ADOPTED REGULATION OF THE

STATE BOARD OF HEALTH

LCB File No. R095-99

Effective November 29, 1999

EXPLANATION – Matter in ***italics*** is new; matter in brackets ~~[omitted material]~~ is material to be omitted.

AUTHORITY: §§1-11, 16, NRS 439.200, 442.140 and 442.190; §§12-14, NRS 439.200 and 442.190; §15, NRS 439.200 and 442.140.

Section 1. Chapter 442 of NAC is hereby amended by adding thereto a new section to read as follows:

"Nevada Check Up" means the program established pursuant to 42 U.S.C. §§ 1397aa to 1397jj, inclusive, to provide health insurance for uninsured children from low-income families in this state.

Sec. 2. NAC 442.600 is hereby amended to read as follows:

442.600 As used in NAC 442.600 to ~~[442.796,]~~ ***442.792,*** inclusive, unless the context otherwise requires, the words and terms defined in NAC 442.602 to ~~[442.709,]~~ ***442.708,*** inclusive, ***and section 1 of this regulation,*** have the meanings ascribed to them in those sections.

Sec. 3. NAC 442.625 is hereby amended to read as follows:

442.625 "Client" means a person who is eligible to participate in the program pursuant to NAC 442.600 to ~~[442.796,]~~ ***442.792,*** inclusive.

Sec. 4. NAC 442.639 is hereby amended to read as follows:

442.639 "Eligible condition" means an eligible medical condition or another condition for which coverage is provided under the program pursuant to NAC 442.600 to ~~[442.796,]~~ ***442.792,*** inclusive.

Sec. 5. NAC 442.700 is hereby amended to read as follows:

442.700 "Program" means the program of the health division that provides reimbursement for the specialized medical ~~[and dental]~~ services required for the maximum alleviation or rehabilitation of the eligible conditions of clients.

Sec. 6. NAC 442.705 is hereby amended to read as follows:

442.705 "Provider" means a person authorized to provide a health care service or product pursuant to NAC 442.600 to ~~[442.796,]~~ ***442.792,*** inclusive, through a signed memorandum of understanding with the health division.

Sec. 7. NAC 442.710 is hereby amended to read as follows:

442.710 1. To be eligible for participation in the program, a person must ~~[be]~~ ***:***

(a) Have an eligible condition;

(b) Be financially eligible pursuant to this section;

(c) Be a resident of this state and:

~~[(a)]~~ ***(1)*** A citizen of the United States;

~~[(b)]~~ ***(2)*** A qualified alien, as defined in 8 U.S.C. § 1641; or

~~[(c)]~~ ***(3)*** An alien who is otherwise eligible for participation in the program pursuant to federal regulations regarding the eligibility of aliens for public assistance ~~[.]~~ ***; and***

(d) Not be eligible for medical services pursuant to any other program, including, without limitation, Medicaid and Nevada Check Up. The person must provide proof of denial to the health division.

2. ***In addition to the requirements set forth in subsection 1, a client who is a child must be evaluated at least once annually by a physician who is certified by the American Board of Pediatrics as a specialist in pediatrics to determine whether the child has an eligible condition.***

3. Financial eligibility for participation in the program varies according to the ~~[adjusted]~~ gross annual income of the client's household in comparison to ~~[200]~~ ***250*** percent of the level of poverty designated for a household of that size by the United States Department of Health and Human Services. ~~[Adjusted gross]~~ ***A client is eligible for diagnostic evaluations pursuant to subsection 7 of NAC 442.751 if his gross annual income is not more than 300 percent of the level of poverty designated for a household of that size by the United States Department of Health and Human Services. Gross*** annual income will be calculated by adding the total income and resources of all members of the client's household ***.*** ~~[and deducting all expenses approved under the program.~~

~~3.]~~

4. Resources to be considered for ***financial*** eligibility to participate in the program include, but are not limited to:

(a) Savings certificates and savings accounts.

(b) Stocks and bonds held by the client or his household, including, but not limited to, individual retirement accounts, money market accounts, tax deferred accounts and accounts established pursuant to 26 U.S.C. § 401(k).

(c) Mortgages and accounts receivable held by the client or his household.

(d) Proceeds from the sale of property.

(e) Income tax refunds or rebates.

(f) Cash gifts, prizes and awards.

(g) Trust funds.

~~[4.]~~ ***5.*** Income to be considered ***for financial eligibility to participate in the program*** includes, but is not limited to:

(a) Wages, salaries and commissions.

(b) Gratuities.

(c) Profits from self-employment, including farms.

(d) Alimony and child support.

(e) Inheritances.

(f) Pensions and benefits.

(g) Judgments and settlements resulting from litigation above the cost of litigation and any casualty losses or medical expenses for which the litigation was initiated.

(h) Interest, dividends and royalties.

(i) Any direct payments of money considered to be a gain or benefit, including, but not limited to, any donations of money.

(j) Money in a trust.

(k) Rental income.

~~[5. Except as otherwise provided in NAC 442.794, the amount of cost sharing for a client's household will be calculated as 10 percent of each increment of $100 of monthly income, based on adjusted gross annual income, exceeding the allowable level of poverty.]~~

Sec. 8. NAC 442.715 is hereby amended to read as follows:

442.715 1. To provide services to clients, physicians and other regular providers of services under the program must have executed a memorandum of understanding with the health division, except that providers who provide services one time or on a sporadic basis are not required to have executed a memorandum of understanding if they agree to accept reimbursement provided under the program as payment in full for those services. The memorandum of understanding must:

(a) Require the physician or other provider to accept the rates of reimbursement set forth in NAC 442.751; and

(b) Provide that households will not be billed by the provider for the remaining balance . ~~[unless cost sharing has been established.]~~

2. Except in cases of emergency, providers must receive authorization before the delivery of a service to a patient, including, but not limited to, a patient for whom a determination of eligibility for Medicaid is pending, to be eligible for reimbursement for that service. Oral authorization for care must be followed by written authorization. Authorizations for services provided during the hours when the offices of the bureau are closed may be issued retroactively if:

(a) The client meets the eligibility requirements of the program; and

(b) The health division is notified by the physician, hospital, medical facility or other provider of services within 72 hours after the services are provided.

3. A physician must provide medical justification for and a description of the anticipated outcome of the services requested at the time he requests prior authorization.

4. Medical treatment authorized for payment must relate to the primary diagnosis or diagnoses for which the applicant was accepted into the program.

5. The following services covered by the primary physician's authorization do not require separate prior authorization:

(a) Ambulance, if required by the authorized physician.

(b) Anesthesiologists or anesthetists, except that the fees of the program prevail. The anesthesiologist or anesthetist must bill the insurance carrier or other third-party payer and the

program directly. The client's household must not be billed for charges in excess of those allowed under the program.

(c) Assistant surgeon, except that the fees of the program prevail. The assistant surgeon must bill the insurance carrier or other third-party payer and the program directly. The client's household must not be billed for charges in excess of those allowed under the program.

(d) Laboratory services, except that the fees of the program prevail. The laboratory must bill the insurance carrier or other third-party payer and the program directly. The client's household must not be billed for charges in excess of those allowed under the program.

Sec. 9. NAC 442.751 is hereby amended to read as follows:

442.751 The program will:

1. Not provide for the total care of a client. ~~[A person may participate in the program only if he has an eligible condition.]~~

2. Provide only services that are related to treating a client's condition.

3. Cover conditions with a poor or variable prognosis only as funding for the program allows.

4. Pay ~~[no]~~ ***not*** more than ~~[$50,000]~~ ***$10,000*** annually for each client unless, subject to budgetary limitations, the state health officer or a person designated by the administrator authorizes the expenditure of an additional amount in an extraordinary situation.

5. Reimburse providers at Medicaid rates for the costs of the services provided to clients. For the costs incurred for orthotic and prosthetic devices provided by medical prescription to enhance a client's ability to perform the activities of daily living, the program will reimburse:

(a) At Medicaid rates; or

(b) At 80 percent of the usual and customary charge if no Medicaid rate is available.

6. Approve services provided outside this state only when:

(a) The services are not available within this state; and

(b) The provider who refers the client for those services agrees to provide ongoing follow-up care to the client.

7. ~~[Cover, regardless of the income of a client,]~~ ***Pay the costs of*** any diagnostic evaluations performed to determine whether a client has an eligible medical condition ~~[.]~~ ***if the gross annual income of the client is not more than 300 percent of the level of poverty designated for a household of that size by the United States Department of Health and Human Services. For the purposes of this subsection, gross annual income will be calculated as provided in NAC 442.710.***

Sec. 10. NAC 442.765 is hereby amended to read as follows:

442.765 A program specialist shall terminate the eligibility of a client for the following reasons:

1. The client reaches ~~[a]~~ ***the*** limitation on age set forth in NAC 442.782 ***.*** ~~[or 442.794.]~~

2. The client has achieved maximum alleviation or rehabilitation of his eligible condition.

3. The income of the client's household no longer meets the requirements of the program for financial eligibility.

4. The client's household chooses not to continue to participate in the program.

5. Failure by the client to cooperate in carrying out recommended treatment or to apply for third-party assistance, including, without limitation, assistance provided through Medicaid or ~~[the State Children's Health Insurance Program established pursuant to 42 U.S.C. §§ 1397aa et seq.]~~ ***Nevada Check Up.***

6. A lack of money for the program ~~[or from cost sharing]~~ for the continuation of the services required by the client.

7. Denial of other third-party coverage based on failure to cooperate.

8. Misrepresentation of material facts in the application.

9. Failure by the client to cooperate in seeking to obtain any applicable payments of child support, unless excused by the chief because of exceptional circumstances.

Sec. 11. NAC 442.770 is hereby amended to read as follows:

442.770 1. Except as otherwise provided in ~~[subsection 2,]~~ ***subsections 2 and 3,*** a provider shall submit a claim for the payment of services provided to a client to third-party payers before submitting the claim to the health division under the program.

2. ~~[The]~~ ***Except as otherwise provided in subsection 3, the*** provider may submit the claim directly to the health division under the program if:

(a) The client does not have any third-party payers;

(b) The provider has exhausted the resources of all third-party payers; or

(c) All third-party payers deny the claim.

3. ***A provider shall submit the claim of a client eligible for services pursuant to a program administered by the Indian Health Service to the health division before submitting the claim to the Indian Health Service.***

4. If a provider submits a claim to the health division under the program, he shall submit a single copy of each completed claim on billing forms acceptable to Medicaid within 120 days after the date:

(a) Of service if the client does not have any third-party payers;

(b) On which the provider exhausts the resources of all third-party payers; or

(c) On which the final third-party payer denies the claim.

FLUSH All claims must be accompanied by legible medical reports and have all appropriate identification as required pursuant to this section or the claim will not be processed.

~~[4.]~~ ***5.*** A claim must not be a duplicate or reflect a balance from claims that the provider previously submitted.

~~[5.]~~ ***6.*** A claim must not be altered.

~~[6.]~~ ***7.*** A claim must include:

(a) The full name, date of birth and address of the client.

(b) The name and address of the provider submitting the claim.

(c) The diagnosis, including the code number for the condition designated by the health division and whether the condition is presumptively covered under the program or is a confirmed eligible medical condition.

(d) The date of service.

(e) The type of service, using the code descriptors designated by the health division.

(f) The usual and customary fee for each type of service.

(g) The provider's taxpayer identification number.

(h) The signature of the provider or his authorized representative.

~~[7.]~~ ***8.*** The primary surgeon's claims and necessary reports must be submitted to the health division before payment can be made to the assistant surgeon, anesthesiologist or anesthetist or for other ancillary services.

~~[8.]~~ ***9.*** If the fee is claimed on the basis of time, the report of the examination must indicate the beginning and ending time of the procedure.

~~[9.]~~ ***10.*** Claims for tissue pathology must include the name of the ordering physician, the source of the specimen obtained and the date, and must be submitted with a description of the findings of each procedure performed.

~~[10.]~~ ***11.*** Claims for radiology must indicate the name of the ordering physician, the date on which each procedure was performed and the site of the procedure, according to current procedural terminology, and must indicate whether the fee was split.

~~[11.]~~ ***12.*** Laboratory and X-ray services ordered by the authorized physician and adjunctive to his services do not require separate prior authorization. Either the reports of such services or their mention in the physician's progress notes or report must accompany the billing for such services.

~~[12. Claims for routine dental care are not required to be accompanied by any medical records if the provider received prior authorization to provide such care.]~~

13. Claims for physical or psychological therapy must include the name of the ordering physician, the date of therapy and documentation of the therapy provided.

Sec. 12. NAC 442.782 is hereby amended to read as follows:

442.782 To be eligible for medical services for an eligible medical condition under the program, a person must:

1. Be below the age of ~~[21]~~ ***19*** years;

2. Have a suspected or confirmed eligible medical condition; and

3. Meet the requirements for eligibility specified in NAC 442.710.

Sec. 13. NAC 442.784 is hereby amended to read as follows:

442.784 1. A client's eligible medical condition will be assigned to one of the following categories to determine the extent of medical services that will be provided under the program:

(a) Category 1 includes conditions:

(1) Which require ambulatory or outpatient services only; and

(2) For which an excellent prognosis is anticipated.

(b) Category 2 includes conditions:

(1) Which require ambulatory or outpatient services or limited inpatient care; and

(2) For which a good prognosis and the prevention of disability or deterioration is anticipated if the condition is treated.

(c) Category 3 includes conditions:

(1) Which require prolonged outpatient treatment and frequent hospitalization with high morbidity if not treated; and

(2) For which a fair prognosis is anticipated.

~~[(d) Category 4 includes conditions:~~

~~(1) Which require long-term, sophisticated and expensive treatment; and~~

~~(2) For which a poor prognosis is anticipated, despite the treatment provided.]~~

FLUSH For the purposes of this subsection, the prognosis must be based on an analysis of the client's functional ability for the activities of daily living.

2. The following conditions are eligible medical conditions:

(a) Blood cell conditions, including, but not limited to:

(1) ~~[ABO incompatibility.~~

~~(2) Aplastic anemia.~~

~~(3) Hemolytic anemia.~~

~~(4) Hemophilia.~~

~~(5) Histiocytosis.~~

~~(6) Idiopathic thrombocytopenic purpura, chronic.~~

~~(7) Leukemia.~~

~~(8) Lymphoma.~~

~~(9) Neutropenia, congenital.~~

~~(10)]~~ Sickle - cell disease.

~~[(11)]~~ ***(2)*** Thalassemia, major.

(b) Cardiovascular conditions, including, but not limited to:

(1) Acquired heart disease.

(2) Arrhythmia.

(3) Congenital malformations of the blood vessels.

(4) Congenital malformations of the heart.

(5) Hypertension.

(6) Vascular occlusion.

(c) Endocrinological conditions, including, but not limited to:

(1) Adrenal dysfunction, including pseudohermaphroditism.

(2) Diabetes mellitus, type 1 (insulin dependent).

(3) Diabetes insipidus.

(4) Thyroid dysfunction.

(5) Pituitary dysfunction, including:

(I) Hypogonadism; and

(II) Dwarfism, if the client's height is less than the third percentile, growth is less than 4 centimeters per year and bone age is more than 2 years behind chronological age.

(d) Craniofacial anomalies, including, but not limited to:

(1) Cleft lip and palate ***and medically necessary dental restoration required as a result of the cleft lip or palate***.

(2) Congenital facial abnormalities associated with chromosomal abnormalities or known syndromes or causing oral or motor dysfunction, or both.

(3) Craniosynostosis.

(e) Ear disorders, including, but not limited to:

(1) ~~[Chronic infection which is unresponsive to initial therapy and requires the insertion of ventilation tubes or additional therapy. The treatment will be limited to not more than two procedures for the insertion of ventilation tubes, except that the state health officer or a person designated by the administrator may upon review authorize additional procedures.~~

~~(2)]~~ Chronic mastoiditis or cholesteatoma.

~~[(3)]~~ ***(2)*** Congenital malformations of the ear.

~~[(4)]~~ ***(3)*** Congenital or acquired hearing loss.

(f) Eye conditions, including, but not limited to:

(1) Eye injuries involving poisoning or trauma. Such injuries will be covered from the time of injury if the potential for rehabilitation exists.

(2) Cataracts.

(3) Congenital herpes.

(4) Glaucoma.

(5) Keratoconus.

(6) Ptosis, if it covers the pupil.

(7) Strabismus that cannot be corrected with eyeglasses.

(g) Gastrointestinal disorders, including, but not limited to:

(1) ~~[Atresia, anorectal and esophageal.~~

~~(2) Congenital and other malformations of the gastrointestinal tract.~~

~~(3) Diaphragmatic hernia.~~

~~(4) Fistula, tracheoesophageal.~~

~~(5) Gastroesophageal reflux with failure to thrive, recurrent aspiration or peptic esophagitis.~~

~~(6) Hepatic conditions, excluding hepatitis.~~

~~(7)]~~ Incarcerated hernia.

~~[(8) Inflammatory bowel disease.~~

~~(9)]~~ ***(2)*** Intestinal obstruction or pseudo-obstruction.

~~[(10)]~~ ***(3)*** Omphalocele and gastroschisis.

~~[(11)]~~ ***(4)*** Pancreatitis, chronic.

~~[(12)]~~ ***(5)*** Ulcerative colitis.

(h) Genitourinary disorders, including, but not limited to:

(1) Ambiguous genitalia.

(2) Epispadius.

(3) Hypospadias.

(4) Incarcerated hernia.

(5) Neurogenic bladder.

(6) Obstructive uropathy.

(7) Testicular torsion.

(8) Undescended testicles.

(9) Ureterocele.

(10) Ureteropelvic junction (UPJ) obstruction.

(11) Vesicoureteral reflux.

(i) Metabolic disorders that are treatable inborn errors of metabolism, including, but not limited to:

(1) Aminoaciduria.

(2) Biotinidase deficiency.

(3) Cystic fibrosis.

(4) Galactosemia.

(5) Glycogen storage disease.

(6) Homocystinuria.

(7) Maple syrup urine disease.

(8) Phenylketonuria.

(9) Tyrosinemia.

(j) Neurological disorders, including, but not limited to:

(1) Arachnoid cysts.

(2) Brain injury or disease.

(3) Seizure disorder.

(4) Dermal sinus of the spine or cranium.

(5) Guillain-Barre syndrome.

(6) Hydrocephalus.

(7) Intracranial neoplasms.

(8) Meningocele.

(9) Tethered cord syndrome (tight filum).

(10) Spina bifida.

(11) Spinal cord disease, including a ruptured disc and spinal fracture causing paraplegia.

(k) Orthopedic conditions, including, but not limited to:

(1) Amputated limbs, congenital or acquired.

(2) Arthrosis.

(3) Blount's disease.

(4) Osteomyelitis.

(5) Complications of fractures, such as chronic infection, nonunion and avascular necrosis.

(6) Congenital deformities of the arm, hand, hip, knee or foot.

(7) Cysts.

(8) Juvenile rheumatoid arthritis.

(9) Osteochondrosis, including Legg-Perthes disease.

(10) Scoliosis.

(11) Tibial torsion that impairs ambulation.

(12) Tumor.

(l) Pulmonary conditions, including, but not limited to:

(1) Asthma that impedes the ability to perform the activities of daily living and requires daily medication to maintain respiratory function.

(2) Broncho-pulmonary dysplasia.

(3) Congenital emphysema.

(4) Lung hypoplasia associated with diaphragmatic hernia.

(5) Respiratory distress syndrome. Coverage under the program is limited to 1 day of acute care for the administration of a pulmonary surfactant treatment to reduce long-term deficits.

(m) Reconstruction, including, but not limited to:

(1) Burn care and reconstruction. Coverage under the program extends to the date of the initial injury.

(2) Hemangioma.

(3) A disfiguring deformity which impedes normal, daily function relative to social or emotional development.

Sec. 14. NAC 442.788 is hereby amended to read as follows:

442.788 1. The program does not pay for dietary supplements or medications relating to eligible medical conditions except as otherwise provided in subsection 2 and in the circumstances specified for the following eligible medical conditions:

(a) Cystic fibrosis, medications related to the eligible medical condition or its complications.

(b) ~~[Hemophilia, blood factors related to control.~~

~~(c)]~~ Epilepsy, subject to individual case and medical review.

~~[(d)]~~ ***(c)*** Juvenile diabetes, subject to individual case and medical review.

~~[(e) Chemotherapeutic agents, subject to individual case and medical review.~~

~~(f)]~~ ***(d)*** Inborn errors of metabolism, including those detected through the program for screening newborn babies conducted pursuant to NRS 442.115 and NAC 442.020 to 442.050, inclusive, dietary supplements as prescribed.

~~[(g) Otitis media that has been unresponsive to an initial course of antibiotics, subject to individual case and medical review.~~

~~(h)~~ ***(e)*** Asthma that requires daily medication for a client to perform the activities of daily living, subject to individual case and medical review.

~~[(i)]~~ ***(f)*** Cardiac conditions that require ongoing medication for a client to perform the activities of daily living, subject to individual case and medical review.

~~[(j)]~~ ***(g)*** Thyroid conditions that require ongoing medication, subject to individual case and medical review.

2. The program will, subject to individual case and medical review, cover dietary supplements and medications required on an ongoing basis for the prevention or amelioration of complications of an eligible medical condition.

3. The program will cover:

(a) Primary care of a client, as recommended by the American Academy of Pediatrics, to the extent that the health division determines such care is necessary to ensure the optimum health of the client;

(b) Services of a registered dietitian, to the extent that the health division determines those services are necessary to ensure the optimum health of a client;

(c) Physical therapy necessary to return a client to functional ability, except that, unless otherwise authorized by the health division, such coverage is limited to not more than 12 sessions annually and 60 minutes per session; and

(d) Psychological therapy relating to emotional support for an ongoing, chronic eligible medical condition, except that, unless otherwise authorized by the health division, such coverage is limited to:

(1) For individual therapy, not more than 12 sessions annually and 60 minutes per session.

(2) For group therapy, not more than 24 sessions annually.

Sec. 15. NAC 442.792 is hereby amended to read as follows:

442.792 1. The prenatal services covered under the program include:

(a) Routine prenatal care, as recommended by the American College of Obstetricians and Gynecologists, except that coverage is limited to:

(1) ~~[~~One ultrasound procedure~~]~~ ***Two ultrasound procedures*** during a pregnancy ***;*** ~~[~~, unless additional ultrasound procedures are medically indicated;~~]~~

(2) Office visits;

(3) Pap smears;

(4) Drug screening;

(5) Testing of urine by urinalysis and dipstick;

(6) Testing of hemoglobin, hematocrit, blood type and blood grouping;

(7) Testing for ***human immunodeficiency virus,*** Rh factor, rubella and sickle cell;

(8) When medically indicated, testing for tuberculosis ***;*** ~~[~~and the human immunodeficiency virus;~~]~~ and

(9) Testing and treatment for sexually transmitted diseases, except that a person who tests positive for the human immunodeficiency virus will be referred to the appropriate state or federal program for treatment and follow-up services.

(b) The provision of not more than 300 tablets of prenatal vitamins, as prescribed by a provider.

(c) In the case of a documented high-risk pregnancy or when otherwise medically indicated:

(1) The transportation of the mother to a hospital that is designated as a level II or level III neonatal unit pursuant to NAC 442.250 to 442.570, inclusive; and

(2) Ultrasound procedures, fetal assessments, non-stress tests and contraction stress tests.

(d) Neonatal transport, if the criteria established pursuant to NAC 442.250 to 442.570, inclusive, are met.

(e) Complications of pregnancy, childbirth and puerperium.

(f) Services directed toward the prevention of disabling conditions of children and pregnant women.

(g) Amniocentesis if:

(1) The mother had a previous child with an eligible medical condition at birth;

(2) The mother is a carrier of a condition that is related to her gender;

(3) The mother and father are carriers of a ~~[~~recessive trait, including, without limitation, Tay-Sachs;~~]~~ ***trait that leads to disability;***

(4) The mother or father has a sibling with neural tube defects;

(5) The mother is over 35 years of age and has at least one other risk factor; or

(6) The mother has an abnormal test of maternal serum alpha feta protein.

FLUSH Genetic counseling by a genetic counselor, if available, must be obtained as a prerequisite for the coverage of amniocentesis under the program.

(h) A class for the cessation of smoking. Coverage is limited to reimbursement of the provider in the amount of not more than $50 upon the client's completion of the class.

2. Prenatal services provided under the program are limited to those which are directed solely to the promotion of a favorable outcome of a pregnancy. Services related to maternal labor and the delivery of a fetus or infant are not covered.

Sec. 16. NAC 442.612, 442.627, 442.630, 442.632, 442.651, 442.692, 442.7085, 442.709, 442.794 and 442.796 are hereby repealed.

TEXT OF REPEALED SECTIONS

442.612 "Amalgam" defined. "Amalgam" means a mixture of metals used for filling cavities in teeth.

442.627 "Composite resin" defined. "Composite resin" means a filled resin used in dental restorations.

442.630 "Cost sharing" defined. "Cost sharing" means the requirement that a household contribute financially toward the cost of services authorized under the program.

442.632 "Dental services" defined. "Dental services" means treatment and facilitating services and necessary appliances directed toward the habilitation and rehabilitation of clients to reasonable dental health.

442.651 "Gold crown" defined. "Gold crown" means a restoration of cast metal which reproduces the surface anatomy of the clinical crown of a tooth and which is affixed to the remains of the natural tooth structure.

442.692 "Porcelain crown" defined. "Porcelain crown" means a restoration of porcelain, or porcelain fused to metal, which reproduces the surface anatomy of the clinical crown of a tooth and which is affixed to the remains of the natural tooth structure.

442.7085 "Sealant" defined. "Sealant" means a filled or unfilled resin applied to seal the crevices on teeth that are prone to decay.

442.709 "Stainless steel crown" defined. "Stainless steel crown" means a restoration of stainless steel which reproduces the surface anatomy of the clinical crown of a tooth and which is affixed to the remains of the natural tooth structure.

442.794 Eligibility. To be eligible for dental services under the program:

1. A person must:

(a) Be below the age of 19 years;

(b) Not have access to dental services through:

(1) Private insurance, including, without limitation, a health maintenance organization;

(2) Medicaid;

(3) The Civilian Health and Medical Program of the Uniformed Services established pursuant to 10 U.S.C. §§ 1071 et seq.; or

(4) The State Children's Health Insurance Program established pursuant to 42 U.S.C. §§ 1397aa et seq.;

(c) Not be eligible to receive dental services free of charge through any other source or program; and

(d) Except as otherwise provided in subsection 2, meet the requirements for eligibility specified in NAC 442.710.

2. The adjusted gross annual income of the person's household must not exceed 200 percent of the level of poverty designated for a household of that size by the United States Department of Health and Human Services. There will be no cost sharing for dental services under the program.

442.796 Services covered under program.

1. The dental services covered under the program include:

(a) Diagnostic services, which include only:

(1) Examinations of the teeth and the surrounding oral structures;

(2) Bitewing radiographs and other radiographs which are necessary for complete diagnosis; and

(3) The cleaning of the teeth for diagnostic purposes.

(b) Emergency services, which include only the care performed:

(1) For the amelioration of conditions causing extreme pain;

(2) Because of the loss of a tooth due to trauma; and

(3) Because of the inability to consume food or drink.

(c) Treatment services, which include only the care required to preserve the health of the teeth and surrounding oral structures. Such care includes, but is not limited to:

(1) The application of amalgams, composite resins, spacers and gold, porcelain and stainless steel crowns;

(2) The extraction of teeth;

(3) The treatment of odontogenic cysts and tumors;

(4) The cleaning of the teeth and topical application of fluoride;

(5) The application of dental sealants;

(6) The prescription and provision of dietary supplements that include fluoride; and

(7) The administration of anesthesia to outpatients.

2. If a provider requests authorization under the program to perform treatment services on a client, the provider must submit to the health division an individualized treatment plan for the client. The plan must:

(a) Describe the treatment requested;

(b) Provide for the education of the child and family regarding the importance of proper dental hygiene and health; and

(c) Provide for a recall examination 6 months after the initial treatment.

3. Orthodontic services are not covered dental services.