MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

January 28, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES, MANAGER, HEARINGS UNIT

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – Physician Services

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600 – Physician Services are being proposed to add a new provider type (PT), Community Health Workers (CHW). This is a result of the passage of Assembly Bill (AB) 191 and Senate Bill (SB) 420 during the 81st Legislative Session.

CHWs will provide recipients culturally and linguistically appropriate health education for the prevention and management of chronic disease under the supervision of a Nevada Medicaid enrolled Physician, Advanced Practice Registered Nurse or Physician Assistant.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: CHW Provider Type (PT 89), Special Clinics PT 17 and Specialty 180 Rural Health Clinics, Specialty 181 Federally Qualified Health Centers and Specialty 169 Licensed Birth Centers; Physician, M.D., Osteopath, D.O. PT 20; Advanced Practice Registered Nurses PT 24; Indian Health Programs PT 47; Nurse Midwives PT 74; and Physician Assistants PT 77.

Financial Impact on Local Government for CHWs. An estimated decrease in annual aggregate expenditures for:

SFY 2022: ($299,486)
SFY 2023: ($839,241)

These changes for CHWs are effective January 29, 2022 pending CMS approval.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL Chapter 600 – Physician Services	MTL 09/21, 04/20 Chapter 600 – Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
605	**Community Health Worker Services**	Added new policy language related to CHW qualifications and coverage and limitations.
606	**Organ Transplant Services**	Moved section 605 to section 606.

605 COMMUNITY HEALTH WORKER SERVICES

Community Health Workers (CHW) are trained public health educators improving health care delivery requiring integrated and coordinated services across the continuum of health. CHWs provide recipients culturally and linguistically appropriate health education to better understand their condition, responsibilities, and health care options. CHW services must be related to disease prevention and chronic disease management that follow current national guidelines, recommendations, and standards of care, including but not limited to, the United States Preventive Services Task Force (USPSTF) A and B recommended screenings. CHWs may provide services to recipients (individually or in a group) within the home, clinical setting, or other community settings.

605.1 COMMUNITY HEALTH WORKER PROVIDER QUALIFICATIONS

A. Certification as a CHW must be obtained through the Nevada Certification Board.

B. Must be supervised by a Nevada Medicaid enrolled physician, physician assistant (PA) or advanced practice registered nurse (APRN).

605.2 COVERAGE AND LIMITATIONS

A. Covered services:

1. Guidance in attaining health care services.

2. Identify recipient needs and provide education from preventive health services to chronic disease self-management.

3. Information on health and community resources, including making referrals to appropriate health care services.

4. Connect recipients to preventive health services or community services to improve health outcomes.

5. Provide education, including but not limited to, medication adherence, tobacco cessation, and nutrition.

6. Promote health literacy, including oral health.

B. Non-covered services:

1. Delegate the CHW to perform or render services that require licensure.

2. Transport a recipient to an appointment.

3. Make appointments not already included within the CHW visit/service (i.e. receptionist duties or front desk support).

4. Deliver appointment reminders.

5. Employment support, including but not limited to, resume building, interview skills.

6. Coordinate and participate in community outreach events not related to individual or group Medicaid recipients.

7. Case management.

8. Accompanying a recipient to an appointment.

9. Provide child-care while the recipient has an appointment.

10. Application assistance for social service programs.

11. Mental health/alcohol and substance abuse services, including peer support services.

C. Service Limitations:

1. CHW services are not reimbursable when services are provided under the supervision of a physician, PA or APRN billing under Behavioral Health Outpatient Treatment PT 14, Behavioral Health Rehabilitative Treatment PT 82, or Special Clinics PT 17, Specialty 215 Substance Abuse Agency Model.

2. Services provided by a CHW are limited to four units (30 minutes per unit) in a 24-hour period, not to exceed 24 units per calendar month per recipient.

3. When providing services in a group setting, the number of participants must be at a minimum of two and a maximum of eight.

D. Prior authorization is not required.

E. For a list of covered procedure codes please refer to the Community Health Worker PT 89 Billing Guide.

~~605~~606 ORGAN TRANSPLANT SERVICES

~~605~~606.1 COVERAGE AND LIMITATIONS

Organ transplantation and associated fees are a limited benefit for Nevada Medicaid recipients. Non-Citizens/Aliens are not eligible for organ transplants. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for eligible emergency conditions.

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

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

a. Non-covered 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;

2. Corneal – allograft/homograft;

3. Kidney – allotransplantation/autotransplantation; and

4. Liver – transplantation for children (under 21 years old) 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.

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

1. 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, CFR, Chapter IV (Centers for Medicare & Medicaid) and Title 21, CFR, Chapter I FDA;

b. The procedure meets appropriate Medicare criteria;

c. The procedure is generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is proposed, or there is authoritative evidence that attests to the proposed procedures safety and effectiveness; and

d. If the authorization request is for chemotherapy to be used as a preparatory therapy for transplants, an approval does not guarantee authorization for any harvesting or transplant that may be part of the treatment regimen.

2. A separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out-of-state.

60~~7~~6 PREVENTIVE HEALTH SERVICES

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

60~~6~~7.1 COVERED SERVICES

Nevada Medicaid reimburses for preventive health services for men, women and children as recommended by the USPSTF A and B recommendations. For the most current list of reimbursable preventive services, please see the USPSTF A and B recommendations located at https://www.uspreventiveservicestaskforce.org/.

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

60~~6~~7.2 NON-COVERED SERVICES

Preventive health services not cataloged or that do not have a current status as either an A or B recommendation by the USPSTF are not covered.

60~~6~~7.3 PRIOR AUTHORIZATIONS

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

60~~6~~7.4 BILLING REQUIREMENTS

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

60~~87~~ GENDER REASSIGNMENT SERVICES

Transgender Services include treatment for gender dysphoria (GD), formerly known as gender identity disorder (GID). Treatment of GD is a Nevada Medicaid covered benefit, including both hormonal and surgical modalities, and psychotherapy, based on medical necessity. Genital reconstruction surgery (GRS) describes a number of surgical procedure options for the treatment of GD.

According to the World Professional Association for Transgender Health (WPATH), the organization that promotes the standards of health care for transsexual, transgender and gender nonconforming individuals, through the articulation of Standards of Care, gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).

60~~78~~.1 COVERAGE AND LIMITATIONS

A. Hormone Therapy

1. Hormone therapy is covered for treatment of GD based on medical necessity; refer to MSM Chapter 1200, Prescribed Drugs, for services and prior authorization requirements.

B. Genital Reconstruction Surgery

1. Genital reconstruction surgery is covered for recipients that are sufficiently physically fit and meet eligibility criteria under Nevada and federal laws.

2. Prior authorization is required for all genital reconstruction surgery procedures.

3. To qualify for surgery, the recipient must be 18 years of age or older.

4. Male-to-Female (MTF) recipient, surgical procedures may include:

   a. breast/chest surgery; mammoplasty

   b. genital surgery; orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy

5. Female-to-Male (FTM) recipient, surgical procedures may include:

   a. breast/chest surgery; mastectomy

   b. genital surgery; hysterectomy/salpingo-oophorectomy, phalloplasty, vaginectomy, vulvectomy, scrotoplasty

6. Augmentation mammoplasty for MTF recipients is a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy.

7. All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization. Refer to MSM Chapter 600, Section 603.4B for information regarding sterilization services.

8. Refer to the Documentation Requirements section below for additional criteria.

C. Mental Health Services

1. Mental health services are covered for treatment of GD based on medical necessity; refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services for services and prior authorization requirements.

D. Non-Covered Services

1. Payment will not be made for the following services and procedures:

a. cryopreservation, storage and thawing of reproductive tissue, and all related services and costs;

b. reversal of genital and/or breast surgery;

c. reversal of surgery to revise secondary sex characteristics;

d. reversal of any procedure resulting in sterilization;

e. cosmetic surgery and procedures including:

1. neck tightening or removal of redundant skin;

2. breast, brow, face or forehead lifts;

3. chondrolaryngoplasty (commonly known as tracheal shave);

4. electrolysis;

5. facial bone reconstruction, reduction or sculpturing, including jaw shortening and rhinoplasty;

6. calf, cheek, chin, nose or pectoral implants;

7. collagen injections;

8. drugs to promote hair growth or loss;

9. hair transplantation;

10. lip reduction or enhancement;

11. liposuction;

12. thyroid chondroplasty; and

13. voice therapy, voice lessons or voice modification surgery.

E. Documentation Requirements

1. The recipient must have:

a. persistent and well-documented case of GD;

b. capacity to make a fully informed decision and give consent for treatment. According to the American Medical Association (AMA) Journal of Ethics, in health care, informed consent refers to the process whereby the patient and the health care practitioner engage in a dialogue about a proposed medical treatment's nature, consequences, harms, benefits, risks and alternatives. Informed consent is a fundamental principle of health care.

c. comprehensive mental health evaluation provided in accordance with WPATH standards of care; and

d. prior to beginning stages of surgery, obtained authentic letters from two qualified licensed mental health professionals who have independently assessed the recipient and are referring the recipient for surgery. The two letters must be authenticated and signed by:

1. A licensed qualified mental health care professional working within the scope of their license who have independently assessed the recipient;

a. one with whom the recipient has an established ongoing relationship; and

b. one who only has an evaluative role with the recipient.

2. Together, the letters must establish the recipient have:

a. a persistent and well-documented case of GD;

b. received hormone therapy appropriate to the recipient's gender goals, which shall be for a minimum of 12 months in the case of a recipient seeking genital reconstruction surgery, unless such therapy is medically contraindicated or the recipient is otherwise unable to take hormones;

c. lived for 12 months in a gender role congruent with the recipient's gender identity without reversion to the original gender, and has received mental health counseling, as deemed medically necessary during that time; and

d. significant medical or mental health concerns reasonably well-controlled; and capacity to make a fully informed decision and consent to the treatment.

3. When a recipient has previously had one or more initial surgical procedures outlined in this chapter, the recipient is not required to provide referral letters to continue additional surgical procedures, at discretion of the surgeon. The surgeon must ensure this is clearly documented in the recipient's medical record.

2. Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization is required.

60~~98~~ MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy (MNT) is nutritional diagnostic, therapy and counseling services for the purpose of management of nutrition related chronic disease states. MNT involves the assessment of an individual's overall nutritional status followed by an individualized course of nutritional intervention treatment to prevent or treat medical illness. MNT is provided by a licensed and Registered Dietitian (RD) working in a coordinated, multidisciplinary team effort with the Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN) referred to as provider throughout this policy and takes into account a person's food intake, physical activity, and course of any medical therapy including medication and other treatments, individual preferences, and other factors. This level of instruction includes individualized dietary assessment that is above basic nutrition counseling.

Nevada Medicaid considers medical nutrition therapy medically necessary for diabetes, obesity, heart disease and hypertension where dietary adjustment has a therapeutic role, when it is prescribed by a provider and furnished by a RD. The only providers that should submit claims for medical nutrition therapy are RDs. Other qualified health care professionals may provide medical nutrition therapy; however, they must submit a claim for evaluation and management services.

60~~89~~.1 POLICY

Medicaid will reimburse for MNT services rendered to Medicaid eligible individuals in accordance with the Nevada Medicaid coverage authority. MNT services must be medically necessary to address nutrition related behaviors that contribute to diabetes, obesity, heart disease and hypertension. Services must be rendered according the written orders of the Physician, PA or an APRN. The treatment regimen must be designed and approved by an RD.

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

60~~89~~.2 COVERAGE AND LIMITATIONS

A. MNT is initiated from a referral from a provider that can refer and includes information on labs, medications and other diagnoses. MNT includes:

1. A comprehensive nutritional and lifestyle assessment determining nutritional diagnosis.

2. Planning and implementing a nutritional intervention and counseling using evidence-based nutrition practice guidelines to achieve nutritional goals and desired health outcomes.

3. Monitoring and evaluating an individual's progress over subsequent visits with a RD.

B. Coverage of services includes:

1. Initial nutrition and lifestyle assessment.

2. One-on-one or group nutrition counseling.

3. Follow-up intervention visits to monitor progress in managing diet.

4. Reassessments as necessary during the 12-rolling month episode of care to assure compliance with the dietary plan.

5. Four hours maximum in the first year.

   a. Additional hours are permitted if treating provider determines a change in medical condition, diagnosis or treatment regimen requires a change in MNT.

   b. Additional hours beyond the maximum four hours in the first year require prior authorization.

   c. Documentation should support the patient's diagnosis of the specific condition, along with the referral from the provider managing the patient's condition.

   d. The documentation should also include a comprehensive plan of care, individualized assessment and education plan with outcome evaluations for each session, as well as referring provider feedback.

   e. There should be specific goals, evaluations and outcome measures for each session documented within the patient's records.

6. Two hours maximum per 12 rolling month period in subsequent years.

7. Services may be provided in a group setting. The same service limitations apply in the group setting.

C. MNT is not to be confused with Diabetic Outpatient Self-Management Training (DSMT)

1. Nevada Medicaid considers DSMT and MNT complementary services. This means Medicaid will cover both DSMT and MNT without decreasing either benefit as long as the referring provider determines that both are medically necessary.

2. See MSM Chapter 600, Attachment A, Policy #6-10 for DSMT coverage.

D. MNT is only covered for the management of diabetes, obesity, heart disease and hypertension-related conditions.

E. MNT may be provided through Telehealth services. See MSM Chapter 3400 for the Telehealth policy.

60~~8~~9.3 PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is required when recipients require additional or repeat training sessions beyond the permitted maximum number of hours of treatment. This can occur if there is a change of diagnosis, medical condition or treatment regimen related to a nutritionally related disease state.

60~~9~~8.4 PROVIDER QUALIFICATIONS

In order to be recognized and reimbursed as an MNT provider, the provider must meet the following requirements:

A. Licensed and RD under the qualifications of NRS 640E.150. An RD is an individual who has earned a bachelor's degree or higher education from an accredited college or university in human nutrition, nutrition education or equivalent education, has completed training and holds a license from the Nevada State Board of Health.

60~~8~~9.5 PROVIDER RESPONSIBILITY

A. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit, or utilization review.

B. The provider will ensure services are consistent with applicable professional standards and guidelines relating to the practice of MNT as well as state Medicaid laws and regulations and state licensure laws and regulations.

C. The provider will ensure caseload size is within the professional standards and guidelines related to the practice of MNT.

610~~09~~ HEARINGS

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