Medicaid Services Manual
Transmittal Letter

October 28, 2025

To: Custodians of Medicaid Services Manual

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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 Section 603.4D are being proposed add coverage of cell-free fetal deoxyribonucleic acid (DNA) testing.

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. References to the Division of Health Care Financing and Policy (DHCFP) were updated to Nevada Medicaid throughout the chapter. References to MSM Chapter 400 were updated to the correct name of Mental Health Services throughout the chapter.

Entities Financially Affected: This policy update affects the following provider types (PT) including but not limited to: Laboratory (PT 43), Outpatient Hospital (PT 10), and Rural Emergency Hospitals (PT 96).

Financial Impact on Local Government:

State Fiscal Year (SFY) 2026: $160,069
SFY 2027: $325,848.

These changes are effective January 1, 2026.

Material Transmitted	Material Superseded
MTL 26/25 Chapter 600– Physician Services	MTL 09/21, 02/22, 21/23, and 25/24 Chapter 600– Physician Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
603.4D(1)	PRENATAL SCREENING AND DIAGNOSTIC TESTING	Updated verbiage of covered screenings, including cell-free DNA testing.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications, and Updates
603.4D(1)(a)		Removed subsection, as verbiage was moved into Section 603.4D(1).

NEVADA MEDICAID

MEDICAID SERVICES MANUAL
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PHYSICIAN SERVICES

600 INTRODUCTION

The Nevada Medicaid Program is dependent upon the participation and cooperation of Nevada providers 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 (APRN);

B. Certified Registered Nurse Anesthetists (CRNA);

C. Chiropractors (DC);

D. Nurse Midwives (NM);

E. Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics with community paramedicine endorsement;

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

G. Physician Assistants (PA/PA-C);

1. PAs who are employed at a Military Treatment Facility (MTF) and who possess a National Commission on Certification Physician Assistants (NCCPA) certification are considered to be allowable Nevada Medicaid providers. With the NCCPA certification, physician assistants employed at an MTF will not be required to be licensed in the state of practice.

H. Podiatrists (DPM); and

I. Registered Dietitians.

To enroll as a provider for the Division of Nevada Medicaid (DNM) 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.

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

Disclaimer: The term "Provider" 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 Provider" (PCP) is considered to be a Physician (M.D/D.O.), APRN, or PA with a specialty in general practice, family practice, internal medicine, pediatrics, obstetrics/gynecology, or nurse midwifery.

601 AUTHORITY

A. Medicaid is provided in accordance with the requirements of Title 42 Code of Federal Regulation (42 CFR) Part 440, Subparts A and B; and Sections 1929 (a), 1902 (e), 1905 (a), 1905 (p), 1915, 1920, and 1925 of the Social Security Act (SSA).

B. Regulations for services furnished by supervising physicians in teaching settings are found in 42 CFR Part 415; Subpart D. Key portion is defined in [Reg. 415.172(a)].

C. The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

1. Section 330 of the Public Health Service (PHS) Act;

2. NRS Chapter 634 – Chiropractic Physicians and Chiropractors' Assistants;

3. NRS Chapter 629 – Healing Arts Generally;

4. NRS Chapter 632 – Nursing;

5. NRS Chapter 630 – Physicians, Physician Assistants, Medical Assistants, Perfusionists and Practitioners of Respiratory Care;

6. NRS Chapter 633 - Osteopathic Medicine;

7. NRS Chapter 635 – Podiatric Physicians and Podiatry Hygienists;

8. NRS Chapter 640E – Registered Dietitians;

9. NRS Chapter 450B – Emergency Medical Services;

10. NRS Chapter 449 – Medical Facilities and Other Related Entities;

11. Section 1861 of the SSA;

12. Section 1905 of the SSA;

13. Section 1461 of the Omnibus Budget Reconciliation Act (OBRA) of 1990;

14. Department of Defense 6025.13-R – Military Health System Clinical Quality Assurance Program Regulation;

15. Air Force Instruction 44-119 – Medical Quality Operations; and

16. Newborns' and Mothers' Health Protection Act (NMHPA).

602 RESERVED

603 PROVIDERS AND LICENSED PROFESSIONAL POLICY

603.1 PROVIDER'S ROLE IN RENDERING SERVICES

603.1A COVERAGE AND LIMITATIONS

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

    a. Examine the recipient;

    b. Make a diagnosis;

    c. Establish a plan of care; and

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

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

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

        1. An injection of medication;

        2. Diagnostic test like an electrocardiogram (ECG);

        3. Blood pressure taken and recorded;

        4. Dressing changes; and

        5. Topical application of fluoride.

    b. Providers or their designee may not bill Medicaid for services provided by, including and not limited to, any of the following professionals below. All providers must enroll into their designated provider type and bill for the services

they provided. Nevada Medicaid will neither accept nor reimburse for professional billing of services or supplies rendered by anyone other than the provider under whose name and provider number the claim is submitted. Refer to MSM Chapter 100, Medicaid Payments to Providers, for additional information regarding incident-to billing.

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

3. Teaching Physicians

Medicaid covers teaching physician services when they participate in the recipient's care. The teaching physician directs no more than four residents at any given time and is in such proximity as to constitute immediate availability. The teaching physician's documentation must show that he or she either performed the service or was physically present while the resident performed the key and critical portions of the service. Documentation must also show participation of the teaching physician in the management of the recipient and medical necessity for the service. When choosing the appropriate procedure code to bill,

consideration is based on the time and level of complexity of the teaching physician, not the resident's involvement or time.

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

4. Out-of-State Providers

   a. If a prior authorization is required for a specific outpatient or inpatient service in-state, then a prior authorization is also required for an out-of-state outpatient or inpatient service by Nevada Medicaid's Quality Improvement Organization (QIO)-like vendor. Conversely, if a prior authorization is not required for a service in-state (i.e. office visit, consultation), then a prior authorization is not required for the same service out-of-state. Refer to MSM Chapter 1900, Transportation Services, for out-of-state transportation policy. The appropriate QIO-like vendor's determination will consider the availability of the services within the State. If the recipient is being referred out-of-state by a Nevada provider, the Nevada provider is required to obtain the prior authorization and complete the referral process. Emergency care will be reimbursed without prior authorization.

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

   c. All servicing providers must enroll in the Nevada Medicaid program prior to billing for any services provided to Nevada Medicaid recipients. See MSM Chapter 100, Medicaid Program.

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

   The EPSDT program provides preventive health care to recipients under the age of 21 years old who are eligible for medical assistance. The purpose of the EPSDT program is the prevention of health problems through early detection, diagnosis, and treatment. The required screening components for an EPSDT examination are to be completed according to the time frames on a periodicity schedule that was adopted by the American Academy of Pediatrics (AAP) and Nevada Medicaid. See MSM Chapter 1500, Healthy Kids Program.

6. Federal Emergency Services Program (also known as Emergency Medicaid Only)

   Professional services provided to an alien/non-citizen may be covered if the condition meets the definition provided in Section 1903(v)(1-3) of the SSA, 42 CFR 440.255 and NRS 422.065. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for policy details.

603.2 PROVIDER OFFICE SERVICES

Covered services are those medically necessary services when the provider either examines the patient in person or is able to visualize some aspect of the recipient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of X-rays, ECG and electroencephalogram (EEG) tapes, tissue samples, etc.

Telehealth services are also covered by Nevada Medicaid. See MSM Chapter 3400, Telehealth Services, for the complete coverage and limitations for Telehealth.

A. Consultation Services

A consultation is a type of evaluation and management service provided by a provider and requested by another provider or appropriate source, to either recommend care for a specific condition or problem or determine whether to accept responsibility for ongoing management of the patient's entire care. A consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. The written or verbal request for consult may be made by a provider or other appropriate source and documented in the patient's medical record by either the consulting or requesting provider or appropriate source. The consultant's opinion and any services that are ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting provider or appropriate source. When a consultant follows up on a patient on a regular basis or assumes an aspect of care on an ongoing basis, the consultant becomes a manager or co-manager of care and submits claims using the appropriate hospital or office codes.

1. When the same consultant sees the same patient during subsequent admissions, the provider is expected to bill the lower-level codes based on the medical records.

2. A confirmatory consultation initiated by a patient and/or their family without a provider request is a covered benefit. Usually, requested second opinions concerning the need for surgery or for major non-surgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) third opinion will be covered if the first two opinions disagree.

B. New and Established Patients

1. The following visits are used to report evaluation and management services provided in the provider's office or in an outpatient or other ambulatory facility:

a. Minimal to low level visits - Most patients should not require more than nine office or other outpatient visits at this level by the same provider or by

providers of the same or similar specialties in a three-month period. No prior authorization is required.

b. Moderate visits - Generally, most patients should not require more than 12 office or other outpatient visits at this level by the same provider or by providers of the same or similar specialties in a 12-month calendar year. No prior authorization is required.

c. High severity visits – Generally, most patients should not require more than two office or other outpatient visits at this level by the same provider or by providers of the same or similar specialties in a 12-month period. Any exception to the limit requires prior authorization.

2. Documentation in the patient's medical record must support the level of service and/or the medical acuity which requires more frequent visits and the resultant coding. Documentation must be submitted to Medicaid upon request. A review of requested reports may result in payment denial and a further review by Medicaid's Surveillance and Utilization Review (SUR) Unit.

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

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

5. Physical therapy administered by a PT on staff or under contract in the provider's office requires a prior authorization before rendering service.

   If the provider bills for physical therapy, the provider, not the PT, must have provided the service.

   A provider may bill an office visit in addition to physical therapy on the same day in the following circumstances:

a. A new patient examination which results in physical therapy on the same day;

b. An established patient with a new problem or diagnosis; and/or

c. An established patient with an unrelated problem or diagnosis.

Reference MSM Chapter 1700, Therapy, for physical therapy coverage and limitations.

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

7. Medication-Assisted Treatment (MAT) services provided by a physician, APRN, physician assistant, nurse midwife, or a pharmacist are available for recipients who meet medical necessity with an opioid use disorder. Refer to MSM Chapter 3800, Medication-Assisted Treatment for coverage and limitations.

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

9. Non-Covered Provider Services

a. Temporomandibular Joint (TMJ) related services (see MSM Chapter 1000, Dental).

C. Referrals

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

D. Hospice

Adult recipients enrolled in hospice have waived their rights to Medicaid payments for any Medicaid services related to the terminal illness and related conditions for which hospice was elected. Providers should contact the designated hospice provider to verify qualifying diagnosis and treatment. Reference MSM Chapter 3200, Hospice, for coverage and limitations.

E. Home Health Agency (HHA)

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

F. Laboratory

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

G. Diagnostic Testing

Reference MSM Chapter 300, Radiology Services, for coverage and limitations for diagnostic services.

H. Vaccinations

Vaccinations are a covered benefit for Nevada Medicaid recipients as a preventative health services benefit.

1. Childhood vaccinations: All childhood vaccinations, per the latest recommendations of the Advisory Committee on Immunization Practices (ACIP), are covered without prior authorization under the Healthy Kids Program for children under the age of 21 years old. Refer to MSM Chapter 1500, Healthy Kids Program, for more information on childhood vaccinations.

2. Adult vaccinations: All adult vaccinations, per the latest recommendations of the ACIP, are covered without prior authorization for those 21 years of age or older. Refer to MSM Chapter 1200, Prescribed Drugs, for more information on adult vaccinations.

I. Pediatric Cancer and Pediatric Rare Disease

1. Pediatric cancer and pediatric rare disease providers are allowed to provide services in a clinic setting to treat children for cancer and other rare disease types as medically necessary.

J. Ordering, Prescribing, and Referring (OPR) Providers

OPR providers do not bill Nevada Medicaid for services rendered, but may order, prescribe, or refer services/supplies for Medicaid recipients.

603.2A AUTHORIZATION PROCESS

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

603.3 FAMILY PLANNING SERVICES

State and federal regulations grant the right for eligible Medicaid recipients of either sex of child-bearing age to receive family planning services provided by any participating clinics, physician, PA, APRN, NM, or pharmacy.

Recipients, who are eligible for Medicaid, are covered for all forms of family planning, including tubal ligation and birth control implantation up to 12 months post-partum including the entire month in which the 365th day falls.

Abortions (surgical or medical) and/or hysterectomies are not included in Family Planning Services. These procedures are a Medicaid benefit for certain therapeutic medical diagnoses.

Family Planning Services and supplies are for the primary purpose to prevent and/or space pregnancies. Providers shall follow current national guidelines, recommendations, and standards of care, including but not limited to, American College of Obstetricians and Gynecologists (ACOG) and/or U.S. Preventive Services Task Force (USPSTF).

A. Prior authorization is not required for:

1. Provider services.

2. Physical examination.

3. Papanicolaou (Pap) smears.

4. Food and Drug Administration (FDA)-approved birth control drugs and delivery devices/methods, including but not limited to the following:

a. Intrauterine contraceptive device (IUD);

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

b. Birth control pills;

c. Diaphragm/cervical cap;

d. Contraceptive foam and/or jelly;

e. Condoms;

f. Implanted contraception capsules/devices;

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

g. Contraceptive injections;

Note: If contraceptive injections are administered in the providers office, the provider may bill for the drug itself with a National Drug Code (NDC) and the intramuscular administration CPT code. Refer to MSM Chapter 1200, Prescribed Drugs, for Outpatient Pharmaceuticals.

h. Vaginal contraceptive suppositories;

i. Contraceptive dermal patch;

j. Contraceptive ring and/or other birth control methods.

5. Vasectomy or tubal ligation (age 21 years or over). In accordance with federal regulations, the recipient must fill out a sterilization consent form at least 30 days prior to the procedure. The provider is required to send the consent form to the fiscal agent with the initial claim. See the appropriate QIO-like vendor website to access the FA-56 Sterilization Consent Form which is also the HHS-687 form.

B. Medicaid has removed all barriers to family planning counseling/education provided by qualified providers (e.g., Physicians, PAs, APRN, NM, Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), Indian Health Programs, etc.). The provider must provide adequate counseling and information to each recipient when they are choosing a birth control method. If appropriate, the counseling should include the information that the recipient must pay for the removal of any implants when the removal is performed after Medicaid eligibility ends.

C. Family planning education is considered a form of counseling intended to encourage children and youth to become comfortable discussing issues such as sexuality, birth control, and prevention of sexually transmitted disease (STD). It is directed at early intervention and prevention of teen pregnancy. Family planning services may be provided to any eligible recipient of childbearing age (including minors who may be considered sexually active).

D. Insertion of Long-Acting Reversible Contraceptives (LARC) and contraceptive injections immediately following delivery and/or post discharge are covered benefits for eligible recipients.

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

F. A pelvic exam or pap smear is not required for self-administered birth control.

603.4 MATERNITY CARE

Maternity Care is a program benefit which includes antepartum care, labor and delivery, and postpartum care provided by a physician, PA, APRN, and/or a NM. Maternity care services can be provided in the home, office, hospital, or freestanding birthing center settings. All maternity care providers are allowed to provide services within all settings that are allowed per their scope of practice and licensure.

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

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

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

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

603.4A STAGES OF MATERNITY CARE

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

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

   a. In accordance with the NMHPA, vaginal deliveries with a hospital stay of two days or less and cesarean-section deliveries with a hospital stay of four days or less do not require prior authorization. Reference MSM Chapter 200, Hospital Services, for inpatient coverage and limitations.

   b. Elective/Non-Medically Necessary Deliveries

      1. Reimbursement for Avoidable Cesarean Section

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

         Reference ICD-10 Diagnosis Codes Accepted by Nevada Medicaid Supporting Medical Necessity for Cesarean Section for a list of ICD-10

diagnosis codes which have already been determined to support the medical necessity for a cesarean section.

2. Early Induction of Labor (EIOL)

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

Nevada Medicaid encourages providers to review the "Early Elective Deliveries Toolkit" compiled by the March of Dimes, the California Maternity Quality Care Collaborative, and the California Department of Public Health, Maternal, Child and Adolescent Health Division at https://www.cmqcc.org/resources-tool-kits/toolkits/early-elective-deliveries-toolkit. The aim of the toolkit is to offer guidance and support to providers, clinical staff, hospitals and healthcare organizations in order to develop quality improvement programs which will help to eliminate elective deliveries <39 weeks gestation.

3. Progesterone therapy to prevent preterm birth.

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

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

Please see the Provider Types 20, 24, 74, and 77 Billing Guides for specific coverage and limitations.

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

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

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

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

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

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

6. All newborns must receive a hearing screen in accordance with NRS 442.540 and corresponding NAC 442.850. This testing and interpretation are included in the facility per diem rate. Hearing screening is not required if parent or legal guardian objects in writing. If a baby is born in the home setting, the nurse midwife may not have the necessary equipment to conduct the hearing screen. Therefore, a referral can be made to a hearing specialist.

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

3. Postpartum care includes hospital, office visits, and home visits following vaginal or cesarean section delivery. Recipients who are eligible for Medicaid on the last day of their pregnancy remain eligible for full Medicaid coverage for 12 months immediately following the last day of pregnancy, including the entire month in which the 365th day falls.

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

Organization. Please refer to MSM Chapter 700, Rates and Supplemental Reimbursement, for more information.

603.4B FETAL NON-STRESS TESTING

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

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

603.4C MATERNAL/FETAL ULTRASOUND STUDIES

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

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

1. Coverage and Limitations

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

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

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

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

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

1. Suspected abnormality in pregnancy, such as:

a. Suspected ectopic pregnancy;

b. Suspected hydatidiform mole;

c. Threatened or missed abortion;

d. Congenital malformation, fetal or maternal;

e. Polyhydramnios;

f. Oligohydramnios;

g. Placenta previa;

h. Abruptio placenta; or

i. Vaginal bleeding.

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

a. Suspected abnormal presentation;

b. Suspected multiple gestation;

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

d. Elevated maternal serum alpha-fetoprotein;

e. Suspected fetal death;

f. Suspected anatomical abnormality of uterus;

g. Maternal risk factors, such as family history of congenital anomalies or chronic systemic disease (hypertension, diabetes, sickle cell disease, anti-phospholipid syndrome, poorly controlled

hyperthyroidism, Hemoglobinopathies, cyanotic heart disease, systemic lupus erythematosus) or substance abuse;

h. Suspected macrosomia; or

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

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

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

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

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

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

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

2. Provider Responsibility

For repeat evaluations, documentation should include, at a minimum:

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

b. Crown-rump length (CRL);

c. Biparietal diameter (BPD);

d. Femur length (FL);

e. Abdominal circumference (AC);

f. Re-evaluation of organ system;

g. Placental location ;

h. Number of fetuses (embryos);

i. Amniotic fluid volume assessment (qualitative or quantitative)

1. Oligohydramnios; or

2. Polyhydramnios.

j. Intrauterine growth restriction (IUGR).

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

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

603.4D PRENATAL SCREENING AND DIAGNOSTIC TESTING

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

1. Screening includes: first trimester and second trimester screenings, including coverage of cell-free fetal deoxyribonucleic acid (DNA) screening.

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

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

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

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

603.4E DOULA SERVICES

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

1. Doula Provider Qualifications

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

2. Coverage And Limitations

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

   a. Covered Services:

      1. Emotional support, including bereavement support.

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

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

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

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

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

         b. Child birthing options.

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

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

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

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

b. Non-Covered Services:

1. Travel time and mileage.

2. Services rendered requiring medical or clinical licensure.

c. Service Limitations:

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

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

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

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

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

603.4F ABORTION/TERMINATION OF PREGNANCY

1. Nevada Medicaid covers induced abortion services under the following circumstances:

a. When the life of the recipient is endangered if the fetus was carried to term;

b. The pregnancy resulted from a sexual assault (rape) or incest; or

c. When an abortion has been determined by a provider to be otherwise medically necessary for the recipient as defined under MSM Chapter 100 Section 103.1, Medicaid Program.

2. Prior authorization is required for Medicaid reimbursement of induced abortion services that are deemed medically necessary, and not the result of rape, incest, or to save the life of the mother.

3. Any abortion that involves inpatient hospitalization requires prior authorization approval from the appropriate QIO-like vendor. See MSM Chapter 200, Hospital Services, Authorization Requirements for further information.

4. In cases of sexual assault or rape, the Nevada mandatory reporting laws related to child abuse and neglect must be followed for all recipients under the age of 18 years old, and providers are still required to report the incident to Child Protective Services (CPS) through the Division of Child and Family Services (DCFS) or, in some localities, through County Child Welfare Services.

5. Providers must attach a signed certification to the claim that based on their professional judgment and supported by adequate documentation that the induced abortion is due to rape, incest, or to save the life of the mother. Refer to the appropriate QIO-like vendor website to access the abortion certification form.

    a. Providers must use the FA-57 Certification Statement for Abortion to Save the Life of the Mother form.

    b. Providers must use the FA-54 Abortion Declaration (Rape) form or the FA-55 Abortion Declaration (Incest) form.

603.5 HYSTERECTOMY

According to federal regulations, a hysterectomy is not a family planning (sterilization) procedure. Hysterectomies performed solely for the purpose of rendering a recipient incapable of reproducing are not covered by Medicaid. All hysterectomy certifications must have an original signature of the physician certifying the forms. Refer to the FA-50 Nevada Medicaid Hysterectomy Acknowledgement Form on the appropriate QIO-like vendor website. A stamp or initial by billing staff is not acceptable. Payment is available for hysterectomies as follows:

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 their representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the recipient permanently incapable of reproducing, and the recipient or their representative has signed a written FA-50 Hysterectomy Acknowledgement Form.

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

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 FA-50 Nevada Medicaid Hysterectomy Acknowledgment Form must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, and anesthesiologist). The physician must include a description of the nature of the emergency and this certification must be dated after the emergency. The recipient does not have to sign this form. An example of this situation would be when the recipient is admitted to the hospital through the emergency room for immediate medical care and the recipient is unable to understand and respond to information pertaining to the Hysterectomy Acknowledgement Form due to the emergency nature of the admission.

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 FA-50 Nevada Medicaid Hysterectomy Acknowledgment Form, which is also the federal HHS-687 form, must be attached to each claim form related to the hysterectomy. The recipient does not have to sign the form. For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.

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 recipient before the operation the procedure would make them sterile. In this case, the recipient and the physician must sign the written statement; or,

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

603.6 GYNECOLOGIC EXAM

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

603.7 CHIROPRACTIC SERVICES POLICY

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

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

A. Prior authorization is not required for:

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

B. Prior authorization is required for:

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

603.8 PODIATRY

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

A. Prior Authorization and Limitations

1. Policy limitations regarding diagnostic testing (not including x-rays), therapy treatments and surgical procedures which require prior authorization, remain in effect. Orthotics ordered as a result of a podiatric examination, or a surgical procedure must be billed using the appropriate CMS Healthcare Common Procedural Coding System (HCPCS) code. Medicaid will pay for the orthotic in addition to the office visit.

2. Radiology Service

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

3. Laboratory Services

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

4. Prescription Drugs

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

5. Telehealth Services

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

B. Covered Services

1. Evaluation and Management Services

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

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

2. Surgical Procedures

   a. Multiple surgeries.

   b. Mycotic procedures.

   c. Casting/strapping/taping.

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

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

3. Infection and Inflammation Services

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

C. Non-Covered Services

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

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

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

603.9 PROVIDER SERVICES PROVIDED IN RURAL HEALTH CLINICS

Rural Health Clinic (RHC)

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

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

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

a. Physician (MD/DO);

b. Dentist;

c. APRN;

d. PA/PA-C;

e. CRNA;

f. NM;

g. Psychologist;

h. Licensed Clinical Social Worker (LCSW);

i. Registered Dental Hygienist (RDH);

j. Podiatrist (DPM);

k. Radiology;

l. Optometrist (OD);

m. Optician;

n. Clinical Laboratory Services;

o. Licensed Marriage and Family Therapist (LMFT);

p. Licensed Pharmacist; and

q. Registered Dietitian (RD).

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

a. Community Health Workers (CHW); and

b. Doulas.

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

1. Core visits include the following:

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

b. Annual preventive gynecological examinations; and

c. Colorectal screenings.

2. Home visits; or

3. Family planning education.

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

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

603.10 ANESTHESIA

Medicaid payments for anesthesiology services provided by physicians and CRNAs are based on the CMS base units.

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

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

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

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

1. Type of surgery;

2. Length of time;

3. Diagnosis;

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

5. Unusual forms of monitoring and/or special circumstances rendered by the anesthesiologist/CRNA are billed separately using the appropriate CPT code. Special circumstances include but are not limited to nasotracheal/bronchial catheter

aspiration, intra-arterial, central venous and Swan-Ganz lines, transesophageal echocardiography, and ventilation assistance.

603.11 PROVIDER SERVICES IN OUTPATIENT SETTING

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

Services requiring prior authorization include the following:

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

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

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

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

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

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

B. Emergency Department Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Observation Services Provided by the Physician

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

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

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

a. Send the recipient home;

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

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

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

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

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

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

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

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

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. ASC Facility and Non-Facility Based

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

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

1. Prior authorization is not required when:

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

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

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

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

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

    c. Designated podiatry procedures; and

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

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

    a. Cosmetic Surgery: The cosmetic surgery exclusion precludes payment for any surgical procedure directed at improving appearance. The condition giving rise to the recipient's preoperative appearance is generally not a consideration. The only exception to the exclusion is surgery for the prompt repair of an accidental injury or the improvement of a malformed body member, to restore or improve function, which coincidentally services some cosmetic purpose. Examples of procedures which do not meet the exception

to the exclusion are facelift/wrinkle removal (rhytidectomy), nose hump correction, moon-face, etc.;

b. Fabric wrapping of abdominal aneurysm;

c. Transvenous (catheter) pulmonary embolectomy;

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

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

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

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

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

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

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

603.12 SERVICES IN THE ACUTE HOSPITAL SETTING

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

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

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

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

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

F. Inpatient Hospital Care

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

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

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

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

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

   d. Post-surgical pain management.

3. The surgeon's initial evaluation or consultation is considered a separate service from the surgery and is paid as a separate service, even if the decision, based on the evaluation, is not to perform the surgery. If the decision to perform a major surgery (surgical procedures with a 90-day global period) is made on the day of or the day prior to the surgery, separate payment is allowed for the visit on which the decision

is made, however supporting documentation may be requested. If post payment audits indicate documentation is insufficient to support the claim, payment will be adjusted accordingly.

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

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

6. Payment for physician services related to patient-controlled analgesia is included in the surgeon's global payment. The global surgical payment will be reduced if post-payment audits indicate that a surgeon's recipients routinely receive pain management services from an anesthesiologist. For a list of covered codes, please refer to the billing manual.

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

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

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

10. Critical Care

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

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

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

c. Services for a recipient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

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

e. Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls, whether taken at home, in the office, or elsewhere in the

hospital) may not be reported as critical care since the physician is not immediately available to the patient.

11. Neonatal and Pediatric Critical Care

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

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

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

d. Care rendered under the pediatric critical care codes includes management, monitoring, and treatment of the recipient including respiratory, enteral and parenteral nutritional maintenance, metabolic and hematologic maintenance, pharmacologic control of the circulatory system, parent/family counseling, case management services, and personal direct supervision of the health care team in the performance of cognitive and procedural activities.

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

1. peripheral vessel catheterization;

2. other arterial catheters;

3. umbilical venous catheters;

4. central vessel catheters;

5. vascular access procedures;

6. vascular punctures;

7. umbilical arterial catheters;

8. endotracheal intubation;

9. ventilator management;

10. bedside pulmonary function testing;

11. surfactant administration;

12. continuous positive airway pressure (CPAP);

13. monitoring or interpretation of blood gases or oxygen saturation;

14. transfusion of blood components;

15. oral or nasogastric tube placement;

16. suprapubic bladder aspiration;

17. bladder catheterization; and

18. lumbar puncture.

Any services performed which are not listed above may be reported separately.

f. Initial and Continuing Intensive Care Services are reported for the child who is not critically ill, but requires intensive observation, frequent interventions and other intensive care services, or for services provided by a physician directing the continuing intensive care of the Low Birth Weight (LBW) (1500-2500 grams) present body weight infant, or normal (2501-5000 grams) present body weight newborn who does not meet the definition of critically ill, but continues to require intensive observation, frequent interventions, and other intensive care services.

603.13 PROVIDER'S SERVICES IN NURSING FACILITIES

A. Provider services provided in a Nursing Facility (NF) are a covered benefit when the service is medically necessary. Provider visits must be conducted in accordance with

federal requirements for licensed facilities. Reference MSM Chapter 500, Nursing Facilities, for coverage and limitations.

B. When the recipient is admitted to the NF in the course of an encounter in another site of service (e.g., hospital emergency room (ER), provider's office), all E/M services provided by that provider in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. Admission documentation and the admitting orders/POC should include the services related to the admission he/she provided in the other service sites.

C. Hospital discharge or observation discharge services performed on the same date of NF admission or readmission may be reported separately. For a recipient discharged from inpatient status on the same date of nursing facility admission or readmission, the hospital discharge services should be reported as appropriate. For a recipient discharged from observation status on the same date of NF admission or readmission, the observation care discharge services should be reported with the appropriate CPT code.

603.14 PROVIDER'S SERVICES IN OTHER MEDICAL FACILITIES

A. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

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

Recertification by a physician or an APRN for the continuing need for ICF/IID care is required within 365 days of the last certification. In no instance is recertification acceptable after the expiration of the previous certification. For further information regarding ICF/IID refer to MSM Chapter 1600, Intermediate Care for Individuals with Intellectual Disabilities.

B. Residential Treatment Center (RTC)

Physician services, except psychiatrists, are not included in the all-inclusive facility rate for RTCs. Please reference MSM Chapter 400, Mental Health Services.

604 COMMUNITY PARAMEDICINE SERVICES

Nevada Medicaid 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 Nevada Medicaid.

604.1 COMMUNITY PARAMEDICINE PROVIDER QUALIFICATIONS

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

1. EMT;

2. AEMT; or

3. Paramedic.

B. Required endorsement:

1. Community paramedicine endorsement from the Nevada Division of Public and Behavioral Health (DPBH), 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 POC under the supervision of a Nevada-licensed EMS agency medical director and coordinated with a PCP. The POC is to be developed after an appropriate assessment and does not have to be in place before

community paramedicine services are started but must be developed while the recipient is receiving community paramedicine services. If a recipient does not have a PCP, the POC must include establishing a medical home with a PCP. It is expected that all health care providers delivering care to community paramedicine recipients coordinate the patient's care to avoid duplication of services to the recipient.

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 POC:

1. Evaluation/health assessment;

2. Chronic disease prevention, monitoring, and education;

3. Medication compliance;

4. 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;

6. Personal Care Services; and

7. Mental and behavioral health/crisis intervention.

C. For a list of covered procedure and diagnosis codes, please refer to the PT 32, Specialty 249 Billing Guide.

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

605 COMMUNITY HEALTH WORKER SERVICES

CHW are trained public health educators improving health care delivery requiring integrated and coordinated services across the continuum of health. CHWs provide recipients culturally and linguistically appropriate health education to better understand their condition, responsibilities, and health care options. CHW services must be related to disease prevention and chronic disease management that follow current national guidelines, recommendations, and standards of care, including but not limited to, the United States Preventive Services Task Force (USPSTF) A and B recommended screenings. CHWs may provide services to recipients (individually or in a group) within the home, clinical setting, or other community settings.

605.1 COMMUNITY HEALTH WORKER PROVIDER QUALIFICATIONS

A. Certification as a CHW must be obtained through the Nevada Certification Board.

B. Must be supervised by a Nevada Medicaid enrolled Physician, PA, APRN, Dentist, LCSW, LMFT, LCPC, NM, and Nurse Anesthetist.

605.2 COVERAGE AND LIMITATIONS

A. Covered services:

1. Guidance in attaining health care services.

2. Identify recipient needs and provide education from preventive health services to chronic disease self-management.

3. Information on health and community resources, including making referrals to appropriate health care services.

4. Connect recipients to preventive health services or community services to improve health outcomes.

5. Provide education, including but not limited to, medication adherence, tobacco cessation, and nutrition.

6. Promote health literacy, including oral health.

B. Non-covered services:

1. Delegate the CHW to perform or render services that require licensure.

2. Transport a recipient to an appointment.

3. Make appointments not already included within the CHW visit/service (i.e. receptionist duties or front desk support).

4. Deliver appointment reminders.

5. Employment support, including but not limited to resume building, interview skills.

6. Coordinate and participate in community outreach events not related to individual or group Medicaid recipients.

7. Case management.

8. Accompanying a recipient to an appointment.

9. Provide child-care while the recipient has an appointment.

10. Application assistance for social service programs.

11. Mental health/alcohol and substance abuse services, including peer support services.

C. Service Limitations:

1. Services provided by a CHW are limited to four units (30 minutes per unit) in a 24-hour period, not to exceed 24 units per calendar month per recipient. If medically necessary, prior authorization can be requested for additional services.

2. When providing services in a group setting, the number of participants must be at a minimum of two and a maximum of eight.

D. Prior authorization is not required.

E. For a list of covered procedure codes please refer to the CHW PT 89 Billing Guide.

606 ORGAN TRANSPLANT SERVICES

606.1 COVERAGE AND LIMITATIONS

Organ transplantation and associated fees are a limited benefit for Nevada Medicaid recipients. Non-Citizens/Aliens are not eligible for organ transplants. Refer to MSM Chapter 200, Hospital Services, Attachment A, Policy #02-02, Federal Emergency Services Program for eligible emergency conditions.

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

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

a. Non-covered conditions for bone marrow/stem cell:

1. Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma (MM);

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 MM;

2. Corneal – allograft/homograft;

3. Kidney – allotransplantation/autotransplantation; and

4. Liver – transplantation for children (under 21 years old) with extrahepatic biliary atresia or for children or adults with any other form of end-stage liver disease. Coverage is not provided with a malignancy extending beyond the margins of the liver or those with persistent viremia.

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

1. A transplant procedure shall only be approved upon a determination that it is a medically necessary treatment by showing that:

a. The procedure is not experimental and/or investigational based on Title 42, CFR, Chapter IV (CMS) and Title 21, CFR, Chapter I FDA;

b. The procedure meets appropriate Medicare criteria;

c. The procedure is generally accepted by the professional medical community as an effective and proven treatment for the condition for which it is proposed, or there is authoritative evidence that attests to the proposed procedures safety and effectiveness; and

d. If the authorization request is for chemotherapy to be used as a preparatory therapy for transplants, an approval does not guarantee authorization for any harvesting or transplant that may be part of the treatment regimen.

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

607 PREVENTIVE 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. The USPSTF is an independent volunteer panel of national experts in prevention and evidence-based medicine authorized by the U.S. Congress. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services. Each recommendation has a letter grade (an A, B, C, D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of a preventive service.

607.1 COVERED SERVICES

Nevada Medicaid reimburses for preventive health services for men, women and children as recommended by the USPSTF A and B recommendations. For the most current list of reimbursable preventive services, please see the USPSTF A and B recommendations located at https://www.uspreventiveservicestaskforce.org/.

Family planning related preventive health services as recommended by the USPSTF are a covered benefit.

607.2 NON-COVERED SERVICES

Preventive health services not cataloged or that do not have a current status as either an A or B recommendation by the USPSTF are not covered.

607.3 PRIOR AUTHORIZATIONS

Prior authorizations are not required for preventive health services that coincide with the USPSTF A and B recommendations.

607.4 BILLING REQUIREMENTS

Most preventive health services may be performed as part of an office visit, hospital visit, or global fee and may not be billed separately. Please see the Preventive Services Billing Guide or the USPSTF website.

608 GENDER REASSIGNMENT SERVICES

Transgender Services include treatment for gender dysphoria and gender incongruence. Treatment of gender dysphoria and gender incongruence is a Nevada Medicaid 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 gender dysphoria and gender incongruence.

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. 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) and gender incongruence describes a marked and persistent experience of an incompatibility of gender identity and the gender expected based on birth-assigned sex.

608.1 COVERAGE AND LIMITATIONS

A. Hormone Therapy

1. Hormone therapy is covered for treatment of gender dysphoria and gender incongruence 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 gender dysphoria and gender incongruence based on medical necessity; refer to MSM Chapter 400, Mental Health 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 not deemed medically necessary.

E. Documentation Requirements

1. The recipient must have:

a. persistent and well-documented case of gender dysphoria and/or gender incongruence;

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 WPATH standards of care; and

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

1. A licensed qualified mental health care professional working within the scope of their license who have independently assessed the recipient;

    a. one with whom the recipient has an established ongoing relationship; and

    b. one who only has an evaluative role with the recipient.

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

    a. a persistent and well-documented case of gender dysphoria and/or gender incongruence;

    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.

3. 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 is required.

609 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 RD working in a coordinated, multidisciplinary team effort with the Physician, PA, or APRN referred to as provider throughout this policy 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.

Nevada Medicaid considers MNT medically necessary for diabetes, obesity, heart disease, and hypertension where dietary adjustment has a therapeutic role, when it is prescribed by a provider and furnished by an RD. The only providers that should submit claims for MNT are RDs. Other qualified health care professionals may provide MNT; however, they must submit a claim for evaluation and management services.

609.1 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 to the written orders of the Physician, PA, or an APRN. The treatment regimen must be designed and approved by an RD.

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

609.2 COVERAGE AND LIMITATIONS

A. MNT is initiated from a referral from a provider that can refer and includes information on labs, medications and other diagnoses. MNT includes:

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

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

3. Monitoring and evaluating an individual's progress over subsequent visits with a RD.

B. Coverage of services includes:

1. Initial nutrition and lifestyle assessment.

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

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

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

5. Four hours maximum in the first year.

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

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

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

   d. The documentation should also include a comprehensive POC, individualized assessment and education plan with outcome evaluations for each session, as well as referring provider feedback.

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

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

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

C. MNT is not to be confused with Diabetic Outpatient Self-Management Training (DSMT)

1. Nevada Medicaid considers DSMT and MNT complementary services. This means Medicaid will cover both DSMT and MNT without decreasing either benefit as long as the referring provider determines that both are medically necessary.

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

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

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

609.3 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.

609.4 PROVIDER QUALIFICATIONS

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

A. Licensed and RD under the qualifications of NRS 640E.150. An RD 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.

609.5 PROVIDER RESPONSIBILITY

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

B. 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.

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

610 LICENSED PHARMACIST SERVICES

A licensed pharmacist is a health care professional licensed to engage in pharmacy duties including dispensing prescription drugs, monitoring drug interactions, and counseling patients regarding the effects and proper usage of drugs and dietary supplements. Billable services are specified within Section 610.2.

610.1 LICENSED PHARMACIST QUALIFICATIONS

Licensed pharmacist qualifications are defined per NRS 639.015 as a person whose name has been entered in the registry of pharmacists by the Nevada State Board of Pharmacy (BOP) and to whom a valid certificate or certificate by endorsement as a registered pharmacist or valid renewal thereof has been issued.

610.2 COVERAGE AND LIMITATIONS

A. Nevada Medicaid reimburses pharmacists for the following services:

1. The dispensing of self-administered hormonal contraceptive based on the protocols established by the BOP regardless of whether a patient has obtained a prescription from a practitioner.

2. The prescribing, dispensing and administration of drugs to prevent the acquisition of human immunodeficiency virus (HIV) and ordering and conducting certain HIV laboratory tests based on protocols established by the BOP.

3. Assessment of a patient to determine if the patient has an opioid use disorder, determine MAT is appropriate, counsel the patient, and prescribe and dispense a drug for MAT.

B. Nevada Medicaid does not reimburse separately for services listed in Section 610.2(A) when provided in an inpatient or outpatient hospital, emergency department, or inpatient psychiatric facility of service.

C. Prior authorization is not required.

D. For a list of covered procedure codes please refer to the PT 91 - Licensed Pharmacist Billing Guide at https://www.medicaid.nv.gov/providers/rx/PDL.aspx.

611 HEARINGS

Please reference Nevada MSM Chapter 3100 for hearings procedures.

POLICY #6-01	QUALIFYING CLINICAL TRIALS	EFFECTIVE DOS 1/1/22

A. DESCRIPTION

The "Consolidated Appropriations Act (CAA), 2021" amended Section 1905(a) of the SSA (42 U.S.C. 1396d) which includes new requirements to promote access to clinical trials by allowing Medicaid recipients coverage of routine patient costs for items and services furnished in connection with participation in Qualifying Clinical Trials (QCTs). This mandate also includes amendments to Sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory.

Pursuant to Sections 1905(a)(30) and 1905(gg)(1) of the Act, routine patient costs must be covered for a recipient participating in a QCT, including any item or service within the Nevada Medicaid State Plan, waiver, or demonstration project under Section 1115 of the Act provided to prevent, diagnose, monitor, or treat complications resulting from participation in the QCT.

For purpose of Section 1905(a)(30) of the Act, a QCT is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

1. To meet the statutory definition, the QCT must also be one or more of the following:

    a. A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:

        1. The National Institutes of Health (NIH);

        2. The Centers for Disease Control and Prevention (CDC);

        3. The Agency for Health Care Research and Quality (AHRQ);

        4. CMS;

        5. A cooperative group or center of any of the entities described above, the Department of Defense, or the Department of Veterans Affairs; or

        6. A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.

    b. A QCT, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Department of Health and Human Services (DHHS) Secretary, determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

        1. The Department of Energy;

        2. The Department of Veterans Affairs; or

        3. The Department of Defense.

c. A QCT that is conducted pursuant to an investigational new drug exemption under Section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under Section 351(a)(3) of the Public Health Service Act; or

d. A clinical trial that is a drug trial exempt from being required to have one of the exemptions listed under Item c. above.

B. PRIOR AUTHORIZATION

Prior Authorization is not required for participation in the QCT; however, if a routine patient cost/service or item requires a prior authorization or exceeds the service limitations, a prior authorization may be required. Please refer to the respective policies for prior authorization requirements.

For medically necessary services requiring a prior authorization, the appropriate QIO-like vendor must review and complete the request within 72 business hours.

C. COVERAGE AND LIMITATIONS

1. For a recipient participating in a QCT, coverage shall:

   a. Be made without regard to the geographic location or network affiliation of the health care provider treating the recipient or the principal investigator of the QCT.

   b. Be based on attestation regarding the appropriateness of the QCT by the health care provider and principal investigator.

   c. Not require submission of the protocols of the QCT or any other documentation that may be proprietary or determined by the DHHS Secretary to be burdensome to provide.

2. The following items and services are not covered under the new mandatory benefit as described under Section 1905(gg) of the Act:

   a. An investigational item or service that is the subject of the QCT and is not otherwise covered outside of the clinical trial under the State Plan, waiver, or demonstration project.

   b. Routine patient cost does not include any item or service that is provided to the recipient solely to satisfy data collection and analysis for the QCT that is not used in the direct clinical management of the recipient and is not otherwise covered under the State Plan, waiver, or demonstration project.

Note: For policy regarding pharmaceutical clinical studies, please refer to MSM Chapter 1200 – Prescribed Drugs.

D. MEDICAID ATTESTATION FORM

1. The QCT principal investigator and the recipient's healthcare provider must complete the Medicaid Attestation Form on the Appropriateness of the QCT (FA-110).

This form is available at the appropriate QIO-like vendor website at https://www.medicaid.nv.gov/providers/forms/forms.aspx. This Medicaid Attestation Form must be submitted to the appropriate QIO-like vendor.

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. 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 CDC guidelines. Photographs are necessary to establish a baseline and to document the progress of the wound, as are weekly measurements. Providers 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 following are included services:

    a. First-Line Wound Care Therapy

        1. First-line wound care is used for acute wounds. If the wound does not improve with the first line treatment, adjunctive second-line therapy may be used. Measurable signs of improved healing include the following:

            a. a decrease in wound size, either in surface area or volume; and/or

            b. a decrease in amount of exudate; and/or

            c. a decrease in amount of necrotic tissue.

        2. First-line wound care therapy includes the following:

            a. cleansing, antibiotics, and pressure off-loading; and/or

            b. compression; and/or

            c. debridement; and/or

            d. dressing; and/or

            e. irrigation; and/or

            f. whirlpool for burns.

    b. Second-Line Wound Care Therapy

1. Second-line wound care therapy is limited to chronic Stage 3 or 4 wounds and may be covered only after first-line therapy has been tried for at least 30 days without measurable signs of improved healing. First-line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the medical condition.

2. Second-line wound therapy includes application of metabolically active skin equivalent/skin substitutes.

3. Skin Substitutes and Surgical Wound Preparation:

a. The application of skin substitutes is a benefit for the treatment of chronic Stage 3 or 4 wounds that have failed to respond to standard wound care treatment after 30 days. A failed response is defined as a wound that has increased in size or depth or has not changed in baseline size of depth and shows not measurable signs of healing improvements after 30 days of appropriate wound care measures.

b. Use of the appropriate specific skin substitute product(s) for the episode of each documented wound is expected. Compliance with FDA assessments and submitted guidelines for the specific skin substitute products(s) used is expected. Skin substitute products not used within the scope of the FDA's intended use and indications are considered experimental and/or investigational.

1. Skin substitute graphs may be reimbursed for the application of skin substitute grafts.

2. Prior authorization is required for all wound substitutes.

3. Prior authorization is not required for debridement of partial thickness burns.

4. Prior authorization is required for wound debridement for subcutaneous tissue, muscle and/or fascia, and bone.

a. For wound debridement for muscle and/or fascia, and bone, at least one of the following conditions are required to be present and documented:

1. Stage 3 or 4 wounds; and/or

2. Venous or arterial in sufficiency ulcers; and/or

3. Dehisced wound or wound with exposed hardware or bone; and/or

4. Neuropathic ulcers; and/or

5. Complications of surgically created or traumatic wounds, where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment.

b. Wound debridement is not appropriate for and will not be authorized for

1. washing bacteria or fungal debris from the feet,

2. paring or cutting of corns or calluses,

3. incision and drainage of an abscess,

4. trimming or debridement of nails, or avulsion of nail plates,

5. acne surgery,

6. destruction of warts,

7. burn debridement.

4. Skin Substitute Grafts and Surgical Wound Preparation:

a. Add together surface area multiple wounds in same anatomical locations as indicated in code descriptor groups.

b. Do not add together multiple wounds at different anatomical site groups.

c. Skin Substitute Grafts include:

1. Biological material used for tissue engineering for growing skin; and

2. Nonautologous human skin such as acellular, allograft, cellular, dermal, epidermal, or homograft; and

3. Non-human grafts.

d. Coverage for Products:

1. Provider shall bill using the specific Q-code on the Fee Schedule for the skin substitute.

2. If there is not a Q-code listed on the Fee Schedule for the skin substitute, providers shall use available code for supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or material provided).

e. Initial request should include the following:

1. location of the wound; and

2. characteristics of the wound, which include all of the following:

a. Dimensions (diameter and depth); and

b. Drainage (amount and type); and

c. Related signs and symptoms (swelling, pain, inflammation); and

d. Presence of necrotic tissue/slough.

f. Negative Pressure Wound Therapy (NPWT) is recommended by a physician or other qualified health care provider to draw out fluid and infection from a wound to help it heal. It may be recommended for burns, pressure ulcers, diabetic ulcers, chronic (long-lasting) wounds, or injury.

g. Hyperbaric Oxygen Treatment (HBOT)—see MSM Chapter 600, Attachment A, Policy #6-03.

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

6. Non-Included services:

a. Infrared therapy

b. Ultraviolet therapy

c. Low-energy ultrasound wound cleaner (MIST therapy)

d. Pulsatile Jet Irrigation

e. Topical Oxygen Wound Therapy (TOWT) closed system

f. Electrical stimulation and electromagnetic therapy

g. Services that are submitted as debridement but do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.

7. Authorization:

a. The treating provider must submit a signed and dated wound care treatment plan or submit a letter of medical necessity that includes the following documentation:

1. the planned interventions for the problem identified; and

2. the treatment goals; and

3. the expected outcomes.

b. For prior authorization, the signed and dated treatment plan or a letter of medical necessity is considered current when signed and dated within 30 calendar days prior to or on the date the procedure is performed. If the signed and dated treatment plan or letter of medical necessity is older than 30 days, prior authorization may be denied.

8. Documentation:

a. The patient's medical record must include a comprehensive wound history that includes:

1. date of onset; and

2. location; and

3. depth and dimension; and

4. exudate characteristics; and

5. circulatory, neuropathy, and nutritional assessments; and

6. current management; and

7. previous treatment regime.

b. All wound care services require documentation of the wound and a comprehensive treatment plan is required to be maintained in the client's medical record.

c. The provider shall document the cultures of all infected wounds prior to initiating systemic antibiotics, per CDC guidelines.

d. Photographs are necessary to establish and document:

1. baseline, and

2. the progress of the wound, and

3. include weekly measurements.

e. The provider shall document in the recipient's medical record the education provided to recipients about the disease process, how to manage their own wound care, and the importance of complying with the treatment plan.

C. COVERED CPT CODES

For a list of covered procedure and diagnosis codes, please refer to the billing guidelines for Outpatient Surgery, Outpatient Hospital, Podiatrist, Physician, APRN, and PA.

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

A. DESCRIPTION

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 atmospheres absolute (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 provider. Attach a copy of the provider'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 two 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 three 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 two 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 dose consistent with baclofen screening trial protocols 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;

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

3. 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.

4. 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 #6-05	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 prior authorization 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 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

POLICY #6-08	HYALGAN® AND SYNVISC® INJECTIONS	EFFECTIVE DOS 9/1/03 Supersedes Policy News N199-09

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 E/M service will not be covered during subsequent visits for injections unless there is a separately identifiable problem.

POLICY #6-09	END STAGE RENAL DISEASE SERVICES	EFFECTIVE DOS 9/1/03 Superseded Policy News N199-10 and New ESRD Policy

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

2. Provider'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. Provider's 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.

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 three 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. Enteral tube feeding contraindicated.

   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 DSMT 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 MSM Chapter 1200, Prescribed Drugs.

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 provider managing the recipient's diabetic condition certifies the comprehensive POC 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 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.

POLICY #6-11	BOTULINUM TOXIN	EFFECTIVE DATE 12/18/04 RE-ISSUE/UPDATE 01/29/20

A. DESCRIPTION

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/or provide adequate perineal hygiene.

B. PRIOR AUTHORIZATION

Prior authorization is required for Botulinum Toxin. Please reference MSM Chapter 1200, Prescribed Drugs, for prior authorization criteria.

POLICY #6-12	RESERVED FOR FUTURE USE	

RESERVED FOR FUTURE USE

A. DESCRIPTION

School Based Health Centers (SBHCs) provide primary and preventive medical services to Medicaid and NCU 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 Health Services (SHS) provided through a Local Education Agency (LEA) or State Education Agency (SEA). SHS policy is located in MSM Chapter 2800, School Health Services.

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 may 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 (QMHP). Nevada Medicaid 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 MSMs.

D. COVERAGE AND LIMITATIONS

1. All services that are provided must be medically necessary (see MSM Chapter 100, Medicaid Program) 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 limited to:

   a. Primary and preventive health care including 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, disorders, and emotional/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. Vaccinations;

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 provided directly by an LEA or SEA.

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

Providers practicing in SBHCs are governed by and must abide by the 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 QIO-like vendor contracted with Nevada Medicaid.

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.

A. DESCRIPTION

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

B. PROVIDER QUALIFICATIONS

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

1. Treating Practitioner (Billing Provider)

   a. Any provider qualified to use evaluation and management codes, (i.e., Physician, APRN, Certified Midwife, or PA) except psychiatrists.

   b. Is a primary care or specialty care provider; and

   c. Must be enrolled in Nevada Medicaid.

   Responsibility:

   d. Directs the behavioral care manager.

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

   f. Remains involved in integrated care through ongoing oversight, management, collaboration, and reassessment.

2. Behavioral Care Manager

   a. Has a bachelor's degree from an accredited college or university in a human service-related field and one year of direct, supervised experience working with individuals in the behavioral health field: or

   b. Has a bachelor’s degree from an accredited college or university in a field other than Human Services and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated by four years of relevant professional experience by proof of resume; and

   c. Works under the supervision of the billing practitioner; or

d. Licensed Behavioral Health Professionals including:

1. Licensed Psychiatrist
2. Psychiatric APRM
3. Psychiatric-PA-C
4. Licensed Psychologist
5. Registered Psychological Intern
6. Registered Psychological Assistant
7. Registered Psychological Trainee
8. LCSW
9. LMFT
10. Licensed Clinical Professional Counselor (LCPC)
11. Clinical Social Worker Intern (CSW-I)
12. Licensed Marriage and Family Intern (LMFT-I)
13. Licensed Clinical Professional Counselor Intern (LCPC-I)
14. Licensed Clinical Alcohol and Drug Counselor (LCADC)
15. Licensed Clinical Alcohol and Drug Counselor Intern (LCADC-I)

e. Enrollment in Nevada Medicaid is not required

Responsibility:

f. Administration of validated rating scales (for example, Patient Health Questionaire-9 [PHQ-9] scale for depression, Generalized Anxiety Disorder-7 [GAD-7] for anxiety).

g. Development of a care plan.

h. Provision of brief psychosocial interventions (i.e., education and prevention).

i. Ongoing collaboration with billing practitioner.

j. Consultation with psychiatric consultant.

k. Maintaining a continuous relationship with the recipient.

l. Responsibility does not include administrative or clerical staff activities; time spent in strictly administrative or clerical duties is not counted towards the time threshold to bill behavioral health integration codes.

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

3. Psychiatric Consultant

a. A licensed psychiatrist, psychiatric APRN, or psychiatric-certified PA.

b. Must be enrolled in Nevada Medicaid; may be enrolled as an OPR Professional.

Responsibility:

c. Meets with the Care Manager to review the recipient's care plan and status at least weekly.

d. Provides the billing practitioner and behavioral health care manager information about diagnosis.

e. Indicates ways to resolve issues with patient adherence and tolerance of behavioral health treatment;

f. Adjusts behavioral health treatment for patients who aren't progressing;

g. Manages any negative interactions between patients' behavioral health and medical treatments;

h. Can (and typically will) be remotely located;

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

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

k. May render services directly to the recipients that are separately billed, if fully enrolled in Nevada Medicaid as a provider, any activities reported separately are not included in the time applied to the CoCM.

4. Eligibility

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

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

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

5. Prior Authorization

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

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

6. Coverage and Limitations

The following services are covered under the CoCM:

Initial Psychiatric CoCM

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

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

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

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

Follow-Up Psychiatric CoCM

e. Participation in weekly caseload consultation with the psychiatric consultant.

f. Ongoing collaboration with and coordination of the patient's behavioral health care with the treating physician or other qualified health care professional and any other treating behavioral health providers.

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

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

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

Non-Covered Services:

j. Administrative or clerical staff time.

k. Services considered Targeted Case Management (TCM).