Medicaid Services Manual
Transmittal Letter

July 30, 2024

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 603.4E – Doula Services Policy is being updated to remove the requirement of a dental service being administered for an additional Dula visit to be covered.

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: Unknown at this time.

Financial Impact on Local Government: Unknown at this time.

These changes are effective: 08/01/2024.

Material Transmitted	Material Superseded
MTL OL MSM Chapter 600- Physician Services	MTL 10/24 MSM Chapter 600- Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.4E(2)(c)(3)	**Doula Services**	Removed the section concerning an additional visit from a Doula if two prenatal/ antepartum visits from a licensed physician, nurse midwife, APRN, or physician assistant occur.
603.4E(2)(c)(3)(a)		Removed the section for paperwork needed associated with 603.4E(2)(c)(3).

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.4E(2)(c)(4)		Removed the section concerning an additional visit from a Doula if a recipient receives dental services during the prenatal/antepartum period.
603.4E(2)(c)(4)(a)		Removed the section for paperwork needed associated with 603.4E(2)(c)(4).

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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 align the chapter with the passing of Assembly Bill (AB) 138 of the 82nd (2023) Legislative Session. AB 138 provides authority to include Medicaid coverage for certain behavioral health integration services and to make appropriation and authorization of certain expenditures for these services. The revisions will add policies regarding the eligibility and usage of services utilizing the Collaborative Care Model, the provider types (PT) that are approved to support this model, and the reimbursement methods authorized for payment.

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: This proposed change affects enrolled Medicaid providers qualified to deliver Behavioral Health Integration Services. Those PTs include but are not limited to Physicians (PT 20), Advanced Practice Registered Nurse (APRN) (PT 24), Nurse Midwife (PT 74), Physician's Assistant (PT 77), Federally Qualified Health Centers (FQHC) (PT 17, Specialty 181), Rural Health Clinics (PT 17, Specialty 180).

Financial Impact on Local Government:

FY 2025: $256,452
FY 2026: $257,050

These changes are effective: July 31, 2024.

Material Transmitted	Material Superseded
MTL OL	MTL
MSM Chapter 600- Physician Services	MSM Chapter 600- Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Attachment A Policy #6-14	**Behavioral Health Integration Services**	New section added to Attachment A to outline the description of Behavioral Health Integration Services, Provider Qualifications, Eligibility, Prior Authorization, and Coverage and Limitations.

a. Karyotype chromosomal testing, fluorescence in situ hybridization (FISH) testing, and chromosomal microarray analysis.

3. Comprehensive patient pretest and post-test genetic counseling from a provider regarding the benefits, limitations, and results of chromosome screening and testing is essential. Nevada Medicaid does not reimburse for genetic counselors but does reimburse for providers that are physicians (M.D./D.O.), physician assistants, APRNs, or nurse midwives.

4. All prenatal chromosomal screening and diagnostic testing should not be ordered without informed consent, which should include discussion of the potential to identify findings of uncertain significance, nonpaternity, consanguinity, and adult-onset disease.

603.4E DOULA SERVICES

A Doula is a non-medical trained professional who provides education, emotional and physical support during pregnancy, labor/delivery, and postpartum period. Doulas may provide services within the home, office, hospital, or freestanding birthing center settings.

1. DOULA PROVIDER QUALIFICATIONS

Certification as a Doula must be obtained through the Nevada Certification Board.

2. COVERAGE AND LIMITATIONS

Doula services may be provided upon the confirmation of pregnancy. Doulas should encourage recipients to receive prenatal/antepartum and postpartum care.

a. Covered Services:

1. Emotional support, including bereavement support.

2. Physical comfort measures during peripartum (i.e., labor and delivery).

3. Facilitates access to resources to improve health and birth-related outcomes.

4. Advocacy in informed decision-making (i.e., patient rights for consent and refusal).

5. Evidence-based education and guidance, including but not limited to, the following:

a. General health practices, including but not limited to, reproductive health.

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b. Child birthing options.

c. Newborn health and behavior, including but not limited to, feeding (i.e., bottle feeding), sleep habits, establishing routines, and pediatric care.

d. Infant care, including but not limited to, soothing, coping skills, and bathing.

e. Family dynamics, including but not limited to, sibling education and transition.

f. Breastfeeding, chestfeeding, lactation support, and providing related resources.

b. Non-Covered Services:

1. Travel time and mileage.

2. Services rendered requiring medical or clinical licensure.

c. Service Limitations:

Doula services for the same recipient and pregnancy are limited to the following:

1. Four visits during the prenatal/antepartum and/or postpartum period (up to 90 days postpartum).

2. One visit at the time of labor and delivery.

~~3. If two prenatal/antepartum visits have occurred with a licensed physician, nurse midwife, APRN, or physician assistant, doulas may receive reimbursement for one additional visit. Doulas are encouraged to navigate recipients to prenatal/antepartum and postpartum care.~~

~~a. Certification for Additional Doula Services form must be completed by the healthcare professional's office who rendered the prenatal/antepartum services or the recipients' primary obstetrics provider and must be attached to the claim for reimbursement of the additional doula service. Refer to the FA-111 Nevada Medicaid Certification for Additional Doula Services form on the QIO-like vendor website.~~

~~4. If a recipient receives any dental service during the prenatal/antepartum period, the doula may receive one additional visit. Doulas are encouraged~~

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~~to navigate recipients to access oral health services which are expanded for adults during pregnancy.~~

~~a. Certification for Additional Doula Services form must be completed by the oral health provider's office who rendered the dental services and must be attached to the claim for reimbursement of the Additional Doula Service. Refer to the FA-111 Nevada Medicaid Certification for Additional Doula Services form on the QIO-like vendor website.~~

d. Prior authorization is required for Doula Services after the initial limitations have been exhausted.

e. Any services requiring medical or clinical licensure are not covered.

f. ~~e.~~ For a list of covered procedure codes please refer to the Doula Services Billing Guide (PT 90).

603.4F ABORTION/TERMINATION OF PREGNANCY

1. Reimbursement is available for an induced abortion to save the life of the recipient, only when a provider 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 recipient would be endangered if the fetus were carried to term. Refer to the appropriate QIO-like vendor website to access the abortion certification form. Providers may use the FA-57 Certification Statement for Abortion to Save the Life of the Mother form or substitute any form that includes the required information.

2. Reimbursement is available for induced abortion services resulting from a sexual assault (rape) or incest. A copy of the appropriate declaration statement must be attached to the claim. Refer to the appropriate QIO-like vendor website to access the abortion declaration forms. Providers may use the FA-54 Abortion Declaration (Rape) form or the FA-55 Abortion Declaration (Incest) form 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 years old and providers 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.

3. 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 appropriate QIO-like vendor. See MSM Chapter

A. DESCRIPTION

Behavioral Health Integration Services to Nevada Medicaid recipients are provided utilizing the Collaborative Care Model (CoCM). The CoCM is when a primary care provider identifies a recipient's behavioral health needs and integrates care management support for the recipient and regular psychiatric inter-specialty consultation with the primary care team. An episode of care can range from three to 12 months in duration. The episode ends when targeted treatment goals are met, there is a referral for direct psychiatric care, or there is a break in episode (no behavioral health integration services for six consecutive months).

B. PROVIDER QUALIFICATIONS

The CoCM involves the delivery of integrated care through a collaborative team. The CoCM team must include a treating practitioner, a behavioral care manager, and a consulting psychiatrist. Each provider must meet the requirements listed below.

1. Treating Practitioner (Billing Provider)

- Any provider that is qualified to use evaluation and management codes, except psychiatrists (ie Physician, Advanced Practice Registered Nurse (APRN), Certified Midwife, or Physician’s Assistant).

- Primary care or specialty care providers.

- Must be enrolled in Nevada Medicaid.

Responsibility:

- Directs the behavioral care manager.

- Oversees the recipient's care, including prescribing medications, providing treatments for medical concerns, and making referrals to specialty care when needed.

- Remains involved through ongoing oversight, management, collaboration, and reassessment.

2. Behavioral Care Manager

- Bachelor's degree in a human service-related field and one year of direct, supervised experience working with individuals in the behavioral health field.

- Works under the supervision of the billing practitioner.

- Enrollment in Nevada Medicaid is not required. However, Behavioral Care Managers must, at minimum, meet the requirement of a Qualified Mental Health Associate (QMHA) listed in MSM 400.

Responsibility:

- Administration of validated rating scales (for example, PHQ-9 scale for depression, GAD-7 for anxiety).
- Development of a care plan.
- Provision of brief psychosocial interventions (ie, education and prevention).
- Ongoing collaboration with billing practitioner.
- Consultation with psychiatric consultant.
- Has continuous relationship with the recipient.
- Does not include administrative or clerical staff; time spent in strictly administrative or clerical duties is not counted towards the time threshold to bill behavioral health integration codes.
- Maintenance of registry for tracking patient follow up and progress.

3. Psychiatric Consultant

- A licensed psychiatrist, psychiatric advanced practice nurse, or psychiatric-certified physician assistant.
- Must be enrolled in Nevada Medicaid; may be enrolled as an Ordering, Prescribing, or Referring (OPR) Professional.

Responsibility:

- Meets with the primary care team to review the recipient's treatment plan and status, meets at least weekly.
- Tells the billing practitioner and behavioral health care manager about diagnosis.
- Indicates ways for resolving issues with patient adherence and tolerance of behavioral health treatment.
- Adjusts behavioral health treatment for patients who aren’t progressing.
- Manages any negative interactions between patients’ behavioral health and medical treatments.
- Can (and typically will) be remotely located.

- Is generally not expected to have direct contact with the patient, prescribe medications, or deliver other treatment directly to the patient.

- Can and should offer a referral for direct provision of psychiatric care when clinically indicated.

- If fully enrolled in Nevada Medicaid, may render services directly to the recipients that are separately billed; activities reported separately are not included in the time applied to the CoCM.

C. ELIGIBILITY

Medicaid recipients of any age are eligible for CoCM services if they have any mental, behavioral health, or psychiatric condition and are working with a treating practitioner whose clinical judgment warrant integrating these behavioral health services for that recipient. The recipients' condition(s) could be pre-existing or diagnosed by the treating practitioner. Recipients may have comorbid, chronic, or other medical conditions that are being managed by the treating practitioner.

The recipients must be informed about these services and provide general consent including permission to consult with other CoCM team recipients, which must be documented in the medical record.

There must be an initiating visit with the treating practitioner prior to the start of CoCM services. For recipients not seen within a year prior to the commencement of CoCM services, CoCM must be initiated by the treating practitioner during a comprehensive Evaluation and Management (E&M) visit. The initiating visit is not part of the CoCM service and can be separately billed.

D. PRIOR AUTHORIZATION

Prior Authorization is not required when billing for services. Time spent rendering care management activities is accumulated monthly and cannot be counted toward any other time-based service. An initial procedure code captures the 70 minutes of service in the first month and an add-on code captures additional 30-minute increments of service per month. In any subsequent month a follow-up procedure code is used for the first 60 minutes of the month and an add-on code captures additional 30-minute increments of service per month. A HCPCS will be available for the initial and subsequent services in 30-minute increments for the first 30 minutes in a month. Time spent by a treating practitioner on behavioral health care management activities may be counted towards CoCM time if not billed by another service code. Providers must follow the billing guide when billing the CoCM codes.

When CoCM services are provided in an outpatient hospital setting, Medicaid-eligible hospitals may receive separate facility reimbursement for these services.

E. COVERAGE AND LIMITATIONS

The following services are covered under the CoCM:

Initial Psychiatric CoCM

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional.

- Initial assessment of the patient, including administering validated rating scales, with the development of an individualized treatment plan.

- Review by the psychiatric consultant with modifications of the plan, if recommended.

- Entering patient in a registry and tracking patient follow-up and progress using the registry, with proper documentation, and participation in weekly caseload consultation with the psychiatric consultant.

- Provision of brief interventions using evidence-based techniques such as behavioral activation, and other focused treatment strategies.

Follow-Up Psychiatric CoCM

- Tracking patient follow-up and progress using the registry, with proper documentation.

- Participation in weekly caseload consultation with the psychiatric consultant.

- Ongoing collaboration with and coordination of the patient’s mental health care with the treating physician or other qualified health care professional and any other treating mental health providers.

- Other review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant.

- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

- Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms, other treatment goals, and prepare for discharge from active treatment.

Non-Covered Services:

- Administrative or clerical staff time.