

	MTL 26/12
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 103
MEDICAID SERVICES MANUAL	Subject: PROVIDER RULES AND REQUIREMENTS

- c. Services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
- d. Services are provided for medical or mental/behavioral reasons rather than for the convenience of the recipient, the recipient's caregiver, or the health care provider.

Medical Necessity shall take into account the ability of the service to allow recipients to remain in a community based setting, when such a setting is safe, and there is no less costly, more conservative or more effective setting.

103.1 AUTHORIZATION

Titles XI and XVIII of the Act provide the statutory authority for the board objectives and operations of the Utilization and Quality Control Quality Improvement Organization (QIO) program. The Peer Review Improvement Act of the Tax Equity and Fiscal Responsibility Act of 1982 established Utilization and Quality Control QIO.

QIOs operate under contract with the Secretary of Health and Human Services (HHS) to review Medicaid services, once so certified by Center for Medicare and Medicaid Services (CMS). They may also contract with Medicaid agencies and private insurers. The utilization review/control requirements of 42 Code of Regulations (CFR) 456 are deemed met if a state Medicaid agency contract with a Medicare certified QIO, designated under Part 475 to perform review/control services (42 CFR 431.630).

PA review is conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid's policy, prior to the delivery of service.

- a. Some services covered by Nevada Medicaid require PA for payment. When the provider learns that a patient has been approved for Medicaid, authorization, as appropriate, must be requested for services provided and/or being provided.

For Medicaid recipients who have been discharged **from a facility**, but are approved retroactively the provider has 90 days from the date of the eligibility decision to submit a request for authorization, with the complete medical record, to the QIO-like vendor. For recipients still in the hospital when the date of decision is determined, the facility is responsible for initiating the admission and concurrent process within **five-ten (10)** working days.

- b. For Medicare and Medicaid dual eligibles there is no requirement to obtain Medicaid PA for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's PA guidelines. PA are not necessary for recipients who are eligible for Qualified Medicare Beneficiary (QMB) only since Medicaid pays only the co-pay and deductible. If Medicare benefits are exhausted (i.e. inpatient) a PA from