

**LCB File No. R212-97**  
**PROPOSED REGULATION CHANGE OF THE**  
**STATE BOARD OF HEALTH**  
**Maternal and Child Health Programs**

EXPLANATION—MATTER IN *ITALICS* AND UNDERLINED IS NEW  
MATTER IN BRACKETS [] IS OMITTED

**AUTHORITY: NRS 439.200 AND 442.190**

[**Section 1.**] *Definitions* Chapter 442 of NAC is hereby amended by adding thereto the provision set forth as sections 2 to [13]\_\_\_\_, inclusive, of this regulation. 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 [13]\_\_\_\_, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in NAC [442.602\_\_\_\_ to [442.705]\_\_\_\_\_, inclusive, and sections 2 to [11] \_\_\_\_, inclusive, of this regulation, have the meanings ascribed to them in those sections.

[**SEC. 2.**] “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.

[**SEC. 3.**] “Acute care” means a level of medical services provided in a hospital.  
*“Administrator” means the administrator of the health division.*  
*“Advanced Nurse Practitioner” is a health care provider who:*  
*1. Is licensed as such by the state where he/she practices;*  
*2. Is authorized by the Board of Nursing to provide services in addition to those that other registered nurses are authorized to provide per NRS 632.010 and NAC 632.020.*  
*3. Has a memorandum of understanding with the program.*

**[SEC. 4.]** “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.

“Amalgam” means a mixture of metals used for filling cavities in teeth.

“Annually” means a consecutive twelve month period of coverage starting at the effective date of the application.

“Bureau” means the bureau of family health services of the health division.

“Client” means a person who is eligible to participate in the program pursuant to NAC \_\_\_\_\_.

“Cost sharing” means the requirement that a household contribute financially toward the cost of the services authorized by the program.

“Dentist” means a dentist licensed pursuant to chapter 631 of NRS.

“Dental review” means the review of a provider’s dental records by, or in consultation with a dentist contracted/ employed by the state.

“Dental services” means treatment and facilitation services and necessary appliances directed toward the habilitation and rehabilitation of eligible children to reasonable dental health.

“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.

“Disabling condition” means an anatomical, physiological or other physical deficiency which inhibits normal growth or the ability to perform the activities of daily living.

“Eligible medical condition” means any medical condition of a client which is covered by the program, as set forth in NAC \_\_\_\_\_.

“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.

“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.

**[SEC. 5.]** “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/her relatives.]

A group of related or non related individuals who are living together as a single economic unit.

**[SEC. 6.]** Hospital” has the meaning ascribed to it in NRS 449.012.

“Inpatient” means a client who requires a stay of more than 24 hours in a hospital for treatment or a diagnostic evaluation.

**[Sec. 7.]** [“**Manager**”] “Chief means the [manager] chief of the bureau of family health services of the health division.

“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 for indigent persons.

**[SEC. 9.]** “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.

“Medical review” means the review of a provider’s medical records by, or in consultation with the medical staff contracted/employed by the health division.

“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.

“Memorandum of Understanding” means a contract or agreement between the MCH program and a provider which defines the type of services a provider will provide to clients and the method by which the program will reimburse the provider.

“Physician” means a provider who:

1. Is licensed by the state where he/she practices: and/or

2. Is certified by or eligible to sit for an examination by a specialty board which is a member of the American Board of Medical Specialties.

3. Has a memorandum of understanding with the program.

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

“Primary Care” means a full spectrum of services including: preventative, diagnostic, treatment, consultation, referral and other services rendered, on an ambulatory basis, and is comprehensive, integrated, longitudinal, and family and community centered.

“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 surface.

[SEC. 9.] “Prognosis” means the prospects of a client reaching a reasonable level of health and an ability to perform the activities of daily living.

“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.

“Program specialist” means a person on the staff of the health division designated by the administrator to determine whether to prior-authorize and then approve payment for claims submitted by providers for services.

“Provider” means a person authorized to provide a health care service or product pursuant to NAC 442. \_\_\_\_\_ to 442. \_\_\_\_\_, inclusive, and sections 2 - \_\_\_\_\_, inclusive of this regulation, through a signed agreement with the health division.

“Registered Dietitian” means a person who meets the criteria and has been determined to be a dietitian by the American dietetic Association.

[SEC. 10.] “Residence” means a place where a person remains when not called elsewhere for labor or other special temporary purposes and to which he returns.

[SEC. 11.] “Resident” means a person who lives in this state and:

1. Intends to make this state his/her 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/her parent or guardian's tour of duty in this state.

"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.

"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.

"Sealant" means a filled or non-filled resin applied to seal the decay prone crevices on teeth.

### **Eligibility**

**[SEC. 12.]** 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.

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

(a) Be below the age of 21 years for medical services for a suspected or confirmed eligible medical condition;

(b) Be below the age of 19 years for dental services;

(c) Be pregnant;

(d) Meet the requirements for financial eligibility specified;

(e) Be:

(1) A citizen of the United States of America; or

(2) A "Qualified alien" as ascribed in 8 U.S.C. § 1641; or qualified per current Federal guidelines pertaining to alien eligibility for public assistance; and

(3) A resident of this state.

(f) Term of eligibility:

Except as otherwise provided, an applicant's eligibility for participation in the program begins:

(1) On the date on which the applicant contacts the program; or

(2) On the date on which a medical facility notifies the program regarding the applicant; or

(3) Within 72 hours after admission to a medical facility if the applicant was admitted on a weekend; and

(4) If, within 30 days after that date, the applicant submits an application to the program.

(g) Application:

(1) 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.

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

(3) An applicant or a client shall submit an updated application:

(a) Annually;

(4) All applicants are required to report applicable child support payments. Those not receiving applicable child support are required to file with the local authorities for such support as part of the application process, unless there are exceptional circumstances warranting an exemption by the Bureau Chief. Program coverage is not dependent on child support collection.

**Financial Eligibility**

Financial eligibility 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 the program.

1. Resources to be considered 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.

2. Income to be considered includes, but is not limited to:

(a) Wages, salaries and commission.

(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.

(j) Any direct payments of money considered to be a gain or benefit.

(j) Money in a trust.

(k) Rental income.

(l) Money awarded from a public fund drive, litigation or settlement is to be used prior to MCH/CSHCN/Pre-Natal/Dental program funds toward the payment for provider medical services and/or related costs. For services already paid, the MCH/CSHCN/Pre-Natal/Dental program will require reimbursement. Clients are required to keep MCH/CSHCN/Pre-Natal/Dental programs informed of all steps taken to recover damages, this includes the name of the attorney and dates of any court hearings.

3. Cost Sharing:

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. 13.] Program Limitations.**

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] \_\_\_\_\_.
2. Provide only services that are [directly] related to treating a client's condition.

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

4. Pay no more than \$50,000 annually for each client.

Exceptions may be made by the state Health Officer in extraordinary situations and within budget limitations.

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

6. 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 services are not available within this state [.] and the referring provider agrees to provide ongoing follow up care.

7. Cover any diagnostic evaluations performed to determine whether a client has an eligible medical condition.

**[SEC. 14.]**

**[SEC. 15. NAC 442.610 is hereby amended to read as follows:**

“Agreement” means a contract or memorandum of understanding between the program 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.]

**[SEC. 16. NAC 442.625 is hereby amended to read as follows:**

“Client” means a person who is eligible to participate in the program pursuant to NAC 442.710.]

**[SEC. 17. NAC 442.630 is hereby amended to read as follows:**

“Cost sharing” means the requirement that a household contribute financially toward the cost of the medical services authorized by the program.]

**[SEC. 18. NAC 442.635 is hereby amended to read as follows:**

“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.]

**[SEC. 19.** NAC 442.640 is hereby amended to read as follows:

“Eligible medical condition” means any medical condition of a client which is covered by the program, as set forth in NAC 442.740.]

**[SEC.20.** NAC 442.650 is hereby amended to read as follows:

“Disabling condition” means an anatomical, physiological or other physical deficiency which inhibits normal growth or the ability to perform the activities of daily living.]

**[SEC. 21.** NAC 442.660 is hereby amended to read as follows:

“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.]

**[SEC. 22** NAC 442.665 is hereby amended to read as follows:

“Inpatient means a client who requires a stay of more than 24 hours in a hospital for treatment or a diagnostic evaluation.]

**[SEC. 23.** NAC 442.670 is hereby amended to read as follows:

“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 for indigent persons.]

**[SEC. 24.** NAC 442.680 is hereby amended to read is follows:

“Medical review” means the review of a provider’s medical records by, or in consultation with, the medical staff employed by the health division.]

**[SEC. 25.** NAC 442.685 is hereby amended to read as follows:

“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.]

**[SEC. 26.** NAC 442.690 is hereby amended to read as follows:

“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 specialty board:

3. Has a memorandum of understanding with the program.]

[**SEC. 27.** NAC 442.700 is hereby amended to read as follows:

“Program” means the program of the health division that provides reimbursement for the specialized medical services required for the maximum alleviation or rehabilitation of the eligible medical conditions of clients.]

[**SEC. 28.** 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 [13] \_\_\_\_\_ , inclusive, of this regulation, through a signed agreement with the health division.]

[**SEC. 29.** NAC 442.710 is hereby amended to read as follows:

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 a resident of this state.

2. Financial eligibility 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 the program.

3. Resources to be considered 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.

(j) Money in a trust.

(k) Rental income.

5. 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. 30.] Provider Provisions**

[NAC 442.715 is hereby amended to read as follows:]

1. To provide medical services to clients, physicians and other regular providers of [medical] services to the program must have executed an agreement with the program, except that providers who provide medical services one time or on a sporadic basis are not required to have executed an agreement [.] provided they agree to accept the program reimbursement as payment in full. The agreement must require a physician or

other provider of [medical] authorized services to accept the state fee schedule as the basis of reimbursement for the professional services, and require that [families] households will not be billed by the provider for the remaining balance unless a cost sharing has been established.

2. Providers of [medical] services must receive authorization before delivery of service in order to be eligible for reimbursement for medical services, except in cases of emergency. Oral authorization for care must be followed by written authorization. Authorizations for services provided during the hours when the offices of the health division 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, client or other provider of services within 72 hours after the services were provided.

3. A physician must [certify] provide medical justification and 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 anesthesiologists. [The authorized physician is responsible for notifying the anesthesiologists that the person is a client of the program and that] [t] The fees of the program prevail. The anesthesiologist 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 the program.

(c) Assistant surgeon. [The authorized physician is responsible for notifying the assistant surgeon that the

(d) person is a client of the program and that] [t] 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 the program.

(e) Laboratory /Other services. The fees of the program prevail. The laboratory/other provider, 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 the program.

**[SEC. 31. NAC 442.725 is hereby amended to read as follows:**

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 the program;
  - (b) On the date on which a medical facility notifies the program 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 the program.
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 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.]

### Claims

Except as otherwise provided , a provider shall submit a claim for the payment of services provided to a client to third-party payer before submitting the claim to the program.

1. The provider may submit the claim directly to 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.
2. If a provider submits a claim to 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.

3. 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, ICD code number, or ADA code number, including whether the condition is presumptively covered by the program or is a confirmed eligible condition.

(d) The date of service.

(e) The type of service, using the code descriptors as designated by the Health Division MCH Program such as those codes from Current Procedural Terminology and HCPCS, published by the American Medical Association; or the American Dental Association billing codes.

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

(g) The provider's taxpayer identification number.

(h) The provider's signature or signature of an authorized representative.

(i) The primary surgeon's claims and necessary reports must be submitted to the program before payment can be made to the assistant surgeon or anesthesiologist or for other ancillary services.

(j) 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.

(k) 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.

(l) 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 terminology contained in current procedure terminology codes and indicating whether or not the fee was split.

(m) Laboratory and x-ray services ordered by the authorized physician and adjunctive to his services do not require 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. \_\_\_\_\_

(n) Dental claims do not need medical records for routine dental care, provide the services received prior authorization.

(o) Claims for therapy, whether physical or psychological, must include the name of the ordering physician, the date of service, and documentation of the services provided. Services are limited to a maximum of 60 minutes per session, and to a maximum of twelve sessions annually, unless otherwise authorized.

#### **Termination of Coverage**

The program will terminate the eligibility of a client for the following reasons:

1. The client reaches the limitation on age or condition.
2. The client has achieved maximum alleviation or rehabilitation of his eligible medical condition.
3. The income of the client's household no longer meets the requirements for financial eligibility.
4. The client's household chooses to no longer participate in the program.
5. Failure by the client to cooperate in carrying out recommended treatment or to apply for third-party assistance.
6. A lack of money for the program for the continuation of the services required by the client.
7. Denial of other third-party coverage based on failure to cooperate.
8. Misrepresentation of material facts in the application.
9. Failure by the client to cooperate in filing for applicable child support payments.

In cases of extraordinary circumstances, the chief may grant an exception.

#### **Appeal**

1. If a provider disagrees with a decision made by the program specialist not to pay a claim, the provider may seek review of the decision by the chief and also request a medical review.

2. The provider must make the request in writing within 30 days after the program notifies him that it denied the claim.

3. The professional staff that performs the medical review must submit a written report to the chief within 30 days after the date on which the provider requested the medical review. The chief must make a decision within 30 days and notify the provider of the report and findings of the medical review and the final decision.

4. The provider may appeal the decision of the chief. A hearing will be conducted pursuant to NRS 449.170 and NAC 439 et seq.

### Children with Special Health Care Needs Program

#### Scope of coverage

#### **[SEC. 32.]**

**[NAC 442.740 is hereby amended to read as follows:]**

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 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 activities of daily living.

*The program will cover any diagnostic evaluations regardless of income, performed to determine whether a client has an eligible medical condition.*

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 initial [medication] therapy and requires additional therapies and/or the insertion of ventilation tubes. The treatment will be limited to not more than two tube insertion procedures. Additional procedures may be authorized upon review by the State Health Officer.

(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 not corrected by 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) Epispadias.
- (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 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] .
  - (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)] (L) Pulmonary conditions, including, but not limited to:

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

(2) Broncho-pulmonary dysplasia.

(3) Congenital emphysema.

(4) Lung hypoplasia associated with diaphragmatic hernia.

(5) Respiratory distress syndrome - coverage limited to a one day acute stay for administration of pulmonary-surfactant type treatment as a measure to reduce long term deficits.

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

- (1) Burn care and reconstruction - coverage extends from the date of initial injury.
- (2) Hemangioma.
- (3) A disfiguring deformity which impedes normal, daily function relative to social or emotional development.

**[SEC. 33. NAC 442.745 is hereby amended to read as follows:]**

Evaluation and diagnostic services will be provided pursuant to NAC 442.600 to 442.780 inclusive and sections 2 to [13] \_\_, inclusive of this regulation for children testing positive for the human immunodeficiency virus.

**CSHCN Program Limitations**

**[Sec. 34. 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 disabilities, mental retardation and problems related to behavior**].

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

**[7]** 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, 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. 35. NAC 442.760 is hereby amended to read as follows:**

**Medications, Dietary Supplements and Other Services**

The program does not pay for dietary supplements or medications except in the circumstances specified for the following eligible medical conditions:

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

2. Hemophilia, blood factors related to control.

3. Epilepsy, subject to individual case and medical review.

4. Juvenile diabetes, subject to individual case and medical review.

5. Chemotherapeutic agents, subject to individual case and medical review.

6. Inborn errors of metabolism such as 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.

7. Otitis Media, which has been unresponsive to an initial course of antibiotics. Case is subject to individual case and medical review.

8. Asthma, which requires daily medication for the performance of ADL. Case is subject to individual case and medical review.

9. Cardiac conditions, which require ongoing medication for the performance of ADL. Case is subject to individual case and medical review.

10. Thyroid conditions, which require ongoing medication. Case is subject to individual case and medical review.

11. Other Services:

a. Primary care as recommended by the American Academy of Pediatrics may be covered by the CSHCN program to assure the optimum health status for these children.

b: Physical therapy for return to functional ability - limited to a maximum of twelve (12) visits annually.

c: Group therapy for counseling relative to emotional support for a chronic, ongoing, eligible condition. Coverage is limited to a maximum of twelve (12) visits annually, with a maximum of 60 minutes per session for individual therapy, and 24 sessions for group therapy.

12. The use of medications and/or dietary supplements on an ongoing basis for the prevention or amelioration of complications of a covered medical condition are covered subject to individual case and medical review.

**[Sec. 36. NAC 442.050 is hereby amended to read as follows:]**

**[The program will terminate the eligibility of a client for the following reasons:**

- 1. The client reaches the limitation on age set forth in NAC 442.710.**
- 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 for financial eligibility set forth in NAC 442.710.**
- 5. The client's family chooses to no longer participate in the program.**
- 6. Failure by the client to cooperate in carrying out recommended treatment or to apply for third-party assistance.**
- 7. A lack of money for the program [or from cost sharing] for the continuation of the medical services required by the client.**

8. Denial of other third-party coverage based on failure to cooperate.
9. Misrepresentation of material facts in the application.]

[ **Sec. 37. NAC 442.770 is hereby amended to read as follows:**

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 program.
2. The provider may submit the claim to 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 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 whether the condition is presumptively covered by 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.
  - (f) The usual and customary fee for each type of service.
  - (g) The provider's taxpayer identification number.
  - (h) The provider's signature.

7. The primary surgeon's claims and necessary reports must be submitted to the program before payment can be made to the assistant surgeon or anesthesiologist 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 terminology contained in the fee schedule, and must indicate if 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.

[ **Sec. 38.** NAC 442.775 is hereby amended to read as follows:

1. If a provider disagrees with a decision made by the case specialist not to pay a claim, the provider may seek review of the decision by the manager and request a medical review.

2. The provider must make the request in writing within 30 days after the program notifies him that it denied the claim.

3. The medical staff that performs the medical review must submit a written report to the manager within 30 days after the date on which the provider requested the medical review. The manager must make a decision within 30 days and notify the provider of the report and findings of the medical review and the final decision.

4. The provider may appeal the decision of the manager in the manner prescribed in NAC 442.780.]

### **Pre-natal Services Program**

#### **General Requirements**

All sections of the general Maternal and Child Health Programs provisions apply to this program. Following are the more specific requirements of the pre-natal program.

## Eligibility

1. To be eligible for coverage under this program a person must:

(a) Be pregnant

(b) Meet the status and financial requirements as listed in the eligibility section of the MCH Program.

## Scope of Services

For the purposes of this section, the following services are eligible in this program:

1. Normal prenatal care per American College of Obstetricians and Gynecologists guideline/recommendations, with diagnostic testing and one ultrasound procedure during a pregnancy, unless more are medically indicated. Coverage will be limited to office visits, pap smear, urinalysis and dipstick urine testing, the testing of hemoglobin, hematocrit, blood type and blood grouping, Rh factor, rubella, drug screening, sickle cell, HIV and TB testing if indicated, and testing and treatment for sexually transmitted diseases, other than HIV, in which case HIV infected women will be referred to appropriate state or federal programs for treatment and follow - up services.

2. Coverage of a maximum of three (3) bottles of one hundred (100) tablets of prenatal vitamins prescribed by a health care provider.

3. In the case of a documented high-risk pregnancy and when medically indicated:

(a) The transportation of the mother to a hospital which has an approved level II or III neonatal intensive care unit;

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

4. Neonatal transport, if the criteria established pursuant to NAC ...to... inclusive, are met.

5. Complications of pregnancy, childbirth and puerperium.

6. Services directed toward the prevention of disabling conditions of pregnant women, infants and children.

7. Amniocentesis if:

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

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

(c) The mother and father are carriers of a recessive trait such as Tay-Sachs;

(d) The mother or father has a sibling with neural tube defects;  
(e) The mother is over 35 years of age and has at least one other risk factor; or  
(f) The mother has an abnormal test of maternal serum alpha - fetoprotein. Genetic counseling, by a genetics counselor, if available, is a prerequisite for coverage of amniocentesis by the program.

8. Smoking Cessation class - up to a maximum of \$50.00 reimbursement to a provider - upon client's completion of the class.

### **Pre-Natal Program Limitations**

1. Services are limited to those which are directed to the promotion of a good pregnancy outcome only. Services related to labor and delivery of an infant or fetus are not covered.

### **Dental Services Program**

#### **General Requirements**

All sections of the general Maternal and Child Health Programs provisions apply to this program except that coverage will be limited to (200% ) two hundred percent of poverty. There will be no cost-sharing participants in this program. Following are the more specific requirements of the dental program.

#### **Eligibility**

1. To be eligible for coverage under this program a person must:

(a) Be under 19 years of age;

(b) Not 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

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

#### **Scope of Services**

1. For the purposes of this section, the following services are eligible in this program:

(A) Diagnostic services, which include only:

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

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

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

2. Emergency services, which include only the care performed:

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

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

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

3. 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:

(a) The application of amalgams, resins, spacers and crowns;

(b) The extraction of teeth;

(c) The treatment of odontogenic cysts and tumors;

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

(e) The application of dental sealants; and

(f) The prescription and provision of vitamin supplements which include fluoride.

(g) The administration of out patient anesthesia.

### **Authorization**

1. If a provider requests authorization from the program to perform treatment services on a client, an individualized treatment plan for the client must be submitted to the program by the provider. The treatment 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.

2. In cases of emergency, authorizations may be issued for those patients pending Medicaid.

### **Dental Program Limitations**

1. Orthodontic services are not a covered benefit of the Dental Services program.