603 PROVIDERS AND LICENSED PROFESSIONAL POLICY

603.1 PROVIDER'S ROLE IN RENDERING SERVICES

603.1A COVERAGE AND LIMITATIONS

1. Nevada Medicaid reimburses for covered medical services that are reasonable and medically necessary, ordered or performed by a physician or under the supervision of a physician, APRN or other licensed health care provider listed in Section 601 – Authority, and that are within the scope of practice of their license as defined by state law. Providers shall follow current national guidelines, recommendations, and standards of care. The provider must:

    a. Examine the recipient;

    b. Make a diagnosis;

    c. Establish a plan of care; and

    d. Document these tasks in the appropriate medical records for the recipient before submitting claims for services rendered. Documentation is subject to review by a state authority or contracted entity.

2. Services must be performed by the provider or by a licensed professional working under the personal supervision of the provider.

    a. The following are examples of services that are considered part of the billable visit when it is provided under the direct and professional supervision of the provider:

        1. An injection of medication;

        2. Diagnostic test like an electrocardiogram (ECG);

        3. Blood pressure taken and recorded;

        4. Dressing changes; and

        5. Topical application of fluoride.

    b. Providers or their designee may not bill Medicaid for services provided by, including and not limited to, any of the following professionals below. All providers must enroll into their designated provider type and bill for the services they provided. Nevada Medicaid will neither accept nor reimburse for professional billing of services or supplies rendered by anyone other than the provider under whose name and provider number the claim is submitted. Refer to MSM Chapter

100, Medicaid Payments to Providers, for additional information regarding incident-to billing.

1. Another Provider;
2. Psychologist;
3. Medical Resident (unless teaching physician);
4. Therapist, including Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (SP), Respiratory Therapist (RT);
5. Counselor/Social Worker;
6. Advanced Practice Registered Nurse (APRN) (other than diagnostic tests done in the office which must be reviewed by the physician);
7. Physician Assistants (PA/PA-C);
8. Certified Registered Nurse Anesthetist (CRNA);
9. Pharmacist;
10. Nurse Midwife (NM);
11. Emergency Medical Technician, Advanced Emergency Medical Technician, and Paramedic with community paramedicine endorsement; or
12. Any other provider that has a designated Nevada Medicaid provider type.

3. Teaching Physicians

Medicaid covers teaching physician services when they participate in the recipient's care. The teaching physician directs no more than four residents at any given time and is in such proximity as to constitute immediate availability. The teaching physician's documentation must show that he or she either performed the service or was physically present while the resident performed the key and critical portions of the service. Documentation must also show participation of the teaching physician in the management of the recipient and medical necessity for the service. When choosing the appropriate procedure code to bill, consideration is based on the time and level of complexity of the teaching physician, not the resident's involvement or time.

Nevada Medicaid follows Medicare coverage guidelines for Teaching Physicians, Interns, and Residents including the exceptions as outlined by Medicare's policy.

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 appropriate 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.~~3. 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.

~~3.~~4. 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.

~~4.~~5. 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.

~~6.~~7. Provider administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200, Prescribed Drugs for coverage and limitations

~~8.~~7. 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.~~8. Qualifying Clinical Trials (QCTs) policy, refer to Attachment A, Policy #6-01.

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

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 appropriate 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.

F. Laboratory

Reference MSM Chapter 800, Laboratory Services for coverage and limitations for laboratory services.

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 appropriate 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~~Recipients, 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~~ recipient has an IUD inserted, ~~she~~ they 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~~ recipient has a contraceptive implant inserted, ~~she~~ they 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 appropriate 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) immediately following delivery is a covered benefit 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.

Provider shall follow current national guidelines, recommendations, and standards of care for maternity care services, including but not limited to, USPSTF, ACOG, Society of Maternal-Fetal Medicine, and the American College of Nurse Midwives.

Per NRS 449.0155 "Freestanding Birthing Center" means a facility that is not part of a hospital and provides services for normal, uncomplicated births. Nevada Administrative Code (NAC) regulations for Freestanding Birthing Centers are located in NAC 449.6113 – 449.61178. Please also refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-01, Freestanding Birthing Centers.

For ~~women~~ recipients who are eligible for pregnancy-related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the entire month in which the 60th day falls. ~~She is~~ They are eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21 years old, and eligible for pregnancy only, are not entitled to EPSDT services.

It is the responsibility of the treating provider to employ a care coordination mechanism to facilitate the identification and treatment of high-risk pregnancies. "High-Risk" is defined as a probability of an adverse outcome to the ~~woman~~ birthing person and/or ~~her~~ the baby greater than the average occurrence in the general population. Home and freestanding birthing center births and corresponding pregnancy services are appropriate for recipients with low-risk pregnancies, intended vaginal delivery, and no reasonably foreseeable expectation of complication. Recipients that are eligible for Freestanding Birthing Center services is outlined in NAC 449.61134. If assessments suggest the likelihood of complications that could make the delivery high-risk, then services will be reimbursed when provided by a provider in the hospital setting.

For those ~~females~~ recipients enrolled in a managed care program, the Managed Care Organization (MCO) physicians are responsible for making referrals for early intervention and case management activities on behalf of those ~~women~~ recipients. Communication and coordination between the MCO physicians, service physicians, and MCO staff is critical to promoting optimal birth outcomes.

603.4A STAGES OF MATERNITY CARE

1. Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery totaling approximately 13 routine visits. Any other visits or services within this time period for non-routine maternity care should be coded separately. Non-emergency antepartum care is not a covered benefit for non-U.S. citizens/aliens who have not lawfully been admitted for permanent residence in the United States or permanently residing in the United States under the color of the law. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for allowable services to non-U.S. citizens.

2. Labor and delivery services include home delivery, admission to the hospital, or freestanding birthing center, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without an episiotomy/operative delivery (vacuum or forceps)), or cesarean delivery in hospital setting. Medical problems complicating labor and delivery management may require additional resources and should be billed utilizing the CPT codes in the Medicine and Evaluation and Management Services sections in addition to codes for maternity care.

   a. In accordance with ~~standard regulations~~ the Newborns' and Mothers' Health Protection Act (NMHPA), vaginal deliveries with a hospital stay of ~~three~~ two days or less and cesarean-section deliveries with a hospital stay of four days or less do not require prior authorization. Reference MSM Chapter 200, Hospital Services for inpatient coverage and limitations.

   b. Elective/Non-Medically ~~Elective~~ Necessary Deliveries

      1. Reimbursement for Avoidable Cesarean Section

         To make certain that cesarean sections are being performed only in cases of medical necessity, Nevada Medicaid will reimburse providers for performing cesarean sections only in instances that are medically necessary and not for the convenience of the provider or patient. Elective/non medically necessary cesarean sections are not a covered service.~~must be prior authorized and will be reimbursed at the vaginal delivery rate.~~

         Reference ICD-10 Diagnosis Codes Accepted by Nevada Medicaid Supporting Medical Necessity for Cesarean Section for a list of ICD-10 diagnosis codes which have already been determined to support the medical necessity for a cesarean section.

      2. Early Induction of Labor (EIOL)

         Research shows that early elective induction (<39 weeks gestation) has no medical benefit and may be associated with risks to both the ~~mother~~ birthing person and infant. Based upon these recommendations, Nevada Medicaid will require prior authorization for hospital admissions for EIOL prior to 39 weeks to determine medical necessity.

         Nevada Medicaid encourages providers to review the "Early Elective Deliveries Toolkit" compiled by the March of Dimes, the California Maternity Quality Care Collaborative, and the California Department of Public Health, Maternal, Child and Adolescent Health Division at http://www.cmqcc.org/resources-tool-kits/toolkits/early-elective-deliveries-toolkit. The aim of the toolkit is to offer guidance and support to

providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

3. Progesterone therapy to prevent preterm birth.

   Preterm birth is determined when a baby is born prior to 37 weeks of pregnancy. ~~Women~~ Birthing persons who have a history of preterm birth are at greater risk of future preterm births. Progesterone therapy is a hormone therapy designed to prevent the onset of preterm birth.

   Nevada Medicaid covers services related to the prevention of preterm birth. Progesterone therapies are initiated between 16 and 20 weeks of pregnancy, with weekly injections until 37 weeks.

   Please see PT 20, 24, 74, and 77 Billing Guides for specific coverage and limitations.

c. Provider responsibilities for the initial newborn examination and subsequent care until discharge includes the following:

   1. The initial physical examination done in the home, freestanding birthing center, or hospital delivery room is a rapid screening for life threatening anomalies that may require immediate billable attention.

   2. Complete physical examination is done within 24 hours of delivery but after the six-hour transition period when the infant has stabilized. This examination is billable.

   3. Brief examinations should be performed daily until discharge. On day of discharge, provider may bill either the brief examination or discharge day code, not both.

   4. Routine circumcision of a newborn male is a Medicaid benefit for males up to one year of age. For males older than one year of age, a prior authorization is required to support medical necessity.

   5. If a newborn is discharged from a hospital or freestanding birthing center less than 24 hours after delivery, Medicaid will reimburse newborn follow-up visits in the provider's office or recipient's home up to four days post-delivery. This is also allowable for all home births.

   6. All newborns must receive a hearing screen in accordance with NRS 442.540 and corresponding NAC 442.850. This testing and interpretation are included in the facility per diem rate. Hearing screening is not required

if parent or legal guardian objects in writing. If a baby is born in the home setting, the nurse midwife may not have the necessary equipment to conduct the hearing screen. Therefore, a referral can be made to a hearing specialist.

7. All newborns must receive a newborn screening blood analysis in accordance with NRS 442.008 and corresponding NAC 442.020 – 442.050. This testing is included in the facility per diem rate. Newborn screening is not required if parent or legal guardian objects in writing.

3. Postpartum care includes hospital, office visits, and home visits following vaginal or cesarean section delivery. ~~Women~~ Recipients, who are eligible for Medicaid on the last day of their pregnancy, remain eligible for all pregnancy related and postpartum medical assistance including family planning education and services for 60 days immediately following the last day of pregnancy, including the entire month in which the 60th day falls. Pregnancy related only eligible ~~women~~ recipients are not covered for any Medicaid benefits not directly related to their pregnancy.

4. Reimbursement: If a provider provides all or part of the antepartum and/or postpartum care but does not perform delivery due to termination of the pregnancy or referral to another provider, then reimbursement is based upon the antepartum and postpartum care CPT codes. A global payment will be paid to the delivering provider, when the ~~pregnant woman~~recipient has been seen seven or more times by the delivering provider. If the provider has seen the ~~pregnant woman~~recipient less than seven times with or without delivery, the provider will be paid according to the Fee-for-Service (FFS) visit schedule using the appropriate CPT codes. For MCO exceptions to the global payment please refer to MSM Chapter 3600, Managed Care Organization. Please refer to MSM Chapter 700, Rates and Supplemental Reimbursement for more information.

603.4B FETAL NON-STRESS TESTING

1. Fetal Non-Stress testing (NST) is a means of fetal surveillance for most conditions that place the fetus at high risk for placental insufficiency. Providers shall follow current national guidelines, recommendations, and standards of care for the indications, techniques, and timing of the appropriate antepartum fetal surveillance methods and management guidelines.

2. Home uterine activity monitoring service may be ordered for a recipient who has a current diagnosis of pre-term labor and a history of pre-term labor/delivery with previous pregnancies. Reference MSM Chapter 1300, Durable Medical Equipment (DME) for coverage and limitation guidelines.

603.4C MATERNAL/FETAL ULTRASOUND STUDIES

Obstetrical ultrasound of a pregnant uterus is a covered benefit of Nevada Medicaid when it is determined to be medically necessary for the ~~woman~~ birthing person and/or the fetus.

Per CPT guidelines, an obstetrical ultrasound includes determination of the number of gestational sacs and fetuses, gestational sac/fetal structure, qualitative assessment of amniotic fluid volume/gestational sac shape, and examination of the maternal uterus and adnexa. The patient's record must clearly identify all high-risk factors and ultrasound findings.

1. Coverage and Limitations

   A first trimester ultrasound may be covered to confirm viability of the pregnancy, to rule out multiple births and better define the Estimated Date of Confinement (EDC).

   One second trimester or third trimester ultrasound per pregnancy with detailed anatomic examination is considered medically necessary to evaluate the fetus for fetal anatomic abnormalities. Refer to most current ACOG guidance for a list of qualified indications.

   An initial screening ultrasound due to late entry prenatal care is a covered benefit. The use of a second ultrasound in the third trimester for screening purposes is not covered. Subsequent ultrasounds, including biophysical profiles should clearly identify the findings from the previous abnormal scan and explain the high-risk situation which makes repeated scans medically necessary. The patient's record must clearly identify all high-risk factors and ultrasound findings.

   It is policy to perform ultrasound with detailed fetal anatomic study only on those pregnancies identified as being at risk for structural defects (e.g. advanced maternal age, prior anomalous fetus, medication exposure, diabetes, etc.).

   a. Ultrasound coverage includes, but is not limited to:

      1. Suspected abnormality in pregnancy, such as:

         a. Suspected ectopic pregnancy;

         b. Suspected hydatiform mole;

         c. Threatened or missed abortion;

         d. Congenital malformation, fetal or maternal;

         e. Polyhydramnios;

         f. Oligohydramnios;

         g. Placenta previa;

h. Abruptio placenta; or

i. Vaginal bleeding.

2. Medical conditions threatening the fetus and/or delivery, such as:

a. Suspected abnormal presentation;

b. Suspected multiple gestation;

c. Significant difference between the size of the uterus and the expected size based on EDC (> 3 cm);

d. Elevated maternal serum alpha-fetoprotein;

e. Suspected fetal death;

f. Suspected anatomical abnormality of uterus;

g. Maternal risk factors, such as family history of congenital anomalies or chronic systemic disease (hypertension, diabetes, sickle cell disease, anti-phospholipid syndrome, poorly controlled hyperthyroidism, Hemoglobinopathies, cyanotic heart disease, systemic lupus erythematosus) or substance abuse;

h. Suspected macrosomia; or

i. Intrauterine Growth Retardation-IUGR ($\leq 15^{th}$ percentile of the combined biometrical parameters-biparietal diameter, head circumference, abdominal circumference, head/abdominal circumference ration, length of femur and length of humerus, and estimated fetal weight).

3. Confirmation of the EDC when clinical history and exam are uncertain. In general, a single ultrasound performed between 14 and 24 weeks is sufficient for this purpose.

4. Diagnosis of "decreased fetal movement" (accompanied by other clinical data, i.e. abnormal kick counts).

5. Follow up ultrasounds which may be considered medically necessary if the study will be used to alter or confirm a treatment plan.

b. Non-coverage – Ultrasound is not covered when it fails to meet the medical necessity criteria listed above or for the reasons listed below:

1. When the initial screening ultrasound (regardless of trimester) is within normal limits or without a significant second diagnosis.

2. When used solely to determine the sex of the neonate, or to provide the mother with a picture of the baby.

2. Provider Responsibility
For repeat evaluations, documentation should include, at a minimum:

a. Documentation of the indication for the study (abnormality or high-risk factors);

b. Crown-rump length (CRL);

c. Biparietal diameter (BPD);

d. Femur length (FL);

e. Abdominal circumference (AC);

f. Re-evaluation of organ system;

g. Placental location;

h. Number of fetuses (embryos);

i. Amniotic fluid volume assessment (qualitative or quantitative)

1. Oligohydramnios; or

2. Polyhydramnios.

j. Intrauterine growth restriction (IUGR).

For a list of maternal/fetal ultrasound codes, please refer to the PT 20, 24, 74, and 77 Billing Guides.

NOTE: The use of the diagnosis of "Supervision of High-Risk Pregnancy" or "Unspecified Complications of Pregnancy" without identifying the specific high risk or complication will result in non-payment.

603.4D PRENATAL SCREENING AND DIAGNOSTIC TESTING

Nevada Medicaid covers current national guidelines, recommendations, and standards of care for prenatal screening and diagnostic testing.

1. Screening includes:

a. First trimester and second trimester screenings. This does not include coverage of cell-free fetal DNA screening.

2. Diagnostic testing includes obtaining specimens through amniocentesis and chorionic villus sampling (CVS) to conduct diagnostic testing such as:

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.

   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 a maximum of 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.

d. Prior authorization is not required.

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 ~~mother~~ 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 ~~mother~~ 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 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~~ recipient 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 Acknowledgement Form on the appropriate QIO-like vendor website. A stamp or initial by billing staff is not acceptable. Payment is available for hysterectomies as follows:

1. Medically Necessary – A medically necessary hysterectomy may be covered only when the physician securing the authorization to perform the hysterectomy has informed the recipient or ~~her~~ their representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the recipient permanently incapable of reproducing, and the recipient or ~~her~~ their representative has signed a written FA-50 Hysterectomy Acknowledgement Form.

2. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the FA-50 Nevada Medicaid Hysterectomy Acknowledgement Form is also required. Therefore, it is advisable to inform the recipient or her authorized representative prior to the exploratory surgery or biopsy.

3. Emergency – The physician who performs the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgment was not possible. The completed FA-50 Nevada Medicaid Hysterectomy Acknowledgment Form must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, and anesthesiologist). The physician must include a description of the nature of the emergency and this certification must be dated after the emergency. The recipient does not have to sign this form. An example of this situation would be when the recipient is admitted to the hospital through the emergency room for immediate medical care and the recipient is unable to understand and respond to information pertaining to the Hysterectomy Acknowledgement Form due to the emergency nature of the admission.

4. Sterility – The physician who performs the hysterectomy certifies in writing that the recipient was already sterile at the time of the hysterectomy and needs to include a statement regarding the cause of the sterility. The completed FA-50 Nevada Medicaid Hysterectomy Acknowledgment Form, which is also the federal HHS-687 form, must be attached to each claim form related to the hysterectomy. The recipient does not have to sign the form. ~~(~~For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.~~)~~

5. Hysterectomies Performed During a Period of Retroactive Eligibility – Reimbursement is available for hysterectomies performed during periods of retroactive eligibility. In order for payment to be made in these cases, the physician must submit a written statement certifying one of the following conditions was met:

   a. He or she informed the ~~woman~~ recipient before the operation the procedure would make ~~her~~ them sterile. In this case, the recipient and the physician must sign the written statement; or,

   b. The ~~woman~~ recipient met one of the exceptions provided in the physician's statement. In this case, no recipient signature is required. Claims submitted for hysterectomies require the authorization number for the inpatient admission. The authorization process will ensure the above requirements were met. Payment is not available for any hysterectomy performed for the purpose of sterilization or which is not medically necessary.

603.6 GYNECOLOGIC EXAM

Nevada Medicaid reimburses providers for preventative gynecological examinations. The examination may include a breast exam, pelvic exam, sexually transmitted disease screening, and tissue collection if needed (also known as Pap Smear). Pelvic exams and pap smears should not be required for self-administered birth control. Providers shall follow current national guidelines, recommendations, and standards of care, including but not limited to, ACOG and/or USPSTF.

603.7 CHIROPRACTIC SERVICES POLICY

Medicaid will pay for a chiropractic manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuro-musculoskeletal condition for which manipulation is the appropriate treatment.

Services are limited to Medicaid eligible children under 21 years of age.

A. Prior authorization is not required for:

Four or less chiropractic office visits (emergent or non-emergent) for children under 21 years of age in a rolling 365 days. The visits must be as a direct result of an EPSDT screening examination, diagnosing acute spinal subluxation.

B. Prior authorization is required for:

Chiropractic visits for children under 21 years of age whose treatment exceeds the four visits. The provider must contact the appropriate Nevada Medicaid QIO-like vendor for prior authorization.

603.8 PODIATRY

Podiatry services are rendered by a podiatrist. Podiatrists are medical specialists who diagnose, treat and care for: injury, disease or other medical conditions affecting the foot, ankle, and structure of the leg. Podiatrists perform surgical procedures and prescribe corrective devices, medications, and physical therapy.

A. Prior Authorization and Limitations

1. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination or a surgical procedure must be billed using the appropriate Centers for Medicare and Medicaid

Services (CMS) Healthcare Common Procedural Coding System (HCPCS) code. Medicaid will pay for the orthotic in addition to the office visit.

2. Radiology Service

a. Radiology services are covered when deemed medically necessary; refer to MSM Chapter 300, Radiology Services for services and prior authorization requirements.

3. Laboratory Services

a. Laboratory services are covered when deemed medically necessary; refer to MSM Chapter 800, Laboratory Services for services and prior authorization requirements.

4. Prescription Drugs

a. Prescription drugs are covered when deemed medically necessary; refer to MSM Chapter 1200, Prescribed Drugs for services and prior authorization requirements.

5. Telehealth Services

a. Telehealth services are covered when deemed medically necessary; refer to MSM Chapter 3400, Telehealth Services for services and prior authorization requirements.

B. Covered Services

1. Evaluation and Management Services

a. Evaluations, examinations, consultations, treatments, health supervision.

b. Office visits, home visits, hospital visits, emergency room visits, nursing home visits.

2. Surgical Procedures

a. Multiple surgeries.

b. Mycotic procedures.

c. Casting/strapping/taping.

1. These procedures are covered when performed by a podiatrist for the treatment of fractures, dislocations, sprains, strains and open

wounds (related to podiatrist's scope of practice) and require prior authorization.

3. Infection and Inflammation Services

a. Trimming of nails, cutting or removal of corns and calluses are allowed if either infection or inflammation is present.

C. Non-Covered Services

1. Preventive care including the cleaning and soaking of feet and the application of creams to insure skin tone.

2. Routine foot care in the absence of infection or inflammation. Routine foot care includes the trimming of nails, cutting or removal of corns and calluses.

a. Preventive care and routine foot care can be provided by Outpatient Hospitals, APRN, physician, or physician assistant.

603.9 PROVIDER SERVICES PROVIDED IN RURAL HEALTH CLINICS

Rural Health Clinic (RHC)

Medicaid covered outpatient services provided in RHCs are reimbursed at an all-inclusive per recipient per encounter rate. Regardless of the number or types of providers seen, only one encounter is reimbursable per day.

A. This all-inclusive rate includes any one or more of the following services provided by a Licensed Qualified Health Professional and/or certified provider.

1. Licensed Qualified Health Professionals approved to furnish services included in the outpatient encounter are:

a. Physician (MD/DO);

b. Dentist;

c. Advance Practice Registered Nurse (APRN);

d. Physician Assistant (PA/PA-C);

e. Certified Registered Nurse Anesthetist (CRNA);

f. Nurse Midwife (NM);

g. Psychologist;

h. Licensed Clinical Social Worker (LCSW);

i. Registered Dental Hygienist (RDH);

j. Podiatrist (DPM);

k. Radiology;

l. Optometrist (OD);

m. Optician;

n. Clinical Laboratory Services;

o. Licensed Marriage and Family Therapist (LMFT);

p. Licensed Pharmacist; and

q. Registered Dietitian (RD).

2. Certified providers approved to furnish services included in the outpatient encounter are:

a. Community Health Workers (CHW); and

b. Doulas.

B. Encounter codes are used for primary care services provided by the RHCs in the following areas:

1. Core visits include the following:

a. Medical and dental office visits, patient hospital visits, injections and oral contraceptives;

b. ~~Women's~~ Recipients annual preventive gynecological examinations; and

c. Colorectal screenings.

2. Home visits; or

3. Family planning education.

a. Up to two times a calendar year the RHC may bill for additional reimbursement along with the encounter rate.

C. For billing instructions for RHC, please refer to PT 17 Special Clinics Billing Guide.

603.10 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and Certified Registered Nurse Anesthetists (CRNAs) are based on the CMS base units.

A. Each service is assigned a base unit which reflects the complexity of the service and includes work provided before and after reportable anesthesia time. The base units also cover usual preoperative and post-operative visits, administering fluids and blood that are part of the anesthesia care, and monitoring procedures.

B. Time for anesthesia procedures begins when the anesthesiologist/CRNA begins to prepare the recipient for the induction of anesthesia and ends when the anesthesiologist/CRNA is no longer in personal attendance, and the recipient is placed under postoperative supervision.

C. All anesthesia services are reported by use of the anesthesia CPT codes. Nevada Medicaid does not reimburse separately for physical status modifiers or qualifying circumstances.

D. Using the CPT/ASA codes, providers must indicate on the claim the following:

1. Type of surgery;

2. Length of time;

3. Diagnosis;

4. Report general anesthesia and continuous epidural analgesia for obstetrical deliveries using the appropriate CPT codes; and

5. Unusual forms of monitoring and/or special circumstances rendered by the anesthesiologist/CRNA are billed separately using the appropriate CPT code. Special circumstances include but are not limited to nasotracheal/bronchial catheter aspiration, intra-arterial, central venous and Swan-Ganz lines, transesophageal echocardiography, and ventilation assistance.

603.11 PROVIDER SERVICES IN OUTPATIENT SETTING

A. Outpatient hospital-based clinic services include non-emergency care provided in the emergency room, outpatient therapy department/burn center, observation area, and any established outpatient clinic sites. Visits should be coded using the appropriate Evaluation/Management (E/M) CPT code (e.g. office visit/observation/etc.). Do not use emergency visit codes.

Services requiring prior authorization include the following:

1. Hyperbaric Oxygen Therapy for chronic conditions (reference Attachment A, Policy #6-03 for Coverage and Criteria);

2. Bariatric surgery for Morbid Obesity (reference Attachment A, Policy #6-07 for Coverage and Criteria);

3. Cochlear implants (See MSM Chapter 2000, Audiology Services);

4. Diabetes training exceeding 10 hours (reference Attachment A, Policy #6-10 for Coverage and Criteria);

5. Vagus nerve stimulation (reference Attachment A, Policy #6-06 for Coverage and Criteria); and

6. Services requiring authorization per Ambulatory Surgical Center (ASC) list.

B. Emergency Department Policy

Nevada Medicaid uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services are defined as "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the recipient (or, with respect to a pregnant ~~woman~~person, the health of the ~~woman~~ person or ~~her~~ the unborn child) in serious jeopardy, serious impairment to bodily functions, or serious function of any bodily organ or part." The threat to life or health of the recipient necessitates the use of the most accessible hospital or facility available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

1. Prior authorization will not be required for admission to a hospital as a result of a direct, same day admission from a provider's office and/or the emergency department. The requirement to meet acute care criteria is dependent upon the appropriate QIO-like vendor's determination. The appropriate QIO-like vendor will continue to review and perform the retrospective review for these admissions based upon approved criteria. Prior authorization is still required for all other inpatient admissions. See MSM Chapter 200, Hospital Services for additional information regarding emergency admissions and retrospective reviews.

2. Direct physical attendance by a physician is required in emergency situations. The visit will not be considered an emergency unless the physician's entries into the record include his or her signature, the diagnosis, and documentation that he or she

examined the recipient. Attendance of a physician assistant does not substitute for the attendance of a physician in an emergency situation.

3. Physician's telephone or standing orders, or both, without direct physical attendance does not support emergency treatment.

4. Reimbursement for physician–directed emergency care and/or advanced life support rendered by a physician located in a hospital emergency or critical care department, engaged in two-way voice communication with the ambulance or rescue personnel outside the hospital is not covered by Medicaid.

5. Services deemed non-emergency and not reimbursable at the emergency room level of payment are:

   a. Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition;

   b. Refusal to comply with currently ordered procedures or treatments;

   c. The recipient had previously been treated for the same condition without worsening signs or symptoms of the condition;

   d. Scheduled visit to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion;

   e. Visits made to receive a "tetanus" vaccination in the absence of other emergency conditions;

   f. The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition;

   g. Medical clearance/screenings for psychological or temporary detention ordered admissions; and

   h. Diagnostic x-ray, diagnostic laboratory, and other diagnostic tests provided as a hospital outpatient service are limited to physician ordered tests considered to be reasonable and necessary for the diagnosis and treatment of a specific illness, symptom, complaint, or injury or to improve the functioning of a malformed body member. For coverage and limitations, reference MSM Chapter 300 for Radiology and Diagnostic Services and MSM Chapter 800 for Laboratory Services.

C. Therapy Services (OT, PT, RT, ST)

Occupational, Physical, Respiratory and Speech Therapy services provided in the hospital outpatient setting are subject to the same prior authorization and therapy limitations found in the MSM Chapter 1700, Therapy.

D. Observation Services Provided by The Physician

1. Observation services are provided by the hospital and supervising physician to recipients held but not admitted into an acute hospital bed for observation. Consistent with federal Medicare regulations, Nevada Medicaid reimburses hospital "observation status" for a period up to, but no more than 48 hours.

2. Observation services are conducted by the hospital to evaluate a recipient's condition or to assess the need for inpatient admission. It is not necessary that the recipient be located in a designated observation area such as a separate unit in the hospital, or in the emergency department in order for the physician to bill using the observation care CPT codes, but the recipient's observation status must be clear.

3. If observation status reaches 48 hours, the physician must make a decision to:

   a. Send the recipient home;

   b. Obtain authorization from the appropriate QIO-like vendor to admit into the acute hospital; or

   c. Keep the recipient on observation status with the understanding neither the physician nor the hospital will be reimbursed for any services beyond the 48 hours.

4. The physician must write an order for observation status, and/or an observation stay that will rollover to an inpatient admission status.

   See MSM Chapter 200, Hospital Services for policy specific to the facility's responsibility for a recipient in "observation status."

E. End Stage Renal Disease (ESRD) Outpatient Hospital/Free-Standing Facilities. The term "end-stage renal disease" means the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

1. Treatment of ESRD in a physician-based (i.e. hospital outpatient) or independently operated ESRD facility certified by Medicare is a Medicaid covered benefit. Medicaid is secondary coverage to Medicare for ESRD treatment except in rare cases when the recipient is not eligible for Medicare benefits. In those cases, private insurance and/or Medicaid is the primary coverage.

2. ESRD Services, including hemodialysis, peritoneal dialysis and other miscellaneous dialysis procedures are Medicaid covered benefits without prior authorization.

3. If an established recipient in Nevada requires out-of-state transportation for ESRD services, the physician or the facility must initiate contact and make financial arrangements with the out-of-state facility before submitting a prior authorization request to the non-emergency transportation (NET) broker. The request must include dates of service and the negotiated rate~~.~~ (~~T~~this rate cannot exceed Medicare's reimbursement for that facility). Refer to MSM Chapter 1900, Transportation Services for requirements of non-emergency transportation.

4. Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are covered services for hemodialysis and Continuous Ambulatory Peritoneal Dialysis (CAPD) recipients who meet all of the requirements for Parenteral and Enteral Nutrition coverage. The recipient must have a permanently inoperative internal body organ or function. Documentation must indicate that the impairment will be of long and indefinite duration.

5. Reference Attachment A, Policy #6-09 for ESRD Coverage.

F. Ambulatory Surgical Centers (ASC) Facility and Non-Facility Based

Surgical procedures provided in an ambulatory surgical facility refers to freestanding or hospital-based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients who do not generally require extended lengths of stay or extensive recovery or convalescent time.

Outpatient surgical procedures designated as acceptable to be performed in a provider's office/outpatient clinic, ambulatory surgery center or outpatient hospital facility are listed on the appropriate QIO-like vendor's website. For questions regarding authorization, the provider should contact the appropriate QIO-like vendor.

1. Prior authorization is not required when:

   a. Procedures listed are to be done in the suggested setting or a setting which is a lower level than suggested;

   b. Procedures are part of the emergency/clinic visit.

2. Prior authorization is required from the appropriate QIO-like vendor when:

a. Procedures are performed in a higher-level facility than it is listed in the ASC surgical list (e.g., done in an ASC but listed for the office);

b. Procedures on the list are designated for prior authorization;

c. Designated podiatry procedures; and

d. The service is an out-of-state service and requires a prior authorization if that same service was performed in-state.

3. Surgical procedures deemed experimental, not well established, or not approved by Medicare or Medicaid are not covered and will not be reimbursed for payment. Below is a list of definitive non-covered services.

a. Cosmetic Surgery: The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the recipient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or the improvement of a malformed body member, to restore or improve function, which coincidentally services some cosmetic purpose. Examples of procedures which do not meet the exception to the exclusion are facelift/wrinkle removal (rhytidectomy), nose hump correction, moon-face, etc.;

b. Fabric wrapping of abdominal aneurysm;

~~c. Intestinal bypass surgery for treatment of obesity;~~

~~d.~~c. Transvenous (catheter) pulmonary embolectomy;

~~e.~~d. Extracranial-Intracranial (EC-IC) Arterial bypass when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries;

~~f.~~e. Breast reconstruction for cosmetic reasons, however breast reconstruction following removal of a breast for any medical reason may be covered;

~~g.~~f. Stereotactic cingulotomy as a means of psychosurgery to modify or alter disturbances of behavior, thought content, or mood that are not responsive to other conventional modes of therapy, or for which no organic pathological cause can be demonstrated by established methods;

~~h.~~g. Radial keratotomy and keratoplasty to treat refractive defects. Keratoplasty that treats specific lesions of the cornea is not considered cosmetic and may be covered;

~~i.~~h. Implants not approved by the FDA; Partial ventriculectomy, also known as ventricular reduction, ventricular remodeling, or heart volume reduction surgery;

~~j. Gastric balloon for the treatment of obesity;~~

~~k.~~i. Cochleostomy with neurovascular transplant for Meniere's Disease; and

~~l.~~j. Surgical procedures to control obesity other than bariatric for morbid obesity with significant comorbidities. See Attachment A, Policy #6-07 for policy limitations.

603.12 SERVICES IN THE ACUTE HOSPITAL SETTING

A. Admissions to acute care hospitals both in and out-of-state are limited to those authorized by Medicaid's appropriate QIO-like vendor as medically necessary and meeting Medicaid benefit criteria. Refer to MSM Chapter 200, Hospital Services for authorization requirements.

B. Physicians may admit without prior approval only as outlined in MSM Chapter 200, Hospital Services, Authorization Requirements.

C. All other hospital admissions both in-state and out-of-state must be prior authorized by the appropriate QIO-like vendor. Payment will not be made to the facility or to the admitting physician, attending physician, consulting physician, anesthesiologist, or primary/assisting surgeon if the authorization is denied by the appropriate QIO-like vendor.

D. Attending physicians are responsible for ordering and obtaining prior authorization for all transfers from the acute hospital to all other facilities.

E. Physicians may admit recipients to psychiatric and/or substance abuse units of general hospitals (regardless of age), or freestanding psychiatric and substance abuse hospitals for recipients 65 years of age and older or those under the age of 21 years old. All admissions must be prior authorized by the appropriate QIO-like vendor with the exception of a psychiatric emergency. Refer to MSM Chapter 400, Mental Health and Alcohol and Substance Abuse Services for coverage and limitations.

F. Inpatient Hospital Care

1. Routine Inpatient Hospital Care is limited to reimbursement for one visit per day (same physician or physicians in the same group practice) except when extra care is documented as necessary for an emergency situation (e.g., a sudden serious deterioration of the recipient's condition).

2. The global surgical package includes the following when provided by the physician who performs the surgery, whether in the office setting, out-patient or in-patient:

   a. Preoperative visits up to two days before the surgery;

   b. Intraoperative services that are normally a usual and necessary part of a surgical procedure;

   c. Services provided by the surgeon within the Medicare recommended global period of the surgery that do not require a return trip to the operating room; and follow-up visits related to the recovery from the surgery which are provided during this time by the surgeon, and

   d. Post-surgical pain management.

3. The surgeon's initial evaluation or consultation is considered a separate service from the surgery and is paid as a separate service, even if the decision, based on the evaluation, is not to perform the surgery. If the decision to perform a major surgery (surgical procedures with a 90-day global period) is made on the day of or the day prior to the surgery, separate payment is allowed for the visit on which the decision is made, however supporting documentation may be requested. If post payment audits indicate documentation is insufficient to support the claim, payment will be adjusted accordingly.

4. If a recipient develops complications following surgery that requires the recipient to be returned to the operating room for any reason for care determined to be medically necessary, these services are paid separately from the global surgery amount. Complications that require additional medical or surgical services but do not require a return trip to the operating room are included in the global surgery amount.

5. Payment may be made for services by the surgeons that are unrelated to the diagnosis for which the surgery was performed during the post-operative period. Supportive documentation may be requested. Services provided by the surgeon for treating the underlying condition and for a subsequent course of treatment that is not part of the normal recovery from the surgery are also paid separately. Full payment for the procedure is allowed for situations when distinctly separate but related procedures are performed during the global period of another surgery in which the recipient is admitted to the hospital for treatment, discharged, and then readmitted for further treatment.

6. Payment for physician services related to patient-controlled analgesia is included in the surgeon's global payment. The global surgical payment will be reduced if post-payment audits indicate that a surgeon's recipients routinely receive pain

management services from an anesthesiologist. For a list of covered codes, please refer to the billing manual.

7. For information on payment for assistant surgeons, please refer to the billing manual.

8. There is no post-operative period for endoscopies performed through an existing body orifice. Endoscopic surgical procedures that require an incision for insertion of a scope will be covered under the appropriate major or minor surgical policy which will include a post-operative period according to the Medicare recommended global period.

9. For some dermatology services, the CPT descriptors contain language, such as "additional lesion", to indicate that multiple surgical procedures have been performed. The multiple procedure rules do not apply because the RVU's for these codes have been adjusted to reflect the multiple nature of the procedure. These services are paid according to the unit. If dermatologic procedures are billed with other procedures, the multiple surgery rules apply. For further information, please refer to the billing manual.

10. Critical Care

Critical Care, the direct delivery of medical care by a physician or physicians for a critically ill or critically injured recipient to treat a single or multiple vital organ system failure and/or to prevent further-life threatening deterioration of the recipient's conditions, is reimbursed by Medicaid. Reimbursement without documentation is limited to a critical illness or injury which acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the recipient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system functions. Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology, critical care may be provided in life threatening situations when these elements are not present.

a. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the recipient, provided that the recipient's condition continues to require the level of physician attention described above. Providing medical care to a critically ill, injured, or post-operative recipient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements.

b. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

c. Services for a recipient who is not critically ill but happen to be in a critical care unit, are reported using other appropriate evaluation/management (E/M) codes.

d. According to CPT, the following services are included in reporting critical care when performed during the critical period by the physicians providing critical care: the interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data) gastric intubation, temporary transcutaneous pacing, ventilatory management and vascular access procedures. Any services performed which are not listed above should be reported separately.

e. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the physician is not immediately available to the patient.

11. Neonatal and Pediatric Critical Care

a. Neonatal and Pediatric Critical Care CPT codes are used to report services provided by a single physician directing the care of a critically ill neonate/infant. The same definitions for critical care services apply for the adult, child, and neonate. The neonatal and pediatric critical care codes are global 24-hour codes (billed once per day) and are not reported as hourly services consistent with CPT coding instructions.

b. Neonatal critical care codes are used for neonates (28 days of age or less) and pediatric critical care codes are used for the critically ill infant or young child age 29 days through 71 months of age, admitted to an intensive or critical care unit. These codes will be applicable as long as the child qualifies for critical care services during the hospital stay.

c. If the physician is present for the delivery and newborn resuscitation is required, the appropriate E&M code can be used in addition to the critical care codes.

d. Care rendered under the pediatric critical care codes includes management, monitoring, and treatment of the recipient including respiratory, enteral and parenteral nutritional maintenance, metabolic and hematologic

maintenance, pharmacologic control of the circulatory system, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

e. In addition to critical services for adults, the pediatric and neonatal critical care codes also include the following procedures:

1. peripheral vessel catheterization;
2. other arterial catheters;
3. umbilical venous catheters;
4. central vessel catheters;
5. vascular access procedures;
6. vascular punctures;
7. umbilical arterial catheters;
8. endotracheal intubation;
9. ventilator management;
10. bedside pulmonary function testing;
11. surfactant administration;
12. continuous positive airway pressure (CPAP);
13. monitoring or interpretation of blood gases or oxygen saturation;
14. transfusion of blood components;
15. oral or nasogastric tube placement;
16. suprapubic bladder aspiration;
17. bladder catheterization; and
18. lumbar puncture.

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.