MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
ADDENDUM – MSM DEFINITIONS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Addendum are being proposed to update policy with the removal of references to the Diagnostic Statistical Manual (DSM), Diagnostic Criteria for ages Zero to Three (DC:0-3), adding International Classification of Diseases (ICD)-10 CM verbiage and update the definition of Medical Emergency.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29198 & 29461 ADDENDUM – MSM DEFINITIONS	MTL 16/15 ADDENDUM – MSM DEFINITIONS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section D	**Diagnostic and Statistical Manual (DSM) Diagnosis**	Deleted definition of Diagnostic and Statistical Manual (DSM) Diagnosis.
	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)	Deleted definition of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).
	Diagnostic Classification: 0-3 (DC:0-3)	Deleted reference to DSM, Axis I diagnosis and PIR-GAS.
Section I	**Intensity of Needs Grid**	Deleted definition of Intensity of Needs Grid as it was updated in MSM Chapter 400.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Deleted grid for Intensity of Need for Children as it was updated in MSM Chapter 400. Deleted grid for Intensity of Needs for Adults as it was updated in MSM Chapter 400.
Section M	**Medical Emergency**	Updated definition of Medical Emergency.
	Mental Health Services	Removed reference to "DSM-IV" and added "the current International Classification of Diseases (ICD)".
	Mental Health Special Clinics	Removed reference to "DSM-IV" and added "current ICD".
Section R	**Rehabilitation Plan**	Removed reference to "DSM or DC:0-3" and added "current ICD".
Section S	**Serious Mental Illness (SMI)**	Removed reference to "DSM" and added "current ICD".
	Severe Emotional Disturbance (SED)	Deleted "Persons from birth through 48 months" and added "Children with SED are persons up to age 18". Removed references to DSM, Axis I diagnosis and PIR-GAS. Deleted "2. Persons from 4 to age 18 who currently or at any time during the past year (continuous 12-month period) have a:". Removed "DSM" and added "current ICD". Replaced "V" code with "Z" code. Replaced "DSM" with "ICD".
Section T	**Target Group – Juvenile Probation Services (JPS)**	Revised sentence from "JPS are covered services provided to" to "JPS services are:". Added "Covered services provided to" juveniles on probation and family members who are Medicaid eligible whose children are on probation.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Deleted "for Washoe County JPS and Clark County Department of Juvenile Justice Services". Added "within all counties of Nevada" to coincide with MSM Chapter 2500.
	Target Group – Non-Seriously Mentally Ill (Non-SMI) Adults	Removed "mental retardation" and added "intellectual disabilities". Removed reference to DSM Axis I diagnosis and V code. Added "A current International Classification of Diseases (ICD) diagnosis, from the current Mental, Behavioral, Neurodevelopmental Disorders section". Added new Z codes "55-65, R45.850 and R45.851 as listed in the current ICD which".
	Target Group – Non-Severely Emotionally Disturbed (Non-SED) Children and Adolescents	Removed reference to DSM Axis I diagnosis. Added "current ICD" and "from the Mental, Behavioral, Neurodevelopmental Disorders section". Replaced "V" code with "Z" code. Added new Z codes "55-65, R45.850 and R45.851 as listed in the current ICD which". Deleted "4. DC:03 Axis I diagnosis or DC:03 Axis II PIR-GAS score of 40 or less".
	Target Group – Serious Mental Illness (SMI) Adults	Deleted "Diagnosis and Statistical Manual of Mental Disorders (DSM-IV)". Added "current ICD Mental, Behavioral, Neurodevelopmental Disorders section". Removed "DSM-IV" and added "current ICD". Deleted "b." and combined paragraph with "a.".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Target Group – Severe Emotional Disturbance (SED)	Deleted "Children from birth through 48 months who currently or at any time during the past year (continuous 12 month period) have a: 1. DC:0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or 2. CD:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or". Removed "age 4" and added "up" (to age 18). Removed "DSM" and added "current ICD". Replaced "V" code with "Z" code in #1 & #2. Removed "mental" and added "from the Mental, Behavioral, Neurodevelopmental Disorders section". Deleted "DSM or their ICD-9-CM equivalent".

DIAGNOSIS

Diagnosis means determination of the nature or cause of physical or mental disease or abnormality through the combined used of health history, physical and developmental examination, and laboratory tests.

~~DIAGNOSTIC AND STATISTICAL MANUAL (DSM) DIAGNOSIS~~

~~The determination of a recipient's mental or emotional disorder as described in the DSM of Mental Disorders, published by the American Psychiatric Association (APA). The principal Axis I diagnosis provides the clinical basis for treatment and must be reassessed annually for recipients under age 18. It is determined through the mental health assessment and any examinations, tests, procedures, or consultations suggested by the assessment, and is entered on a written individualized Treatment Plan. A DSM "V" code condition except 995.54 (Physical Abuse of Child Victim), 995.53 (Sexual Abuse of Child – Victim) and 995.54 (Neglect of Child – Victim), substance use disorder or mental retardation may not be considered the principal diagnosis, although these conditions or disorders may co-occur with the diagnosable mental disorder.~~

DIAGNOSTIC AND STATISTICAL MANUAL (DSM) OF MENTAL DISORDERS

The latest text revision of the DSM of Mental Disorders published by the APA.

~~DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (DSM-IV)~~

~~Published by the APA, the DSM-IV's primary purpose is to provide clear descriptions of diagnostic categories to enable clinicians to diagnose, communicate about, study and treat people with various mental disorders.~~

DIAGNOSTIC CLASSIFICATION: 0-3 (DC:0-3)

The determination of a mental or emotional disorder for a childbirth through 48 months of age as described in the latest text version of the Manual for DC:0-3 published by the National Center for Clinical Infant Programs. ~~The principal Axis I diagnosis or the Axis II PIR-GAS score of 40 or less provides the clinical basis for treatment and must be reassessed every 6 months for children under age 4. The DC:0-3 diagnosis may be used in place of the DSM Axis I Diagnosis to determine eligibility for and provide mental health services to recipients under 4 years of age.~~

DIRECT CARE COMPONENT

Direct care component means the portion of Medicaid reimbursement rates that are attributable to the salaries and benefits of RNs, Licensed Practical Nurses (LPNs), certified nursing assistants, rehabilitation nurses, and contracted nursing services.

primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such (42 CFR 435.1009). In Nevada, IMDs are commonly referred to as "psychiatric hospitals."

Nevada Medicaid only reimburses for services to IMD/psychiatric hospital patients who are age 65 or older, or under age 21.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

IADLs are activities related to independent living including preparing meals, shopping for groceries or personal items, performing light or heavy housework, communication and money management.

INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of Needs Determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

These components include:

1. A comprehensive assessment of the recipient's level of functioning;

2. The clinical judgment of the QMHP; and

3. A proposed Treatment and/or Rehabilitation Plan.

~~INTENSITY OF NEEDS GRID~~

~~1. The intensity of needs grid is an approved LOC utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse. Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.~~

~~2. Intensity of Need for Children:~~

~~Child and Adolescent Service Intensity Instrument (CASII)~~	~~Service Criteria~~
~~Levels I Basic Services: Recovery Maintenance and Health Management~~	~~• Significant Life Stressors and/or V-code Diagnosis that does not meet SED criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).~~
~~Level II Outpatient Services~~	~~• DSM Axis I Diagnosis that does not meet SED criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less.~~
~~Level III Intensive Outpatient Services~~	~~• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED Determination~~
~~Levels IV Intensive Integrated Services~~	~~• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED Determination~~
~~Level V Non-secure, 24 hour Services with Psychiatric Monitoring~~	~~• DSM Axis I Diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and • SED determination; and • Requires specialized treatment (e.g., sex offender treatment, etc).~~
~~Level VI Secure, 24 hour, Services with Psychiatric Management~~	~~• DSM Axis I Diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); or • DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR - GAS score of 40 or less; and • SED determination; and • Requires inpatient/secured LOC.~~

~~3. Intensity of Needs for Adults:~~

~~Level of Care Utilization System for Adults (LOCUS)~~	~~Service Criteria~~
~~Levels I Basic Services: Recovery Maintenance and Health Management~~	~~• DSM Axis I diagnoses, including "V" codes, that do not meet SMI criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).~~
~~Level II Low Intensity Community Based Services~~	~~• DSM Axis I diagnoses, including "V" codes that do not meet SMI criteria (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).~~
~~Level III High Intensity Community Based Services (HCBS)~~	~~• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination~~
~~Levels IV Medically Monitored Non-Residential Services~~	~~• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination~~
~~Level V Medically Monitored Residential Services~~	~~• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc).~~
~~Level VI Medically Managed Residential Services~~	~~• DSM Axis I diagnosis (excluding "V" codes, dementia, mental retardation, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.~~

INTERDISCIPLINARY GROUP

A group of qualified individuals with expertise in meeting the special needs of hospice recipients and their families. This group must consist of but is not limited to the following:

1. Physician;

2. RN;

3. Social worker; and

MEDICAL EMERGENCY

Medical Emergency is ~~a situation~~ the sudden onset of an acute condition where a delay of 24 hours in treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self or bodily harm to others. This is a higher degree of need than one implied by the words "medically necessary" and requires a physician's determination that it exists.

MEDICAL HOME

Refers to inclusion of a program recipient on the patient panel of a Primary Care Physician and the ability of the recipient to rely on the PCP for access to and coordination of their medical care.

MEDICAL SUPERVISION

The documented oversight which determines the medical appropriateness of the mental health program and services rendered. Medical supervision must be documented at least annually and at all times when determined medically appropriate based on review of circumstance. Medical supervision includes the on-going evaluation and monitoring of the quality and effectiveness of the services provided and may be provided through on and offsite means of communication. Medical supervision may be secured through a current written agreement, job description, or similar type of binding document. BHCNs and all inpatient mental health services are required to have medical supervision.

MEDICAL SUPERVISOR

A licensed physician with at least two years experience in a mental health treatment setting who, as documented by the BHCN, has the competency to oversee and evaluate a comprehensive mental and/or behavioral health treatment program including rehabilitation services and medication management to individuals who are determined as SED or SMI.

MEDICAL TRANSPORTATION

Transportation is any conveyance of a Medicaid recipient to and from providers of medically necessary Medicaid covered services, or medical services that Medicaid would cover except for the existence of prior resources such as Medicare, Veterans' coverage, workers' compensation, or private health insurance.

MEDICARE SAVINGS PROGRAM

1. QMBs without other Medicaid (QMB Only) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. FFP equals the Federal Medical Assistance Percentage (FMAP).

2. QMBs with full Medicaid (QMB Plus) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less, resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, to the extent consistent with the Medicaid State Plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

4. Qualified Disabled and Working Individuals (QDWIs) - These individuals no longer have Medicare Part A benefits due to a return to work. However, they are eligible to purchase Medicare Part A benefits if they have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only. FFP equals FMAP.

5. Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2), these individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down their resources to qualify for Medicaid or meet the requirements for a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services received from Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a state option; however, states may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

MEDICOACH, MEDIVAN, MEDICAR

These interchangeable terms refer to a motor vehicle staffed and equipped to transport one or two persons in wheelchairs or on gurneys or stretchers, door-to-door.

MENTAL HEALTH AND DEVELOPMENTAL SERVICES (MHDS)

MHDS is a State agency that is part of the Nevada DHHS. MHDS is the operating agency for the HCBW for Persons with Mental Retardation and Related Conditions.

MENTAL HEALTH SERVICES

Mental health services are those techniques, therapies, or treatments provided to an individual who has an acute, clinically identifiable psychiatric disorder for which periodic or intermittent treatment is recommended, as

identified in ~~DSM-IV~~ the current International Classification of Diseases (ICD) of mental disorders. These techniques, therapies, or treatments must be provided by a QMHP. Mental health services are provided in a medical or in a problem-oriented format that includes an assessment of the problem, limitations, a diagnosis, and a statement of treatment goals and objectives, recipient strengths and appropriate community based resources. Treatment should generally be short term and goal oriented or, in the case of chronic disorders, intermittent and supportive and rehabilitative.

MENTAL HEALTH SPECIAL CLINICS

These are public or private entities that provide:

1. outpatient services, including specialized services for children, the elderly, individuals who are experiencing symptoms relating to ~~DSM-IV~~ current ICD diagnosis or who are mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment;

2. 24-hour per day emergency care services; and

3. screening for recipients being considered for admission to inpatient facilities.

MENTAL RETARDATION

Mental retardation means significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period prior to age 18. A diagnosis of mental retardation is made based on commonly used standardized tests of intelligence and standardized adaptive behavior instruments.

MENTALLY INCOMPETENT INDIVIDUAL

Mentally incompetent individual means an individual who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction for any purpose.

MILEAGE REIMBURSEMENT

Car mileage is reimbursement at a per mile rate, paid when appropriate and approved by the NET broker for the transport of an eligible recipient to a covered service. Reimbursement will be at the Internal Revenue Service (IRS) rate for medical/moving mileage reimbursement unless otherwise agreed to in writing by DHCFP.

MINIMUM DATA SET (MDS)

MDS refers to a federally required resident assessment tool. Information from the MDS is used by the Division for determining the Medicaid average CMI to adjust the direct care component of each free-standing NF's rate.

REHABILITATION PLAN

1. A comprehensive, progressive, and individualized written Rehabilitative Plan must include all the prescribed Rehabilitation Mental Health (RMH) services. RMH services include:

   a. Basic Skills Training (BST);

   b. Program for Assertive Community Treatment (PACT);

   c. Day Treatment;

   d. Peer-to-Peer Support;

   e. Psychosocial Rehabilitation (PSR); and

   f. Crisis Intervention (CI).

   The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the recipient to their best possible functional level. The plan must ensure the transparency of coverage and medical necessity determinations, so that the recipient, their family (in the case of legal minors), or other responsible individuals would have a clear understanding of the services that are made available to the recipient. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible - while sustaining overall health. All prescribed services must be medically necessary, clinically appropriate, and contribute to the rehabilitation goals and objectives.

2. The Rehabilitation Plan must include recovery goals. The plan must establish a basis for evaluating the effectiveness of the RMH care offered in meeting the stated goals and objectives. The plan must provide for a process to involve the beneficiary, and family (in the case of legal minors) or other responsible individuals, in the overall management of the RMH care. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress.

3. The reevaluation of the plan must involve the recipient, the recipient's family (in the case of legal minors), or other responsible individuals. The reevaluation of the plan must include a review of whether the established goals and objectives are being met and whether each of the services prescribed in the plan has contributed to meeting the stated established goals and objectives. If it is determined that there has been no measurable reduction of disability and/or function level restoration, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, objectives, services, and/or methods. The plan must identify the rehabilitation goals and objectives that would be achieved under the plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities.

4. Rehabilitation goals and objectives are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal and objectives as defined in the rehabilitation plan. The plan must be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative mental and/or behavioral health services to an individual with the individual's condition(s). The written rehabilitation plan must ensure that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. Rehabilitation plans are living documents and therefore must evolve in concert (show progressive transformations in the amount, duration, and scope of services provided) with the recipient's functional progress. The rehabilitation plan must also demonstrate that the services requested are not duplicative (redundant) of each other. The written rehabilitation plan must:

   a. be based on a comprehensive assessment of an individual's rehabilitation needs including ~~DSM or DC:0-3~~ current ICD diagnoses and presence of a functional impairment in daily living;

   b. ensure the active participation of the individual, individual's family (in the case of legal minors), the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review and modification of these goals and services;

   c. be approved by a QMHP, working within the scope of their practice under state law;

   d. be signed by the individual responsible for developing the plan;

   e. specify the individual's rehabilitation goals and objectives to be achieved, including recovery goals for persons with mental health related disorders;

   f. identify the RMH services intended to reduce the identified physical impairment, mental and/or behavioral health related disorder;

   g. identify the methods that would be used to deliver services;

   h. indicate the frequency, amount and duration of the services;

   i. indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service;

   j. specify a timeline for reevaluation of the plan, based on the individual's assessed needs and anticipated progress, but not longer than every 90 days or more frequently if needs change;

   k. document that the individual, the individual's family (in the case of legal minors), or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan; and

a person with a disability by a personal care assistant without obtaining any license required for a provider of health care or his assistance, under very specific circumstance pursuant to NRS 629.091.

SERIOUS MENTAL ILLNESS (SMI)

Persons who are 18 years of age and older who currently or at any time during the past year (continuous 12 month period):

1. have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified in the ~~DSM~~ current ICD (excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with a serious mental illness that meets ~~DSM~~ current ICD criteria); and

2. have a functional impairment which substantially interferes with or limits one or more major life activity such as psychological, social, occupational or educational and may include limiting an adult from achieving or maintaining housing, employment, education, relationships or safety.

3. SMI determinations are made by a QMHP within the scope of their practice under state law and expertise.

SERVICE AREA

The geographic area served by the Contractor as approved by State regulatory agencies and/or as detailed in the certificate of authority issued by the Nevada State Department of Insurance (DOI).

SERVICE AUTHORIZATION REQUEST (SAR)

A managed care enrollee's request for the provision of a service. The request may be made by the enrollee, a provider, or some other entity or individual acting on behalf of the enrollee. A SAR may be made either in writing or orally.

SERVICE LEVELS

Service levels are various measurable requirements that pertain to the delivery system structure of the contract and are used for evaluating contract performance and compliance.

SERVICE PLAN

The service plan is an authorization tool that is developed by the facility using the Physician Evaluation Form and the Universal Needs Assessment Tool. The service plan addresses the delivery of services, provides guidelines for monitoring recipient's progress and identifies the title of the staff that will be providing the specific services identified in the POC. The service plan requires pre-approval for services to be provided, authorization for new treatment, and is part of the PA process.

SEVERE EMOTIONAL DISTURBANCE (SED)

1. ~~Persons from birth through 48 months~~ Children with SED are persons up to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

   ~~a. DC:0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or~~

   ~~b. DC:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or~~

~~2. Persons from 4 to age 18 who currently or at any time during the past year (continuous 12-month period) have a:~~

   a. Diagnosable mental or behavioral disorder or diagnostic criteria that meet~~s~~ the coding and definition criteria specified in the ~~DSM~~ current ICD (excluding substance abuse or addictive disorders, irreversible dementias, mental retardation, developmental disorders, and ~~V~~Z codes, unless they co-occur with a serious mental disorder that meets ~~DSM~~ ICD criteria); and have a:

   b. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent, and persistent features are included, however may vary in term of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

~~3.~~2. SED determinations are made by a QMHP within the scope of their practice under state law and expertise.

SEVERE FUNCTIONAL DISABILITY (SFD)

As defined by NRS 426.721 to 731, severe functional disability means:

1. Any physical or mental condition pursuant to which a person is unable, without substantial assistance from another person, to eat, bathe, and toilet themselves.

2. A traumatic brain injury.

SHORT-TERM OBJECTIVES/BENCHMARK

An IEP must contain a statement of annual goals, including a description of short term objectives or benchmarks that are measurable and outcome oriented. Goals should be related to the child's unique needs to enable the child with a disability to participate and function in the general curriculum.

d. Social or emotional development; or

e. Adaptive development.

3. Children also are eligible who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delays.

4. Informed clinical opinion must be used in determining eligibility for services as a result of a development delay.

TARGET GROUP – JUVENILE PROBATION SERVICES (JPS)

JPS ~~are covered~~ services ~~provided to~~ are:

1. Covered services provided to juveniles on probation (referred or under the supervision of juvenile caseworkers) ~~for Washoe County JPS and Clark County Department of Juvenile Justice Services~~ within all counties of Nevada.

2. Covered services provided to family member(s) who are Medicaid eligible whose children are on probation.

TARGET GROUP – NON-SERIOUSLY MENTALLY ILL (NON-SMI) ADULTS

Adults, who are non-SMI, excluding dementia and ~~mental retardation~~ intellectual disabilities, are recipients 18 years of age and older with significant life stressors and have a:

1. ~~DSM Axis I~~ A current International Classification of Diseases (ICD) diagnosis, from the current Mental, Behavioral, Neurodevelopmental Disorders section including ~~V~~Z-codes, 55-65, R45.850 and R45.851, which ~~that~~ does not meet SMI criteria.

2. LOCUS score of Level I or II.

TARGET GROUP – NON-SEVERELY EMOTIONALLY DISTURBED (NON-SED) CHILDREN AND ADOLESCENTS

Children and adolescents, who are Non-SED, excluding dementia and mental retardation, are recipients with significant life stressors and have:

1. A ~~DSM Axis I~~ current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section that does not meet SED criteria.

2. ~~V~~Z-codes 55-65, R45.850 and R45.851 ~~DSM diagnosis~~ as listed in the current ICD which ~~that~~ does not meet SED criteria.

3. CASII Level of 0, 1, 2, or above.

~~4. DC:03 Axis I diagnosis or DC:03 Axis II PIR-GAS score of 40 or less.~~

TARGET GROUP – PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS (MRRC)

Persons with MRRC are persons who are significantly sub-average in general intellectual functioning (IQ of 70 or below) with concurrent related limitations in two or more adaptive skill areas, such as communication, self-care, social skills, community use, self-direction, health and safety, functional academics, leisure and work activities.

Persons with related conditions are individuals who have a severe chronic disability. It is manifested before the person reaches age 22 and is likely to continue indefinitely. The disability can be attributable to cerebral palsy, epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a mentally retarded person and requires treatment or services similar to those required by these persons.

The related condition results in substantial functional limitations in three or more of the following areas of major life activity:

1. Self care.

2. Understanding and use of language.

3. Learning.

4. Mobility.

5. Self-direction.

6. Capacity for independent living.

TARGET GROUP -- SERIOUS MENTAL ILLNESS (SMI) ADULTS

Adults with a SMI are persons:

1. 18 years of age and older; and;

2. Who currently, or at any time during the past year (continuous 12 month period);

   a. have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the ~~Diagnosis and Statistical Manual of Mental Disorders (DSM-IV)~~ current ICD Mental, Behavioral, Neurodevelopmental Disorders section (excluding

substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with another serious mental illness that meets ~~DSM-IV~~ current ICD criteria)~~;~~

~~b.~~ that resulted in functional impairment which substantially interferes with or limits one or more major life activities;

3. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health-illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

TARGET GROUP -- SEVERE EMOTIONAL DISTURBANCE (SED)

~~Children from birth through 48 months who currently or at any time during the past year (continuous 12 month period) have a:~~

~~1. DC:0-3 Axis I diagnostic category in place of a DSM Axis I diagnostic category; or~~

~~2. CD:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or~~

Children with a SED are persons ~~age 4~~ up to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

1. Diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the ~~DSM~~ current ICD. This excludes substance abuse or addictive disorders, irreversible dementias, as well as mental retardation and ~~V~~Z codes, unless they co-occur with another serious mental illness that meets ~~DSM~~ current ICD criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities, and

2. These disorders include any ~~mental~~ disorder from the Mental, Behavioral, Neurodevelopmental Disorders section (including those of biological etiology) listed in ~~DSM or their ICD-9-CM equivalent~~ (and subsequent revisions), with the exception of ~~DSM~~ "Z~~V~~" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however they vary in terms of severity and disabling effects; and

3. Have a functional impairment defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 400 are being proposed to update policy by removing references to the Diagnostic Statistical Manual (DSM), Diagnostic Criteria for ages zero to three (DC:0-3) and adding International Classification of Diseases (ICD)-10 CM verbiage throughout the chapter and to clarify the provider's responsibility when submitting a concurrent inpatient review to obtain authorization by Nevada Medicaid's Quality Improvement Organization (QIO)-like vendor.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29313 & 29452 CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES	MTL 06/15 CHAPTER 400 – MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.1	**Outpatient Service Delivery Models**	Revised reference to Diagnostic and Statistical Manual (DSM) to current International Classification of Diseases (ICD).
403.2B.2.d.1	**Documentation**	Removed language "DSM or DC:0-3" and added "a covered, current ICD".
403.3.B.3	**Provider Qualifications – Outpatient Mental Health Services**	Removed language "DSM and/or DC:0-3 Axis I and multiaxial DSM" and added "current ICD".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.4.a.2	**Outpatient Mental Health Services**	Removed language "conclude with a DSM-5 axial diagnosis or DC:0-3" and added "a covered, current ICD diagnosis".
403.4.a.4		Removed language "DSM-5 axial" and added "current ICD".
403.4.a.5		Removed language "DSM-5 axial" and added "current ICD".
403.4.a.10		Deleted reference to Global Assessment of Functioning (GAF) language.
403.4.c.4.b.1		Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.2		Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.3		Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.4		Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.5		Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.6		Added "and/or Reactive Attachment Disorders". Changed 40 to 50 sessions. Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.7		Removed reference to ICD-9 and updated current ICD Codes.
403.4.c.4.b.8		Deleted reference to Reactive Attachment Disorders and combined with 403.4.c.4.b.6.
403.4.c.4.b.9		Removed reference to ICD-9 and updated current ICD Codes.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.4.d.3		Deleted reference to ICD-9 and codes 290.0-319. Added language "Mental, Behavioral and Neurodevelopmental Disorders".
403.5.B.2	**Intensity of Needs Grid**	Removed reference to V-Code Diagnosis. Updated current ICD codes. Removed language "mental retardation" and added "intellectual disabilities and related conditions". Removed language "DSM Axis I" and added "Current ICD". Removed language "DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and". Added language "Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders".
403.5.D.1	**Non-Covered OMH Services**	Removed language "DSM or DC:0-3" and added "covered, current ICD".
403.5.D.2		Removed "DSM" and added "covered, current ICD".
403.5.D.3		Removed "DSM" and added "covered, current ICD".
403.5.D.4		Removed "DSM" and added "covered, current ICD".
403.6B.1	**Rehabilitative Mental Health (RMH) Services**	Removed language "DSM or DC:0-3" and added "covered, current ICD".
403.6B.5.f		Removed language "mental retardation or related conditions" and added "intellectual disabilities and related conditions".
403.6B.5.m		Removed language "DSM or DC:0-3" and added "covered, current ICD".
403.6B.5.n		Removed language "DSM or DC:0-3" and added "covered, current ICD".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.6B.5.o		Removed language "DSM or DC:0-3" and added "covered, current ICD".
403.6B.5.p		Removed language "DSM or DC:0-3" and added "covered, current ICD".
403.6B.6.a.1		Removed language "DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 70 or less" and added "A covered, current ICD".
403.6B.6.a.2		Deleted "2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and".
403.6B.6.b.1		Removed "DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 60 or less" and added "A covered, current ICD".
403.6B.6.b.2		Removed language "DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and".
403.6B.6.c.1		Removed "DSM IV diagnosis (See DSM DIAGNOSIS definition), GAF Score of 50 or less" and added "A covered, current ICD".
403.6B.6.c.2		Deleted "2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and".
403.6B.6.d.1		Removed "2. DSM IV diagnosis (See DSM DIAGNOSIS definition), GAF Score of 50 or less" and added "A covered, current ICD".
403.6B.6.d.2		Deleted "2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 30 or less; and".
403.8A.1	**Coverage and Limitations**	Deleted "(for Axis I, II and III diagnoses)".
403.8.5.g		Removed "DSM Axis I or Axis II diagnosis" and added "covered, current ICD".
403.8C.1.b.3		Removed "DSM" and added "Covered, current ICD".
403.9.A	**Inpatient Mental Health Services Policy**	Removed "DSM Axis I" and added "covered, current ICD".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
403.9C.2	**Authorization Process**	Added clarification to align MSM Chapter 400 with MSM Chapter 200 and to be consistent with Hewlett Packard Enterprise Services (HPES) billing manuals. Removed the time frame of two business days to provide the additional information.
403.12A.3		Removed reference to ICD-9 and updated current ICD Codes. Added "and depressive type psychosis and other nonorganic psychoses" to Affective psychoses. Deleted "298.00 298.9 Depressive type psychosis and other nonorganic psychoses".
Attachment A Policy #4-01	**Day Treatment Ages 3-6**	Removed "Diagnostic and Statistical Manual (DSM) or DC: 0-3 Axis I diagnosis" and added "covered, current ICD diagnosis".
Attachment A Policy #4-02	**Day Treatment Ages 7-18**	Removed "DSM or Axis I diagnosis" and added "covered, current ICD diagnosis".
Attachment A Policy #4-03	**Day Treatment Ages 19 and Older**	Removed "DSM or Axis I diagnosis" and added "covered, current ICD diagnosis".
Attachment B Policy #4-04	**Substance Abuse Agencies Model (SAAM)**	Revised definition of Substance abuse. Removed "Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or ICD9" and added "International Classification o Diseases (ICD)". Removed "DSM/ICD9" and added "covered, current ICD".

403 POLICY

403.1 OUTPATIENT SERVICE DELIVERY MODELS

Nevada Medicaid reimburses for outpatient mental health and/or mental health rehabilitative services under the following service delivery models:

a. Behavioral Health Community Networks (BHCN)

Public or private entities that provides or contracts with an entity that provides:

1. Outpatient services, such as assessments, therapy, testing and medication management, including specialized services for Nevada Medicaid recipients who are experiencing symptoms relating to a ~~Diagnostic and Statistical Manual (DSM) Axis I~~ covered, current International Classification of Diseases (ICD) diagnosis or who are individuals with a mental illness and residents of its mental health service area who have been discharged from inpatient treatment;

2. 24-hour per day emergency response for recipients; and

3. Screening for recipients under consideration for admission to inpatient facilities.

BHCNs are a service delivery model and are not dependent on the physical structure of a clinic. BHCNs can be reimbursed for all services covered in this chapter and may make payment directly to the qualified provider of each service. BHCNs must coordinate care with mental health rehabilitation providers.

b. Independent Professionals - State of Nevada licensed: psychiatrists, psychologists, clinical social workers, marriage and family therapists and clinical professional counselors. These providers are directly reimbursed for the professional services they deliver to Medicaid-eligible recipients in accordance with their scope of practice, state licensure requirements and expertise.

c. Individual Rehabilitative Mental Health (RMH) providers must meet the provider qualifications for the specific service. If they cannot independently provide Clinical and Direct Supervision, they must arrange for Clinical and Direct Supervision through a contractual agreement with a BHCN or qualified independent professional. These providers may directly bill Nevada Medicaid or may contract with a BHCN.

3. This supervision may occur in a group and/or individual settings.

b. Their face-to-face and/or telephonic meetings with the servicing provider(s).

1. These meetings must occur before treatment/rehabilitation begins and, at a minimum, every 30 days thereafter;

2. The documentation regarding this supervision must reflect the content of the training and/or clinical guidance; and

3. This supervision may occur in group and/or individual settings;

c. Assist the Clinical Supervisor with Treatment and/or Rehabilitation Plan(s) reviews and evaluations.

403.2B DOCUMENTATION

1. Treatment Plan-A written individualized plan that is developed jointly with the recipient, their family (in the case of legal minors) and/or their legal representative and a QMHP within the scope of their practice under state law. When RMH services are prescribed, the provider must develop a Rehabilitation Plan (see definition). The Treatment Plan is based on a comprehensive assessment and includes:

a. The strengths and needs of the recipients and their families (in the case of legal minors and when appropriate for an adult);

b. Intensity of Needs Determination;

c. Specific, measurable (observable), achievable, realistic, and time-limited goals and objectives;

d. Specific treatment, services and/or interventions including amount, scope, duration and anticipated provider(s) of the services;

e. Discharge criteria specific to each goal; and for

f. High-risk recipients accessing services from multiple government-affiliated and/or private agencies, evidence of care coordination by those involved with the recipient's care.

The recipient, or their legal representative, must be fully involved in the treatment planning process, choice of providers, and indicate an understanding of the need for services and the elements of the Treatment Plan. Recipient's, family's (when appropriate)

and/or legal representative's participation in treatment planning must be documented on the Treatment Plan.

Temporary, but clinically necessary, services do not require an alteration of the Treatment Plan, however, must be identified in a progress note. The note must indicate the necessity, amount, scope, duration and provider of the service.

2. Rehabilitation Plan

a. A comprehensive, progressive, and individualized written Rehabilitative Plan must include all the prescribed Rehabilitation Mental Health (RMH) services. RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR), and Crisis Intervention (CI). The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the recipient to their best possible functional level. The plan must ensure the transparency of coverage and medical necessity determinations, so that the recipient, their family (in the case of legal minors), or other responsible individuals would have a clear understanding of the services that are made available to the recipient. In all situations, the ultimate goal is to reduce the duration and intensity of medical care to the least intrusive level possible – while sustaining overall health. All prescribed services must be medically necessary, clinically appropriate, and contribute to the rehabilitation goals and objectives.

b. The Rehabilitation Plan must include recovery goals. The plan must establish a basis for evaluating the effectiveness of the RMH care offered in meeting the stated goals and objectives. The plan must provide for a process to involve the beneficiary, and family (in the case of legal minors) or other responsible individuals, in the overall management of the RMH care. The plan must document that the services have been determined to be rehabilitative services consistent with the regulatory definition, and will have a timeline, based on the individual's assessed needs and anticipated progress.

c. The reevaluation of the plan must involve the recipient, the recipient's family (in the case of legal minors), or other responsible individuals. The reevaluation of the plan must include a review of whether the established goals and objectives are being met and whether each of the services prescribed in the plan has contributed to meeting the stated established goals and objectives. If it is determined that there has been no measurable reduction of disability and/or function level restoration, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, objectives, services, and/or methods. The plan must identify the rehabilitation goals and objectives that would be achieved under

that plan in terms of measurable reductions in a diagnosed physical or mental disability and in terms of restored functional abilities.

d. Rehabilitation goals and objectives are often contingent on the individual's maintenance of a current level of functioning. In these instances, services that provide assistance in maintaining functioning may be considered rehabilitative only when necessary to help an individual achieve a rehabilitation goal and objectives as defined in the rehabilitation plan. The plan must be reasonable and based on the individual's diagnosed condition(s) and on the standards of practice for provisions of rehabilitative mental and/or behavioral health services to an individual with the individual's condition(s). The written rehabilitation plan must ensure that services are provided within the scope (therapeutic intent) of the rehabilitative services and would increase the likelihood that an individual's disability would be reduced and functional level restored. Rehabilitation plans are living documents and therefore must evolve in concert (show progressive transformations in the amount, duration, and scope of services provided) with the recipient's functional progress. The rehabilitation plan must also demonstrate that the services requested are not duplicative (redundant) of each other. The written rehabilitation plan must:

1. Be based on a comprehensive assessment of an individual's rehabilitation needs including ~~DSM or DC:0 3~~ a covered, current ICD diagnoses and presence of a functional impairment in daily living;

2. Ensure the active participation of the individual, individual's family (in the case of legal minors), the individual's authorized health care decision maker and/or persons of the individual's choosing in the development, review and modification of these goals and services;

3. Be approved by a QMHP, working within the scope of their practice under state law;

4. Be signed by the individual responsible for developing the plan;

5. Specify the individual's rehabilitation goals and objectives to be achieved, including recovery goals for persons with mental health related disorders;

6. Identify the RMH services intended to reduce the identified physical impairment, mental and/or behavioral health related disorder

7. Identify the methods that would be used to deliver services;

8. Indicate the frequency, amount and duration of the services;

e. a plan for assisting the recipient in accessing these services.

5. Discharge Summary – Written documentation of the last service contact with the recipient, the diagnosis at admission and termination, and a summary statement that describes the effectiveness of the treatment modalities and progress, or lack of progress, toward treatment goals and objectives, as documented in the mental health Treatment and/or Rehabilitation Plan(s). The Discharge Summary also includes the reason for discharge, current level of functioning, and recommendations for further treatment. Discharge summaries are completed no later than 30 calendar days following a planned discharge and 45 calendar days following an unplanned discharge. In the case of a recipient's transfer to another program, a verbal summary must be given at the time of transition and followed with a written summary within seven calendar days of the transfer. The Discharge Summary is a summation of the results of the Treatment Plan, Rehabilitation Plan and the Discharge Plan.

403.3 PROVIDER QUALIFICATIONS – OUTPATIENT MENTAL HEALTH SERVICES

A. QMHA - A person who meets the following documented minimum qualifications:

1. Licensure as a RN in the State of Nevada or holds a Bachelor's Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or

2. Holds an Associate's Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders; or

3. An equivalent combination of education and experience as listed in Section 403.3.A.1-2 above; and

4. Whose education and experience demonstrate the competency under clinical supervision to:

a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;

b. Identify presenting problem(s);

c. Participate in Treatment Plan development and implementation;

d. Coordinate treatment;

e. Provide parenting skills training;

f. Facilitate Discharge Plans; and

g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A.

B. Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a person who meets the definition of a QMHA and also meets the following documented minimum qualifications:

1. Holds any of the following educational degrees and licensure:

a. Doctorate degree in psychology and license;

b. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);

c. Independent Nurse Practitioner; Graduate degree in social work and clinical license;

d. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; or

2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and

3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, ~~diagnosis a DSM and/or DC:0-3 Axis I~~ diagnose a mental or emotional disorder and document a ~~multiaxial DSM~~ current ICD diagnosis, determine intensity of services needs, establish measurable goals, objectives and discharge criteria, write and supervise a Treatment Plan and provide direct therapeutic treatment within the scope and limits of their expertise.

4. Interns/Psychological Assistants

The following are also considered QMHPs:

a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).

b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

Reimbursement for Interns/Psychological Assistants is based upon the rate of a QMHP, which includes the clinical and direct supervision of services by a licensed supervisor.

403.4 OUTPATIENT MENTAL HEALTH SERVICES

These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services.

a. Assessments are covered for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a QMHP or designated QMHA in the case of a Mental Health Screen.

1. Mental Health Screen – A behavioral health screen to determine eligibility for admission to treatment program.

2. Comprehensive Assessment – A comprehensive, evaluation of a recipient's history and functioning which, combined with clinical judgment, is to ~~conclude with a DSM 5-axial diagnosis or DC:0-3~~ include a covered, current ICD diagnosis and a summary of identified rehabilitative treatment needs.

3. Health and Behavior Assessment – Used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health needs. The focus of the assessment is not on the mental health needs, but on the biopsychosocial factors important to physical health needs and treatments. The focus of the intervention is to improve the recipient's health and well-being utilizing cognitive, behavioral, social and/or psycho-physiological procedures designed to ameliorate specific disease related needs. This type of assessment is covered on an individual basis, family with the recipient present or family without the recipient present.

4. Psychiatric Diagnostic Interview – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychiatric diagnostic interview may consist of a clinical interview, a medical and mental history, a mental status examination, behavioral observations, medication evaluation and/or prescription by a licensed psychiatrist. The psychiatric diagnostic interview is to conclude with a written report which contains a ~~DSM 5 axial~~ current ICD diagnosis and treatment recommendations.

5. Psychological Assessment – Covered once per calendar year without prior authorization. If there is a substantial change in condition, subsequent assessments may be requested through a prior-authorization from the QIO-like vendor for Nevada Medicaid. A psychological assessment may consist of a clinical interview, a biopsychosocial history, a mental status examination and behavioral observations. The psychological assessment is to conclude with a written report which contains a ~~DSM 5 axial~~ current ICD diagnosis and treatment recommendations.

6. Functional Assessment - Used to comprehensively evaluate the recipient's skills, strengths and needs in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function; as such, environment is consistent with the goals listed in the recipient's individualized Treatment Plan. A functional assessment is used to assess the presence of functional strengths and needs in the following domains: vocational, education, self-maintenance, managing illness and wellness, relationships and social.

   A person-centered conference is covered as part of the functional assessment to collaboratively develop and communicate the goals and objectives of the individualized Treatment Plan. The conference must include the recipient, a QMHP, family or legal representative, significant others and case manager(s). The case manager(s) or lead case manager, if there are multiple case managers shall provide advocacy for the recipient's goals and independence, supporting the

recipient's participation in the meeting and affirming the recipient's dignity and rights in the service planning process.

7. Intensity of Needs Determination - A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the QMHP and/or trained QMHA. This assessment was previously known as a level of care assessment. Currently, the DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by the DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.

8. Severe Emotional Disturbance (SED) Assessment - Covered annually or if there is a significant change in functioning. The SED assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

9. Serious Mental Illness (SMI) Assessment - Covered annually or if there is a significant change in functioning. The SMI assessment is a tool utilized to determine a recipient's eligibility for higher levels of care and Medicaid service categories.

~~10. Global Assessment of Functioning (GAF) Scale: GAF ratings are based on clinical judgment; GAF ratings measure overall psychological functioning and psychiatric disturbances; and are used to collaborate Intensity of Needs Determinations. The GAF scale is located in DSM-IV.~~

b. Neuro-Cognitive, Psychological and Mental Status Testing

1. Neuropsychological Testing with interpretation and report involves assessment and evaluation of brain behavioral relationships by a neuropsychologist. The evaluation consists of qualitative and quantitative measurement that consider factors such as the interaction of psychosocial, personality/emotional, intellectual, environmental, neurocognitive, biogenetic, and neurochemical aspects of behaviors in an effort to understand more fully the relationship between physiological and psychological systems. This service requires prior authorization from the QIO-like vendor.

2. Neurobehavioral Testing with interpretation and report involves the clinical assessment of thinking, reasoning and judgment, acquired knowledge, attention,

memory, visual spatial abilities, language functions and planning. This service requires prior authorization.

3. Psychological Testing with interpretation and report is the administration, evaluation and scoring of standardized tests which may include the evaluation of intellectual functioning, clinical strengths and needs, psychodynamics, insight, motivation and other factors influencing treatment outcomes.

c. Mental Health Therapies

Mental health therapy is covered for individual, group and/or family therapy with the recipient present and for family therapy without the recipient present and described as follows:

1. Family Therapy

Mental health treatment service provided to a specific recipient by a QMHP using the natural or substitute family as the means to facilitate positive family interactions among individuals. The recipient does not need to be present for family therapy services; however, the services must deal with issues relating to the constructive integration/reintegration of the recipient into the family.

2. Group Therapy

Mental Health treatment service facilitated by a QMHP within their scope of licensure or practice, which utilizes the interactions of more than one individual and the focus of the group to address behavioral health needs and interpersonal relationships. The therapy must be prescribed on the Treatment Plan and must have measurable goals and objectives. Group therapy may focus on skill development for learning new coping skills, such as stress reduction, or changing maladaptive behavior, such as anger management. Participation in group therapy must be documented on the clinical record. Minimum group size is three and maximum therapist to participant ratio is one to ten. Group therapy can be less than three but more than one based on unforeseen circumstances such as a no-show or cancellation, but cannot be billed as individual therapy. Group therapy may also include a family without the recipient present and/or multi-family groups.

3. Individual Therapy Services

Mental health treatment service provided to a specific recipient for a presenting need by an individual therapist for a specified period of time. The amount, scope and duration of individual therapy services may vary depending on the stage of the presenting mental health need, treatment program and recipient's response to the

treatment approach. Individual is one recipient. Each direct one-on-one episode must be of a sufficient length of time to provide the appropriate skilled treatment in accordance with each patient's treatment/rehabilitative plan.

4. Neurotherapy

a. Neurotherapy is individual psychological therapy incorporating biofeedback training combined with psychotherapy as a treatment for mental health disorders. Medicaid will reimburse for medically necessary neurotherapy when administered by a licensed QMHP within the scope of their practice and expertise. A certified Biofeedback Technician may assist in the provision of biofeedback treatment; however, a QMHP must provide the associated psychotherapy. Reimbursement for biofeedback treatment provided by a Biofeedback Technician is imbedded in the QMHP rate.

b. Prior authorization requirements and QIO-like vendor responsibilities are the same for all out-patient therapies, except for the following allowable service limitations for neurotherapy used for treatment of the following covered ICD-9-CM Codes:

1. Attention Deficit Disorders – 40 sessions
Current ICD~~-9-~~Codes: ~~314, 314.0, 314.00, 314.1, 314.2, 314.8 and 314.9~~ F90.0, F90.8 and F90.9

2. Anxiety Disorders – 30 sessions
Current ICD~~-9-~~Codes: ~~300, 300.0, and 300.4~~ F41.0 and F34.1

3. Depressive Disorders – 25 sessions
Current ICD~~-9-~~Codes: ~~296.2, 296.3 and 298.0~~ F32.9, F33.40, F33.9, F32.3, and F33.3

4. Bipolar Disorders - 50 sessions
Current ICD~~-9-~~Codes: ~~296, 296.0, 296.1, 296.4, 296.5, 296.6, 296.7, 296.8 and 296.9~~ F30.10, F30.9, F31.0, F31.10, F31.89, F31.30, F31.60, F31.70, F31.71, F31.72, F31.9, and F39

5. Obsessive Compulsive Disorders – 40 sessions
Current ICD~~-9-~~Codes: ~~300.3~~ F42

6. Opposition Defiant Disorders and/or Reactive Attachment Disorders – ~~40~~50 sessions
Current ~~ICD-9-~~Codes: ~~313, 313.81 and 313.89~~ F93.8, F91.3, F94.1, F94.2, F94.9, and F98.8

7. Post Traumatic Stress Disorders – 35 sessions
Current ICD~~-9~~-Codes: ~~309, 309.81~~ F43.21, F43.10, F43.11, and F43.12

~~8. Reactive Attachment Disorders – 50 sessions~~
~~ICD-9-Codes 313, 313.81 and 313.89~~

~~9.~~8. Schizophrenia Disorders – 50 sessions
Current ICD~~-9~~-Codes: ~~295, 295.0, 295.1, 295.2, 295.3, 295.4, 295.5, 295.6, 295.7, 295.8 and 295.9~~ F20.89, F20.1, F20.2, F20.0, F20.81, F20.89, F20.5, F25.0, F25.1, F25.8, F25.9, F20.3 and F20.9

Prior authorization may be requested for additional services based upon medical necessity.

d. Mental Health Therapeutic Interventions

1. Partial Hospitalization Program (PHP) - Traditional - Services furnished under a medical model by a hospital, in an outpatient setting, which encompass a variety of psychiatric treatment modalities designed for recipients with mental or substance abuse disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment not generally provided in an outpatient setting. These services are expected to reasonably improve or maintain the individual's condition and functional level to prevent relapse of hospitalization. The services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an exacerbation of a severe and persistent mental illness. PHP services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and maintaining or improving functioning to prevent relapse or hospitalization.

2. Intensive Outpatient Program (IOP) – A comprehensive interdisciplinary program of an array of direct mental health and rehabilitative services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization. The services are provided to individuals who are diagnosed as severely emotionally disturbed or seriously mentally ill.

3. Medication Management - A medical treatment service using psychotropic medications for the purpose of rapid symptom reduction, to maintain improvement in a chronic recurrent disorder, or to prevent or reduce the chances of relapse or reoccurrence. Medication management must be provided by a psychiatrist or physician licensed to practice in the State of Nevada and may include, through consultation, the use of a physician's assistant or a certified nurse practitioner licensed to practice in the State of Nevada within their scope of practice.

Medication management may be used by a physician who is prescribing pharmacologic therapy for a recipient with an organic brain syndrome or whose diagnosis is in the current ICD~~9 range~~ section of ~~290.0-319~~ Mental, Behavioral and Neurodevelopmental Disorders, and is being managed primarily by psychotropic drugs. It may also be used for the recipient whose psychotherapy is being managed by another mental health professional and the billing physician is managing the psychotropic medication. The service includes prescribing, monitoring the effect of the medication and adjusting the dosage. Any psychotherapy provided is minimal and is usually supportive only. If the recipient received psychotherapy and drug management at the same visit, the drug management is included as part of that service by definition and medication management should not be billed in addition.

4. Medication Training and Support – Provided by a professional other than a physician, is covered for monitoring of compliance, side effects, recipient education and coordination of requests to a physician for changes in medication(s).

403.5 OUTPATIENT MENTAL HEALTH (OMH) SERVICES - UTILIZATION MANAGEMENT

A. INTENSITY OF NEEDS DETERMINATION

The assessed level of needs and the amount, scope and duration of RMH services required to improve or retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient. Intensity of needs determination is completed by a trained QMHP or QMHA. Intensity of Needs Determinations are based on several components consistent with person and family centered treatment/rehabilitation planning. Intensity of Needs redeterminations must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

These components include:

1. A comprehensive assessment of the recipient's level of functioning;

2. The clinical judgment of the QMHP; and

3. A proposed Treatment and/or Rehabilitation Plan.

B. INTENSITY OF NEEDS GRID

1. The intensity of needs grid is an approved Level of Care (LOC) utilization system, which bases the intensity of services on the assessed needs of a recipient. The determined level on the grid guides the interdisciplinary team in planning treatment to improve or retain a recipient's level of functioning or prevent relapse.

Each Medicaid recipient must have an intensity of needs determination completed prior to approval to transition to more intensive services (except in the case of a physician or psychologist practicing as independent providers). The intensity of needs grid was previously referred to as level of services grid.

2. Intensity of Need for Children:

Child and Adolescent Service Intensity Instrument (CASII)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	• Significant Life Stressors and/or ~~V-code Diagnosis~~ current ICD codes, Z55-Z65, R45.850, and R45.821 that does not meet SED criteria (excluding ~~"V" codes,~~ dementia~~, mental retardation,~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Outpatient Services	• ~~DSM Axis I~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders that does not meet SED criteria (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness)~~; or~~. ~~• DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less.~~
Level III Intensive Outpatient Services	• ~~DSM Axis I~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); ~~or~~ and ~~• DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and~~ • SED Determination.
Levels IV Intensive Integrated Services	• ~~DSM Axis I~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); ~~or~~ and ~~• DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and~~ • SED Determination.

Level V Non-secure, 24 hour Services with Psychiatric Monitoring	• ~~DSM Axis I~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); ~~or~~ and • ~~DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIRGAS score of 40 or less; and~~ • SED determination; and • Requires specialized treatment (e.g., sex offender treatment, etc).
Level VI Secure, 24 hour, Services with Psychiatric Management	• ~~DSM Axis I~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); ~~or~~ and • ~~DC:0-3 Axis I Diagnosis or DC:0-3 Axis II PIR - GAS score of 40 or less; and~~ • SED determination; and • Requires inpatient/secured LOC.

3. Intensity of Needs for Adults:

Level of Care Utilization System for Adults (LOCUS)	Service Criteria
Levels I Basic Services: Recovery Maintenance and Health Management	• ~~DSM Axis I diagnoses~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders, including ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, that do not meet SMI criteria (excluding ~~"V" codes~~, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level II Low Intensity Community Based Services	• ~~DSM Axis I diagnoses~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders, including ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes that do not meet SMI criteria (excluding ~~"V" codes~~, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness).
Level III High Intensity Community Based Services (HCBS)	• ~~DSM Axis I diagnosis~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental~~

	~~retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Levels IV Medically Monitored Non-Residential Services	• ~~DSM Axis I diagnosis~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination.
Level V Medically Monitored Residential Services	• ~~DSM Axis I diagnosis~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires specialized treatment (e.g. sex offender treatment, etc).
Level VI Medically Managed Residential Services	• ~~DSM Axis I diagnosis~~ Current ICD diagnosis in Mental, Behavioral, and Neurodevelopmental Disorders (excluding ~~"V"~~ Z55-Z65, R45.850, and R45.821 codes, dementia, ~~mental retardation~~ intellectual disabilities and related conditions, or a primary diagnosis of a substance abuse disorder, unless these conditions co-occur with a mental illness); and • SMI determination; and • Requires inpatient/secured LOC.

C. Utilization Management for outpatient mental health services is provided by the DHCFP QIO-like vendor as follows:

1. For BHCN, all service limitations are based upon the Intensity of Needs Grid in the definitions. The recipient must have an Intensity of Needs determination to supplement clinical judgment and to determine the appropriate service utilization. The provider must document in the case notes the level that is determined from the Intensity of Needs grid;

2. Independent psychologists are not subject to the service limitations in the Intensity of Needs Grid. The following service limitations are for psychologists:

   a. Assessments – two per calendar year, additional services require prior authorization from the QIO-like vendor; and

b. Therapy (group, individual, family) – a combination of up to twenty-six visits per calendar year is allowed without prior authorization. Additional services require prior authorization from the QIO-like vendor.

3. Independent psychiatrists are not subject to the service limitations in the Intensity of Needs grid. No prior authorization is required for this particular provider.

4. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents.

Child and Adolescent Service Intensity Instrument (CASII)	Intensity of Services (Per Calendar Year[1])
Levels I Basic Services: Recovery Maintenance and Health Management	• Assessment 2 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy 10 total sessions; • Medication Management 6 total sessions
Level II Outpatient Services	• Assessments: 4 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 26 total sessions
Level III Intensive Outpatient Services	All Level Two Services Plus: • IOP
Levels IV Intensive Integrated Services	All Level Three Services • PHP
Level V Non-secure, 24 Hour Services with Psychiatric Monitoring	All Level Four Services
Level VI Secure, 24 Hour, Services with Psychiatric Management	All level Five services

Prior Authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Levels III and above only.

a. Service provision is based on the calendar year beginning on January 1.

b. Sessions indicates billable codes for this service may include occurrence based codes, time-based, or a combination of both. Session = each time this service occurs regardless of the duration of the service.

5. Medicaid Behavioral Health Intensity of Needs for Adults

Level of Care Utilization System for Adults (LOCUS)	**Intensity of Service** (Per Calendar Year[1])
Levels I Basic Services - Recovery Maintenance and Health Management	• Assessment: 2 total sessions (does not include Mental Health Screen) • Individual, Group or Family Therapy: 6 total sessions • Medication Management: 6 total sessions
Level II Low Intensity Community Based Services	• Assessment: (2 assessments; does not include Mental Health Screen) • Individual, Group or Family Therapy: 12 total sessions • Medication Management: 8 total sessions
Level III High Intensity Community Based Services	• Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 12 total sessions • Medication Management: 12 total sessions
Level IV Medically Monitored Non-Residential Services	• Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family Therapy: 16 total sessions • Medication Management (12 sessions) • Partial Hospitalization
Level V Medically Monitored Residential Services	• Assessment (2 assessments; does not include Mental Health Screen) • Individual, Group and Family therapy: 18 total sessions • Medication Management (12 sessions) • Partial Hospitalization
Level VI Medically Managed Residential Services	All Level Five Services

Prior Authorization may be requested from the QIO-like vendor for additional assessment and therapy services for Level III and above only.

a. Service provision is based on the calendar year beginning on January 1.

b. Sessions indicates billable codes for this service may include occurrence based codes, time-based, or a combination of both. Session = each time this service occurs regardless of the duration of the service.

D. Non-Covered OMH Services

The following services are not covered under the OMH program for Nevada Medicaid and Nevada Check Up (NCU):

1. Services under this chapter for a recipient who does not have a ~~DSM or DC:0 3~~ covered, current ICD diagnosis;

2. Therapy for marital problems without a ~~DSM~~ covered, current ICD diagnosis;

3. Therapy for parenting skills without a ~~DSM~~ covered, current ICD diagnosis;

4. Therapy for gambling disorders without a ~~DSM~~ covered, current ICD diagnosis;

5. Custodial services, including room and board;

6. Support group services other than Peer Support Services;

7. More than one provider seeing the recipient in the same therapy session;

8. Services not authorized by the QIO-like vendor if an authorization is required according to policy; and

9. Respite.

403.6 PROVIDER QUALIFICATIONS

403.6A REHABILITATION MENTAL HEALTH (RMH) SERVICES

RMH services may be provided by specific providers who meet the following qualifications for an authorized service:

1. QBA - Is a person who has an educational background of a high-school diploma or General Education Development (GED) equivalent and has been determined competent by

initially and annually thereafter. Testing and surveillance shall be followed as outlined in NAC 441A.375.3.

f. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and /or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the BHCN or Independent RMH provider. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The BHCN or Independent RMH provider must document the comparability of the written verification to the QBA training requirements.

2. QMHA, refer to Section 403.3A.

3. QMHP, refer to Section 403.3B.

403.6B REHABILITATIVE MENTAL HEALTH (RMH) SERVICES

1. Scope of Service: RMH services must be recommended by a QMHP within the scope of their practice under state law. RMH services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the recipient's to their best possible mental and/or behavioral health functioning. RMH services must be coordinated in a manner that is in the best interest of the recipient. RMH services may be provided in a variety of community and/or professional settings. The objective is to reduce the duration and scope of care to the least intrusive level of mental and/or behavioral health care possible while sustaining the recipient's overall health. All RMH services must be directly and medically necessary.

Prior to providing RMH services, a QMHP must conduct a comprehensive assessment of an individual's rehabilitation needs including the presence of a functional impairment in daily living and a mental and/or behavioral health diagnosis. This assessment must be based on accepted standards of practice and include a ~~DSM or DC:0 3~~ covered, current ICD diagnosis. The assessing QMHP must approve a written Rehabilitation Plan. The rehabilitation strategy, as documented in the Rehabilitation Plan, must be sufficient in the amount, duration and scope to achieve established rehabilitation goals and objectives. Simultaneously, RMH services cannot be duplicative (redundant) of each other. Providers must assure that the RMH services they provide are coordinated with other servicing providers. Case records must be maintained on recipients receiving RMH services. These case records must include and/or indicate:

a. the recipient's name;

b. progress notes must reflect the date and time of day that RMS services were provided; the recipient's progress toward functional improvement and the attainment of established rehabilitation goals and objectives; the nature, content and number of RMH service units provided; the name, credential(s) and signature of the person who provided the RMH service(s). Progress notes must be completed after each session and/or daily; progress notes are not required on days when RMH services are not provided; a single progress note may include any/all the RMH services provided during that day;

c. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement of their freedom to select a qualified Medicaid provider of their choosing;

d. indications that the recipients and their families/legal guardians (in the case of legal minors) were involved in all aspects care planning;

e. indications that the recipients and their families/legal guardians (in the case of legal minors) are aware of the scope, goals and objectives of the RMH services made available; and

f. the recipients and their families/legal guardians (in the case of legal minors) acknowledgement that RMH services are designed to reduce the duration and intensity of care to the least intrusive level of care possible while sustaining the recipient's overall health.

2. Inclusive Services: RMH services include Basic Skills Training (BST), Program for Assertive Community Treatment (PACT), Day Treatment, Peer-to-Peer Support, Psychosocial Rehabilitation (PSR) and Crisis Intervention (CI).

3. Provider Qualifications:

a. QMHP: QMHPs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR and CI services.

b. QMHA: QMHAs may provide BST, PACT, Day Treatment, Peer-to-Peer Support, PSR services under the Clinical Supervision of a QMHP.

c. QBA: QBAs may provide BST services under the Clinical Supervision of QMHP and the Direct Supervision of a QMHP/QMHA. QBAs may provide Peer-to-Peer Support services under the Clinical/Direct Supervision of a QMHP.

4. Therapeutic Design: RMH services are adjunct (enhancing) interventions designed to compliment more intensive mental health therapies and interventions. While some

rehabilitative models predominately utilize RMH services, these programs must demonstrate the comprehensiveness and clinical appropriateness of their programs prior to receiving prior authorization to provide RMH services. RMH services are time-limited services, designed to be provided over the briefest and most effective period possible. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. Also taken into consideration are other social, educational and intensive mental health obligations and activities. RMH services are planned and coordinated services.

5. Non-Covered Services: RMH services do not include (from CMS 2261-P):

a. RMH services are not custodial care benefits for individuals with chronic conditions but should result in a change in status;

b. custodial care and/or routine supervision: Age and developmentally appropriate custodial care and/or routine supervision including monitoring for safety, teaching or supervising hygiene skills, age appropriate social and self-care training and/or other intrinsic parenting and/or care giver responsibilities;

c. maintaining level of functioning: Services provided primarily to maintain a level of functioning in the absence of RMH goals and objectives, impromptu non-crisis interventions and routine daily therapeutic milieus;

d. case management: Conducting and/or providing assessments, care planning/ coordination, referral and linkage and monitoring and follow-up;

e. habilitative services;

f. services provided to individuals with a primary diagnosis of ~~mental retardation or related conditions~~ intellectual disabilities and related conditions (Unless these conditions co-occur with a mental illness) and which are not focused on rehabilitative mental and/or behavioral health;

g. cognitive/intellectual functioning: Recipients with sub-average intellectual functioning who would distinctly not therapeutically benefit from RMH services;

h. transportation: Transporting recipients to and from medical and other appointments/services;

i. educational, vocational or academic services: General and advanced private, public and compulsory educational programs; personal education not related to the reduction of mental and/or behavioral health problem; and services intrinsically

provided through the Individuals with Disabilities Education Improvement Act (IDEA);

j. inmates of public institutions: To include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent;

k. room and board: Includes housing, food, non-medical transportation and other miscellaneous expenses, as defined below:

1. Housing expenses include shelter (mortgage payments, rent, maintenance and repairs and insurance), utilities (gas, electricity, fuel, telephone, and water) and housing furnishings and equipment (furniture, floor coverings, major appliances and small appliances);

2. Food expenses include food and nonalcoholic beverages purchased at grocery, convenience and specialty store;

3. Transportation expenses include the net outlay on purchase of new and used vehicles, gasoline and motor oil, maintenance and repairs and insurance;

4. Miscellaneous expenses include clothing, personal care items, entertainment and reading materials;

5. Administrative costs associated with room and board;

l. non-medical programs: Intrinsic benefits and/or administrative elements of non-medical programs, such as foster care, therapeutic foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation and juvenile justice;

m. services under this chapter for a recipient who does not have a ~~DSM or DC:0-3~~ covered, current ICD diagnosis;

n. therapy for marital problems without a ~~DSM~~ covered, current ICD diagnosis;

o. therapy for parenting skills without a ~~DSM~~ covered, current ICD diagnosis;

p. therapy for gambling disorders without a ~~DSM~~ covered, current ICD diagnosis;

q. support group services other than Peer Support services;

r. more than one provider seeing the recipient in the same RMH intervention with the exception of CI services;

s. respite care;

t. recreational activities: Recreational activities not focused on rehabilitative outcomes;

u. personal care: Personal care services intrinsic to other social services and not related to RMH goals and objectives; and/or

v. services not authorized by the QIO-like vendor if an authorization is required according to policy.

6. Service Limitations: All RMH services require prior authorization by Medicaid's QIO-Like vendor. RMH services may be prior authorized up to 90-days.

a. Intensity of Need Levels I & II: Recipients may receive BST and/or Peer-to-Peer services provided:

1. ~~DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 70 or less~~ A covered, current ICD and CASII/LOCUS Levels I or II; ~~or~~ and

2. ~~DC:0-3 Axis I diagnosis or DC:0-3 Axis II Parent-Infant Relationship Global Assessment (PIR-GAS) score of 50 or less; and~~

~~3.~~2. clinical judgment; and

~~4.~~3. the overall combination does not exceed a maximum of two hours per day; and

~~5.~~4. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

b. Intensity of Need Level III: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

1. ~~DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 60 or less~~ A covered, current ICD, and CASII/LOCUS Level III; ~~or~~ and

2. ~~DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and~~

~~3.~~2. SED or SMI determination; and

~~4.~~3. clinical judgment; and

~~5.~~4. the overall combination does not exceed a maximum of four hours per day; and

~~6.~~5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

c. Intensity of Need Level IV: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

1. ~~DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF Score of 50 or less~~ A covered, current ICD and CASII/LOCUS Level IV; ~~or~~ and

~~2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 40 or less; and~~

~~3.~~2. SED or SMI determination; and

~~4.~~3. clinical judgment; and

~~5.~~4. the overall combination does not exceed a maximum of six hours per day; and

~~6.~~5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

d. Intensity of Need Levels V & VI: Recipients may receive any combination of BST, PSR, Day Treatment and/or Peer-to-Peer services provided:

1. ~~DSM IV diagnosis (see DSM DIAGNOSIS definition), GAF score of 40 or less~~ A covered, current ICD and CASII/LOCUS Levels V or VI; ~~or~~ and

~~2. DC:0-3 Axis I diagnosis or DC:0-3 Axis II PIR-GAS score of 30 or less; and~~

~~3.~~2. SED or SMI determination; and

~~4.~~3. clinical judgment; and

~~5.~~4. the overall combination does not exceed a maximum of eight hours per day; and

~~6.~~5. the services provided in combination may not exceed the maximum individual daily limits established for each RMH service.

e. Additional RMH Service Authorizations: Recipients may receive any combination of additional medically necessary RMH services beyond established daily maximums. Additional RMH services must be prescribed on the recipient's Rehabilitation Plan and must be prior authorized by Medicaid's QIO-Like vendor. Additional RMH services authorizations may only be authorized for 30-day periods. These requests must include:

1. a lifetime history of the recipient's inpatient psychiatric admissions; and

2. a 90-day history of the recipient's most recent outpatient psychiatric services; and

3. progress notes for RMH services provided over the most current two-week period.

7. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request. It is recommended that the new request be submitted 15 days prior to the end date of the existing service period, so an interruption in services may be avoided for the recipient. In order to receive authorization for RMH services all of the following must be demonstrated in the Rehabilitation Plan and progress notes (if applicable).

a. The recipient will reasonably benefit from the RMH service or services requested;

b. The recipient meets the specific RMH service admission criteria;

c. The recipient possesses the ability to achieve established treatment goals and objectives;

d. The recipient and/or their family/legal guardian (in the case of legal minors) desire to continue the service;

e. The recipient's condition and/or level of impairment does not require a more or less intensive level of service;

reaches age 21. If the individual was receiving services in an RTC immediately before reaching age 21, these must be provided before:

1. the date the individual no longer requires the services; or

2. the date the individual reaches 22; and

3. is certified in writing to be necessary in the setting in which it will be provided.

B. The objective of a RTC services is to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders, or conditions, who are no longer at or appropriate for an acute level of care, or who cannot effectively receive services in a less restrictive setting and who meet medical necessity and admission criteria for RTC services.

RTCs are part of the mental health continuum of care and are an integral part of Nevada Medicaid's behavioral health system of care. Recipients who respond well to treatment in an RTC are anticipated to be discharged to a lower level of care, such as intensive home and community-based services, or to the care of a psychiatrist, psychologist, or other QMHP.

All Medicaid policies and requirements for RTC's (such as prior authorization, etc.) are the same for NCU, except where noted in the NCU Manual, Chapter 1000.

C. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Accredited Residential Treatment Center (RTC)	Not Authorized

403.8A COVERAGE AND LIMITATIONS

1. Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing

services, all medications ~~(for Axis I, II and III diagnoses)~~, quarterly RTC-sponsored family visits, psycho-educational services and supervised work projects.

2. The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, dental, optometry, durable medical equipment, radiology, lab and therapies (physical, speech and occupational) or formal educational services. Services that are Medicaid benefits must be billed separately by the particular service provider and may require prior authorization.

3. The QIO-like vendor may authorize all RTC stays, both fee for service and Health Maintenance Organization (HMO) (see MSM Chapter 3600) Medicaid in three-month (or less) increments. For Medicaid recipients to remain in RTCs longer than three months, the RTC must, prior to the expiration of each authorization, submit a Continuing Stay Request to the QIO-like vendor for authorization.

4. For recipients under the age of 21 in the custody of a public child welfare agency, Nevada Medicaid will reimburse for prior authorized RTC services only when the public child welfare agency has also approved the admission.

5. Criteria for Exclusion from RTC Admission

   One or more of the following criteria must be met which prohibit the recipient from benefiting rehabilitatively from RTC treatment or involve the RTC's inability to provide a necessary specialized service or program, clinical decisions will be made individually on a case-by-case basis:

   a. Psychiatric symptoms requiring acute hospitalization;

   b. The following conditions which limits the recipient's ability to fully participate in RTC services and cannot be reasonably accommodated by the RTC;

      1. Physical Disability;

      2. Learning Capacity;

      3. Traumatic Brain Injury (TBI);

      4. Organic brain syndrome;

   c. Pregnancy, unless the RTC can appropriately meet the needs of the adolescent, including obtaining prenatal care while in the facility. In the case of the birth of the infant while the recipient is in the RTC, planning for the infant's care is included in the Discharge Plan. (In such an instance the infant would be covered

individually by Medicaid for medically necessary costs associated with medical care);

d. Chronic unmanageable violent behavior incompatible with RTC services which poses unacceptable and unsafe risks to other clients or staff for any reason (i.e., a danger to self, others or property);

e. Medical illness which limits the recipient's ability to fully participate in RTC services and is beyond the RTC's capacity for medical care;

f. Drug and/or alcohol detoxification is required as a primary treatment modality before a recipient can benefit rehabilitatively from RTC services; or

g. A diagnosis of Oppositional Defiant Disorder (ODD) and/or Conduct Disorder, alone and apart from any other ~~DSM Axis I or Axis II~~ covered, current ICD diagnosis.

6. RTC Therapeutic Home Passes

RTC Therapeutic Home Passes are to be utilized to facilitate a recipient's discharge back to their home or less restrictive setting. RTC recipients are allowed to utilize Therapeutic Home Passes based on individualized treatment planning needs and upon the recommendations of the RTC clinical treatment team. A total of three Therapeutic Home Passes are allowed per calendar year and Therapeutic Home Passes cannot be accumulated beyond a calendar year period. Duration per pass is no greater than 72 hours unless there is a documented medically necessary reason for a longer-term pass. The QIO-like vendor must be notified by the RTC of all therapeutic home passes at least 14 days prior to the pass being issued to the recipient. The notification form can be located on the QIO-like vendor website. All passes which exceed 72 hours must be prior authorized by the QIO-like vendor.

a. The following guidelines must be adhered to for reimbursement. Failure to follow these guidelines will result in non-payment to RTCs during the time the recipient was away on a Therapeutic Home Pass:

1. A physician's order is required for all Therapeutic Home Passes. If it is clinically appropriate for the recipient to travel alone, this must be specified in the physician's order.

2. A Therapeutic Home Pass will only occur within 90 days of the recipient's planned discharge and in coordination with their discharge plan. The recipient must have demonstrated a series of successful incremental day

10. Federal Requirements

RTCs must comply with all Federal and State Admission Requirements. Federal Regulations 42 CFR 441.151 to 441.156 address certification of need, individual plan of care, active treatment and composition of the team developing the individual plan of care.

403.8C AUTHORIZATION PROCESS

1. Admission Criteria

All RTC admissions must be prior authorized by the QIO-like vendor. RTCs must submit the following documentation to the QIO-like vendor:

a. RTC Prior Authorization Request Form which includes a comprehensive psychiatric assessment current within six months of the request for RTC admission; and

b. A Certificate of Need (CON) signed by a physician which includes:

1. The current functioning of the recipient;

2. The strengths of the recipient and their family;

3. ~~DSM~~ Covered, current ICD diagnosis;

4. Psychiatric hospitalization history;

5. Medical history; and

6. Current medications.

c. An initial individualized Treatment Plan; and

d. A proposed Discharge Plan.

2. The QIO-like vendor must verify the medical necessity for all RTC services and verify:

a. The Level of Intensity of Needs for RTC services;

b. The ability for the recipient to benefit rehabilitatively from RTC services;

c. The Treatment Plan includes active participation by the recipient and their family (when applicable); and

e. The legal guardian for the Medicaid recipient has requested the services be withdrawn or terminated;

f. The services are not a Medicaid benefit; and/or

g. A change in federal or state law has occurred (the Medicaid recipient is not entitled to a hearing in this case; see MSM Chapter 3100).

9. Reimbursement

RTC's all-inclusive daily rates are negotiated by the provider through the DHCFP's Rates and Cost Containment Unit. Please see MSM Chapter 700 and the Nevada Medicaid State Plan, Attachment 4.19-A describing the methods and standards for reimbursement of Residential Treatment Centers.

403.9 INPATIENT MENTAL HEALTH SERVICES POLICY

A. Inpatient mental health services are those services delivered in freestanding psychiatric hospitals or general hospitals with a specialized psychiatric unit which include a secure, structured environment, 24-hour observation and supervision by mental health professionals and provide a multidisciplinary clinical approach to treatment.

Inpatient mental health services includes treatments or interventions provided to an individual who has an acute, clinically identifiable ~~DSM Axis I~~ covered, current ICD psychiatric diagnosis to ameliorate or reduce symptoms for improved functioning and return to a less restrictive setting.

B. Medicaid Behavioral Health Intensity of Needs for Children and Adolescents:

Child and Adolescent Service Intensity Instrument (CASII)	Children: CASII	Adults: LOCUS
Levels I to V	Not Authorized	Not Authorized
Level VI Secure, 24 Hour, Services with Psychiatric Management	Inpatient Hospitalization Authorized	Inpatient Hospitalization Authorized

11. Patient Liability

IMD's/freestanding psychiatric hospitals are exempt from Patient Liability (PL) requirements.

403.9C AUTHORIZATION PROCESS

The QIO-like vendor contracts with Medicaid to provide utilization and quality control review (UR) of Medicaid inpatient psychiatric hospital admissions. Within the range of the QIO-like vendors UR responsibilities are admission and length of stay criteria development, prior authorization, concurrent and retrospective review, certification and reconsideration decisions. The QIO-like vendor must approve both emergency and non-emergency inpatient psychiatric inpatient admissions. Any hospital which alters, modifies or changes any QIO-like vendor certification in any way, will be denied payment.

1. For purposes of Medicaid mental health services, an emergency inpatient psychiatric admission to either a general hospital with a psychiatric unit or freestanding psychiatric hospital, is defined as meeting at least one of the following three criteria:

   a. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 30 days; or

   b. Active suicidal ideation within the past 30 days accompanied by physical evidence (e.g. note) or means to carry out the suicide threat (e.g., gun, knife, or other deadly weapon); or

   c. Documented aggression within the 72-hour period before admission:

      1. Which resulted in harm to self, others, or property;

      2. Which manifests that control cannot be maintained outside an inpatient hospitalization; and

      3. Which is expected to continue without treatment.

2. Concurrent Reviews

For non-emergency admissions, the prior authorization request form and CON must be submitted at least one business day prior to admission. For emergency admissions, the prior authorization request form and CON must be submitted no later than one business day following admission. Prior authorization requests, if medically and clinically appropriate, will be authorized up to seven days. If ~~a~~ additional inpatient days are required ~~provider wishes for the client to remain longer than seven days, the~~ a provider

must submit, ~~prior to the expiration of the initial prior authorization,~~ a ~~second, or C~~concurrent (~~C~~continuing ~~S~~stay) ~~A~~authorization ~~R~~request ~~Form~~ prior to or by the last day of the current/existing authorization period. ~~If, upon notification that additional information is needed for clinical review, the provider has two business days to provide the additional information~~ The request and information submitted must identify all pertinent written medical information that supports a continued inpatient stay. The request and information submitted must be in the format and within the timeframes required by the QIO-like vendor. Failure to provide all pertinent medical information as required by the QIO-like vendor will result in authorization denial. Inpatient days not authorized by the QIO-like vendor are not covered. ~~(~~These concurrent review procedures also apply to inpatient substance abuse detoxification and treatment services~~)~~.

~~During this time of the initial authorization t~~The psychiatric assessment, discharge plan and written treatment plan must be initiated, with the attending physician's involvement, ~~must be initiated~~ during the initial authorization period. In addition, when a recipient ~~For the recipient to~~ remains hospitalized longer than seven days~~,~~ the attending physician~~, who must be involved with the recipient's treatment plan, must, on a daily basis, also document the medical and acute necessity of why any additional inpatient days are necessary. QIO-like vendor authorization and approval of medical necessity is required for the entire stay~~ must document the medical necessity of each additional inpatient day.

3. Nevada Medicaid will reimburse for services for recipients admitted with a mental health or psychiatric condition to a general hospital without a psychiatric unit only under one of the following conditions:

   a. The admission is an emergency admission and is certified by the QIO-like vendor (who must be contacted within 24 hours or the first working day after the admission). The hospital must make all efforts to stabilize the recipient's condition and discharge the recipient to a psychiatric hospital or general hospital with a psychiatric unit as expeditiously as possible; or

   b. The recipient has been dually diagnosed as having both medical and mental conditions/diagnoses which warrant inpatient general hospital services, as determined by the QIO-like vendor.

   Also, if a recipient is initially admitted to a hospital for acute care and is then authorized to receive mental health services, the acute care is paid at the medical/surgical tiered rate. The substance abuse services are paid at the substance abuse service rate. Hospitals are required to bill Medicaid separately for each of the types of stays. The QIO-like vendor must certify the two types of stays separately.

4. Acute inpatient admissions authorized by the QIO-like vendor do not require an additional

in the chart reflecting adequate discharge planning.

403.11B PROVIDER RESPONSIBILITIES

Please consult Section 403.10B of this Chapter for provider responsibilities.

403.11C RECIPIENT RESPONSIBILITIES

1. Medicaid recipients are required to provide a valid monthly Medicaid eligibility card to their service providers.

2. Medicaid recipients are expected to comply with the service provider's treatment, care and service plans, including making and keeping medical appointments.

403.11D AUTHORIZATION PROCESS

If appropriate, the QIO-like vendor certifies administrative days at either an SNL or ICL level of care.

403.12 ELECTROCONVULSIVE THERAPY (ECT)

Effective Date 03/01/2004. ECT is a treatment for mental disorders, primarily depression, but also acute psychotic episodes in Schizophrenia and Bipolar Disorder. A low voltage alternating current is used to induce a generalized seizure that is monitored electrographically while under general anesthesia and muscle relaxation.

Medicaid will reimburse medically necessary ECT treatments when administered by a Board Certified Psychiatrist in a qualified acute care general hospital, contracted acute care psychiatric hospital, or in a hospital outpatient surgery center/ambulatory surgery center. Recipients receiving outpatient ECT do not require a global treatment program provided in the inpatient setting prior to outpatient services.

Prior Authorization is required.

403.12A COVERAGE AND LIMITATIONS

ECT is generally used for treatment of affective disorders unresponsive to other forms of treatment. It has also been used in schizophrenia, primarily for acute schizophrenic episodes.

1. Prior authorization requires documentation of the following medically necessary indicators:

   a. Severe psychotic forms of affective disorders.

b. Failure to respond to other therapies.

c. Medical preclusion to use of drugs.

d. Need for rapid response.

e. Uncontrolled agitation or violence to self or others.

f. Medically deemed for probable preferential response to ECT.

2. Recipients (under 16) years of age must have all of the above indicators and:

a. Two prior medication trials predetermined by a physician.

b. Two concurring opinions by a Board Certified Psychiatrist.

c. Informed written consent by custodial parent(s)/legal guardian.

3. Covered, current ICD~~-9-CM~~ Codes:

~~295.00 – 295.94~~ F20-F29 Schizophrenic disorders

~~296.00 – 296.90~~ F30-F33.9 Affective psychoses and depressive type psychosis and other nonorganic psychoses

~~298.00 – 298.9 Depressive type psychosis and other nonorganic psychoses~~

4. Covered CPT Codes:

90870 – Electroconvulsive therapy (includes necessary monitoring); single seizure.

5. Reasons for Denial

a. Continuing use of ECT without evidence of recipient improvement.

b. Diagnostic codes not encompassed in the foregoing list.

6. Coding Guidelines

a. Anesthesia administration for ECT is a payable service only if provided by a physician other than the one administering ECT.

POLICY #4-01	DAY TREATMENT AGES 3-6	

A. DESCRIPTION

Day Treatment services are interventions performed in a therapeutic milieu designed to provide evidence based strategies to reduce emotional, cognitive, and behavioral problems. Day Treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day Treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community based settings.

B. POLICY

Day Treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day Treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day Treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and Rehabilitative Mental Health (RMH) services; and
3. Provided under a Behavioral Health Community Network (BHCN) medical model.

C. **PRIOR AUTHORIZATION IS REQUIRED**

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. Early Childhood Service Intensity Instrument (ECSII) level II or Child and Adolescent Service Intensity Instrument (CASII) score of III or higher;

b. A primary ~~Diagnostic and Statistical Manual (DSM) or DC: 0-3 Axis I diagnosis~~ covered, current ICD diagnosis;

c. Determined Severe Emotional Disturbance (SED);

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, head start, school and/ or home placements.

Service Limitations	Ages 3-6: CASII
Levels I & II	No Services Authorized
Level III	Maximum of 3 hours per day
Level IV	Maximum of 3 hours per day
Levels V & VI	Maximum of 3 hours per day

POLICY #4-02	DAY TREATMENT AGES 7-18	

A. DESCRIPTION

Day Treatment services are interventions performed in a therapeutic milieu designed to provide evidence based strategies to reduce emotional, cognitive, and behavioral problems. Day Treatment services target emotional, cognitive and behavioral functioning within a variety of actual and/or simulated social settings. Day Treatment services provide recipients the opportunity to implement and expand upon (trial and error) what they previously learned/gained from other mental and/or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to restore recipients to their highest level of functioning while preparing them for reintegration back into home and community based settings.

B. POLICY

Day Treatment coverage is limited to medically necessary services and is reimbursed at an hourly rate. Day Treatment services must:

1. Have goals and objectives that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Provide for a process to involve the recipient, and family or other responsible individuals; and
3. Not be contingent on the living arrangements of the recipient.

Day Treatment services are:

1. Facility based out of home services;
2. A fluid combination of Outpatient Mental Health and RMH services; and
3. Provided under a BHCN medical model.

C. **PRIOR AUTHORIZATION IS REQUIRED**

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate the recipient meets all of the following criteria to be considered a covered benefit:

a. CASII score of III or higher;

b. A primary ~~DSM or Axis I diagnosis~~ covered, current ICD diagnosis;

c. Determined SED;

d. Requires and will benefit from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community based environments;

e. Clinical evidence that the recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. Adequate social support system available to provide the stability necessary for maintenance in the program; and

g. Emotional, cognitive and behavioral health issues which:

1. are incapacitating, interfering with daily activities or places others in danger to the point that it causes anguish or suffering;

2. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

3. cannot be appropriately addressed in a day care or school setting, as the issues are impacting their ability to function in those settings and/or are contributing to expulsion or near expulsion from day care, school and/ or home placements.

Service Limitations	Ages 7-18: CASII
Levels I & II	No Services Authorized
Level III	Maximum of 4 hours per day
Level IV	Maximum of 5 hours per day
Levels V & VI	Maximum of 6 hours per day

POLICY #4-03	DAY TREATMENT AGES 19 AND OLDER	

A. DESCRIPTION

Day Treatment services are RMH interventions performed in a therapeutic milieu to provide evidence based strategies to restore and/or retain psychiatric stability, social integration skills, and/or independent living competencies to function as independently as possible. Services provide recipients the opportunity to implement and expand upon what was previously learned from other mental or behavioral health therapies and interventions in a safe setting. The goal of Day Treatment services is to prepare recipients for reintegration back into home and community based settings, prevent hospitalizations and ensure stability.

B. POLICY

Day Treatment coverage and reimbursement is limited to medically necessary services and are covered at an hourly rate. Day Treatment services must:

1. Have goals and objective that are:
    a. time specific;
    b. measurable (observable);
    c. achievable;
    d. realistic;
    e. time limited;
    f. outcome driven;
    g. individualized;
    h. progressive; and
    i. age/developmentally appropriate.
2. Must involve the recipient and family or other individuals, as appropriate, and
3. Not be contingent on the living arrangements of the recipient.

Day Treatment services are:

1. Facility based, out of home services.
2. A fluid combination of all the RMH services.
3. Provided under a BHCN medical model.

C. **PRIOR AUTHORIZATION IS REQUIRED**

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Clinical documentation must demonstrate that the recipient meets all of the following criteria:

a. Must have Level of Care Utilization System for Adults (LOCUS) score of IV, V or VI;

b. A primary ~~DSM Axis I diagnosis~~ covered, current ICD diagnosis;

c. Determined as Serious Mental Illness (SMI);

d. Requires and benefits from opportunities to test their acquired emotional, cognitive and behavioral skills in settings that emulate their normal home and community based environments;

e. The recipient's condition requires a structured program with treatment that cannot be provided in a less intensive outpatient setting;

f. An adequate social support system is available to provide the stability necessary for maintenance in the program; and

g. Recipient's emotional, cognitive and behavioral issues which:

1. require intensive, coordinated, multifaceted interventions within a therapeutic milieu; and

2. are incapacitating, interfere with daily activities or place others in danger to the point that it causes anguish or suffering.

Service Limitations	Ages 19 and older: LOCUS
Levels I & II	No Services Authorized
Level III	No Services Authorized
Level IV	Maximum of 5 hours per day
Levels V & VI	Maximum of 6 hours per day

2. NON COVERED SERVICES

a. Transportation or services in transit.

POLICY #4-04	SUBSTANCE ABUSE AGENCIES MODEL (SAAM)	

A. DESCRIPTION/POLICY

B. SUBSTANCE ABUSE AGENCIES MODEL (SAAM)

The Division of Health Care Financing and Policy (DHCFP) covers services for prevention and treatment for recipients who have been diagnosed or at risk of substance abuse disorders. The Substance Abuse policy is under the rehabilitative authority of the State Plan for behavioral health services. Services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

The below coverage policies are developed based upon the Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (DHHS) and are best-practice guidelines for the treatment of substance abuse disorders.

In addition, the DHCFP utilizes American Society of Addiction Medicine (ASAM) patient placement criteria to establish guidelines for level of care placements within the substance abuse continuum. For mental health continuum the DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients as described under 403.4(7).

The DHCFP encourages providers to utilize SAMHSA's working definition, dimensions and guiding principles of recovery from Substance Use Disorders in their clinical decisions. The definition is continually changing due to updates in the clinical field reference http://www.samhsa.gov/ for the latest best practices.

There are four major dimensions that support a life in recovery:

1. Health-Overcoming or managing one's disease(s) or symptoms;

2. Home-a stable and safe place to live;

3. Purpose-Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and

4. Community-Relationships and social networks that provide support, friendships, love and hope.

The guiding principles of recovery are:

1. Recovery emerges from hope;

2. Recovery is person-driven;

3. Recovery occurs via many pathways;

4. Recovery is holistic;

5. Recovery is supported by peers and allies;

6. Recovery is supported through relationship and social networks;

7. Recovery is culturally-based and influenced;

8. Recovery is supported by addressing trauma;

9. Recovery involves individual, family, and community strengths and responsibility; and

10. Recovery is based on respect.

C. DEFINITIONS

1. Co-Occurring Capable (COC) programs - are those that "address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content and discharge planning" (The ASAM Criteria 2013, p. 416.)

2. Co-Occurring Enhanced (COE) programs - have a higher level of integration of substance abuse and mental health treatment services. These programs are able to provide primary substance abuse treatment to clients and "are designed to routinely (as opposed to occasionally) deal with patients who have mental health or cognitive conditions that are more acute or associated with more serious disabilities."

   (The ASAM Criteria, 2013, p. 29) Enhanced-level service "place their primary focus on the integration of service for mental and substance use disorders in their staffing, services and program content." (The ASAM Criteria, 2013, p. 417).

3. Recovery - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

4. Substance abuse - as defined in DSM~~-I~~V~~-TR~~ (~~4~~5th edition, Text Revision; APA 2013~~00~~) is a "~~maladaptive pattern of substance abuse manifested by recurrent and significant adverse consequences related to the repeated abuse of substance~~ ~~substance~~ cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (APA 2013~~00~~, p. 483~~198~~)

5. Substance dependence - is more serious than abuse. This maladaptive pattern of substance abuse includes such features as increased tolerance for the substance, resulting in the need for ever greater amounts of the substance to achieve the intended effect; an obsession with securing the substance and with its use; or persistence in using the substance in the face of serious physical or mental health problems.

6. Integrated interventions - are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or integration, or in a series of interactions or multiple sessions. Integrated interventions can include a wide range of techniques. Some examples include:

If the Clinical Supervisor will supervise interns, they are required to have the appropriate additional licensure needed per the Board of Examiners in addition to their professional licensure. Supervision must be within the scope of their practice and field.

H. COVERAGE AND LIMITATIONS

The DHCFP reimburses for integrated interventions in a substance abuse medical treatment delivery model provided by qualified Medicaid providers. Patients are assessed as meeting diagnostic criteria for substance-related disorders (including substance use disorder or substance-induced disorders) and/or mental health disorders as defined in the current ~~Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or ICD9~~ International Classification of Diseases (ICD).

1. Screening - A brief systematic process to determine the possibility of a co-occurring disorder.

   a. The following screens are covered within the DHCFP program. Screens must be a nationally accepted screening instrument through SAMHSA/CSAT Treatment Improvement Protocols or other Peer Supported Literature. Below is a list of recognized tools:

      1. Clinical Institute Withdrawal Assessment (CIWA)
      2. Michigan Alcohol Drug Inventory Screen (MADIS)
      3. Michigan Alcoholism Screening Test (MAST)
      4. Modified Mini
      5. Problem Behavior Inventory (PBI)
      6. Substance Abuse Subtle Screening Inventory (SASSI)
      7. Substance Use Disorder (SUDDS)
      8. Recovery Attitude and treatment Evaluator (RAATE)
      9. Treatment Intervention Inventory (TII)
      10. Western Personality Interview (WPI)

2. Assessment - A Comprehensive Co-occurring Assessment is an individualized examination which establishes the presence or absence of mental health and substance abuse disorders, determines the recipient's readiness for change, and identifies the strengths or problem areas that may affect the recipient's treatment. The comprehensive assessment process includes an extensive recipient history which may include: current medical conditions, past medical history, labs and diagnostics, medication history, substance abuse history, legal history, family, educational and social history, and risk assessment. The information collected from this comprehensive assessment shall be used to determine appropriate interventions and treatment planning.

3. Level of Care Determination and Authorization Requirements

   a. The DHCFP utilizes the ASAM Criteria, for individuals presenting with substance use disorder(s) to determine appropriate placement in a level of care. In addition, the DHCFP utilizes medical necessity as defined in Medicaid Services Manual (MSM) Chapter 100, Section 103.1. The process considers assessment and documentation of the following six dimensions:

      1. Dimension 1: Acute Intoxication and/or Withdrawal Potential

      2. Dimension 2: Biomedical Conditions and Complications

      3. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

      4. Dimension 4: Readiness to Change

      5. Dimension 5: Relapse, Continued Use, or Continued Problem Potential

      6. Dimension 6: Recovery/Living Environment

   b. The DHCFP utilizes the Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Screening Intensity Instrument (CASII) for children when assessing the mental health level of care needs of recipients.

   c. Each authorization is for an independent period of time as indicated by the start and end date of the service period. If a provider believes it is medically necessary for services to be rendered beyond the scope (units, time period or both), of the current authorization, the provider is responsible for the submittal of a new prior authorization request.

   d. Reference Attachment C for authorization requirements for Substance Abuse Agency Model.

4. Treatment Services – The DHCFP covers the below levels based upon the ASAM patient placement criteria. Reference Attachment C for the coverage and utilization management requirements.

   a. Level 0.5 Early Intervention/Prevention

   b. Level 1 Outpatient Services

   c. Level 2.1 Intensive Outpatient Program

   d. Level 2.5 Partial Hospitalization

   e. Level 3 Outpatient Services provided in a Licensed Level 3 environment

   f. Level 4 Medically Managed Intensive Inpatient Treatment

5. Pharmaceutical coverage - For coverage and limitations of Narcotic Withdrawal Therapy Agents (Opioid Dependent Drugs) refer to Chapter 1200 of the MSM.

6. Opioid Use Treatment

   a. Provided in a Nevada licensed entity through SAPTA as an Opioid Use Disorder Treatment Program.

   b. Coverage of the service:

      1. Requires diagnosis of Opioid Use Disorder; and

      2. Requires documentation as meeting the assessment criteria of all six dimensions of opioid treatment program in The ASAM Criteria.

   c. The following service is covered for Opioid Treatment Program:

      1. Medication assessment, prescribing, administering, reassessing and regulating dose levels appropriate to the individual, supervising withdrawal management from opioids, opioid use disorder treatment, overseeing and facilitating access to appropriate treatment, including medication for other physical and mental health disorders;

   d. Opioid use disorder treatment program is required to perform:

      1. Linkage with or access to psychological, medical and psychiatric consultation;

      2. Linkage with or access to emergency medical and psychiatric care through affiliations with more intensive levels of care;

      3. Linkage with or access to evaluation and ongoing primary medical care;

      4. Ability to conduct or arrange for appropriate laboratory and toxicology tests;

         a. Availability of physicians to evaluate, prescribe and monitor use of methadone and levo-alpha-acetylmethadol (LAAM), and of nurses and pharmacists to dispense and administer methadone or LAAM; and

         b. Ability to assist in arrangements for transportation services for patients who are unable to drive safely or who lack transportation.

7. Non-Covered Services - the following services are not covered under the substance abuse services program for the DHCFP:

   a. Services for recipients without an assessment documenting diagnostic criteria for substance-related disorder (including substance use disorder or substance-induced disorders) or mental health disorder as defined in the current ~~Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or~~ ICD~~9~~;

b. Services for marital problems without a ~~DSM/ICD9~~ covered, current ICD diagnosis;

c. Services for parenting skills without a ~~DSM/ICD9~~ covered, current ICD diagnosis;

d. Services for gambling disorders without a ~~DSM/ICD9~~ covered, current ICD diagnosis;

e. Custodial services, including room and board;

f. More than one provider seeing the recipient in the same therapy session;

g. Services not authorized by the QIO-like vendor if an authorization is required according to policy;

h. Respite;

i. Services for education;

j. Services for vocation training;

k. Habilitative services;

l. Phone consultation services;

m. Services for individual ages 22-64 in an Institution for Mental Disease (IMD);

n. Services provided by agencies not receiving funding by Nevada Division of Public and Behavioral Health (DPBH) for Levels I-III under NAC458.103;

o. Services provided under Nevada State Certification Level 2WM – 3.7 Withdrawal Management programs;

p. Counseling services for Opioid Treatment Programs; and

q. Care Coordination and treatment planning.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600 are being proposed to include reference to MSM Chapter 400 for integrated interventions as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). The DHCFP added clarification to the coverage guidelines regarding teaching physicians. Clarification has been added to Out-of-State Physicians regarding prior authorizations and reference to the out-of-state transportation policy. Clarification has been added regarding reimbursement for Long Acting Reversible Contraception (LARC) insertion immediately following delivery, and for elective cesarean section births that are not prior-authorized. We are aligning Hyperbaric Oxygen Therapy (HBOT) for diabetic wounds with the current recommendations of the Centers for Medicare and Medicaid Services (CMS). We are adding the American Association of Diabetic Educators (AADE) as a certifying program for diabetic outpatient self-management programs. Preeclampsia prevention in pregnant women has been added as a covered service in accordance with the United States Preventive Services Task Force (USPSTF) recommendations. The DHCFP has updated policy that depression screenings in children can be billed separately on the same day of a well child visit. Finally, the DHCFP updated policy for medically necessary circumcisions.

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.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29380 CHAPTER 600 - PHYSICIAN SERVICES	MTL 10/15 CHAPTER 600 - PHYSICIAN SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
600	**Introduction**	Deleted "Practitioners of Nursing". Added "Practice Registered Nurse".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added acronyms to the list of health care professionals. Added reference to Chapter 400 for integrated interventions as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA).
603.1A.2.a.2	**Coverage and Limitations**	Added "electrocardiogram" and updated acronym.
603.1A.3		Added "/D.O."
603.1A.2.b.6		Added "Advanced Practice Registered" to Nurse and updated acronym to "(APRN)".
603.1A.2.b.7		Added acronym "(PA/PA-C)" to Physician Assistants.
603.1A.2.b.8		Added acronym "(CRNA)" to Certified Registered Nurse Anesthetist.
603.1A.3	**Teaching Physicians**	Deleted "with additional". Added "including the".
603.1A.4	**Out-of-State Physicians**	Provided clarification to the prior authorization requirements and reference for out of state transportation.
603.2	**Physician Office Services**	Added acronym "(ECG)" to electrocardiogram. Added acronym "(EEG) to electroencephalogram.
603.2.b.6		Deleted "physical therapist" and added acronym "PT".
603.3	**Family Planning Services**	Deleted "physician's assistant" and added acronym "PA". Deleted "Nurse Practitioner" and added acronym "APRN". Deleted "certified nurse midwife" an added acronym "CNM". Deleted "They" and added "These procedures".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.3.c		Deleted “can” and replaced with “may”. Deleted “to be”.
603.3.d		Added language to state that the DHCFP currently reimburses for the immediate insertion of Long Acting Reversible Contraception (LARC) following delivery.
603.3.a.5		Updated DHCFP’s web address.
603.4.a.2.a	**Maternity Care**	Replaced “c-section” with “cesarean-section”.
603.4.a.2.b.1		Removed language to Provides clarification that the DHCFP requires a prior authorization for elective cesarean sections and will only reimburse at the vaginal delivery rate.
603.4.a.2.c.4		Medically necessary circumcision for males up to one year of age is a covered benefit. Males older than one year will require a prior authorization from the QIO-like vendor.
603.4B.2.a	**Provider Responsibility**	Updated DHCFP’s web address.
603.4B.2.b		Updated DHCFP’s web address.
603.7	**Podiatry**	Replaced “Qualified Medicare Beneficiary” with the acronym “QMB”.
603.8.A.1	**Physician Services Provided in Rural Health Clinics**	Added acronyms to the list of health care professionals.
603.9	**Anesthesia**	Removed “Certified Registered Nurse Anesthetists”.
603.13.A	**Physician’s Services in Other Medical Facilities**	Deleted “advanced practice nurse practitioner of” added acronym “APRN”.
Attachment A Policy #6-02	**Wound Management**	Removed reference to ICD-9-CM.
Attachment A	**Outpatient**	Updated coverage and limitation criteria in the use

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Policy #6-03	**Hospital Based Hyperbaric Oxygen Therapy**	of HBOT on diabetic wounds. Removed reference to "ICD-9-CM".
Attachment A Policy #6-04	**Intrathecal Baclofen Therapy (ITB)**	Spelled out acronym, "ITB".
Attachment A Policy #6/10	**Diabetic Outpatient Self-Management Training Services**	Added the American Association of Diabetes Educators (AADE) as a certifying program for Diabetic Outpatient Self-Management Training Programs. This aligns us with CMS' certification requirement for these services.
Attachment A Policy #6-12	**Women's Preventive Health-Pregnant and Non-Pregnant**	Updated that the DHCFP covers services for prevention of preeclampsia per the recommendations of the USPSTF.
Attachment A Policy #6-14	**Children's Preventive Health**	Removed asterisk from "Depression screening: adolescents". This changes the screening for depression to a service that can be billed separately on the same day as a well child visit for children.
Attachment A Policy #6-16	**School Based Health Center**	Updated health care professional names with acronyms.
Attachment A Policy #06-17	**Federally Qualified Health Centers**	Updated health care professional names with acronyms.

600 INTRODUCTION

The Nevada Medicaid Program is dependent upon the participation and cooperation of Nevada physicians and other licensed professionals who provide health care to Medicaid recipients. Licensed professionals providing services within the scope of their license are recognized by Nevada as independently contracted Medicaid providers. The policy in this chapter is specific to the following identified health care professionals:

a. Advanced Practice Registered Nurse~~Practitioners of Nursing (~~APRN~~);.~~

b. Certified Registered Nurse Anesthetists (CRNA);~~.~~

c. Chiropractors (DC)~~.~~;

d. Certified-Nurse Midwives (CNM);~~.~~

e. Physicians (M.D. and D.O. including those in a teaching hospital);~~.~~

f. Physician Assistants (PA/PA-C ~~M.D./D.O.~~);~~.~~and

g. Podiatrists (DPM).

To enroll as a physician or health care professional for the Division of Health Care Financing and Policy (DHCFP) in the Nevada Medicaid Program, the above listed licensed professionals working within their scope of practice must be authorized by the licensing authority of their profession to practice in the state where the service is performed at the time the state services are provided. Specific service exclusions will be noted in policy.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the four areas where Medicaid and NCU policies differ as documented in the NCU Services Manual, Chapter 1000.

The DHCFP encourages integrated interventions as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA). Please reference Medicaid Services Manual (MSM) Chapter 400 for specific policy.

Disclaimer: The term “Physician” used throughout this chapter is an all inclusive description relative to the above identified providers working within their respective scope of practice and does not equate one professional to another. It serves only to make the document more reader-friendly. A Primary Care Physician (PCP) is considered to be an M.D/D.O with a specialty in general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology.

603 PHYSICIANS AND LICENSED PROFESSIONAL POLICY

603.1 PHYSICIAN'S ROLE IN RENDERING SERVICES

603.1A COVERAGE AND LIMITATIONS

1. The Division of Health Care Financing and Policy (DHCFP) reimburses for covered medical services that are reasonable and medically necessary, ordered or performed by a physician or under the supervision of a physician, and that are within the scope of practice of their prognosis as defined by state law. The physician 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 physician or by a licensed professional working under the personal supervision of the physician.

    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 physician:

        1. An injection of medication;

        2. Diagnostic test like an electrocardiogram (E~~K~~CG);

        3. Blood pressure taken and recorded between M.D./D.O. visits;

        4. Dressing changes; and

        5. Topical application of fluoride.

    b. Physicians or their designee may not bill Medicaid for services provided by, but not limited to, the following:

        1. Another Provider;

2. Psychologist;

3. Medical Resident (unless teaching physician);

4. Therapist: Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (SP), Respiratory Therapist (RT);

5. Counselor/Social Worker;

6. Advanced Practice Registered Nurse ~~Practitioner~~ (APRN) (other than diagnostic tests done in the office which must be reviewed by the physician);

7. Physician Assistants (PA/PA-C); and

8. Certified Registered Nurse Anesthetist (CRNA).

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.

The DHCFP follows Medicare coverage guidelines for Teaching Physicians, Interns, and Residents including the ~~with additional~~ exceptions as outlined by Medicare's policy.

4. Out-of-State Physicians

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. (Please refer to Medicaid Services Manual (MSM) Chapter 1900, Transportation Services, for out-of-state transportation policy.) The QIO-like vendor's determination will consider the availability of the services within the State. If the recipient is being referred out-

of-state by a Nevada physician, the Nevada physician is required to obtain the prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.

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

c. All service physicians must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. (See ~~Medicaid Services Manual (~~MSM~~)~~ Chapter 100.)

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

The EPSDT program provides preventative health care to recipients (from birth through age 20 years) 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.

603.2 PHYSICIAN OFFICE SERVICES

Covered services are those medically necessary services when the physician 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 services under the DHCFP. See MSM Chapter 3400 for the complete coverage and limitations for Telehealth.

a. Consultation Services

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

3. Medicaid does not reimburse physicians for telephone calls between physicians and patients (including those in which the physician gives advice or instructions to or on behalf of a patient) except documented psychiatric treatment in crisis intervention (e.g. threatened suicide).

4. New patient procedure codes are not payable for services previously provided by the same physician or another physician of the same group practice, within the past three years.

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

6. Physical therapy administered by a ~~p~~Physical ~~t~~Therapist (PT) on staff or under contract in the physician's office requires a prior authorization before rendering service.

   If the physician bills for physical therapy, the physician, not the ~~physical therapist~~PT, must have provided the service.

   A physician 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 for physical therapy coverage and limitations.

7. Physician administered drugs are a covered benefit under Nevada Medicaid. Reference MSM Chapter 1200 for coverage and limitations.

8. Non-Covered Physician services

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

   b. Reimbursement for clinical trials and investigational studies.

   c. Temporomandibular Joint (TMJ) related services (see MSM Chapter 1000-Dental).

1. Referrals

   When a prior authorization is required for either in-state or out-of-state services, the referring physicians are responsible for obtaining a prior authorization from the QIO-like vendor. If out-of-state services are medically necessary, the recipient must go to the nearest out-of-state provider for services not provided in-state. It is also the responsibility of the referring physician to obtain the authorization for a recipient to be transferred from one facility to another, either in-state or out-of-state.

2. Hospice

   Physicians are responsible for obtaining prior authorization for all services not related to the morbidity that qualifies the recipient for Hospice. Physicians should contact Hospice to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200 for coverage and limitations.

3. Home Health Agency (HHA)

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

4. Laboratory

   Reference MSM Chapter 800 for coverage and limitations for laboratory services.

5. Diagnostic Testing

   Reference MSM Chapter 300 for coverage and limitations for diagnostic services.

603.2A AUTHORIZATION PROCESS

Certain physician services require prior authorization. There is no prior authorization requirement for allergy testing, allergy injections or for medically necessary minor office procedures unless specifically noted in this chapter. Contact the QIO-like vendor for prior authorization information.

603.3 FAMILY PLANNING SERVICES

State and federal regulations grant the right for eligible Medicaid recipients of either sex of child-bearing age to receive family planning services provided by any participating clinics, physician, ~~physician's assistant~~PA, ~~nurse practitioner~~APRN, ~~certified nurse midwife~~CNM, or pharmacy.

Females, who are enrolled for pregnancy-related services only, are covered for all forms of family planning, including tubal ligation and birth control implantation up to 60 days post partum including the month in which the 60th day falls.

Abortions (surgical or medical) and/or hysterectomies are not included in Family Planning Services. ~~They~~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.

a. Prior authorization is not required for:

1. Physician services.

2. Physical examination.

3. Annual pap smear for family planning.

4. Birth control devices which include but are not limited to the following:

a. Intrauterine contraceptive device (IUD);

b. Birth control pills;

c. Diaphragm;

d. Foam and/or jelly;

e. Condoms;

f. Implanted contraception capsules/devices;

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

g. Depo-Provera injections; (if drug obtained by Rx, physician bills for IM admin only). If in the case of birth control injections the only service rendered is the injection, an appropriate minimal office visit may be listed in addition to the injection.

1. Vaginal suppositories;

2. Contraceptive dermal patch; and/or

3. Contraceptive injection, other.

5. Vasectomy or tubal ligation (age 21 and over). In accordance with federal regulations, the recipient must fill out a consent form at least 30 days prior to the procedure. The physician is required to send the consent form to the fiscal agent with the initial claim. (See the DHCFP website at ~~http://www.dhcfp.nv.gov~~ http://dhcfp.nv.gov/ under Forms and the Hewlett Packard Enterprise Services (HPES) provider portal at: https://www.medicaid.nv.gov/providers/forms/forms.aspx for consent forms).

b. Medicaid has removed all barriers to family planning counseling/education provided by qualified physicians. (e.g. Physicians, Rural Health Clinics/Federally Qualified Clinics, Indian Health Services/Tribal Clinics, and Home Health Agencies, etc.) The physician 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 ~~can~~may be considered ~~to be~~ sexually active).

~~e.~~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.

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

603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, delivery, and postpartum care provided by a physician and/or a nurse midwife. For women who are eligible for pregnancy-related services only, their eligibility begins with enrollment and extends up to 60 days postpartum including the month in which the 60th day falls. She is eligible for pregnancy related services only which are prenatal care and postpartum services, including family planning education and services. Recipients under age 21, and eligible for pregnancy only, are not entitled to EPSDT services.

It is the responsibility of the treating physician 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 and/or her baby greater than the average occurrence in the general population.

For those females 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. Communication and coordination between the physicians, service physicians, and MCO staff is critical to promoting optimal birth outcomes.

a. 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. Antepartum care is not a covered benefit for illegal non-U.S. citizens.

2. Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without an episiotomy/forceps), or cesarean delivery. Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the ~~(~~CPT~~)~~ Medicine and

Evaluation and Management Services section in addition to codes for maternity care.

a. In accordance with standard regulations, vaginal deliveries with a hospital stay of three days or less and ~~C~~cesarean-section deliveries with a hospital stay of four days or less~~,~~ do not require prior authorization. Reference MSM Chapter 200 for inpatient coverage and limitations.

b. Non-Medically Elective Deliveries

1. Reimbursement for Avoidable ~~C-Sections~~Cesarean Section

To make certain that cesarean sections are being performed only in cases of medical necessity, the DHCFP will reimburse physicians for performing cesarean sections only in instances that are medically necessary and not for the convenience of the provider or patient. ~~Elective or avoidable cesarean sections will be reviewed to determine medical necessity. Those cesarean sections that do not qualify for medical necessity will be reimbursed at the same rate as a vaginal delivery.~~ Elective cesarean sections must be prior authorized and will be reimbursed at the vaginal delivery rate.

2. Early Induction of Labor (EIOL)

The American Congress of Obstetricians and Gynecologists (ACOG) issued a Revision of Labor Induction Guidelines in July 2009, citing, "The rate of labor induction in the US has more than doubled since 1990. In 2006, more than 22% (roughly one out of every five) of all pregnant women had their labor induced." The revision further states, "… the ACOG recommendations say the gestational age of the fetus should be determined to be at least 39 weeks or that fetal lung maturity must be established before induction."

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

The DHCFP encourages providers to review the 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. The aim of the toolkit is to offer guidance and support to Obstetrician/Gynecologist (OB/GYN) providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

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

1. The initial physical examination done in the 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, physician may bill either the brief examination or discharge day code, not both.

4. Routine circumcision of a newborn male is ~~not~~ a Medicaid benefit~~.~~ ~~Obtain authorization from the QIO-like vendor for covered medically necessary (e.g., phimosis) circumcision prior to the service.~~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 less than 24 hours after delivery, Medicaid will reimburse newborn follow-up visits in the physician's office up to four days post delivery.

6. In accordance with Nevada Revised Statute (NRS) 442.540, all newborns must receive hearing screenings. This testing and interpretation is included in the facility's per diem rate.

3. Postpartum care includes hospital and office visits following vaginal or cesarean section delivery. Women, 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. Pregnancy related only eligible

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

603.4B PROVIDER RESPONSIBILITY

1. 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~~.~~;and

2. Polyhydramnios.

j. Intrauterine growth restriction (IUGR).

The following table offers a guideline for biophysical profile.

BPP SCORE	**ASSESSMENT**	**MANAGEMENT**
10/10 or 8/10 with normal AFV*	Low risk	• for high risk pregnancies • may repeat in 1 week
8/10 with abnormal AFV*	High Risk	re-eval for AVF* within 24 hours**
6/10 with normal AFV*	Equivocal Result	may repeat in 24 hours**
6/10 with abnormal AFV*	High Risk	may repeat in 24 hours**
0/10, 2/10, 4/10	High Risk	intervention or delivery

* AFV – Amniotic Fluid Volume

** The repeat biophysical profile must clearly indicate the previous abnormal result and reason for repeating this exam.

2. Abortion/Termination of pregnancy

a. Reimbursement is available for an induced abortion to save the life of the mother, only when a physician 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. (See the DHCFP website at ~~https://dhcfp.nv.gov~~ http://dhcfp.nv.gov/under Forms and the HPES provider portal at: http://www.medicaid.nv.gov/providers/forms/forms.aspx or substitute any form that includes the required information.)

b. Reimbursement is available for induced abortion services resulting from a sexual assault (rape) or incest. A copy of the appropriate certification statement must be attached to the claim (See the DHCFP website at ~~https://dhcfp.nv.gov~~ http://dhcfp.nv.gov/under Forms and the HPES portal at https://www.medicaid.nv.gov/providers/forms/forms.aspx 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 and physicians 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.

c. 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 for further information.

3. 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. A stamp or initial by billing staff is not acceptable. Payment is available for hysterectomies as follows:

a. 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 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 representative has

signed a written Acknowledgment of Receipt of Hysterectomy Information Form (See the DHCFP website at ~~https://dhcfp.nv.gov~~ http://dhcfp.nv.gov/under Forms and the HPES provider portal at http://www.medicaid.nv.gov/providers/forms/forms.aspx for a sample of the form).

b. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form is also required. Therefore, it is advisable to inform the recipient or her authorized representative prior to the exploratory surgery or biopsy.

c. 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 Physician Statement 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 acknowledgment of receipt of hysterectomy information due to the emergency nature of the admission.

d. 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 Physician Statement 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.)

e. 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:

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

2. The woman 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.

603.5 ANNUAL GYNECOLOGIC EXAM

Nevada Medicaid reimburses providers for annual preventative gynecological examinations, along with the collection of a Pap smear, for women who are or have been sexually active or are age 18 or older. The examinations include breast exam, pelvic exam and tissue collection (also known as Pap smear).

603.6 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 and Qualified Medicare Beneficiaries (QMB's).

a. Prior authorization is not required for:

1. 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.

2. Chiropractic services provided to a QMB recipient.

b. Prior authorization is required for:

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

603.7 PODIATRY

Podiatry services are those services provided by health professionals trained to diagnose and treat diseases and other disorders of the feet. A podiatrist performs surgical procedures and prescribes corrective devices, medications and physical therapy. For Nevada Medicaid recipient's podiatric services are limited to QMB~~ualified Medicare Beneficiary~~ recipients and

Medicaid eligible children referred as the result of a Healthy Kids (EPSDT) screening examination.

a. Prior Authorization

1. Prior authorization is not required for podiatric office visits provided for children as a direct result of a Healthy Kids (EPSDT) screening examination).

2. 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.

3. Prior authorization is not required for Podiatry services provided to a QMB or QMB/MED recipient. Medicaid automatically pays the co-insurance and deductible up to Medicaid's maximum reimbursement after Medicare pays. If Medicare denies the claim, Medicaid will also deny payment.

b. Non Covered Services

Preventive care including the cleaning and soaking of feet, the application of creams to insure skin tone, and routine foot care are not covered benefits. Routine foot care includes the trimming of nails, cutting or removal of corns and calluses in the absence of infection or inflammation.

603.8 PHYSICIAN SERVICES PROVIDED IN RURAL HEALTH CLINICS

A. Rural Health Clinic (RHC)

1. 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.

This all-inclusive rate includes any one or more of the following services and medical professionals:

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. Certified ~~Registered~~ Nurse Midwife (CNM);

g. Psychologist;

h. Licensed Clinical Social Worker (LCSW);

i. Registered Dental Hygienist;

j. Podiatrist (DPM);

k. Radiology;

l. Optometrist (OD);

m. Optician (including dispensing of eyeglasses); and

n. Clinical Laboratory.

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

a. Core visits include the following:

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

2. Women's annual preventive gynecological examinations; and

3. Colorectal screenings.

b. Home visits;~~.~~ and

c. Family planning education.

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

3. For billing instructions for RHC, please refer to Billing Manual for Provider Type 17.

B. Indian Health Programs (IHP)

Please refer to MSM Chapter 3000.

603.9 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and ~~Certified Registered Nurse Anesthetists (~~CRNA~~s)~~ are based on the Centers for Medicare and Medicaid Services (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 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 five digit procedure 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.

603.10 PHYSICIAN 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.) on a CMS-1500 billing form. Do not use emergency visit codes.

Services requiring prior authorization include the following:

1. Hyperbaric Oxygen Therapy for chronic conditions (reference Appendix for Coverage and Criteria);

2. Bariatric surgery for Morbid Obesity;

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

4. Diabetes training exceeding 10 hours;

5. Vagus nerve stimulation; and

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

B. Emergency Room Policy

The DHCFP 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 lay person, 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, the health of the woman or her 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 physician's office and/or the emergency department. The requirement to meet acute care criteria is dependent upon the QIO-like vendor's determination. The QIO-like vendor will continue to review and perform the retrospective authorization for these admissions based upon approved criteria. Prior authorization is still required for all other inpatient admissions.

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's 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" injection 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; ~~and~~

   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, the DHCFP 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 room 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 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.

5. 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 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 needs to travel out of state, 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 QIO-like vendor. The request must include dates of service and the negotiated rate. (This rate cannot exceed Medicare's reimbursement for that facility).

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 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 physician's office/outpatient clinic, ambulatory surgery center or outpatient hospital facility are listed on the QIO-like vendors website. For questions regarding authorization, the physician should contact the 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; and

c. If the recipient is a QMB the procedure is covered first by Medicare, and Medicaid reimburses the co-insurance and deductible, up to the Medicaid allowable.

2. Prior authorization is required from the 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, routine circumcision, etc;

b. Fabric wrapping of abdominal aneurysm;

c. Intestinal bypass surgery for treatment of obesity;

d. Transvenous (catheter) pulmonary embolectomy;

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

g. 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. 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. 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. Transsexual surgery, also known as sex reassignment surgery or intersex surgery and all ancillary services including the use of pharmaceuticals;

l. Cochleostomy with neurovascular transplant for Meniere's Disease;

m. Surgical procedures to control obesity other than bariatric for morbid obesity with significant comorbidities. See Appendix A for policy limitations; and

n. Organ transplantation and associated fees are a limited benefit for Nevada Medicaid recipients.

4. The following organ transplants, when deemed the principal form of treatment are covered:

a. Bone Marrow/Stem Cell – allogeneic and autologous;

b. Noncovered 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;

c. Corneal – allograft/homograft;

d. Kidney – allotransplantation/autotransplantation; and

e. Liver – transplantation for children (under age 21) 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.

5. Prior authorization is required for bone marrow, kidney, and liver transplants from Medicaid's contracted QIO-like vendor.

6. 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, Code of Federal Regulations (CFR), Chapter IV (Health Care Financing Administration) and Title 21, CFR, Chapter I FDA;

b. The procedure meets appropriate Medicare criteria; ~~or~~

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. A separate authorization is required for inpatient/outpatient harvesting or transplants, both in-state and out of state.

603.11 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 QIO-like vendor as medically necessary and meeting Medicaid benefit criteria.

B. Physicians may admit without prior approval only in the following situations:

1. An emergency (defined in MSM Chapter 100);

2. Obstetrical labor and delivery; or

3. Direct Admission from doctor's office.

603.12 PHYSICIAN'S SERVICES IN NURSING FACILITIES

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

603.13 PHYSICIAN'S SERVICES IN OTHER MEDICAL FACILITIES

A. Intermediate Care Facility/Mentally Retarded (ICF/MR)

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

Recertification by a physician or an ~~advanced practice nurse practitioner of~~APRN for the continuing need for ICF/MR 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/MR refer to MSM Chapter 1600.

B. Residential Treatment Center (RTC)
Physician services, except psychiatrist are not included in the all inclusive facility rate for RTCs. Please reference MSM Chapter 400.

POLICY #6-02	WOUND MANAGEMENT	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-01

A. DESCRIPTION

A wound is defined as impaired tissue integrity that may involve the epidermis, dermis, and subcutaneous tissue, and may extend down to the underlying fascia and supporting structures. The wound may be aseptic or infected.

B. POLICY

Wound care is a Nevada Medicaid covered benefit for recipients who have a viable healing process.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. The patient's medical record must include a comprehensive wound history that includes date of onset, location, depth and dimension, exudate characteristics, circulatory, neuropathy, and nutritional assessments, current management and previous treatment regime. The provider must culture all infected wounds prior to initiating systemic antibiotics, per Center for Disease Control guidelines. Photographs are necessary to establish a baseline and to document the progress of the wound, as are weekly measurements. Physicians are expected to educate recipients about the disease process, how to manage their own wound care, and the importance of complying with the treatment plan. This education should be documented in the recipient's medical record.

2. The use of supplies during wound care treatment is considered part of the treatment. Do not bill separately.

3. Burn Care

   a. Burn care provided in the outpatient hospital setting will follow wound care guidelines with the exception of requiring a prior authorization.

   b. All ~~ICD-9-CM~~ diagnosis codes must be coded to the highest level of specificity.

E. COVERED CPT CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-03	OUTPATIENT HOSPITAL BASED HYPERBARIC OXYGEN THERAPY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-03

A. DESCRIPTION

Hyperbaric Oxygen Therapy (HBOT) is therapy in which a recipient breathes 100% oxygen intermittently while the pressure of the treatment chamber is increased to a point higher than sea level pressure (i.e.,>1 atm abs.). Breathing 100% oxygen at 1 atm of pressure or exposing isolated parts of the body does not constitute HBOT; the recipient must receive the oxygen by inhalation within a pressurized chamber.

B. POLICY

1. This Nevada Medicaid benefit is covered in an outpatient hospital, with limitations, for chronic conditions. Payment will be made where HBOT is clinically practical. HBOT is not to be a replacement for other standard successful therapeutic measures. Treatment of acute conditions, e.g., acute carbon monoxide intoxication, decompression illnesses, cyanide poisoning, and air or gas embolism may be provided in an outpatient hospital.

2. PRIOR AUTHORIZATION IS REQUIRED for chronic conditions (see billing manual)

3. PRIOR AUTHORIZATION IS NOT REQUIRED for acute conditions (see billing manual)

4. Documentation supporting the reasonableness and necessity of the procedure must be in the recipient's medical record including recipient's risk factors and submitted with the PA when required.

C. COVERAGE AND LIMITATIONS

1. Wound Therapy

Approval will be restricted to requests documenting that the wound has not responded to conventional treatments as outlined in the WOUND MANAGEMENT POLICY (6-02), and initiated by a physician. Attach a copy of the physician's order to the request for treatment. Maximum numbers of treatments authorized on consecutive days are 45. Therapy is conducted once or twice daily for a maximum of 2 hours each treatment.

2. HBOT must be provided and attended by an HBOT physician. Reimbursement will be limited to therapy provided in a chamber (including the one person unit). No payment will be made for topical HBOT, or for other than the covered diagnosis.

3. Diabetic wounds of the lower extremities in patients who meet the following three criteria:

   a. Patient has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;

   b. Patient has would classified as Wagner grade III or higher; and

   c. Patient has failed an adequate course of standard wound therapy.

D. COVERED ~~ICD-9-CM~~ DIAGNOSIS CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

POLICY #6-04	INTRATHECAL BACLOFEN THERAPY (ITB)	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-04

A. DESCRIPTION/POLICY

FDA approved Intrathecal Baclofen Therapy (ITB) is a Nevada Medicaid covered benefit for recipients with severe spasticity of spinal cord origin, (e.g. Multiple Sclerosis (MS), Spinal Cord Injury (SCI), or spasticity of cerebral origin, e.g., Cerebral Palsy (CP), and Brain Injury (BI)), who are unresponsive to oral Baclofen therapy or who have Intolerable Central Nervous System (CNS) side effects.

B. PRIOR AUTHORIZATION IS NOT REQUIRED

C. COVERAGE AND LIMITATIONS

1. Coverage of treatment will be restricted to recipients with the following indicators:

   a. Spasticity due to CP or BI (if BI, the injury must have occurred over one year prior to be considered for ITB therapy;

   b. Severe spasticity (as defined by a score of 3 or more on the Ashworth Scale) in the extremities for a duration of six months or longer;

   c. Recipients with increased tone that significantly interferes with movement and/or care;

   d. Spasm score of 2 or more; documentation to include pre and post testing of strength, Degree of muscle tone, and frequency of spasm (Spasm Scale not applicable to CP recipients as spasms are not a frequent symptom in these recipients;

   e. Recipient is four years or older and has sufficient body mass to support the infusion pump;

   f. Documented six-weeks or more of failed oral antispasmodic drug therapy at the maximum dose. Recipient is refractory to oral Baclofen, or has intolerable side effects;

   g. Recipient has adequate cerebrospinal fluid flow as determined by myelogram or other studies;

   h. Recipient has no known allergy to Baclofen;

   i. Documentation of a favorable response to a trial dose of ITB prior to pump implantation. If recipient requires a second and/or third trial dose of ITB, documentation needs to include videotape of the recipient's arm and leg range of motion to assess spasticity and muscle tone before and after increased test doses of ITB. Recipients who do not respond to a 100-mcg intrathecal bolus of medication are not candidates for an implanted pump for chronic infusion therapy. Recipient must be free of infection at the time of the trial dose;

   j. Recipient, family, and physicians should agree on treatment goals. Recipient, family and caregivers should be motivated to achieve the treatment goals and be committed to meet the follow-up care requirements;

k. Recipient must be free of systemic infection and/or infection at the implantation site at the time of surgery; and/or

l. Benefit coverage includes up to three trial doses of ITB, surgical implantation of the device, and follow-up physician office visits for dose adjustments and pump refills.

2. Documentation in the recipient's medical record should include what the expected functional outcomes and improvements in quality of life are for the recipient post procedure, e.g., increased independence, ease of caretaking activities, decreased pain, increased ADL's, and improved communication. Also, document why the recipient is not a candidate for Botox injections.

3. Reimbursement for recipients with low muscle tone (often described as floppy muscles), chorea (uncontrollable, small jerky types of movements of toes and fingers), or athetosis (involuntary movements of face, arms or trunk) are not a Nevada Medicaid benefit.

D. COVERED CODES

For a list of covered procedure and diagnostic codes, please see the billing manual.

POLICY #6-10	DIABETIC OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES	EFFECTIVE DOS 9/1/03 Supersedes Policy News N299-08

A. DESCRIPTION

1. Nevada Medicaid defines Diabetic Outpatient Self-Management Training Services as the development of a specific treatment plan for Type I and Type II diabetics to include blood glucose self-monitoring, diet and exercise planning, and motivates recipients to use the skills for self-management.

2. Reimbursement will follow Medicare guidelines for initial recipient and group training sessions. For information regarding blood glucose monitors and diabetic supplies see Chapter 1300.

3. Services must be furnished by certified programs which meet the National Diabetes Advisory Board (NDAB) standards, and hold an Education Recognition Program (ERP) certificate from the American Diabetes Association and/or the American Association of Diabetic Educators. Program instructors should include at least a nurse educator and dietician with recent didactic and training in diabetes clinical and educational issues. Certification as a diabetes educator by the National Board of Diabetes Educators is required.

B. PRIOR AUTHORIZATION IS REQUIRED

When recipients require additional or repeat training sessions that exceed ten hours of training.

C. COVERAGE AND LIMITATIONS

1. The physician managing the recipient's diabetic condition certifies the comprehensive plan of care to provide the recipient with the necessary skills and knowledge in the management of their condition, and to ensure therapy compliance. The program must be capable of offering, based on target population need, instruction in the following content areas:

   a. Diabetes review~~.~~;

   b. Stress and psychological adjustment~~.~~;

   c. Family involvement and social support~~.~~;

   d. Medications~~.~~;

   e. Monitoring blood glucose and interpretation of results~~.~~;

   f. Relationships between nutrition, exercise and activity, medication, and glucose levels~~.~~;

   g. Prevention, detection, and treatment of both acute and chronic diabetic complications, including instruction related to care of feet, skin, and teeth~~.~~;

   h. Behavioral change strategies, goal setting, risk factor reduction, and problem solving~~.~~;

   i. Benefits, risks, and management options for improvement of glucose control~~.~~;

   j. Preconception care, pregnancy, and gestational diabetes~~.~~; and

k. Utilization of health care systems and community resources.

2. Indications for repeat training Prior Authorization (PA) is required for recipients whose diabetes is poorly controlled include:

a. Hemoglobin A 1 c blood levels of 8.5 or greater~~.~~;

b. Four or more serious symptomatic hypoglycemic episodes in a two month period;

c. Two or more hospitalizations for uncontrolled diabetes in a six month period;

d. Any ketoacidosis or hyperosmolar state~~.~~;

e. Pregnancy in a previously diagnosed diabetic~~.~~; and

f. Diabetics beginning initial insulin therapy.

3. No coverage will be provided for initial training which exceeds ten hours, or for repeat training, without a prior authorization.

D. COVERED CODES

For a list of covered procedure and diagnosis codes, please refer to the billing manual.

	adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
Intimate partner violence screening: women of childbearing age*	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
Obesity screening and counseling: adults*	The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Osteoporosis screening: women	The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures.
Preeclampsia prevention: aspirin*	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventative medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24-28 weeks gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Skin cancer behavioral counseling*	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.

A. DESCRIPTION

Preventive medicine/health refers to health care that focuses on disease (or injury) prevention. Preventive health also assists the provider in identifying a patient's current or possible future health care risks through assessments, lab work and other diagnostic studies.

B. POLICY

Nevada Medicaid reimburses for preventive medicine services for children as recommended by the U. S. Preventive Services Task Force (USPSTF) A and B Recommendations.
USPSTF A and B Recommendations

C. PRIOR AUTHORIZATION: YES ☐ NO ☒

D. COVERAGE AND LIMITATIONS:

The following preventive health services are covered by the Division of Health Care Financing and Policy (DHCFP) for children as is age appropriate:

Topic	Description
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF also recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
Depression screening: adolescents*	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Gonorrhea prophylactic medication: newborns*	The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
Hearing loss screening: newborns*	The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns*	The USPSTF recommends screening for sickle cell disease in newborns.
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
Hypothyroidism screening: newborns*	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for

POLICY #6-16	SCHOOL BASED HEALTH CENTER	EFFECTIVE DATE 01/01/15

A. DESCRIPTION

School Based Health Centers (SBHCs) provide primary and preventive medical services to Medicaid and Nevada Check Up recipients. SBHCs are health centers located on or near a school facility of a school district, independent school, or board of an Indian tribe or tribal organization. An SBHC operates as a separate delivery model from School Based Child Health Services (SBCHS) provided through an Individual Education Plan (IEP).

B. POLICY

1. The center(s) will, through providers of healthcare operating within the scope of their practice under state law, be used exclusively to provide primary and preventive health services to children and adolescents in accordance with recommended guidelines. Each center will be organized through the school, community, and health care provider agreements, and will be administered by a sponsoring agency.

2. Staffing and providers include but are not limited to: Support Staff, Site Director, Immunization Coordinator, Medical Doctor, Osteopathic Doctor, ~~Advanced Practice Registered Nurse Practitioner~~ APRN, Ph.D. of Nursing, PA/PA-~~Chysician's Assistant~~, and Qualified Mental Health Professionals. The ~~Division of Health Care Financing and Policy (~~DHCFP~~)~~ reimburses for services that are medically necessary and performed by a qualified provider within the scope of practice as defined by state law.

C. PRIOR AUTHORIZATION

Medical services provided by SBHCs must follow prior authorization policy for each service provided under corresponding prior authorization rules throughout the Medicaid Services Manuals (MSMs).

D. COVERAGE AND LIMITATIONS

1. All services that are provided must be medically necessary (see MSM Chapter 100) to be considered covered SBHC services. Medically necessary services provided by a qualified provider practicing within their scope of work may include but are not be limited to:

   a. Primary and preventive health care and medical screenings;

   b. Treatment for common illnesses and minor injuries;

   c. Referral and follow-up for serious illnesses and emergencies;

   d. Care and consultation, as well as referral and follow-up for pregnancy, chronic diseases and disorders, and emotional and behavioral problems;

   e. Referral, preventive services, and care for high risk behaviors and conditions such as drug and alcohol abuse, violence, injuries, and sexually transmitted diseases;

   f. Sports physicals as part of a comprehensive well child check up;

A. DESCRIPTION

Federally Qualified Health Centers (FQHCs) are defined by the Health Resources and Services Administration (HRSA) as health centers providing comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations.

B. POLICY

Nevada Medicaid reimburses for medically-necessary services provided at FQHCs and follows State and Federal laws pertaining to them.

C. AUTHORITY

1. Section 4161 of the Omnibus Budget Reconciliation Act of 1990
2. Section 330 of the Public Health Service (PHS) Act
3. Section 1861 of the Social Security Act
4. Section 1905 of the Social Security Act

D. HEALTH SERVICES

1. The DHCFP reimburses FQHCs an outpatient encounter rate.
    a. Encounter: Any one or more of the following medical professionals are included in the all-inclusive, daily outpatient encounter:
        1. Physician or Osteopath;
        2. Dentist;
        3. ~~Advance Practice Registered Nurse~~APRN;
        4. Physician Assistant;
        5. CRNA~~ertified Registered Nurse Anesthetist~~;
        6. Certified Registered Nurse Midwife;
        7. Psychologist;
        8. Licensed Clinical Social Worker;
        9. Registered Dental Hygienist;
        10. Podiatrist;

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1100 - OCULAR SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1100 are being proposed to clarify and eliminate duplicative language, and remove reference to the International Classification of Diseases and Related Health Problems (ICD)-9 codes.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29339 CHAPTER 1100 - OCULAR SERVICES	MTL 32/03, 24/08, 20/09, 33/11 CHAPTER 1100 - OCULAR SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1103.1A.1.b	**Coverage and Limitations**	Deleted “EPSDT) from title, HEALTHY KIDS.
1103.1A.2.b		Spelled out acronym EPSDT - "Early and Periodic Screening, Diagnosis and Treatment". Removed "(e.g., conjunctivitis, glaucoma examination)". Added language "within the scope of their license". Removed language "to receive services. Medical diagnosis ICD-9 codes must substantiate the service".
1103.1A.2.d		Removed language "Ocular examinations for the following medical conditions are covered based

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		upon medical necessity and do not require prior authorization and are not limited to the 12 month restriction for examination and lenses”. Added “Following cataract surgery, if the recipient is Medicare eligible and requires eyeglasses, the provider must bill Medicare first and attach the Medicare Explanation of Benefits (EOB) to the claim for co-insurance and deductible”. Deleted language "1. Glaucoma 2. Diabetes. 3. Healthy Kids/EPSDT referral services. 4. Or, following cataract surgery. If the recipient is Medicare eligible, and requires eyeglasses, the provider must bill Medicare first and attach the Medicare EOB to the claim for co-insurance and deductible".

1103 POLICY

1103.1 OCULAR SERVICES

1103.1A COVERAGE AND LIMITATIONS

Medicaid will reimburse for routine comprehensive ophthalmological examinations and/or refractive examinations of the eyes and glasses with a prescription for and provision of corrective eyeglasses to eligible Medicaid recipients of all ages once every twelve ~~(12)~~ months. Any exceptions require prior authorizations.

1. HEALTHY KIDS ~~(EPSDT)~~

   a. Nevada Medicaid provides for vision screenings as referred by any appropriate health, developmental, or educational professional after a Healthy Kids Screening Exam. Optometrists and ophthalmologists may perform such exams without prior authorization upon request or identification of medical need. "Medical Need" may be identified as any ophthalmological examination performed to diagnose, treat, or follow any ophthalmological condition that has been identified during the Healthy Kids examination.

   b. Glasses may be provided at any interval without prior authorization for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) recipients, as long as there is a change in refractive status from the most recent exam, or for broken or lost glasses. Physician records must reflect this change and the records must be available for review for the time mandated by the federal government. Recipients enrolled in a Managed Care plan are mandated to access Healthy Kids EPSDT ocular services through their Managed Care provider.

2. EXAMINATIONS

   a. Refractive examinations performed by an optometrist or ophthalmologist are covered for Medicaid recipients of all ages once every twelve ~~(12)~~ months. Any exceptions require prior authorization.

   b. Ocular examinations performed by an optometrist for ~~a~~ medical conditions ~~(e.g., conjunctivitis, glaucoma examination)~~ within the scope of their license do not require a prior authorization ~~to receive services. Medical diagnosis ICD-9 codes must substantiate the service~~.

   c. Ocular examinations performed by an ophthalmologist for medical conditions do not require prior authorization and are considered a regular physician visit. Current limitations are based on medical necessity.

d. ~~Ocular examinations for the following medical conditions are covered based upon medical necessity and do not require prior authorization and are not limited to the 12 month restriction for examination and lenses~~ Following cataract surgery, if the recipient is Medicare eligible and requires eyeglasses, the provider must bill Medicare first and attach the Medicare Explanation of Benefits (EOB) to the claim for co-insurance and deductible.

~~1. Glaucoma;~~

~~2. Diabetes;~~

~~3. Healthy Kids/EPSDT referral services;~~

~~4. Or, following cataract surgery. If the recipient is Medicare eligible, and requires eyeglasses, the provider must bill Medicare first and attach the Medicare EOB to the claim for co-insurance and deductible.~~

3. LENSES

Lenses are covered for recipients of all ages. No prior authorization is needed for recipients under 21. For recipients over 21, a prior authorization is required if the 12 month limitation is exceeded.

a. COVERED

The following are covered for Nevada Medicaid recipients of all ages as noted:

1. A change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within the 12 month limitation;

2. Lens material may be tempered glass tillyer grade or equivalent, or standard plastic, at recipient's option;

3. Ultra lightweight plastics, e.g., Lite Style and polycarbonate-style, are covered when they are medically necessary to avoid very heavy glasses which would hurt the bridge of the nose. The acceptable means for avoiding severe imbalance of the weight of the glasses are up to ±7 diopters in children;

4. Polycarbonate lenses are covered under EPSDT when medically necessary.

5. Safety lenses when the recipient has vision in only one eye;

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1200 – PRESCRIBED DRUGS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1200 are being proposed to comply with the Health Insurance Portability and Accountability Act (HIPAA) mandate to transition claims processing from ICD-9 (International Classification of Diseases) to ICD-10.

Verbiage "ICD code" was approved by the DUR Board as a transition to ICD-10 diagnosis coding.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29437 CHAPTER 1200 – PRESCRIBED DRUGS	MTL 12/15 CHAPTER 1200 – PRESCRIBED DRUGS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1203.1A.7.c	**Emergency supply of medication**	Deleted "-9" and added "(International Classification of Diseases)".
Appendix A Section C	**Agents used for the treatment of Attention Deficit Disorder (ADD)/ Attention Deficit Hyperactivity Disorder (ADHD)**	Added language "An ICD code for Attention Deficit Disorder with or without Hyperactivity". Removed language "One of the following ICD-9 codes and codes 314.0 314.9".
Appendix A Section N	**Psychotropic Medications for Children and Adolescents**	Removed language "the following" and added "ICD Codes". Remove language "diagnoses beginning with 345 beginning with 780.3 779.0".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		Added "ICD codes". Deleted "diagnoses, -9, and codes 299.00 299.01".
Appendix A Section O	**Lidoderm 5% Patched**	Deleted “-9” and added "for herpes zoster". Removed language "beginning with 053”.
Appendix A Section Z	**Cymbalta® (duloxetime)**	Deleted “-9” and “of 250.6”. Deleted “-9” and “729.1” and added "for Fibromyalgia".
Appendix A Section AA	**Savella® (milnacipran)**	Deleted “-9” and “729.1”.
Appendix A Section CC	**Ampyra® (dalfampridine)**	Deleted “ICD-9 code of 340”.
Appendix A Section DD	**Androgel®, Androderm®, Testim® (Testosterone gel and transdermal system)**	Deleted “-9” "diagnosis code of 257.2” and added "code for hypogonadism".
Appendix A Section 4	**Blood Glucose Testing**	Deleted “9”, “250.00 through 250.03”, “648.0”, and “(Diabetes Mellitus complicating pregnancy)” Added "Diabetes gestational (in pregnancy)”.

1203 POLICY

Nevada Medicaid reimburses pharmacies for prescriptions dispensed to each Medicaid recipient, with a maximum of a 34 day supply. Maintenance medications have a maximum of 100 day supply.

1203.1 PHARMACEUTICALS

All legend and non-legend pharmaceuticals must be prescribed by a licensed physician, podiatrist, osteopath, dentist, Advanced Practitioner of Nursing (APN), or physician's assistant within the scope of their practice.

1203.1A COVERAGE AND LIMITATIONS

1. Covered

The Nevada Medicaid Drug program will pay for the following prescribed pharmaceuticals with a written prescription, dispensed per the manufacturer's guidelines, and may be subject to restrictions (such as prior authorization, quantity limitations etc):

a. Medicaid is mandated by Federal statute to require all written (non-electronic) prescriptions for all outpatient drugs for Medicaid recipients to be on tamper-resistant prescription pads. This requirement does not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber. Refer to Medicaid Services Manual (MSM) Addendum for more information on tamper-resistant prescription pads.

b. Legend and non-legend pharmaceuticals manufactured by companies participating in the federal Medicaid Drug Rebate Program, not on the excluded list (see below).

c. Preferred Drug List (PDL) is a list of preferred outpatient drugs established by the Pharmacy and Therapeutics (P&T) Committee. Reference Medicaid Operations Manual (MOM) Chapter 200 for the P&T bylaws. Pharmaceuticals not on the preferred drug list, but within drug classes reviewed by the P&T Committee require prior authorization, unless exempt under Nevada Revised Statute (NRS) or federal law, or excluded through recommendations of the P&T Committee or excluded by the Division of Health Care Financing and Policy (DHCFP).

1. New pharmaceutical products not within reviewed PDL drug classes and not excluded under the state plan are available under prior authorization

guidelines until the P&T Committee reviews the product or evidence.

2. Existing pharmaceutical products for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs and are not excluded under state plan, are available under prior authorization guidelines until the P&T Committee can review the new evidence.

3. Pharmaceuticals may require prior authorization due to step therapy protocols regardless of inclusion in the PDL.

4. If the P&T Committee determines that there are no significant differences between drugs within specific classes based on clinical efficacy and safety, DHCFP or its Quality Improvement Organization (QIO)-like vendor may consider cost in determining which drugs are selected for inclusion on the PDL.

5. The Drug Utilization Review (DUR) Board shall not be required to develop, review or approve prior authorization policies necessary for the operations of the PDL.

6. Due to the 76th Special Session and in accordance with Senate Bill (SB) 4, every therapeutic prescription drug that is classified as an anticonvulsant medication or antidiabetic medication that was covered by the Medicaid program on June 30, 2010 must be included on the PDL as a preferred drug. If a therapeutic prescription drug that is included on the list of preferred prescription drugs is prescribed for a clinical indication other than the indication for which it was approved as of June 30, 2010, the Committee shall review the new clinical indication for that drug in accordance with Section 1203 of this chapter.

7. Due to the 76th Special Session and in accordance with SB 4, the P&T Committee must prefer atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness, anticonvulsant medications and antidiabetic medications for a patient who is receiving services pursuant to Medicaid if the patient:

   a. was prescribed the prescription drug on or before June 30, 2010, and takes the prescription drug continuously, as prescribed, on and after that date; and

   b. maintains continuous eligibility for Medicaid.

d. Pharmaceuticals prescribed for a medically accepted indication.

e. Family planning items such as diaphragms, condoms, foams and jellies.

Reference Appendix A for coverage and limitations of medications with special criteria.

2. Standard Preferred Drug List Exception Criteria

Drugs that have a "non-preferred" status are a covered benefit for recipients if they meet the coverage criteria.

a. Coverage and Limitations

1. Allergy to all preferred medications within the same class;

2. Contraindication to or drug-to-drug interaction with all preferred medications within the same class;

3. History of unacceptable/toxic side effects to all preferred medications within the same class;

4. Therapeutic failure of two preferred medications within the same class.

5. If there are not two preferred medications within the same class therapeutic failure only needs to occur on the one preferred medication;

6. An indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or a Food and Drug Administration (FDA)-approved indication;

7. Antidepressant Medication – Continuity of Care.

Recipients discharged from acute mental health facilities on a non-preferred antidepressant will be allowed to continue on that drug for up to 90 days following discharge. After 90 days, the recipient must meet one of the above five PDL Exception Criteria; or

8. For atypical or typical antipsychotic, anticonvulsant and antidiabetic medications the recipient demonstrated therapeutic failure on one preferred agent.

b. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms/aspx

3. Excluded

The Nevada Medicaid Drug Rebate program will not reimburse for the following pharmaceuticals:

a. Agents used for weight loss.

b. Agents used to promote fertility.

c. Agents used for cosmetic purposes or hair growth.

d. Yohimbine.

e. Drug Efficacy Study and Implementation (DESI) list "Less than Effective Drugs": In accordance with current policy, federal financial participation is not allowed for any drug on the Federal Upper Limit (FUL) listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the DESI program which has been found to be a less than effective or is Identical, Related or Similar to the DESI drug. The DESI drug is identified by the FDA or reported by the drug manufacturer for purposes of the Medicaid Drug Rebate Program. This listing is available on the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.gov/MedicaidDrugRebateProgram/12_LTEIRSDrugs.asp

This includes pharmaceuticals designated "ineffective" or "less than effective" (including identical, related or similar drugs) by the FDA as to substance or diagnosis for which prescribed.

f. Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed. Pharmaceuticals manufactured by companies not participating in the federal Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

g. Agents used for impotence/erectile dysfunction.

4. Refills

A refill is a prescription subject to the limitations below:

a. Authorized refills are valid only from the pharmaceutical provider dispensing the original prescription, pursuant to Nevada Administrative Code (NAC) Chapter 639.

b. Refill intervals must be consistent with the dosage schedule indicated on the original prescription. If a prescription is for a 34-day supply, a consistent refill would be filled in 30 days; an inconsistent refill date would be filled in 20 days from the original fill.

c. Lost Medications. Nevada Medicaid does not pay for replacement of lost, stolen or otherwise destroyed medications even if a physician writes a new prescription for the medication. It is the responsibility of the recipient to replace these medications. Prior authorization may be granted in life-threatening situations and for maintenance medications only. See Quantity of Medication in this chapter for more information on maintenance medications.

5. Early Refills

Nevada Medicaid only pays for up to a 34 day supply of medications (100 day supply for maintenance medications) for recipients each month. A prescription refill will be paid for by Nevada Medicaid only when 80% of the non-controlled substance prescription, and 90% of the controlled substance prescription, is used in accordance with the prescriber's orders on the prescription and on the label of the medication.

In the instance that a recipient will be out of town when a refill is due, the pharmacist may enter the appropriate override code to allow an early refill. This override will be monitored by Nevada Medicaid for misuse/abuse by the recipient and/or provider.

Medicaid will not pay for an early prescription refill when gross negligence or failure to follow prescriber's prescription instructions has been displayed by the recipient.

6. Quantity of medication

The maximum quantity of medication per prescription payable by the Medicaid program is a 34 day supply. Exceptions are allowed for maintenance medications.

a. In long-term care facilities, if the prescriber fails to indicate the duration of therapy for a maintenance drug, the pharmacy must estimate and provide at least a 30-day supply. Exceptions may be based on reasonable stop orders. (For oral liquid medications only, a 16 fluid ounce quantity will be considered sufficient to fulfill the 30-day supply requirement.)

b. Prescription quantities may be reviewed; in those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the dispensing fee may be disallowed.

c. The maximum quantity of medication per prescription for maintenance pharmaceuticals for chronic conditions for outpatients, payable by Medicaid, may be a 100-day supply.

The following drug categories are considered maintenance medications:

1. Antianginals;
2. Antiarrhythmics;
3. Anticonvulsants;
4. Antidiabetics;
5. Antihypertensives;
6. Cardiac Glycosides;
7. Diuretics;
8. Thyroid preparations;
9. Estrogens;
10. Progesterone; and
11. Oral/Topical Contraceptives.

7. Emergency supply of medication

a. In an emergency situation, after QIO-like vendor working hours and weekends, dispensing of up to a 96 hour supply those covered outpatient drugs that require prior authorization will be allowed.

b. Nevada Medicaid requires prior payment authorization for medications identified as requiring prior authorization.

c. The physician must indicate the diagnosis on the prescription (preferably with an International Classification of Diseases (ICD)~~9~~ code~~)~~ to support the use of the emergency policy.

d. As a follow-up to the dispensing of the emergency supply of medication, the provider must contact the QIO-like vendor, to obtain a verbal verification number.

C. Agents used for the treatment of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)

Therapeutic Class: ADHD/ADD Agents
Last Reviewed by the DUR Board: January 24, 2008

Agents, both stimulants and non-stimulants used for the treatment of ADD/ADHD are subject to prior authorization for pediatric, adolescent, and adult clients that meet the criteria for coverage.

1. Coverage and Limitations

Approval for medications will be given at the therapeutics class level if the following criteria is met and documented:

a. General Criteria (Children and Adults)

1. Only one long-acting agent at a time may be used for the treatment of ADD/ADHD (applies to the entire ADD/ADHD/Stimulant Class); a 30-day transitional overlap in therapy will be allowed.

2. The following two criteria's must be met and documented in the recipient's medical record for adult and pediatric recipients.

a. The decision to medicate for ADD or ADHD must be based on problems that are persistent and sufficiently severe to cause functional impairment in one or more of the following social environments: school, home, work or with peers; and

b. Before treatment with pharmacological methods is instituted, other treatable causes have been ruled out.

b. Children (up to age 18 years)

In addition to the general criteria above, the following conditions apply and must be documented in the recipient's medical record.

1. Prescriptions for ADD/ADHD medications do not require prior authorizations for children five years of age, up to eighteen years of age, if the following conditions apply:

a. The medication is prescribed by a psychiatrist; and

b. An ICD code for Attention Deficit Disorder with or without Hyperactivity ~~One of the following ICD-9 codes~~ is documented on the prescription~~: 314.0-314.9~~.

N. Psychotropic Medications for Children and Adolescents

Therapeutic Class: Psychotropic Agents
Last Reviewed by the DUR Board: July 26, 2012

Psychotropic medications for children and adolescents are subject to prior authorization.

1. Coverage and Limitations

Nevada Medicaid has adopted the following practice standards to strengthen treatment outcomes for our children and adolescents.

These practices include:

a. For psychotropic medications in this age group, when possible, be prescribed by or in consultation with a child psychiatrist.

b. Psychotropic medication must be part of a comprehensive treatment plan that addresses the education, behavioral management, living home environment and psychotherapy.

c. Physician monitoring is required while the recipient is utilizing the medication.

1. For recipients who are in initial treatment or are unstable on the medication therapy, medical documentation must support a monthly or more frequent visit with the prescribing practitioner. If the recipient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician.

2. For recipients who are considered stable in their medication therapy, medical documentation must support visits with the treating physician at least every three months.

d. Prescribing more than one medication from the same class or prescribing three or more psychotropic medications from different drug classes is to be avoided. Each pharmaceutical prescribed must be independently treating a specific condition (diagnosis). To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatments of medication side effects must be documented. Recipients must fail a trial of a single medication within the same class before treatment with multiple agents in the same class will be considered. This will be demonstrated by medical attestation by the treating physician.

2. Nevada Medicaid requires prior authorization for all psychotropic medications for recipients less than 18 years of age. Therapeutic classes subject to prior authorization for this age group include:

   a. Antianxiety Agents;

   b. Anticonvulsants;

   c. Antidepressants;

   d. Lithium Preparations;

   e. Sedatives; and

   f. Antipsychotics.

   Exceptions to this policy are:

   g. Treatment for seizure disorders with ~~the following~~ ICD Codes ~~diagnoses beginning with 345~~ for ~~(~~Epilepsy~~),~~ ~~beginning with 780.3 (~~Convulsions~~)~~ and ~~779.0 (~~Convulsions in Newborn~~)~~ will be approved. These ICD codes ~~diagnoses~~ written on the prescription and on the claim will bypass the prior authorization requirement in the pharmacy POS or the prior authorization requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system.

   h. The current policy for treatment of ADD/ADHD is to be followed. Refer to this Chapter's Appendix A.

   i. For treatment with Abilify, if an ICD~~-9~~ code~~s of 299.00 or 299.01 (~~ for autistic disorder~~) are~~ is written on the prescription and on the claim it will bypass the prior authorization requirement in the pharmacy POS system.

3. Prior Authorization Criteria

   a. Each medication prescribed must be independently treating a specific condition (diagnosis).

   b. To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatment of side effects must be documented.

   c. Recipients must fail a trial of a single medication within the same class before treatment with multiple agents in the same class will be considered.

   d. Physician monitoring is required while the recipient is utilizing the medication(s).

O. Lidoderm 5% Patches®

Therapeutic Class: Topical, Local Anesthetics
Last Reviewed byt the DUR Board: April 30, 2009

1. Coverage and Limitations

Topical Lidoderm Patches® are subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

Authorization will be given if one of the following criteria are met and documented:

a. If an ICD~~-9~~ code for herpes zoster ~~beginning with 053., herpes zoster,~~ is documented on the prescription; or

b. Completion of a prior authorization documenting a diagnosis of Post Herpetic Neuralgia/Neuropathy.

Z. Cymbalta® (duloxetine)

Therapeutic Class: Sertonin-Norepinephrine Reuptake Inhibitor (SNRI)
Last Reviewed by the DUR Board: July 25, 2013

Cymbalta® is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval will be given if the following criteria are met and documented. Recipients must meet at least one diagnosis listed below:

a. Diabetic Peripheral Neuropathy (DPN):

1. If an ICD~~-9~~ code ~~of 250.6~~ for Diabetes with Neurological Manifestations is documented on the prescription and transmitted on the claim; or

2. Completion of a prior authorization documenting a diagnosis of Diabetes with Neurological Manifestations.

b. Fibromyalgia:

1. If an ICD~~-9~~ code ~~729.1~~ for Fibromyalgia, Myalgia and Myositis unspecified is documented on the prescription and transmitted on the claim; or

2. Completion of a prior authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

c. Chronic Musculoskeletal Pain:

The recipient must meet one of the following:

1. The recipient has experienced an inadequate response or adverse event to at least two oral or topical non-steroidal anti-inflammatory drug (NSAIDS); or

2. The recipient has an allergy or contraindication to two NSAIDS.

d. Generalized Anxiety Disorder:

The recipient must meet the following:

AA. Savella® (milnacipran)

Therapeutic Class: Fibromyalgia Agents: Serotonin-Norephinephrine Reuptake Inhibitor
Last Reviewed by DUR Board: June 3, 2010

Savella® (milnacipran) is subject to prior authorization.

Coverage and Limitations

1. Diagnosis of Fibromyalgia:

   a. If an ICD ~~-9~~ code ~~729.1~~ for Myalgia and Myositis unspecified is documented on the prescription; or

   b. Completion of a prior authorization documenting a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified.

Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

CC. Ampyra® (dalfampridine)

Therapeutic Class: Agents for the treatment of Neuromuscular Transmission Disorder
Last Reviewed by the DUR Board: July 25, 2013

Ampyra® (dalfampridine) is subject to prior authorization and quantity limitations based on the Application of Standards in Section 1927 of the Social Security Act and/or approved by the DUR Board. Refer to the Nevada Medicaid and Check Up Pharmacy Manual for specific quantity limits.

1. Coverage and Limitations

Approval for Ampyra® (dalfampridine) will be given if all of the following criteria are met and documented:

a. Ampyra® (dalfampridine)

The recipient must meet all of the following:

1. The recipient must have a diagnosis of Multiple Sclerosis ~~(ICD-9 code of 340)~~; and

2. The medication is being used to improve the recipient's walking speed; and

3. The medication is being prescribed by or in consultation with a neurologist; and

4. The recipient is ambulatory and has an EDSS score between 2.5 and 6.5; and

5. The recipient does not have moderate to severe renal dysfunction (CrCL >50 ml/min); and

6. The recipient does not have a history of seizures; and

7. The recipient is not currently pregnant or attempting to conceive.

2. Prior Authorization Guidelines

a. Initial Prior Authorization approval will be for three months.

b. Requests for continuation of therapy will be approved for one year.

c. Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

DD. Androgel®, Androderm®, Testim® (Testosterone gel and transdermal system)

Therapeutic Class: Androgenic Agents
Last Reviewed by the DUR Board: July 22, 2010

Topical Androgens are subject to prior authorization.

1. Coverage and Limitations

Recipients must meet all of the criteria for coverage:

2. Criteria for approval

a. Recipient is a male;

b. Use is for the FDA Approved Indication:

Primary (congenital or acquired) or secondary (congenital or acquired) hypogonadism with an ICD ~~-9 diagnosis code of 257.2~~ code for hypogonadism;

c. The patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used;

d. The patient does not have breast or prostate cancer, a palpable prostate nodule or induration, prostate-specific antigen greater than 4 ng/ml or severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) > 19;

e. The patient does not have a hematocrit > 50%;

f. The patient does not have untreated severe obstructive sleep apnea; and

g. The patient does not have uncontrolled or poorly controlled heart failure.

3. Prior Authorization Guidelines

Prior authorization approval will be for up to one year.

Prior Authorization forms are available at:
http://www.medicaid.nv.gov/providers/rx/rxforms.aspx

Length of authorization: one year.

4. BLOOD GLUCOSE TESTING

Nevada Medicaid and NCU participate in a Diabetic Supply Procurement Program. This program allows for the State to receive additional rebates for diabetic monitors and test strips. Effective March 1, 2009, diabetic monitors and test strips are covered for Nevada Medicaid and NCU from preferred manufacturers. Preferred manufacturers are listed in the pharmacy billing manual. This policy does not negatively impact freedom of choice for recipients. The providers billing for the service will continue to be all willing enrolled pharmacies.

Blood glucose monitors and testing supplies for home use are subject to quantity limitations. A written prescription with a diagnosis is required and must be kept on the premise of the provider for 37 months. A recipient or their caregiver must specifically request refills of glucose supplies before they are dispensed. The provider must not automatically dispense a quantity of supplies on a predetermined regular basis, even if a recipient has "authorized" in advance.

For all items in excess of the limitations, a prior authorization must be obtained from the Nevada Medicaid QIO-like vendor.

Blood Glucose monitors with special features (e.g. voice synthesizers) require a prior authorization. For special blood glucose monitors, the recipient must be legally blind. A diagnosis, a statement from the physician of visual impairment, and manufacturers' invoice in required with the prior authorization.

ICD~~-9~~ codes ~~250.00 through 250.93 (~~ for Diabetes Mellitus~~)~~ or ~~648.0 (Diabetes Mellitus complicating pregnancy)~~ Diabetes, gestational (in pregnancy) will be covered. No coverage will be provided for any other ICD~~-9~~ code.

Blood glucose monitors and related supplies are billed on the National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) or on-line through the Point of Sale (POS) system with the correct NDC number, complete description, including brand name and package size. Reimbursement is Wholesale Acquisition Cost (WAC) plus 8% and handling and dispensing fee of $1.54 per prescription.

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1300 – DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1300 are being proposed to change reference to the International Classification of Diseases (ICD) and Related Health Problems, and ICD-9 diagnosis codes to ICD-10 diagnosis coding updates.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29414 CHAPTER 1300 - DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS	MTL 13/15 CHAPTER 1300 - DME, DISPOSABLE SUPPLIES AND SUPPLEMENTS

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1303.2.A.1.c.6	**Documentation Requirements**	Change reference from medical diagnosis ICD-9 codes to ICD the most current appropriate diagnosis code(s).
1303.4.A.4.a.2	**Prior Authorization**	Change reference from medical diagnosis ICD-9 codes to ICD the most current appropriate diagnosis code(s).
Appendix B	**Diabetic Services**	Change reference from medical diagnosis ICD-9 codes to ICD the most current appropriate diagnosis code(s).
Appendix B	**Mobility Assistive Equipment (MAE)**	Removed specific ICD-9 codes.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Appendix B	**Nutritional Services**	Removed specific ICD-9 codes
Appendix B	**Orthotic and Prosthetic Devices**	Removed ICD-9 diagnosis code 718.47.
Appendix B	**Respiratory Services**	Remove specific ICD-9 codes and changed reference to ICD-9 to ICD.

7. Return all rented equipment to the DMEPOS provider when no longer being used, or upon the DME provider's request. Failure to return rented equipment could result in a recipient's financial responsibility for the retail price of the rented equipment, even if the equipment is lost/stolen, the recipient has moved, or they are no longer eligible for Nevada Medicaid/NCU.

8. Comply with additional requirements as specified throughout this Chapter and its Appendices and MSM Chapter 100.

1303.2 DOCUMENTATION REQUIREMENTS

A. Supplier/provider records must substantiate the medical necessity for all DMEPOS items dispensed to recipients. The following describes the requirements for specific types of documentation associated with DMEPOS.

1. ORDERS / PRESCRIPTIONS

a. All DME items, Prosthetics, Orthotics, or Disposable Supplies (POS) dispensed must have an order/prescription from the treating physician or practitioner, (To determine included practitioners, refer to MSM, Chapter 600 – Physician's Services), such as a Physician's Assistant (PA), or Advanced Practitioner of Nursing (APN), when within their scope of practice and in accordance with federal and state laws governing that entity, prior to dispensing the item.

In accordance with the Patient Protection and Affordable Care Act (PPACA) (The Affordable Care Act) of 2010 (Public Law 111-148), all orders for DMEPOS items, whether verbal or written, must be incidental to a physician-documented face-to-face encounter between the recipient and the prescribing physician/practitioner (as allowed by The Act) within 30 days prior to the start date of the order. The encounter must be relevant to the need for the prescribed DMEPOS.

Refer to Appendix B of this Chapter for additional order requirements on specific products.

General standards of care/practice mandate that if an order is not clear, a clarification of the order must be obtained from the ordering practitioner prior to acting on it.

b. Verbal Orders:

1. Verbal orders from the prescribing physician/practitioner may be accepted for DMEPOS items that do not require prior authorization by the DHCFP (except when Medicare is primary and Medicaid co-payment will be requested, and Medicare requires a written order for that item prior to delivery). Refer online to the DME MAC Jurisdiction D Supplier Manual, Chapter 3 – Documentation Requirements, for a current listing of those items at: https://www.noridianmedicare.com/dme/news/manual/chapter3.html

2. The verbal dispensing order must include:

   a. A description of the item;

   b. The recipient's name;

   c. The physician's name;

   d. The start date and length of need of the order; and

   e. Additional information sufficient to allow appropriate dispensing of the item.

3. Suppliers must maintain written documentation of the verbal order and, if the verbal order is used for dispensing the item, the supplier must obtain a detailed written order prior to billing the DHCFP.

c. Written Orders:

1. Written orders are acceptable for all transactions involving DMEPOS and must be obtained prior to submitting a prior authorization for any DMEPOS items. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document.

2. All written orders must, at a minimum:

   a. Clearly specify the start date of the order;

   b. Include the length of need;

c. Be sufficiently detailed, including all options or additional features that are needed to meet the recipient's needs. The description must be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number; and

d. Be signed and dated by the treating physician/practitioner. Signature includes computer signature and pen and ink, no signature stamps allowed.

3. Certain items require additional elements in the written orders, as follows:

a. If the written order is for supplies that will be provided on a periodic basis, the written order must include appropriate information on the quantity used, frequency of change, and duration of need. (For example, an order for surgical dressings might specify one 4x4-hydrocolloid dressing that is changed one to two times per week for one month or until the ulcer heals).

b. If the written order is for an item such as, but not limited to, enteral formula, oxygen, etc., the order must specify the name of the product, concentration (if applicable), dosage, frequency and route of administration, and duration of infusion (if applicable).

c. Custom-fabricated items must be clearly indicated on the written order that has been signed and dated by the prescribing physician/practitioner.

4. There are additional specifications for orders for certain items, such as, but not limited to, Power Mobility Devices (PMDs). Refer to Appendix B for details.

5. The detailed description of the item(s) may be completed by an employee of the ordering physician/practitioner; however, the prescriber must review the detailed description and personally indicate agreement by signing and dating the order.

6. Medical necessity information (such as ~~an~~ the most current appropriate diagnosis code(s) (ICD)~~-9~~ diagnosis code, narrative description of the recipient's condition, abilities, and limitations) is

in addition to all other requirements and qualifications for a specific item/device:

1. the anticipated length of need (per physician's order) is long term (more than six months); and

2. the provider will be supplying a new device/item to the recipient; or

3. the item is only available for purchase.

2. Purchase Used Equipment Option:

a. Certain products are identified by Nevada Medicaid with a purchase option for used equipment. When an item was new at the time it was dispensed to a recipient for rental purposes, and prior to billing the third month of rental, it is determined the item will be needed indefinitely, the DHCFP may purchase the item for the recipient for ongoing use. The DHCFP does not purchase used equipment from the provider's inventory of rental items used for re-issuance to same or multiple persons over time (rental fleets, etc.).

b. The DHCFP will only purchase used equipment when, in addition to all other requirements and qualifications for the item:

1. the recipient meets the criteria for purchase of new equipment;

2. the item was new when placed in the recipient's use and has been used for less than three months; and

3. the item is currently being used by the same recipient during a trial period and it has been determined the length of need will now be indefinite.

c. A prior authorization must be submitted to request purchase of a used item, with all supportive medical documentation to show the date the item was initially issued to the recipient and that the recipient continues to have an ongoing need for the item.

1303.4 PRIOR AUTHORIZATION

A. Prior authorization is a review conducted by the Quality Improvement Organization (QIO)-like vendor's medical professionals who review the prior authorization form and any additional information submitted to evaluate medical necessity, appropriateness, location of service, and compliance with the DHCFP's policy, prior to delivery of service.

Reference the MSM, Chapter 100 and the general Billing Manual for detailed information on prior authorizations and Medicaid eligibility for all providers at: http://www.medicaid.nv.gov/providers/BillingInfo.aspx.

1. Submission:

   a. Prior authorizations must be completed and submitted by a current Medicaid provider (requestor), and the approval must be received, prior to delivery of services. The exception to this is if the recipient is determined eligible for Medicaid retroactively or if number four of this section applies.

   b. A prior authorization is required for most durable medical equipment, prosthetics, orthotics, and oxygen.

   c. A Medicaid provider may submit the prior authorization electronically using the QIO-like vendor's on-line prior authorization system or may fax or mail the prior authorization to the QIO-like vendor. For more information, refer to the prior authorization section posted at: https://www.medicaid.nv.gov.

   d. Requestors must submit a prior authorization with the most appropriate HCPCS code available and may not unbundle items included in the HCPCS code description. If an item has a designated code available, the miscellaneous code cannot be used. Providers may contact the Medicare Pricing, Data Analysis and Coding (PDAC) contractor, or the DME MAC for guidance on correct coding.

   e. Documentation requirements are the same regardless of which mode of submission is used (e.g. the on-line prior authorization system, faxed, or mailed). Documentation submitted for consideration of the request must include the physician's order and must clearly support coverage qualifications and recipient's medical need for the equipment. Failure to provide all of the supporting medical documentation in its entirety, and within the required timeframes, will result in a denial of the prior authorization request, regardless of mode of submission.

   f. Unless otherwise stated in policy, a prior authorization may be submitted to request authorization to exceed established quantity limitations when the medical documentation supports medical necessity for the increased quantity or frequency.

2. Review Consideration:

   a. In addition to the specifications mentioned previously, for reviewing the prior authorization, products and services must be medically necessary, safe and appropriate for the course and severity of the condition using the least costly equally effective alternative to meet the recipient's needs.

   b. The recipient must have a medical need for, and the requested item must be suitable for use within the home. Consideration will also be based on the recipient's additional use of the item for the conditions in each of the environments the recipient is likely to encounter in their daily routines, such as, but not limited to: attending school, work, and shopping. This information must be included in the supportive documentation submitted with the prior authorization.

   c. For durable medical equipment, prosthetics, orthotics, and disposable medical supplies and appliances where coverage and limitation policies have not been established within this Chapter or its Appendices, the DHCFP may defer to DME MAC Jurisdiction D, Local Coverage Determination (LCD) and policy articles for coverage and limitation criteria. These can be accessed at: http://www.noridianmedicare.com/dme. The item must meet the definition of durable medical equipment, prosthetic, orthotic, or disposable medical supply and must be necessary to meet the medical needs of the recipient, and must be part of the prescribing physician's/practitioner's Plan of Care (POC).

   d. The DHCFP has the option of requesting an Independent Medical Evaluation (IME) to determine the recipient's limitations and abilities to support medical necessity.

3. Prior Authorization Requirements for Third Party Liability (TPL) and Medicare Crossovers:

   a. Refer to MSM, Chapter 100, for more information on TPL, and Medicare Crossovers and the requirements for securing prior authorizations.

4. Prior Authorization Emergency Situations:

   a. In an emergency situation, when an order is received by the supplier after the QIO-like vendor working hours or over weekends or State holidays, dispensing of a 72-hour supply of those DMEPOS items that require prior authorization will be allowed only when:

1. A delay of 24 hours of treatment could result in very severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others; and

2. The treating physician/practitioner indicates the most current appropriate diagnosis code(s)~~a diagnosis~~ /ICD~~-9~~ code on the prescription that supports the use of the emergency policy.

b. The provider/supplier must submit the prior authorization the next business day with all required supportive documentation. The documentation must include proof of the date and time the order was received by the supplier and documentation to support both 1303.4(a.)(1.) and (2.).

5. DMEPOS Specific Prior Authorization Forms:

All forms must be completed and submitted by a current Medicaid provider. Forms used must be the most current version.

a. All Forms and Form Release Memorandums or instructions may be accessed at the DHCFP's website: https://dhcfp.nv.gov/index/htm. The instructions provide detailed guidance on form completion requirements.

b. Specific DME prior authorization forms are found on the QIO-like vendor's website: https://www.medicaid.nv.gov/providers/forms/forms.aspx. All DMEPOS items that require prior authorization must be requested on these forms and submitted electronically, by fax or by mail to the QIO-like vendor for approval.

c. Usage Evaluation – For Continuing Use of Bi-Level and Continuous Positive Airway Pressure (BIPAP and CPAP) Devices use the form, found on the QIO-like vendor's website. This form may be completed and submitted for continuing usage of BIPAP or CPAP devices.

d. Mobility Assessment for Mobility Devices, Wheelchair Accessories and Seating Systems, form found on the QIO-like vendor's website. This form must be submitted for all mobility devices, wheelchair accessories and seating systems.

6. Denied Prior Authorization Requests:

a. There are various processing levels associated with prior authorization requests which do not support medical necessity. These may include, but are not limited to: a contact to the provider by the QIO-like vendor, a

system generated technical denial, a system generated denial or reduction of services, a provider-requested reconsideration, a provider-requested peer-to-peer review with the physician. For specific information on time limits and an explanation of each, refer to the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/billinginfo.aspx.

b. If a prior authorization request is denied or reduced, the provider and recipient will be sent a Notice of Decision (NOD) with a citation/reason to provide a general explanation of the denial. The provider may request consideration of the denial by submitting additional supportive information and requesting a "Reconsideration" in writing.

c. If a reconsideration is not appropriate or is also denied, the recipient may be entitled to request an appeal or hearing. Refer to MSM Chapter 3100 – Hearings.

B. COVERAGE AND LIMITATIONS

1. Coverage and limitations are explained throughout this Chapter, including its appendices. Appendix B details coverage qualifications, prior authorization documentation requirements, and limitations for specific items.

2. Refer to the Nevada Medicaid Provider Type 33 – DME Fee Schedule posted at: http://dhcfp.nv.gov/RatesUnit.htm for covered services. The Fee Schedule identifies covered services/items (listed in alpha-numeric order according to HCPCS code), and rates. Codes are updated yearly. Codes not included in the fee schedule after the yearly update are considered non-covered.

C. PROVIDER RESPONSIBILITY

1. The requesting DME provider (supplier) and the prescribing physician/practitioner must work collaboratively to accurately and timely complete and submit prior authorization requests, including all supportive documentation in order to ensure the item(s) being requested is/are the most appropriate to meet the recipient's medical needs. This must be done prior to dispensing any DMEPOS item requiring a prior authorization. Refer to the prior authorization section of the general Billing Manual for all providers at: https://www.medicaid.nv.gov/providers/billinginfo.aspx for detailed information on form completion and submission/transmission of prior authorization requests.

2. In the event additional information is requested by the QIO-like vendor, the provider should submit the requested information within established time limits, and/or review the notice of decision to determine the reason for denial, make any

Policy: DIABETIC SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
External Ambulatory Infusion Pump, Insulin (E0784)	Covered ICD-~~9~~ codes: ~~250 250.93 Diabetes Mellitus~~ ~~648.0~~ Diabetes Mellitus ~~648.8~~ Gestational Diabetes All of the following conditions must be met: 1. Fasting serum C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method or as an alternative must be beta cell autoantibody positive. 2. Recipient has completed a comprehensive diabetic education program within the last year. 3. Recipient is motivated to achieve and maintain improved glycemic control. 4. Recipient has been on a program of multiple daily injections of insulin (e.g., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to request for the insulin pump. 5. Documented frequency of glucose self-testing is an average of at least 4 times per day during the 2 months prior to starting the insulin pump. 6. Glycosylated hemoglobin level (HbA1C) > 7.0% In addition, one or more of the following indications must be present: 1. History of recurring hypoglycemia; 2. Wide fluctuations in blood glucose before mealtime (e.g., preprandial blood glucose level commonly exceeds 140 mg/dl; 3. Dawn phenomenon with fasting blood sugars frequently >200 ml/dl;	1. A prescription from a physician who manages recipients with insulin pumps and who works closely with a team including nurses, diabetes educators, and dietitians. 2. Prior authorization is required for the insulin pump with all of the following documentation: a. Certification of Diabetic Education Class with first time request. b. Signed statement from the physician acknowledging medical necessity and the following: 1. Recipient is motivated to achieve and maintain improved glycolic control, indicated by showing documented finger sticks (at least 4 times per day) with multiple injections. 2. Recipient has been on a program of multiple injections of insulin (at least 3 times per day) with frequent self-adjustment of insulin doses at least 6 months prior to initiation of the insulin pump. 3. Cognitive ability to operate pump and calculate insulin dosages. 3. Qualifying lab results per qualifications. 4. Physician current history and physical including one or more of the additional indications listed in the qualification column. 5. Documentation requirements for recipients using the insulin pump prior to Medicaid eligibility requires a PA with the following documentation: a. A current HbA1C level. b. Signed narrative from the physician documenting the recipient's compliance and ability to self adjust the insulin pump	1. External ambulatory infusion pump recipients with Gestational Diabetes whom do not meet conditions 1 through 6 but do meet qualifications under Gestational Diabetes approval of the insulin pump will be on a rental basis until the end of the pregnancy. 2. Insulin Pump-related Supplies through the DMEPOS program: E0784 - External Ambulatory Infusion pump, Insulin A4230 - Infusion set for external pump, non-needle cannula type A4231 - Infusion set for external pump, needle type A4232 - Syringe with needle for external insulin pump, sterile, 3cc

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
Custom Fabricated Seat Cushion (E2609)	1. May be covered if the recipient meets all qualifications for a prefabricated skin protection seat cushion or positioning seat cushion; and 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.		
Custom Fabricated Back Cushion (E2617)	1. May be covered if the recipient meets all qualifications for a prefabricated positioning back cushion; and 2. The documentation and Mobility Assessment form clearly explains why a prefabricated seating system is not sufficient to meet the recipient's seating and positioning needs.		
Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)	1. May be covered for a recipient who has a manual or power wheelchair with a sling/solid seat/back; and either of the following: a. Current or past history of a pressure ulcer on the area of contact with the seating surface; or b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia ~~(344.00-344.1)~~, other spinal cord disease ~~(336.0-336.3)~~, multiple sclerosis ~~(340)~~, other demyelinating disease ~~(341.0-341.9)~~, cerebral palsy ~~(343.0-343.9)~~, anterior horn cell diseases including amyotrophic lateral sclerosis ~~(335.0-335.21, 335.23-335.9)~~, post polio paralysis ~~(138)~~, traumatic brain injury resulting in quadriplegia ~~(344.09)~~, spina		

Policy: MOBILITY ASSISTIVE EQUIPMENT (MAE)			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Skin Protection Seat Cushion (E2603, E2604, K0734, K0735) (Pre-fabricated)**	bifida ~~(741.00-741.93)~~, childhood cerebral degeneration ~~(330.0-330.9)~~, Alzheimer's disease ~~(331.0)~~, or Parkinson's disease ~~(332.0)~~.		
Positioning Seat Cushion (E2605, E2606), Positioning Back Cushion (E2613-E2616, E2620, E2621) and/or Positioning Accessory (E0955-E0957, E0960)	1. May be covered for a recipient who: a. Has a manual or power wheelchair with a sling/solid seat/back; and b. Has any significant postural asymmetries that are due to one of the diagnoses listed in Skin Protection Seat Cushion qualification 1.b. above, or to one of the following diagnoses: monoplegia of the lower limb ~~(344.30-344.32, 438.40-438.42)~~ or hemiplegia ~~(342.00-342.92, 438.20-438.22)~~ due to stroke, traumatic brain injury, or other etiology, muscular dystrophy ~~(359.0, 359.1)~~, torsion dystonias ~~(333.4, 333.6, 333.71)~~, spinocerebellar disease ~~(334.0-334.9)~~.		
Combination Skin Protection and Positioning Seat Cushion (E2607, E2608, K0736, K0737)	1. May be covered for a recipient who meets the qualifications for both a Skin Protection Seat Cushion and a Positioning Seat Cushion as indicated previously.		

Policy: NUTRITIONAL SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Medical Foods for Inborn Errors of Metabolism **(S9435)**	1. Authorization of "medical foods" will be considered for recipients under the age of 21 years as an EPSDT service with a diagnosis of an inherited metabolic disease in which treatments are restricted and a monitored diet consisting of specially formulated low-protein foods are an established standard of care. The following inherited metabolic conditions fit the category, but are not limited to: Phenylketonuria (PKU) ~~ICD-9 270.1~~ Homocystinuria ~~ICD-9 270.4~~ Maple Syrup Urine Disease ~~ICD-9 270.3~~ 2. Definitions and qualifications: a. Medical foods refer to products designed for the specific nutrition management of a disease or condition for which distinctive nutrition requirements based on recognized scientific principles are established by medical evaluation. b. "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law. c. Medical foods are products specially formulated or modified to have less than one gram of protein per serving. This does not include a food that is naturally low in protein. d. Medical food is prescribed by and consumed under the direction of a physician for the dietary treatment of a qualifying metabolic disease. e. The recipient is currently receiving comprehensive nutrition services by a physician and dietician for the dietary	1. A prescription signed by the requesting physician specializing in the treatment of metabolic conditions for requested "medical foods"; 2. A completed prior authorization form that includes: a. types of medical food (e.g., LP baking mix); b. product line company names and product code numbers; c. total amount (units or case) of each medical food; d. number of servings for each product unit (number of servings per box, can or case); e. cost per unit or case for each medical food product; f. total cost of all products submitted; and g. Dates and duration of request 3. History and physical examination and current evaluation (within the last six months) which includes all existing diagnoses and medical conditions from the physician specializing in the treatment of metabolic conditions or an appropriate specialist. Documentation must include test results used in establishing the diagnosis and any other pertinent medical data/reports to justify products being requested; 4. A copy of the nutritional assessment and treatment plan by a registered dietitian and/or physician specializing in nutritional assessment and treatment of metabolic conditions; and including: a. Daily number of phenylalanine exchange	1. Medical foods will be approved after review of submitted documentation if found to meet the following conditions: a. Documentation supports dietary treatment of the metabolic disease or conditions mentioned in this policy for which nutritional requirements are established by medical evaluation, but does not include a natural food that is naturally low in protein; b. Submitted supporting documentation is found to support inherited metabolic diagnosis; and c. Approved time-frame will be for a maximum of six-months and the servicing provider can only be a Medicaid Pharmacy or DME provider. Grocery stores, health food stores, and/or retail vendors may not be authorized as providers for medical foods.

Policy: ORTHOTIC AND PROSTHETIC DEVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Orthotics **Ankle-Foot Orthoses (AFO)** **Knee-Ankle-Foot Orthoses (KAFO)**	1. Appliances necessary for the straightening or correction of a deformity are covered by the DHCFP for eligible recipients. 2. <u>AFOs used in non-ambulatory recipients</u>: A static AFO (L4396) is covered if all of the following criteria are met: a. Plantar flexion contracture of the ankle ~~(ICD-9 diagnosis code 718.47)~~ with dorsiflexion on passive range of motion testing of at least 10 degrees (e.g., a non-fixed contracture); b. Reasonable expectation of the ability to correct the contracture; c. Contracture is interfering or expected to interfere significantly with the recipient's functional abilities; and d. Used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons. 3. <u>AFO/KAFOs used in ambulatory recipients:</u> A molded-to-patient-model, or custom-fabricated are covered for ambulatory recipients if the following are met: a. The recipient could not be fit with a prefabricated AFO; b. The condition necessitating the orthotic is expected to be permanent or of longstanding duration (more than six months); c. There is a need to control the knee, ankle or foot in more than one place; d. The recipient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or e. The recipient has a healing fracture which	1. Physician order. 2. Prior Authorization. 3. Original orthotics, adjustments, repairs, replacement of parts or an entire orthosis require medical documentation and may be subject to limitations of costs and frequency which are deemed reasonable by the program.	1. Orthotics include but may not be limited to: braces, orthopedic shoes, elastic stockings, back supports/ corsets, splints, and garments for treating burn patients. 2. Providers of this type of equipment are to identify each component by L-code identifiers according to the American Orthotic and Prosthetic Association.

Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Apnea Monitor	1. One year qualification for at least one of: a. ~~765.0 1 p~~Prematurity (gestational age must be listed on CMS 1500); b. ~~764.0 9~~ Substantially small for gestational age; c. ~~760.71~~ HX of maternal alcohol abuse; d. ~~760.72~~ HX of maternal narcotics abuse; and/or e. ~~760.73~~ HX of maternal hallucinogenic agent abuse. 2. Six month qualification for at least one of: a. ~~530.1~~ Gastro-esophageal reflux; b. ~~786.09~~ Abnormal pneumogram indicating desaturating apnea; c. ~~799.0~~ Periodic respirations; d. ~~727.9~~ Significant bradycardia or tachycardia of unknown or specified origin; e. ~~746.9~~ Congenital heart defect; f. ~~770.7~~ Bronchopulmonary dysplasia or newborn respiratory distress; g. ~~770.8~~ Respiratory distress; h. ~~798.0~~ Family history of SIDS (siblings only); i. ~~480.1~~ Respiratory Syncytial Virus (RSV); j. ~~770.8~~ Apparent Life Threatening Episode (ALTE) with subsequent visits to physician or emergency room; k. ~~478.74~~ Laryngeotracheal malacia; l. ~~748.3~~ Tracheal stenosis; and/or m. ~~787.2~~ Swallowing abnormality.	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Program limit to one year for diagnoses including prematurity and maternal substance abuse. 2. Other diagnoses limited to six months. 3. Beyond stated time limit requires prior authorization with medical justification. 4. Original prior authorization not required for ICD~~-9~~ codes listed under qualifications. Other diagnoses require prior authorization. 5. Reference DMEPOS PT 33 Fee Schedule for quantity limits. 6. An Apnea Monitor is a non-reimbursable service in conjunction with an E0463 or E0464 pressure ventilator, with pressure control pressure support, and flow triggering features.

Policy: RESPIRATORY SERVICES

EQUIPMENT OR ITEM	QUALIFICATIONS	FORMS AND DOCUMENTATION REQUIREMENTS	MISCELLANEOUS POLICY STATEMENTS
Nebulizers and Compressors	1. A small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570, E0571) are covered when: a. It is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease ~~(ICD-9 diagnosis codes 491.0-505)~~; b. It is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alfa to a recipient with cystic fibrosis ~~(ICD-9 diagnosis code 277.00)~~; c. It is medically necessary to administer pentamidine to recipients with HIV ~~(ICD-9 diagnosis code 042)~~, pneumocystosis ~~(ICD-9 diagnosis code 136.3)~~, and complications of organ transplants ~~(ICD-9 diagnosis codes 996.8-996.89)~~; or d. It is medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions ~~(ICD-9 diagnosis codes 480.0-505, and 786.4)~~. Note: For criterion (a) to be met, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs. The reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an MDI must be documented in the recipient's medical record and be available to Medicaid on request. 2. A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or	1. Prescription and/or MD signed Prior Authorization Form. 2. Medical documentation supporting qualifying factors.	1. Reference DMEPOS PT 33 fee schedule. 2. Small volume ultrasonic nebulizer (E0574) and large volume ultrasonic nebulizer (E0575) will be reimbursed at the least costly alternative of a pneumatic compressor (E0570).

Policy: RESPIRATORY SERVICES			
EQUIPMENT OR ITEM	**QUALIFICATIONS**	**FORMS AND DOCUMENTATION REQUIREMENTS**	**MISCELLANEOUS POLICY STATEMENTS**
(continued) **Nebulizers and Compressors**	saline (A7018 or A4216) are covered when it is medically necessary to deliver humidity to a recipient with thick, tenacious secretions, who has cystic fibrosis ~~(ICD-9 diagnosis code 277.00)~~, bronchiectasis ~~(ICD-9 diagnosis code 494 or 748.61)~~, a tracheostomy ~~(ICD-9 diagnosis code V44.0 or V55.0)~~, a tracheobronchial stent ~~(ICD-9 diagnosis code 519.1)~~. Combination code E0585 will be covered for the same indications. An E0565 or E0572 compressor and filtered nebulizer (A7006) are also covered when it is medically necessary to administer pentamidine to recipients with HIV ~~(ICD-9 diagnosis code 042)~~. If a large volume nebulizer, related compressor/generator, and water or saline are used predominantly to provide room humidification it will be denied as non-covered.		

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 1700 - THERAPY

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 1700 are being proposed to comply with the transition to International Classification of Disease 10th Revision, Clinical Modification (ICD 10-CM) as required by the Health Insurance Portability and Accountability Act (HIPAA) mandate. In order to be in compliance with this mandate, the Division of Health Care Financing and Policy (DHCFP) is proposing the removal of ICD 9-CM codes and adding verbiage regarding current diagnosis code(s).

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29342 CHAPTER 1700 - THERAPY	MTL 16/11, 04/14 CHAPTER 1700 - THERAPY

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1703.1	**Policy**	Added the word Registered to Advanced Practitioner of Nursing to now read Advanced Practitioner of Registered Nursing (APRN).
1703.2A.7	**Covered Services**	Removed ICD-9-CM reference and added with "current"
1703.3A.1	**Coverage and Limitations**	Removed ICD-9-CM reference and added "coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs".

1703 POLICY

1703.1 Medicaid will reimburse physical, occupational, speech therapy services rendered to eligible Medicaid recipients and eligible participants in the Nevada Check Up (NCU) Program. Therapy must be medically necessary (reference Medicaid Services Manual (MSM) Chapter 100; section 103.1) to restore or ameliorate functional limitations that are the result of an illness or injury which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time. It must be rendered according to the written orders of the physician, physician's assistant or an Advanced Practitioner of Registered Nursing (APRN) and be directly related to the active treatment regimen designed by the therapist and approved by the professional who wrote the order.

Requests for therapy must specify the functional deficits present and include a detailed description assessing the measurable degree of interference with muscle and/or joint mobility of persons having congenital or acquired disabilities, measurable deficits in skills for daily living, deficits of cognitive and perceptual motor skills and integration of sensory functions. Identify measurable speech and/or communication deficits through testing, identification, prediction of normal and abnormal development, disorders and problems, deficiencies concerning the ability to communicate and sensorimotor functions of a person's mouth, pharynx and larynx.

A written individualized plan addressing the documented disabilities needs to include the therapy frequency, modalities and/or therapeutic procedures and goals of the planned treatment. The primary diagnosis must identify the functional deficit which requires therapeutic intervention for the related illness or injury diagnosis.

Therapy services provided in the community-based and/or hospital outpatient setting are subject to the same coverage and therapy limitations.

Services that are provided within the School Based Child Health Services (SBCHS) Program are covered under MSM Chapter 2800.

1703.2 COVERAGE AND LIMITATIONS

1703.2A COVERED SERVICES

1. Medicaid covers outpatient therapy for individual and/or group therapy services administered by the professional therapist within the scope of their license for the following:

   a. An individual therapy session may be covered up to a max of one hour when service is provided to the same recipient by the same therapist on the same day.

   b. Group therapy (comprised of no more than two to four individuals) may be covered up to a max of 90 minutes per session when the service is provided to the

same recipient by the same therapist on the same day. The leader of the group must be a Medicaid provider. Documentation in the medical record is expected to be available on each Medicaid recipient in the group.

2. Therapy services may be ordered under an EPSDT referral by a physician, physician's assistant or an APN. The examination must identify a functional limitation to either acquire or correct/ameliorate a functional deficit/condition based upon medical necessity, not withstanding in relation to illness or injury which includes realistic and obtainable therapy goals.
3. The application of a modality that does not require direct (one-on-one) patient contact by the licensed therapist may be provided by a licensed therapy assistant under the supervision of the licensed Medicaid therapist.

4. Evaluations administered per therapy discipline within the scope of their license and meets the following criteria:

    a. Initial evaluations.

    b. Re-evaluations may be covered when there is a break in service greater than 90 days.

5. To be considered reasonable and medically necessary all of the following conditions must be met:

    a. Meet the definition of medical necessity in MSM Chapter 100.

    b. The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's functional deficit/condition.

    c. The services must be of such a level of complexity and sophistication, or the condition of the patient must be such, that the services required can be safely and effectively performed only by a qualified therapist or qualified assistant under the therapist's supervision.

    d. There must be an expectation that the functional deficit/condition will improve in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient's realistic rehabilitative/restorative potential in consultation with the qualified therapist

    e. The amount, frequency, and duration for restorative therapy services must be appropriate and reasonable based on best practice standards for the illness or injury being treated.

6. Cochlear Implant Therapy: Speech and Language Pathologist (SLP) services are covered under cochlear implantation protocol for speech evaluation and therapy services. Codes used by speech therapists will require the appropriate therapy modifier. (Refer to MSM Chapter 2000 for comprehensive cochlear policy.)

7. Therapy for Development Delay disorders may be covered for speech and language, fine motor and/or gross motor skills development when the functional deficit(s), identified by ~~ICD-9-CM~~ current diagnosis code(s) meet all medical necessity requirements.

8. Respiratory therapy is considered reasonable and necessary for the diagnosis and/or treatment of an individual's illness or injury when it is:

   a. Consistent with the nature and severity of the recipient's medical symptoms and diagnosis;

   b. Reasonable in terms of modality, amount, frequency and duration of the treatment; or

   c. Generally accepted by the professional community as being safe and effective treatment for the purpose used.

9. In certain circumstances the specialized knowledge and judgment of a qualified therapist may be covered when medically necessary to establish a safe and effective home maintenance therapy program in connection with a specific disease state.

10. SLP evaluations may be covered according to MSM Chapter 1300, Appendix B for a dedicated speech generating device evaluation and therapeutic services.

1703.2B PRIOR AUTHORIZATION REQUIREMENTS

1. With the exception of initial therapy evaluations and re-evaluations, all therapy services must be prior authorized by the Quality Improvement Organization (QIO-like) vendor.

2. Initial and re-evaluations do not require prior authorization. Appropriate therapy evaluations must be accomplished and submitted with prior authorization requests.

3. To obtain prior authorization for therapy services, all coverage and limitations requirements must be met (Section 1703.2A).

1703.2C NON-COVERED SERVICES

1. Services which do not meet Nevada Medicaid medical necessity requirements.

Network for primary and secondary lymphedema.

1703.3A COVERAGE AND LIMITATIONS

1. Complete or Combined Decongestive Physiotherapy (CDP) ~~therapy is covered by Medicaid for ICD-9 codes 457.0, 457.1, and 757.0~~ coverage is limited to non infectious disorders of the lymphatic channels and hereditary edema of legs when all of the following conditions are met:

   a. A treating or consulting practitioner (MD, DO, DPM, APN, and PA), within their scope of practice, documents a diagnosis of lymphedema due to a low output cause and specifically orders CDP therapy;

   b. The lymphedema causes a limitation of function related to self-care, mobility, and/or safety;

   c. The recipient or recipient caregiver has the ability to understand and provide home-based CDP;

   d. CDP services must be performed by a health care professional who has received CDP training;

   e. The frequency and duration of the services must be necessary and reasonable; and

   f. Lymphedema in the affected area is not reversible by exercise or elevation.

2. A CDP course of treatment by either OT or PT is considered a once in a lifetime benefit consisting of 90 minutes (six units) per session, three to five times per week for a maximum of three consecutive weeks with prior authorization.

1703.3B PRIOR AUTHORIZATION REQUIREMENTS

1. All lymphedema therapy services must be prior authorized by the QIO-like vendor.

2. To obtain prior authorization for therapy services, all coverage and limitations requirements must be met (Section 1703.2A).

1703.3C NON-COVERED SERVICES

1. Non-covered services include the following:
   a. Therapy limited to exercise or elevation of the affected area;

   b. Other services such as skin care and the supplies associated with the compressions wrapping. (they are included in the services and are not paid separately);

MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

September 29, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2500 – CASE MANAGEMENT

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 2500 are being proposed to update policy with the removal of references to the Diagnostic Statistical Manual (DSM), Diagnostic Criteria for ages zero to three (DC:0-3) and adding International Classification of Diseases (ICD)-10 CM verbiage.

These changes are effective October 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL 29453 CHAPTER 2500 – CASE MANAGEMENT	MTL 15/15 CHAPTER 2500 – CASE MANAGEMENT

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2502.6.a	**Target Group-Non-Seriously Mentally Ill (Non-SMI) Adults**	Removing reference to DSM and Axis I diagnosis and V codes. Add current ICD language, Z and R codes.
2502.7.b.1	**Target Group-Serious Mental Illness (SMI) Adults**	Deleted “DSM-IV” and added “current ICD”.
2502.8.a	**Target Group-Non-Severely Emotionally Disturbed(Non-SED) Children and Adolescents**	Deleted "DSM IV Axis I" and added " current ICD from the Mental, Behavioral, Neurodevelopmental Disorders section which”.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2502.8.b		Removed "V code" and DSM-IV diagnosis" and added, Z-codes 55-65, R45.850 and R45.851 as listed in the current ICD.
2502.8.d		Deleted "d. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) Axis I diagnosis or DC:0-3 Axis II Parent-Infancy Relationship Global Assessment Scale (PIR-GAS) score of 40 or less".
2502.9	**Target Group-Severe Emotional Disturbance (SED)**	Remove reference to birth thru 48 months, DSM, DC:0-3 Axis I diagnosis, and PIR-GAS. Clarify age is up to 18.
2502.9.a		Delete "DSM-IV" and added "current ICD". Deleted "mental retardation" and added "and other related conditions". Replace "V" code with "Z" code.
2509.9.b		Deleted "mental" and added "from the Mental, Behavioral, Neurodevelopmental Disorders section". Deleted "DSM-IV or their International Classification of Diseases" and added "current". Deleted reference to ICD-9, DSM-IV, and replaced "V" code with "Z" code.
2503.1A.3.c.1	**Target Group-Non-Seriously Mentally Ill (Non-SMI) Adults**	Deleted "Diagnostic and Statistical manual of Mental Disorders (DSM-IV), Axis I diagnosis" and added "A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section". Replace "V" code with "Z" code. Added codes "55-56, R45.850 and R45.851, which does not meet SMI criteria". Deleted "DSM-IV" and added "current ICD".

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
2503.1A.4.d.1.a	**Target Group-Adults With A Serious Mental Illness (SMI)**	Deleted "DSM-IV, AXIS I or II" and added "A current ICD". Replace "V" code with "Z" code. Deleted "DMS-IV" and added "current ICD".

3. Learning.

4. Mobility.

5. Self-direction.

6. Capacity for independent living.

2502.6 TARGET GROUP — NON-SERIOUSLY MENTALLY ILL (NON-SMI) ADULTS

Adults, who are Non-SMI, excluding dementia and intellectual disabilities, are recipients 18 years of age and older with significant life stressors and have:

a. A current International Classification of Diseases (ICD) ~~D~~diagnos~~tic~~is from the current Mental, Behavioral, Neurodevelopmental Disorders section ~~and Statistical Manual of Mental Disorders (DSM-IV) Axis I diagnosis,~~ including ~~V~~Z-codes 55-65, R45.850 and R45.851, ~~that~~ which does not meet SMI criteria.

b. A Level of Care Utilization System (LOCUS) score of Level I or II.

2502.7 TARGET GROUP — SERIOUS MENTAL ILLNESS (SMI) ADULTS

Adults with an SMI are persons:

a. 18 years of age and older;

b. Who currently, or at any time during the past year (continuous 12 month period);

1. Have had a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the ~~DSM-IV~~current ICD (excluding substance abuse or addictive disorders, irreversible dementias as well as intellectual disabilities, unless they co-occur with another SMI that meets ~~DSM-IV~~current ICD criteria);

2. That resulted in functional impairment which substantially interferes with or limits one or more major life activities;

c. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

2502.8 TARGET GROUP — NON-SEVERELY EMOTIONALLY DISTURBED (NON-SED) CHILDREN AND ADOLESCENTS

Children and adolescents, who are Non-SED, excluding dementia and intellectual disabilities, are recipients with significant life stressors and have:

a. A current ICD ~~DSM-IV Axis I~~ diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section which ~~that~~ does not meet SED criteria.

b. ~~V~~Z-codes 55-65, R45.850 and R45.851, as listed in the current ICD ~~DSM-IV diagnosis that~~ which does not meet SED criteria.

c. Child and Adolescent Services Intensity Instrument (CASII) Level of 0, 1, 2, or above.

~~d. Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) Axis I diagnosis or DC:0-3 Axis II Parent-Infancy Relationship Global Assessment Scale (PIR-GAS) score of 40 or less.~~

2502.9 TARGET GROUP — SEVERE EMOTIONAL DISTURBANCE (SED)

~~Children from birth through 48 months who currently or at any time during the past year (continuous 12 month period) have a:~~

~~a. DC:0-3 Axis I diagnostic category in place of a DSM-IV Axis I diagnostic category; or~~

~~b. DC:0-3 Axis II PIR-GAS score of 40 or less (the label for a PIR-GAS score of 40 is "Disturbed"); or~~

Children with a SED are persons ~~age four~~ up to age 18 who currently or at any time during the past year (continuous 12-month period) have a:

a. Diagnosable mental, behavioral or diagnostic criteria that meet the coding and definition criteria specified in the ~~DSM-IV~~ current ICD. This excludes substance abuse or addictive disorders, irreversible dementias, as well as ~~mental retardation/~~intellectual disabilities and other related conditions and ~~V~~ Z codes, unless they co-occur with another SMI that meets ~~DSM-IV~~ current ICD criteria that results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities~~,~~; and

b. These disorders include any ~~mental~~ disorder from the Mental, Behavioral, Neurodevelopmental Disorders section (including those of biological etiology) listed in ~~DSM-IV or their International Classification of Diseases (~~ current ICD~~)-9-~~Clinical Modification (CM) equivalent (and subsequent revisions), with the exception of ~~DSM-IV~~ "~~V~~ Z" codes, substance use and developmental disorders, which are excluded unless

2503 POLICY

2503.1 CASE MANAGEMENT SERVICES POLICY

2503.1A COVERAGE AND LIMITATIONS

A maximum of 30 hours per target group, per calendar month, per recipient, is allowed for case management services. (Maximum hours do not apply to providers who are paid a capitated, per member/per month rate).

1. Case management services are reimbursable when:

   a. Provided to Medicaid eligible recipients, on a one-to-one (telephone or face-to-face) basis.

   b. Medically necessary.

   c. Provided by a qualified provider enrolled to serve the target group in which the recipient belongs.

   d. Provided by the recipient's chosen provider.

   e. Contacts by the case manager with individuals who are not eligible for Medicaid when the purpose of the contact is directly related to the management of the eligible recipient's care.

   f. There are no third parties liable to pay for these services, including as reimbursement under a medical, social, educational or other federally funded program. Third party insurance payments for case management services must be pursued for all recipients.

      The provider must determine whether the recipient has other health insurance. Providers may survey health care insurance companies to determine whether case management is a covered benefit. Exception: This is not necessary for Medicare since it is not a covered service. If the health care provider covers case management, it must be billed for all recipients for services provided. For Medicaid recipients, the health care insurance company must be billed before Medicaid is billed. Once payment is received, if the other company did not pay the entire cost of services, Medicaid may be billed. If the health care insurance company will not pay for case management services, documentation of this must be maintained in the recipient’s case record.

   g. The service is not an integral component or administrative service of another covered Medicaid service.

2. Case management services not reimbursable under the Nevada Medicaid Program include, but are not limited to:

   a. The actual or direct provision of medical services or treatment. Examples include, but are not limited to:

      1. Training in daily living skills;

      2. Training in work skills and social skills;

      3. Grooming and other personal services;

      4. Training in housekeeping, laundry, cooking;

      5. Transportation services;

      6. Individual, group or family therapy services;

      7. Crisis intervention services; and/or

      8. Diagnostic testing and assessments.

   b. Services which go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:

      1. Paying bills and/or balancing the recipient's checkbook;

      2. Completing application forms, paper work, evaluations and reports including applying for Medicaid eligibility;

      3. Escorting or transporting recipients to scheduled medical appointments; and/or

      4. Providing child care so the recipient can access services.

   c. Traveling to and from appointments with recipients.

   d. Traveling to and from appointments (without recipients).

   e. Case management services provided to recipients between 22 and 64 years of age who are in an Institution for Mental Disease (IMD).

   f. Using case management codes for billing, when the recipient does not meet the criteria for the target group.

g. Recipient Outreach – Outreach activities in which a state agency or other provider attempts to contact potential recipients of a service do not constitute case management services.

h. The direct delivery of foster care services and therapeutic foster care services. The following activities are not considered to qualify as components of Medicaid case management services:

1. Research gathering and completion of documentation required by the foster care program.

2. Assessing adoption placements.

3. Recruiting or interviewing potential foster care parents.

4. Serving legal papers and attendance at court appearances.

5. Home investigations.

6. Providing transportation.

7. Administering foster care subsidies.

8. Making placement arrangements.

9. Training, supervision, compensation for foster care parents.

i. If the case manager also provides other services under the plan, the State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals. Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the service.

j. Services provided as "administrative case management", including Medicaid eligibility determination, intake processing, preadmission screening for inpatient care, utilization review and prior authorization for Medicaid services are not reimbursable.

k. Administrative functions for recipients under the Individuals with Disabilities Education Act (IDEA) such as the development of an Individual Education Plan and the implementation and development of an Individual Family Service Plan for Early Intervention Services are not reimbursable as case management services.

3. Target Group – Non-Seriously Mentally Ill (NON-SMI) Adults

a. Service Eligibility:

The determination for adults with a NON-SMI is made by a licensed, qualified mental health professional (psychiatrist, psychologist, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Master's degree psychiatric nurse).

b. Provider Qualifications:

Minimum qualification of a case manager providing services for NON-SMI adults are a service coordinator with a bachelor's degree in a health-related field, Registered Nurse (RN), Master's level professional (LSCW or LMFT), Advanced Practice Registered Nurse (APRN) in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

c. Service Criteria:

Admission Criteria includes:

1. ~~Diagnostic and Statistical manual of Mental Disorders (DSM-IV), Axis I diagnosis,~~ A current ICD diagnosis from the Mental, Behavioral, Neurodevelopmental Disorders section including ~~V~~Z-codes 55-65, R45.850 and R45.851,which does not meet SMI criteria (including dementia, intellectual disabilities or primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness that meets ~~DSM-IV~~ current ICD criteria).

2. Recipients require assistance in obtaining and coordinating medical, social, educational and other support services.

d. Continuing Stay Criteria:

1. Continues to meet admission criteria.

2. Individualized care plan identifies all medical, social, educational and other support services currently being provided, as well as unmet needs of the recipient.

3. Documentation supports progress towards specific case management goals identified in the established care plan with barriers identified and addressed.

e. Discharge/Exclusionary Criteria:

1. No longer meets NON-SMI determination.

2. No longer meets the admission and continuing stay criteria.

3. Recipient or family chooses not to participate in the program or is non-compliant.

4. Recipient requires inpatient psychiatric hospitalization, Institution for Mental Diseases (IMD), or Nursing Facility (NF) placement.

5. Has sufficient support system to sustain stability not requiring unnecessary or frequent acute admission.

4. Targeted Group – Adult with a Serious Mental Illness (SMI)

a. Reference definition under Section 2502.6.

b. Service Eligibility Determination

The determination for adults with a SMI is made by a licensed mental health professional (psychiatrist, psychologist, LCSW, LMFT, or Master's degree psychiatric nurse).

c. Provider Qualifications

Minimum qualifications of a case manager providing services for SMI adults (which can only be provided by a state agency and its employees or contractors or an organization affiliated with the University of Nevada School of Medicine) are a case manager with a Bachelor's degree in a health-related field, Registered Nurse (RN), Master's level professional (LCSW or LMFT), APRN in mental health, psychologist, or mental health professional who works under the direct supervision of a person listed above.

d. Service Criteria

1. Admission Criteria:

Must meet of all the following:

a. ~~DSM-IV, AXIS I or II,~~ A current ICD diagnosis (excluding ~~V~~Z-codes, dementia, intellectual disabilities or a primary diagnosis of a substance abuse disorder, unless these co-occur with another mental illness That meets ~~DMS-IV~~ current ICD criteria).