

10-003.04 Personal Care Items: NMAP covers personal care items, such as lotion, toothpaste, admit kits, etc., when they are necessary for the care of a client during inpatient or outpatient services.

10-003.05 Radiology and Pathology: NMAP covers medically necessary radiological and pathological services provided to inpatients and outpatients. NMAP covers only those services which are directly related to the patient's diagnosis. On claims for radiology and pathology, the provider ~~shall~~ must indicate the diagnosis which reflects the condition for which the service is performed, and if necessary, include a notation on the claim which documents the need.

Prior Authorization of Radiology Procedures: Effective July 1, 2009, all non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans, and other identified over-utilized or high-cost radiology services will require prior authorization. See 471 NAC 18-004.30A. These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room.

10-003.05A Outpatient Diagnostic Services Provided by Arrangement: NMAP covers medically necessary diagnostic services provided to an outpatient by arrangement (i.e., another hospital or independent clinical laboratory).

10-003.05A1 Diagnostic Services Provided by an Independent Clinical Laboratory: An independent clinical laboratory is one which is independent both of an attending or consulting physician's office and of a hospital. A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered to be a consulting physician.

A laboratory which is operated by or under the supervision of a hospital (or the organized medical staff of the hospital) which does not meet the definition of a hospital is considered to be an independent laboratory. However, a laboratory serving hospital inpatients and outpatients and operated on the premises of a hospital which meets the definition of a hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not classified as an independent clinical laboratory. The hospital's certification covers the services performed in this laboratory.

A clinical laboratory must meet the following criteria:

1. When state or applicable local law provides for licensing of independent clinical laboratories, the laboratory must be licensed under the law; and
2. The laboratory must also meet the health and safety requirements prescribed by the Secretary of Health and Human Services.

Note: A radiological laboratory is not considered an "independent laboratory" under NMAP.

10-005 Limitations and Requirements for Certain Services

10-005.01 Prior Authorization: NMAP requires that physicians request prior authorization from the Division of Medicaid and Long-Term Care before providing -

1. Medical transplants as follows:
 - a. Heart transplants;
 - b. Kidney transplants;
 - c. Bone marrow transplants (allogenic and autologous); and
 - d. Liver transplants;
2. Abortions;
3. Cosmetic and reconstructive surgery;
4. Gastric bypass surgery for obesity which includes the following procedures:
 - a. Gastric bypass;
 - b. Gastric stapling; and
 - c. Vertical banded gastroplasty;
5. Out-of-State Services. Exception: Prior authorization is not required for emergency services;
6. Established procedures of questionable current usefulness;
7. Procedures which tend to be redundant when performed in combination with other procedures;
8. New procedures of unproven value; ~~and~~
9. Certain drug products, as specified in 471 NAC 10-005.01D; and
10. All non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans, and other identified over-utilized or high-cost radiology services. See 471 NAC 18-004.30A.

18-004 Limitations and Requirements for Certain Services

18-004.01 Prior Authorization: NMAP requires that physicians request prior authorization from the Medicaid Division before providing -

1. Medical transplants, as follows:
 - a. Heart transplants;
 - b. Kidney transplants;
 - c. Bone marrow transplants (allogenic and autologous); and
 - d. Liver transplants;
2. Abortions;
3. Cosmetic and reconstructive surgery;
4. Gastric bypass surgery for obesity which includes the following procedures:
 - a. Gastric bypass;
 - b. Gastric stapling; and
 - c. Vertical banded gastroplasty;
5. Out-of-State services (Exception: Prior authorization is not required for emergency services);
6. Established procedures of questionable current usefulness;
7. Procedures which tend to be redundant when performed in combination with other procedures;
8. New procedures of unproven value; ~~and~~
9. Certain drug products, as specified in 471 NAC 18-004.25C and 18-004.25C1; and
10. All non-emergency outpatient Computerized tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans, and other identified over-utilized or high-cost radiology services. See 471 NAC 18-004.30A.

18-004.01A Prior Authorization Procedures: The physician must request prior authorization for these services in writing or electronically using the standard electronic Health Care Services Review – Request for Review and Response transaction (ASC X12N 278) (see Standard Electronic Transactions Instruction at 471-000-50) prior to providing the service.

18-004.01A1 Request for Additional Evaluations: NMAP shall request additional evaluations when the medical history for the request is questionable or when there is not sufficient information to support the requirements for authorization.

18-004.01A2 Prior Authorization Approval/Denial Process: The prior authorization request review and determination must be completed by one or all of the following Department representatives:

1. Medical Director;
2. Designated Department Program Specialists; and
3. Medical Consultants for the Department for certain specialties.

NMAP may cover laboratory tests that have been referred by one independent lab to another.

The Department does not reimburse a lab for handling services for tests referred to a second lab.

When a physician's private office sends the specimen to an independent clinical lab for processing, the Department pays for the procedure directly to the independent clinical lab. The Department does not reimburse the lab for collecting, handling, or drawing the specimen, sent in by a physician's office. The Department pays for specimens collected by venipuncture or catheterization obtained by the hospital or independent lab for hospital or independent lab patients. The Department does not reimburse the private physician for processing or interpreting tests performed outside his/her office. The Department does not allow reimbursement for collection of specimens in a nursing home or long term care facility.

If a physician performs some tests on a specimen and then sends the same specimen to an outside facility for additional procedures, the private physician may be reimbursed for the medically necessary procedures performed in his/her office plus a fee for drawing the specimen by venipuncture or obtaining urine by catheterization sent to a hospital or independent lab. The physician must indicate on or with the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49) that the fee for obtaining the specimen by venipuncture or catheterization is for tests performed outside his/her office and submit the name of the facility performing the tests on the claim.

A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal, such as a throat culture, a routine capillary puncture, or a pap smear.

18-004.30 Radiology Services: Radiology services are medically necessary services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic services and associated medical services necessary for the diagnosis and treatment of a patient. These services may be provided in -

1. A physician's or group of physicians' private office; or
2. A hospital whose certification covers the radiological services provided.

Claims for radiology procedures must have at least a provisional diagnosis or statement of symptoms. NMAP will not accept claims with a diagnosis of "routine radiology."

18-004.30A Prior Authorization of Radiology Procedures: Effective July 1, 2009, all non-emergency outpatient Computerized Tomography (CT) scans, Magnetic Resonance Angiogram (MRA) scans, Magnetic Resonance Imaging (MRI) scans, Magnetic resonance spectroscopy (MRS) scans, Nuclear Medicine Cardiology scans, Positron Emission Tomography (PET) scans, Single Photon Emission Computed Tomography (SPECT) scans, and other identified over-utilized or high-cost radiology services will require prior authorization. -These prior authorization requirements apply for all Medicaid clients enrolled in fee-for-service programs and must be completed prior to the scan being performed. These requirements do not apply to these scans when performed during an inpatient hospitalization or as an emergency through the hospital's emergency room.

18-004.30A-B Physician's Private Office: When both the technical and professional components of medically necessary radiological procedures are performed in a physician's private office, NMAP may reimburse the physician's private office for the total procedure.

18-004.30B-C Hospital Radiology Services: When a physician orders medically necessary radiological services performed in a hospital, NMAP makes payment directly to the hospital and/or radiologist according to the terms of the financial arrangements between the hospital and the radiologist. NMAP does not reimburse the private physician(s) for interpreting radiology procedures performed outside his/her office.

18-004.30CD Mammograms: NMAP covers mammograms when provided based on a medically necessary diagnosis. In the absence of a diagnosis, NMAP covers mammograms provided according to the American Cancer Society's periodicity schedule.

18-004.31 Ultrasound Diagnostic Procedures: NMAP covers ultrasound diagnostic procedures listed by Medicare under Category I. NMAP may review claims for these procedures to ensure that the techniques are medically appropriate and the general indications of Medicare's categories are met.

Because of rapid changes in the field of ultrasound diagnosis with respect to new diagnostic uses and medical appraisal of the safety and effectiveness of existing techniques, claims for uses other than those listed under Medicare's Category I will be reviewed before payment.

NMAP does not cover ultrasound procedures listed by Medicare under Category II.

18-004.32 Computerized Tomography (CT) Scans: NMAP covers diagnostic examinations of the head (head scans) and of certain other parts of the body (body scans) performed by computerized tomography (CT) scanners when -

1. Medical and scientific literature and opinion support the use of a scan for the condition;
2. The scan is reasonable and necessary for the individual patient; and
3. The scan is performed on a model of CT equipment that meets Medicare's criteria for coverage.

To be determined reasonable and necessary for the individual patient as required in item 2, the use of the CT scan must be medically appropriate considering the patient's symptoms and preliminary diagnosis. The Department may determine that the use of a CT scan as the initial diagnostic test was not reasonable and necessary because it was not supported by the patient's symptoms and complaints stated on the claim form or electronic format. The Department reviews claims for CT scans for evidence of abuse, such as the absence of reasonable indications for the scans, an excessive number of scans, or unnecessarily expensive types of scans.

18-004.33 Professional and Technical Components for Hospital Inpatient and Outpatient Diagnostic and Therapeutic Services: Hospital diagnostic and therapeutic services are procedures performed to determine the nature and severity of an illness or injury, or procedures used to treat disease or disorders. Hospital diagnostic and therapeutic services include both inpatient and outpatient hospital services.

Hospital diagnostic and therapeutic services are comprised of two distinct elements: the professional component and the technical component. Hospital services which have professional and technical components include but may not be limited to -

1. Pathology:
 - a. Anatomical;
 - b. Clinical;
2. Radiology;
3. Specialized diagnostic and therapeutic services:
 - a. CT scans;
 - b. Nuclear medicine;
 - c. Dialysis treatments;
 - d. Radiation therapy;
 - e. Ultrasound;
4. Anesthesia;
5. Psychiatric services; and
6. Miscellaneous:
 - a. Pulmonary function tests;
 - b. EEG's; and
 - c. EKG's.

NMAP may designate other services as having professional and technical components when the services are identified.