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201 AUTHORITY

- A. In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation for states that elect to offer medical programs. The states must offer at least 11 basic required medical services. Two of these services are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20).
- B. Other authorities include:
1. Section 1861 (b) and (e) of the Social Security Act (Definition of Services)
 2. 42 CFR Part 482 (Conditions of Participation for Hospitals)
 3. 42 CFR Part 456.50 to 456.145 (Utilization Control)
 4. Nevada Revised Statutes (NRS) 449 (Classification of Hospitals in Nevada)
 5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers and Newborns)
 6. Section 2301 of the Affordable Care Act (ACA) (Federal Requirements for Birth Centers)
 7. NRS Chapter 449 (**Hospitals, Classification of Hospitals and Obstetric/Birth Center Defined**)
 8. Nevada Administrative Code (NAC) Chapter 449 (Provision of Certain Special Services-Obstetric Care)
 9. 42 CFR Part 440.255 Limited services available to certain aliens.
 10. NRS Chapter 422 Limited Coverage for certain aliens including dialysis for kidney failure.
 11. 42 CFR 435.406 (2)(i)(ii) (permitting States an option with respect to coverage of certain qualified aliens subject to the five-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria).
 12. **42 CFR 441, Subpart F (Sterilization)**
 13. **42 CFR 447.253 b ii B, Other requirements**

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203 POLICY

203.1 INPATIENT HOSPITAL SERVICES POLICY

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:

- a. is maintained primarily for the care and treatment of patients with disorders other than mental disease;
- b. is licensed as a hospital by an officially designated authority for state standard-setting;
- c. meets the requirements for participation in Medicare; and
- d. 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 Level of Care (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 Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.

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 Chapter 100, Out-of-State Services and Out-of-State Provider Participation.

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, 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

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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 met 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 nonemergent transfer from the QIO-like vendor prior to the transfer, and prior to the receiving hospital's agreeing to accept/admit the recipient.

203.1A COVERAGE AND LIMITATIONS

1. Admission

a. Admission Criteria

Division of Health Care Financing and Policy (DHCFP) considers the recipient admitted to the hospital when:

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

acute care services are rendered;

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

4. 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, Medical Rehabilitation or Long Term Acute Care (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 203.1B.11.c.

b. Admission Order

Physician orders for admission must be written at the time of admission or during the hospital stay and are only valid if they are signed by the physician. Admission orders written after discharge are not accepted. Verbal and telephone orders written by other allied personnel must be co-signed by the physician.

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The role of the QIO-like vendor is to determine whether an admission is medically necessary based on the medical record documentation, not to determine physician intent to admit.

c. Admission Date

The admission date must be reflected on the authorization as the date and time the admission order was written during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies the documentation most relevant to the admission determination contingent upon provision of acute care services. The QIO-like vendor makes every effort to identify the documented admission date; however, it is ultimately the hospital's responsibility to provide complete and accurate admission information.

d. Planned and Transfer Admissions

For those instances in which the admission order was written (as defined above) before the recipient arrives at the hospital (planned elective admission), a signed physician order meets the requirements for admission. For transfers from other acute care hospitals, a signed physician order (as defined above) must be contained in the accepting facility's record. The admission date and time for the authorization is based on documentation most relevant and available to the admission determination contingent upon provision of acute care services and admission certification by the QIO-like vendor. Reference 203.1B.16 regarding provider responsibilities related to in-state and out-of-state acute hospital transfers.

e. Inpatient Admission from Observation

Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order.

f. Military or Veterans' Hospitals

Inpatient hospital admission at a military or Veterans' hospital is not a Medicaid benefit.

g. **Obstetric** Admissions for Early Induction of Labor (EIOL) Prior to 39 Weeks Gestation

~~1.~~ To be eligible for reimbursement, **an obstetric** hospital admissions for EIOL prior to 39 weeks gestation must be prior authorized by the QIO-like vendor as medically necessary. **Failure to obtain prior authorization from the QIO-like vendor will result in denial of claim reimbursement.**

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h. **Obstetric** Admissions for Elective or Avoidable Scheduled Cesarean **Delivery**

1. To be eligible for reimbursement, an obstetric inpatient admission for an elective cesarean delivery must be authorized. Failure to obtain authorization from the QIO-like vendor will result in denial of claim reimbursement.
2. Coverage/reimbursement of non-medically necessary **obstetric** admissions for elective or avoidable cesarean section (e.g. performed for the convenience of the physician or recipient), **authorized by the QIO-like vendor**, is limited to the minimum federal requirement for a normal vaginal delivery.

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2. Authorization Requirements

Authorization review is conducted to evaluate medical necessity, appropriateness, location of service and compliance with the DHCFP's policy. All inpatient hospital admissions must be authorized by the QIO-like vendor for reimbursement by the DHCFP. The QIO-like vendor certifies LOC and length of stay.

Reference Medicaid Services Manual (MSM) Chapter 100, section 103.1 regarding criteria related to medical necessity.

- e.a. All inpatient QIO-like vendor determinations are based on pertinent medical information documented initially by the requesting physician and provided to the QIO-like vendor by a hospital with the request for admission.
- e.b. Authorization refers only to the determination of medical necessity and appropriateness. Authorization does not guarantee benefit plan payment. Plan coverage is also conditional upon the recipient's eligibility and is subject to all other coverage terms and conditions of the Nevada Medicaid and Nevada Check Up (NCU) programs.
- e.c. Services requiring prior authorization which have not been prior authorized by the QIO-like vendor are not covered and will not be reimbursed. A prior authorization request inappropriately submitted for inpatient admission after an unauthorized, planned, elective inpatient procedure or surgery is performed, will be rejected and returned without consideration. Concurrent services related to these unauthorized admissions will also be returned without consideration, unless the services are specifically related to stabilization of an emergency medical condition that develops. Once the emergency medical condition is stabilized, no additional services related to this unauthorized elective admission will be reimbursed.
- f.d. A prior authorization is valid for the dates of service authorized. If the service cannot be provided for any reason during authorized service dates (e.g. a recipient has a change of condition) the prior authorization becomes invalid. A new or updated prior authorization must be obtained for reimbursement of corresponding dates of service.

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g.c. Out-of-state authorization determinations are based upon several conditions such as the availability of the service within the state at other facilities and the LOC not being met at the transferring facility.

h.f. Providers must submit pertinent clinical information and obtain prior authorization from the QIO-like vendor for the following services:

1. Any surgery, treatment or invasive diagnostic testing unrelated to the reason for admission; or days associated with unauthorized surgery, treatment or diagnostic testing.
2. Hospital admissions for EIOL prior to 39 weeks gestation.
3. Hospital admissions for elective or avoidable scheduled cesarean sections.
4. Antepartum admissions for the purpose of delivery when an additional elective procedure is planned (excluding tubal ligations).
5. Additional inpatient days must be requested **prior to or by the last before authorized inpatient days of the current/existing authorization period expire.**
6. Dental admissions. Two prior authorizations for inpatient hospitalization for a dental procedure are necessary:
 - a. The Medicaid dental consultant must prior authorize the dental procedure; and
 - b. The QIO-like vendor must authorize it is medically necessary for the recipient to be hospitalized for the performance of the dental procedure.
7. An admission for a family planning procedure (e.g. a tubal ligation or vasectomy).
8. Non-emergency admissions to in-state and out-of-state facilities.
9. Psychiatric admissions to a free standing psychiatric hospital IMD for recipients age 65 or older or under age 21 or to a psychiatric wing of a general acute hospital, regardless of age.

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10. All changes in LOC and/or transfer between units (e.g. medical/surgical, intensive care, obstetrics, newborn, neonatal intensive care, trauma level 1, psychiatric/detoxification, rehabilitation, administrative, and outpatient observation.) Per diem reimbursement amounts are based on the LOC authorized by the QIO-like vendor.
 11. Substance abuse detoxification and treatment (inpatient) admissions. This includes transfers from detoxification to treatment within the same hospital. Reference Chapter 400 for admission criteria.
 12. Swing bed admissions in rural or Critical Access hospital. Reference Section 203.3 of this Chapter.
 13. A leave of absence or therapeutic pass from an acute or Medical Rehabilitation Specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference 203.1A.3 , Absences.
 14. When Third Party Liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference Chapter 100, section 104.
 15. Non-Medicare covered days within 30 days of the receipt of the Medicare EOB indicating Part A Medicare benefits are exhausted. Reference Chapter 100, section 103.2.
 16. Admissions resulting from EPSDT screening.
- i.g.** Providers must submit pertinent clinical information and request authorization from the QIO-like vendor within one business day of patient admission for the following services:
1. All in-patient admission for an emergent condition including, but not limited to, any emergency admission (e.g. from a physician's office, urgent care or emergency room) or an emergency transfer from one in-state and/or out-of-state hospital to another.
 2. Obstetric ~~or newborn~~ admissions which, from the date of delivery, exceed three calendar days for vaginal or four calendar days for a medically necessary or emergency cesarean delivery.
 3. Newborn admissions which, from the date of delivery, exceed three calendar days for vaginal or four calendar days for a medically necessary or elective/ avoidable cesarean delivery.

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~~3.4.~~ When delivery of a newborn ~~or fetal demise during delivery~~ occurs immediately prior to arrival at a hospital for an obstetric/newborn admission.

~~4.5.~~ Direct inpatient admissions initiated through an emergency room and/or observation status as part of one continuous episode of care (encounter) at the same facility when a physician writes an acute inpatient admission order (rollover admissions).

The following criteria applies:

- a. Observation and ancillary services resulting in a direct inpatient admission provided as part of one continuous episode of care on the same calendar date and at the same facility as the inpatient admission are included in the first inpatient day per diem rate. Observation and ancillary services rendered on a calendar date preceding the rollover inpatient admission date can be billed separately.
- b. Emergency room services resulting in a direct inpatient admission at the same facility and provided as part of one continuous episode of care are included in the first inpatient hospital day per diem rate, even if the emergency services are provided on the calendar date preceding the admission date.

~~5.6.~~ Any newborn/neonate admission to a Neonatal Intensive Care Unit (NICU).

~~6.7.~~ Admission to hospitals without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit. Refer to MSM Chapter 400.

h. Utilization Review (UR) Process

The QIO-like vendor evaluates the medical necessity, appropriateness, location of service and compliance with the DHCFP's policy related to inpatient admission requests. The QIO-like vendor reviews if services furnished or proposed to be furnished on an inpatient basis could (consistent with provision of appropriate medical care) be safely, effectively and more economically furnished on an outpatient basis, in a different type of inpatient health care facility or at a lower LOC within a general hospital. Once the QIO-like vendor is provided pertinent clinical admission information, a review of the medical information from the

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facility is conducted to determine the appropriate LOC and authorized time period for the length of stay.

1. Concurrent Review

Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period that services are being provided. Initially the QIO-like vendor assigns a length of stay based on the diagnosis and condition of the recipient. For complex cases, additional days may be authorized to manage the medical condition through the concurrent review process. ~~When a~~ **Additional inpatient days review days are must be** requested, ~~the provider must contact the QIO-like vendor~~ prior to or by the last day of the current/existing authorization period.

2. Retrospective Review

Retrospective review is a review of clinical information to determine whether the services will be approved after the service is delivered. Retrospective review, for the purpose of this chapter, refers to cases in which eligibility is determined after services are provided. If the clinical information does not support the medical necessity or appropriateness of the setting, services are denied or reduced. The provider is notified when the QIO-like vendor's reviewer determines clinical information supports either a reduction in LOC, discharge, or denial of days.

~~3. Administrative Days~~

~~a. Administrative days are inpatient days reimbursed at a lower per diem rate when a recipient's status does not meet an acute LOC and placement in an alternative appropriate setting is not available, despite a hospital's documented, comprehensive discharge planning efforts.~~

~~b. At least one acute inpatient hospital day (24 hours) must immediately precede an Administrative Skilled Nursing or Intermediate LOC. A patient cannot be admitted directly to or from an outpatient setting (e.g. emergency room, observation status, a physician's office, urgent care or clinic) to an inpatient hospital administrative skilled nursing or intermediate LOC.~~

~~e. Administrative days are authorized through the QIO-like vendor based on medical necessity and as a reduction of LOC. The QIO-~~

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~~like vendor may authorize administrative days up to seven calendar days with the initial and each subsequent request, when medically necessary.~~

~~d. Levels of Administrative Days~~

~~1. Skilled Nursing Level (SNL) provides for ongoing hospital services for those recipients who do not require acute care and discharge to an alternate appropriate placement is required. SNL days are authorized when one or more of the following conditions apply or as deemed necessary by the physician reviewer:~~

~~a. A recipient is waiting for evaluation and/or placement regarding a NF/extended care facility, group home or other treatment setting for continuity of medical services (e.g. transfers to other facilities, rehabilitation, independent living, or hospice).~~

~~b. A recipient is being discharged home and is waiting for home equipment set up/availability, nursing services, and/or other caretaker requirements (e.g. home health nursing, public health nursing, Durable Medical Equipment (DME), or respite).~~

~~c. Medical interventions are required that prevent a non-acute recipient from leaving the hospital (e.g., monitoring of labs, cultures for staph infection or any treatment/work up that could not be safely and effectively accomplished in another setting).~~

~~d. A recipient is waiting for placement at a RTC, a psychiatric or an alcohol/substance abuse treatment hospital or a hospital with a psychiatric or an alcohol/substance abuse treatment unit for continuity of services.~~

~~e. A newborn is waiting for placement due to medical complications.~~

~~f. A recipient is being prepared for surgery, which may not have been the original reason for admission, and the services do not meet an acute LOC.~~

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~~g. A recipient with mental disabilities preventing NF placement is waiting for placement in an Institution for Mental Disease.~~

~~2. Intermediate Care Level (ICL) is for those recipients who cannot be discharged due to social reasons.~~

~~ICL days are authorized when one or more of the following apply or as determined by the physician reviewer:~~

~~a. A stable newborn is waiting for adoption or discharge home when the mother is discharged.~~

~~b. A recipient is waiting medical assisted transportation.~~

~~c. A recipient is a victim of crime and requires assessment and evaluation.~~

~~3. Administrative days are denied and no reimbursement is provided to the facility when any of the following occur:~~

~~a. A recipient, recipient's family or physician refuse to cooperate with discharge planning efforts or refuse placement at a NF psychiatric RTC or other available alternative setting.~~

~~b. Administrative days are only for the convenience of the recipient or the recipient's family or physician.~~

~~c. A recipient did not meet an acute inpatient LOC and was not approved for at least one acute inpatient hospital day immediately preceding the request for administrative days.~~

~~d. Days when a hospital is unable to provide documented evidence of comprehensive discharge planning efforts (e.g. Monday through Friday contacts, results and modifications of the discharge plan, as applicable).~~

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~~4. To obtain authorization for administrative days, providers must:~~

~~a. notify the QIO-like vendor when acute care services are no longer required and there is a reduction in LOC to administrative days.~~

~~b. submit a request for additional administrative days by the last day of the current/existing authorized period.~~

~~c. maintain documentation of comprehensive, appropriate discharge planning efforts in a recipient's medical record. Reference 203.1B.11 regarding provider discharge planning requirements.~~

~~d. submit all pertinent discharge planning effort information (e.g. a social worker's, case manager's or nurse's discharge planning notes, phone logs of calls to post-acute providers, physician's orders and progress notes, reasons for discharge delays) to the QIO-like vendor with authorization requests for administrative days.~~

3. Leave of Absence

a. Absences from an acute hospital or Medical Rehabilitation Specialty hospital are allowed:

1. in special circumstances, such as when a recipient is in the hospital on a long-term basis and needs to be absent for a few hours for a trial home visit or death of an immediate family member; or
2. up to, but not exceeding 32 hours from a Medical Rehabilitation Specialty hospital for therapeutic reasons, such as preparing for independent living.

b. Prior authorization must be obtained for a leave of absence expected to:

1. last longer than eight hours from an acute hospital; or
2. last longer than eight hours or involving an overnight stay from a Medical Rehabilitation hospital.

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- c. A leave of absence from an acute inpatient hospital is not covered if a recipient does not return to the hospital by midnight of the day the leave of absence began (a reserved bed).
- d. For a therapeutic leave of absence, the following information must be documented in a recipient's medical record:
 - 1. A physician's order specifying the number of hours for the pass;
 - 2. The medically appropriate reason for the pass prior to issuance of the pass; and
 - 3. An evaluation of the therapeutic effectiveness of the pass when the recipient returns.

203.1B PROVIDER RESPONSIBILITIES

1. Patient Liability

- a. Determination: Patient Liability (PL) is determined by eligibility personnel in the local Division of Welfare and Supportive Services (DWSS) District Office. The hospital is notified of PL on the Notice of Decision (NOD) form. For questions regarding PL, please contact the local DWSS District Office.
- b. Collection: When a case is approved or PL changes, the recipient, facility and fiscal agent (and authorized representative, where appropriate) are notified of the amount and effective date. Collection of PL is the facility's responsibility.
 - 1. If the application is approved, the facility is sent a NOD indicating the amount of PL due and the effective date. The recipient and the fiscal agent are also notified. If eligibility is retroactive and the date of decision on months of eligibility more than 24 months from month of decision, a Medicaid Case Status Form (2214-EM) will be sent to the medical facility.
 - 2. PL for new approvals is effective the first month of eligibility for Medicaid. When a recipient's income changes, PL is adjusted beginning with the month of the change.
 - 3. The monthly PL is deducted from the initial claim received by the QIO-like vendor from a qualified facility. There is no prorating of PL for recipients transferring facilities within the month.

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4. If a recipient expires mid-month, the DWSS prorates PL as in number 3 above. The facility will be sent a notice indicating the adjusted PL amount.
5. No PL is taken from Medicaid recipients during periods of Medicare coverage. Beginning with the first non-Medicare covered day, hospitals must access PL at the Medicaid LOC and per diem rate for that hospital.

2. Conditions of Participation

a. To be enrolled with the DHCFP, providers must:

1. be in compliance with applicable licensure requirements.
2. be certified to participate in the Medicare program. Hospitals currently accredited by the Joint Commission or by the American Osteopathic Association (AOA) are deemed to meet all of the conditions of participation in Medicare. Centers for Medicare and Medicaid Services (CMS) makes the final determination of whether a hospital meets all Medicare criteria based on the recommendation of the state certifying agency (42 CFR Part 482).
3. have a Provider Contract with the DHCFP. Refer to Chapter 100, section 102, Provider Enrollment.

b. Termination

The DHCFP may terminate a provider contract for failure of a hospital to adhere to the conditions of participation, reimbursement principles, standards of licensure, or to conform to federal, state, and local laws. Either party may terminate its agreement without cause at any time during the term of agreement by prior written notice to the other party.

Loss of Medicare certification results in concomitant loss of a Medicaid contract.

Refer to MSM, Chapter 100, for termination, lockout, suspension, exclusion, and non-renewal of Medicaid provider enrollment.

3. Utilization Review (UR)

Parts 456.100 through 456.145 of Section 42 CFR prescribe the requirements for a written

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UR plan for each hospital providing Medicaid services. The UR plan is deemed met for Medicare and Medicaid if a QIO-like vendor is conducting binding review.

CFR 482.30 provides that hospitals participating in the Medicaid program must have in effect a UR program under a QIO-like or CMS has determined that the UR procedures established by the Medicaid program are superior to the procedures under the QIO-like vendor, and meet the UR plan requirements under 42 CFR 456.50 through 456.245.

4. Quality Assurance - Hospital Medical Care Evaluation Studies

The purpose of hospital medical care evaluation studies is to promote the most effective and efficient use of available health facilities and services consistent with recipient needs and professionally recognized standards of care. (CFR 456.141 to 456.145)

As part of the conditions of participation in the Medicaid Title XIX program, a minimum of one medical care evaluation study must be in progress at any time. Additionally, one study must be completed each year. The completed study must be submitted to the QIO-like vendor at the end of each calendar year along with the study in progress topic. (A report summarizing the study topics will be submitted to Nevada Medicaid by the QIO-like vendor.)

Hospitals may design and choose their own study topic or, at the request of Medicaid, perform a topic designed by Medicaid, and forward a copy of the completed study to the QIO-like vendor office within the specified time frames.

5. Civil Rights Compliance

As recipients of federal funding, hospitals must assure compliance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (including HIV, AIDS and AIDS-related conditions), the Age Discrimination Act of 1975, and the Americans with Disabilities Act (ADA) of 1990.

6. Patient Self-Determination Act (Advance Directives) Compliance

Pursuant to the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), and federal regulations at 42 CFR 489.100, hospitals which participate in and receive funding for Medicare and/or Medicaid must comply with the Patient Self Determination Act (PSDA) of 1990, including Advance Directives. The DHC FP is responsible for monitoring/reviewing hospitals periodically to determine whether they are complying with federal and state advance directive requirements.

7. Form 3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form 3058 to their local DWSS District Office

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whenever a hospital admission, discharge, or death occurs.

Failure to submit this form could result in payment delay or denial. To obtain copies of Form 3058, please contact the local DWSS.

8. Patient Rights

Pursuant to 42 CFR 482.13, a hospital must protect and promote each patient's rights. Hospitals are also required to comply with Nevada Revised Statutes (NRS) 449.730 pertaining to patient's rights.

9. Claims for Denied Admissions

After having an inpatient service authorized by the QIO-like vendor, hospitals are not permitted to submit the claim to the fiscal agent as an outpatient service. The only exception to this is if an outpatient or non-inpatient related service was truly rendered prior to the inpatient admission order by the physician but the inpatient stay was denied by the QIO-like vendor (e.g., admit from ER or rollover from observation days).

10. Hospital Responsibilities for Services

Any hospital receiving authorization from the QIO-like vendor to admit and provide services for a recipient is responsible for the recipient's service and treatment needs. If a hospital does not have the proper or functional medical equipment or services, and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing, evaluation, and/or treatment, it is the transferring hospital's responsibility to fund the particular services and transportation if necessary.

11. Admission Medical Record Documentation

a. Pre-Admission Authorization

The physician (or his/her staff) must obtain prior authorization from the QIO-like vendor for all non-emergency, elective, planned hospital procedures/admissions. Lack of a prior authorization for an elective procedure or admission results in an automatic denial which cannot be appealed. Reference Chapter 600.

Dental, oral and maxillofacial surgeons must also secure prior authorization from the DHCFP dental consultant to assure payment for the procedure. (Reference 203.1A.2.f.4) and Chapters 600 and 1000 regarding covered dental benefits.

b. Physician Certification

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A physician's order, written prior to or at the time of admission, is required for all inpatient admissions. If a recipient applies for assistance while in the hospital, a physician's order for inpatient admission is required before reimbursement is authorized.

A physician, or physician's assistant or nurse practitioner acting within the scope of practice, as defined by state law and under the supervision of a physician, must re-certify for each applicant or recipient that inpatient services in a hospital are medically necessary. Re-certification must be made at least every 60 calendar days after the initial order. (42 CFR 456.60)

c. Plan of Care

Before admission to a hospital or before authorization for 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. (42 CFR 456.80)

The plan of care must include:

1. diagnoses, symptoms, complaints, and complications indicating the need for admission;
2. a description of the functional level of the individual;
3. any orders for medications, treatments, restorative and rehabilitative services, activities, social services, diet;
4. plans for continuing care, as appropriate; and
5. plans for discharge, as appropriate.

12. Discharge Planning

- a. The hospital must designate separate, identifiable staff whose primary responsibility is discharge planning. The discharge planners must review all Medicaid admissions.
- b. Discharge planning activities must commence within 48 hours of admission (or up to 72 hours involving weekends) for every recipient.
- c. The discharge planner formulates and records a discharge plan. The plan must specify goals and resolution dates. All alternatives to NF placement must be explored (e.g., home health services, homemaker services, placement with family, subsidized housing, meals programs, group care, etc).

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- d. The discharge planner must coordinate the discharge plan with primary care staff, the family, the physician, the placement setting (if applicable) and the recipient.
- e. The planner must be aware of and identify the LOC or level of services necessary to maintain the recipient out of the hospital setting.
- f. The plan must be updated with changes in the recipient's condition.
- g. There must be documentation that immediate action is taken regarding discharge alternatives whenever a specific discharge intervention or placement effort fails.
- h. Evaluation and reevaluation of a recipients needs must be conducted as necessary during the discharge planning process.
- i. Documentation must be explicit, thorough and recorded on the date a service is provided. There must be documented evidence of frequent attempts by the provider to discharge the recipient to an alternative appropriate setting. The frequency of documentation will depend on the barriers to discharge.

Failure of a hospital to have documented evidence of comprehensive discharge planning efforts will result in non-coverage of corresponding dates of service.
- j. Significant contacts with family, the recipient, and/or ancillary personnel must be documented in the medical record.
- k. The recipient's understanding of his/her condition and situation should be described.
- l. When a recipient requires transfer to a NF, the hospital must request a Pre-Admission Screening (PASRR) from the QIO-like vendor. Each nursing home contact must be recorded by the discharge planner. Reasons why nursing facilities refuse the placement must also be documented. Placement efforts need to be concentrated on those facilities capable of handling the recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.
- m. A recipient's or recipient's family's or physician's refusal to cooperate with discharge planning efforts to either find or accept available appropriate placement at NF, RTC or other appropriate alternate setting must be documented in the recipient's medical record. Inpatient or administrative days are not reimbursed as of the date of the refusal.

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- n. A discharge from the hospital is validated by a physician's discharge order. Any readmission following a discharge is treated as a new/separate admission, even if the readmission occurs within 24 hours of the discharge.
- o. As a condition of participation in the Medicare and Medicaid programs, hospitals must comply with all discharge planning requirements set forth in 42 CFR 482.43.

13. Financial Data and Reports

Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the DHCFP program.

All providers shall permit any representative of the single state agency to examine the records and documents necessary to determine the proper amount of payments due. These records shall include, but are not limited to, provider ownership, organization, and operation; fiscal, medical, and other record keeping systems; federal income tax status; asset acquisition, lease, sale, or other action; franchise or management arrangements; patient service charge schedules; costs of operation; amounts of income received, by source and purpose; flow of funds and working capital; statistical and other reimbursement information.

14. Medicare/Medicaid Crossovers

Concurrent review is not conducted for Medicare/Medicaid crossover admissions unless acute days have been exhausted and/or there has been a termination of Medicare benefits and the recipient is at an acute or administrative LOC. Medicaid authorization is provided for acute and administrative days only.

A provider must:

- a. notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted.
- b. attach a copy of the Medicare Explanation of Benefits (EOB) (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted when requesting a QIO-like vendor review.
- c. obtain prior authorization from DHCFP's QIO-like vendor in accordance with 203.1A.2.f.15.

QMB claims denied by Medicare are also denied by DHCFP.

15. Maternity/Newborn Federal Length of Stay Requirements

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A provider must allow a recipient receiving maternity care or a newborn infant receiving pediatric care to remain in the hospital for no less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section delivery except when an attending physician makes a decision to discharge a mother or newborn infant prior to these timeframes.

16. Sterilization Consent Form

~~Providers must ensure that there is a sterilization consent form meeting federal requirements on file when a tubal ligation is performed. There must be 30 calendar days, but not more than 180 calendar days, between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. If premature delivery occurs within the 30 calendar day period, the physician must document the expected delivery date and certify the sterilization was performed less than 30 calendar days but not less than 72 hours after the date of recipient's signature on the Sterilization Consent Form. Reference, A copy of this form can be found in MSM Chapter 600, Attachment B, Sterilization Consent Form and the QIO- like vendor's Sterilization and Abortion policy under Provider, Billing Instructions, Billing Information.~~

17. In-State or Out-of-State Hospital Transfers

a. Non Emergency Transfers

1. It is the responsibility of the transferring physician/facility to obtain prior authorization for nonemergent transfers between in-state and out-of-state facilities, prior to the transfer of the recipient and to give the authorization number to the receiving hospital.
2. A receiving hospital is responsible for verifying that the transferring hospital obtained prior authorization for a non emergency transfer, prior to agreeing to accept or admitting the recipient and prior to the transfer.