

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 7, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL
FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE
SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1500 - HEALTHY KIDS PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1500 – Healthy Kids Program is being proposed to add language allowing separate billing for objective vision testing for amblyopia.

These changes are effective June 8, 2016.

MATERIAL TRANSMITTED

MTL 16/16
Chapter 1500 - Healthy Kids Program

MATERIAL SUPERSEDED

MTL 29/15
Chapter 1500 - Healthy Kids Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1503.3A(1)(g)	Coverage and Limitations	Added language to allow separate billing for objective vision testing for amblyopia.
1503.3A(2)		Added language to include exception of separate billing for amblyopia.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

1500 INTRODUCTION

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are preventive and diagnostic services available to most recipients under age 21. In Nevada, the EPSDT program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary treatment to correct such conditions. Healthy Kids offers the opportunity for optimum health status for children through regular, preventive health services and the early detection and treatment of disease.

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1501 AUTHORITY

- A. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21.

Services available under the Healthy Kids Program are provided as defined in the following:

1. Omnibus Budget Reconciliation Act of 1989;
2. Social Security Act 1905 (a) and (r);
3. Social Security Act 1902 (a);
4. Social Security Act 1903 (i);
5. 42 Code of Federal Regulations (CFR), Subpart B, 441.50 – 441.62;
6. State Medicaid Manual (Part 5); and
7. Nevada Medicaid’s State Plan.

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1502 RESERVED

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1503 POLICY

1503.1 EARLY PERIODIC SCREENINGS

A child's health is assessed as early as possible in the child's life, in order to prevent or find potential diseases and disabilities in their early stages, when they are most effectively treated. Assessment of a child's health at regularly scheduled intervals assures that a condition, illness or injury is not developing or present. The Healthy Kids program has established a periodicity schedule for screening, vision, hearing and dental services based upon the American Academy of Pediatrics (AAP). The periodicity schedule utilized by the Healthy Kids program can be found at the Bright Futures /AAP website: <http://brightfutures.aap.org>.

1503.1A COVERAGE AND LIMITATIONS

1. The Healthy Kids program encourages providers to follow the recommended schedule for developmental screenings offered by the AAP. Recipients will be sent letters by the division's Quality Improvement Organization (QIO)-like vendor reminding them to schedule a screening visit on a periodic basis.
2. Dental services are outlined in Medicaid Services Manual (MSM) Chapter 1000, Dental. Dental services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, they must include relief of pain and infection, restoration of teeth, and maintenance of dental health. Generally, dental services should be age-appropriate and must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.
3. Vision services are outlined in MSM Chapter 1100, Ocular Services. Vision services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services must include diagnosis and treatment for defects in vision, including eye glasses. Generally, vision services should be age-appropriate and must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.
4. Hearing services are outlined in MSM Chapter 2000, Audiology. Hearing services can occur at intervals outside the established periodicity schedule when indicated as medically necessary to determine the existence of a suspected illness or condition. At a minimum, services should be age-appropriate and must include diagnosis and treatment for defects in hearing, including hearing aids. Generally, hearing services must be provided at intervals which meet reasonable standards of medical practice as recognized by medical organizations involved with child health care.

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1503.1B PROVIDER RESPONSIBILITY

1. The provider is expected to follow the periodicity guidelines as recommended when conducting Healthy Kids examinations whenever possible. The provider should offer services as deemed medically appropriate.
2. The provider shall determine whether a screening request is medically necessary when it falls outside the periodicity schedule and will conduct the intervention necessary to address suspected medical problems.
3. The provider should assure the elements listed in Section 1503.3A are included in a screening examination. The provider should seek out and incorporate information regarding the child's usual functioning from parents, teachers, and others familiar with the child when conducting an examination. Medical records should document the assessments and significant positive and negative findings. Discussions with the child and family about the findings should be an integral part of every examination and documented as well. A referral to another Medicaid provider should occur if the provider is unable to perform any screening component. Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening forms and EPSDT Participation Reports can be found on the Division of Health Care Financing and Policy (DHCFP) website: <https://dhcfnv.gov/epsdt.htm>.
4. Medical records should contain the following information specific to EPSDT screening services:
 - a. Reason for the visit;
 - b. The date screening services were performed, the specific tests or procedures performed, the results of these tests and the person who provided the service;
 - c. Documentation of medical contraindication or a written statement from a parent or a guardian of a screened child, for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations;
 - d. Identification of any screening component not completed, the medical contraindication or other reason why it could not be completed, and attempts the screening provider made to complete the screening;
 - e. Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as the medical screening;
 - f. Documentation of declination of screening services by the parent;

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- g. Referrals made for diagnosis, treatment or other medically necessary health services for conditions found in the screenings;
 - h. Date the next screening is due; and
 - i. Documentation of direct referral for age-appropriate dental services.
5. Providers should submit claims using the established billing codes related to the Healthy Kids screening examination. These examination codes can be found in the Hewlett Packard Enterprise Services (HPES) Billing Guide, Physician Billing Guide.
 6. The provider should make referrals for diagnostic testing after discussing the need for such services with the recipient/parent/legal guardian during a post screening interview. The physician's progress notes should indicate the need for such testing.
 7. A dated written referral should be given to the recipient or parents or forwarded to the referral service provider. The referral should include the following information:
 - a. The name of the child;
 - b. The Medicaid ID number of the child;
 - c. The date of the screening;
 - d. The abnormality noted;
 - e. The name, address, telephone and fax numbers of the child's primary physician if different from the screening provider; and
 - f. The physician to whom the referral applies if known.
 8. The provider should advise recipients of possible resources for obtaining testing as appropriate.

1503.2 INTERPERIODIC SCREENINGS

Healthy Kids screenings are provided to all eligible persons under the age of 21, which may include medically necessary intervals that are outside an established periodicity schedule, also known as interperiodic screenings.

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1503.2A COVERAGE AND LIMITATIONS

1. The DHCFP has identified a periodicity schedule that allows for access to screening, vision, hearing and dental services at intervals which meet reasonable standards of medical practice. The periodicity schedule can be found at the Bright Futures /AAP website: <http://brightfutures.aap.org>.
2. A recipient may request a health care screening or any component of the health screening at any time. Screening services which are medically necessary, such as when a new health problem has occurred or when a previously diagnosed condition has become more severe or changed sufficiently to require a new examination, will be offered, regardless of whether the request falls into the periodicity schedule established by the State.

1503.3 COMPREHENSIVE SCREENING EXAMINATION

A comprehensive child health assessment is provided to determine if a child has a condition, illness or injury that should be referred for further evaluation and/or treatment. A Healthy Kids screening examination must comply with 1905(r) of the Social Security Act (SSA). http://www.socialsecurity.gov/OP_Home/ssact/title19/1905.htm.

1503.3A COVERAGE AND LIMITATIONS

1. Screening services are designed to evaluate the general physical and mental health, growth, development and nutritional status of infants, children and adolescents.

The following is a description of each of the required age-appropriate screening components:

a. COMPREHENSIVE HEALTH AND DEVELOPMENTAL/BEHAVIORAL HISTORY

At the initial screening, the provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

1. Family medical history (health of the parents and current family members, identification of family members with chronic, communicable or hereditary diseases);

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2. Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies, current health problems and medications);
3. Nutritional history;
4. Immunization history;
5. Environmental risk;
6. Family background of emotional problems, problems with drinking or drugs, or history of violence or abuse;
7. Patient history of behavioral and/or emotional problems;
8. History of sexual activity, if appropriate; and
9. Menstrual and obstetrical history for females, if appropriate.

b. DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

1. Assessment of developmental and behavioral status should be completed at each visit by observation, interview, history and appropriate physical examination. The developmental assessment should include a range of activities to determine whether or not the child has reached an age-appropriate level of development.
2. Nevada Medicaid will reimburse separately for developmental screenings, provided that a valid, standardized developmental screening tool, (i.e. Parents Evaluation of Developmental Status (PEDS), Ages and Stages, Early Language Milestone Screen) has been utilized and entered into the child's health care record. Although the American Academy of Pediatrics recommends the use of a standardized screening tool at ages nine, 18, and 30 months, and three and four years of age, the exact frequency of standardized testing depends on the clinical setting and provider's judgment as to medical necessity. Asking questions about development as part of the general informal developmental survey or history is not a "standardized screening" and is not separately reportable. Providers may be subject to a random audit of records to assure the use of the screening tool. For billing instructions, see the HPES Billing Manual at: <http://www.medicaid.nv.gov/providers/BillingInfo.aspx>.

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c. **COMPREHENSIVE UNCLOTHED PHYSICAL EXAM**

A completed unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques. The examination must include all body parts and systems listed below:

1. Cranium and face;
2. Hair and scalp;
3. Ears;
4. Eyes;
5. Nose;
6. Throat;
7. Mouth and teeth;
8. Neck;
9. Skin and lymph nodes;
10. Chest and back;
11. Abdomen;
12. Genitalia;
13. Musculoskeletal system;
14. Extremities; and
15. Nervous system.
16. The examination should include screening for congenital abnormalities and responses to voices and other external stimuli.

d. **APPROPRIATE IMMUNIZATIONS**

1. The child's immunization status must be reviewed each screening visit.

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Appropriate immunizations that are due must be administered during the screening visit and according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines: <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>.

2. Nevada Medicaid cannot reimburse for immunizations (except administration fees) that are available through the State Health Division as part of the Vaccines for Children (VFC) program. Providers are encouraged to enroll with the VFC program which provides the VFC vaccines at no cost to eligible children. Medicaid cannot be billed for the cost of a vaccine obtained through VFC, (even if the provider is not enrolled with VFC) unless there is a documented statewide shortage. To become a VFC provider, please access the website via <http://health.nv.gov/>.
3. Nevada Check Up (NCU) provides the same vaccines through a different funding source, but providers must use the same billing guidelines.
4. For specific guidelines for the Human Papilloma Virus (HPV) vaccine, please refer to MSM Chapter 1200, Pharmacy Services.

e. LABORATORY PROCEDURES

Age-appropriate laboratory procedures must be performed at intervals in accordance with the Healthy Kids periodicity schedule. These include blood lead level assessment appropriate to age and risk, urinalysis, Tuberculin Skin Test (TST), Sickle-cell, hemoglobin or hematocrit and other tests and procedures that are age-appropriate and medically necessary, such as Pap smears.

f. HEALTH EDUCATION

1. Health education related to the physical assessment should be provided at each screening visit. It is designed to help children and their parents understand the health status of the child as well as provide information which emphasizes health promotion and preventive strategies. Health education explains the benefits of a healthy lifestyle, prevention of disease and accidents, normal growth and development, and age-appropriate family planning services.
2. Anticipatory guidance should be offered which includes discussion of information on what to expect in the child's current and next developmental phase. It is given in anticipation of health problems or decisions which may occur before the next periodicity visit.

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3. Information should also include a summarization of the results of the screening and laboratory tests, review of the child’s health status, and discussion regarding any specific problems detected in the screening.

g. VISION SCREENING

The purpose is to detect potentially blinding diseases and visual impairments, such as congenital abnormalities and malformations, eye diseases, color blindness and refractive errors. The screening should include distance visual acuity, color perception and ocular alignment tests. The vision screening is part of the complete physical examination and should be given by age three. **Screening for amblyopia may be separately reimbursed.**

h. HEARING SCREENING

The purpose is to detect sensorineural and conductive hearing loss, congenital abnormalities, noise-induced hearing loss, central auditory problems, or a history of conditions that may increase the risk for potential hearing loss. The examination must include information about the child’s response to voice and other auditory stimuli, speech and language development, and specific factors or health problems that place a child at risk for hearing loss.

i. DENTAL SCREENING

An oral inspection must be performed by the screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries should be noted. The oral inspection is not a substitute for a complete dental screening examination provided by a dentist. An initial dental referral should be provided on any child age three or older unless it is known that the child is already receiving regular dental care. When the screening indicates a need for dental services at an earlier age, referral must be made. The importance of regular dental care should be discussed with the family (and the child as appropriate) on each screening visit for children three years and older.

2. Immunizations and laboratory tests should be billed separately from the screening visit. Objective vision and hearing testing performed during the same visit as the physical examination should not be billed separately, **with the exception of testing for amblyopia.** If hearing and vision testing needs to be performed separately from the exam, these procedures should be billed as outlined in applicable MSM chapters.

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3. Nevada Medicaid does not cover “sick kid” visits under the Healthy Kids program. A majority of the screening elements should be completed during a screening appointment to be billed as a Healthy Kids screening. The screening visit should be rescheduled if the child is too ill to complete the examination and the current visit should be billed using a routine office visit code.

1503.4 DIAGNOSTIC SERVICES

Nevada Medicaid provides diagnostic services as indicated through a Healthy Kids screening.

1503.4A COVERAGE AND LIMITATIONS

1. Any condition discovered during a screening should be followed up for diagnosis. Prior authorization is not necessary for these diagnostic examinations if they are part of or referred through a Healthy Kids screening. Referrals can include but are not limited to:
 - a. Vision Services.
 - b. Dental Services.
 - c. Hearing Services.
 - d. Other Necessary Health Care.
2. Although preferred, a Healthy Kids screening is not a requirement for medically necessary diagnostic services.

1503.5 TREATMENT

Nevada Medicaid provides for medically necessary treatment as indicated through a Healthy Kids screening and diagnosis.

1503.5A COVERAGE AND LIMITATIONS

1. Health care and treatment is available to correct or improve defects and physical and mental illnesses or conditions discovered by Healthy Kids screening and diagnostic services. Covered services include all mandatory and optional services that a state can cover under the benefit plan, whether or not such services are covered for adults. The scope of medical services available are described in the SSA, Section 1905(a).
2. Services that are not medical in nature, including educational interventions, are excluded. Treatment must be medically necessary and prior authorized if not typically included in

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the benefit plan. The QIO-like vendor will review the suggested treatment to ensure it meets with current medical practice standards for the given diagnosis.

3. When treatment is needed to correct or improve identified conditions, the DHCFP's established requirements for prior authorization apply. See the MSM Chapters related to the requested service to determine if prior authorization is needed before treatment is rendered.
4. Although it is preferred, a Healthy Kids screening is not a requirement for medically necessary treatment under EPSDT guidelines [SSA, Section 1905(r)].

1503.6 FAMILY PLANNING

Family planning services are available to recipients.

1503.6A COVERAGE AND LIMITATIONS

Family planning information should be offered during a Healthy Kids examination as appropriate and requested.

1503.7 TRANSPORTATION

Assistance with transportation is available to and from a Healthy Kids examination. (Please reference MSM Chapter 1900, Transportation).

1503.7A COVERAGE AND LIMITATIONS

Nevada Medicaid pays for transportation in order for a recipient to receive medically necessary care and services. Transportation requires prior authorization in all but emergency situations. The guidelines outlined in MSM Chapter 1900 should be followed.

1503.8 PREGNANCY RELATED ONLY

The Healthy Kids benefit package is not available to recipients who are eligible solely because of pregnancy.

1503.8A COVERAGE AND LIMITATIONS

A recipient who is less than 21 years old and whose eligibility status is pregnancy related only (P) is not eligible for Healthy Kids. She is eligible for pregnancy related services only, which includes prenatal care, labor and delivery services, and postpartum care for 60 days after the date of delivery, including the month in which the 60th day falls. The recipient may be eligible for

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services that relate to conditions that might complicate the pregnancy, but those services cannot be billed as a Healthy Kids service.

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1504 HEARINGS

Please reference Medicaid Services Manual (MSM) Chapter 3100 for Medicaid Recipient Hearing process policy.

ATTACHMENT A

POLICY #15-1	CLINICAL STUDIES	EFFECTIVE DATE: NOVEMBER 1, 2014
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DESCRIPTION

Nevada Medicaid covers the routine costs of qualifying phase III and IV clinical trials for children less than 21 years of age. Reasonable and necessary items and services used to diagnose and treat complications arising from participation in phase III and IV clinical trials are covered. These services must be a Nevada Medicaid covered service.

POLICY

Any clinical trial receiving Medicaid coverage of routine costs must meet the following requirements:

1. The subject or purpose of the trial must be the evaluation of an item or service that is covered by Nevada Medicaid (e.g., physicians' service, Durable Medical Equipment (DME), diagnostic test) and is not excluded from coverage (e.g., cosmetic surgery);
2. The trial must not be designed exclusively to test toxicity or disease pathophysiology, it must have therapeutic intent;
3. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers; and
4. The clinical trial is approved by one of the following:
 - a. National Institute of Health (NIH);
 - b. Department of Defense (DOD);
 - c. Veterans Affairs (VA);
 - d. Centers for Disease Control (CDC);
 - e. Centers for Medicare & Medicaid Services (CMS);
 - f. Agency for Healthcare Research & Quality (AHRQ); or
 - g. National Cancer Institute (NCI).

PRIOR AUTHORIZATION IS REQUIRED

Clinical trials that meet the qualifying coverage criteria will receive Medicaid coverage of routine costs after prior authorization from the Quality Improvement Organization (QIO)-like vendor.

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POLICY #15-1	CLINICAL STUDIES	EFFECTIVE DATE: NOVEMBER 1, 2014
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COVERAGE AND LIMITATIONS

Covered Services

1. Items or services that are typically provided absent a clinical trial (e.g., conventional care);
2. Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service in particular, for the diagnosis or treatment of complications.

Non-Covered Services

1. Phase I or II clinical trials.
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly Computed Tomography (CT) scans for a condition usually requiring only a single scan).
3. Items and services customarily provided by the research sponsors free of charge for the enrollee in the trial.
4. For items and services, including items and services for which Medicaid reimbursement is not available, Medicaid only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated reasonable and necessary care. However, if the item or service is not covered by Medicaid and is the focus of a qualifying clinical trial, the routine costs of the clinical trial (as defined above) will be covered by Medicaid but the non-covered item or service, itself, will not.

NOTE: For policy regarding pharmaceutical clinical studies, please refer to MSM Chapter 1200, Prescribed Drugs.

ATTACHMENT A

POLICY #15-2	EXPERIMENTAL TREATMENT	EFFECTIVE DATE: NOVEMBER 1, 2014
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DESCRIPTION/POLICY

Nevada Medicaid does not cover any item or service that is not medically necessary, that is unsafe or is not generally recognized as an accepted method of medical practice or treatment.

PRIOR AUTHORIZATION IS REQUIRED

If experimental treatment is medically necessary, providers must request prior authorization for services which may fall into the above category prior to rendering service.

COVERAGE AND LIMITATIONS

Nevada Medicaid completes prior authorization on medical services to assure that the care and the services proposed are actually needed, are equally effective, less expensive alternatives have been given consideration, and the proposed service and materials conform to commonly accepted standards.

Nevada Medicaid's QIO-like vendor completes the authorization review.

ATTACHMENT B

POLICY #15-3	APPLIED BEHAVIOR ANALYSIS	EFFECTIVE DATE: JANUARY 1, 2016
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INTRODUCTION

Applied Behavior Analysis (ABA) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior. ABA is a behavior intervention model based on reliable evidence based practices focusing on targeted skills in all areas of development. The Division of Health Care Financing and Policy (DHCFP) utilizes the Center for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and Behavior Analyst Certification Board (BACB) “Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.)” as guiding principles for this policy.

All DHCFP policies and requirements (such as prior authorizations, etc.) except for those listed in the Nevada Check Up (NCU) Chapter 1000 are the same for NCU.

All DHCFP policies and requirements for Outpatient Physical, Occupational, Speech, and Maintenance Therapy are listed in Chapter 1700 of the Medicaid Services Manual (MSM). Chapter 1500, Attachment #15-3 specifically covers ABA services; for other Medicaid services, coverage, limitations and provider responsibilities the specific MSM needs to be referenced.

AUTHORITY

A comprehensive array of preventive, diagnostic, and treatment services are a mandatory benefit under the Medicaid program for categorically needy individuals under age 21, including children with Autism Spectrum Disorder (ASD).

1. ABA is an evidence based behavior intervention meeting the provision of the law as defined in the following:
 - a. Social Security Act 1905(a) and (r);
 - b. 42 Code of Federal Regulation (CFR), Subpart B, 441.50-441.62;
 - c. Nevada Revised Statute (NRS) Chapter 641 describes persons deemed to practice ABA services; and
 - d. Nevada Medicaid State Plan describes the amount, duration and scope of ABA services provided to the categorically needy.

DEFINITIONS

1. Applied Behavior Analysis (ABA) is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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POLICY #15-3	APPLIED BEHAVIOR ANALYSIS	EFFECTIVE DATE: JANUARY 1, 2016
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2. Autism Spectrum Disorder (ASD) is a group of developmental disabilities that can cause significant social, communication and behavioral challenges.

POLICY

Medicaid will reimburse for ABA rendered to Medicaid eligible individuals under age 21 in accordance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage authority. The behavior intervention must be medically necessary (reference MSM 100) to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of ASD or other condition for which ABA is recognized as medically necessary. It must be rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner Registered Nurse (APRN). The treatment regimen must be designed and signed off on by the qualified ABA provider.

The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, or in the recipient's home.

All services must be documented as medically necessary and appropriate and must be prescribed on an individualized treatment plan.

COVERAGE AND LIMITATIONS

Covered Services

1. There are two types of ABA treatment delivery models recognized by the DHCFP, Focused and Comprehensive. Based upon the Behavior Analyst Certification Board (BACB), Inc. (2014) within each of the two delivery models there are key characteristics which must be demonstrated throughout the assessment and treatment. These characteristics include:
 - a. Comprehensive assessment that describes specific levels of baseline behaviors when establishing treatment goals.
 - b. Establishing small units of behavior which builds towards larger changes in functioning in improved health and levels of independence.
 - c. Understanding the current function and behaviors targeted for treatment.
 - d. Use of individualized and detailed behavior analytic treatment.
 - e. Ongoing and frequent direct assessment, analysis and adjustments to the treatment plan by a Behavior Analyst by observations and objective data analysis.
 - f. Use of treatment protocols that are implemented repeatedly, frequently, and consistently across all environments.
 - g. Direct support and training of family members and other involved qualified professionals.

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POLICY #15-3	APPLIED BEHAVIOR ANALYSIS	EFFECTIVE DATE: JANUARY 1, 2016
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- h. Supervision and management by a licensed provider with expertise and formal training in ABA for treatment of ASD. “Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2014) (2nded.)”.
http://bacb.com/Downloadfiles/ABA_Guidelines_for_ASD.pdf

2. Focused Delivery Model

- a. Focused ABA is treatment directly provided to the individual for a limited number of specific behavioral targets.
 - 1. The appropriate target behaviors are prioritized. When prioritizing multiple target areas, the following behaviors are considered:
 - a. behaviors that may threaten the health and safety of themselves or others; and
 - b. absence of developmentally appropriate adaptive, social or functional skills.
 - 2. Treatment may be delivered in individual or small group format.

3. Comprehensive Delivery Model

- a. Comprehensive ABA is treatment provided to the individual for a multiple number of targets across domains of functioning including cognitive, communicative, social and emotional.
 - 1. The behavior disorders may include co-occurring disorders such as aggression, self-injury and other dangerous disorders.
 - 2. Treatment hours are increased and decreased as recipient responds to treatment goals.
 - 3. Treatment is intensive and initially provided in a structured therapy setting. As recipient progresses towards treatment goals the setting may be expanded to alternative environments such as group settings.

4. Services covered within the ABA delivery models

- a. Behavioral Screening - A brief systematic process to determine developmental delays and disabilities during regular well-child doctor visits. Screens must be a nationally accepted Developmental Screen. A recommended list of screens may be found at: <http://www.medicalhomeinfo.org/downloads/pdfs/DPIPscreeningtoolgrid.pdf>. Refer to Chapter 600 of the MSM for coverage of developmental screens.
- b. Comprehensive Diagnostic Evaluations - Is the further review and diagnosis of the child’s behavior and development. Coverage of this service is found within Chapter 600 of the MSM.
- c. Behavioral Assessment - A comprehensive assessment is an individualized examination which establishes the presence or absence of developmental delays and/or disabilities and determines the recipient’s readiness for change and identifies the strengths or problem areas that may affect

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the recipient’s treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

- d. Adaptive Behavioral Treatment Intervention - Is the systematic use of behavioral techniques and intervention procedures to include intensive direction instruction by the interventionist and family training and support.
 - e. Adaptive Behavioral Family Treatment - The training in behavioral techniques to be incorporated into daily routines of the child and ensure consistency in the intervention approach. The training should be extensive and ongoing and include regular consultation with the qualified professional. The training is broken down into two components:
 - 1. Family Treatment with the child present – Is training that includes the parent/guardian or authorized representative in behavioral techniques during the behavior intervention with the child.
 - 2. Family Treatment without the child present – Is training in behavioral techniques provided to the parent/guardian or authorized representative without the child present. The training may be for the review of prior adaptive behavioral treatment sessions to break down the exhibited behavior and training techniques.
5. The coverage of ABA services requires the following medical coverage criteria to be met:
- a. The recipient must be zero to under 21 years of age;
 - b. Have an established supporting diagnosis of ASD;
 - c. The individual exhibits excesses and/or deficits of behavior that impedes access to age appropriate home or community activities (examples include, but are not limited to aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);
 - d. ABA services are rendered in accordance with the individual’s treatment plan with realistic and obtainable treatment goals to address the behavioral dysfunction;
 - e. Treatment may vary in intensity and duration based on clinical standards. Approval of fewer hours than recommended/supported in clinical literature requires justification based on objective findings in the medical records;
 - f. A reasonable expectation on the part of the treating healthcare professional that the individual will improve, or maintain to the maximum extent practical functional gains with behavior intervention services;

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- g. The treatment plan must be based on evidence-based assessment criteria and the individual’s test results;
 - h. Behavioral assessments which are previously performed at the Local Education Agency (LEA) must be utilized and not duplicatively billed under the DHCFP if current (within six months) and clinically appropriate; and
 - i. Services must be prior authorized.
6. Services may be delivered in an individual or group (two to eight individuals) treatment session.
 7. Services may be delivered in the natural setting (i.e. home and community-based settings, including clinics).
 8. Individuals with Disabilities Education Act (IDEA) related services:
 - a. Part C, Early Intervention ages zero up to three - Services identified on an Individualized Family Services Plan (IFSP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under “provider qualifications” for ABA service. These providers must directly bill the DHCFP.
 - b. Part B, Special Education and related services ages three up to 21 - Services identified on an Individual Educational Plan (IEP) may be billed to the DHCFP when the providers are enrolled and meet the provider qualifications as outlined under “provider qualifications” for ABA services. These providers must directly bill the DHCFP.

PRIOR AUTHORIZATION REQUIREMENTS

1. Behavioral Screens do not require prior authorization.
2. Behavioral Initial assessment and re-assessments do not require prior authorization. Assessments are limited to one in every 180 days or unless prior authorized.
3. Adaptive Behavioral Treatment (individual and group) requires prior authorization from the Quality Improvement Organization (QIO)-like vendor.
4. Adaptive Family Behavioral training (individual and group) requires prior authorization from the QIO-like vendor.
5. ABA services identified through an IEP. When an IEP is issued by the school system, the IEP must accompany a request for ABA services and coordination of services is expected.
6. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both) of the current authorization, the provider is responsible for the submittal of a new prior authorization request.

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NON COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.
2. Services used to reimburse a parent/guardian for participation in the treatment plan.
3. Services rendered by the parent/guardian.
4. Services that are duplicative services under an IFSP or an IEP.
5. Treatment whose purpose is vocationally or recreationally based.
6. Services, supplies, or procedures performed in a non-conventional setting including but not limited to Resorts, Spas, and Camps.
7. Custodial services:
 - a. For the purpose of these provisions, custodial care:
 1. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs) such as bathing, dressing, eating, and maintaining personal hygiene and safety;
 2. is provided primarily for maintaining the recipient's or anyone else's safety; and
 3. could be provided by persons without professional skills or training.
8. Parenting services without a diagnosis of ASD.
9. Services not authorized by the QIO-like vendor if an authorization is required according to policy.
10. Respite services.
11. Child care services.
12. Services for education.
13. Equine therapy.
14. Hippotherapy.
15. Phone consultation services.
16. Care coordination and treatment planning billed independently of direct service.
17. ABA services cannot be reimbursed on the same day as other rehabilitative mental health services as described within Chapter 400 of the MSM.

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PROVIDER QUALIFICATIONS

In order to be recognized and reimbursed as an ABA provider by the DHCFP, the provider must be one of the following:

1. Licensure as a Physician by the Nevada State Board of Medical Examiners acting within their scope of practice (NRS 630.630, 630.165, 630.195, 633 Nevada Administrative Code (NAC) 630.080), and 42 CFR §440.50.
2. A Psychologist licensed under NRS 641.170.3. A qualified Behavior Analyst is an individual who has earned a master's degree level and/or doctorate from an accredited college or university in a field of social science or special education and holds a current certificate as a Board Certified Behavior Analyst (BCBA and BCBA-D) by the BACB, Inc., and licensed by the Nevada State Board of Psychological Examiners under NRS 641.170.
3. A qualified Assistant Behavior Analyst is an individual who has earned a bachelor's degree from an accredited college or university in a field of social science or special education and holds a current certification as a Board Certified Assistant Behavior Analyst (BCaBA) by the BACB, Inc., and licensed by the Nevada State Board of Psychological Examiners under NRS 641.170 and is under the direction of a physician, psychologist, BCBA-D, or BCBA.
4. A Registered Behavior Technician (RBT) is an individual who has earned a high school diploma or equivalent, completed training and testing as approved and credentialed by the BACB, Inc., and acting within the scope of practice under direction of a physician, psychologist, BCBA-D, BCBA, or BCaBA.

SUPERVISION STANDARDS

Clinical Supervision as established by NRS 641.100, which includes: program development, ongoing assessment and treatment oversight, report writing, demonstration with the individual, observation, interventionist and parent/guardian training/education, and oversight of transition and discharge plans. All supervision must be overseen by a Licensed Psychologist, BCBA-D or BCBA who has experience in the treatment of autism, although the actual supervision may be provided by a BCaBA at their direction. The amount of supervision must be responsive to individual needs and within the general standards of care and may temporarily increase to meet the individual needs at a specific period in treatment.

PROVIDER RESPONSIBILITY

1. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.
2. Once an approved prior authorization request has been received, providers are required to notify the recipient in a timely manner of the approved service units and service period dates.
3. Ensure services are consistent with applicable professional standards and guidelines relating to the practice of ABA as well as state Medicaid laws and regulations and state licensure laws and regulations.
4. Ensure caseload size is within the professional standards and guidelines relating to the practice of ABA.

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PARENT/GUARDIAN RESPONSIBILITY

The parent/guardian when applicable must:

1. Be present during all provider training and supervisory visits that occur during home-based services. A parent/guardian may designate an authorized representative, who is 18 years of age or older, to participate in the parent/guardian's absence during home-based services.
2. Participate in discussions during supervisory visits and training.
3. Participate in training by demonstrating taught skills to support generalization of skills to the home and community environment.
4. Sign the treatment plan indicating an understanding and agreement of the plan.
5. Participate in treatment hours.
6. Keep scheduled appointments.
7. Inform provider within 24 hours if the appointment needs to be rescheduled.

TREATMENT PLAN

All ABA services must be provided under a treatment plan developed and approved by a licensed psychologist, BCBA-D or BCBA, supported by a BCaBA where applicable. The licensed psychologist, BCBA-D, or BCBA trains the BCaBA and RBT to implement assessment and intervention protocols with the individual and provides training and instruction to the parent/guardian and caregiver as necessary to support the implementation of the ABA treatment plan. The licensed psychologist, BCBA-D, or BCBA is responsible for all aspects of clinical direction, supervision, and case management.

ABA services shall be rendered in accordance with the individual's treatment plan that is reviewed no less than every six months by a licensed psychologist, BCBA-D, or BCBA. All treatment plans are based on documentation of medical necessity for specific treatment goals to address specific behavior targets based on the appropriate treatment model. The treatment plan shall include:

1. Goals derived from the functional assessment and/or skill assessment that occur prior to initiation of treatment, and relating to the core deficit derived from the assessment;
2. Specific and measurable objectives to address each skill deficit and behavioral excess goal:
 - a. Delineate the baseline levels of target behaviors;
 - b. Identify short, intermediate, and long-term goals and objectives that are behaviorally defined;
 - c. Criteria that will be used to measure achievement of behavioral objectives; and
 - d. Target dates for when each goal will be mastered.

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3. Interventions consistent with ABA techniques;
4. Specific treatment, intervention including amount, scope, duration and anticipated provider(s) of the services;
5. Training and supervision to enable the BCaBAs and RBTs to implement assessment and treatment protocols;
6. Care coordination involving the parent/guardian, community, school, and behavior health and/or medical providers who are concurrently providing services. Care coordination must include parent/guardian's documented consent;
7. Parent/guardian training, support and participation;
8. Parent/guardian or designated authorized representative responsibility to be physically present and observant during intervention process occurring in the home;
9. Parent/guardian signature; and
10. Discharge criteria to include requirements of discharge, anticipated discharge date, next level of care, and coordination of other services.

DISCHARGE PLAN

All ABA services must include discharge criteria as a written component of the treatment plan at the initiation of services and updated throughout the treatment process; involving a gradual step down in services. Discharge planning should include the details of monitoring and follow up for the individual.

1. Discharge planning should occur when:
 - a. The individual has achieved treatment goals; or
 - b. The individual no longer meets the diagnostic criteria for ASD; or
 - c. The individual does not demonstrate progress towards goals for successive authorization periods;
or
 - d. The parent/guardian requests to discontinue services; or
 - e. The parent/guardian and provider are unable to reconcile concerns in treatment planning and delivery.
2. Discharge plan must identify:
 - a. The anticipated duration of the overall services;
 - b. Discharge criteria;

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- c. Required aftercare services;
- d. The identified agency(ies) or Independent Provider(s) to provide the aftercare services; and
- e. A plan for assisting the recipient in accessing these services.

A discharge summary is written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, towards treatment goals and objectives, as documented in the ABA treatment plan. The discharge summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment.