Physician, M.D. and Osteopath, D.O., Advanced Practice Registered Nurses (APRN) and Physician's Assistant (PA)

Policy

Nevada Medicaid and Nevada Check Up reimburse Physicians, Advanced Practice Registered Nurses (APRNs) and Physician's Assistants (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 (Physician Services) for complete policy, coverage and limitations.

See MSM Chapter 1200 (Prescribed Drugs) for immunization/vaccine information.

See MSM Chapter 1500 Healthy Kids Program (EPSDT).

Rates

Rates information is on the DHCFP website at http://dhcfp.nv.gov (select "Rates" from the "Resources" menu). Rates are available on the Provider Web Portal at www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Electronic Verification System Provider Login (EVS) webpage under Resources (you do not need to login). Any provider-specific rates will not be shown in the Search Fee Schedule function.

Prior authorization (PA)

PA requirements for provider types 20, 24 and 77 are provided in MSM Chapter 600, Section 603.2, titled "Physician Office Services." Providers may also use the Authorization Criteria search function in the Provider Web Portal at www.medicaid.nv.gov to verify which services require authorization. Authorization Criteria can be accessed on the Provider Login (EVS) webpage under Resources (you do not need to login).

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.

Claims that reimburse in error are subject to recoupment.

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

Nevada Medicaid requires a National Drug Code (NDC) and an NDC quantity for each claim line with a physician-administered drug. For billing specifications, see the Nevada Medicaid NDC Billing Reference (select "NDC" from the "Providers" menu, then click "Billing Reference").

Vaccines

Nevada Medicaid and Nevada Check Up do not reimburse providers for Vaccines for Children (VFC) vaccines. Providers are encouraged to enroll with the **VFC program**, which provides free vaccines for eligible children.

Physician, M.D. and Osteopath, D.O., Advanced Practice Registered Nurses (APRN) and Physician's Assistant (PA)

To enroll as a VFC provider, visit the Nevada Division of Public and Behavioral Health (DPBH) website. Bill administration codes at the usual and customary charge, and bill vaccines at a zero dollar amount. See the Centers for Disease Control and Prevention (CDC) website for more information on the VFC program.

For claims beginning with date of service July 1, 2015, providers who service regular Medicaid and Nevada Check Up recipients may continue to bill for the vaccine administration using the most appropriate CPT code. All vaccine serum will now require National Drug Codes (NDCs) for Nevada Medicaid or Nevada Check Up. Providers must continue to use a zero rate for reimbursement for VFC vaccines, or the SL modifier. Even with a zero rate on the claim, quantity must be included on the claim or the claim will deny.

Vaccine claims are billed with the NDC and are limited to one vaccine per claim line and one unit of measure per individual product.

Bill non-VFC vaccinations with the NDC and the usual and customary rate.

Recognizing the difference between Nevada Check Up and regular Medicaid in the Electronic Verification System (EVS): The type of eligibility will not affect the new way of billing for vaccines, as both Nevada Check Up and regular Medicaid will be billed the same way. For information purposes, in the EVS, regular Medicaid is recognized with a Roman numeral XIX (19) and Nevada Check Up is recognized with a Roman numeral XXI (21).

HPV vaccine uses and restrictions

The following uses and restrictions for Human Papilloma Virus (HPV) vaccines Gardasil® and Cervarix® are in effect.

- Gardasil vaccine, formerly for females only, may be used for boys and young men age 9-26. Please note that for recipients age 9-18, Gardasil is reimbursed through the VFC Program.
- Cervarix vaccine is an FDA-approved HPV vaccine for females only age 9-26. For recipients age 9-18, Cervarix is reimbursed through the VFC Program.
- The three-dose HPV vaccine schedule for recipients over age 18 must begin and end before the recipient turns age 27. Medicaid cannot reimburse for any dose(s) given after the recipient turns 27 years of age, because the vaccine is not approved by the FDA for recipients over the age of 26.

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 www.medicaid.nv.gov and select "Billing Information" under the "Providers" menu, then click "Anesthesia" under the "Billing Instructions (by Service Type)" heading.

Annual Gynecological Exams

Providers may bill the following HCPCS codes for the annual gynecological exam for women age 21 and older:

- G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination)
- Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory)

Bariatric surgery for morbid obesity

Bariatric surgery policy for morbid obesity is discussed in MSM Chapter 600, Attachment A, Policy #6-07. Covered CPT codes are 43644, 43645, 43770-43775, 43842, 43845, 43846, 43860, 43865 and 43886-43888.

Botulinum toxin type A and type B

Medicaid covers Botulinum toxin Type A (onabotulinumtoxinA, abobotulinumtoxinA and incobotulinumtoxinA) and Type B (RimabotulinumtoxinB – MyoBloc).

Botulinum toxin policy is discussed in MSM Chapter 600, Attachment A, Policy #6-11. Covered diagnosis codes are: D31.60, G24.02, G24.1, G24.3, G24.4, G24.5, G24.8, G24.9, G25.89, G35, G36.0, G37.0, G37.1, G37.2, G37.3, G37.5, G37.9, G51.2, G51.4, G51.8, G80.3, G80.9, G81.11, G81.12, G81.13, G81.14, H49.00, H49.10, H49.20, H49.30, H49.40, H49.889, H50.00, H50.011, H50.012, H50.021, H50.022, H50.031, H50.032, H50.041, H50.042, H50.05, H50.06, H50.07, H50.08, H50.10, H50.111, H50.112, H50.121, H50.122, H50.131, H50.132, H50.141, H50.142, H50.15, H50.16, H50.17, H50.18, H50.21, H50.22, H50.30, H50.311, H50.312, H50.32, H50.331, H50.332, H50.34, H50.40, H50.411, H50.412, H50.42, H50.43, H50.50, H50.51, H50.52, H50.53, H50.54, H50.55, H50.60, H50.611, H50.612, H50.69, H50.811, H50.812, H50.89, H51.0, H51.11, H51.12, H51.20, H51.8, H51.9, J38.5, K60.2, M62.40, M62.838, M62.89, N39.41, N39.46.

Medicaid covers the following codes when electromyography (EMG) guidance is used: 95860, 95861, 95867- 95868, 95869, 95870, 95873 and 95874. Bill only one EMG per injection site.

Follow CPT guidelines for chemodenervation, including the appropriate National Drug Code (NDC) for agents used.

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.

The following dermatology CPT codes do not require a PA when billed by any provider type:

11004	11005	11006	11008	11057	11200	11301
11302	11303	11306	11307	11308	11310	11311
11312	11313	11400	11401	11402	11403	11404
11406	11420	11421	11422	11423	11424	11426
11440	11441	11442	11443	11444	11450	11451
11960	11970	11971	17004	17111	19370	19371

Developmental testing

Developmental testing (CPT code 96111) is covered and requires a PA.

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) E10.21, E10.29, E10.311, E10.319, E10.36, E10.39, E10.40, E10.51, E10.620, E10.621, E10.622, E10,628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.68, E10.69, E10.8, E10.9, E10.10, E10.11, E11.00, E11.01, E11.21, E11.29, E11.311, E11.319, E11.36, E11.39, E11.40, E11.51, E11.641, E11.65, E11.69, E11.8, E11.9, E74.8, E83.10, E83.19, E83.110, E83.111, E83.118, E83.119, O24.419, O24.429, O24.439, O24.93, O24.911, O24.912, O24.913, O24.93, O99.810, O99.814, O99.815.

Medicaid covers up to 10 hours of initial training. Repeat or additional training is covered only when a PA has been obtained. 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).

Endoscopic payment methodology

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.

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.

Essure Contraceptive System

The Essure Contraceptive System must be billed using CPT code 58565 for the procedure. The supply must be billed using HCPCS code A4264, which has been assigned a dollar rate.

CPT code 58565 does not require a PA. HCPCS code A4264 does not require PA. PA is required for the supply for dates of service on or before December 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.

Gender Reassignment Surgical Services

- Genital reconstruction surgery (GRS) services are a Medicaid covered benefit for PTs 20, 24 and 77. All GRS services require a PA, and the recipient must be age 18 or older, and have diagnosis of gender dysphoria. For additional GRS guidelines and information, please see MSM Chapter 600, Section 607.
- Covered diagnosis codes for gender identity disorders (gender dysphoria) include: F64.1, F64.2, F64.8, F64.9.

Physician, M.D. and Osteopath, D.O., Advanced Practice Registered Nurses (APRN) and Physician's Assistant (PA)

Providers may bill the following surgical codes for GRS services in conjunction with the KX modifier to bypass gender edits:

14000	14001	15200	15201	19303	19304	19316
19318	19324	19325	19340	19342	19350	53415
53420	53425	53430	54120	54125	54400	54401
54405	54406	54408	54410	54411	54415	54416
54417	54520	54522	54530	54535	54550	54560
54600	54620	54640	54650	54660	54670	54680
54690	55175	55180	55866	56620	56625	56800
56805	56810	57106	57107	57109	57110	57111
57291	57292	57295	57296	57335	57426	58150
58152	58180	58260	58262	58275	58580	58285
58290	58291	58541	58542	58543	58544	58550
58552	58553	58554	58570	58571	58572	58573
58660	58661	58720	58940			

Gene Analysis Testing

Use code Z80.42 when performing BRCA1/BRCA2 gene analysis testing for female recipients who have a family history of prostate cancer. Claims that contain ICD-10 diagnosis code Z80.42 (Family history of malignant neoplasm of prostate) will not deny with a gender edit when the recipient is identified as a female. Please refer to the PT 43 Billing Guide for additional information on billing and claims.

Hyalgan and Synvisc® injections

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

Covered diagnosis codes are M15.9, M17.10, M17.5, M17.9, M19.90, M19.91, M19.93.

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

Hyperbaric oxygen therapy (HBOT)

HBOT policy is discussed in MSM Chapter 600, Attachment A, Policy #6-03.

Bill CPT code 99183 for this service.

Covered diagnosis codes for other than acute conditions are: A42.0, A42.1, A42.2, A42.81, A42.82, A42.89, A43.8, B47.9, I74.2, I74.3, I74.5, L08.1, L97.509, M27.8, M72.6, M86.60, M86.619, M86.629, M86.639, M86.642, M86.659, M86.669, M86.679, M86.68, M86.69, S47.9XXA, S57.00XA, S57.80XA, S67.20XA, S67.30XA, S77.00XA, S77.10XA, S77.20XA, S87.00XA, S87.80XA, S97.00XA, S97.80XA, S97.109A, T66.XXXA, T86.820, T86.821.

Covered diagnosis codes for acute conditions are: T53.91XA, T55.0X1A, T55.0X2A, T55.0X3A, T55.0X4A, T55.1X1A, T55.1X2A, T55.1X3A, T55.1X4A, T57.3X1A, T57.3X2A, T57.3X3A, T57.3X4A, T57.8X1A, T57.8X2A, T57.8X3A, T57.91XA, T57.92XA, T57.93XA, T57.94XA, T58.01XA, T58.02XA, T58.03XA, T58.04XA, T58.11XA, T58.12XA, T58.13XA, T58.14XA, T58.2X1A, T58.2X2A, T58.2X3A, T58.2X4A,

T58.8X1A, T58.8X2A, T58.8X3A, T58.8X4A, T58.91XA, T58.92XA, T58.93XA, T58.94XA, T60.0X1A, T60.0X2A, T60.0X3A, T60.0X4A, T60.1X1A, T60.1X2A. T60.1X3A, T60.1X4A, T60.2X1A, T60.2X2A, T60.2X3A, T60.2X4A, T60.3X1A, T60.3X2A, T60.3X3A, T60.3X4A, T60.4X1A, T60.4X2A, T60.4X3A, T60.4X4A, T60.8X1A, T60.8X2A, T60.8X3A, T60.8X4A, T60.91XA, T60.92XA, T60.93XA, T60.94XA, T63.001A, T63.002A, T63.003A, T63.004A, T63.011A, T63.012A, T63.013A, T63.014A, T63.021A, T63.022A, T63.023A, T63.024A, T63.031A, T63.032A, T63.033A, T63.034A, T63.041A, T63.042A, T63.043A, T63.044A, T63.061A, T63.062A, T63.063A, T63.064A, T63.071A, T63.072A, T63.073A, T63.074A, T63.081A, T63.082A, T63.083A, T63.084A, T63.091A, T63.092A, T63.093A, T63.094A, T63.111A, T63.112A, T63.113A, T63.114A, T63.121A, T63.122A, T63.123A, T63.124A, T63.191A, T63.192A, T63.193A, T63.194A, T63.2X1A, T63.2X2A, T63.2X3A, T63.2X4A, T63.301A, T63.302A, T63.303A, T63.304A, T63.311A, T63.312A, T63.313A, T63.314A, T63.321A, T63.322A, T63.323A, T63.324A, T63.331A, T63.332A, T63.333A, T63.334A, T63.391A, T63.392A, T63.392A, T63.394A, T63.411A, T63.412A, T63.413A, T63.414A, T63.421A, T63.422A, T63.423A, T63.424A, T63.431A, T63.432A, T63.433A, T63.434A, T63.441A, T63.442A, T63.443A, T63.444A, T63.451A, T63.452A, T63.453A, T63.454A, T63.461A, T63.462A, T63.463A, T63.464A, T63.481A, T63.482A, T63.483A, T63.484A, T63.511A, T63.512A, T63.513A, T63.514A, T63.591A, T63.592A, T63.593A, T63.594A, T63.611A, T63.612A, T63.613A, T63.614A, T63.621A, T63.622A, T63.623A, T63.624A, T63.631A, T63.632A, T63.633A, T63.634A, T63.691A, T63.692A, T63.693A, T63.694A, T63.711A, T63.712A, T63.713A, T63.714A, T63.791A, T63.792A, T63.793A, T63.794A, T63.811A, T63.812A, T63.813A, T63.814A, T63.821A, T63.821A, T63.822A, T63.823A, T63.824A, T63.831A, T63.832A, T63.833A, T63.834A, T63.891A, T63.892A, T63.893A, T63.894A, T63.91XA, T63.92XA, T63.93XA, T63.94XA, T64.01XA, T64.02XA, T64.03XA, T64.04XA, T64.81XA, T64.82XA, T64.83XA, T64.84XA, T65.0X1A, T65.0X2A, T65.0X3A, T65.0X4A, T65.1X1A, T65.1X2A, T65.1X3A, T65.1X4A, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, T65.5X1A, T65.5X2A, T65.5X3A, T65.5X4A, T65.6X1A, T65.6X2A, T65.6X3A, T65.6X4A, T65.811A, T65.812A, T65.813A, T65.814A, T65.821A, T65.822A, T65.823A, T65.824A, T65.831A, T65.832A, T65.833A, T65.834A, T65.891A, T65.892A, T65.893A, T65.894A, T65.91XA, T65.92XA, T65.93XA, T65.94XA, T70.20XA, T70.29XA, T70.3XXA, T79.0XXA, T80.0XXA.

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 G35, G80.9, I67.89, R25.0, R25.1, R25.2, R25.3, R25.9, S06.0X0A, S14.109A, S24.109A, S34.109A, S34.139A.

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

Medical Nutrition Therapy

Medical Nutrition Therapy services are reimbursable under PT 15 (Registered Dietitian). Please refer to the PT 15 Billing Guide for medical nutrition therapy information.

Podiatry

Podiatry services are reimbursable under PT 21. Please refer to the PT 21 Billing Guide for podiatry information.

Presumptive and Definitive Drug Screening and Testing

For presumptive and definitive drug screening and testing information, refer to the Provider Type 43 Billing Guide.

Preventive Screenings

Preventive Services for men, women, and children are covered as recommended by the U.S. Preventive Task Force (USPSTF) A & B recommendations. No PA is required for these services.

Radiology codes payable for PTs 24 and 77

Effective on claims with dates of service on or after January 1, 2016, provider types 24 (Advanced Practice Registered Nurses) and 77 (Physician's Assistant) are reimbursed for radiology codes (70000-79999).

Routine Office Visits

Routine office visits must be billed with the appropriate level of Evaluation and Management (E&M) CPT codes. System reviews (i.e. eyes, cardiovascular, respiratory, skin, constitutional) are included in an office visit. System reviews may be billed separately only when a separate, identifiable need is present and must be reflected in the patient file).

Tobacco Cessation Counseling for Pregnant Women

CPT codes 99406 and 99407 are used to bill tobacco cessation counseling for pregnant women only. For all other recipients, these services are billed using the appropriate Evaluation and Management (E&M) office visit code.

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 G40.111, G40.119, G40.211, G40.219, G40.911, G40.919.

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.

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).

Fetal Ultrasound Codes

The following table offers a guideline for fetal ultrasound CPT codes:

Code	Description	Gestation	Approved Indications
76801	Fetal/maternal eval	<14 weeks	• Once per pregnancy
76805	Fetal and maternal eval after first trimester	>14 weeks	• Payable one time only, per practice • To screen for congenital malformation • To exclude multiple pregnancy • To verify dates and growth • To identify placental position • Non-payable if 76811 has been utilized, unless a significant 2nd diagnosis
76811	Fetal and maternal eval w/detailed fetal anatomic exam	14-26 weeks	• Payable one time only, per practice • To screen for congenital malformation • To exclude multiple pregnancy • To verify dates and growth • To identify placental position
76813	Fetal nuchal translucency measurement	< 14 weeks	One time only with calculation of risk based on: • Maternal age • Human chorionic gonadotropin • Pregnancy-associated plasma protein A
76815	Limited (fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume, one or more fetuses)		• To answer specific questions required • Investigation • In an emergency to verify cardiac activity • To verify fetal presentation during labor • Generally not appropriate if a prior complete exam is not on record
76816	Follow up to eval fetal size, amniotic fluid volume or re-eval of organ system	26+ weeks	• Follow up fetal size, assess for growth • Re-evaluation of organ system • Verify placental position ○ Records must clearly state what the previous growth was. Follow up ultrasound to evaluate growth is not payable if the growth was noted to be within normal limits on the initial ultrasound, unless there is a medical reason to suspect aberrant growth (e.g. chronic hypertension, diabetes, maternal obesity, multifetal gestation, prior macrosomic fetus)

76817	Transvaginal	Dependent on diagnosis	• To confirm pregnancy • To r/o ectopic or molar pregnancies • To confirm cardiac pulsation • To measure crown rump length • To identify number of gestational sacs • To evaluate vaginal bleeding • To monitor cervix in cases of incompetent cervix, or maternal history of premature delivery < 35 weeks
76818	Fetal biophysical profile with non-stress testing	Third trimester	• High risk for significant fetal academia • Suspected fetal compromise • Increased risk of stillbirth • Significant deterioration in clinical status • Severe oligohydramnios
76820	Doppler velocimetry, fetal; umbilical artery		• Allowed only in cases with documented as asymmetrical IUGR • Oligohydramnios • Discordant twins
76821	Doppler velocimetry, fetal; middle cerebral artery		• To determine fetus at risk for anemia (e.g., red blood cell iso-immunization, parvovirus infection) • Poor fetal growth affecting management of mother
76825	Echocardiography Fetal		Once per pregnancy for: • A potential defect noted in the original ultrasound (76805 or 76811) • A high risk of a potential heart defect (congenital history parent or sibling, abnormal screen) • Extra cardiac abnormality • Increased risk of chromosomal abnormality • Fetal cardiac arrhythmia • Non-immune hydrops • Question of cardiac anomaly on prior sonogram • IUGR • Teratogenic exposure (alcohol, amphetamines, anticonvulsives, lithium) • Maternal disorders (diabetes, collagen vascular disease, PKU, rubella, inherited familial syndromes)
76826	Follow up study; fetal echocardiography		Once per pregnancy if: • 76825 is abnormal earlier in the pregnancy and the F/U up scan will alter or affect the treatment plan

76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display complete		Once per pregnancy: • Where a potential defect was noted in the original ultrasound (76805 or 76811) • When there is high risk of a potential heart defect (congenital history, abnormal screen) • **Requires Prior Authorization**
76828	Follow up or repeat study of Doppler echocardiography, fetal		Once per pregnancy if: • 76827 was abnormal earlier in the pregnancy and the follow up study will alter the treatment plan • **Requires Prior Authorization**
93325	Color flow mapping		• If echocardiography is questionable or ambiguous • If diagnosis depends on hemodynamic evaluation of intracardiac circulation which can only be obtained by Doppler • When the diagnosis rests on measuring the fetal cardiac output • To more precisely define a complicated diagnosis • Add-on code and must be used in conjunction with 76825, 76826, 76827 or 76828

Telehealth Services

Providers must follow guidelines set forth in MSM Chapter 3400 (Telehealth Services). A licensed professional operating within the scope of their practice under state law may provide the following Telehealth services for Medicaid recipients:

- annual wellness visits;
- diabetic outpatient self-management;
- documented psychiatric treatment in crisis intervention (e.g., threatened suicide); and
- office or other outpatient visits.

Originating site: Use procedure code Q3014.
Distant site: Use the appropriate procedure code for the service provided with the GT modifier.

Healthy Kids (EPSDT)

The following EPSDT instructions do not apply to Indian Health Services (IHS) providers.

Policy

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program provides coverage for diagnostic and preventive 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.

See MSM Chapter 1200 for additional immunization/vaccine information.

Providers can access the EPSDT screening forms from the Division of Health Care Financing and Policy (DHCFP) EPSDT webpage at http://dhcfp.nv.gov/Pgms/CPT/EPSDT/.

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 a PA.

Vaccines, 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.

Use CPT codes 90460 and 90461 to bill for vaccine administration for recipients age 0 through 18.

Developmental screenings are a covered benefit and may be billed separate from the Healthy Kids exam. See MSM Chapter 1500, Section 1503.2 for requirements.

Medicaid also provides coverage for scheduled, **non-emergency transportation** to and from a Healthy Kids exam. Please contact Medical Transportation Management (MTM) directly at (844) 879-7341 to arrange for transportation services. See MSM Chapter 1900 for additional information on Medicaid-covered travel services.

Exam codes

Use CPT codes 99381-99385 and 99391-99395 to bill for a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s), laboratory/diagnostic procedures. Additional specifications are listed in the table below.

Use modifier EP or TS with the appropriate exam code in the table below.

- **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 most current diagnosis code(s) that reflects the condition requiring follow up.
- **Modifier 25** must be used with other non-preventive medicine Evaluation & Management (E&M) services (e.g., codes 99212-99215) when reported in conjunction with vaccine administration when the E&M service is significant and separately identifiable. (See Web Announcement 565 for additional instructions for the use of modifiers 25 and EP with vaccine and vaccine administration codes.) Continue to use EP and TS modifiers as well.

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)

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Code	Modifier	Description
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)

Services to be billed separately

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

Code	Modifier	Description
90460	No Modifier	Immunization Administration through 18 years of age; first vaccine/toxoid component (Bill at the usual and customary charge)
90461	No Modifier	Immunization Administration through 18 years of age; each additional vaccine/toxoid component (Add-on code to 90460)
90471	No Modifier	Vaccine Administration – Single
90472	No Modifier	Vaccine Administration – Each Additional Unit
90476-90749	No Modifier	Vaccines (Bill the appropriate vaccine code at a zero dollar amount.)
96110	59	Developmental Screening
96160	No Modifier	Administration of patient-focused health risk assessment instrument
96127	No Modifier	Brief emotional/behavioral assessment (e.g., Depression inventory, ADHD) with scoring and documentation per standardized instrument
99174	No Modifier	Instrument-based ocular screening. Note: Screening for amblyopia may be separately reimbursed.
99188	No Modifier	Application of fluoride varnish by physician or other qualified health care professional
99401	FP	Family Planning Services

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.**

PA Requirements

Healthy Kids exams and diagnostics do not require prior authorization.

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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 a PA as described in the applicable MSM chapter.

PA requests must include enough information to justify medical necessity. The requested service must be safe, effective and not considered experimental. All **PA forms** are available on the Nevada Medicaid website at www.medicaid.nv.gov. Some services may be requested online through the Provider Web Portal.

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)