Physician, M.D. and Osteopath, Advanced Practitioner of Nursing (APN) and 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."

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 a National Drug Code (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 (select "NDC" from the "Providers" menu, then click "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.

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

Annual Wellness Visits

Use HCPCS codes G0438 (Annual Wellness Visit; includes a personalized prevention plan of service (pps), initial visit) and G0439 (Annual Wellness Visit; includes a personalized prevention plan of service (pps), subsequent visit). These codes can be billed once every 12 months (365 days) per recipient only for recipients age 21 and older.

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

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: 95860, 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: 550.0-550.9, 556.0-556.9, V10.05-V10.06, V12.72, V16.80, V18.5
CPT codes: 45330, 45378, 82270, 74270.

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 January 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 January 1, 2011, 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.

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.

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.

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.

Qualitative drug screening

For qualitative drug screening information, refer to the Provider Type 43 Billing Guide.

Tobacco Cessation Counseling for Pregnant Women

As of October 13, 2011, 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 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).

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,		• 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

Code	Description	Gestation	Approved Indications
	one or more fetuses)		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

Code	Description	Gestation	Approved Indications
			• 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

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."

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

Refer to MSM Chapter 1500 online at https://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.

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.

Use CPT codes 90460 and 90461 to bill for immunization 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 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 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 ICD-9 code that reflects the condition requiring follow up.

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)

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
96110	59	Developmental Screening
99401	FP	Family Planning Services
D1203	No Modifier	Fluoride Varnish Application
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)
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.

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://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)