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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 17-003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 1, 2017

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 17-003. The SPA updates Attachment 4.19-B to reflect changes to the reimbursement methodologies for multiple out-patient services. The SPA was submitted to my office on March 27, 2017.

The approval is effective January 1, 2017. Attached are copies of the following pages to be incorporated into your State Plan:

- Attachment 4.19-B, Pgs. 1, 1a, 1d, 1d (continued), 1e, 2d, and 4a

If you have any questions, please contact Peter Banks by phone at (415) 744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam Louie
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Marta Jensen: Acting Administrator, DHCFP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-01 93

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **17-003**	2. STATE: **NEVADA**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2017**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: PV
State Plan Under Title XIX of the Social Security Act: 42 CFR 447	**a. FFY 2017** ~~**($-563,995)**~~ ($797,949) **b. FFY 2018** ~~**($1,143,865)**~~ ($1,090,728) **c. FFY 2019** ~~**($1,158,341)**~~ ($1,105,305)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 1 **Attachment 4.19-B, Page 1a** **Attachment 4.19-B, Page 1d** and 1d (continued) PB **Attachment 4.19-B, Page 1e** **Attachment 4.19-B, Page 2d** **Attachment 4.19-B, Page 4a**	**Attachment 4.19-B, Page 1** **Attachment 4.19-B, Page 1a** **Attachment 4.19-B, Page 1d** **Attachment 4.19-B, Page 1e** **Attachment 4.19-B, Page 2d** **Attachment 4.19-B, Page 4a**

10. SUBJECT OF AMENDMENT:

Attachment 4.19-B, Page 1: Information will be added to the Nevada Medicaid State Plan for services provided in an Outpatient Hospital setting. The amendment will add language to explain the payment methodologies used for services and the effective date of 01/01/2017.

Attachment 4.19-B, Page 1a: Information will be added to the Nevada Medicaid State Plan for Laboratory services. The amendment will update language explaining the payment methodology used for laboratory services and the effective date of 01/01/2017.

Attachment 4.19-B, Page 1d: Information will be added to the Nevada Medicaid State Plan for Podiatrist, Optometrist, Chiropractor, Advanced Practitioner of Nursing, Physician Assistants and Nurse Midwife services. The amendment will update language explaining the payment methodologies used for these services and the effective date of 01/01/2017.

Attachment 4.19-B, Page 1e: Information will be added to the Nevada Medicaid State Plan for Nurse Anesthetist and Psychologist services. The amendment will update language explaining the payment methodology used for these services and the effective date of 01/01/2017.

Attachment 4.19-B, Page 2d: Information will be added to the Nevada Medicaid State Plan for Therapy services. The amendment will update language explaining the payment methodology used for these services and the effective date of 01/01/2017.

Attachment 4.19-B, Page 4a: Information will be added to the Nevada Medicaid State Plan for rate methodology language for covered services. The amendment will update language explaining the usage of the 2014 Medicare Physician Fee Schedule for rate setting for covered services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

11. GOVERNOR'S REVIEW *(Check One)*:

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☒ OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Richard Whitley

14. TITLE:
Director, Department of Health and Human Services

15. DATE SUBMITTED: 3/27/17

16. RETURN TO:

Lynne Foster, Chief of Division Compliance
DHCFP/Medicaid
1100 East William Street, Suite 101
Carson City, NV 89701

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/27/17

18. DATE APPROVED: June 1, 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/17

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Henrietta Sam Louie

22. TITLE: Assistant Regional Administrator

23. REMARKS: Pen and Ink Request: Box 7: Updated to read - FY17: ($797,949), FY18 ($1,090,728), FY19 ($1,105,305). Box 8: Updated to read - "and 1d (continued)". Box 15: Updated to read - "3/27/17".

PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
      i. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical service codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
      ix. Prescribed drugs (page 3, paragraph 12a).
      x. Outpatient laboratory and pathology services (page 1a, paragraph 3).
      xi. Dental services (CDT codes, page 2c, paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (page 2, paragraph 7c); and disposable supplies (page 2, paragraph 7d).

      Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient hospital fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

   b. (This paragraph intentionally left blank.)

3. Laboratory and pathology services deemed to be Nevada Medicaid covered benefits will be paid at:

a. For codes 80000 - 89999, the lower of billed charges not to exceed 50% of the rate allowed by the 2014 Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada;
b. Allowed laboratory and pathology codes/services outside of the ranges listed in 3.1 and 3.2 or not listed in the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada will be paid in accordance with other sections of this State Plan based on rendering provider type;
c. For "BR" (by report) and "RNE" (relativity not established) codes that fall within the code range 80000 - 89999, the payment will be set at 62% of billed charges; or
d. Contracted or negotiated amount.

6. Medical care and any other type of remedial care provided by licensed practitioners:

a. Payment for services billed by a Podiatrist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare facility rate.
   2. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
   5. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

b. Payment for services billed by an Optometrist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare non-facility rate.
   2. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate. See also Page 3a, 12.d.

c. Payment for services billed by a Chiropractor will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Radiology codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   2. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   3. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
2. Radiology codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.
3. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Obstetrical service codes 59000 – 59999 will be reimbursed at 75% of the Medicare non-facility rate.

e. Payment for services billed by a Nurse Anesthetist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges or the amounts specified below:

1. Anesthesia codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia codes 01967 – 01969 are occurrence based codes that are paid a flat rate. Anesthesia codes 99100 – 99140 are not covered.
2. Surgical codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
3. Medicine codes 90000 – 99199 and Evaluation and Management codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.

f. Payment for services billed by a Psychologist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Medicine codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility based rate.
2. Vaccine Products require a NDC and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
3. Evaluation and Management codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility based rate.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. Podiatrist, Optometrist, Chiropractor, Nurse Anesthetist and Psychologist fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

11. Physical therapy, occupational therapy, respiratory therapy and audiology services for individuals with speech, hearing and language disorders will be reimbursed the lower of a) billed charges, or b) fee schedule rate which is 77% of the Medicare non-facility rate. The Medicare non-facility rate is calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service. The agency's therapy fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

24. RESERVED

25. Newly developed Current Procedural Terminology (CPT) codes determined to be for Nevada Medicaid covered services: Codes for those services with a rate methodology which uses resource based relative value scale (RBRVS), as specified elsewhere in this Attachment, will be entered into the system using the Nevada specific unit value developed by Medicare. The 2014 Medicare Physician Fee Schedule conversion factor will be used to calculate payment for these newly developed codes where the RBRVS is used. The maximum allowable will be established by multiplying the unit value and the 2014 conversion factor and then paying the appropriate percentage, as specified elsewhere in this Attachment, based on the provider type, service type and CPT code range.

If a code is billed that has no Nevada specific Medicare rate, the Division will determine if there is national Medicare pricing. If so, the service will be paid at the appropriate percentage of the rate, as specified elsewhere in this Attachment. If there is no national Medicare pricing, the Division will establish pricing based on similar services.