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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:

1. a physician provides the order for admission at the time of admission or during the hospital stay, as verified by the date and time;
2. 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

To be eligible for reimbursement, an obstetric hospital admission 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

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) is limited to the minimum federal requirement (two days) for a normal vaginal delivery.

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.

- 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.
- 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.
- 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.
- 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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- e. 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.
- 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 day of the current/existing authorization period.
 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.
 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

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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 Chapter 200, Attachment A, Hospital With Swing Beds.
 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.
- 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. An 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. An obstetric admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or emergency cesarean delivery.
 3. A newborn admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or elective/avoidable cesarean delivery.
 4. When delivery of a newborn occurs immediately prior to arrival at a hospital for an obstetric/newborn admission.

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5. A 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.
6. Any newborn/neonate admission to a Neonatal Intensive Care Unit (NICU).
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 facility is conducted to determine the appropriate LOC and authorized time period for the length of stay.

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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. Additional inpatient review days must be requested 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~~

~~Reference Chapter 200, Attachment A, Policy #02-03.~~

43. 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