MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 21, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600, PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600, Physician Services, are being proposed to include coverage for genital reconstruction surgery for Medicaid recipients with diagnosis of gender dysphoria. Services will expand to include genital reconstruction surgical procedures, based on medical necessity.

Renumbering and re-arranging of this section was necessary.

Entities Financially Affected: Provider Type (PT) 20 Physician, MD, Osteopath, PT 24 Advanced Practice Registered Nurse, PT 77 Physicians Assistant.

Financial Impact on Local Government: No financial impact is anticipated for local government.

These changes are effective January 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 23/17 PHYSICIAN SERVICES	MTL 25/15, 14/16 PHYSICIAN SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.10.F.3.k	Physician Services in Outpatient Setting	Removed language related to transsexual surgery or sex reassignment surgery and all ancillary services including the use of pharmaceuticals, deemed as experimental.
607	Transgender Services	Added new language describing for gender reassignment services.
607.1	Coverage and Limitations	Added new language clarifying coverage including Hormone Therapy, Genital Reconstruction Surgery, and Mental Health Therapy.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
607.1A	Hormone Therapy	Added new language reference to MSM Chapter 1200, Prescription Drugs.
607.1B	Genital Reconstruction Surgery	Added new language describing genital reconstruction surgery coverage for transgender recipients based on medical necessity and gender dysphoria diagnosis.
607.1C	Mental Health Services	Added new language reference to MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services, for services and prior authorization requirements.
607.1D	Non-Covered Services	Added new language describing non-covered services for transgender recipients.
607.1E	Documentation Requirements	Added new language describing recipient requirements and appropriate documentation in the recipient's medical record.

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TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

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SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600 – PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600 – Physician Services are being proposed to Sections 600, 601 and 608 to add language regarding coverage and limitations for Medical Nutrition Therapy (MNT) provided by Registered Dietitians (RDs). MNT services may only be provided by RDs and must be part of a coordinated multidisciplinary team. These changes received budgetary approval during the 2017 Legislative session.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type (PT) 15 – Registered Dietitians, PT 17 – Special Clinics, PT 20 – Physicians, PT 24 – Certified RN Practitioner, PT 47 – Indian Health Services and Tribal Clinics, and PT 77 – Physician's Assistant.

Financial Impact on Local Government:

SFY 2018: a projected increase in State General Fund expenditures of $864,996
SFY 2019: a projected increase in State General Fund expenditures of $933,414

These changes are effective January 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 23/17 Physicians Services	MTL 25/15, 16/16, 14/16 Physicians Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
600	**Introduction**	Added "Registered Dietitians" to the list of health care professionals.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
601	**Authority**	Added "NRS Chapter 640E – Registered Dietitian" to the standards of practice listing.
608	**Medical Nutrition Therapy**	Introduction of policy for Medical Nutrition Therapy added.
608.1	**Policy**	Policy for Medical Nutrition Therapy added.
608.2	**Coverage and Limitations**	Coverage and limitations for Medical Nutrition Therapy added.
608.3	**Prior Authorization Requirements**	Prior authorization requirements added.
608.4	**Provider Qualifications**	Registered Dietitian qualifications added.
608.5	**Provider Responsibility**	Language defining responsibilities of billing providers added.

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TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 600– PHYSICIAN SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 600 – Physician Services are being proposed to expand coverage of Podiatry Services as authorized during the 2017 Legislative session. Podiatry services are being expanded to include coverage for all Medicaid eligible individuals.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type 21 – Podiatry.

Financial Impact on Local Government: none known.

These changes are effective January 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 23/17 Physician Services	MTL 25/15 Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
603.7	**Podiatry**	Language removed and edited to remove reference to limitation of services, added language to defining podiatry services.
603.7A	**Prior Authorization**	Changed name of section to include Limitations. Deleted Healthy Kids reference, renumbered policy limitations and added language to references for radiology, laboratory, prescription of drugs and telehealth services.

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 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.

604 COMMUNITY PARAMEDICINE SERVICES

The Division of Health Care Financing and Policy (DHCFP) reimburses for medically necessary community paramedicine services which are designed to provide health care services to the medically underserved. Community Paramedicine services fill patient care gaps in a local health care system and prevent duplication of services while improving the healthcare experience for the recipient. Prevention of unnecessary ambulance responses, emergency room visits, and hospital admissions and readmissions can result in cost reductions for the DHCFP.

604.1 COMMUNITY PARAMEDICINE PROVIDER QUALIFICATIONS

A. The following Nevada-licensed providers may provide community paramedicine services for Nevada Medicaid recipients:

1. Emergency Medical Technician (EMT);
2. Advanced Emergency Technician (AEMT);
3. Paramedic; or
4. Community Paramedic.

B. Required endorsement:

1. Community paramedicine endorsement from the Nevada Division of Public and Behavioral Health, Office of Emergency Medical Services; or
2. Community paramedicine endorsement from the Southern Nevada Health District's Board of Health.

C. Must be enrolled as a Nevada Medicaid provider and employed by a permitted Emergency Medical System (EMS) agency.

D. Must possess a scope of service agreement, based upon the provider's skills, with the Medical Director of the EMS agency under which they are employed.

1. The Medical Director of the EMS agency providing community paramedicine services must be enrolled as a Nevada Medicaid Provider.

604.2 COVERAGE AND LIMITATIONS

Community paramedicine services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed primary care provider (PCP), including a physician

(MD/DO), an advanced practice registered nurse (APRN) or physician's assistant (PA) following an appropriate assessment. The PCP must consult with the EMS agency service's medical director to coordinate the care plan with all local community health providers and the local public health agencies, including home health and waiver services, to avoid duplication of services to the recipient. If a fee-for-service recipient requires more than five visits in the home during a three-month period, they will be referred to the Care Management Organization (CMO) by the EMS agency.

A. The following services can be provided within a community paramedicine provider's scope of practice as part of a community paramedicine visit when requested in a primary care provider's care plan:

1. Evaluation/health assessment;

2. Chronic disease prevention, monitoring and education;

3. Medication compliance;

4. Immunizations and vaccinations;

5. Laboratory specimen collection and point of care lab tests;

6. Hospital discharge follow-up care;

7. Minor medical procedures and treatments within their scope of practice as approved by the EMS agency's medical director;

8. A home safety assessment; and

9. Telehealth originating site.

B. Non-covered services:

1. Travel time;

2. Mileage;

3. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital;

4. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code;

5. Duplicated services; and

6. Personal Care Services.

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

D. Prior authorization is not required for community paramedicine services.

605 FEDERALLY QUALIFIED HEALTH CENTERS

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

605.1 HEALTH SERVICES

A. The DHCFP reimburses FQHCs an outpatient encounter rate.

1. Encounter: Any one or more of the following medical professionals are included in the all-inclusive, daily outpatient encounter:

a. Physician or Osteopath;

b. Dentist;

c. Advanced Practice Registered Nurse (APRN);

d. Physician Assistant;

e. Certified Registered Nurse Anesthetist (CRNA);

f. Certified Registered Nurse Midwife;

g. Psychologist;

h. Licensed Clinical Social Worker;

i. Registered Dental Hygienist;

j. Podiatrist;

k. Radiology;

l. Optometrist;

m. Optician; and

n. Clinical Laboratory

B. Encounters are used by FQHCs for Medicaid-covered, HRSA-approved services which include:

1. Primary care services: medical history, physical examination, assessment of health status, treatment of a variety of conditions amendable to medical management on an ambulatory basis by an approved provider and related supplies;

2. Vital signs including temperature, blood pressure, pulse, oximetry and respiration;

3. Early periodic screenings (Refer to Medicaid Services Manual (MSM) Chapter 1500, Healthy Kids), for EPSDT screening policy and periodicity recommendations;

4. Preventive health services recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF) and education (Refer to MSM Chapter 600, Physicians Services, Attachments #6-12 through #6-14 for preventive services policy);

5. Home visits;

6. Diagnostic laboratory and radiology services, including but not limited to cholesterol screening, stool testing for occult blood, tuberculosis testing for high risk patients, dipstick urinalysis;

7. Family Planning services including contraceptives;

   Up to two times a calendar year, the FQHC may bill for additional reimbursement for family planning education on the same date of service as the encounter.

8. For women: annual preventive gynecological examinations, prenatal and post-partum care, prenatal services, clinical breast examination, thyroid function test;

9. Vision and hearing screenings;

10. Dental office visits;

Dental encounters are to be billed as applicable with the FQHC encounter reimbursement methodology. An FQHC may bill a dental encounter for each face-to-face encounter. Dentures provided by an FQHC are included in the daily encounter rate unlike the denture policy established in MSM Chapter 1000, Dental, for fee-for-service recipients who obtain dentures at non-FQHC facilities. Medicaid will pay for a maximum of one emergency denture reline and/or a maximum of six adjustments (dental encounters) done not more often than every six months, beginning six months after the date of partial/denture purchase. A prior authorization is not required for relines. The FQHCs in-office records must substantially document the medical emergency need.

Denture/partial relines and adjustments required within the first six months are considered prepaid with the Medicaid's Dental encounter payment for the prosthetic. All other coverage policies (covered and non-covered for dental, MSM Chapter 1000) are still applicable.

11. Service Limits: An FQHC may reimburse for up to three service specific visits per patient per day to allow for a medical, mental health, and dental visit to occur on a single day for the same patient.

C. Non-covered services under an FQHC encounter:

1. Group therapy;
2. Eyeglasses;
3. Hearing aids;
4. Durable medical equipment, prosthetics, orthotics and supplies; and
5. Ambulance services.

605.2 ANCILLARY SERVICES

All services not recognized by HRSA as approved FQHC encounter services which are an approved Nevada Medicaid State plan service.

A. Ancillary services may be reimbursed on the same date of service as an encounter by a qualified Medicaid provider.

B. The FQHC must enroll within the appropriate provider type and meet all MSM coverage guidelines for the specific ancillary service.

605.3 MEDICAL NECESSITY

In order to receive reimbursement, all services provided must be medically necessary as defined in MSM Chapter 100 - Medical Program.

605.4 PRIOR AUTHORIZATION

A. FQHC encounters do not require prior authorization.

B. Ancillary services billed outside of an encounter must follow prior authorization policy guidelines for the specific service provided.

For billing instructions for FQHCs, please refer to the Billing Manual for Provider Type 17.

For Indian Health Programs (IHP) policy, please refer to MSM Chapter 3000, Indian Health.

606 PREVENTITIVE HEALTH SERVICES

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.

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

USPSTF A and B Recommendations

606.1 PRIOR AUTHORIZATION

A. No prior authorization is required.

606.2 COVERAGE AND LIMITATIONS

A. The following preventive health services are covered by Nevada Medicaid for women:

Topic	Description
Abnormal blood glucose and Type 2 diabetes mellitus: screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Alcohol misuse counseling*	The USPSTF recommends clinicians screen adults age 18 years or older, including pregnant women, for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
Aspirin to prevent CVD: women	The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.

Topic	Description
BRCA risk assessment and genetic counseling/testing*	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer preventive medication	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Breast cancer screening	The USPSTF recommends biennial screening mammography for women aged 50-74.
Breastfeeding counseling*	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.

Topic	Description
Depression screening: adults*	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to assure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	The USPSTF recommends screening abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant woman after 24 weeks' gestation.
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
Healthy diet counseling*	The USPSTF recommends intensive behavioral dietary counseling for 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: non-pregnant 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.

Topic	Description
High blood pressure in adults: screening*	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: pregnant women	The USPSTF strongly recommends that clinicians screen all pregnant women for HIV including those who present in labor who are untested and whose HIV status is unknown.
HIV screening: non-pregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
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 preventive 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

Topic	Description
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults*	The USPSTF recommends that clinicians ask all adults about tobacco use, and advise them to stop using tobacco, and provide behavioral interventions U.S. Food and Drug Administration (FDA) approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, and advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

B. The following preventive health services are covered by Nevada Medicaid for men:

Topic	Description
Abnormal blood glucose and type 2 diabetes mellitus: screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol misuse: screening and counseling*	The USPSTF recommends clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

Topic	Description
Aspirin to prevent CVD: men	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Depression screening: adults*	The USPSTF recommends screening for depression in the general adult population. Screening should be implemented with adequate systems in place to assure accurate diagnosis, effective treatment, and appropriate follow-up.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Healthy diet counseling*	The USPSTF recommends intensive behavioral dietary counseling for 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: 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.

Topic	Description
High blood pressure in adults: screening*	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
HIV screening: adolescents and adults	The USPSTF strongly recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Young adolescents and older adults who are at increased risk should also be screened.
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.
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.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults*	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to adults who use tobacco.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.

C. The following preventive health services are 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.

Topic	Description
Depression screening: adolescents	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD). Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective therapy and appropriate 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: adolescents	The USPSTF strongly recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
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 iron deficiency anemia.
Obesity screening and counseling: children*	The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
PKU / metabolic screening: newborns*	The USPSTF recommends screening for phenylketonuria (PKU) in newborns.
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.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.

Topic	Description
Tobacco use interventions: children and adolescents*	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Visual acuity screening in children*	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

* These screening tests may be performed as part of an office visit, hospital visit or global fee and may not be billed separately.

607 GENDER REASSIGNMENT SERVICES

Transgender Services include treatment for gender dysphoria (GD), formerly known as gender identity disorder (GID). Treatment of GD is a DHCFP covered benefit, including both hormonal and surgical modalities, and psychotherapy, based on medical necessity. Genital reconstruction surgery (GRS) describes a number of surgical procedure options for the treatment of GD.

According to the World Professional Association for Transgender Health (WPATH), the organization that promotes the standards of health care for transsexual, transgender and gender nonconforming individuals, through the articulation of Standards of Care (SOC), gender dysphoria is defined as discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics).

607.1 COVERAGE AND LIMITATIONS

A. Hormone Therapy

1. Hormone therapy is covered for treatment of GD based on medical necessity; refer to MSM Chapter 1200, Prescribed Drugs, for services and prior authorization requirements.

B. Genital Reconstruction Surgery

1. Genital reconstruction surgery is covered for recipients that are sufficiently physically fit and meet eligibility criteria under Nevada and federal laws.

2. Prior authorization is required for all genital reconstruction surgery procedures.

3. To qualify for surgery, the recipient must be 18 years of age or older.

4. Male-to-Female (MTF) recipient, surgical procedures may include:

   a. breast/chest surgery; mammoplasty

   b. genital surgery; orchiectomy, penectomy, vaginoplasty, clitoroplasty, vulvoplasty, labiaplasty, urethroplasty, prostatectomy

5. Female-to-Male (FTM) recipient, surgical procedures may include:

   a. breast/chest surgery; mastectomy

   b. genital surgery; hysterectomy/salpingo-oophorectomy, phalloplasty, vaginectomy, vulvectomy, scrotoplasty

6. Augmentation mammoplasty for MTF recipients is a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy.

7. All legal and program requirements related to providing and claiming reimbursement for sterilization procedures must be followed when transgender care involves sterilization. Refer to MSM Chapter 600, Section 603.4B for information regarding sterilization services.

8. Refer to the Documentation Requirements section below for additional criteria.

C. Mental Health Services

1. Mental health services are covered for treatment of GD based on medical necessity; refer to MSM Chapter 400, Mental Health and Alcohol/Substance Abuse Services for services and prior authorization requirements.

D. Non-Covered Services

1. Payment will not be made for the following services and procedures:

a. cryopreservation, storage and thawing of reproductive tissue, and all related services and costs;

b. reversal of genital and/or breast surgery;

c. reversal of surgery to revise secondary sex characteristics;

d. reversal of any procedure resulting in sterilization;

e. cosmetic surgery and procedures including:

i. neck tightening or removal of redundant skin;

ii. breast, brow, face or forehead lifts;

iii. chondrolaryngoplasty (commonly known as tracheal shave);

iv. electrolysis;

v. facial bone reconstruction, reduction or sculpturing, including jaw shortening and rhinoplasty;

vi. calf, cheek, chin, nose or pectoral implants;

vii. collagen injections;

viii. drugs to promote hair growth or loss;

ix. hair transplantation;

x. lip reduction or enhancement;

xi. liposuction;

xii. thyroid chondroplasty; and

xiii. voice therapy, voice lessons or voice modification surgery.

E. Documentation Requirements

1. The recipient must have:

a. persistent and well-documented case of GD;

b. capacity to make a fully informed decision and give consent for treatment. According to the American Medical Association (AMA) Journal of Ethics, in health care, informed consent refers to the process whereby the patient and the health care practitioner engage in a dialogue about a proposed medical treatment's nature, consequences, harms, benefits, risks and alternatives. Informed consent is a fundamental principle of health care.

c. comprehensive mental health evaluation provided in accordance with Version 7 of the WPATH SOC; and

d. prior to beginning stages of surgery, obtained authentic letters from two qualified licensed health care professionals who have independently assessed the recipient and are referring the recipient for surgery. The two letters must be authenticated and signed by:

i. a licensed psychiatrist or psychologist with which the recipient has an established and ongoing relationship; and

ii. a licensed psychiatrist, psychologist or physician, working within the scope of their license that has only had an evaluation role with the recipient.

iii. Together, the letters must establish the recipient have:

a. a persistent and well-documented case of GD;

b. received hormone therapy appropriate to the recipient's gender goals, which shall be for a minimum of 12 months in the case of a recipient seeking genital reconstruction surgery, unless such therapy is medically contraindicated or the recipient is otherwise unable to take hormones;

c. lived for 12 months in a gender role congruent with the recipient's gender identity without reversion to the original gender, and has received mental health counseling, as deemed medically necessary during that time; and

d. significant medical or mental health concerns reasonably well-controlled; and capacity to make a fully informed decision and consent to the treatment.

iv. When a recipient has previously had one or more initial surgical procedures outlined in this chapter, the recipient is not required to provide referral letters to continue additional surgical procedures, at discretion of the surgeon. The surgeon must ensure this is clearly documented in the recipient's medical record.

2. Documentation supporting medical necessity for any of the above procedures must be clearly documented in the recipient's medical record and submitted when a prior authorization (PA) is required.

608 MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy (MNT) is nutritional diagnostic, therapy and counseling services for the purpose of management of nutrition related chronic disease states. MNT involves the assessment of an individual's overall nutritional status followed by an individualized course of nutritional intervention treatment to prevent or treat medical illness. MNT is provided by a licensed and Registered Dietitian (RD) working in a coordinated, multidisciplinary team effort with the Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN) and takes into account a person's food intake, physical activity, and course of any medical therapy including medication and other treatments, individual preferences, and other factors. This level of instruction includes individualized dietary assessment that is above basic nutrition counseling.

The DHCFP considers medical nutrition therapy medically necessary for diabetes, obesity, heart disease and hypertension where dietary adjustment has a therapeutic role, when it is prescribed by a Physician, PA or APRN and furnished by a RD. The only providers that should submit claims for medical nutrition therapy are registered dietitians. Other qualified health care professionals may provide medical nutrition therapy; however, they must submit a claim for evaluation and management services.

608.1 POLICY

Medicaid will reimburse for MNT services rendered to Medicaid eligible individuals in accordance with the Nevada Medicaid coverage authority. MNT services must be medically necessary to address nutrition related behaviors that contribute to diabetes, obesity, heart disease and hypertension. Services must be rendered according the written orders of the Physician, PA or an APRN. The treatment regimen must be designed and approved by a registered dietitian.

All services must be documented as medically necessary and be prescribed on an individualized treatment plan.

608.2 COVERAGE AND LIMITATIONS

1. MNT is initiated from a referral from a primary care physician, PA or APRN and includes information on labs, medications and other diagnoses. MNT includes:

    a. A comprehensive nutritional and lifestyle assessment determining nutritional diagnosis.

    b. Planning and implementing a nutritional intervention and counseling using evidence based nutrition practice guidelines to achieve nutritional goals and desired health outcomes.

c. Monitoring and evaluating an individual's progress over subsequent visits with a registered dietitian.

2. Coverage of services includes:

a. Initial nutrition and lifestyle assessment.

b. One-on-one or group nutrition counseling.

c. Follow-up intervention visits to monitor progress in managing diet.

d. Reassessments as necessary during the 12-rolling month episode of care to assure compliance with the dietary plan.

e. Four hours maximum in the first year.

i. Additional hours are permitted if treating physician determines a change in medical condition, diagnosis or treatment regimen requires a change in MNT.

ii. Additional hours beyond the maximum four hours in the first year require prior authorization.

iii. Documentation should support the patient's diagnosis of the specific condition, along with the referral from the physician managing the patient's condition.

iv. The documentation should also include a comprehensive plan of care, individualized assessment and education plan with outcome evaluations for each session, as well as referring physician feedback.

v. There should be specific goals, evaluations and outcome measures for each session documented within the patient's records.

f. Two hours maximum per 12 rolling month period in subsequent years.

g. Services may be provided in a group setting. The same service limitations apply in the group setting.

3. MNT is not to be confused with Diabetic Outpatient Self-Management Training

a. The DHCFP considers Diabetic Outpatient Self-Management Training and MNT complementary services. This means Medicaid will cover both Diabetes Outpatient

Self-Management Training and MNT without decreasing either benefit as long as the referring physician determines that both are medically necessary.

b. See MSM Chapter 600, Attachment A, Policy #6-10 for DSMT coverage.

4. MNT is only covered for the management of diabetes, obesity, heart disease and hypertension-related conditions.

5. MNT may be provided through Telehealth services. See MSM Chapter 3400 for the Telehealth policy.

608.3 PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization is required when recipients require additional or repeat training sessions beyond the permitted maximum number of hours of treatment. This can occur if there is a change of diagnosis, medical condition or treatment regimen related to a nutritionally-related disease state.

608.4 PROVIDER QUALIFICATIONS

In order to be recognized and reimbursed as an MNT provider, the provider must meet the following requirements:

1. Licensed and Registered Dietitian under the qualifications of NRS 640E.150. A Registered Dietitian is an individual who has earned a bachelor’s degree or higher education from an accredited college or university in human nutrition, nutrition education or equivalent education, has completed training and holds a license from the Nevada State Board of Health.

608.5 PROVIDER RESPONSIBILITY

1. The provider will allow, upon request of proper representatives of the DHCFP, access to all records which pertain to Medicaid recipients for regular review, audit or utilization review.

2. The provider will ensure services are consistent with applicable professional standards and guidelines relating to the practice of MNT as well as state Medicaid laws and regulations and state licensure laws and regulations.

3. The provider will ensure caseload size is within the professional standards and guidelines related to the practice of MNT.

~~607~~609 HEARINGS

Please reference Nevada Medicaid Services Manual (MSM) - 3100 for hearings procedures.

POLICY #6-01	RESERVED FOR FUTURE USE	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06

RESERVED FOR FUTURE USE

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 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.

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 wound classified as Wagner grade III or higher; and

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

D. COVERED DIAGNOSIS CODES

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

A. DESCRIPTION/POLICY

FDA approved Intrathecal Baclofen (ITB) Therapy 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 REQUIRED

C. COVERAGE AND LIMITATIONS

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

   a. Spasticity due to spinal cord origin or spasticity of cerebral origin. If spasticity is result of 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;

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 #6-06	RESERVED FOR FUTURE USE	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-06

RESERVED FOR FUTURE USE

A. DESCRIPTION

Vagus Nerve Stimulation (VNS) is a method for treating recipients with refractory epilepsy who are not candidates for intracranial surgery and/or continue to be refractory following epilepsy surgery. The programmable NeuroCybernetic Prosthesis (NCP) is surgically implanted in the upper left chest with the leads tunneled to the vagus nerve in the left neck. An external magnet is provided to activate the generator and deliver additional impulses when needed. The external magnet may also be used to inhibit the NCP generator in the event of a malfunction.

B. POLICY

The Vagus Nerve Stimulator (VNS) is a covered Nevada Medicaid benefit. The benefit includes diagnostic EEG, surgical procedure, device and medically necessary follow-up office visits for analysis and reprogramming.

C. PRIOR AUTHORIZATION IS REQUIRED

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

D. COVERAGE AND LIMITATIONS

1. Implantation of VNS is used as an adjunctive therapy in reducing the frequency of seizures in adults and children over age six who have seizures which are refractory to Antiepileptic Drugs (AED). It is also indicated in recipients for whom surgery is not an option, or in whom prior surgery has failed.

2. Coverage is restricted to those recipients with the following indicators:

    a. Diagnosis of intractable epilepsy;

    b. Failed antiepileptic drug (AED) therapy tried for two to four months. The medical record should indicate changes/alterations in medications prescribed for the treatment of the recipient's condition. Documentation to include maintaining a constant therapeutic dose of AED as evidenced by laboratory results per manufacturer's recommendations;

    c. Have six or more medically intractable seizures per month;

    d. Have no other independent diagnosis that could explain why seizures are failing to respond to treatment;

    e. A recipient whose epileptologist/neurologist has recommended VNS implantation;

    f. A surgeon experienced with implantation of the VNS;

    g. The VNS will be managed by a physician familiar with the settings and protocols for use of the device;

h. Recipients from three to six years of age must have all of the above indicators;

i. Be the result of a Healthy Kids Screening (EPSDT) referral for treatment; and

j. Be supported by peer review literature, and a written recommendation for VNS implantation and use from two Board Certified Pediatric Neurologists (other than the treating neurologist(s).

3. Reasons for non-coverage include, but are not limited to the following diagnoses/conditions: status epilepticus, progressive or unstable neurologic or systemic disorders, severe mental retardation, drug abuse, gastritis, gastric/duodenal ulcers, status post bilateral or left cervical vagotomy, unstable medical condition, pregnancy, use of investigational AED's, bradycardia, hypersecretion of gastric acid and/or a seizure disorder etiology more appropriately treated by other means (i.e., operation).

E. COVERED CODES

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

POLICY #6-07	BARIATRIC SURGERY FOR MORBID OBESITY	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-08

A. DESCRIPTION/POLICY

1. Bariatric Surgery is a covered Nevada Medicaid benefit reserved for recipients with severe and resistant morbid obesity in whom efforts at medically supervised weight reduction therapy have failed and who are disabled from the complications of obesity. Morbid obesity is defined by Nevada Medicaid as those recipients whose Body Mass Index (BMI) is 35 or greater, and who have significant disabling comorbidity conditions which are the result of the obesity or are aggravated by the obesity. Assessment of obesity includes BMI, waist circumference, and recipient risk factors, including family history.

2. This benefit includes the initial work-up, the surgical procedure and routine post-surgical follow-up care. The surgical procedure is indicated for recipients between the ages of 21 and 55 years with morbid obesity. (Potential candidates older than age 55 will be reviewed on a case by case basis.)

B. PRIOR AUTHORIZATION IS REQUIRED

Documentation supporting the reasonableness and necessity of bariatric surgery must be in the recipient's record and submitted with the PA.

C. COVERAGE AND LIMITATIONS

1. Coverage is restricted to recipients with the following indicators:

   a. BMI of 35 or greater;

   b. Waist circumference of more than 40 inches in men, and more than 35 inches in women;

   c. Obesity related comorbidities that are disabling;

   d. Strong desire for substantial weight loss;

   e. Well-informed and motivated;

   f. Committed to a lifestyle change; and

   g. Negative history of significant psychopathology that contraindicates this surgical procedure.

2. Documentation supporting the reasonableness and necessity of the surgery must be in the medical record, and should include evidence of participation in a medically supervised weight loss program for a minimum of three months prior to the surgery. There must also be documentation of weight loss therapy participation including recipient efforts at dietary therapy, physical activity, behavior therapy, pharmacotherapy, combined therapy or any other medically supervised therapy.

3. No coverage will be provided for pregnant women, women less than six months postpartum, or women who plan to conceive in a time frame less than 18 to 24 months post gastric bypass surgery.

D. COVERED CODES

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

E. REFERENCES:

1. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/mm5013.pdf

2. http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/ncd103c1_part2.pdf

A. DESCRIPTION

Hyalgan and Synvisc are injectable drugs that are used to treat osteoarthritis of the knee. These solutions act like an "oil" to cushion and lubricate the knee joint. Hyalgan is injected directly into the osteoarthritic knee for a single course of treatment. Injections are administered one week apart for a total of five injections. Synvisc is administered as a total of three intra-articular injections into the knee joint during a three-week period. Each course of treatment must be performed by a qualified physician.

B. POLICY

1. Hyalgan and Synvisc injectables are a covered Nevada Medicaid benefit for the treatment of pain due to osteoarthritis of the knee. Diagnosis must be supported by radiological evidence.

2. Repeat treatment is not reimbursable, as it is not medically indicated, if the first course of treatment is not beneficial to the recipient.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. Hyalgan and Synvisc are indicated for recipients who do not obtain adequate relief from simple pain medication and/or from exercise and physical therapy.

2. An Evaluation & Management (E&M) service will not be covered during subsequent visits for injections unless there is a separately identifiable problem.

A. DESCRIPTION

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN) are a covered service 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.

B. PRIOR AUTHORIZATION IS NOT REQUIRED

C. COVERAGE AND LIMITATIONS

1. A physician’s service furnished to dialysis recipients who are treated as outpatients, are divided into two major categories: direct recipient care and administrative.

2. Physician’s evaluation and management-type services, “unrelated” to the dialysis procedure (not provided during a dialysis treatment) may be billed in addition to the dialysis procedure.

3. Physicians providing evaluation and management-type services “related” to the dialysis procedure same day dialysis is performed, or during a dialysis treatment) are billed as included in the dialysis procedure. Service units’ equal number of treatments. (Fee schedule paid to physician.)

4. Criteria for instituting IDPN/IPN:

   a. Three-month average predialysis serum albumin level of <3.4 mg/dl.

   b. Three-month average predialysis serum creatine of <8.0 mg/dl.

   c. Three-month average predialysis serum pre-albumin level of <25 mg/dl.

   d. Weight loss of 7.5% of usual body weight over 3 months.

   e. A clinical exam consistent with moderate to severe malnutrition.

   f. A dietary history of reduced food intake (protein <0.8 g/kg/day; calories <25 cal/kg/day).

   g. Failed attempts at dietary and oral supplementation.

   h. Eternal tube feeding contraindicted.

   i. Gastrointestinal diagnosis, supported by GI consult, GI medications (Prilosec, Reglan, Imodium, etc.).

5. Criteria for discontinuing IDPN/IPN:

   a. Three-month average predialysis serum albumin level of >3.8 mg/dl.

   b. Three-month average predialysis serum creatine of >10 mg/dl.

   c. Three-month average predialysis serum pre-albumin level of >28 mg/dl.

   d. A clinical exam consistent with improved nutritional status.

   e. A dietary history of increased food intake (protein 1.0 g/kg/day; calories 30 cal/kg/day).

   f. Absence of active inflammation or other serious condition characterized by high albumin turnover.

   g. No improvement with IDPN/IPN treatment after six months.

   h. Complications or intolerance associated with IDPN/IPN treatment.

6. No coverage will be provided for situations involving temporary impairments (less than 90 days). No coverage will be provided if recipients are noncompliant with the plan of treatment.

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; or

   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.

A. DESCRIPTION

1. Botulinum toxin is a neuromodulator derived from neurotoxins produced by the bacteria Clostridium botulinum, a gram positive bacillus. Botulinum toxin inhibits the release of acetylcholine at presynaptic cholinergic nerve terminals of the peripheral nervous system and atganglionic nerve terminals of the autonomic nervous system, thereby preventing neurotransmission and inducing flaccid paralysis. Three botulinum toxin type A products are approved by the Food and Drug Administration (FDA), including abobotulinumtoxinA (Dysport®), incobotulinumtoxinA (Xeomin®) and onabotulinumtoxinA (Botox®). RimabotulinumtoxinB (Myobloc®) is the only botulinum toxin B product approved by the FDA. FDA-approved indications differ among the individual botulinum toxin products.

2. The botulinum toxin products are not interchangeable with one another. The potency (in units) of one botulinum toxin product is specific to the preparation and assay method utilized by the manufacturer and units of biological activity of one product cannot be compared to or converted into units of any other botulinum toxin products assessed with any other specific assay method. All botulinum toxin products include a boxed warning in their labeling regarding the risk of botulinum toxin spreading beyond the site of injection, resulting in adverse events and death in some cases. Follow CPT guidelines for chemodenervation. Bill using the National Drug Code (NDC) for agents administered. See billing guide for billing instructions.

Current Medications Available in Therapeutic Class

Non-Proprietary Name (Trade Name)	**FDA-Approved Indication(s)**
OnabotulinumtoxinA (BOTOX®)	• Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., SCI, MS) in adults who have an inadequate response to or are intolerant of an anticholinergic medication; • Prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting four hours a day or longer); • Treatment of upper limb spasticity in adult patients, to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and finger flexors (flexor digitorum profundus and flexor digitorum sublimis); • Treatment of adults with cervical dystonia, to reduce the severity of abnormal head position and neck pain associated with cervical dystonia; • Treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents; and • Treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders in patients 12 years of age and above.

AbobotulinumtoxinA (DYSPORT®)	• Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients.
IncobotulinumtoxinA (XEOMIN®)	• Treatment of adults with cervical dystonia to decrease the severity of abnormal head position and neck pain in both botulinum toxin-naïve and previously treated patients; and • Treatment of adults with blepharospasm who were previously treated with onabotulinumtoxinA (Botox).
RimabotulinumtoxinB (MYOBLOC®)	• Treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia.

B. POLICY

Botulinum Toxin injections are a Nevada Medicaid covered benefit for certain spastic conditions including, but not limited to cerebral palsy, stroke, head trauma, spinal cord injuries, and multiple sclerosis. The injections may also reduce spasticity or excessive muscular contractions to relieve pain, to assist in posturing and ambulation, to allow better range of motion, to permit better physical therapy, and provide adequate perineal hygiene.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. For a complete list of covered indications, please refer to the “Provider Type 20, 24 and 77 Billing Guide,” applicable to botulinum toxins. It is expected that physicians will be familiar with and experienced in the use of the botulinum toxin product(s), and utilize FDA-approved product labeling, compendia, and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each patient condition.

2. Before consideration of coverage can be made, it must be established that the patient has been unresponsive to conventional methods of treatment such as medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions.

3. Coverage is limited to certain conditions listed in the covered diagnosis code section of the billing manual.

4. In order to determine the proper injection(s) site, electromyography (EMG) guidance may be required.

5. The patient who has a spastic or excessive muscular contraction condition is usually started with a low dose of Botulinum Toxin with increases as required. Some spastic or muscular contraction conditions, e.g., eye muscle disorders, (e.g., blepharospasm) may require lesser amounts. For larger muscle groups, it is generally agreed that once a maximum dose per site has been reached, and there is no response, the treatment is discontinued. Treatments may be resumed at a later date if indicated. If a response is positive, the effect of the injections generally continues for three

months, at which time the patient may need to repeat the injections for continued control. It is seldom medically necessary to repeat injections more frequently than every 90 days, unless acceptable justification is documented for more frequent use in the initial therapy.

6. Medicaid will allow payment for one injection per site, regardless of the number of injections made into the site. A site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, neck, etc.

7. Coverage will not be provided for injections given for cosmetic or for investigational purposes.

8. Anesthesia for Botulinum injections is usually provided as a local anesthetic (e.g., for blepharospasm), or conscious sedation, although some patients, such as pediatric, may require more than conscious sedation. (See appropriate anesthesia CPT codes listed below).

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 family planning 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 Nevada Medicaid for Family Planning purposes:

Topic	Description
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
STIs counseling*	The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.

* These screening tests may be performed as part of an office visit, hospital visit or global fee and may not be billed separately.

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, APRN, Ph.D. of Nursing, PA/PA-C, and Qualified Mental Health Professionals. The 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 checkup;

   g. Immunizations;

h. Diagnostic and preventive dental, and referral services; and

i. Laboratory testing.

2. NON-COVERED SERVICES

Non-covered services include, but are not limited to:

a. Services that are not medically necessary;

b. Services that require prior authorization and one has not been obtained or approved; and

c. Medical services listed on the recipient's IEP.

Note: An IEP is identified with SBCHS and are not covered under the SBHC.

E. PARENTAL CONSENT

1. A parent or guardian must sign a written consent form for a student to receive SBHC services. Once the parent signs the written consent form and the center-specific forms, the Health Center will provide or refer the student for any of the services that the child needs. Parents may indicate if they do not want the child to receive a specific service by writing the name of the service in the appropriate space on the center-specific form.

2. Although the Health Center will attempt to keep parents informed of the services their child receives, signing the Uniform Consent gives the Health Center permission to provide medical and behavioral health services to the child without contacting the parent each time the child visits the Center. Except in an emergency situation, no child is treated, counseled or referred without a consent form signed by a parent.

3. In emergencies, the Health Center will call the parent, but the Health Center is required by law to treat the child even when the parent cannot be reached.

F. MINOR CONSENT LAWS

Physicians practicing in SBHCs are governed by and must abide by the Nevada Revised Statutes (NRS) Minor's Consent for examination and treatment.

G. THIRD PARTY LIABILITY (TPL)

SBHCs must follow TPL and other health care coverage guidelines as set forth in the MSM Chapter 100 (Medicaid Program). There are no regulatory exceptions regarding TPL for SBHCs. SBHCs must bill the appropriate TPL and other health care coverage prior to submitting reimbursement claims to the Quality Improvement Organization (QIO)-like vender contracted with the DHCFP.

H. PROVIDER RESPONSIBILITIES

1. The provider must be certified by the Division of Public and Behavioral Health as an SBHC.

2. Enroll with the QIO-like vendor for Nevada Medicaid, meeting all provider qualifications as an SBHC.

3. Ensure the billing number and servicing number are the same.

4. Follow all billing guidelines for SBHCs.

5. Provider must work within the scope of services for each professional providing services.