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

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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 456.24

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 DHCFP 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 whenever a hospital admission, discharge, or death occurs.

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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

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

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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 hospital must ensure that the following criteria are met:

- a. ~~The hospital must designate separate, identifiable staff whose primary responsibility is discharge planning. The discharge planners must review all Medicaid admissions.~~
- b.a. ~~A discharge planning activities must commence evaluation is initiated~~ within 48 hours of admission (or up to 72 hours involving weekends) for every recipient **and is documented in a recipient’s medical record.**
- e.b. ~~The discharge planner formulates and records~~ A registered nurse, social worker, or other appropriately qualified personnel reviews all Medicaid admissions and develops or supervises the development of a discharge plan. The **discharge plan**

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must specify goals and resolution dates, identify needed discharge services, and ~~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).~~ d. The discharge planner must be developed with input from the primary care staff, ~~and the physician, recipient and/or family, and the placement setting, (ifas applicable) and the recipient.~~

~~d.c.~~ c. Reevaluation of a recipient's needs is conducted, as necessary, during the discharge planning process and the discharge plan is updated with changes in a recipient's condition.

~~e.~~ 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.~~ f. The plan must be updated with changes in the recipient's condition.

~~g.d.~~ d. The discharge plan includes documented evidence of:

1. frequent attempts to discharge the recipient to an alternative appropriate setting, when applicable, and reasons and timeframes for unavoidable delays (e.g., awaiting assignment of a court-appointed guardian or for a court hearing related to out-of-state placement). Dates of service lacking documented evidence of comprehensive discharge planning or unavoidable delay reasons and timeframes, when applicable, are not reimbursed;

~~2.~~ g. There must be documentation that immediate actions implemented is taken regarding discharge alternatives whenever a specific discharge intervention or placement is unsuccessful ~~effort fails.~~

~~h.~~ h. Evaluation and reevaluation of a recipients needs must be conducted as necessary during the discharge planning process.

~~i.~~ 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.

~~j.~~ j. Failure of a hospital to have documented evidence of comprehensive discharge planning efforts will result in non-coverage of corresponding dates of service.

3. Significant contacts with ~~family,~~ the recipient, family, and/or ancillary personnel ~~must be documented in the medical record.~~

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4. ~~The~~ a recipient's understanding of his/her condition, discharge evaluation results, and discharge plansituation should be described.
5. reasonable efforts seeking alternatives to nursing facility (NF) placement (e.g., home health services, homemaker services, placement with family, subsidized housing, meals programs, group care), when applicable.
- m6. ~~When a recipient requires transfer to a NF, the hospital must request a Pre-Admission Screening (PASRR) from the QIO like vendor. Each home if NF placement is required, NF contacts and contact results, when NF placement is required. must be recorded by the discharge planner. Reasons why nursing facilities refuse the placement must also be documented. NF Pplacement efforts need to be concentrated on those facilities capable of handling the~~ a recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.
- n7. ~~Arefusal by a recipient's or a 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 acute or administrative days are not reimbursed, effective as of the date of the refusal.
- o8. ~~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.
- e. Prior to Nursing Facility (NF) placement the following documents are completed and in a recipient's medical record:
1. a HLevel of eCare (LOC) and a pre-admission screening and resident review (PASRR) Level I screening, as soon as imminent discharge to an NF is identified.
 2. a PASRR level II screening, when applicable.
 3. a Summary of Findings determination letter indicating that a recipient is appropriate for an NF placement, prior to a recipient's discharge recipient to an NF.

Refer to MSM Chapter 500 for nursing facility placement screening requirements.

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pf. ~~As a condition of participation in the Medicare and Medicaid programs, hospitals must comply~~ Hospitals must be in compliance with ~~all~~ discharge planning requirements ~~set forth specified~~ 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 DHCFFP 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 DHCFFP's QIO-like vendor in accordance with Section 203.1A.2.f.15.

QMB claims denied by Medicare are also denied by DHCFFP.

15. Maternity/Newborn Federal Length of Stay Requirements

A provider must allow a recipient receiving maternity care or a newborn infant receiving

1. Verbal information provided by an individual other than a recipient's

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attending physician must be supported by either written attestation of this information by the attending physician or evidence of this information in the medical record specifically provided to the QIO-like vendor with the authorization or reconsideration review request.

2. If a provider disagrees with the results of the QIO-like vendor's peer to peer and/or reconsideration review, the provider may request a fair hearing through DHCFP. A provider must utilize internal grievance processes available through the QIO-like vendor

21. Adherence to Requirements

To receive reimbursement for covered services, a hospital must adhere to all conditions stated in the Provider Contract, all applicable DHCFP policies related to the specific service provided, all state and federal requirements, the QIO like vendor/DHCFP billing requirements, and current International Classification of Diseases, Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) billing guidelines.

203.2 ~~SPECIALTY HOSPITAL ADMINISTRATIVE DAY POLICY~~

203.2 A ~~DESCRIPTION~~

~~Administrative days are inpatient hospital days reimbursed at a lower per diem rate when a recipient's status no longer meets an acute Level of eCare (LOC), and if discharge is ordered, a recipient's medical record must contain documentation that placement in an alternative appropriate placement setting is not available, despite a hospital's documented, comprehensive discharge planning efforts.~~

~~Specialty hospitals policy is consistent with the inpatient services for prior authorization and UR.~~

~~a. Medical (Rehabilitation) Hospital Services Policy~~

~~Medical (Rehabilitation) Hospitals provide intensive and acute services for the purpose of restoring an individual's capacity to function at an optimal level, following an accident or illness, contingent upon the individual's abilities and disabilities. Rehabilitation involves both retraining and relearning to bring about maximal restoration of physical, physiological, behavioral, social, and vocational function. Most commonly, rehabilitation hospitals treat persons who have suffered a head or spinal cord injury, and who must be able to tolerate and benefit from a minimum of three hours of physical, speech or occupational therapy per day.~~

~~Inpatient rehabilitation services may be provided in either a freestanding rehabilitation hospital or a rehabilitation unit of a general hospital.~~

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~~1. Admissions are only permitted from either an acute hospital or NF.~~

~~2. The inpatient admission must occur within one year from the initial injury or illness or most recent surgery/hospitalization as a result of the initial illness or injury that requires inpatient rehab services.~~

~~b. Long Term Acute Care (LTAC) Hospital Services Policy~~

~~LTAC hospitals provide comprehensive long term acute care designed for patients who have suffered an acute illness, injury or exacerbation of a disease process.~~

~~Most commonly, specialty or LTAC hospitals treat patients who require ventilator, wound care, or stroke-related services.~~

~~Inpatient specialty or LTAC services may be provided in either a freestanding specialty/long term acute care hospital or a specialty/long term acute unit of a general hospital.~~

~~Pain Management Services standing alone (e.g., relaxation techniques, stress management, coma stimulation, biofeedback) are not a DHCFP benefit.~~

203.2 B AUTHORIZATION REQUIREMENTS

1. Prior authorization is required.
2. Retrospective authorization must be obtained when Medicaid eligibility is determined after admission; to, or discharge from, an inpatient bed.
3. Administrative day policy is consistent with inpatient prior authorization and utilization review policies.

203.2 C COVERAGE AND LIMITATIONS

1. COVERED SERVICES

~~a. The DHCFP reimburses two levels of administrative days, skilled nursing or intermediate, administrative days when authorized by the QIO-like vendor in increments usually not exceeding seven calendar days per request: a skilled nursing level (skilled administrative days), and an intermediate care level (intermediate administrative days).~~

~~b. At least one acute inpatient hospital day (24 hours) must immediately precede an initial request for an skilled or intermediate administrative skilled nursing or~~

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~~intermediate-LOC~~ days. Reimbursement is not available for ~~admission-directly~~ admission to an administrative level of care or for admission to an administrative level of care from an outpatient setting (e.g., emergency room, observation status, a physician's office, urgent care or clinic).

- c. Skilled ~~nursing~~-administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital as a reduction in level of care for:
1. a recipient waiting for evaluation and/or placement ~~regarding~~ in a Nursing Facility (NF)/extended care facility, group home, residential treatment center (RTC) Institution for Mental Disease, psychiatric or alcohol/substance abuse treatment hospital or unit, or other treatment settings (e.g., hospice) for continuity of medical services.
 2. delays in discharge related to durable medical equipment availability, home equipment set up, or home health or hospice service arrangements.
 3. a newborn with medical complications (not requiring acute care services) waiting for placement.
 4. a recipient requiring medical interventions, not meeting acute care criteria, that prevent the recipient from leaving the hospital (e.g., monitoring laboratory results, obtaining cultures, a specific treatment/workup.)
 5. preparation for a surgery unrelated to the original reason for admission that does not meet acute care criteria.
- d. Intermediate administrative (Intermediate Care Level) days are covered in an inpatient or critical access hospital when:
1. services do not meet an acute level of care;
 2. the days are authorized by the QIO-like vendor; and
 3. a recipient cannot be discharged for social reasons (e.g., a stable newborn either waiting for adoption or for the mother to be discharged, a recipient waiting for medical assisted transportation, a recipient requiring evaluation after being a victim of crime.)

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2. NON COVERED SERVICES

Administrative days are not covered when:

- a. ~~a recipient was not approved for~~ at least one acute inpatient hospital day did not immediately ~~preceeding~~ precede the initial request for administrative days.
- b. the days are only for the convenience of the recipient, recipient's family or physician.
- c. a recipient, recipient's family or physician refuse to cooperate with discharge planning efforts or refuse placement at a NF, psychiatric facility or other available alternative setting.
- d. a discharge order is written and a hospital has not provided documented evidence of a comprehensive discharge plan or an acceptable reason and timeframe for an unavoidable delay, such as awaiting a specifically identified court date (~~e.g., 12-10-2013~~) for court appointed guardianship related to out-of-state NF placement.

203.2 D PROVIDER RESPONSIBILITY

1. Submit all pertinent discharge planning information to the QIO-like vendor with ~~the~~ a prior authorization request, when applicable, and obtain authorization for administrative days within timeframes required by the QIO-like vendor.
2. Notify the QIO-like vendor when there is a reduction in LOC to administrative days.
3. Maintain documentation of appropriate, comprehensive discharge planning in a recipient's² medical records. This includes, but is not limited to:
 - a. ~~Monday through Friday~~ all placement efforts, contacts and contact results, if applicable;
 - b. discharge planning notes from applicable social workers, case managers, and/or nurses;
 - c. physicians' orders and/or progress notes;
 - d. modifications to the discharge plan, whenever applicable; and
 - e. reasons and timeframes of unavoidable discharge planning delays.

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203.3 SWING-BED SERVICES POLICY

Reference Chapter 200, Attachment A, Policy #02-04, Hospitals with Swing Beds.

203.4 OUTPATIENT HOSPITAL SERVICES POLICY

General Medical/Surgical Hospitals commonly provide several outpatient services, included but not limited to general, clinic, office, emergency room, ambulatory surgery center, and observation services.

203.4A COVERAGE AND LIMITATIONS

1. Outpatient hospital services provided by hospitals are subject to the same service limitations as other outpatient service providers. Providers must refer to Medicaid/DHCFP service manuals relevant to the specific services being provided. The following is a list of some of the chapters a hospital should reference:
 - a. For physician, advanced practitioner of nursing, physician assistants, urgent care sites, and outpatient hospital clinic visits, refer to MSM Chapter 600.
 - b. For radiologic services, refer to MSM Chapter 300.
 - c. For pharmaceutical services, refer to MSM Chapter 1200.

This is not an all inclusive list. The MSM in its entirety needs to be reviewed.

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- i. a recipient is going to be rolled-over from ambulatory or observation status to an acute inpatient admission.

7. Prior Authorization is Not Required When:

- a. reference Accredited Standards Committee (ASC) Physician’s Assistant list.
- b. a procedure is covered by Medicare Part B and Medicaid (QMB eligible) is only required to pay coinsurance, up to the DHCFP allowable maximum.

203.6

~~NURSING — FACILITY — (NF) — PLACEMENT — SCREENING — REQUIREMENTS~~
~~LONG-TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL SERVICES~~

~~There are two types of Screenings required for potential NF Placements.~~

- ~~a. Level of Care (LOC) — The LOC screening must be completed prior to discharge from the hospital for all DHCFP eligible individuals.~~
- ~~b. Pre Admission Screening and Resident Review (PASRR) — Please see Chapter 500.~~

~~The hospital completes the PASRR Level I Identification screening and the LOC screening forms and submits to the QIO-like vendor. The QIO-like vendor reviews and makes a determination (for both screening types — LOC or PASRR Level I Identification) and when indicated makes the referral for PASRR Level II evaluation. Magellan Medicaid Administration (MMA) sends the requestor the determination letter to confirm the completion of the screenings.~~

~~Hospital Responsibilities for Discharge to a NF must include:~~

- ~~1. making a reasonable effort to seek placement alternatives with appropriate documentation of such efforts.~~
- ~~2. complete the LOC and/or PASRR Level I Identification forms with complete, accurate, and sufficient information. Submit the forms to MMA as soon as an imminent discharge to a NF is identified.~~
- ~~3. do not discharge the patient to the NF until a determination letter (LOC for Medicaid eligible’s, PASRR Level I Identification for all payment sources, and/or PASRR Level II for all payment sources, when indicated) is received showing the individual is appropriate to be admitted to a NF.~~

~~Time Frames for Screening Process:~~

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~~4. PASRR Screening Process:~~

- ~~a. PASRR Level I Identification screenings are completed for acute care facilities within one business day of receipt.~~
- ~~b. PASRR Level II Evaluations are generally completed within one to seven business days from the time the Level I identifies Mentally Ill (MI), Mentally Retarded (MR) or related condition (RC). Administrative day reimbursement is available to acute care facilities for Medicaid recipients if discharge is delayed due to completion of Level II PASRR, when properly documented.~~

~~5. Level of Care (LOC) Screening Process:~~

~~LOC screenings are completed for acute care facilities within one business day of receipt.~~

203.6 A DESCRIPTION

~~LTAC specialty hospitals meet Medicare inpatient hospital Conditions of Participation, maintain an average length of stay greater than 25 days, and provide comprehensive long-term acute care to individuals with complex medical conditions and/or an designed for patients who have suffered acute illness, injury, or exacerbation of a disease process. Most commonly, specialty or LTAC hospitals treat patients who require ventilator, wound care, or stroke-related services.~~

203.6 B PRIOR AUTHORIZATION

1. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Reference Medicaid Services Manual (MSM), Chapter 100.
2. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to or discharge from an LTAC specialty hospital.
3. LTAC specialty hospital policy is consistent with inpatient prior authorization and utilization review policies.

203.6 C COVERAGE AND LIMITATIONS

1. COVERED SERVICES

- ~~a. Inpatient specialty or LTAC services may be~~ The DHCFP reimburses medically

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necessary services meeting coverage requirements, provided in either a freestanding ~~specialty~~/long-term acute care hospital or a ~~specialty~~/long-term acute care unit of a general hospital.

- b. All of the following criteria must be met:
1. Frequent, specialized, therapeutic interventions are required on an inpatient basis.
 2. Services are ordered and supervised by a physician or another individual authorized by State licensure law to prescribe treatment.
 3. Services include skilled nursing services, with 24-hour, on-site, registered nurse availability.
 4. Services are provided in accordance with a multidisciplinary, coordinated plan of care.
 5. Services are authorized as medically necessary by the QIO like vendor.

2. NON COVERED SERVICES

Services are not covered in a long term acute care hospital when:

- a. a recipient does not meet eligibility requirements;
- b. the services do not meet medical necessity requirements, or are only for the convenience of a recipient or a recipient's family or physician; or
- c. the services are limited to only rehabilitation, coma stimulation, or ~~P~~ain ~~M~~management interventions—~~Services standing alone~~—(e.g., relaxation techniques, stress management, ~~coma stimulation~~, biofeedback). ~~are not a DHCFP benefit.~~

203.6 D PROVIDER RESPONSIBILITIES

Providers must:

1. be in compliance with provider responsibilities specified in 203.1B.
2. maintain evidence of Medicare certification and state licensure as an LTAC.

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203.7 INPATIENT REHABILITATION SPECIALTY HOSPITAL

203.7 A DESCRIPTION

~~Medical Inpatient (Rehabilitation) specialty Hhospitals and distinct inpatient rehabilitation units in a general or critical access hospital provide intensive, and acute multidisciplinary, coordinated rehabilitation services (e.g., physical, occupational, speech or prosthetics/orthotics therapy) for the purpose of to restore restoring an individual's capacity to function at an optimal level function, following an accident or illness, contingent upon the individual's abilities and disabilities (e.g., spinal cord injury, brain injury, stroke, neurologic disorders, congenital deformity, burns, amputation, major multiple trauma, fractures of the femur or hip, severe advanced osteoarthritis, active polyarticular rheumatoid arthritis, systemic vasculitis with joint inflammation, knee or hip replacement). Inpatient Rrehabilitation involves both retraining and relearning to bring about achieve the maximal level of function possible, based on a recipient's abilities and disabilities restoration of physical, physiological, behavioral, social, and vocational function. Most commonly, rehabilitation hospitals treat persons who have suffered a head or spinal cord injury, and who must be able to tolerate and benefit from a minimum of three hours of physical, speech or occupational therapy per day.~~

203.7 B PRIOR AUTHORIZATION

1. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Refer to Medicaid Services Manual (MSM), Chapter 100.
2. Prior authorization is also required for a leave of absence expected to last longer than eight hours or involving an overnight stay or a brief exception to the intensity of service rule.
3. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to, or discharge from, an inpatient rehabilitation hospital.
4. Medical rehabilitation hospital policy is consistent with inpatient prior authorization and utilization review policies.

203.7 C COVERAGE AND LIMITATIONS

1. COVERED SERVICES

- a. The DHCFP reimburses medically necessary, intensive, Inpatient rehabilitation services ~~may be meeting coverage requirements~~, provided in either a freestanding inpatient rehabilitation hospital or a rehabilitation unit of a

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general or critical access hospital.

b. All of the following criteria must be met:

1. Services are ordered and provided under the direction of a physician with specialized training or experience in rehabilitation
2. Services are authorized as medically necessary by the QIO-like vendor.
3. The inpatient Admissions are is ~~only permitted~~ from either an acute hospital or NF and is: ~~2. The inpatient admission must occur~~ within one year from the initial injury or illness or most recent surgery/hospitalization as a result of the initial illness or injury ~~that requires inpatient rehab services.~~
4. Active and ongoing therapeutic interventions from multiple therapy disciplines are required on an inpatient basis.
5. Rehabilitative services are provided a minimum of either three hours per day, five days per week, or ~~fifteen~~ 15 hours within each seven consecutive day period, beginning the date of admission.
- ~~3.6.~~ Physical and/ or occupational therapy must be a component of rehabilitative services provided.
- ~~4.7.~~ Inpatient rehabilitation is only ordered when a recipient is capable of making significant, measureable, functional improvement in activities of daily living within a specified period of time.

b.c. A brief exception to the intensity of service requirement, during which a recipient is unable to participate in the intensive therapy program due to an unexpected clinical event (e.g., severe flu symptoms, bed rest due to signs of deep vein thrombosis, prolonged intravenous chemotherapy or blood transfusions), is covered when:

1. the exception is limited to once per admission and does not exceed three consecutive days;
2. comprehensive documentation of the unexpected clinical event is provided to the QIO-like vendor; and
- ~~1.3.~~ a preadmission screening, post admission physician evaluation and the plan of care support that the recipient was initially able to actively

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participate in the inpatient rehabilitation program.

- d. In cases of brain injury, a recipient can be admitted on a trial basis lasting no longer than seven days if a comprehensive preadmission assessment supports that the recipient could reasonably be expected to benefit from an inpatient stay with an interdisciplinary team approach to the delivery of rehabilitation services. Additional days can be requested if assessments during the trial period demonstrate the recipient will benefit from inpatient medical rehabilitation services.
- e. A leave of absence not exceeding 32 hours for a therapeutic reason (e.g., preparing for independent living) is covered when authorized by the QIO-like vendor and when the following information is documented in a recipient's medical record:
 - 1. a physician's order that specifies the number of hours for the leave;
 - 2. the medically appropriate reason for the leave; and
 - 3. —an evaluation of the therapeutic effectiveness of the leave.

2. NON COVERED SERVICES

Inpatient medical rehabilitation services are not covered when:

- a. the services do not meet authorization or other policy coverage requirements (e.g., a preadmission screening demonstrates a recipient cannot participate with intensive rehabilitation services);
- b. the level of rehabilitative care required can be safely and effectively rendered in an alternate, less intensive setting such as an outpatient rehabilitation department or a skilled nursing facility; or
- c. treatment goals necessitating inpatient services are achieved or further progress toward established rehabilitation goals is not occurring or is unlikely to occur.

203.7 D PROVIDER RESPONSIBILITIES

- 1. Providers must be in compliance with Provider Responsibilities specified in 203.1B.

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2. Providers must ensure that the following documentation must be maintained in a recipient's medical record and submitted to the QIO-like vendor, as applicable:
 - a. a preadmission screen specifying the condition that caused the need for rehabilitation, the recipient's level of function, functional improvement goals and the expected frequency and duration of treatments required to accomplish these goals, any risk for clinical complications, and the anticipated post discharge destination.
 - b. a post-admission assessment performed by a rehabilitation physician documenting a recipient's status and any discrepancies between this assessment and the preadmission screening.
 - c. evidence of no less than ~~fifteen~~ (15) hours of therapy being provided per week, beginning with the date of admission, unless comprehensive documentation is provided to the QIO-vendor regarding an unexpected clinical event that meets the exception to intensity of service criteria.

3. Providers must ensure that the rehabilitation plan of care is:
 - a. comprehensive and developed and managed by a coordinated multidisciplinary team that includes, but is not limited to, a physician and nurse with special training or experience in the field of rehabilitation and a physical and/or occupational therapist;
 - b. individualized and specify the intensity, frequency and duration of therapies, and the anticipated, quantifiable treatment goals; and
 - c. modified with changes in medical or functional status, as applicable.

POLICY #02-03	ADMINISTRATIVE DAYS	EFFECTIVE DATE: MARCH 1, 2015
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~~A. DESCRIPTION~~

~~Administrative days are inpatient days reimbursed at a lower per diem rate when a recipient's status no longer meets an acute level of care (LOC) and placement in an alternative appropriate setting is not available despite a hospital's documented, comprehensive discharge planning efforts.~~

~~B. POLICY~~

~~The DHCFP reimburses skilled nursing or intermediate administrative days authorized by the QIO-like vendor in increments not exceeding seven calendar days per request.~~

~~At least one acute inpatient hospital day (24 hours) must immediately precede an administrative skilled nursing or intermediate LOC. Reimbursement is not available for admission directly to an administrative level of care or for admission to an administrative level of care from an outpatient setting (e.g., emergency room, observation status, a physician's office, urgent care or clinic.)~~

~~C. PRIOR AUTHORIZATION IS REQUIRED.~~

~~Retrospective authorization must be obtained when Medicaid eligibility is determined after admission, to or discharge from an inpatient bed.~~

~~D. COVERAGE AND LIMITATIONS~~~~1. COVERED SERVICES~~

~~a. Skilled nursing administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital as a reduction in level of care for:~~

- ~~1. A recipient waiting for evaluation and/or placement regarding a Nursing Facility (NF)/extended care facility, group home, residential treatment center (RTC) Institution for Mental Disease, psychiatric or alcohol/substance abuse treatment hospital or unit, or other treatment settings (e.g., hospice) for continuity of medical services.~~
- ~~2. delays in discharge related to durable medical equipment availability, home equipment set up, or home health or hospice service arrangements.~~
- ~~3. a newborn with medical complications (not requiring acute care services) waiting for placement.~~
- ~~4. a recipient requiring medical interventions not meeting acute care criteria that prevent the recipient from leaving the hospital (e.g., monitoring laboratory results, obtaining cultures, a specific treatment/workup.)~~
- ~~5. preparation for a surgery unrelated to the original reason for admission that does not meet acute care criteria.~~

POLICY #02-03	ADMINISTRATIVE DAYS	EFFECTIVE DATE: MARCH 1, 2015
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~~b. Intermediate administrative (Intermediate Care Level) days are covered in an inpatient or critical access hospital when:~~

- ~~1. services do not meet an acute level of care;~~
- ~~2. the days are authorized by the QIO like vendor; and~~
- ~~3. a recipient cannot be discharged for social reasons (e.g., a stable newborn either waiting for adoption or for the mother to be discharged, a recipient waiting for medical assisted transportation, a recipient requiring evaluation after being a victim of crime.)~~

~~2. NON COVERED SERVICES~~

~~Administrative days are not covered when:~~

- ~~a. a recipient was not approved for at least one acute inpatient hospital day immediately preceding the initial request for administrative days.~~
- ~~b. the days are only for the convenience of the recipient, recipient's family or physician.~~
- ~~c. a recipient, recipient's family or physician refuse to cooperate with discharge planning efforts or refuse placement at a NF, psychiatric facility or other available alternative setting.~~
- ~~d. a hospital has not provided documented evidence of a comprehensive discharge plan or an acceptable reason and timeframe for an unavoidable delay, such as awaiting a specifically identified court date (e.g., 12-10-2013) for court appointed guardianship related to out-of-state NF placement.~~

~~E. PROVIDER RESPONSIBILITIES~~

- ~~1. Submit all pertinent discharge planning information to the QIO like vendor with the prior authorization request and obtain authorization for administrative days within timeframes required by the QIO like vendor.~~
- ~~2. Notify the QIO like vendor when there is a reduction in LOC to administrative days.~~

~~F. DOCUMENTATION~~

~~Maintain documentation of appropriate, comprehensive discharge planning efforts in recipients' medical records. This includes, but is not limited to:~~

- ~~1. Monday through Friday placement efforts, contacts and contact results;~~
- ~~2. discharge planning notes from applicable social workers, case managers, and/or nurses;~~

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3. ~~physicians' orders and/or progress notes;~~
4. ~~modifications to the discharge plan, whenever applicable; and~~
5. ~~acceptable reasons and timeframes of unavoidable discharge planning delays.~~

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