LCB File No. R089-09

PROPOSED REGULATION OF THE STATE BOARD OF HEALTH

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

Section 2. ***Community Agency means a community based agency that has been approved by the Health Division to serve eligible clients with participating providers and make payments for approved treatment under guidelines established by NAC 442.600 – 442.788 and by the Health Division***

Section 3. ***1. The Health Division may contract with a Community Agency in Nevada to perform the functions of the Health Division set forth in these regulations NAC 442.600 through 442.788 including but not limited to setting up a provider network, determining eligibility of applicants, authorizing treatment for eligible clients, and processing payment for treatment in accordance with payment schedule developed by the Community Agency.***

2. The Health Division will ensure management of the program operates in accordance with these regulations.

Section 4. NAC 442.617 is hereby amended to read as follows**:**
"Bureau" means the Bureau of ~~[Family Health Services]~~ ***Child, Family and Community Wellness*** of the Health Division of the Department of Health and Human Services.

Section 5. NAC 442.710 is hereby amended to read as follows:

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

(a) Have an eligible condition;

(b) Be financially eligible pursuant to this section;

(c) Be a resident of this State and:

(1) A citizen of the United States;

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

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

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

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

3. Financial eligibility for participation in the program varies according to the gross annual income of the client's household in comparison to 250 percent of the level of poverty annually designated for a household of that size by the United States Department of Health and Human Services. A client is eligible for diagnostic evaluations pursuant to subsection 7 of NAC 442.751 if his gross annual income is not more than 300 percent of the level of poverty designated for a

household of that size by the United States Department of Health and Human Services. Gross annual income will be calculated by adding the total income and resources of all members of the client's household.

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

(a) Savings certificates and savings accounts.

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

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

(d) Proceeds from the sale of property.

(e) Income tax refunds or rebates.

(f) Cash gifts, prizes and awards.

(g) Trust funds.

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

(a) Wages, salaries and commissions.

(b) Gratuities.

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

(d) Alimony and child support.

(e) Inheritances.

(f) Pensions and benefits.

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

(h) Interest, dividends and royalties.

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

(j) Money in a trust.

(k) Rental income.

Section 6. NAC 442.720 is hereby amended to read as follows:

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

Section 7. NAC 442.751 is hereby amended as follows:

The program will:

1. Not provide for the total care of a client.

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

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

4. Pay not more than ~~[$10,000]~~ ***$5,000*** annually for each client unless, subject to budgetary limitations, the State Health Officer or a person designated by the Administrator authorizes the expenditure of an additional amount in an extraordinary situation.

5. Reimburse providers at ***a rate no higher*** than Medicaid rates for the costs of the services provided to clients. For the costs incurred for orthotic and prosthetic devices provided by medical prescription to enhance a client's ability to perform the activities of daily living, the program will reimburse:

(a) At ***or below*** Medicaid rates; or

(b) At ~~[80 percent of the usual and customary charge]~~ ***a negotiated rate*** if no Medicaid rate is available.

6. Approve services provided outside this State only when:

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

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

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

Section 8. NAC 442.770 is amended as follows:

1. Except as otherwise provided in subsections 2 and 3, a provider shall submit a claim for the payment of services provided to a client to third-party payers before submitting the claim to the Health Division under the program.

2. Except as otherwise provided in subsection 3, the provider may submit the claim directly to the Health Division under the program if:

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

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

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

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

4. If a provider submits a claim to the Health Division under the program, he shall submit a single copy of each completed claim on billing forms acceptable to Medicaid within ~~[120]~~ ***90*** days after the date: (a) Of service if the client does not have any third-party payers;

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

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

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

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

6. A claim must not be altered.

7. A claim must include:

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

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

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

(d) The date of service.

(e) The type of service, using the code descriptors designated by the Health Division.

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

(g) The provider's taxpayer identification number.

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

8. The primary surgeon's claims and necessary reports must be submitted to the Health Division before payment can be made to the assistant surgeon, anesthesiologist or anesthetist or for other ancillary services.

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

Section 9. NAC 442.788 is hereby amended 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) Epilepsy, subject to individual case and medical review.

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

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

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

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

(g) Thyroid conditions that require ongoing medication, subject to individual case and medical review.

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

3. The program will cover ***the following providers as prescribed by a physician***:

(a) Primary care of a client, as recommended by the American Academy of Pediatrics, to the extent that the Health Division 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.

(e) Speech therapy necessary to correct a client's speech, 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.

(f) Occupational therapy; such coverage is limited to more than 12 session annually and 60 minutes per session.

Section 10. NAC 442.660 is hereby repealed.

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