MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 13, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 200 – Hospital Services are being proposed to remove Section 203(D) – Newborns and Neonatal Intensive Care Unit (NICU). This section defined newborn and NICU revenue codes and provided a crosswalk from levels of care by InterQual/ MCG, to levels of care by UB Editor, to the revenue codes.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Hospital, Inpatient (Provider Type (PT) 11), Critical Access Hospital (PT 75).

Financial Impact on Local Government: None anticipated.

These changes are effective August 15, 2020.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL OL Chapter 200 – Hospital Services	MTL 05/20 Chapter 200 – Hospital Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
203(D)	**Inpatient Hospital Services Policy**	Removed all language in 203(D). This section defined newborn and NICU revenue codes and provided a crosswalk from levels of care by InterQual/ MCG, to levels of care by UB Editor, to the revenue codes.

203 INPATIENT HOSPITAL SERVICES POLICY

A. Inpatient hospital services are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that:

1. Is maintained primarily for the care and treatment of patients with disorders other than mental disease;

2. Is licensed as a hospital by an officially designated authority for state standard-setting;

3. Meets the requirements for participation in Medicare; and

4. Has in effect a Utilization Review (UR) plan, applicable to all Medicaid recipients, that meets the requirements of 42 CFR 482.30 and 42 CFR 456.50-456.145.

Inpatient hospital services do not include Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) services furnished by a hospital with a swing bed approval (42 CFR 440.10).

A hospital is an inpatient medical facility licensed as such to provide services at an acute LOC for the diagnosis, care and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an ICF for Individuals with Intellectual Disabilities (IID), regardless of name or licensure.

B. Out-of-State Acute Hospital Services

Non-emergency out-of-state acute inpatient hospital care requires prior authorization by the Quality Improvement Organization (QIO)-like vendor for Medicaid eligible recipients. Out-of-state inpatient hospital services may be authorized for specialized medical procedures not available in Nevada. The referral for out-of-state services must come from the referring/transferring Nevada physician and/or hospital. Reference MSM Chapter 100, Out-of-State Services and Out-of-State Provider Participation.

C. In-State and Out-of-State Acute Hospital Transfers

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, long-term acute care (LTAC) specialty, inpatient rehabilitation specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor must make a determination regarding the availability of such services at the referring hospital or

within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being available at the transferring facility.

It is always the receiving hospital's responsibility to confirm with the QIO-like vendor whether the transferring physician/hospital obtained authorization for a non-emergent transfer from the QIO-like vendor prior to the transfer and prior to the receiving hospital's agreeing to accept/admit the recipient.

~~D. Newborns and Neonatal Intensive Care Unit (NICU)~~

~~The DHCFP utilizes InterQual[1], MCG[2] and the Uniform Billing (UB) Editor[3] to define LOCs needed for each infant and revenue billing codes[4]. These LOCs and revenue codes indicate the nursing care provided to newborn and premature infants in nursery accommodations. These revenue codes range from a healthy newborn to intensive care.~~

~~The following newborn UB revenue codes are utilized by the DHCFP to reimburse hospitals for the LOC provided to newborns for inpatient hospital stays. The LOC should be clinically evaluated on a daily basis, typically based on the resources provided to the infant. Please note that the levels identified below reference the LOC provided and not the licensure level of the facility. Licensure level of hospitals for newborn care is per Nevada Administrative Codes 442.380, 442.390, 442.401, and 442.405. LOCs are defined in the UB Editor. Levels III and IV are paid at the same rate due to the fluctuation of a newborn's health status. The revenue code of the newborns' highest LOC reached during a calendar day shall be billed by the hospital for that day. The intention of the DHCFP is to reimburse for the highest LOC per day based upon clinical documentation and review.~~

~~1. 0170 = General.~~

~~2. 0171 = Newborn – UB Level I: This level reflects routine care of apparently normal full-term or preterm neonates (considered to be newborn nursery).~~

~~3. 0172 = Newborn – UB Level II: This level reflects low birth-weight neonates who are not sick but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (considered to be continuing care).~~

~~4. 0173 = Newborn – UB Level III: This level reflects sick neonates who do not require intensive care but require six to 12 hours of nursing each day (considered to be intermediate care).~~

~~5. 0174 = Newborn – UB Level IV: This level reflects newborns who need constant nursing and continuous cardiopulmonary and other support for severely ill infants (considered to be intensive care).~~

~~The following table is a crosswalk from InterQual and MCG LOCs, to the UB Editor for LOCs and revenue codes for reimbursement. Hospitals will submit authorization requests~~

~~in the Provider Web Portal at the most appropriate InterQual or MCG LOC and UB revenue code(s) based upon the table below:~~

~~LOCs by InterQual[1], MCG[2]~~	~~LOCs by UB Editor[3]~~	~~UB Revenue Codes[4] by UB Editor[3]~~
~~Newborn Nursery~~	~~Level I~~	~~0170 / 0171~~
~~InterQual I / MCG Level I / Transitional Care~~	~~Level II~~	~~0172~~
~~InterQual II / MCG Level II~~	~~Level III~~	~~0173~~
~~InterQual III & IV / MCG Level III & IV~~	~~Level IV~~	~~0174~~

~~[1]InterQual is published by Change Healthcare. All rights reserved.~~
~~[2]MCG. All rights reserved.~~
~~[3]Uniform Billing Editor is published by Optum360®. All rights reserved.~~
~~[4]Correspond with National Uniform Billing Committee revenue code descriptions and guidelines by the Uniform Billing Editor published by Optum360®.~~

~~InterQual is proprietary, nationally recognized standard utilized by Nevada Medicaid's QIO like vendor to perform utilization management, determine medical necessity and appropriate LOC. Many hospitals in Nevada also use this same selected tool for self-monitoring. However, hospitals may also use MCG to perform the same tasks.~~

203.1 COVERAGE AND LIMITATIONS

A. Admission

1. Admission Criteria

The DHCFP considers the recipient admitted to the hospital when:

a. A physician provides the order for admission at the time of admission or during the hospital stay, as verified by the date and time;

b. Acute care services are rendered;

c. The recipient has been transferred to, or is awaiting transfer to, an acute care bed from the emergency department, operating room, admitting department, or other hospital services; and

d. The admission is certified by the QIO-like vendor based on pertinent supporting documentation/submitted by the provider with the admission authorization request.

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, critical access, inpatient rehabilitation, or LTAC specialty hospitals) or before authorization of payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. Reference MSM Chapter 200, Admission Medical Record Determination, Plan of Care.