Medicaid Services Manual
Transmittal Letter

November 1, 2023

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief 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 add a section for Pediatric Cancer and Pediatric Rare Disease providers are allowed to provide services in a clinic setting to treat children for cancer and other rare disease types as medically necessary; to allow injectable contraception or insertion of certain long-acting reversible contraception to be administered immediately after giving birth if requested by a patient; to add supervising providers for community health workers (CHW). This is a result of the passage of Senate Bill (SB) 117 during the 82nd Legislative; and to include gender incongruence along with the definition of gender incongruence. Also included is the coverage of cosmetic surgery when deemed medically necessary.

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: Those provider types include, but are not limited to: Outpatient Surgery, Hospital Based (PT 10); Hospital , Inpatient (PT 11); Hospital, Outpatient (PT 12); Psychiatric Hospital, Inpatient (PT 13); Behavioral Health, Outpatient Treatment (PT 14); Registered Dietitian (PT 15); Special Clincs (PT 17 including specialties, 180-Rural Health Clinics, 181-Federally Qualified Health Centers, and 169-Licensed Birth Centers);); Physician, M.D., Osteopath, D.O. (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); Radiology & Noninvasive Diagnostic Centers (PT 27); Pharmacy (PT 28); DMEPOS (PT 33); Therapy (PT 34); Chiropractor (PT 36); Laboratory (PT 43); End Stage Renal Disease Facility (PT 45); Ambulatory Surgical Centers (PT 46); Indian Health Services, Inpatient, Tribal (PT 51); Indian Health Services Hospital, Tribal, Outpatient (PT 52); School Based (PT 60); Nurse Anesthetist (PT 72); Nurse Midwife (PT 74); Audiologist (PT 76); Physician Assistant (PT 77); Indian Health Services, Non-Tribal, Inpatient (PT 78); Indian Health Services, Non-Tribal, Outpatient (PT 79); Behavioral Health Rehabilitative Treatment (PT 81); Applied Behavior Analysis (PT 85); Community Health Workers (PT 89).

Financial Impact on Local Government: Unknown at this time.

These changes are effective November 1, 2023.

Material Transmitted	Material Superseded
MTL OL	MTL 09/21; 02/22

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.3D	**Family Planning Services**	Updated language to allow contraceptive injections to be administered immediately following delivery.
605.1B	**Community Health Worker Provider Qualifications**	Added updated allowable supervising providers for CHWs.
605.2C	**Coverage and Limitations**	Removed supervising provider type limitations.
608	**Gender Reassignment Services**	Added language to include gender incongruence including the definition.
608.1	**Coverage and limitations**	Added language to include gender incongruence.
608.1D(e)	**Coverage and limitations**	Updated language to state non-covered services to include cosmetic surgery not deemed medically necessary.
603.14C	**Provider Office Services**	Added language that pediatric cancer and pediatric rare diseases in the clinic setting are covered when medically necessary.

G. Diagnostic Testing

Reference MSM Chapter 300, Radiology Services for coverage and limitations for diagnostic services.

H. Vaccinations

Vaccinations are a covered benefit for Nevada Medicaid recipients as a preventative health services benefit.

1. Childhood vaccinations: All childhood vaccinations, per the latest recommendations of the Advisory Committee on Immunization Practices (ACIP), are covered without prior authorization under the Healthy Kids Program for children under the age of 21 years old. Refer to MSM Chapter 1500, Healthy Kids Program, for more information on childhood vaccinations.

2. Adult vaccinations: All adult vaccinations, per the latest recommendations of the ACIP, are covered without prior authorization for those 21 years of age or older. Refer to MSM Chapter 1200, Prescribed Drugs, for more information on adult vaccinations.

I. Ordering, Prescribing, and Referring (OPR) Providers

OPR providers do not bill Nevada Medicaid for services rendered, but may order, prescribe, or refer services/supplies for Medicaid recipients.

603.2A AUTHORIZATION PROCESS

Certain provider 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 assistant, APRN, 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 entire month in which the 60th day falls.
Abortions (surgical or medical) and/or hysterectomies are not included in Family Planning Services. These procedures 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. Providers shall follow current national guidelines, recommendations, and standards of care, including but not limited to, American College of Obstetricians and Gynecologists (ACOG) and/or U.S. Preventive Services Task Force (USPSTF).

A. Prior authorization is not required for:

1. Provider services.

2. Physical examination.

3. Pap smears.

4. FDA approved birth control drugs and delivery devices/methods, including but not limited to the following:

a. Intrauterine contraceptive device (IUD);

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

b. Birth control pills;

c. Diaphragm/cervical cap;

d. Contraceptive foam and/or jelly;

e. Condoms;

f. Implanted contraception capsules/devices;

Note: When a woman has a contraceptive implant 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. Contraceptive injections;

Note: If contraceptive injections are administered in the providers office, the provider may bill for the drug itself with a National Drug Code (NDC) and the intramuscular administration CPT code. Refer to MSM Chapter 1200, Prescribed Drugs for Outpatient Pharmaceuticals.

h. Vaginal contraceptive suppositories;

i. Contraceptive dermal patch;

j. Contraceptive ring and/or other birth control methods.

5. Vasectomy or tubal ligation (age 21 years or over). In accordance with federal regulations, the recipient must fill out a sterilization consent form at least 30 days prior to the procedure. The provider is required to send the consent form to the fiscal agent with the initial claim. See the QIO-like vendor website to access the FA-56 Sterilization Consent Form which is also the HHS-687 form.

B. Medicaid has removed all barriers to family planning counseling/education provided by qualified providers (e.g. Physicians, Physician Assistants, APRN, Nurse Midwife, Rural Health Clinics, Federally Qualified Health Centers, Indian Health Programs, etc.). The provider 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 may be considered sexually active).

D. Insertion of Long-Acting Reversible Contraceptives (LARC) and contraceptive injections immediately following delivery and/or post discharge are ~~is a~~ covered benefits for eligible recipients. ~~LARC insertion is a covered benefit post discharge as medically necessary.~~

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

F. A pelvic exam or pap smear is not required for self-administered birth control.

603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, labor and delivery, and postpartum care provided by a physician, physician assistant, APRN, and/or a nurse midwife. Maternity care services can be provided in the home, office, hospital, or freestanding birthing center settings. All maternity care providers are allowed to provide services within all settings that are allowed per their scope of practice and licensure.

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.

603.13 PROVIDER'S SERVICES IN NURSING FACILITIES

A. Provider services provided in a Nursing Facility (NF) are a covered benefit when the service is medically necessary. Provider visits must be conducted in accordance with federal requirements for licensed facilities. Reference MSM Chapter 500, Nursing Facilities 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, provider's office), all E/M services provided by that provider 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.

603.14 PROVIDER'S SERVICES IN OTHER MEDICAL FACILITIES

A. Intermediate Care Facility for Individuals with Intellectual Disabilities) ICF/IID

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

Recertification by a physician or an APRN for the continuing need for ICF/IID 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/IID refer to MSM Chapter 1600, Intermediate Care for Individuals with Intellectual Disabilities.

B. Residential Treatment Center (RTC)

Physician services, except psychiatrists are not included in the all-inclusive facility rate for RTCs. Please reference MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services.

C. Cancer and Rare Disease Clinic:

Providers operating in a Cancer and Rare Disease Clinic as outlined in our state plan are allowed to provide services in a licensed rare disease clinic. Clinics must screen, evaluate, diagnose and treat pediatric patients with cancer and/or another known rare disease as is medically necessary. A rare disease is defined as a condition that affects fewer than 200,000 people in the United States

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 P~~p~~hysician, P~~p~~hysician A~~a~~ssistant (PA), ~~or~~ A~~a~~dvanced P~~p~~ractice R~~r~~egistered N~~n~~urse (APRN), Dentist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Professional Counselor (LCPC), Nurse Midwife, and Nurse Anesthetist.

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.~~1. 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.~~2. 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.

608 GENDER REASSIGNMENT SERVICES

Transgender Services include treatment for gender dysphoria ~~(GD),~~and gender incongruence ~~formerly known as gender identity disorder (GID)~~. Treatment of ~~GD~~ gender dysphoria and gender incongruence 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~~gender dysphoria and gender incongruence.

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~~.,~~ G~~g~~ender 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) and gender incongruence describes a marked and persistent experience of an incompatibility of gender identity and the gender expected based on birth-assigned sex.

608.1 COVERAGE AND LIMITATIONS

A. Hormone Therapy

1. Hormone therapy is covered for treatment of ~~GD~~ gender dysphoria and gender incongruence 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~~ gender dysphoria and gender incongruence 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~~not deemed medically necessary.~~:~~

~~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.~~1. ~~voice therapy, voice lessons or voice modification surgery.~~

E. Documentation Requirements

1. The recipient must have:

a. persistent and well-documented case of ~~GD~~gender dysphoria and/or gender incongruence;

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~~gender dysphoria and/or gender incongruence;

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.