PROPOSED REGULATION OF

THE STATE BOARD OF HEALTH

LCB File No. R212-97

January 28, 1998

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

AUTHORITY: §§ 2, 5, 6, 8, 10, 14, 15, 21 and 22, NRS 442.140; §§ 3, 4, 7, 9, 12, 16, 17, 23, 24, 27, 28, 31-36, 38 and 41-45, NRS 442.140 and 442.190; §§ 11, 13, 18, 19, 20, 25, 26, 29, 30, 37, 39 and 40, NRS 442.190.

Section 1. Chapter 442 of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 22, inclusive, of this regulation.

Sec. 2. *"Amalgam" means a mixture of metals used for filling cavities in teeth.*

Sec. 3. *"Annually" means for each continuous period of 12 months of participation in the program.*

Sec. 4. *"Chief" means the chief of the bureau.*

Sec. 5. *"Composite resin" means a filled resin used in dental restorations.*

Sec. 6. *"Dental services" means treatment and facilitating services and necessary appliances directed toward the habilitation and rehabilitation of clients to reasonable dental health.*

Sec. 7. *"Eligible condition" means an eligible medical condition or another condition for which coverage is provided under the program pursuant to NAC 442.600 to 442.780, inclusive, and sections 2 to 22, inclusive, of this regulation.*

Sec. 8. *"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.*

Sec. 9. *"Memorandum of understanding" means an agreement that defines the type of services a provider will provide to clients and the method by which the provider will be reimbursed for those services under the program.*

Sec. 10. *"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.*

Sec. 11. *"Primary care" means a full range of comprehensive, integrated and longitudinal health services that are based in the community of a client, centered on the family of a client and provided on an ambulatory basis, including, but not limited to, services for prevention, diagnosis, treatment, consultation and referral.*

Sec. 12. *"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.

Sec. 13. *"Registered dietitian" means a person who holds a credential as a registered dietitian issued by the American Dietetic Association.*

Sec. 14. *"Sealant" means a filled or unfilled resin applied to seal the crevices on teeth that are prone to decay.*

Sec. 15. *"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.*

Sec. 16. *1. An applicant for participation in the program or a client shall report to the health division any payments of child support received for his support.*

2. An applicant or client who is not receiving all payments of child support to which he is entitled for his support shall, unless excused by the chief because of exceptional circumstances, file with the welfare division of the department of human resources or the district attorney of the county in which he resides, an application for assistance in obtaining that support.

Sec. 17. *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 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. 18. *To be eligible for medical services for an eligible medical condition under the program, a person must:*

1. Be below the age of 21 years;

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

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

Sec. 19. *To be eligible for prenatal services under the program, a person must:*

1. Be pregnant; and

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

Sec. 20. *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 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 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;

(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.

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. 21. *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; or

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

Sec. 22. *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.

Sec. 23. NAC 442.600 is hereby amended to read as follows:

442.600 As used in NAC 442.600 to 442.780, inclusive, *and sections 2 to 22, inclusive, of this regulation,* unless the context otherwise requires, the words and terms defined in NAC 442.602 to 442.708, inclusive, *and sections 2 to 15, inclusive, of this regulation* have the meanings ascribed to them in those sections.

Sec. 24. 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 **[**442.710.**]** *442.600 to 442.780, inclusive, and sections 2 to 22, inclusive, of this regulation.*

Sec. 25. NAC 442.630 is hereby amended to read as follows:

442.630 "Cost sharing" means the requirement that a household contribute financially toward the cost of **[**the medical**]** services authorized **[**by**]** *under* the program.

Sec. 26. NAC 442.640 is hereby amended to read as follows:

442.640 "Eligible medical condition" means **[**any**]** *a* medical condition of a client **[**which is covered by the program, as set forth**]** *described* in NAC 442.740.

Sec. 27. NAC 442.663 is hereby amended to read as follows:

442.663 "Household" means **[**:

1. Two or more persons who reside together and who may or may not be related by birth, marriage or adoption; or

2. A person under the age of 18 years who is an emancipated minor pursuant to chapter 129 of NRS and does not live with his relatives.**]** *an association of persons who live together as a single economic unit, regardless of whether they are related.*

Sec. 28. NAC 442.670 is hereby amended to read as follows:

442.670 "Medicaid" means the program established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical **[**services**]** *care* for indigent persons.

Sec. 29. 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, **[**the**]** *a* medical staff *composed of persons who are* employed by the health division **[**.**]** *or have a contract with the health division for the performance of those services.*

Sec. 30. 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 practices;

2. Is certified by or eligible to take an examination for certification from **[**the appropriate American**]** *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 .**[**; and

4. Has an agreement with Medicaid to provide medical services.**]**

Sec. 31. 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 **[**medical**]** conditions of clients.

Sec. 32. 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 442.780, inclusive, *and sections 2 to 22, inclusive, of this regulation* through a signed **[**agreement**]** *memorandum of understanding* with the health division.

Sec. 33. NAC 442.708 is hereby amended to read as follows:

442.708 "Resident" means a person who lives in this state and:

1. Intends to make this state his home permanently or for an indefinite period; or

2. Is employed or seeking employment in this state.

This term includes a person who does not have a fixed place of residence in this state, is temporarily absent from the state but intends to return to this state when he has accomplished the purpose of the absence, or is a dependent of military personnel for the duration of **[**his parent's**]** *the* tour of duty *of his parent or guardian* in this state.

Sec. 34. 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) Be below the age of 21 years or pregnant;

(b) Have a suspected or confirmed eligible medical condition;

(c) Meet the requirements for financial eligibility specified in subsection 2;

(d) Be:

(1) A citizen of the United States;

(2) An alien who was legally admitted into the United States for permanent residency;

(3) An alien who is permanently residing in the United States under color of law; or

(4) An entrant from Cuba or Haiti who has been granted temporary residency under the Immigration Reform and Control Act of 1986 (8 U.S.C. § 1255a); and

(e) Be**]** *be* a resident of this state **[**.**]** *and:*

(a) A citizen of the United States;

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

(c) An alien who is otherwise eligible for participation in the program pursuant to federal regulations regarding the eligibility of aliens for public assistance.

2. Financial eligibility *for participation in the program* varies according to the adjusted gross annual income of the client's household in comparison to 200 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 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 **[**by**]** *under* the program.

3. Resources to be considered *for 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. Income to be considered 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. **[**The**]** *Except as otherwise provided in section 21 of this regulation, 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. 35. NAC 442.715 is hereby amended to read as follows:

442.715 1. To provide **[**medical**]** services to clients, physicians and other regular providers of **[**medical services to**]** *services under* the program must have executed **[**an agreement**]** *a memorandum of understanding* with the health division, except that providers who provide **[**medical**]** services one time or on a sporadic basis are not required to have executed **[**an agreement. The agreement**]** *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 **[**a**]** *the* physician or other provider **[**of medical services**]** to accept the rates of reimbursement set forth in NAC 442.751 *;* **[**for the provision of medical services or orthotic and prosthetic devices;**]** and

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

2. **[**Providers of medical services**]** *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 **[**medical services, except in cases of emergency.**]** *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 *;* **[**set forth in NAC 442.710;**]** 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 **[**certify**]** *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 **[**directly**]** 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 **[**. The authorized physician is responsible for notifying the anesthetists that the person is a client of the program and**]** *, 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 **[**by**]** *under* the program.

(c) Assistant surgeon **[**. The authorized physician is responsible for notifying the assistant surgeon that the person is a client of the program and**]** *, 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 **[**by**]** *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. 36. 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 **[**an administrative officer;**]** *a program specialist;*

(b) On the date on which a medical facility notifies **[**an administrative officer**]** *a program specialist* 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 **[**an administrative officer.**]** *a program specialist.*

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 **[**15**]** *30* working days after the initial application is submitted to retain the effective date of the initial application.

4. An applicant or a client shall submit an updated application **[**:

(a) Annually; or

(b) When there is a substantial change in the income, expenses or composition of his household.**]** *annually.*

Sec. 37. NAC 442.740 is hereby amended to read as follows:

442.740 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 **[**by**]** *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.

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) 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.

(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 **[**medication**]** *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 may upon review authorize additional procedures.*

(2) Chronic mastoiditis or cholesteatoma.

(3) Congenital malformations of the ear.

(4) 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 . **[**, or both.**]**

(6) Hepatic conditions, excluding hepatitis.

(7) Incarcerated hernia.

(8) Inflammatory bowel disease.

(9) Intestinal obstruction **[**.**]** *or pseudo-obstruction.*

(10) Omphalocele and gastroschisis.

(11) Pancreatitis, chronic.

(12) 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) **[**Complicated or uncontrolled seizure**]** *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) **[**Chronic osteomyelitis that lasts more than 12 weeks.**]** *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) **[**Prenatal conditions, limited to ambulatory or outpatient services only, including, but not limited to:

(1) Normal prenatal care with diagnostic testing and not more than one ultrasound procedure during a pregnancy. Treatment will be limited to office visits, urinalysis and dipstick urine testing, the testing of hemoglobin, hematocrit, blood type and blood grouping and testing for sexually transmitted diseases.

(2) In the case of a documented high-risk pregnancy:

(I) The transportation of the mother to a hospital which has an approved neonatal intensive care unit.

(II) Ultrasound procedures.

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

(4) Complications of pregnancy, childbirth and puerperium.

(5) Services directed toward the prevention of disabling conditions.

(6) Amniocentesis if:

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

(II) The mother is a carrier of a condition that is related to her sex;

(III) The mother and father are carriers of a recessive trait such as tay-sachs;

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

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

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

Genetic counseling by a genetic counselor, if available, is a prerequisite for coverage of amniocentesis by the program.

(m)**]** Pulmonary conditions, including, but not limited to:

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

(2) Broncho-pulmonary dysplasia.

(3) Congenital emphysema.

(4) Lung hypoplasia associated with diaphragmatic hernia.

[(n)**]** *(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. 38. 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 **[**medical condition that is listed in NAC 442.740.**]** *condition.*

2. Provide only services that are **[**directly**]** 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 more than $50,000 annually for each client **[**.**]** *unless, subject to budgetary limitations, the state health officer authorizes the expenditure of an additional amount in an extraordinary situation.*

5. Reimburse providers at Medicaid rates for the costs of the **[**medical**]** 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 **[**the**]** *:*

(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,* any diagnostic evaluations performed to determine whether a client has an eligible medical condition.

Sec. 39. NAC 442.755 is hereby amended to read as follows:

442.755 The program does not cover the following conditions and services:

1. Acute infectious diseases . **[**, learning**]**

2. Learning disabilities, mental retardation and problems related to behavior.

[2.**]** *3.* Allergies.

[3.**]** *4.* The alteration of a construction or dwelling.

[4.**]** *5.* Benign inflammatory conditions.

[5.**]** *6.* Blood and plasma, except for processing and **[**administration fees.

6.**]** *administrative fees.*

7. Chronic sinusitis **[**.

7.**]** *, except in cases of severe respiratory impairment.*

8. Cosmetic surgery as an isolated indication.

[8.**]** *9.* Custodial care.

[9.**]** *10.* Diagnostic or therapeutic procedures, techniques, instrumentalities or agents that:

(a) Have not been approved by the Food and Drug Administration; or

(b) Are experimental.

[10.**]** *11.* Disorders of the immune system.

[11.**]** *12.* Educational services.

[12.**]** *13.* Flat feet, tibial torsion and metatarsus adductus.

[13.**]** *14.* Hypertrophy of the tonsils and adenoids, unless the tonsils and adenoids significantly contribute to, interfere with, or complicate the management of an eligible medical condition.

[14.**]** *15.* Initial acute care of accidents, poisoning and violence.

[15.**]** *16.* Ordinary refractive errors.

[16.**]** *17.* Prematurity alone.

[17.**]** *18.* Second opinions that have not been requested by a physician of record with documentation of medical necessity.

[18.**]** *19.* Services for homemakers.

[19.**]** *20.* Strabismus, where nonsurgical treatment suffices.

[20.**]** *21.* Transplant surgeries and drugs and supplies directly related to the transplant.

[21.**]** *22.* The transportation of a client or a member of his **[**family,**]** *household,* except that transportation by ambulance is covered in unusual circumstances if it is requested in advance and there is documentation of the unusual circumstances that created the need.

Sec. 40. NAC 442.760 is hereby amended to read as follows:

442.760 *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:

[1.**]** *(a)* Cystic fibrosis, medications **[**directly**]** related to the eligible medical condition or its complications.

[2.**]** *(b)* Hemophilia, blood factors related to control.

[3.**]** *(c)* Epilepsy, subject to individual case and medical review.

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

[5.**]** *(e)* Chemotherapeutic agents, subject to individual case and medical review.

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

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

(j) 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. 41. NAC 442.765 is hereby amended to read as follows:

442.765 **[**An administrative officer**]** *A program specialist* shall terminate the eligibility of a client for the following reasons:

1. The client reaches **[**the**]** *a* limitation on age set forth in **[**NAC 442.710.**]** *section 18 or 21 of this regulation.*

2. The client has achieved maximum alleviation or rehabilitation of his eligible **[**medical**]** condition.

3. **[**The client's condition has remained static for 1 year.

4.**]** The income of the client's household no longer meets the requirements *of the program* for financial eligibility . **[**set forth in NAC 442.710.

5.**]** *4.* The client's **[**family**]** *household* chooses not to continue to participate in the program.

[6.**]** *5.* Failure by the client to cooperate in carrying out recommended treatment or to apply for third-party assistance.

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

[8.**]** *7.* Denial of other third-party coverage based on failure to cooperate.

[9.**]** *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. 42. NAC 442.770 is hereby amended to read as follows:

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

2. 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. 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.

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

5. A claim must not be altered.

6. 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 **[**by**]** *under* the program or is a confirmed eligible medical condition.

(d) The date of service.

(e) The type of service, using the code descriptors **[**from current procedural terminology.**]** *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 **[**provider's signature.**]** *signature of the provider or his authorized representative.*

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

8. 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. 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. 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 *,* **[**contained in the fee schedule,**]** and must indicate **[**if**]** *whether* the fee was split.

11. 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. 43. NAC 442.775 is hereby amended to read as follows:

442.775 1. **[**An administrative officer**]** *A program specialist* shall determine whether to pay a claim for **[**medical**]** services furnished by a provider.

2. If the **[**administrative officer**]** *program specialist* determines that the claim will not be paid, he 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 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 chapter 439 of NAC.

Sec. 44. NAC 442.780 is hereby amended to read as follows:

442.780 1. If **[**an administrative officer**]** *a program specialist* determines that an applicant for **[**medical**]** services *under the program* does not meet the requirements for eligibility, or that a client receiving **[**medical**]** services *under the program* no longer meets those requirements, he shall notify the applicant or client in writing of the reason why the **[**medical**]** services will not be provided.

2. The applicant or client may request a review of the denial of **[**medical**]** services *under the program* by submitting a written request to the bureau within 30 days after he 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 chapter 439 of NAC.

Sec. 45. Sections 2, 3 and 5 of LCB File No. R039-97, which was adopted by the State Board of Health and was filed with the Secretary of State on October 30, 1997, and NAC 442.610, 442.645, 442.745, 442.800, 442.802, 442.804, 442.806, 442.808, 442.810, 442.812, 442,814, 442.816, 442.818, 442.820, 442,822, 442.824, 442.826, 442.828, 442.830, 442.832, 442.834, 442.836 and 442.838 are hereby repealed.

TEXT OF REPEALED SECTIONS

Sec. 2. "Administrative officer" means a person who is designated by the administrator to determine eligibility for the receipt of medical services pursuant to the program.

Sec. 3. "Administrative officer" means a person who is designated by the administrator to determine eligibility for the receipt of dental services pursuant to the program.

Sec. 5. "Bureau" means the bureau of family health services of the health division of the department of human resources.

442.610 "Agreement" defined. "Agreement" means a contract or memorandum of understanding between the health division and a provider which defines the type of medical services a provider will provide to clients and the method by which the program will reimburse the provider.

442.645 "Family" defined. "Family" means:

1. Two or more persons related by birth, marriage or adoption who reside together; or

2. A person 18 years of age or older who is not living with any relatives.

442.745 Services for children testing positive for human immunodeficiency virus. Evaluation and diagnostic services will be provided pursuant to NAC 442.600 to 442.780, inclusive, for children testing positive for the human immunodeficiency virus.

442.800 Definitions. As used in NAC 442.800 to 442.838, inclusive, the words and terms defined in NAC 442.802 to 442.818, inclusive, have the meanings ascribed to them in those sections.

442.802 "Administrator" defined. "Administrator" means the administrator of the health division.

442.804 "Client" defined. "Client" means a child who has been certified, pursuant to NAC 442.824, as eligible to receive dental services through the program.

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

442.808 "Dentist" defined. "Dentist" means a dentist licensed pursuant to chapter 631 of NRS.

442.810 "Family" defined. "Family" means two or more persons related by birth, marriage or adoption who reside together.

442.812 "Health division" defined. "Health division" means the health division of the department of human resources.

442.814 "Medicaid" defined. "Medicaid" means the program established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.) to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

442.816 "Program" defined. "Program" means the program of the health division that provides dental services pursuant to NAC 442.800 to 442.838, inclusive, to children who are found to be eligible to receive such services.

442.818 "Provider" defined. "Provider" means a dentist who is entitled to receive reimbursement for providing dental services to clients through an agreement with the health division pursuant to NAC 442.828.

442.820 Eligibility of child to receive dental services. For a child to be eligible to receive dental services through the program, the following requirements must be met:

1. The child must be under 13 years of age and be a resident of this state.

2. The child must not:

(a) Have access to dental services through private insurance, from a health maintenance organization, through Medicaid or through the Civilian Health and Medical Program of the Uniformed Services established pursuant to 10 U.S.C. §§ 1071 et seq.; or

(b) Be eligible to receive dental services free of charge through any other source or program.

3. The gross annual income of the child's family must not exceed 130 percent of the level of poverty designated for a family of that size by the United States Department of Health and Human Services.

442.822 Application for child to receive dental services. An application for a child to receive dental services through the program must be submitted to the health division, on a form to be provided by the health division. Each application must include the following:

1. The full name, date of birth and address of the child.

2. The date of application.

3. The gross annual income of the child's family.

4. The number of persons in the child's family.

5. The marital status of the child's parents.

442.824 Certification of eligibility to receive dental services.

1. If an administrative officer determines that a child who has submitted an application is eligible to receive dental services through the program, he shall certify that the applicant is eligible to receive those services and notify the applicant of the certification.

2. Each client must be financially recertified annually or when there is a substantial change in the income of his family, whichever occurs first.

442.826 Denial of coverage: Notice and hearing.

1. If an administrative officer determines that an applicant for the program does not meet the requirements for eligibility, or that a client no longer meets those requirements, he shall notify the applicant or client in writing of the reason why coverage through the program will not be provided.

2. An applicant or client who has been denied coverage pursuant to subsection 1 may request a review of the denial of coverage by submitting a written request to the bureau within 30 days after he receives notice of the denial of coverage.

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 chapter 439 of NAC.

442.828 Prerequisites to reimbursement for provision of dental services.

1. To receive reimbursement from the program for providing dental services to clients, a dentist must execute an agreement with the health division. The agreement must:

(a) Specify the type of dental services that the dentist will provide.

(b) Provide that Medicaid rates, as established semiannually by the welfare division of the department of human resources, are the basis of reimbursement from the program for the provision of dental services.

2. Except as otherwise provided in subsection 3, a provider must receive authorization from the health division before he delivers dental services to a client in order to be eligible for reimbursement from the program for providing such services.

3. In cases of emergency, authorizations may be issued retroactively if:

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

(b) The health division is notified by the provider within 72 hours after the services are provided.

4. An authorization provided pursuant to subsection 2 or 3 may be written or oral, but an oral authorization must be followed by written confirmation from the health division.

442.830 Authorized dental services; submission and contents of individualized treatment plan.

1. Dental services which may be provided through the program are limited to the following:

(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, resins, spacers 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; and

(5) The application of dental sealant.

2. If a provider requests authorization from the health division to perform treatment services on a client, an individualized treatment plan for the client must be submitted to the health division by the provider. 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 a covered benefit of the program.

4. As used in this section:

(a) "Amalgam" means a mixture of metals used for filling cavities in teeth.

(b) "Resin" means a composite resin consisting of an acrylic substance to which a filler substance has been added to produce a material used in dental restorations.

(c) "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.

442.832 Submission and contents of claim for reimbursement of provider. A provider must submit a claim to the health division to request reimbursement for the dental services he has performed. The claim must include:

1. The full name of the client.
2. The American Dental Association billing codes indicating the type of service provided.
3. The tooth number of each tooth on which services were performed.
4. The date that the services were performed.
5. The amount billed for the service.
6. The full name, address and identification number of the provider.
7. The signature of the provider.
8. A copy of the authorization provided by the health division to perform the dental services.

442.834 Payment or denial of claim for reimbursement of provider.

1. An administrative officer shall determine whether to pay a claim for reimbursement made by a provider. All dental services must have authorization pursuant to NAC 442.828 before payment may be made for those services. Reimbursement for allowable dental services must be at Medicaid rates established semiannually by the department of human resources.

2. If an administrative officer determines that a claim for reimbursement will not be paid, he 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 denial of the claim by submitting a written request to the bureau within 30 days after he receives notice that the claim will not be paid.

4. If the bureau receives a request for a review pursuant to subsection 3, it shall issue a written decision and notify the provider, in writing, of its decision.

5. The provider may appeal the decision of the bureau in the manner prescribed in chapter 439 of NAC.

442.836 Grounds for termination of services. Services may be terminated for the following reasons:

1. The client reaches the age limitation established for eligibility in the program.
2. The client has achieved maximum alleviation or rehabilitation of his dental problem.
3. The condition of the client's dental problem has remained static for 1 year.
4. The income of the client's family no longer falls within the required limits.
5. The client's family chooses not to participate in the program any longer.
6. The client fails to cooperate in carrying out recommended treatment or to apply for third-party assistance.
7. The client is denied other third-party coverage based on his failure to cooperate.
8. Material facts were misrepresented in the application.

442.838 Coverage dependent on federal funding. Coverage of dental services under the program will be provided only to the extent that federal funding is available.