REVISED PROPOSED REGULATION OF THE

STATE BOARD OF HEALTH

LCB File No. R089-09

November 9, 2009

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

AUTHORITY: §§1-19 and 21, NRS 442.140 and 442.190; §20, NRS 442.190.

A REGULATION relating to public health; authorizing the Health Division of the Department of Health and Human Services to contract for the provision of certain services relating to the program that provides reimbursement for the specialized medical services of certain persons; revising provisions relating to the administration of the program; revising provisions governing reimbursements for certain medical services provided under the program; and providing other matters properly relating thereto.

Section 1. Chapter 442 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this regulation.

Sec. 2. ***"Local program administrator" means:***

1. If the Health Division has not entered into a contract pursuant to section 3 of this regulation for the geographic area in which a client receives services, the Health Division; or

2. If the Health Division has entered into a contract pursuant to section 3 of this regulation for the geographic area in which a client receives services, the person who entered into such a contract for that geographic area.

Sec. 3. ***1. The Health Division may contract with a person who provides community-based services in this State to perform the duties of the Health Division under the program, including, without limitation, developing a provider network, determining the eligibility of***

clients, authorizing services for clients, establishing a schedule for the payment of services and processing claims for the payment of services.

2. If the Health Division enters into a contract pursuant to subsection 1, the Health Division shall:

(a) Ensure that the program is operated in accordance with the provisions of NAC 442.600 to 442.788, inclusive, and sections 2 and 3 of this regulation; and

(b) Supervise the manner in which the person administers the program.

Sec. 4. NAC 442.600 is hereby amended to read as follows:

442.600 As used in NAC 442.600 to 442.788, inclusive, ***and sections 2 and 3 of this regulation,*** unless the context otherwise requires, the words and terms defined in NAC 442.602 to 442.708, inclusive, ***and section 2 of this regulation*** have the meanings ascribed to them in those sections.

Sec. 5. NAC 442.617 is hereby amended to read as follows:

442.617 "Bureau" means the Bureau of ~~[Family Health Services]~~ ***Child, Family and Community Wellness*** of the Health Division ***.*** ~~[of the Department of Health and Human Services.]~~

Sec. 6. NAC 442.680 is hereby amended to read as follows:

442.680 "Medical review" means the review of a provider's medical records by, or in consultation with, a medical staff composed of persons who are employed by the ~~[Health Division]~~ ***local program administrator*** or have a contract with the Health Division for the performance of those services.

Sec. 7. NAC 442.690 is hereby amended to read as follows:

442.690 "Physician" means a provider who:

1. Is licensed by the state where ~~[he]~~ ***the provider*** practices;

2. Is certified by or eligible to take an examination for certification from a specialty board that is a member of the American Board of Medical Specialties; and

3. Has a memorandum of understanding with the ~~[Health Division.]~~ ***local program administrator.***

Sec. 8. 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 442.788, inclusive, ***and sections 2 and 3 of this regulation*** through a signed memorandum of understanding with the ~~[Health Division.]~~ ***local program administrator.***

Sec. 9. NAC 442.710 is hereby amended to read as follows:

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

(a) Have an eligible condition;

(b) Be financially eligible pursuant to this section;

(c) Be a resident of this State and:

(1) A citizen of the United States;

(2) A qualified alien, as defined in 8 U.S.C. § 1641; or

(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.]~~ ***local program administrator.***

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 gross annual income of the client's household in comparison to 250 percent of the level of poverty designated ***for the year*** for a household of that size by the United States Department of Health and Human Services. A client is eligible for diagnostic evaluations pursuant to subsection 7 of NAC 442.751 if ~~[his]~~ ***the*** gross annual income ***of the client*** is not more than 300 percent of the level of poverty designated ***for the year*** 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.

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]~~ ***the client's*** 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]~~ ***the client's*** household.

(d) Proceeds from the sale of property.

(e) Income tax refunds or rebates.

(f) Cash gifts, prizes and awards.

(g) Trust funds.

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.

Sec. 10. NAC 442.711 is hereby amended to read as follows:

442.711 1. An applicant for participation in the program or a client shall report to the ~~[Health Division]~~ ***local program administrator*** any payments of child support received for ~~[his]~~ ***the applicant's or client's*** support.

2. Except as otherwise provided in this subsection, an applicant or client who is not receiving all payments of child support to which ~~[he]~~ ***the applicant or client*** is entitled for his ***or her*** support shall file with the Division of Welfare and Supportive Services of the Department of Health and Human Services or the district attorney of the county in which he ***or she*** resides an

application for assistance in obtaining that support. The Chief may, because of exceptional circumstances, excuse an applicant or client from compliance with the requirements of this subsection.

Sec. 11. NAC 442.712 is hereby amended to read as follows:

442.712 Any money received by or on behalf of a client from any donations, judgments or settlements relating to an eligible condition for which the client receives services from a provider under the program must be applied to pay for the cost of those services and related costs before money may be expended under the program for that purpose. If money is expended under the program for that purpose before a client receives money from such a source, the client shall reimburse the program for that expenditure. A client shall inform the ~~[Health Division]~~ ***local program administrator*** of all actions taken to obtain such a judgment or settlement, including, without limitation, the name of any attorney retained for that purpose and the dates of any court hearings scheduled for that purpose.

Sec. 12. 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,]~~ ***local program administrator,*** 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.

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]~~ ***local program administrator*** 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]~~ ***the physician*** 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. 13. NAC 442.720 is hereby amended to read as follows:

442.720 Forms used for application, financial eligibility, authorization and payment must be in a format satisfactory to the ~~[program.]~~ ***Health Division.***

Sec. 14. NAC 442.725 is hereby amended to read as follows:

442.725 1. Except as otherwise provided in subsection 2, an applicant's eligibility for participation in the program begins:

(a) On the date on which the applicant contacts ~~[a program specialist;]~~ ***the local program administrator;***

(b) On the date on which a medical facility notifies ~~[a program specialist]~~ ***the local program administrator*** regarding the applicant; or

(c) Within 72 hours after admission to a medical facility if the applicant was admitted on a weekend,

➥ if, within 30 days after that date, the applicant submits an application to ~~[a program specialist.]~~ ***the local program administrator.***

2. If an applicant submits an application after the 30-day limit, the applicant's date of eligibility will be the date on which the applicant completed the application.

3. Incomplete applications must be completed within 30 working days after the initial application is submitted to retain the effective date of the initial application.

4. An ***applicant's or client's eligibility for participation in the program expires 1 year after the date on which the applicant or client became eligible for the program, and the***

applicant or ~~[~~a~~]~~ client shall submit an updated application annually ~~[~~.~~]~~ ***to continue participation in the program.***

Sec. 15. 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.

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 not more than ~~[~~$10,000~~]~~ ***$5,000*** 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~~]~~ ***Except as otherwise provided in this subsection, reimburse*** providers at ***a rate not to exceed*** 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 ***or less than*** Medicaid rates; or

(b) At ~~[~~80 percent of the usual and customary charge~~]~~ ***the rate negotiated for the costs incurred for the orthotic or prosthetic device*** 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. 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 the year*** 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. 16. NAC 442.765 is hereby amended to read as follows:

442.765 ~~[A program specialist]~~ ***The local program administrator*** shall terminate the eligibility of a client for the following reasons:

1. The client reaches the limitation on age set forth in NAC 442.782.

2. The client has achieved maximum alleviation or rehabilitation of his ***or her*** 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 Nevada Check Up.

6. A lack of money for the program 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. 17. NAC 442.770 is hereby amended to read as follows:

442.770 1. Except as otherwise provided in 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]~~ ***local program administrator*** under the program.

2. Except as otherwise provided in subsection 3, the provider may submit the claim directly to the ~~[Health Division]~~ ***local program administrator*** 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]~~ ***local program administrator*** before submitting the claim to the Indian Health Service.

4. If a provider submits a claim to the ~~[Health Division]~~ ***local program administrator*** under the program, he ***or she*** shall submit a single copy of each completed claim on billing forms acceptable to Medicaid within ~~[120]~~ ***90*** 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.

➥ 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.

5. A claim must not be a duplicate or reflect a balance from claims that the provider previously submitted.

6. A claim must not be altered.

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~~]~~ ***the provider's*** authorized representative.

8. The primary surgeon's claims and necessary reports must be submitted to the ~~[~~Health Division~~]~~ ***local program administrator*** before payment can be made to the assistant surgeon, anesthesiologist or anesthetist or for other ancillary services ~~[.]~~ ***, including, without limitation, laboratory services.***

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.

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.

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.

12. Laboratory and X-ray services ordered by the authorized physician and adjunctive to his ***or her*** 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.

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

Sec. 18. NAC 442.775 is hereby amended to read as follows:

442.775 1. ~~[A program specialist]~~ ***The local program administrator*** shall determine whether to pay a claim for services furnished by a provider.

2. If the ~~[program specialist]~~ ***local program administrator*** determines that the claim will not be paid, ~~[he]~~ ***the local program administrator*** shall notify the provider, in writing, of the reason why the claim will not be paid.

3. The provider may request a review of the decision denying payment of the claim.

4. The provider must submit a written request to the Bureau within 30 days after ~~[he]~~ ***the provider*** receives notice that the claim has been denied.

5. If the Bureau receives a request for a review pursuant to subsection 4, it shall issue a written decision and notify the provider, in writing, of its decision.

6. The provider may appeal the decision of the Bureau in the manner prescribed in NAC 439.190 to 439.395, inclusive.

Sec. 19. NAC 442.780 is hereby amended to read as follows:

442.780 1. If ~~[a program specialist]~~ ***the local program administrator*** determines that:

(a) An applicant for services under the program does not meet the requirements for eligibility;

(b) A client receiving services under the program no longer meets those requirements; or

(c) The eligibility of a client must be terminated in accordance with NAC 442.765,

➥ ~~[he]~~ ***the local program administrator*** shall notify the applicant or client in writing of the reason why the services will not be provided.

2. The applicant or client may request a review of the denial of services under the program by submitting a written request to the Bureau within 30 days after ~~[he]~~ ***the applicant or client*** receives notice of that denial.

3. If the Bureau receives a request for a review pursuant to subsection 2, it shall issue a written decision and notify the applicant or client, in writing, of its decision.

4. The applicant or client may appeal the decision of the Bureau in the manner prescribed in NAC 439.190 to 439.395, inclusive.

Sec. 20. 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) Epilepsy, subject to individual case and medical review.

(c) Juvenile diabetes, subject to individual case and medical review.

(d) Inborn errors of metabolism, including those detected through the program for screening newborn babies conducted pursuant to NRS 442.008 and NAC 442.020 to 442.050, inclusive, dietary supplements as prescribed.

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

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

(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 ~~[:]~~ ***the following services, as prescribed by a physician:***

(a) Primary care of a client, as recommended by the American Academy of Pediatrics, to the extent that the ~~[Health Division]~~ ***local program administrator*** 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]~~ ***local program administrator*** 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,]~~ ***local program administrator,*** such coverage is limited to not more than 12 sessions annually and 60 minutes per session; ~~[and]~~

(d) ***Speech therapy necessary to correct a client's speech, except that, unless otherwise authorized by the local program administrator, such coverage is limited to not more than 12 sessions annually and 60 minutes per session;***

(e) Occupational therapy, except that, unless otherwise authorized by the local program administrator, such coverage is limited to not more than 12 sessions annually and 60 minutes per session; and

(f) Psychological therapy relating to emotional support for an ongoing, chronic eligible medical condition, except that, unless otherwise authorized by the ~~[Health Division,]~~ ***local program administrator,*** 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. 21. NAC 442.660 and 442.702 are hereby repealed.

TEXT OF REPEALED SECTIONS

442.660 "High-risk pregnancy" defined. (NRS 442.190) "High-risk pregnancy" means a pregnancy which, on the basis of age or genetic, medical, nutritional or environmental factors, can be considered likely to require more than standard, routine obstetric care.

442.702 "Program specialist" defined. (NRS 442.140, 442.190) "Program specialist" means an employee of the Health Division who is designated by the Administrator to determine:

1. Eligibility for the receipt of services under the program;

2. Whether to authorize the provision of services under the program before those services are rendered; and

3. Whether to approve claims for compensation submitted by providers under the program.