LCB File No. R095-99

PROPOSED REGULATION OF THE HEALTH DIVISION OF THE DEPARTMENT OF HUMAN RESOURCES

NOTICE OF PUBLIC HEARING

NOTICE IS HEREBY GIVEN that the State Board of Health will hold a public hearing and act on the adoption of a proposed regulation contained in Nevada Administrative Code (NAC) 442.600-796. **The hearing is scheduled to begin at 9:00 a.m. on Thursday, October 7, 1999, at the Grant Sawyer Building, Room 4410, and 555 E. Washington Avenue, Las Vegas, Nevada.**

These proposed regulations are required by the Maternal and Child Health Bureau and Title V of the Social Security Act. These proposed amendments are needed in order to administer the Children with Special Health Care Needs program. The substance of the amendments is to remove Category 4 coverage, eliminate dental coverage, reduce expenditure limits to $10,000, change eligibility limits to 250% of poverty for ongoing coverage and 300% of poverty for diagnostic coverage.

Adoption of the regulation will result in the following *economic* impacts:

1. Anticipated economic effects on the business which NAC 442.600-796 regulates:

   A. Adverse: No adverse effects are anticipated.
   B. Beneficial: Providers will be able to serve women and children.
   C. Immediate: Specialty Providers will be able to serve women and children.
   D. Long term: More women and children will receive specialty services.

2. Anticipated economic effects on the public:

   A. Adverse: No adverse effects are anticipated.
   B. Beneficial: Program participants will receive specialty services.
   C. Immediate: Women and children will have increased quality and access to care.
   D. Long term: The health of women and children in Nevada will improve. Quality resources of care and increased access will be developed throughout the state.

3. Estimated cost to the Health Division for enforcement of the proposed regulation: None

The proposed regulation does not overlap or duplicate any other Nevada state regulation.

Members of the public may make oral comments at this meeting. Persons wishing to submit written testimony or documentary evidence in excess of two typed, 8 ½" x 11"" pages must submit the material to the Board's secretary, Yvonne Sylva, by September 22, 1999, at the following address:

Secretary, State Board of Health
Nevada State Health Division
505 East King Street, Room 201
Carson City, NV 89701-4797

Written comments, testimony, or documentary evidence in excess of two typed pages will not be accepted at the time of the hearing. The purpose of this requirement is to allow Board members adequate time to review the documents.

A copy of the notice and proposed regulations are on file for inspection and/or may be copied at the following locations during normal business hours:

Nevada State Health Division
505 East King Street Room 201
Carson City, NV 89701

Nevada State Library & Archives
100 Stewart Street
Carson City, NV 89701

Copies may be obtained in person, by mail, or by calling (775) 684-4235. Copies are also available for review at all physical locations of program offices or main public libraries in each county where no agency office exists (see below).

Per NRS 233B.064(2), upon adoption of any regulation, the agency, if requested to do so by an interested person, either prior to adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, and incorporate therein its reason for overruling the consideration urged against its adoption.

The following are the addresses of the "main public library in each county." Copies of the public notice and the proposed amendments are to be on file in the main library of each county where no program office is located.

- Carson City Library, 900 North Roop St., Carson City, NV 89701
- Churchill County Library, 553 South Erie Maine St., Fallon, NV 89406
- Clark County Library, 4020 Maryland Parkway, Las Vegas, NV 89119
- Douglas County Library 1625 Library Lane, Minden, NV (PO Box 337) 89423
- Elko County Library, 720 Court St., Elko, NV 89801
- Goldfield Public Library (Esmeralda Co.), Corner of Crook and Ramsey, Goldfield NV (PO Box 430) 89013
- Eureka Branch Library, 10190 Monroe Street, Eureka, NV 89316
- Humboldt County Library, 85 East 5th St., Winnemucca, NV 89445
- Battle Mountain Branch Library (Lander Co.), 6255 Broad St., Battle Mountain, NV 89820
- Lincoln County Library, 63 Maine St., Pioche, NV (PO Box 330) 89043
- Lyon County Library, 20 Nevin Way,Yerington, NV 89447
- Mineral County Library, 125 A St., Hawthorne, NV (PO Box 1390) 89415
- Pershing County Library, 125 Central, Lovelock, NV (PO Box 781) 89419
- Storey County Library, 95 South R St.,Virginia City, NV (PO Box 14) 89440
- Tonopah Public Library, (Nye Co.), 171 Central, Tonopah, NV (PO Box 449) 89049
- Washoe County Library, 301 South Center St., Reno, NV (PO Box 2151) 89505
- White Pine County Library, 950 Campton St., Ely, NV 89301

Members of the public who are disabled and require special accommodations or assistance at the meeting are requested to notify Lynn Libby in writing at the Nevada State Health Division, 505 East King St., Room 201, Carson City, NV 89701, or by calling (775) 684-4200.

Summary of Changes to CSHCN Program Regulations
June, 1999

These changes will be brought before the State Board of Health at its meeting to be held on October 7, 1999.

Added

Section 6.

Repealed

Section 1. - NAC 442.612 - Repealed
Section 2. - NAC 442.627 - Repealed
Section 3. - NAC 442.630 - Repealed
Section 4. - NAC 442.632 - Repealed
Section 5. - NAC 442.651 - Repealed
Section 7. - NAC 442.692 - Repealed
Section 8. - NAC 442.7085 - Repealed
Section 9. - NAC 442.709 - Repealed
Section 11 - NAC 442.710#5 - Repealed
Section 18 - NAC 442.770#2 - Repealed
Section 20 - NAC 442.784#1 - Repealed
Section 29 - NAC 442.794 - Repealed

Amended

Section 10. - NAC 442.710#2 - Amended
Section 12. - NAC 442.712 - Amended
Section 13. - NAC 442.715a - Amended
Section 14. - NAC 442.751#4 - Amended
Section 15. - NAC 442.751#4 - Amended
Section 16. - NAC 442.751#7 - Amended
Section 17. - NAC 442.765#6 - Amended
Section 19. - NAC 442.782#1 - Amended
Section 21. - NAC 442.786#2a - Amended
Section 22. - NAC 442.786#2c - Amended
Section 23. - NAC 442.786#2d - Amended
Section 24. - NAC 442.786#2e - Amended
Section 25. - NAC 442.786#2g - Amended
Section 26. - NAC 442.788#1 - Amended
Section 27. - NAC 442.792#1a - Amended
Section 28. - NAC 442.792#1g - Amended

SERVICES UNDER SOCIAL SECURITY ACT
General Provisions

NAC 442.600 Definitions. (NRS:439.200, 442.140, 442.190) As used in NAC 442.600 to 442.796, inclusive, unless the context otherwise requires, the words and terms defined in NAC 442.602 to 442.709, inclusive, have the meanings ascribed to them in those sections.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; 10-30-97; R212-97, 7-23-98)

NAC 442.602 "Activities of daily living" defined. "Activities of daily living" means activities that a person performs independently to care for his personal needs, including, but not limited to, bathing, grooming, using the toilet, eating, brushing his teeth, transferring from a bed to a chair or ambulating.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.603 "Acute care" defined. "Acute care" means a level of medical services provided in a hospital.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.605 "Administrator" defined. "Administrator" means the administrator of the health division.

(Added to NAC by Bd. of Health, eff. 11-27-89)

Section 1. NAC 442.612 is hereby repealed.
~~[NAC 442.612 "Amalgam" defined. (NRS439.200, 442.140) "Amalgam" means a mixture of metals used for filling cavities in teeth.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.614 "Ambulatory or outpatient services" defined. "Ambulatory or outpatient services" means limited medical services provided for the diagnosis or treatment of a client who does not require care in a medical facility for more than 24 hours.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.616 "Annually" defined. (NRS439.200, 442.140, 442.190) "Annually" means for each continuous period of 12 months of participation in the program.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.617 "Bureau" defined. (NRS442.190) "Bureau" means the bureau of family health services of the health division of the department of human resources.

(Added to NAC by Bd. of Health, eff. 10-30-97)

NAC 442.619 "Chief" defined. (NRS439.200, 442.140, 442.190) "Chief" means the chief of the bureau.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.620 "Chronic" defined. "Chronic" means a medical condition persisting for more than 12 weeks.

(Added to NAC by Bd. of Health, eff. 11-27-89)

NAC 442.625 "Client" defined. (NRS439.200, 442.140, 442.190) "Client" means a person who is eligible to participate in the program pursuant to NAC 442.600 to 442.796, inclusive.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

Section 2. NAC 442.627 is hereby repealed.
~~[NAC 442.627 "Composite resin" defined. (NRS439.200, 442.140) "Composite resin" means a filled resin used in dental restorations.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

Section 3. NAC 442.630 is hereby repealed.
~~[NAC 442.630 "Cost sharing" defined. (NRS439.200, 442.190) "Cost sharing," means the requirement that a household contribute financially toward the cost of services authorized under the program.]~~

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

Section 4. NAC 442.632 is hereby repealed.
~~[NAC 442.632 "Dental services" defined. (NRS439.200, 442.140) "Dental services" means treatment and facilitating services and necessary appliances directed toward the habilitation and rehabilitation of clients to reasonable dental health.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)
NAC 442.635 "Diagnostic evaluation" defined. "Diagnostic evaluation" means the performance of a medical history, a physical examination, laboratory tests, radiological procedures, sonography, magnetic resonance imaging, or specific, limited surgical procedures necessary for the definition of pathology.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94)
NAC 442.637 "Disabling condition" defined. "Disabling condition" means an anatomical, physiological or other physical deficiency which inhibits normal growth or the ability to perform the activities of daily living.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94)-(Substituted in revision for NAC 442.650)

NAC 442.639 "Eligible condition" defined. (NRS439.200, 442.140, 442.190) "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, inclusive.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.640 "Eligible medical condition" defined. (NRS439.200, 442.190) "Eligible medical condition" means a medical condition of a client described in NAC 442.784.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

Section 5. NAC 442.651 is hereby repealed.

~~[NAC 442.651 "Gold crown" defined. (NRS439.200, 442.140) "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.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.655 "Health division" defined. "Health division" means the health division of the department of human resources.

(Added to NAC by Bd. of Health, eff. 11-27-89)

NAC 442.660 "High-risk pregnancy" defined. "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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94)

NAC 442.662 "Hospital" defined. "Hospital" has the meaning ascribed to it in NRS 449.012.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.663 "Household" defined. (NRS439.200, 442.140, 442.190) "Household" means an association of persons who live together as a single economic unit, regardless of whether they are related.

(Added to NAC by Bd. of Health, eff. 1-18-94; A by R212-97, 7-23-98)

NAC 442.665 "Inpatient" defined. "Inpatient" means a client who requires a stay of more than 24 hours in a hospital for treatment or a diagnostic evaluation.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94)

NAC 442.670 "Medicaid" defined. (NRS439.200, 442.140, 442.190) "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 for indigent persons.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

NAC 442.676 "Medical facility" defined. "Medical facility" means an establishment that provides treatment and services directed toward the habilitation and rehabilitation of a client to a reasonable level of health and ability to perform the activities of daily living.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.680 "Medical review" defined. (NRS439.200, 442.190) "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 or have a contract with the health division for the performance of those services.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

NAC 442.685 "Medical services" defined. "Medical services" means services rendered by a provider and other treatment, services and necessary appliances directed toward the habilitation and rehabilitation of a client to a reasonable level of health and ability to perform the activities of daily living.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94)

NAC 442.687 "Memorandum of understanding" defined. (NRS439.200, 442.140, 442.190) "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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

Section 6. Chapter 442 is hereby amended by adding thereto a new section to read as follows:

"Nevada Check-Up is the name assigned to the federal 'Children's Health Insurance Program' (CHIP), pursuant to Title XXI of the Social Security Act, which was initiated to provide health insurance to the uninsured, low income children who are not eligible for Medicaid.

NAC 442.690 "Physician" defined. (NRS439.200, 442.190) "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 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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; 10-30-97; R212-97, 7-23-98)

Section 7. NAC 443.692 is hereby repealed.
~~[NAC 442.692 "Porcelain crown" defined. (NRS439.200, 442.140) "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.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.694 "Primary care" defined. (NRS439.200, 442.190) "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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.696 "Prognosis" defined. "Prognosis" means the prospects of a client reaching a reasonable level of health and an ability to perform the activities of daily living.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.700 "Program" defined. (NRS439.200, 442.140, 442.190) "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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

NAC 442.702 "Program specialist" defined. (NRS439.200, 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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.705 "Provider" defined. (NRS439.200, 442.140, 442.190) "Provider" means a person authorized to provide a health care service or product pursuant to NAC 442.600 to 442.796, inclusive, through a signed memorandum of understanding with the health division.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

NAC 442.706 "Registered dietitian" defined. (NRS439.200, 442.190) "Registered dietitian" means a person who holds a credential as a registered dietitian issued by the American Dietetic Association.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.707 "Residence" defined. "Residence" means a place where a person remains when not called elsewhere for labor or other special temporary purposes, and to which he returns.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.708 "Resident" defined. (NRS439.200, 442.140, 442.190) "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 the tour of duty of his parent or guardian in this state.

(Added to NAC by Bd. of Health, eff. 1-18-94; A by R212-97, 7-23-98)

Section 8. NAC 442.7085 is hereby repealed.
~~[NAC 442.7085 "Sealant" defined. (NRS439.200, 442.140) "Sealant" means a filled or unfilled resin applied to seal the crevices on teeth that are prone to decay.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

Section 9. NAC 442.709 is hereby repealed.
~~[NAC 42.709 "Stainless steel crown" defined. (NRS439.200, 442.140) "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.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.710 Eligibility of clients under program. (NRS439.200, 442.140, 442.190)

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

Section 10. NAC.710 #2 is amended to read as follows:

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]~~ ***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]~~ ~~[g]~~ ***G***ross annual income will be calculated by adding the total income and resources of all members of the client's household ***,per NAC.*** ~~[and deducting all expenses approved under the program.]~~

The Children with Special Health Care Needs program is the payer of last resort, except for Indian Health Services. Clients must have proof of denial from programs such as Medicaid, Nevada Check-Up and other community resources, and must meet other program requirements, in order to qualify for assistance.

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.

Section 11. NAC 442.710 #5 is hereby repealed.

~~5. [Except as otherwise provided in NAC442.794, 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.]~~

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

NAC 442.711 Report by applicant of receipt of child support; application for assistance in obtaining child support. (NRS439.200, 442.100, 442.190)

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. Except as otherwise provided in this subsection, an applicant or client who is not receiving all payments of child support to which he is entitled for his support shall 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. The chief may, because of exceptional circumstances, excuse an applicant or client from compliance with the requirements of this subsection.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

Section 12. NAC 442.712 is amended to read as follows:

NAC 442.712 Receipt of donations, judgments or settlements. (NRS439.200, 442.140, 442.190) 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. ***Per NAC 442.215, recovery of money expended for corrective treatment may be recovered by the Health Division.*** 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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.715 Eligibility of providers under program. (NRS439.200, 442.140, 442.190)

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 NAC442.751; and

Section 13. NAC 442.715 #1 - is amended to read as follows:

(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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; 10-30-97; R212-97, 7-23-98)

NAC 442.718 Prohibition against discrimination. No person may exclude from, deny the benefits of or otherwise discriminate against a person who wishes to participate in the program because of that person's race, creed, color, national origin or sex.

(Added to NAC by Bd. of Health, eff. 1-18-94)

NAC 442.720 Format of forms to be used. Forms used for application, financial eligibility, authorization and payment must be in a format satisfactory to the program.

(Added to NAC by Bd. of Health, eff. 11-27-89)

NAC 442.725 Date of eligibility for participation; submission of application; annual updates. (NRS439.200, 442.140, 442.190)

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;

(b) On the date on which a medical facility notifies 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 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 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 annually.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; 10-30-97; R212-97, 7-23-98)

NAC 442.751 Limitations of program. (NRS439.200, 442.140, 442.190) 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.

Section 14. NAC 442.751 #2 is amended to read as follows:
2. Provide only services that are related to treating a client's condition. ***Eligible children must be evaluated at least yearly by a pediatric sub-specialty physician to document the need for continued services.***

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

Section 15. NAC 442.751 #4 is amended to read as follows:
4. Pay no 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.

Section 16. NAC 442.751 #7 is amended to read as follows:

7. Cover,~~[regardless of the income of a client,]~~ ***up to 300% of the Federal poverty level,*** any diagnostic evaluations performed to determine whether a client has an eligible medical condition.

(Added to NAC by Bd. of Health, eff. 1-18-94; A by R212-97, 7-23-98)

NAC 442.765 Grounds for terminating eligibility of client. (NRS439.200, 442.140, 442.190) A program specialist shall terminate the eligibility of a client for the following reasons:

1. The client reaches a 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.

Section 17. NAC 442.765 #6 is amended to read as follows:

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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; 10-30-97; R212-97, 7-23-98)

NAC 442.770 Submission and contents of claims. (NRS439.200, 442.140, 442.190)

1. Except as otherwise provided in subsection 2, 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 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 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. 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. 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, and must indicate 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.

Section 18. NAC 442.770 #12 is hereby repealed.
~~[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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)

NAC 442.775 Payment or denial of claim for medical services: Notification of denial to provider; procedure for review of denial and appeal of decision of bureau. (NRS439.200, 442.140, 442.190)

1. A program specialist shall determine whether to pay a claim for services furnished by a provider.

2. If the 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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; 10-30-97; R212-97, 7-23-98)

NAC 442.780 Denial of medical services: Notification of applicant or client; procedure for review of denial and appeal of decision of bureau. (NRS439.200, 442.140, 442.190)

1. If a program specialist 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 NAC442.765,
he/she 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 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.
(Added to NAC by Bd. of Health, eff. 11-27-89; A 10-30-97; R212-97, 7-23-98)

Services for Children With Special Health Care Needs

NAC 442.782 Eligibility for medical services. (NRS439.200, 442.190) To be eligible for medical services for an eligible medical condition under the program, a person must:

Section 19. NAC 442.782 #1 is hereby amended to read as follows:
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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.784 Eligible medical conditions: Categories; identification. (NRS439.200, 442.190)

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.

Section 20. NAC 442.784 #1 – d is hereby repealed.

~~[(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:

Section 21. NAC 442.786 #2 – a is hereby amended to read as follows:

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

~~[(1) ABO incompatibility.]~~

~~[(2) A plastic anemia.]~~

~~[(3) Hemolytic anemia.]~~

~~[(4) Hemophilia.]~~

~~[(5) Histiocytosis.]~~

~~[(6) idiopathic thrombocytopenic purpura, chronic.]~~

~~[(7) Leukemia.]~~

~~[(8) Lymphoma.]~~

~~[(9) Neutropenia, congenital.]~~

~~[(10)]~~ ***(1.)*** 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.

Section 22. NAC 442.786 #2 – c is hereby amended to read as follows:

(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.

Section 23. NAC 442.786 #2 – d is hereby amended to read as follows:

(d) Craniofacial anomalies, including, but not limited to:
(1) Cleft lip and palate ***and medically necessary dental restoration.***
(2) Congenital facial abnormalities associated with chromosomal abnormalities or known syndromes or causing oral or motor dysfunction, or both.
(3) Craniosynostosis.

Section 24. NAC 442.786 # 2 – e is hereby amended to read as follows:

(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)]~~ ***(1.)***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.

Section 25. NAC 442.786 #2 – g is hereby amended to read as follows:

(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)]~~ ***(1.)*** 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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)-(Substituted in revision for NAC442.740)

NAC 442.786 Ineligible conditions and services. (NRS439.200, 442.190) The program does not cover the following conditions and services:

1. Acute infectious diseases.

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

3. Allergies.

4. The alteration of a construction or dwelling.

5. Benign inflammatory conditions.

6. Blood and plasma, except for processing and administrative fees.

7. Chronic sinusitis, except in cases of severe respiratory impairment.

8. Cosmetic surgery as an isolated indication.

9. Custodial care.

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.

11. Disorders of the immune system.

12. Educational services.

13. Flat feet, tibial torsion and metatarsus adductus.

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.

15. Initial acute care of accidents, poisoning and violence.

16. Ordinary refractive errors.

17. Prematurity alone.

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

19. Services for homemakers.

20. Strabismus, where nonsurgical treatment suffices.

21. Transplant surgeries and drugs and supplies directly related to the transplant.

22. The transportation of a client or a member of his 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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)-(Substituted in revision for NAC442.755)

NAC 442.788 Payment for dietary supplements and medications; additional covered services. (NRS439.200, 442.190)

Section 26. NAC 442.788 #1 is hereby amended to read as follows:

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)]~~ ***(b)*** 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.

(Added to NAC by Bd. of Health, eff. 11-27-89; A 1-18-94; R212-97, 7-23-98)-(Substituted in revision for NAC442.760)

Prenatal Services

NAC 442.790 Eligibility. (NRS439.200, 442.190) 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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.792 Services covered under program. (NRS439.200, 442.190)

Section 27. NAC 442.792 # 1- a is hereby amended to read as follows:

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]~~ ***Two*** 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 ***disease, and the human immunodeficiency virus***;

(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.

Section 28. NAC 442.792 #1 – g is hereby amended to read as follows:

(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 ***dominant*** recessive trait ~~[, including, without limitation, Tay-Sachs]~~ ***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.
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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

Section 29. NAC 442.794 is hereby repealed.

~~[Dental Services]~~

~~[NAC 442.794 Eligibility. (NRS439.200, 442.140) 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.

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)

NAC 442.796 Services covered under program. (NRS439.200, 442.140)

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.]~~

(Added to NAC by Bd. of Health by R212-97, eff. 7-23-98)