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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, birth, and postpartum period. Doulas may provide services during the pregnancy, labor, birth and postpartum period within the home, office, hospital, or free-standing birth center settings.

1. DOULA PROVIDER QUALIFICATIONS

Doulas must meet minimum qualifications and core competencies as outlined in Provider Enrollment Checklist for a PT ? - Doulas.

2. COVERAGE AND LIMITATIONS

Doula services may be provided upon the confirmation of pregnancy.

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
 - 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

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- 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 a maximum of the following:

 - 1. Four (4) visits during the prenatal/antepartum and/or postpartum period (up to 90 days postpartum)
 - 2. One (1) visit at the time of labor and delivery
- d. Prior authorization is not required.
- e. For a list of covered procedure codes please refer to the PT ? - Doula Services Billing Guide at (link).

603.4 F ABORTION/TERMINATION OF PREGNANCY

- 1. Reimbursement is available for an induced abortion to save the life of the mother, 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 mother would be endangered if the fetus were carried to term. Refer to the 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 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

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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 QIO-like vendor. See MSM Chapter 200, Hospital Services, Authorization Requirements for further information.

603.5 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. Refer to the FA-50 Nevada Medicaid Hysterectomy

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605 COMMUNITY HEALTH WORKER SERVICES

Community Health Workers (CHW) are trained health educators within health care teams improving health care delivery requiring integrated and coordinated services across the continuum of health. CHWs provide recipients culturally and linguistically appropriate health or nutrition 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 and recommendations, including but not limited to, the United States Preventive Health Services Task Force (USPSTF) A and B recommended screenings, and ~~standards of care~~ scope of practice in accordance with NRS 449.0027. 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 healthcare services
 2. Patient assessment, screening, and education for chronic disease self-management and prevention
 3. Information on health and community resources, including making referrals to appropriate healthcare services
 4. Direct preventive services or services to improve health outcomes
 5. Provide education on medication adherence
 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
 4. Deliver appointment reminders
 5. Employment support, including but not limited to, resume building, interview skills

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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. Assist with completing community resource applications
11. Mental health/alcohol and substance abuse services[BV2]

C. Service Limitations:

1. CHW services are not reimbursable when services are provided under the supervision of a physician, PA or APRN billing under a provider type (PT) 14 [BV3]- Behavioral Health Outpatient Treatment or PT 82 - Behavioral Health Rehabilitative Treatment service models.
2. Services provided by a CHW are limited to 4 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 (2) and a maximum of eight (8).

D. Prior authorization is not required.

E. For a list of covered procedure codes please refer to the PT ? - Community Health Worker Billing Guide at [\(link\)](#).

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~~6065~~ ORGAN TRANSPLANT SERVICES

~~6065.1~~ 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;

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- 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.