



Physician, M.D. and Osteopath Advanced Practitioner of Nursing (APN) Physician's Assistant (PA)

Policy

Nevada Medicaid and Nevada Check Up reimburse Physicians, APNs and PAs for covered services that are reasonable and medically necessary and within the provider's scope of practice as defined by state law.

Please see the Medicaid Services Manual (MSM) [Chapter 600](#) for complete coverage and limitations.

Prior authorization

Prior authorization requirements for provider types 20, 24 and 77 are provided in MSM Chapter 600, Section 603.2, titled *Physician Office Services*.

Prior authorization is **not required** for minor office procedures (CPT codes 10000- 69999) with a reimbursement rate of \$40 or less.

Non-covered services

Medicaid does not reimburse attending/admitting physicians for services rendered to a recipient when the prior authorization request for hospital admission was denied.

Medicaid does not reimburse providers for telephone calls between providers and recipients except documented psychiatric treatment in crisis intervention (e.g. threatened suicide).

Medicaid does not provide coverage for radiology codes when billed by an APN or PA.

Covered services

Medicaid covered benefits include but are not limited to office visits, consultations, surgery, routine obstetrical care, some laboratory services, dressing changes, diagnostic testing and other services as discussed in this document.

Physician-administered drugs

On January 1, 2008, Nevada Medicaid began requiring an NDC and an NDC quantity for each claim line with a physician administered drug. For billing specifications, see the HP Enterprise Services NDC Billing Reference.

Immunizations

Nevada Medicaid and Nevada Check Up do not reimburse providers for vaccines. Providers are encouraged to enroll with the **VFC program**, which provides free vaccines for eligible children. To enroll as a VFC provider, visit the [Nevada State Health Division](#) website. Bill administration codes at the usual and customary charge, and bill vaccines at a zero dollar amount. See the [Centers for Disease Control \(CDC\)](#) website for more information on the VFC program.



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HPV vaccine uses and restrictions

The following uses and restrictions for Human Papilloma Virus (HPV) vaccines CPT code 90649 (Gardasil®) and CPT code 90650 (Cervarix®) are effective for claims dates of service on/after Oct. 21, 2009.

- CPT code 90649, formerly for females only, may be used for boys and young men age 9-26. Please note that for recipients age 9-18, code 90649 is reimbursed through the Vaccines For Children (VFC) program.
- CPT code 90650 is an FDA-approved HPV vaccine for females only age 9-26. For recipients age 9-18, code 90650 is reimbursed through the VFC program.
- The three-dose schedule for either code for recipients over age 18 must begin and end before the recipient turns 27. Medicaid cannot reimburse for any dose(s) given after the recipient turns 27, because the vaccine is not approved by the FDA for recipients over the age of 26.
- Any claims for CPT codes 90649 and 90650 submitted on/after Oct. 21, 2009, that denied inappropriately have been reprocessed and the adjudication is reported on remittance advices.

For additional HPV guidelines and information, please see Medicaid Services Manual (MSM) Chapter 1200 or the Centers for Disease Control and Prevention (CDC) website

Anesthesia

For instructions on billing anesthesia services (including obstetrical deliveries and Botulinum toxin Type A), go to the HP Enterprise Services website at <http://medicaid.nv.gov/>

Botulinum toxin type A

Botulinum toxin Type A policy is discussed in MSM Chapter 600, Attachment A, Policy #6-11.

Covered diagnosis codes are: 224.1, 333.6-333.7, 333.81-333.84, 333.89, 340, 341.0-341.9, 342.11-342.12, 343.9, 351.8, 378, 478.75, 565.0, 728.85 and 728.89.

Medicaid covers the following codes when electromyography (EMG) guidance is used: 5860, 95861, 95867-95868, 95869, 95870, 95873 and 95874. Bill only one EMG per injection site.

Colorectal cancer screening

Colorectal cancer screening policy is discussed in MSM Chapter 600, Attachment A, Policy #6-01.

Nevada Medicaid covers the following services for the early detection of colorectal cancer:

ICD-9-CM codes: 550.0-55.9, 556.0-556.9, V10.05-V10.06, V12.72, V16.80, V18.5

CPT codes: 45330, 45378, 82270, 74270



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Dermatology services

For some dermatology services, the CPT descriptors contain language, such as *additional lesion*, to indicate that multiple surgical procedures have been performed. The multiple procedures rules do not apply because the Relative Value Units (RVUs) 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.

Developmental testing

Developmental testing (CPT code 96111) is covered and requires prior authorization.

Diabetic outpatient self-management training

Diabetic outpatient self-management training policy, including prior authorization requirements, is discussed in MSM Chapter 600, Attachment A, Policy #6-10.

Diabetic outpatient self-management training is available to recipients with diagnosis code(s) 250.0-250.93, 648.0, 648.8, 271.4 and 275.0.

Medicaid covers up to 10 hours of initial training. Repeat training is covered only when prior authorized. Use procedure code G0108 to bill for individual training (1 unit = 30 minutes) and G0109 to bill for group training (2 or more recipients, 1 unit = 30 minutes).

Essure contraceptive system

The Essure Contraceptive System must be billed using CPT code 58565 for the procedure. Effective dates of service on or after Jan. 1, 2011, the supply must be billed using HCPCS code A4264, which has been assigned a dollar rate.

CPT code 58565 does not require prior authorization (PA). Effective dates of service on or after Jan. 1, 2011, HCPCS code A4264 does not require PA. PA is required for the supply for dates of service on or before Dec. 31, 2010, and the PA must have included the manufacturer's invoice.

The Sterilization Request Consent Form (FA-56) must accompany the claim for the procedure. Do not send the manufacturer's invoice with the claim.

Endoscopic procedure payment methodology

In the case of multiple endoscopic procedures, the full value of the higher valued endoscopy will be recognized, plus the difference between the next highest valued endoscopy and the primary endoscopy.

In situations when two series of endoscopies are performed, the special endoscopy rules are applied to each series, followed by the multiple surgery rules of 100%, 50%, etc. In the case of two unrelated endoscopic procedures, the usual multiple surgery rules apply.



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When two related endoscopies and a third unrelated endoscopy are performed in the same operative session, the special endoscopic rules apply only to the related endoscopies. To determine payment for the unrelated endoscopy, the multiple surgery rules are applied. The total payment for the related endoscopies is considered one service and the unrelated endoscopy is considered another service.

Fetal non-stress tests

Per American Medical Association (AMA) guidelines, bill multiple units on one claim line to receive proper reimbursement in the case of a twin gestation.

Gastric bypass surgery for morbid obesity

Gastric bypass surgery policy for morbid obesity is discussed in MSM Chapter 600, Attachment A, Policy #6-07.

Covered CPT codes are 43644, 43770-43774, 43842, 43845, 43846 and 43886-43888.

Hyalgan and synvisc injections

Hyalgan and synvisc injection policy is discussed in MSM Chapter 600, Attachment A, Policy #6-08.

Covered diagnosis codes are 715.16, 715.18, 715.26, 715.28, 715.36, 715.38, 715.96, 715.98 and 715.9.

Bill CPT code 20610 for this service. Submit the entire injection series on the same claim.

Hyperbaric oxygen therapy (HBOT)

Hyperbaric oxygen therapy (HBOT) policy is discussed in MSM Chapter 600, Attachment A, Policy #6-03.

Covered diagnosis codes for other than acute conditions are: 039.0-039.4, 039.8, 039.9, 444.21, 444.22, 444.81, 526.89, 707.15, 728.86, 730.10-730.19, 927.00-927.03, 927.09-927.11, 927.20-927.21, 927.8-927.9, 928.00-928.01, 928.10-928.11, 928.20-928.21, 928.3, 928.8-928.9, 929.0, 929.9, 929.90-929.99, 990 and 996.52.

Covered diagnosis codes for acute conditions are: 986, 993.2, 993.3, 987.7, 989, 958.0 and 999.1.

Bill CPT code 99183 for this service.

Intrathecal Baclofen Therapy (ITB)

Intrathecal Baclofen Therapy (ITB) policy is discussed in MSM Chapter 600, Attachment A, Policy #6-04.

Covered diagnosis codes for ITB are 340, 952.9, 781.0, 850.9 and 343.9 and 436.

Covered CPT codes are 99211-99215, 99355-99356, 62350, 62351, 62355, 62365, 62367, 62368 and 96530.



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Qualitative drug screening

For qualitative drug screening information, refer to the [Provider Type 43 Billing Guide](#).

Vagus Nerve Stimulator (VNS)

Vagus Nerve Stimulator (VNS) policy is discussed in MSM Chapter 600, Attachment A, Policy #6-06.

A 90-day global period applies to implantation.

Covered diagnosis codes for VNS are 345.41, 345.51 and 345.91.

Covered CPT codes are 99211-99215, 99355-99356, 62350, 62351, 62355, 62365, 62367, 62368 and 96530.

Wound Care

Wound management policy is discussed in MSM Chapter 600, Attachment A, Policy #6-02.

Prior authorization is required to exceed 24 wound treatments in a calendar year.

Bill the appropriate E/M and CPT code(s) for the management of both wound and burn care (e.g., 16000-16036, 97602 and 97110).

Healthy Kids (EPSDT)

The following EPSDT instructions do not apply to IHS providers.

Policy

The Early and Periodic Screening, Diagnostic and Treatment (*EPSDT*) program provides coverage for diagnostic and preventative services. It evaluates the physical and mental health, growth, development and nutritional status of infants, children and adolescents. In Nevada, the EPSDT program is known as *Healthy Kids*.

Refer to [MSM Chapter 1500](#) online at <http://dhcfp.nv.gov> for additional program information and for the periodicity and immunization schedules.

Covered services

A Healthy Kids exam is covered regardless of whether it falls within the recommended periodicity schedule. Ongoing treatment identified or referred from a Healthy Kids exam may require prior authorization.

The following services are considered part of a Healthy Kids exam and **should not be billed separately**:

- Consultation
- Hearing exam
- Hematocrit/Hemoglobin
- Lead screening
- Objective vision exam



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- Office visit
- PPD or tine test
- Urinalysis dipstick

Immunizations, certain laboratory tests and family planning services are covered benefits. Family planning information should be offered during a Healthy Kids exam as appropriate and requested. Bill these services on a separate claim line than the exam.

Developmental screenings are a covered benefit and may be billed separate from the Healthy Kids exam. See MSM, Section 1503.2 for requirements.

Medicaid also provides coverage for scheduled, **non-emergency transportation** to and from a Healthy Kids exam. Please contact Logisticare directly at (800) 486-7647 ext. 461 to arrange for transportation services. See the MSM [Chapter 1900](#) for additional information on Medicaid-covered travel services.

Exam codes

Use modifier EP or TS with the appropriate exam code in Table A.

- **Modifier EP** indicates a normal, routine screening.
- **Modifier TS** indicates that referral or follow-up services are recommended. When using modifier TS, complete Field 21 on the CMS-1500 claim form with the ICD-9 code that reflects the condition requiring follow-up.

Table A

Code	Modifier	Description
99381	EP or TS	New patient, infant (age under 1 year)
99382	EP or TS	New patient, early childhood (age 1-4)
99383	EP or TS	New patient, late childhood (age 5-11)
99384	EP or TS	New patient, adolescent (age 12-17)
99385	EP or TS	New patient, adult (age 18-20)
99391	EP or TS	Established patient, infant (age under 1 year)
99392	EP or TS	Established patient, early childhood (age 1-4)
99393	EP or TS	Established patient, late childhood (age 5-11)
99394	EP or TS	Established patient, adolescent (age 12-17)
99395	EP or TS	Established patient, adult (age 18-20)



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Services to be billed separately

Services listed in Table B are not considered part of a Healthy Kids exam and should be **billed separately**, on their own claim line.

Table B

Code	Modifier	Description
96110	59	Developmental Screening
99401	FP	Family Planning Services
D1203	No Modifier	Fluoride Varnish Application
90476-90749	No Modifier	Vaccines (Bill the appropriate vaccine code at a zero dollar amount.)
90471	No Modifier	Vaccine Administration – Single
90472	No Modifier	Vaccine Administration – Each Additional Unit

Non-covered services

Medicaid does not cover a **sick kid visit** and a Healthy Kids exam for the same recipient on the same date of service. A Healthy Kids exam should be rescheduled if the child is too ill to complete the exam.

Services that are **not medical in nature**, including educational interventions, are not Medicaid covered benefits.

Healthy Kids exams are not available to recipients who are Medicaid-eligible solely because of **pregnancy**.

Prior Authorization Requirements

Healthy Kids exams and diagnostics do not require prior authorization.

Any service that is not covered under the recipient's benefit plan or that exceeds program limitations, but is recommended as a result of a Healthy Kids exam, must be prior authorized.

Services referred as a result of a Healthy Kids exam may require prior authorization as described in the applicable MSM chapter.





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Prior authorization requests must include enough information to justify medical necessity. The requested service must be safe, effective and not considered experimental.

All **prior authorization forms** are available on the HP Enterprise Services website at <http://medicaid.nv.gov>. If you have prior authorization questions, please contact the Prior Authorization Department at **(800) 525-2395**.

Referrals

When services are referred as a result of a Healthy Kids exam, a written referral should be furnished to the recipient, the parent/guardian or the provider who will perform the referred service.

Referrals should include:

- Recipient's name
- Recipient ID
- Date
- Description of the abnormality
- Contact information for the recipient's primary physician (if different from the screening provider)
- Name of the provider who is to perform the referred service (if known)