MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 8, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to MSM Chapter 600 are being proposed to change the required duration of participation in a medically-supervised weight loss program prior to bariatric surgery for morbid obesity. The duration of participation is being reduced from three years to three months prior to surgery. This change aligns the Chapter with the national standards for bariatric surgery.

Additional revisions are being proposed to update the chapter with new and revised A and B Recommendations from the United States Preventive Services Task Force (USPSTF), a panel of national experts in prevention and evidence-based medicine. These recommendations from the Task Force are based upon a peer-reviewed evidence and intended to help primary care providers and their patients determine the best preventive service that is appropriate for their needs. An "A" rating indicates a high certainty the net benefit of a service is substantial. A "B" rating indicates there is high certainty the net benefit is moderate to substantial.

These changes are effective February 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 03/15 CHAPTER 600 – PHYSICIAN SERVICES	MTL 20/14 CHAPTER 600 – PHYSICIAN SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Attachment #6-07	**Coverage and Limitations**	The length of the required medically-supervised weight loss program is being reduced from three years to three months.
Attachment #6-12	**Coverage and Limitations**	Updated language from the USPSTF recommendation that 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.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added language from the USPSTF recommendation for screening gestational diabetes mellitus in asymptomatic pregnant woman after 24 weeks gestation. Added language from the USPSTF recommendation for screening hepatitis B virus infection in persons at high risk for infection. Added language for the USPSTF recommendation for screening hepatitis C virus (HCV) infection in all persons at high risk for infection and a one-time screening for HCV infection to adults born between 1945 and 1965. Added language for the USPSTF recommendation that clinicians screen woman of childbearing age for intimate partner violence. Updated language for the USPSTF recommendation for screening of osteoporosis in women aged 65 years and older and in younger woman whose fracture risk is equal to or greater than that of a 65-year old white woman who has no additional risk factors be screened routinely for osteoporosis. Added language for the USPSTF recommendation for 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.
Attachment #6-13	**Coverage and Limitations**	Updated language from the USPSTF recommendation that 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. Added language from the USPSTF recommendation for screening hepatitis B virus infection in persons at high risk for infection. Added language for the USPSTF recommendation for screening hepatitis C virus (HCV) infection in all persons at high risk for infection and a one-time screening for HCV infection to adults born between 1945 and 1965.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added language for the USPSTF recommendation for 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.
Attachment #6-14	**Coverage and Limitations**	Updated language for the USPSTF recommendation for fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. Added language for the USPSTF recommendation of application of fluoride varnish to primary teeth of all infants and children starting at the age of 6 months for children whose water supply is fluoride deficient. Added language for the USPSTF recommendation for 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. Added language for the USPSTF recommendation that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. Updated the USPSTF recommendation for 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.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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600 INTRODUCTION

The Nevada Medicaid Program is dependent upon the participation and cooperation of Nevada physicians and other licensed professionals who provide health care to Medicaid recipients. Licensed professionals providing services within the scope of their license are recognized by Nevada as independently contracted Medicaid providers. The policy in this chapter is specific to the following identified health care professionals:

a. Advanced Practitioners of Nursing (APN).

b. Certified Registered Nurse Anesthetists (CRNA).

c. Chiropractors.

d. Certified-Nurse Midwives.

e. Physicians (M.D. and D.O. including those in a teaching hospital).

f. Physician Assistants (PA -M.D./D.O.).

g. Podiatrists.

To enroll as a physician or health care professional for the Division of Health Care Financing and Policy (DHCFP) in the Nevada Medicaid Program, the above listed licensed professionals working within their scope of practice must be authorized by the licensing authority of their profession to practice in the state where the service is performed at the time the state services are provided. Specific service exclusions will be noted in policy.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Services Manual, Chapter 1000.

Disclaimer: The term “Physician” used throughout this chapter is an all inclusive description relative to the above identified providers working within their respective scope of practice and does not equate one professional to another. It serves only to make the document more reader-friendly. A Primary Care Physician (PCP) is considered to be an M.D/D.O with a specialty in general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology.

601 AUTHORITY

A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (CFR) Part 440, Subpart A – Definitions, Subpart B and sections 1929 (a), 1902 (e), 1905 (a), 1905 (p), 1915, 1920, and 1925 of the Act. Physician's services are mandated as a condition of participation in the Medicaid Program Nevada Revised Statute (NRS) 630A.220.

B. Regulations for services furnished by supervising physicians in teaching settings are found in 42 CFR Part 415; Subpart D. Key portion is defined in [Reg. 415.172(a)].

C. The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

1. NRS Chapter 634 - Chiropractic;

2. NRS Chapter 629 - Healing Arts Generally;

3. NRS Chapter 632 - Nursing;

4. NRS Chapter 630 - Physicians and Physician Assistants and Practitioners of Respiratory Care General Provisions;

5. NRS Chapter 633 - Osteopathic Medicine; and

6. NRS Chapter 635 - Podiatry.

602 RESERVED

603 PHYSICIANS AND LICENSED PROFESSIONAL POLICY

603.1 PHYSICIAN'S ROLE IN RENDERING SERVICES

603.1A COVERAGE AND LIMITATIONS

1. The Division of Health Care Financing and Policy (DHCFP) reimburses for covered medical services that are reasonable and medically necessary, ordered or performed by a physician or under the supervision of a physician, and that are within the scope of practice of their prognosis as defined by state law. The physician must:

    a. Examine the recipient;

    b. Make a diagnosis;

    c. Establish a plan of care; and

    d. Document these tasks in the appropriate medical records for the recipient before submitting claims for services rendered. Documentation is subject to review by a state authority or contracted entity.

2. Services must be performed by the physician or by a licensed professional working under the personal supervision of the physician.

    a. The following are examples of services that are considered part of the billable visit when it is provided under the direct and professional supervision of the physician:

        1. An injection of medication;

        2. Diagnostic test like an EKG;

        3. Blood pressure taken and recorded between MD visits;

        4. Dressing changes; and

        5. Topical application of fluoride.

    b. Physicians or their designee may not bill Medicaid for services provided by, but not limited to, the following:

        1. Another Provider;

        2. Psychologist;

3. Medical Resident (unless teaching physician);

4. Therapist: Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (SP), Respiratory Therapist (RT);

5. Counselor/Social Worker;

6. Nurse Practitioner (other than diagnostic tests done in the office which must be reviewed by the physician);

7. Physician Assistants; and

8. Certified Registered Nurse Anesthetist.

3. Teaching Physicians

Medicaid covers teaching physician services when they participate in the recipient's care. The teaching physician directs no more than four residents at any given time and is in such proximity as to constitute immediate availability. The teaching physician's documentation must show that he or she either performed the service or was physically present while the resident performed the key and critical portions of the service. Documentation must also show participation of the teaching physician in the management of the recipient and medical necessity for the service. When choosing the appropriate procedure code to bill, consideration is based on the time and level of complexity of the teaching physician, not the resident's involvement or time.

The DHCFP follows Medicare coverage guidelines for Teaching Physicians, Interns, and Residents.

4. Out-of-State Physicians

a. If a prior authorization is required for a specific outpatient or inpatient service in-state, then a prior authorization is also required for an out-of-state outpatient or inpatient service by the Nevada Medicaid Quality Improvement Organization (QIO)-like vendor. The QIO-like vendor's determination will consider the availability of the services within the State. If the recipient is being referred out-of-state by a Nevada physician, the Nevada physician is required to obtain the prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.

b. 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.

c. All service physicians must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. (See Medicaid Services Manual (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 and electroencephalogram 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).

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 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 physical therapist, 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.

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

c. 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.

d. 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.

e. Home Health Agency (HHA)

Home Health Agency 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.

f. Laboratory

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

g. Diagnostic Testing

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

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.

603.3 FAMILY PLANNING SERVICES

State and federal regulations grant the right for eligible Medicaid recipients of either sex of child-bearing age to receive family planning services provided by any participating clinics, physician, physician's assistant, nurse practitioner, certified nurse midwife, or pharmacy.

Females, who are enrolled for pregnancy-related services only, are covered for all forms of family planning, including tubal ligation and birth control implantation up to 60 days post partum including the month in which the 60th day falls.

Abortions (surgical or medical) and/or hysterectomies are not included in Family Planning Services. They are a Medicaid benefit for certain therapeutic medical diagnoses.

Family Planning Services and supplies are for the primary purpose to prevent and/or space pregnancies.

a. Prior authorization is not required for:

1. Physician services.

2. Physical examination.

3. Annual pap smear for family planning.

4. Birth control devices which include but are not limited to the following:

a. Intrauterine contraceptive device (IUD);

b. Birth control pills;

c. Diaphragm;

d. Foam and/or jelly;

e. Condoms;

f. Implanted contraception capsules/devices;

Note: When a woman has an implanted device inserted, she may no longer be eligible for Medicaid when it is time to remove the implant. There is no process for Medicaid reimbursement when the recipient is not Medicaid-eligible.

g. Depo-Provera injections; (if drug obtained by Rx, physician bills for IM admin only). If in the case of birth control injections the only service rendered is the injection, an appropriate minimal office visit may be listed in addition to the injection.

h. Vaginal suppositories;

i. Contraceptive dermal patch; and/or

j. Contraceptive injection, other.

5. Vasectomy or tubal ligation (age 21 and over). In accordance with federal regulations, the recipient must fill out a consent form at least 30 days prior to the procedure. The physician is required to send the consent form to the fiscal agent with the initial claim. (See Attachment-B for consent forms).

b. Medicaid has removed all barriers to family planning counseling/education provided by qualified physicians. (e.g., Physicians, Rural Health Clinics/Federally Qualified Clinics, Indian Health Services/Tribal Clinics, and Home Health Agencies, etc.) The physician must provide adequate counseling and information to each recipient when they are choosing a birth control method. If appropriate, the counseling should include the information that the recipient must pay for the removal of any implants when the removal is performed after Medicaid eligibility ends.

c. Family planning education is considered a form of counseling intended to encourage children and youth to become comfortable discussing issues such as sexuality, birth control and prevention of sexually transmitted disease. It is directed at early intervention and prevention of teen pregnancy. Family planning services may be provided to any eligible recipient of childbearing age (including minors who can be considered to be sexually active).

d. Family Planning Services are not covered for those recipients, regardless of eligibility, whose age or physical condition precludes reproduction.

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 C-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

1. Reimbursement for Avoidable C-Sections

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 or avoidable cesarean sections will be reviewed to determine medical necessity. Those cesarean sections that do not qualify for medical necessity will be reimbursed at the same rate as a vaginal delivery.

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 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.

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 not a Medicaid benefit. Obtain authorization from the QIO-like vendor for covered medically necessary (e.g., phimosis) circumcision prior to the service.

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

603.4A COVERAGE AND LIMITATIONS

1. Ultrasound coverage includes, but is not limited to:

   a. Suspected abnormality in pregnancy, such as:

      1. Suspected ectopic pregnancy;

      2. Suspected hydatiform mole;

      3. Threatened or missed abortion;

      4. Congenital malformation, fetal or maternal;

      5. Polyhydramnios;

      6. Oligohydramnios;

      7. Placenta previa;

      8. Abruptio placenta; or

      9. Vaginal bleeding.

   b. Medical conditions threatening the fetus and/or delivery, such as:

      1. Suspected abnormal presentation;

      2. Suspected multiple gestation;

      3. Significant difference between the size of the uterus and the expected size based on EDC (> 3 cm);

      4. Elevated maternal serum alpha-fetoprotein;

      5. Suspected fetal death;

      6. Suspected anatomical abnormality of uterus;

      7. Maternal risk factors, such as family history of congenital anomalies or chronic systemic disease (hypertension, diabetes, sickle cell disease, anti-phospholipid syndrome, poorly controlled hyperthyroidism,

hemoglobinopathies, cyanotic heart disease, systemic lupus erythematosus) or substance abuse;

8. Suspected macrosomia; or

9. Intrauterine Growth Retardation-IUGR ($\leq 15^{th}$ percentile of the combined biometrical parameters-biparietal diameter, head circumference, abdominal circumference, head/abdominal circumference ration, length of femur and length of humerus, and estimated fetal weight).

c. Confirmation of the EDC when clinical history and exam are uncertain. In general, a single ultrasound performed between 14 and 24 weeks is sufficient for this purpose.

d. Diagnosis of "decreased fetal movement" (accompanied by other clinical data, i.e. abnormal kick counts).

e. Follow up ultrasounds which may be considered medically necessary if the study will be used to alter or confirm a treatment plan.

2. Noncoverage - Ultrasound is not covered when it fails to meet the medical necessity criteria listed above or for the reasons listed below:

a. When the initial screening ultrasound (regardless of trimester) is within normal limits or without a significant second diagnosis.

b. When used solely to determine the sex of the neonate, or to provide the mother with a picture of the baby.

603.4B PROVIDER RESPONSIBILITY

1. For repeat evaluations, documentation should include, at a minimum:

a. Documentation of the indication for the study (abnormality or high risk factors).

b. Crown-rump length (CRL).

c. Biparietal diameter (BPD).

d. Femur length (FL).

e. Abdominal circumference (AC).

f. Re-evaluation of organ system.

g. Placental location.

h. Number of fetuses (embryos).

i. Amniotic fluid volume assessment (qualitative or quantitative).

1. Oligohydramnios.

2. Polyhydramnios.

j. Intrauterine growth restriction (IUGR).

The following table offers a guideline for biophysical profile.

BPP SCORE	**ASSESSMENT**	**MANAGEMENT**
10/10 or 8/10 with normal AFV*	Low risk	• for high risk pregnancies • may repeat in 1 week
8/10 with abnormal AFV*	High Risk	re-eval for AVF* within 24 hours**
6/10 with normal AFV*	Equivocal Result	may repeat in 24 hours**
6/10 with abnormal AFV*	High Risk	may repeat in 24 hours**
0/10, 2/10, 4/10	High Risk	intervention or delivery

*AFV – Amniotic Fluid Volume

**The repeat biophysical profile must clearly indicate the previous abnormal result and reason for repeating this exam.

2. Abortion/Termination of pregnancy

a. Reimbursement is available for an induced abortion to save the life of the mother, only when a physician has attached a signed certification to the claim that on the basis of his/her professional judgment, and supported by adequate documentation, the life of the mother would be endangered if the fetus were carried to term. (See Attachment G or substitute any form that includes the required information.)

b. Reimbursement is available for induced abortion services resulting from a sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to the claim (See Attachment H or substitute any form that includes the required information). The Nevada mandatory reporting laws related to child abuse and neglect must be followed for all recipients under the age of 18 and physicians are still required to report the incident to Child Protective Services (CPS) through

the Division of Child and Family Services (DCFS) or, in some localities, through County Child Welfare Services.

c. Reimbursement is available for the treatment of incomplete, missed, or septic abortions under the criteria of medical necessity. The claim should support the procedure with sufficient medical information and by diagnosis. No certification or prior authorization is required.

NOTE: Any abortion that involves inpatient hospitalization requires a prior authorization from the QIO-like vendor. See MSM Chapter 200 for further information.

3. Hysterectomy

According to federal regulations, a hysterectomy is not a family planning (sterilization) procedure. Hysterectomies performed solely for the purpose of rendering a female incapable of reproducing are not covered by Medicaid. All hysterectomy certifications must have an original signature of the physician certifying the forms. A stamp or initial by billing staff is not acceptable. Payment is available for hysterectomies as follows:

a. Medically Necessary – A medically necessary hysterectomy may be covered only when the physician securing the authorization to perform the hysterectomy has informed the recipient or her representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the recipient permanently incapable of reproducing, and the recipient or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form (See Attachment E, at the end of this chapter for a sample of the form).

b. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form is also required. Therefore, it is advisable to inform the recipient or her authorized representative prior to the exploratory surgery or biopsy.

c. Emergency – The physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The completed Physician Statement must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, and anesthesiologist). The physician must include a description of the nature of the emergency and this certification must be dated after the emergency. The recipient does not have to sign this form. An example of this situation would be when the recipient is admitted to the hospital through the emergency room for immediate medical care and the recipient is unable to understand and respond to information pertaining to the acknowledgment

of receipt of hysterectomy information due to the emergency nature of the admission.

d. Sterility – The physician who performs the hysterectomy certifies in writing that the recipient was already sterile at the time of the hysterectomy and needs to include a statement regarding the cause of the sterility. The completed Physician Statement must be attached to each claim form related to the hysterectomy. The recipient does not have to sign the form. (For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.)

e. Hysterectomies Performed During a Period of Retroactive Eligibility – Reimbursement is available for hysterectomies performed during periods of retroactive eligibility. In order for payment to be made in these cases, the physician must submit a written statement certifying one of the following conditions was met:

1. He or she informed the woman before the operation the procedure would make her sterile. In this case, the recipient and the physician must sign the written statement; or,

2. The woman met one of the exceptions provided in the physician's statement. In this case, no recipient signature is required. Claims submitted for hysterectomies require the authorization number for the inpatient admission. The authorization process will ensure the above requirements were met. Payment is not available for any hysterectomy performed for the purpose of sterilization or which is not medically necessary.

603.5 ANNUAL GYNECOLOGIC EXAM

Nevada Medicaid reimburses providers for annual preventative gynecological examinations, along with the collection of a Pap smear, for women who are or have been sexually active or are age 18 or older. The examinations include breast exam, pelvic exam and tissue collection (also known as Pap smear).

603.6 CHIROPRACTIC SERVICES POLICY

Medicaid will pay for a chiropractic manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuro-musculoskeletal condition for which manipulation is the appropriate treatment.

Services are limited to Medicaid eligible children under 21 years of age and Qualified Medicare Beneficiaries (QMB's).

a. Prior authorization is not required for:

1. Four or less chiropractic office visits (emergent or non-emergent) for children under 21 years of age in a rolling 365 days. The visits must be as a direct result of an EPSDT screening examination, diagnosing acute spinal subluxation.

2. Chiropractic services provided to a QMB recipient.

b. Prior authorization is required for:

Chiropractic visits for children under 21 years of age whose treatment exceeds the four visits. The physician must contact the Nevada Medicaid QIO-like vendor for prior authorization.

603.7 PODIATRY

Podiatry services are those services provided by health professionals trained to diagnose and treat diseases and other disorders of the feet. A podiatrist performs surgical procedures and prescribes corrective devices, medications and physical therapy. For Nevada Medicaid recipient's podiatric services are limited to Qualified Medicare Beneficiary recipients and Medicaid eligible children referred as the result of a Healthy Kids (EPSDT) screening examination.

a. Prior Authorization

1. Prior authorization is not required for podiatric office visits provided for children as a direct result of a Healthy Kids (EPSDT) screening examination).

2. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination or a surgical procedure must be billed using the appropriate Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS) code. Medicaid will pay for the orthotic in addition to the office visit.

3. Prior authorization is not required for Podiatry services provided to a QMB or QMB/MED recipient. Medicaid automatically pays the co-insurance and deductible up to Medicaid's maximum reimbursement after Medicare pays. If Medicare denies the claim, Medicaid will also deny payment.

b. Non Covered Services

Preventive care including the cleaning and soaking of feet, the application of creams to insure skin tone, and routine foot care are not covered benefits. Routine foot care includes the trimming of nails, cutting or removal of corns and calluses in the absence of infection or inflammation.

603.8 PHYSICIAN SERVICES PROVIDED IN OUTPATIENT CLINICS

A. Rural Health Clinic/Federally Qualified Health Center(RHC/FQHC)

1. Medicaid covered outpatient services provided in RHC's and/or FQHC's are reimbursed at an all inclusive per recipient per encounter rate. Regardless of the number or types of providers seen, only one encounter is reimbursable per day.

This all-inclusive rate includes any one or more of the following services and medical professionals:

a. Physician (MD/DO)

b. Dentist

c. Advance Practice Registered Nurse

d. Physician Assistant

e. Certified Registered Nurse Anesthetist

f. Certified Registered Nurse Midwife

g. Psychologist

h. Licensed Clinical Social Worker

i. Registered Dental Hygienist

j. Podiatrist

k. Radiology

l. Optometrist

m. Optician (including dispensing of eyeglasses)

n. Clinical Laboratory

2. Encounter codes are used for primary care services provided by the FQHCs and RHCs in the following areas:

a. Core visits include the following:

1. Medical and dental office visits, patient hospital visits, injections and oral contraceptives;

2. Women's annual preventive gynecological examinations; and

3. Colorectal screenings.

b. Home visit.

c. Family planning education.

Up to two times a calendar year the RHC/FQHC may bill for additional reimbursement along with the encounter rate.

3. For billing instructions for RHC/FQHCs, please refer to Billing Manual for Provider Type 17.

B. Indian Health Programs (IHP)

Please refer to MSM Chapter 3000.

603.9 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and Certified Registered Nurse Anesthetists (CRNA) are based on the Centers for Medicare and Medicaid Services (CMS) base units.

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

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

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

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

1. Type of surgery;

2. Length of time;

3. Diagnosis;

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

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

603.10 PHYSICIAN SERVICES IN OUTPATIENT SETTING

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

Services requiring prior authorization include the following:

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

2. Bariatric surgery for Morbid Obesity;

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

4. Diabetes training exceeding 10 hours;

5. Vagus nerve stimulation; and

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

B. Emergency Room Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Observation Services Provided By The Physician

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

2. Observation services are conducted by the hospital to evaluate a recipient's condition or to assess the need for inpatient admission. It is not necessary that the recipient be located in a designated observation area such as a separate unit in the

3. hospital, or in the emergency room in order for the physician to bill using the observation care CPT codes, but the recipient's observation status must be clear.

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

   a. Send the recipient home;

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

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

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

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

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

1. Treatment of ESRD in a physician-based (i.e. hospital outpatient) or independently operated ESRD facility certified by Medicare is a Medicaid covered benefit. Medicaid is secondary coverage to Medicare for ESRD treatment except in rare cases when the recipient is not eligible for Medicare benefits. In those cases, private insurance and/or Medicaid is the primary coverage

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

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

4. Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are covered services for hemodialysis and Continuous Ambulatory Peritoneal Dialysis

(CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.

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

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

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

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

1. Prior authorization is not required when:

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

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

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

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

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

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

   c. Designated podiatry procedures; and

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

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

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

   b. Fabric wrapping of abdominal aneurysm;

   c. Intestinal bypass surgery for treatment of obesity;

   d. Transvenous (catheter) pulmonary embolectomy;

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

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

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

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

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

   j. Gastric balloon for the treatment of obesity;

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

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

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

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

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

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

b. Noncovered conditions for bone marrow/stem cell:

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

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

c. Corneal – allograft/homograft;

d. Kidney – allotransplantation/autotransplantation; and

e. Liver – transplantation for children (under age 21) with extrahepatic biliary atresia or for children or adults with any other form of end-stage liver disease. Coverage is not provided with a malignancy extending beyond the margins of the liver or those with persistent viremia.

5. Prior authorization is required for bone marrow, kidney, and liver transplants from Medicaid's contracted QIO-like vendor.

6. A transplant procedure shall only be approved upon a determination that it is a 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; or

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.

d. If the authorization request is for chemotherapy to be used as a preparatory therapy for transplants, an approval does not guarantee authorization for any harvesting or transplant that may be part of the treatment regimen. A separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out of state.

603.11 SERVICES IN THE ACUTE HOSPITAL SETTING

A. Admissions to acute care hospitals both in and out of state are limited to those authorized by Medicaid's QIO-like vendor as medically necessary and meeting Medicaid benefit criteria.

B. Physicians may admit without prior approval only in the following situations:

1. An emergency (defined in MSM Chapter 100);

2. Obstetrical labor and delivery; or

3. Direct Admission from doctor's office.

C. All other hospital admissions both in-state and out-of-state must be prior authorized by the QIO-like vendor. Payment will not be made to the facility or to the admitting physician, attending physician, consulting physician, anesthesiologist, or assisting surgeons denied by the QIO-like vendor admissions.

D. Attending physicians are responsible for ordering and obtaining prior authorization for all transfers from the acute hospital to all other facilities.

E. Physicians may admit recipients to psychiatric and/or substance abuse units of general hospitals (regardless of age), or freestanding psychiatric and substance abuse hospitals for recipients 65 and older or those under the age of 21. All admissions must be prior

authorized by the QIO-like vendor with the exception of a psychiatric emergency. Refer to MSM Chapter 400 for coverage and limitations.

F. Inpatient Hospital Care

1. Routine Inpatient Hospital Care is limited to reimbursement for one visit per day (same physician or physicians in the same group practice) except when extra care is documented as necessary for an emergency situation (e.g., a sudden serious deterioration of the recipient's condition).

2. The global surgical package includes the following when provided by the physician who performs the surgery, whether in the office setting, out-patient or in-patient:

   a. Preoperative visits up to two days before the surgery;

   b. Intraoperative services that are normally a usual and necessary part of a surgical procedure;

   c. Services provided by the surgeon within the Medicare recommended global period of the surgery that do not require a return trip to the operating room; and follow-up visits related to the recovery from the surgery which are provided during this time by the surgeon; and

   d. Post surgical pain management.

3. The surgeon's initial evaluation or consultation is considered a separate service from the surgery and is paid as a separate service, even if the decision, based on the evaluation, is not to perform the surgery. If the decision to perform a major surgery (surgical procedures with a 90-day global period) is made on the day of or the day prior to the surgery, separate payment is allowed for the visit on which the decision is made, however supporting documentation may be requested. If post payment audits indicate documentation is insufficient to support the claim, payment will be adjusted accordingly.

4. If a recipient develops complications following surgery that requires the recipient to be returned to the operating room for any reason for care determined to be medically necessary, these services are paid separately from the global surgery amount. Complications that require additional medical or surgical services but do not require a return trip to the operating room are included in the global surgery amount.

5. Payment may be made for services by the surgeons that are unrelated to the diagnosis for which the surgery was performed during the post operative period. Supportive documentation may be requested. Services provided by the surgeon for treating the underlying condition and for a subsequent course of treatment that is not part of the normal recovery from the surgery are also paid separately. Full payment for the procedure is allowed for situations when distinctly separate but related procedures are performed during the global period of another surgery in which the recipient is admitted to the hospital for treatment, discharged, and then readmitted for further treatment.

6. Payment for physician services related to patient-controlled analgesia is included in the surgeon's global payment. The global surgical payment will be reduced if post-payment audits indicate that a surgeon's recipients routinely receive pain management services from an anesthesiologist. (For a list of covered codes, please refer to the billing manual).

7. For information on payment for assistant surgeons, please refer to the billing manual.

8. There is no post-operative period for endoscopies performed through an existing body orifice. Endoscopic surgical procedures that require an incision for insertion of a scope will be covered under the appropriate major or minor surgical policy which will include a post-operative period according to the Medicare recommended global period.

9. For some dermatology services, the CPT descriptors contain language, such as "additional lesion", to indicate that multiple surgical procedures have been performed. The multiple procedure rules do not apply because the RVU's for these codes have been adjusted to reflect the multiple nature of the procedure. These services are paid according to the unit. If dermatologic procedures are billed with other procedures, the multiple surgery rules apply. For further information, please refer to the billing manual.

10. Critical Care

Critical Care, the direct delivery of medical care by a physician or physicians for a critically ill or critically injured recipient to treat a single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the recipient's conditions, is reimbursed by Medicaid. Reimbursement without documentation is limited to a critical illness or injury which acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the recipient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system

functions. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology, critical care may be provided in life threatening situations when these elements are not present.

a. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the recipient, provided that the recipient's condition continues to require the level of physician attention described above. Providing medical care to a critically ill, injured, or post-operative recipient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

b. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

c. Services for a recipient who is not critically ill but happen to be in a critical care unit, are reported using other appropriate evaluation/management (E/M) codes.

d. According to CPT, the following services are included in reporting critical care when performed during the critical period by the physicians providing critical care: the interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) gastric intubation, temporary transcutaneous pacing, ventilatory management and vascular access procedures. Any services performed which are not listed above should be reported separately.

e. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient.

11. Neonatal and Pediatric Critical Care

a. Neonatal and Pediatric Critical Care CPT codes are used to report services provided by a single physician directing the care of a critically ill neonate/infant. The same definitions for critical care services apply for the adult, child and neonate. The neonatal and pediatric critical care codes are

global 24-hour codes (billed once per day) and are not reported as hourly services consistent with CPT coding instructions.

b. Neonatal critical care codes are used for neonates (28 days of age or less) and pediatric critical care codes are used for the critically ill infant or young child age 29 days through 71 months of age, admitted to an intensive or critical care unit. These codes will be applicable as long as the child qualifies for critical care services during the hospital stay.

c. If the physician is present for the delivery and newborn resuscitation is required, the appropriate E&M code can be used in addition to the critical care codes.

d. Care rendered under the pediatric critical care codes includes management, monitoring, and treatment of the recipient including respiratory, enteral and parenteral nutritional maintenance, metabolic and hematologic maintenance, pharmacologic control of the circulatory system, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

e. In addition to critical services for adults, the pediatric and neonatal critical care codes also include the following procedures:

1. peripheral vessel catheterization;

2. other arterial catheters;

3. umbilical venous catheters;

4. central vessel catheters;

5. vascular access procedures;

6. vascular punctures;

7. umbilical arterial catheters;

8. endotracheal intubation;

9. ventilator management;

10. bedside pulmonary function testing;

11. surfactant administration;

12. continuous positive airway pressure (CPAP);

13. monitoring or interpretation of blood gases or oxygen saturation;

14. transfusion of blood components;

15. oral or nasogastric tube placement;

16. suprapubic bladder aspiration;

17. bladder catheterization; and

18. lumbar puncture.

Any services performed which are not listed above, may be reported separately.

f. Initial and Continuing Intensive Care Services are reported for the child who is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, or for services provided by a physician directing the continuing intensive care of the Low Birth Weight (LBW) (1500-2500 grams) present body weight infant, or normal (2501-5000 grams) present body weight newborn who does not meet the definition of critically ill, but continues to require intensive observation, frequent interventions, and other intensive care services.

603.12 PHYSICIAN'S SERVICES IN NURSING FACILITIES

A. Physician services provided in a Nursing Facility (NF) are a covered benefit when the service is medically necessary. Physician visits must be conducted in accordance with federal requirements for licensed facilities. Reference MSM Chapter 500 for coverage and limitations.

B. When the recipient is admitted to the NF in the course of an encounter in another site of service (e.g., hospital ER, physician's office), all E/M services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. Admission documentation and the admitting orders/plan of care should include the services related to the admission he/she provided in the other service sites.

C. Hospital discharge or observation discharge services performed on the same date of NF admission or readmission may be reported separately. For a recipient discharged from inpatient status on the same date of nursing facility admission or readmission, the hospital discharge services should be reported as appropriate. For a recipient discharged from observation status on the same date of NF admission or readmission, the observation care discharge services should be reported with the appropriate CPT code.

603.13 PHYSICIAN'S SERVICES IN OTHER MEDICAL FACILITIES

A. Intermediate Care Facility/Mentally Retarded (ICF/MR)

A physician must certify the need for ICF/MR care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/MR, before the Nevada Medicaid Office authorizes payment.) The certification must refer to the need for the ICF/MR level of care, be signed and dated by the physician and be incorporated into the resident's record as the first order in the physician's orders.

Recertification by a physician or a nurse practitioner of the continuing need for ICF/MR care is required within 365 days of the last certification. In no instance is recertification acceptable after the expiration of the previous certification. For further information regarding ICF/MR refer to MSM Chapter 1600.

B. Residential Treatment Center (RTC)

Physician services, except psychiatrist are not included in the all inclusive facility rate for RTCs. Please reference MSM Chapter 400.

604 HEARINGS

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

ATTACHMENT A

RESERVED

POLICY #6-02	WOUND MANAGEMENT	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-01

DESCRIPTION

A wound is defined as impaired tissue integrity that may involve the epidermis, dermis, and subcutaneous tissue, and may extend down to the underlying fascia and supporting structures. The wound may be aseptic or infected.

POLICY

Wound care is a Nevada Medicaid covered benefit for recipients who have a viable healing process.

PRIOR AUTHORIZATION IS NOT REQUIRED

COVERAGE AND LIMITATIONS

The patient's medical record must include a comprehensive wound history that includes date of onset, location, depth and dimension, exudate characteristics, circulatory, neuropathy, and nutritional assessments, current management and previous treatment regime. The provider must culture all infected wounds prior to initiating systemic antibiotics, per Center for Disease Control guidelines. Photographs are necessary to establish a baseline and to document the progress of the wound, as are weekly measurements. Physicians are expected to educate recipients about the disease process, how to manage their own wound care, and the importance of complying with the treatment plan. This education should be documented in the recipient's medical record.

The use of supplies during wound care treatment is considered part of the treatment. Do not bill separately.

Burn Care

Burn care provided in the outpatient hospital setting will follow wound care guidelines with the exception of requiring a prior authorization.

All ICD-9-CM diagnosis codes must be coded to the highest level of specificity.

COVERED CPT CODES: For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-03	OUTPATIENT HOSPITAL BASED HYPERBARIC OXYGEN THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-03

DESCRIPTION

Hyperbaric oxygen therapy (HBOT) is therapy in which a recipient breathes 100% oxygen intermittently while the pressure of the treatment chamber is increased to a point higher than sea level pressure (i.e.,>1 atm abs.). Breathing 100% oxygen at 1 atm of pressure or exposing isolated parts of the body does not constitute HBOT; the recipient must receive the oxygen by inhalation within a pressurized chamber.

POLICY

This Nevada Medicaid benefit is covered in an outpatient hospital, with limitations, for chronic conditions. Payment will be made where HBOT is clinically practical. HBOT is not to be a replacement for other standard successful therapeutic measures. Treatment of acute conditions, e.g., acute carbon monoxide intoxication, decompression illnesses, cyanide poisoning, and air or gas embolism may be provided in an outpatient hospital.

PRIOR AUTHORIZATION IS REQUIRED for chronic conditions (see billing manual)

PRIOR AUTHORIZATION IS NOT REQUIRED for acute conditions (see billing manual)

Documentation supporting the reasonableness and necessity of the procedure must be in the recipient's medical record including recipient's risk factors and submitted with the PA when required.

COVERAGE AND LIMITATIONS

1. Wound Therapy

   Approval will be restricted to requests documenting that the wound has not responded to conventional treatments as outlined in the WOUND MANAGEMENT POLICY (6-02), and initiated by a physician. Attach a copy of the physician's order to the request for treatment. Maximum numbers of treatments authorized on consecutive days are 45. Therapy is conducted once or twice daily for a maximum of 2 hours each treatment.

2. HBOT must be provided and attended by an HBOT physician. Reimbursement will be limited to therapy provided in a chamber (including the one person unit). No payment will be made for topical HBOT, or for other than the covered diagnosis.

   COVERED ICD-9-CM CODES: For a list of covered procedure and diagnosis codes, please refer to the billing manual.

DESCRIPTION/POLICY

FDA approved ITB is a Nevada Medicaid covered benefit for recipients with severe spasticity of spinal cord origin, (e.g. Multiple Sclerosis (MS), Spinal Cord Injury (SCI), or spasticity of cerebral origin, e.g., Cerebral Palsy (CP), and Brain Injury (BI)), who are unresponsive to oral Baclofen therapy or who have Intolerable Central Nervous System (CNS) side effects.

PRIOR AUTHORIZATION IS NOT REQUIRED

COVERAGE AND LIMITATIONS

Coverage of treatment will be restricted to recipients with the following indicators:

Spasticity due to CP or BI (if BI, the injury must have occurred over one year prior to be considered for ITB therapy;

Severe spasticity (as defined by a score of 3 or more on the Ashworth Scale) in the extremities for a duration of six months or longer;

Recipients with increased tone that significantly interferes with movement and/or care;

Spasm score of 2 or more; documentation to include pre and post testing of strength, degree of muscle tone, and frequency of spasm (Spasm Scale not applicable to CP recipients as spasms are not a frequent symptom in these recipients;

Recipient is four years or older and has sufficient body mass to support the infusion pump;

Documented six-weeks or more of failed oral antispasmodic drug therapy at the maximum dose. Recipient is refractory to oral Baclofen, or has intolerable side effects;

Recipient has adequate cerebrospinal fluid flow as determined by myelogram or other studies;

Recipient has no known allergy to Baclofen;

Documentation of a favorable response to a trial dose of ITB prior to pump implantation. If recipient requires a second and/or third trial dose of ITB, documentation needs to include videotape of the recipient's arm and leg range of motion to assess spasticity and muscle tone before and after increased test doses of ITB. Recipients who do not respond to a 100-mcg intrathecal bolus of medication are not candidates for an implanted pump for chronic infusion therapy. Recipient must be free of infection at the time of the trial dose;

Recipient, family, and physicians should agree on treatment goals. Recipient, family and caregivers should be motivated to achieve the treatment goals and be committed to meet the follow-up care requirements;

Recipient must be free of systemic infection and/or infection at the implantation site at the time of surgery;

Benefit coverage includes up to three trial doses of ITB, surgical implantation of the device, and follow-up physician office visits for dose adjustments and pump refills.

Documentation in the recipient's medical record should include what the expected functional outcomes and improvements in quality of life are for the recipient post procedure, e.g., increased independence, ease of caretaking activities, decreased pain, increased ADL's, and improved communication. Also, document why the recipient is not a candidate for Botox injections.

Reimbursement for recipients with low muscle tone (often described as floppy muscles), chorea (uncontrollable, small jerky types of movements of toes and fingers), or athetosis (involuntary movements of face, arms or trunk) are not a Nevada Medicaid benefit.

COVERED CODES: For a list of covered procedure and diagnostic codes, please see the billing manual.

RESERVED FOR FUTURE USE

DESCRIPTION

Vagus Nerve Stimulation (VNS) is a method for treating recipients with refractory epilepsy who are not candidates for intracranial surgery and/or continue to be refractory following epilepsy surgery. The programmable NeuroCybernetic Prosthesis (NCP) is surgically implanted in the upper left chest with the leads tunneled to the vagus nerve in the left neck. An external magnet is provided to activate the generator and deliver additional impulses when needed. The external magnet may also be used to inhibit the NCP generator in the event of a malfunction.

POLICY

The Vagus Nerve Stimulator (VNS) is a covered Nevada Medicaid benefit. The benefit includes diagnostic EEG, surgical procedure, device and medically necessary follow-up office visits for analysis and reprogramming.

PRIOR AUTHORIZATION IS REQUIRED: Documentation supporting the medical necessity of the procedure must be in the recipient's medical record and submitted with the PA when required.

COVERAGE AND LIMITATIONS

Implantation of VNS is used as an adjunctive therapy in reducing the frequency of seizures in adults and children over age six who have seizures which are refractory to Antiepileptic Drugs (AED). It is also indicated in recipients for whom surgery is not an option, or in whom prior surgery has failed.

Coverage is restricted to those recipients with the following indicators:

- Diagnosis of intractable epilepsy;
- Failed antiepileptic drug (AED) therapy tried for two to four months. The medical record should indicate changes/alterations in medications prescribed for the treatment of the recipient's condition. Documentation to include maintaining a constant therapeutic dose of AED as evidenced by laboratory results per manufacturer's recommendations;
- Have six or more medically intractable seizures per month;
- Have no other independent diagnosis that could explain why seizures are failing to respond to treatment;
- A recipient whose epileptologist/neurologist has recommended VNS implantation;
- A surgeon experienced with implantation of the VNS;
- The VNS will be managed by a physician familiar with the settings and protocols for use of the device;
- Recipients from three to six years of age must have all of the above indicators;

- Be the result of a Healthy Kids Screening (EPSDT) referral for treatment; and

- Be supported by peer review literature, and a written recommendation for VNS implantation and use from two Board Certified Pediatric Neurologists (other than the treating neurologist(s).

Reasons for non-coverage include, but are not limited to the following diagnoses/conditions: status epilepticus, progressive or unstable neurologic or systemic disorders, severe mental retardation, drug abuse, gastritis, gastric/duodenal ulcers, status post bilateral or left cervical vagotomy, unstable medical condition,

pregnancy, use of investigational AED's, bradycardia, hypersecretion of gastric acid and/or a seizure disorder etiology more appropriately treated by other means (i.e., operation).

COVERED CODES: For a list of covered procedure and diagnosis codes, please see the billing manual.

DESCRIPTION/POLICY

Bariatric Surgery is a covered Nevada Medicaid benefit reserved for recipients with severe and resistant morbid obesity in whom efforts at medically supervised weight reduction therapy have failed and who are disabled from the complications of obesity. Morbid obesity is defined by Nevada Medicaid as those recipients whose Body Mass Index (BMI) is 35 or greater, and who have significant disabling comorbidity conditions which are the result of the obesity or are aggravated by the obesity. Assessment of obesity includes BMI, waist circumference, and recipient risk factors, including family history.

This benefit includes the initial work-up, the surgical procedure and routine post surgical follow-up care. The surgical procedure is indicated for recipients between the ages of 21 and 55 years with morbid obesity. (Potential candidates older than age 55 will be reviewed on a case by case basis.)

PRIOR AUTHORIZATION IS REQUIRED

Documentation supporting the reasonableness and necessity of bariatric surgery must be in the recipient's record and submitted with the PA.

COVERAGE AND LIMITATIONS

Coverage is restricted to recipients with the following indicators:

1. BMI of 35 or greater;
2. Waist circumference of more than 40 inches in men, and more than 35 inches in women;
3. Obesity related comorbidities that are disabling;
4. Strong desire for substantial weight loss;
5. Well-informed and motivated;
6. Commited to a lifestyle change; and
7. Negative history of significant psychopathology that contraindicates this surgical procedure.

Documentation supporting the reasonableness and necessity of the surgery must be in the medical record, and should include evidence of participation in a medically supervised weight loss program for a minimum of three months prior to the surgery. There must also be documentation of weight loss therapy participation including recipient efforts at dietary therapy, physical activity, behavior therapy, pharmacotherapy, combined therapy or any other medically supervised therapy.

No coverage will be provided for pregnant women, women less than six months postpartum, or women who plan to conceive in a time frame less than 18 to 24 months post gastric bypass surgery.

COVERED CODES: For a list of covered procedure codes, please see the billing manual.

REFERENCES:

1. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5013.pdf

2. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf

DESCRIPTION

Hyalgan and Synvisc are injectable drugs that are used to treat osteoarthritis of the knee. These solutions act like an "oil" to cushion and lubricate the knee joint. Hyalgan is injected directly into the osteoarthritic knee for a single course of treatment. Injections are administered one week apart for a total of five injections. Synvisc is administered as a total of three intra-articular injections into the knee joint during a three week period. Each course of treatment must be performed by a qualified physician.

POLICY

Hyalgan and Synvisc injectables are a covered Nevada Medicaid benefit for the treatment of pain due to osteoarthritis of the knee. Diagnosis must be supported by radiological evidence.

Repeat treatment is not reimbursable, as it is not medically indicated, if the first course of treatment is not beneficial to the recipient.

PRIOR AUTHORIZATION IS NOT REQUIRED

COVERAGE AND LIMITATIONS

Hyalgan and Synvisc are indicated for recipients who do not obtain adequate relief from simple pain medication and/or from exercise and physical therapy.

An Evaluation & Management (E&M) service will not be covered during subsequent visits for injections unless there is a separately identifiable problem.

DESCRIPTION

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are a covered service 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.

PRIOR AUTHORIZATION IS NOT REQUIRED

COVERAGE AND LIMITATIONS

A physician's service furnished to dialysis recipients who are treated as outpatients, are divided into two major categories: direct recipient care and administrative.

Physician's evaluation and management-type services, "unrelated" to the dialysis procedure (not provided during a dialysis treatment) may be billed in addition to the dialysis procedure.

Physicians providing evaluation and management-type services "related" to the dialysis procedure same day dialysis is performed, or during a dialysis treatment) are billed as included in the dialysis procedure. Service units equal number of treatments. (Fee schedule paid to physician.)

Criteria for instituting IDPN/IPN:

- Three month average predialysis serum albumin level of <3.4 mg/dl.
- Three month average predialysis serum creatine of <8.0 mg/dl.
- Three month average predialysis serum pre-albumin level of <25 mg/dl.
- Weight loss of 7.5% of usual body weight over 3 months.
- A clinical exam consistent with moderate to severe malnutrition.
- A dietary history of reduced food intake (protein <0.8 g/kg/day; calories <25 cal/kg/day).
- Failed attempts at dietary and oral supplementation.
- Eternal tube feeding contraindicated.

- Gastrointestinal diagnosis, supported by GI consult, GI medications (Prilosec, Reglan, Imodium, etc.).

Criteria for discontinuing IDPN/IPN:

- Three month average predialysis serum albumin level of >3.8 mg/dl.
- Three month average predialysis serum creatine of >10 mg/dl.
- Three month average predialysis serum pre-albumin level of >28 mg/dl.
- A clinical exam consistent with improved nutritional status.
- A dietary history of increased food intake (protein 1.0 g/kg/day; calories 30 cal/kg/day).
- Absence of active inflammation or other serious condition characterized by high albumin turnover.
- No improvement with IDPN/IPN treatment after six months.
- Complications or intolerance associated with IDPN/IPN treatment.

No coverage will be provided for situations involving temporary impairments (less than 90 days). No coverage will be provided if recipients are noncompliant with the plan of treatment.

DESCRIPTION

Nevada Medicaid defines Diabetic Outpatient Self-Management Training Services as the development of a specific treatment plan for Type I and Type II diabetics to include blood glucose self-monitoring, diet and exercise planning, and motivates recipients to use the skills for self-management.

Reimbursement will follow Medicare guidelines for initial recipient and group training sessions. For information regarding blood glucose monitors and diabetic supplies see Chapter 1300.

Services must be furnished by certified programs which meet the National Diabetes Advisory Board (NDAB) standards, and hold an Education Recognition Program (ERP) certificate from the American Diabetes Association. Program instructors should include at least a nurse educator and dietician with recent didactic and training in diabetes clinical and educational issues. Certification as a diabetes educator by the National Board of Diabetes Educators is required.

PRIOR AUTHORIZATION IS REQUIRED: When recipients require additional or repeat training sessions that exceed ten hours of training.

COVERAGE AND LIMITATIONS

The physician managing the recipient's diabetic condition certifies the comprehensive plan of care to provide the recipient with the necessary skills and knowledge in the management of their condition, and to ensure therapy compliance. The program must be capable of offering, based on target population need, instruction in the following content areas:

- Diabetes review.
- Stress and psychological adjustment.
- Family involvement and social support.
- Medications.
- Monitoring blood glucose and interpretation of results.
- Relationships between nutrition, exercise and activity, medication, and glucose levels.
- Prevention, detection, and treatment of both acute and chronic diabetic complications, including instruction related to care of feet, skin, and teeth.
- Behavioral change strategies, goal setting, risk factor reduction, and problem solving.
- Benefits, risks, and management options for improvement of glucose control.
- Preconception care, pregnancy, and gestational diabetes.

- Utilization of health care systems and community resources.

Indications for repeat training Prior Authorization (PA) is required for recipients whose diabetes is poorly controlled include:

- Hemoglobin A 1 c blood levels of 8.5 or greater.
- Four or more serious symptomatic hypoglycemic episodes in a two month period.
- Two or more hospitalizations for uncontrolled diabetes in a six month period.
- Any ketoacidosis or hyperosmolar state.
- Pregnancy in a previously diagnosed diabetic.
- Diabetics beginning initial insulin therapy.

No coverage will be provided for initial training which exceeds ten hours, or for repeat training, without a prior authorization.

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

DESCRIPTION

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 at ganglionic 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.

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)
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.

POLICY

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.

PRIOR AUTHORIZATION IS NOT REQUIRED

COVERAGE AND LIMITATIONS:

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).

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.

POLICY

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

PRIOR AUTHORIZATION: YES ☐ NO ☒

COVERAGE AND LIMITATIONS:

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

Topic	Description
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.
Blood pressure screening in adults*	The USPSTF recommends screening for high blood pressure in adults aged 18 and older.
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 screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.
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.
Depression screening: adults*	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
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: nonpregnant 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.
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
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.
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.
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 provide tobacco cessation interventions for those who use tobacco products.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.

Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

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

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.

POLICY

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

PRIOR AUTHORIZATION: YES ☐ NO ☒

COVERAGE AND LIMITATIONS:

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

Topic	Description
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.
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.
Blood pressure screening in adults*	The USPSTF recommends screening for high blood pressure in adults aged 18 and older.
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 adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic

	adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
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.
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
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 and provide tobacco cessation interventions for those who use tobacco products.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.

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

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.

POLICY

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

PRIOR AUTHORIZATION: YES ☐ NO ☒

COVERAGE AND LIMITATIONS:

The following preventive health services are covered by the Division of Health Care Financing and Policy (DHCFP) 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.
Depression screening: adolescents*	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and 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	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
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.
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.

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.

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

PRIOR AUTHORIZATION: YES ☐ NO ☒

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.

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

DESCRIPTION

School Based Health Centers (SBHCs) provide primary and preventive medical services to Medicaid and Nevada Check Up recipients. SBHCs are health centers located on or near a school facility of a school district, independent school, or board of an Indian tribe or tribal organization. An SBHC operates as a separate delivery model from School Based Child Health Services (SBCHS) provided through an Individual Education Plan (IEP).

POLICY

The center(s) will, through providers of healthcare operating within the scope of their practice under state law, be used exclusively to provide primary and preventive health services to children and adolescents in accordance with recommended guidelines. Each center will be organized through the school, community, and health care provider agreements, and will be administered by a sponsoring agency.

Staffing and providers include but are not limited to: Support Staff, Site Director, Immunization Coordinator, Medical Doctor, Osteopathic Doctor, Nurse Practitioner, Ph.D. of Nursing, Physician's Assistant, and Qualified Mental Health Professionals. The Division of Health Care Financing and Policy (DHCFP) reimburses for services that are medically necessary and performed by a qualified provider within the scope of practice as defined by state law.

PRIOR AUTHORIZATION

Medical services provided by SBHCs must follow prior authorization policy for each service provided under corresponding prior authorization rules throughout the Medicaid Services Manuals (MSMs).

COVERAGE AND LIMITATIONS

All services that are provided must be medically necessary (see MSM Chapter 100) to be considered covered SBHC services. Medically necessary services provided by a qualified provider practicing within their scope of work may include but are not be limited to:

- Primary and preventive health care and medical screenings;
- Treatment for common illnesses and minor injuries;
- Referral and follow-up for serious illnesses and emergencies;
- Care and consultation, as well as referral and follow-up for pregnancy, chronic diseases and disorders, and emotional and behavioral problems;
- Referral, preventive services, and care for high risk behaviors and conditions such as drug and alcohol abuse, violence, injuries, and sexually transmitted diseases;
- Sports physicals as part of a comprehensive well child check up;
- Immunizations;

- Diagnostic and preventive dental, and referral services; and
- Laboratory testing.

NON-COVERED SERVICES

Non-covered services include, but are not limited to:

- Services that are not medically necessary;
- Services that require prior authorization and one has not been obtained or approved; and
- Medical services listed on the recipient's IEP.

Note: An IEP is identified with SBCHS and are not covered under the SBHC.

PARENTAL CONSENT

A parent or guardian must sign a written consent form for a student to receive SBHC services. Once the parent signs the written consent form and the center-specific forms, the Health Center will provide or refer the student for any of the services that the child needs. Parents may indicate if they do not want the child to receive a specific service by writing the name of the service in the appropriate space on the center-specific form.

Although the Health Center will attempt to keep parents informed of the services their child receives, signing the Uniform Consent gives the Health Center permission to provide medical and behavioral health services to the child without contacting the parent each time the child visits the Center. Except in an emergency situation, no child is treated, counseled or referred without a consent form signed by a parent.

In emergencies, the Health Center will call the parent, but the Health Center is required by law to treat the child even when the parent cannot be reached.

MINOR CONSENT LAWS

Physicians practicing in SBHCs are governed by and must abide by the Nevada Revised Statutes (NRS) Minor's Consent for examination and treatment.

THIRD PARTY LIABILITY (TPL)

SBHCs must follow TPL and other health care coverage guidelines as set forth in the MSM Chapter 100 (Medicaid Program). There are no regulatory exceptions regarding TPL for SBHCs. SBHCs must bill the appropriate TPL and other health care coverage prior to submitting reimbursement claims to the Quality Improvement Organization (QIO)-like vender contracted with the DHCFP.

PROVIDER RESPONSIBILITIES

1. The provider must be certified by the Division of Public and Behavioral Health as an SBHC.
2. Enroll with the QIO-like vendor for Nevada Medicaid, meeting all provider qualifications as an SBHC.

3. Ensure the billing number and servicing number are the same.

4. Follow all billing guidelines for SBHCs.

5. Provider must work within the scope of services for each professional providing services.

Division of Health Care, Financing and Policy

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by and operation known as a_____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____.
Mo Day Year

I, _____, herby consent of my own free will to be sterilized by _____
(Doctor)

by a method called_____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, and Human services; or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
(Signature) Mo Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

ف American Indian or Alaska Native
ف Asian or Pacific Island
ف Black (not of Hispanic origin)
ف Hispanic
ف White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an Interpreter is provided to assist the Recipient to be sterilized:

I have translated the information and advice presented orally to the recipient to be sterilized by the person obtaining this consent.

I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter (Signature) (Date)

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
(name of recipient)

consent form I explained to him/her the nature of the sterilization operation_____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient to be sterilized that alternative methods of birth control are available which are temporary., I explained that sterilization is different because it is permanent.

I informed the recipient to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the recipient to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
(Signature of person obtaining consent) (Date)

_____
(Facility)

_____
(Address)

■ PHYSICIAN'S STATEMENT ■

(TO BE COMPLETED FOLLOWING SURGERY)

Shortly before I performed a sterilization operation upon _____on _____
(Name of recipient sterilized) (Date of sterilization operation)

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the recipient to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the recipient to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

Instructions for use of alternative final paragraphs: Use the first paragraph below when the sterilization is performed less than 30 days after the date of the recipient's signature on the consent form except in the case of premature delivery or emergency abdominal surgery. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used

.(1) At least thirty days have passed between the date of the recipient's signature on this consent form and the date the sterilization was performed.

This sterilization was performed less than 30 days but more than 72 hours after the date of the recipient's signature on this consent form because of the following circumstances: (check applicable box and fill in the information requested).

Premature delivery
Recipient's expected date of delivery_____
(Date)

Emergency abdominal surgery
Describe circumstances _____
_____
_____

(Physician's Signature) (Date)

STAMPED SIGNATURES ARE NOT ACCEPTABLE.
ALL APPLICABLE BLANKS MUST BE COMPLETED.

ACKNOWLEDGMENT

RECEIPT OF HYSTERECTOMY INFORMATION

(BEFORE SURGERY)

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be undone and it will permanently prevent you from having children. A hysterectomy should only be done when there is a disease of the woman's uterus (womb) or some other problem that can only be treated by removing the uterus (womb). It is a serious operation and there are discomforts and a chance of serious health problems.

A hysterectomy is not eligible for payment from Medicaid if the reason you are having it is to avoid bearing children.

I understand that the hysterectomy will render me permanently incapable of having a baby. I hereby acknowledge receipt of this information.

Recipient's Signature Date

ACKNOWLEDGMENT

RECEIPT OF HYSTERECTOMY INFORMATION

(AFTER SURGERY)

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be undone and it will permanently prevent you from having children. A hysterectomy should only be done when there is a disease of the woman's uterus (womb) or some other problem that can only be treated by removing the uterus (womb). It is a serious operation and there are discomforts and a chance of serious health problems.

A hysterectomy is not eligible for payment from Medicaid if the reason you had it was to avoid bearing children.

I was informed before the surgery and understood the hysterectomy would render me permanently incapable of having a baby. I hereby acknowledge receipt of this information.

Recipient's Signature Date

Division of Health Care Financing and Policy

RECEIPT OF HYSTERECTOMY INFORMATION ACKNOWLEDGMENT FORM

RECIPIENT ACKNOWLEDGMENT

Recipient Eligibility Number:_____

it has been explained to _____of
(Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

_____ _____
(Recipient's or Representative's Signature) (Date)

If Required:_____ _____
(Interpreter's Signature) (Date)

PHYSICIAN STATEMENT

I, Doctor_____, certify that the hysterectomy

performed_____on_____of
(Date of Operation) (Recipient's Name)

_____, _____, _____
(Address) (City & State) (Date)

(X) MARK THE APPROPRIATE BLOCK

☐ Hysterectomy was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.

☐ Hysterectomy was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Receipt of Hysterectomy Information Acknowledgment Form. The life-threatening emergency situation was

_____

_____

(A Description of the Nature of the Emergency)

☐ The hysterectomy was performed subsequent to the recipient being sterile. This judgment is based on the following condition(s):

_____

_____

_____ _____
(Physician's Signature) (Date)

NOTE: A COPY OF THE COMPLETED CERTIFICATION MUST BE ATTACHED TO EACH INVOICE FOR A HYSTERECTOMY PROCEDURE. THE SURGEON MUST PROVIDE COPIES TO OTHER PHYSICIANS FOR THEIR USE WHEN BILLING MEDICAID.

PHYSICIAN COPY

ATTACHMENT F

RESERVED

Certification Statement for Abortion to Save the Life of the Mother

This form must be attached to all claims for payment. Please Print.

Section I. (Patient information)

Patient's Name:_____

Patient's Address:_____

NV Medicaid Billing Number:_____ Patient's DOB_____

Date Services Rendered_____ Gestational age of unborn:_____

Medical records attached: _____YES _____NO

Section II. (Provider Information)

Provider's Name:_____

Provider's Address:_____

Provider's Phone No:_____ Medicaid Provider No:_____

Medical condition necessitating induced abortion. Please include ICD-9 Diagnosis Code(s):

_____

_____

Description of services and procedure code(s) billed:

_____

_____

Name of facility where services were provided:

_____

Provider Signature:_____ Date:_____

NOTE: The provider performing the abortion is responsible for sending the required documentation to other providers (i.e. facility, anesthesia provider, etc.) for billing purposes. In addition, the facility may choose to obtain their own certification for their billing purposes.

Certification Statement for Abortion due to Sexual Assault (Rape) or Incest

This form must be attached to all claims for payment. Please Print.

Section 1. (To be completed by patient)

Patient's Name:_____

NV Medicaid Billing Number:_____ Patient's DOB_____

Select one of the statements below that describes your situation:

_____ Pregnancy resulting from sexual assault (rape) _____ Pregnancy resulting from incest

Date of incident:_____

I reported the incident to the following local law enforcement or human services agency (specify):

_____ Date reported:_____

I did not report the incident (explain):_____

_____

I certify that the above statement is true and I understand that all medical records relating to this abortion must be provided to representatives of Nevada Medicaid upon request.

Signature_____ Date_____

Section II. (Provider Information)

Provider's Name:_____

Provider's Address:_____

Provider's Phone No:_____ Medicaid Provider No:_____

NOTE: The provider performing the abortion is responsible for sending the required documentation to other providers (i.e. facility, anesthesia provider, etc.) for billing purposes. In addition, the facility may choose to obtain their own certification for their billing purposes.