



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. Providers shall follow current national guidelines, recommendations and standards of care.

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, and for Botulinum Toxin injections.

See [MSM Chapter 1100 Ocular Services](#)

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) Requirements

PA requirements for provider types 20, 24 and 77 are provided in [MSM Chapter 600, Physician Services](#), Section 603.2, titled "Provider 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), an NDC quantity and the Healthcare Common Procedure Coding System (HCPCS) code 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

Vaccinations are a covered preventative health services benefit. All childhood and adult vaccinations, per the Advisory Committee on Immunization Practices (ACIP), are covered without prior authorization.

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. To enroll as a VFC provider, visit the [Nevada Division of Public and Behavioral Health \(DPBH\)](#) website. Bill administration codes at the



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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.

When Third Party Liability (TPL) is present, providers are allowed to bill Nevada Medicaid directly for VFC administration fees without first obtaining a denial from the primary insurer. Providers do not need to submit the primary carrier's denied Explanation of Benefits (EOB) to Nevada Medicaid. Refer to the EVS User Manual Chapter 3 for instructions on completing the claim when TPL information is present. See [Web Announcement 1941](#) for instructions on billing services that are not covered by the recipient's other health coverage.

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 males and females up to 45 years of age. 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 9-25. 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 [MSM Chapter 1200, Prescribed Drugs](#) or the Centers for Disease Control and Prevention (CDC) website

https://www.cdc.gov/vaccines/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fdefault.htm or the FDA vaccine website <https://www.fda.gov/vaccines-blood-biologics/vaccines>.

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.

Gynecological Exams

Providers may bill the following HCPCS codes for the gynecological exam for women. 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 Task Force (USPSTF) recommendations.



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- 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, Physician Services](#), Attachment A, Policy #6-07. Covered CPT codes are 43644, 43645, 43770-43775, 43842, 43845, 43846, 43860, 43865 and 43886-43888.

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, Physician Services](#), 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



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multiple surgery rules are applied. The total payment for the related endoscopies is considered one service and the unrelated endoscopy is considered another service.

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, Physician Services](#), Section 607.
- Covered diagnosis codes for gender identity disorders (gender dysphoria) include: F64.1, F64.2, F64.8, F64.9.

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	19316	19318
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	58280	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, Physician Services](#), 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, Physician Services](#), 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,



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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, Physician Services](#), 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.



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Ocular Services

For recipients of all ages, Medicaid covers:

- Exams (annual exams or exams for medical reasons)
- Ocular medical services (e.g., eye infection, foreign body in eye, glaucoma, cataract services)
- Ocular prosthesis
- Vision therapy
- Qualifying eyeglass lenses and frames with a prescription
- Polycarbonate Lenses

Prior authorization is required for procedure code V2784 (Lens, polycarbonate or equal, any index, per lens) for recipients age 21 and older when the service limit of 2 units per 12 months per recipient is exhausted. Prior authorization is required for the following codes delivered to individuals age 21 and older when the service limit is exhausted. The service limitation is one (1) visit every 12 months rolling:

92002	Eye exam new patient
92004	Eye exam new patient, comprehensive
92012	Eye exam established patient
92014	Eye exam and treatment for established patient, comprehensive, one or more visits
92015	Determine refractive state
92018	New eye exam and treatment, under general anesthesia
92019	Eye exam and treatment, limited
92020	Special eye evaluation
92060	Special eye evaluation
92081	Visual field examination(s)
92082	Visual field examination(s), intermediate
92083	Visual field examination(s), extended
V2020	Vision services, frames

Ocular examinations performed for medical conditions are considered a regular physician visit; payment may be recouped if the above codes are billed for a medical service. Procedure codes 92002 and 92012 are used when providing examination services, such as prescribing lenses.

Service Groups: Multiple claims from a single service group may not be billed within a 12-month rolling period unless a PA is submitted and approved. Recipients age 20 and under are exempt from this requirement.

- Procedure codes 92002, 92004, 92012 and 92014
- Procedure codes 92015, 92018, 92019, 92020, 92060, 92081, 92082 and 92038

Podiatry

Podiatry services are reimbursable under PT 21. Please refer to the [PT 21 Billing Guide](#) for podiatry information.



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Presumptive and Definitive Drug Screening and Testing

For presumptive and definitive drug screening and testing information, refer to the [PT 43 Billing Guide](#).

Preventive Screenings

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

Progesterone Therapy

Progesterone therapy to prevent preterm birth is a covered benefit for Nevada Medicaid recipients. Progesterone therapy is a hormone that helps the uterus to grow and prevent contractions. There are two types of progesterone therapy:

- Vaginal progesterone – to prevent preterm birth when a recipient has a short cervix and is pregnant with only one baby. Vaginal progesterone begins before or up to 24 weeks of pregnancy and continues until 37 weeks.
- Progesterone shots – to prevent preterm birth when a recipient had a previous spontaneous premature birth and is pregnant with only one baby. Progesterone shots begin between weeks 16 and 24 and continue until 37 weeks.

Progesterone therapy is not intended for women who are pregnant with multiples.

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).

- **Attention PTs 20, 24 and 77:** When presented with a need to submit a claim for a radiology code with modifier RT (right side) and modifier LT (left side), bill the radiology code with both modifiers on one claim line with 2 units. Claims submitted with modifiers RT and LT on separate lines will deny with edit code 1111 (Unbundling of professional/technical portions of radiology).

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).

Smoking/Tobacco Cessation Counseling

Current Procedural Terminology (CPT) codes 99406 (Smoking and tobacco use cessation counseling visit, intermediate, 3-10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes) may be used to bill smoking cessation counseling for all Nevada Medicaid recipients. Procedure codes 99406 and 99407 are no longer restricted to counseling for pregnant women only. The limitation for both codes is a maximum of 24 encounters per year. These limitations can be exceeded if determined medically necessary by Nevada Medicaid.

Vagus Nerve Stimulator (VNS)

Vagus Nerve Stimulator (VNS) policy is discussed in [MSM Chapter 600, Physician Services, 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.



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Wound Care

Wound management policy is discussed in [MSM Chapter 600, Physician Services](#), 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	<ul style="list-style-type: none">Once per pregnancy
76805	Fetal and maternal eval after first trimester	>14 weeks	<ul style="list-style-type: none">Payable once per trimesterTo screen for congenital malformationTo exclude multiple pregnancyTo verify dates and growthTo identify placental positionNon-payable if 76811 has been utilized, unless a significant 2nd diagnosis
76811	Fetal and maternal eval w/detailed fetal anatomic exam	14-26 weeks	<ul style="list-style-type: none">Payable one time only, per practiceTo screen for congenital malformationTo exclude multiple pregnancyTo verify dates and growthTo identify placental position
76813	Fetal nuchal translucency measurement	< 14 weeks	One time only with calculation of risk based on: <ul style="list-style-type: none">Maternal ageHuman chorionic gonadotropinPregnancy-associated plasma protein A
76815	Limited (fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume, one or more fetuses)		<ul style="list-style-type: none">To answer specific questions requiredInvestigationIn an emergency to verify cardiac activityTo verify fetal presentation during laborGenerally 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	<ul style="list-style-type: none">Follow up fetal size, assess for growthRe-evaluation of organ systemVerify placental position<ul style="list-style-type: none">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)



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Code	Description	Gestation	Approved Indications
76817	Transvaginal	Dependent on diagnosis	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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		<ul style="list-style-type: none">• Allowed only in cases with documented as asymmetrical IUGR• Oligohydramnios• Discordant twins
76821	Doppler velocimetry, fetal; middle cerebral artery		<ul style="list-style-type: none">• 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		<p>Once per pregnancy for:</p> <ul style="list-style-type: none">• 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		<p>Once per pregnancy if:</p> <ul style="list-style-type: none">• 76825 is abnormal earlier in the pregnancy and the F/U up scan will alter or affect the treatment plan



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Code	Description	Gestation	Approved Indications
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display complete		Once per pregnancy: <ul style="list-style-type: none">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)
76828	Follow up or repeat study of Doppler echocardiography, fetal		Once per pregnancy if: <ul style="list-style-type: none">76827 was abnormal earlier in the pregnancy and the follow up study will alter the treatment plan
93325	Color flow mapping		<ul style="list-style-type: none">If echocardiography is questionable or ambiguousIf diagnosis depends on hemodynamic evaluation of intracardiac circulation which can only be obtained by DopplerWhen the diagnosis rests on measuring the fetal cardiac outputTo more precisely define a complicated diagnosisAdd-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 in addition to the appropriate Place of Service (POS) code and modifier.

Please review the [Telehealth Billing Instructions](#) for additional information, including a list of POS codes and modifiers.

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, Healthy Kids Program](#) for additional program information and for the periodicity and immunization schedules. See [MSM Chapter 1200, Prescribed Drugs](#) 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/>.



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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, Healthy Kids Program](#), 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, Transportation Services](#), 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)
99385	EP or TS	New patient, adult (age 18-39)
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 18-39)



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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	Vaccine Administration through 18 years of age; first vaccine/toxoid component (Bill at the usual and customary charge)
90461	No Modifier	Vaccine 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

Medicaid may cover a Sick Visit and a Healthy Kids examination for the same recipient, at the same time of service, and for the same provider. All screening elements must be completed during a Healthy Kids examination as indicated in the Periodicity Schedule/Bright Futures and MSM Chapter 1500. Appropriate diagnosis and modifiers must be billed for each respective visit. Vaccines may be administered during a Sick Visit at the medical professional's discretion.

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 (PA) 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 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.



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Referrals should include:

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