
~~Hepatitis B screening: pregnant women~~	~~The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.~~
~~Hepatitis B screening: non-pregnant adolescents and adults~~	~~The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.~~
~~Hepatitis C virus infection screening: adults~~	~~The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.~~
~~Topic~~	~~Description~~

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~~High blood pressure in adults: screening*~~	~~The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.~~
~~HIV screening: pregnant women~~	~~The USPSTF strongly recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.~~
~~HIV screening: non-pregnant adolescents and adults~~	~~The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.~~
~~Intimate partner violence screening: women of childbearing age*~~	~~The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.~~
~~Obesity screening and counseling: adults*~~	~~The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.~~
~~Osteoporosis screening: women~~	~~The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.~~
~~Preeclampsia prevention: aspirin*~~	~~The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia~~
~~Rh incompatibility screening: first pregnancy visit~~	~~The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.~~
~~Rh incompatibility screening: 24-28 weeks' gestation~~	~~The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative.~~
~~Skin cancer behavioral counseling*~~	~~The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer~~

~~Topic~~	~~Description~~

STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults*	The USPSTF recommends that clinicians ask all adults about tobacco use, and advise them to stop using tobacco, and provide behavioral interventions U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, and advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

B. The following preventive health services are covered by Nevada Medicaid for men:

Topic	Description
Abnormal blood glucose and type 2 diabetes mellitus: screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol misuse: screening and counseling*	The USPSTF recommends clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

~~Topic~~	~~Description~~
~~Aspirin to prevent CVD: men~~	~~The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.~~
~~Cholesterol abnormalities screening: men 35 and older~~	~~The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.~~
~~Cholesterol abnormalities screening: men younger than 35~~	~~The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.~~
~~Colorectal cancer screening~~	~~The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.~~
~~Depression screening: adults*~~	~~The USPSTF recommends screening for depression in the general adult population. Screening should be implemented with adequate systems in place to assure accurate diagnosis, effective treatment, and appropriate follow-up.~~
~~Diabetes screening~~	~~The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.~~
~~Healthy diet counseling*~~	~~The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.~~
~~Hepatitis B screening: adolescents and adults*~~	~~The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.~~
~~Hepatitis C virus infection screening: adults~~	~~The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.~~

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Topic	Description
High blood pressure in adults: screening*	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: adolescents and adults	The USPSTF strongly recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Young adolescents and older adults who are at increased risk should also be screened.
Obesity screening and counseling: adults*	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Skin cancer behavioral counseling*	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults*	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.

C. The following preventive health services are for children as is age appropriate:

Topic	Description
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF also recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.

~~Topic~~	~~Description~~
~~Depression screening: adolescents~~	~~The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD). Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective therapy and appropriate follow-up.~~
~~Gonorrhea prophylactic medication: newborns*~~	~~The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.~~
~~Hearing loss screening: newborns*~~	~~The USPSTF recommends screening for hearing loss in all newborn infants.~~
~~Hemoglobinopathies screening: newborns*~~	~~The USPSTF recommends screening for sickle cell disease in newborns.~~
~~HIV screening: adolescents~~	~~The USPSTF strongly recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.~~
~~Hypothyroidism screening: newborns*~~	~~The USPSTF recommends screening for congenital hypothyroidism in newborns.~~
~~Iron supplementation in children~~	~~The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.~~
~~Obesity screening and counseling: children*~~	~~The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.~~
~~PKU / metabolic screening: newborns*~~	~~The USPSTF recommends screening for phenylketonuria (PKU) in newborns.~~
~~Skin cancer behavioral counseling*~~	~~The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.~~
~~STIs counseling*~~	~~The USPSTF recommends high intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.~~
~~Syphilis screening: non-pregnant persons~~	~~The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.~~

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~~Topic~~	~~Description~~
~~Tobacco use interventions: children and adolescents*~~	~~The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.~~
~~Visual acuity screening in children*~~	~~The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.~~

~~* These screening tests may be performed as part of an office visit, hospital visit or global fee and may not be billed separately.~~

DRAFT

A. DESCRIPTION

Botulinum Toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries, and multiple sclerosis. The injections may also reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow better range of motion, to permit better physical therapy, and/or provide adequate perineal hygiene.

~~1. Botulinum toxin is a neuromodulator derived from neurotoxins produced by the bacteria Clostridium botulinum, a gram positive bacillus. Botulinum toxin inhibits the release of acetylcholine at presynaptic cholinergic nerve terminals of the peripheral nervous system and atganglionic nerve terminals of the autonomic nervous system, thereby preventing neurotransmission and inducing flaccid paralysis. Three botulinum toxin type A products are approved by the Food and Drug Administration (FDA), including abobotulinumtoxinA (Dysport®), incobotulinumtoxinA (Xeomin®) and onabotulinumtoxinA (Botox®). RimabotulinumtoxinB (Myobloc®) is the only botulinum toxin B product approved by the FDA. FDA-approved indications differ among the individual botulinum toxin products.~~

~~2. The botulinum toxin products are not interchangeable with one another. The potency (in units) of one botulinum toxin product is specific to the preparation and assay method utilized by the manufacturer and units of biological activity of one product cannot be compared to or converted into units of any other botulinum toxin products assessed with any other specific assay method. All botulinum toxin products include a boxed warning in their labeling regarding the risk of botulinum toxin spreading beyond the site of injection, resulting in adverse events and death in some cases. Follow CPT guidelines for chemodenervation. Bill using the National Drug Code (NDC) for agents administered. See billing guide for billing instructions.~~

~~Current Medications Available in Therapeutic Class~~

~~Non-Proprietary Name (Trade Name)~~	**~~FDA-Approved Indication(s)~~**

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OnabotulinumtoxinA (BOTOX®)	• Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., SCI, MS) in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting four hours a day or longer); • Treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis); • Treatment of adults with cervical dystonia, to reduce the severity of abnormal head position and neck pain associated with cervical dystonia; • Treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents; and • Treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above.
AbobotulinumtoxinA (DYSPORT®)	• Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin naïve and previously treated patients.
IncobotulinumtoxinA (XEOMIN®)	• Treatment of adults with cervical dystonia to decrease the severity of abnormal head position and neck pain in both botulinum toxin naïve and previously treated patients; and • Treatment of adults with blepharospasm who were previously treated with onabotulinumtoxinA (Botox).
RimabotulinumtoxinB (MYOBLOC®)	• Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

B. POLICYPRIOR AUTHORIZATION

Prior authorization is required for Botulinum Toxin. Please reference MSM Chapter 1200, Prescribed Drugs for prior authorization criteria.

Botulinum Toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries, and multiple sclerosis. The injections may also reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow better range of motion, to permit better physical therapy, and provide adequate perineal hygiene.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

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1. ~~For a complete list of covered indications, please refer to the "Provider Type 20, 24 and 77 Billing Guide," applicable to botulinum toxins. It is expected that physicians will be familiar with and experienced in the use of the botulinum toxin product(s), and utilize FDA approved product labeling, compendia, and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each patient condition.~~

2. ~~Before consideration of coverage can be made, it must be established that the patient has been unresponsive to conventional methods of treatment such as medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions.~~

3. ~~Coverage is limited to certain conditions listed in the covered diagnosis code section of the billing manual.~~

4. ~~In order to determine the proper injection(s) site, electromyography (EMG) guidance may be required.~~

5. ~~The patient who has a spastic or excessive muscular contraction condition is usually started with a low dose of Botulinum Toxin with increases as required. Some spastic or muscular contraction conditions, e.g., eye muscle disorders, (e.g., blepharospasm) may require lesser amounts. For larger muscle groups, it is generally agreed that once a maximum dose per site has been reached, and there is no response, the treatment is discontinued. Treatments may be resumed at a later date if indicated. If a response is positive, the effect of the injections generally continues for three months, at which time the patient may need to repeat the injections for continued control. It is seldom medically necessary to repeat injections more frequently than every 90 days, unless acceptable justification is documented for more frequent use in the initial therapy.~~

6. ~~Medicaid will allow payment for one injection per site, regardless of the number of injections made into the site. A site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, neck, etc.~~

7. ~~Coverage will not be provided for injections given for cosmetic or for investigational purposes.~~

8. ~~Anesthesia for Botulinum injections is usually provided as a local anesthetic (e.g., for blepharospasm), or conscious sedation, although some patients, such as pediatric, may require more than conscious sedation. (See appropriate anesthesia CPT codes listed below).~~

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A. DESCRIPTION

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a patient's current or possible future health care risks through assessments, lab work and other diagnostic studies.

B. POLICY

Nevada Medicaid reimburses for preventive medicine services for family planning as recommended by the U. S. Preventive Services Task Force (USPSTF) A and B Recommendations.

USPSTF A and B Recommendations

C. PRIOR AUTHORIZATION: YES ☐ NO ☒

D. COVERAGE AND LIMITATIONS:

The following preventive health services are covered by Nevada Medicaid for Family Planning purposes:

Topic	**Description**
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

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~~* These screening tests may be performed as part of an office visit, hospital visit or global fee and may not be billed separately.~~

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