MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

October 25, 2022

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CASEY ANGRES
MANAGER OF DIVISION COMPLIANCE

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 allow Medicaid recipients' coverage of routine patient cost for items and services furnished in connection with participation in Qualifying Clinical Trials (QCT).

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:

The following Provider Types (PTs) may potentially be affected by this change, but are not limited to PTs: Outpatient Surgery (PT 10); Hospital, Inpatient (PT 11); Hospital, Outpatient (PT 12); Psychiatric (PT 13); Behavioral Health Outpatient Treatment (PT 14); Special Clinics (PT 17); Physician/Osteopath (PT 20); Podiatrist (PT 21); Dentist (PT 22); Hearing Aid Dispenser and Related Supplies (PT 23); Advanced Practice Registered Nurse (PT 24); Optometrist (PT 25); Psychologist (PT 26); Radiologist and Noninvasive Diagnostic Center (PT 27); Pharmacy (PT 28); Ambulance Air or Ground (PT 32); Durable Medical Equipment (DME), Disposable, Prosthetics (PT 33); Therapy (PT 34); Opticians (PT 41); Laboratory, Pathology/Clinical (PT 43); End Stage Renal Disease (ESRD) Facility (PT 45); Ambulatory Surgical Centers, Freestanding (PT 46); Indian Health Programs and Tribal Clinics (PT 47); Indian Health Service Hospital, Inpatient (Tribal) (PT 51), Indian Health Service Hospital, Outpatient (Tribal) (PT 52); Transitional Rehabilitative Center, Outpatient (PT 55); Inpatient Rehabilitation and Long Term Acute Care (LTAC) Specialty Hospitals (PT 56); Residential Treatment Center (PT 63); Hospice (PT 64); Hospice, Long Term Care (PT 65); Nurse Anesthetist (PT 72); Nurse Midwives (PT 74); Critical Access Hospital (CAH), Inpatient (PT 75); Audiologist (PT 76); Physician's Assistant (PT 77); Indian Health Service Hospital, Inpatient (Non-Tribal) (PT 78); Indian Health Service Hospital, Outpatient (Non-Tribal) (PT 79); Hospital Based End Stage Renal Disease (ESRD) PT 81; Provider Behavioral Health Rehabilitative Treatment (PT 82); Applied Behavioral Analysis (PT 85).

Financial Impact on Local Government: No impact on local government known.

These changes are effective: October 26, 2022.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL MSM 600 - Physician Services	MTL 09/21 MSM 600 - Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
MSM 603.2(B)	**New and Established Patients**	Deleted language under bullet #9 (a) and (b) related to investigational and experimental studies. Added reference to QCT policy under #9. Section for Non covered services renumbered to #10.
Attachment A Policy #6-01	**Qualifying Clinical Trials (QCT)**	Added new QCT policy, including Description, Prior Authorization, Coverage and Limitations and Medicaid Attestation Form sections.

4. Out-of-State Providers

   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. Conversely, if a prior authorization is not required for a service in-state (i.e. office visit, consultation), then a prior authorization is not required for the same service out-of-state. Refer to MSM Chapter 1900, Transportation Services, for out-of-state transportation policy. 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 provider, the Nevada provider is required to obtain the prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.

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

   c. All servicing providers must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. See MSM Chapter 100, Medicaid Program.

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

   The EPSDT program provides preventive health care to recipients under the age of 21 years old who are 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 Program.

6. Federal Emergency Services Program (also known as Emergency Medicaid Only)

   Professional services provided to an alien/non-citizen may be covered if the condition meets the definition provided in Section 1903(v)(1-3) of the SSA, 42 CFR 440.255 and NRS 422.065. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for policy details.

603.2 PROVIDER OFFICE SERVICES

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

Telehealth services are also covered by Nevada Medicaid. See MSM Chapter 3400, Telehealth Services for the complete coverage and limitations for Telehealth.

A. Consultation Services

A consultation is a type of evaluation and management service provided by a provider and requested by another provider 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 provider or other appropriate source and documented in the patient's medical record by either the consulting or requesting provider 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 provider 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 provider 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 provider 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 provider'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 provider or by providers 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 provider or by providers 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 provider or by providers 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) Unit.

3. Medicaid does not reimburse providers for telephone calls between providers and patients (including those in which the provider 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 provider or another provider of the same group practice and same specialty, within the past three years.

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

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

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

   A provider 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, Therapy for physical therapy coverage and limitations.

7. Provider administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200, Prescribed Drugs for coverage and limitations.

8. Medication-Assisted Treatment (MAT) services provided by a physician, APRN, physician assistant, or nurse midwife with a DATA 2000 waiver are available for recipients who meet medical necessity with an opioid use disorder. Refer to MSM Chapter 3800, Medication-Assisted Treatment for coverage and limitations.

9. Qualifying Clinical Trials (QCTs) policy, refer to Attachment A, Policy #6-01.

~~9.~~10. Non-Covered Provider Services

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

~~b. Reimbursement for clinical trials and investigational studies.~~

~~c~~a. Temporomandibular Joint (TMJ) related services (see MSM Chapter 1000, Dental).

C. Referrals

When a prior authorization is required for either in-state or out-of-state services, the referring provider is 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 provider to obtain the authorization for a recipient to be transferred from one facility to another, either in-state or out-of-state.

D. Hospice

Adult recipients enrolled in hospice have waived their rights to Medicaid payments for any Medicaid services related to the terminal illness and related conditions for which hospice was elected. Providers should contact the designated hospice provider to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200, Hospice for coverage and limitations.

E. Home Health Agency (HHA)

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

POLICY #6-01	RESERVED FOR FUTURE USE	EFFECTIVE DOS ~~9/1/03~~ Supersedes Policy News N199-06

~~RESERVED FOR FUTURE USE~~

A. DESCRIPTION

The "Consolidated Appropriations Act (CAA), 2021" amended Section 1905(a) of the Social Security Act (SSA) (42 U.S.C. 1396d) which includes new requirements to promote access to clinical trials by allowing Medicaid recipients coverage of routine patient costs for items and services furnished in connection with participation in Qualifying Clinical Trials (QCTs). This mandate also includes amendments to Sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory.

Pursuant to Sections 1905(a)(30) and 1905(gg)(1) of the Act, routine patient costs must be covered for a recipient participating in a QCT, including any item or service within the Nevada Medicaid State Plan, waiver, or demonstration project under Section 1115 of the Act provided to prevent, diagnose, monitor, or treat complications resulting from participation in the QCT.

For purpose of Section 1905(a)(30) of the Act, a QCT is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

1. To meet the statutory definition, the QCT must also be one or more of the following:

   a. A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:

      1. The National Institutes of Health (NIH);

      2. The Centers for Disease Control and Prevention (CDC);

      3. The Agency for Health Care Research and Quality (AHRQ);

      4. The Centers for Medicare and Medicaid Services (CMS);

      5. A cooperative group or center of any of the entities described above, the Department of Defense, or the Department of Veterans Affairs; or

      6. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

   b. A QCT, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Department of Health and Human Services (DHHS) Secretary, determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

      1. The Department of Energy;

      2. The Department of Veterans Affairs; or

      3. The Department of Defense.

c. A QCT that is conducted pursuant to an investigational new drug exemption under Section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under Section 351(a)(3) of the Public Health Service Act; or

d. A clinical trial that is a drug trial exempt from being required to have one of the exemptions listed under Item c. above.

B. PRIOR AUTHORIZATION

Prior Authorization is not required for participation in the QCT; however, if a routine patient cost/service or item requires a prior authorization or exceeds the service limitations, a prior authorization may be required. Please refer to the respective policies for prior authorization requirements.

For medically necessary services requiring a prior authorization, the appropriate QIO-like vendor must review and complete the request within 72 business hours.

C. COVERAGE AND LIMITATIONS

1. For a recipient participating in a QCT, coverage shall:

a. Be made without regard to the geographic location or network affiliation of the health care provider treating the recipient or the principal investigator of the QCT.

b. Be based on attestation regarding the appropriateness of the QCT by the health care provider and principal investigator.

c. Not require submission of the protocols of the QCT or any other documentation that may be proprietary or determined by the DHHS Secretary to be burdensome to provide.

2. The following items and services are not covered under the new mandatory benefit as described under Section 1905(gg) of the Act:

a. An investigational item or service that is the subject of the QCT and is not otherwise covered outside of the clinical trial under the State Plan, waiver, or demonstration project.

b. Routine patient cost does not include any item or service that is provided to the recipient solely to satisfy data collection and analysis for the QCT that is not used in the direct clinical management of the recipient and is not otherwise covered under the State Plan, waiver, or demonstration project.

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

D. MEDICAID ATTESTATION FORM

1. The QCT principal investigator and the recipient's healthcare provider must complete the Medicaid Attestation Form on the Appropriateness of the QCT (FA-110). This form is available at the appropriate QIO-like vendor website at

https://www.medicaid.nv.gov/providers/forms/forms.aspx. This Medicaid Attestation Form must be submitted to the appropriate QIO-like vendor.