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 Nevada Medicaid website at nevadamedicaid.nv.gov (select "Rates" from the "Resources" menu). Rates are available on the Provider Web Portal at medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Provider Web Portal (PWP) 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 medicaid.nv.gov to verify which services require authorization. Authorization Criteria can be accessed on the Provider Login (PWP) webpage under Resources (you do not need to login).

Transplants

Submit outpatient medical/surgical authorization requests as soon as the recipient is placed on a wait list and include PT 12 or PT 20 as the rendering provider and the transplant CPT code. Dates of service requested will be 365 days. This request will be reviewed for medical necessity of the service.

Once the organ is available and the recipient is admitted to the hospital, an inpatient medical/surgical authorization request must be submitted to cover the inpatient stay.

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

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 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 PWP 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 PWP: 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 PWP, 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.

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

For additional HPV guidelines and information, please see MSM Chapter 1200, Prescribed Drugs or the Centers for Disease Control and Prevention (CDC) website cdc.gov/vaccines/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fdefault.htm or the FDA vaccine website fda.gov/vaccines-blood-biologics/vaccines.

Anesthesia

For instructions on billing anesthesia services (including obstetrical deliveries and Botulinum toxin Type A), go to medicaid.nv.gov and select "Billing Information" under the "Providers" menu, then click "Anesthesia" under the "Billing Instructions (by Service Type)" heading.

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.

Behavior Health

Please refer to the PT 14 or PT 26 Billing Guide for behavior health services information.

Behavioral Health Integration

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

The complete policy requirements for these services are located in MSM chapter 600, Attachment A, Policy #6-14.

Covered procedure codes include the following:

Procedure Code	Procedure Code Description
99492	Initial Psychiatric Collaborative Care Management, first 70 minutes in the first calendar month
99493	Subsequent Psychiatric Collaborative Care Management, first 60 minutes in a subsequent month
99494 (Add-on Code)	Initial or Subsequent Psychiatric Collaborative Care Management, each additional 30 minutes in a calendar month
G2214	Initial or Subsequent Psychiatric Collaborative Care Management, first 30 minutes in a month

Use G2214 when the services provided do not meet the time requirement for 99492 or 99493.

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

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 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.

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.

- 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)

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,

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

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, 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.

Maternity Services

Nevada Medicaid covers antepartum care, labor, delivery, and postpartum care. See MSM 600 Physician Services for complete coverage information.

Non-emergency antepartum care is not a covered benefit for non-U.S. citizens eligible for emergency medical only (EMO) coverage. Refer to the Emergency Medicaid Only Billing Instructions for additional details on coverage.

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

Delivering Provider

Labor and delivery services include home delivery, admission to the hospital, or a freestanding birthing center, the admission history and physical examination, management of uncomplicated labor, and delivery (vaginal delivery with or without an episiotomy/operative delivery (vacuum or forceps)), or cesarean delivery). Postpartum care includes hospital and office visits following delivery.

Whenever possible, medical care provided during pregnancy, including antepartum/prenatal care, labor and delivery, and postpartum care should be billed using the global obstetrical (OB) CPT codes. A global OB payment will be paid to the delivering provider if they have seen the recipient at least 7 times for prenatal care, performed the delivery, and provide postpartum care.

The following table offers a guideline for delivery CPT codes:

Services Rendered	Current Procedural Terminology (CPT) Codes and Description
Delivery only (no antepartum or postpartum care provided)	• 59409 - Vaginal delivery • 59514 - Cesarean delivery • 59612 - Vaginal delivery after previous cesarean (VBAC) • 59620 - Cesarean delivery following attempt of vaginal delivery after previous VBAC
Delivery with postpartum care (no antepartum care provided)	• 59410 - Vaginal delivery with postpartum care • 59515 - Cesarean delivery with postpartum care • 59614 - Vaginal delivery after previous cesarean (VBAC) with postpartum care • 59622 - Cesarean delivery following attempt of vaginal delivery after previous VBAC with postpartum care
Delivery with less than 7 prenatal visits (no postpartum care)	Routine prenatal visits should be billed using appropriate E/M or Antepartum CPT codes, following the Antepartum Care Schedule. Bill *Delivery Only* codes separately.
Delivery with less than 7 prenatal visits, and postnatal care	Routine prenatal visits should be billed using appropriate E/M or Antepartum CPT codes, following the Antepartum Care Schedule. Bill *Delivery with postpartum care* separately.
Global OB Services (7+ prenatal visits, delivery, and postpartum care)	• 59400 - Vaginal Delivery with routine antepartum and postpartum care • 59510 - Cesarean with routine antepartum and postpartum care • 59610 - Vaginal delivery after previous cesarean (VBAC) with routine antepartum and postpartum care • 59618 - Cesarean delivery following attempt of vaginal delivery after previous VBAC, with routine antepartum and postpartum care

Transfer of Care

If a provider provides all or part of the antepartum and/or postpartum care but does not perform delivery due to termination of the pregnancy, or referral to another provider, then reimbursement is based upon the antepartum and postpartum care CPT codes.

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

The following table offers a guideline for antepartum or postpartum CPT codes:

Antepartum Visits completed	CPT Codes and Descriptions
1-3 routine visits	Bill individual visits, using appropriate E/M CPT codes, following visit schedule.
4-6 routine visits	59425 - Antepartum care only, 4-6 visits
7 + routine visits	59426 - Antepartum care only, 7 or more visits
Postpartum care only	59430 - Postpartum care only

Antepartum Care Schedule

Antepartum care is defined as routine prenatal visits following the antepartum visit schedule that includes:

- The initial visit,
- Monthly visits up to 28 weeks gestation,
- Bi-weekly visits to 36 weeks gestation, and
- Weekly visits until delivery.

Up to 13 antepartum visits are covered for routine physical examinations that include recording of weight, blood pressures, fetal heart tones, and routine chemical urinalysis.

Non-Routine Maternity Care/Complications of Pregnancy

Visits occurring outside of the Antepartum Care Schedule for complications of pregnancy or non-routine care are billable by using the appropriate E/M CPT codes. Use modifier 25 to indicate a separately identifiable service.

NOTE: Non-routine visits within the global surgical period will deny when billed with a normal pregnancy diagnosis or gestational age diagnosis (Z33.1, Z34.00, Z34.80, Z34.90, or Z3A.0 - Z3A.49). Diagnosis' pointed on the claim line should indicate the complication/reason for the additional visit only.

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 once per trimester • 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

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

Code	Description	Gestation	Approved Indications
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 heartbeat, 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

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

Code	Description	Gestation	Approved Indications
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)
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

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

Code	Description	Gestation	Approved Indications
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

Lactation Services and Breastfeeding Pumps and Supplies

Lactation services conducted by a qualified, non-enrolled lactation health care professional, such as an International Board Certified Lactation Consultant (IBCLC), can be billed under a PT 20 (Physician), PT 24 (APRN), and PT 77 (Physician's Assistant) and may include procedure codes 96156 through 96171. Procedure code S9443 is not a covered code. For further information on how to bill for lactation services, please see the American Academy of Pediatrics, Supporting Breastfeeding and Lactation: The Primary Care Pediatrician's Guide to Coding, 2022.

Breast pumps and supplies are covered **for Nursing Mothers with infants up to 12 months of age**. In the outpatient setting, PT 20 (Physician), PT 24 (APRN), and PT 77 (Physician's Assistant) are able to deliver these items to Nevada Medicaid recipients and be reimbursed for the codes below. Please note that hospital grade electric breast pumps (prior authorized), and replacement breast pump supplies, can be prescribed through Durable Medical Equipment (DME).

Code	Description	Service Limitations
E0602	Manual Breast Pump Rental or Purchase	RR (rental) – 1 unit per mo for 10 mos NU (purchase) – 1 unit per 3 yrs
E0603	Electric Breast Pump Rental or Purchase	RR (rental) – 1 unit per mo for 10 mos NU (purchase) – 1 unit per 3 yrs
A4287	Disposable collection and storage bag for breast milk	200 units per 30 rolling days

Prior authorization for breast pumps and supplies are required when service limitations are exhausted.

Inpatient Hospital Care Including Critical Care

The following scenarios apply when a provider has already billed initial and/ or subsequent hospital care services in one day for one recipient:

1. Providers of the **same billing group** with the **same rendering provider specialty**:
    - **May not** be reimbursed for 99221-99223, 99231-99233, or 99252–99255 on the same DOS/ same recipient since another provider of the same group with the same specialty has already billed one of these codes.
    - **May** be reimbursed for 99291 and 99292 (if applicable) on the same DOS for the same recipient as any of

the codes listed above if critical care is necessary, regardless of what code or provider bills first.

2. Physicians of a **different billing group** with the **same rendering provider specialty**:
    - **May** be reimbursed for 99221-99223, 99231-99233, or 99252–99255 on the same DOS/ same recipient but only once per day, per provider of a different group with the same specialty.
    - **May** be reimbursed for 99291 and 99292 (if applicable) on the same DOS for the same recipient as any of the codes listed above if critical care is necessary, regardless of what code or provider bills first.
3. Physicians of the **same billing group or different billing groups** with **different rendering provider specialties**:
    - **May** be reimbursed for 99221-99223, 99231-99233, or 99252–99255 on the same DOS/ same recipient but only once per day, per provider of the same group or different groups with different specialties.
    - **May** be reimbursed for 99291 and 99292 (if applicable) on the same DOS for the same recipient as any of the codes listed above if critical care is necessary, regardless of what code or provider bills first.

COVID-19 Testing

Nevada Medicaid covers COVID-19 diagnostic and serology antibody testing up to twice per rolling month for each recipient. If additional testing is deemed medically necessary, a prior authorization may be submitted.

Code	Description
87635	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), amplified probe technique
87636	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) and influenza virus types A and B, multiplex amplified probe technique
87637	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique
87811	Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19])

Biofeedback Services

Nevada Medicaid covers code 90901 (Biofeedback training by any modality) for up to 6 units per 4-week period. If additional services are medically necessary, providers may submit a request for prior authorization. This code applies to any of several modalities of biofeedback training used for treatment of conditions including, but not limited to, high blood pressure, incontinence, Raynaud's syndrome, and anticipatory nausea due to chemotherapy.

Please note, codes 90875 or 90876 should be utilized for Individual psychophysiological therapy incorporating biofeedback training by any modality. These codes should be billed when the treating clinician gives individual psychophysiological therapy by utilizing biofeedback training together with psychotherapy to modify behavior. Please see the PT 14 Billing Guide for more information.

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.

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

Ocular Services

Please refer to the Provider Type 25-41 Billing Guide for ocular coverage 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 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

Radiology services are payable to PTs 20, 24 and 77.

When submitting a claim for a radiology code with modifier RT (right side) and modifier LT (left side), bill the radiology codes on separate claim lines.

When billing for only the technical component, use modifier TC (Technical Component). If only the professional component was completed, apply modifier 26 (Professional Component).

Note: Modifiers TC and 26 cannot be billed with global procedure codes for the same recipient and same date of service. Global services include both the professional and technical components of a service and therefore will deny with error code 6134 (Unbundling of technical/professional modifiers).

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.

Wound Care Management

For further information on medically necessary wound care applications and skin substitutes, please refer to Medicaid Services Manual (MSM) Chapter 600, Physician Services, Attachment A, #6-02 and to the Nevada Medicaid Fee For Service (FFS) Fee Schedule.

The following skin substitutes are billable and require prior authorization: Q4133, Q4186, Q4101. Either the signed and dated treatment plan or the letter of medical necessity must be uploaded with the Outpatient Medical/Surgical Services Prior Authorization Request (Form FA-6).

The following application codes are billable without a prior authorization: 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278.

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 billing guidelines do not apply to Indian Health Services (IHS) providers.

In Nevada, the EPSDT Program is known as "Healthy Kids." Refer to MSM Chapter 1500, Healthy Kids Program for benefit coverage, limitation information, and for the periodicity schedules.

Appropriate vaccinations that are due must be administered according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines. See MSM Chapter 1200, Prescribed Drugs for additional

immunization/vaccine information.

Providers can access EPSDT screening forms from the Nevada Medicaid EPSDT webpage at nevadamedicaid.nv.gov/programs/epsdt-healthy-kids/.

A Healthy Kids exam can be billed either when it aligns with the established periodicity schedule or when it takes place outside of the scheduled recommendations.

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.

For Medicaid recipients seeking assistance in accessing Healthy Kids (EPSDT) case management services, call the statewide Medicaid customer service line at (702) 668-4200 or (775) 687-1900, and a Health Care Coordinator will be assigned to assist.

Exam codes

Use comprehensive preventive medicine Evaluation and Management (E&M) CPT codes 99381-99385 and 99391-99395 to bill for services delivered to an individual. Additional specifications are listed in the table below.

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)

Use modifier EP or TS with the appropriate exam code in the list 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 by the same physician on the same day of the procedure or other service. Continue to use EP and TS modifiers as well.

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

Services to be billed separately

If hearing and vision testing needs to be performed separately from the exam, these procedures must be billed as outlined in applicable MSM chapters.

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.)
92060	No Modifier	Sensorimotor examination with multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
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

Prior Authorization (PA) Requirements

Healthy Kids exams do not require prior authorization.

Diagnostic services and/or treatment identified or referred from a Healthy Kids exam may require a PA. Any service that is not covered under the state plan or that exceeds program limitations must be prior authorized. See the appropriate billing guide by service type for PA requirements.

All Fee-for-Service prior authorizations must be submitted online through the Provider Web Portal at medicaid.nv.gov. Any necessary forms are available on the Nevada Medicaid provider website. If you have prior authorization questions, please contact the Gainwell Technologies Prior Authorization Department at (800) 525-2395.

All Managed Care prior authorizations must be submitted according to the specific plan requirements. Contact the individual health plan with questions or for more information.