

DRAFT	MTL 27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 200
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

200 INTRODUCTION

Inpatient **and outpatient hospital** services are a federally mandated Medicaid benefit. 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 Individuals with Intellectual Disabilities (ICF/IID), regardless of name or licensure.~~

Medicaid Services Manual (MSM), Chapter 200, describes the following hospital services: inpatient, swing-bed, outpatient, ambulatory surgical, long term acute care, inpatient rehabilitation specialty hospital, birth centers, federal emergency services program including dialysis, and outpatient observation services.

The Division of Health Care Financing and Policy (DHCFP) may reimburse ~~acute~~ hospitals for providing ~~the following~~ medically necessary services, as defined in the MSM 100 under Medical Necessity, including, but not limited to: medical/surgical/intensive care, maternity, newborn, neonatal intensive care, **pediatric care, emergency care,** trauma level I, ~~medical~~inpatient rehabilitation, ~~or~~ long-term acute care specialty, administrative skilled or intermediate days, ~~and~~ emergency psychiatric, ~~and~~ substance abuse treatment, and acute medical detoxification. Reference MSM Chapter 100 for Extended Services and the interim billing requirements.

In Nevada, hospitals are licensed by the Bureau of Health Care Quality and Compliance (HCQC) within the Nevada Division of Public and Behavioral Health (DPBH).

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), ~~with the exception of~~ **except** those listed in the NCU Manual, Chapter 1000.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 201
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

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
 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 (Sterilizations).
 13. 42 CFR 447.253 (b) (1) (ii) (B) Other requirement.

DRAFT	MTL 17/15
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 202
MEDICAID SERVICES MANUAL	Subject: AUTHORITY RESERVED

202 RESERVED

DRAFT

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203~~ ——— ~~POLICY~~

~~203.1~~ 203 INPATIENT HOSPITAL SERVICES POLICY

- ~~1.~~ A. Inpatient hospital services are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that:
 - ~~a.~~ 1. ~~is~~ maintained primarily for the care and treatment of patients with disorders other than mental disease;
 - ~~b.~~ 2. ~~is~~ licensed as a hospital by an officially designated authority for state standard-setting;
 - ~~c.~~ 3. ~~meets~~ the requirements for participation in Medicare; and
 - ~~d.~~ 4. ~~has~~ in effect a Utilization Review (UR) plan, applicable to all Medicaid recipients, that meets the requirements of 42 CFR 482.30 and 42 CFR 456.50-456.145.

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

A hospital is an inpatient medical facility licensed as such to provide services at an acute ~~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-ICF~~ for the Individuals with Intellectual Disabilities (~~ICF/IID~~), regardless of name or licensure.

~~2.~~ B. Out-of-State Acute Hospital Services

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

~~3.~~ C. In-State and Out-of-State Acute Hospital Transfers

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, ~~long-term acute care (LTAC) specialty, inpatient rehabilitation, specialty~~) in or out-of-state is responsible to request

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor must make a determination regarding the availability of such services at the referring hospital or within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being **available** at the transferring facility.

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

~~203.1A~~ 203.1 COVERAGE AND LIMITATIONS

~~1.~~ A. Admission

~~a.~~ 1. Admission Criteria

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

- ~~1.~~ a. ~~a~~A physician provides the order for admission at the time of admission or during the hospital stay, as verified by the date and time;
- ~~2.~~ b. ~~a~~Acute care services are rendered;
- ~~3.~~ c. ~~†~~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.~~ d. ~~†~~The admission is certified by the QIO-like vendor based on pertinent supporting documentation/submitted by the provider with the admission authorization request.

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, ~~C~~ritical ~~A~~ccess, ~~i~~npatient ~~M~~edical ~~R~~ehabilitation, or ~~L~~ong ~~T~~erm ~~A~~cute ~~C~~are (LTAC) ~~S~~pecialty 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)(e)~~.MSM Chapter 200, Admission Medical Record Determination – Plan of Care.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

b. 2. Admission Order

Physician orders for admission must be written **and signed** 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 **within the timeframes required by law.**

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.

e. 3. 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 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. 4. 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)~~ **MSM Chapter 200, Provider Responsibilities – In-State or Out-of-State Hospital Transfers** regarding provider responsibilities related to in-state and out-of-state acute hospital transfers.

e. 5. 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. 6. Military or Veteran's² Hospitals

Inpatient hospital admission at a military or Veteran's² ~~h~~Hospital is not a Medicaid benefit.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

~~g.~~ 7. 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 weeks² gestation must be prior authorized by the QIO-like vendor. ~~will result in denial of claim reimbursement.~~

~~h.~~ 8. 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 **and must be prior authorized.**

~~2.~~ B. 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 Medical Necessity~~ regarding criteria related to medical necessity.

~~a.~~ 1. 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. **Pertinent information supporting the medical necessity and appropriateness of an inpatient admission must be submitted in the format and timeframes required by the QIO-like vendor as part of the authorization request. Failure of a provider to submit the required medical documentation in the format and within the timeframes specifically required by the QIO-like vendor will result in an authorization denial.**

~~b.~~ 2. Authorization refers only to the determination of medical necessity and appropriateness. Authorization does not guarantee ~~benefit plan payment service reimbursement. Plan coverage~~ Service reimbursement is also ~~conditional dependent~~ -upon the recipient's eligibility status and is subject to all other coverage terms and conditions of the Nevada Medicaid and ~~Nevada Check-Up (NCU)~~ programs.

~~e.~~ 3. 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~~

DRAFT	MTL 17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

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 **rejected and** 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.~~ 4. A ~~prior~~-authorization is **only** 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. **If a new authorization request is submitted, the previous one must be cancelled to avoid duplication.**

~~e.~~ 5. ~~Out-of-state authorization determinations are based upon several conditions such as the availability of service within the state at other facilities and the LOC not being met at the transferring facility.~~ When available, in-state providers and facilities should be utilized. Out-of-state inpatient admission authorization determinations will be considered when appropriate services are not available in-state or when out-of-state resources are geographically and/or fiscally more appropriate than in-state resources. Reference MSM, Chapter 100, ~~Out-of-State Services.~~

~~f.~~ 6. **Inpatient Admission Requiring Prior Authorization**

Prior authorization is authorization obtained before services are delivered. Additional inpatient days must be requested prior to or by the last day of the current/existing authorization period.

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

~~1.~~ a. Any surgery, treatment, or invasive diagnostic testing unrelated to the reason for admission; or days associated with unauthorized surgery, treatment, or diagnostic testing.

~~2.~~ b. Hospital admissions for EIOL prior to 39 weeks² gestation.

~~3.~~ c. Hospital admissions for elective ~~or avoidable scheduled~~ cesarean sections.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~4.~~ d. 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.~~ ~~e.~~ Dental admissions. Two prior authorizations for inpatient hospitalization for dental procedure are necessary:
- ~~a.~~ 1. The Medicaid dental consultant must prior authorize the dental procedure; and
 - ~~b.~~ 2. The QIO-like vendor must authorize it is medically necessary for the recipient to be hospitalized for ~~the performance of~~ the dental procedure.
- ~~7.~~ ~~f.~~ An admission for a family planning procedure (e.g. a tubal ligation or vasectomy).
- ~~8.~~ g. Non-emergency admissions to in-state and out-of-state facilities. ~~An out-of-state non-emergency admission may be denied by the QIO-like vendor if the service is available in Nevada.~~
- ~~9.~~ h. 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. ~~Reference MSM, Chapter 400 for authorization requirements.~~
- ~~10.~~ i. 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, ~~inpatient~~ rehabilitation, administrative and outpatient observation.) Per diem reimbursement amounts are based on the LOC authorized by the QIO-like vendor.
- ~~11.~~ j. Substance abuse detoxification and treatment (inpatient) admissions. This includes transfers from detoxification to treatment within the same hospital. Reference ~~MSM, Chapter 400 for admission criteria~~ authorization requirements.
- ~~12.~~ k. Swing bed admissions in a rural or ~~Critical A~~access ~~H~~hospital (CAH). Reference ~~MSM, Chapter 200, Attachment A, Policy # 02-03, Hospital with Swing Beds.~~

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~13.~~ l. A leave of absence or therapeutic pass from an acute or ~~inpatient~~ ~~medical~~ ~~rehabilitation~~ ~~specialty~~ hospital expected to last longer than eight hours or involving an overnight stay. Reference **MSM 200, Section 203.1A(3), Leave of Absences.**
- ~~14.~~ m. Admission ~~When~~ Third Party Liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference **MSM, Chapter 100, Section 104, Third Party Liability (TPL) – Other Health Care Coverage.**
- ~~15.~~ n. Non-Medicare covered days within 30 days of the receipt of the Medicare ~~Eligibility Explanation of Benefits (EOB)~~ indicating Part A Medicare benefits are exhausted. Reference **MSM, Chapter 100, Section 103.2 Authorization.**
- ~~16.~~ o. Admissions resulting from **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** screening.
- ~~g.~~ **7. Inpatient Admission Requiring Authorization Within Three Business Days**
- ~~g.~~ Providers must submit pertinent clinical information and request authorization from the QIO-like vendor within ~~one~~ **three** business days of patient admission for the following services:
- ~~1.~~ a. An emergency inpatient admission, transfer, or change in LOC. ~~for an emergent condition including, but not limited to, any emergency admission (e.g. an emergency inpatient admission from a physician’s office, urgent care, or emergency room department, transfer to Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU), an emergency transfer from one in-state and/or out-of-state hospital to another, an emergency psychiatric or detoxification admission to a general acute hospital with or without a specific psychiatric or detoxification unit) or an emergency transfer from one in-state and/or out-of-state hospital to another.~~ Reference **MSM Chapter 400** regarding emergency psychiatric or alcohol/substance use disorder treatment admission requirements.
- ~~2.~~ b. 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.~~ c. 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.

DRAFT	MTL 17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

~~4.~~ d. When delivery of a newborn occurs immediately prior to arrival at a hospital for an obstetric/newborn admission.

e. Any newborn/neonate admission or transfer to a Neonatal Intensive Care Unit (NICU).

~~5.~~ f. A direct inpatient admission initiated through an emergency ~~room~~ department 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.~~ 1. 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.~~ 2. Emergency ~~room~~ department 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.~~ g. Admission to hospitals without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit. Refer to MSM Chapter 400.

~~h.~~ 8. All inpatient hospital admissions must be authorized by the QIO-like vendor, except for:

~~1.~~ a. Admission related to Qualified Medicare Beneficiary (QMB) recipients who are eligible for both Medicare and Medicaid and are still receiving Medicare A benefits. Authorization is only required if Medicare acute days have been exhausted and/or there has been a termination of Medicare benefits. QMB claims denied by Medicare are also denied by DHCFP. Reference MSM, Chapter 200 Inpatient Hospital Services Policy – Coverage and Limitations – Authorization Requirements – Non-Medicare Covered Days for Dual Eligible

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

Recipients and Chapter 100 for authorization timeframes related to non-Medicare covered days for a dual eligible recipient.

- 2. b. A length of stay not exceeding either three obstetric and newborn inpatient days for a vaginal delivery performed at or after 39 weeks gestation or four obstetric and newborn days for a medically necessary cesarean delivery. This does not apply to neonatal intensive care days. All NICU days must be authorized. Reference MSM 200, Inpatient Admission Requiring Authorization Within Three Business Days regarding newborn authorization requirements.

~~h.~~ 9. 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.

~~1.~~ a. 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. If the clinical condition does not support the medical necessity or appropriateness of the setting, services are denied or reduced.

~~2.~~ b. Retrospective Review

Retrospective review is a review of clinical information to determine whether the services will be approved after ~~the~~ services ~~are~~ 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

DRAFT	MTL 27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

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.

10. Changes in Eligibility Between Fee-for-Services (FFS) and/or Managed Care Organization (MCO)

When there is a change in eligibility between FFS and/or MCOs during an inpatient stay, each authorizing vendor maintains the right to determine the medical necessity and LOC regarding inpatient days.

a. Timeframes in which a provider must submit authorization requests can be extended if:

1. A provider submits documentation that substantiates delays in the availability of recipient's eligibility status in the Electronic Verification System (EVS), or the change in eligibility occurred on the date or on the day after discharge; and
2. The authorization is submitted no later than either within 90 calendar days of a recipient's Medicaid change of eligibility date of decision, or within 30 calendar days of the date on the initial FFS or MCO vendor denial EOB, when a provider submits the initial vendor's EOB to the subsequent authorizing vendor.

11. Authorization Requirements for Recipients Not Medicaid Eligible Upon Admission

Providers must submit the initial admission authorization request within the following timeframes for presumptively eligible, in-house retroactive eligible, and retrospective eligible recipients.

- a. Once the eligibility is showing in EVS, the provider has 10 business days to submit the Within 10 business days of the eligibility date of decision for a presumptively eligible recipient.
- b. Within 10 business days of the eligibility date of decision for a recipient deemed Medicaid eligible after admission, but while a recipient is still in the hospital (in-house retroactive eligible).

DRAFT	MTL 27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

- c. Within 90 calendar days from an eligibility date of decision for a retroactive eligible recipient after services have been provided or after hospital discharge (retrospective authorization).

12. Non-Medicare Covered Days for Dual Eligible Recipients

Providers must submit an authorization request within 30 calendar days of the receipt of the Medicare EOB indicating Part A Medicare benefits are exhausted. Reference MSM, Chapter 100, Authorization.

13. Outpatient Hospital and Freestanding Facilities

Authorization requirements for other services or procedures performed in an outpatient hospital setting or in another type of freestanding facility (emergency department, observation, ambulatory surgical center, Federal Emergency Services Program, freestanding birth centers, etc.) are referenced throughout MSM, Chapter 200.

3. C. Leave of Absence

1. Absences from an acute hospital or ~~inpatient~~ ~~medical~~ ~~rehabilitation~~ ~~specialty~~ hospital are allowed:
 - a. ~~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
 - b. ~~Up to~~, but not exceeding 32 hours from ~~an inpatient~~ ~~medical~~ ~~rehabilitation~~ ~~specialty~~ hospital for therapeutic reasons, such as preparing for independent living.
2. Prior authorization must be obtained for a leave of absence expected to:
 - ~~+~~ a. ~~Last~~ longer than eight hours from an acute hospital; or last longer than eight hours or involving an overnight stay from ~~an inpatient~~ ~~medical~~ ~~rehabilitation~~ ~~specialty~~ hospital.
3. 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).
4. For a therapeutic leave of absence, the following information must be documented in a recipient's medical record:

DRAFT	MTL 17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~1.~~ a. A physician's order specifying the number of hours for the pass;
- ~~2.~~ b. The medically appropriate reason for the pass prior to issuance of the pass; and
- ~~3.~~ c. An evaluation of the therapeutic effectiveness of the pass when the recipient returns.

~~203.1B~~ 203.2 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.
 - ~~4.~~ If a recipient expires mid-month, the DWSS prorates PL as in number 3 in. 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.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

~~2.~~ A. Conditions of Participation

~~a.~~ 1. To be enrolled with the DHCFP, providers must:

~~1.~~ a. ~~b~~Be in compliance with applicable licensure requirements.

~~2.~~ b. ~~b~~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.~~ c. ~~h~~Have a Provider Contract with the DHCFP. Refer to **MSM**, Chapter 100, ~~Section 102~~, Provider Enrollment.

~~b.~~ 2. 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.~~ B. 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.

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 ~~p~~Plan requirements under 42 CFR 456.50 through 456.~~24145~~.

~~4.~~ C. Quality Assurance - Hospital Medical Care Evaluation Studies

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

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. D. 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. E. 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. F. Form 3058 (Admit/Discharge/Death Notice)

All hospitals are required to submit Form 3058 to their local **Nevada Division of Welfare and Supportive Services (DWSS)** District Office 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. G. Patient Rights

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DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

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. H. 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 EDR or rollover from observation days).

10. I. 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. J. Admission Medical Record Documentation

a. 1. 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 MSM, Chapter 200 and 600.

Dental, oral and maxillofacial surgeons must also secure prior authorization from the DHCFP dental consultant to assure payment for the procedure. ~~Reference Section 203.1A(2)(f)(4)~~ MSM Chapter 200, Inpatient Hospital Services Policy – Coverage and Limitations – Authorization Requirements and MSM, Chapters 600 and 1000 regarding covered dental benefits.

b. 2. 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 authorized.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

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)

~~e.~~ 3. Plan of Care

Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the recipients 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.~~ a. ~~d~~Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- ~~2.~~ b. ~~a~~A description of the functional level of the ~~individual~~ recipient;
- ~~3.~~ c. ~~a~~Any orders for medications, treatments, restorative and rehabilitative services, activities, social services, diet;
- ~~4.~~ d. ~~p~~Plans for continuing care, as appropriate; and
- ~~5.~~ e. ~~p~~Plans for discharge, as appropriate.

~~12.~~ K. Discharge Planning

A hospital must ensure the following requirements are met:

- ~~a.~~ 1. There is documented evidence that a discharge evaluation is initiated as soon as ~~practical~~ after admission ~~as practicable~~ and in a manner to prevent discharge delays for: a recipient identified as likely to suffer an adverse health consequence upon discharge if adequate discharge planning is not ~~received initiated and completed~~; a recipient or a person acting on the behalf of a recipient requesting a discharge evaluation; or when requested by a physician.
- ~~b.~~ 2. 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 must specify goals and resolution dates, identify needed discharge services, and be developed with input from the primary care staff, recipient and/or family, and physician, ~~-(as applicable).~~

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~ε~~ 3. Re-evaluation of a recipient's **condition and** needs is conducted, as necessary, during the discharge planning process and the plan must be updated with changes **in a recipient's condition identified**.
- ~~ϛ~~ 4. The discharge plan includes documented evidence of:
- ~~1.~~ **a. frequent**-All 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.~~ **b. evidence of**-An alternate plan when a specific discharge intervention or placement effort fails.
 - ~~3.~~ **c. s**Significant contacts with the recipient, ~~and~~ family, **or legally authorized representative**, when applicable.
 - ~~4.~~ **d. a**A recipient's understanding of his/her condition, discharge evaluation results, and discharge plan.
 - ~~5.~~ **e. r**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, etc.), when applicable.
 - ~~6.~~ **f. n**F contacts and contact results, when NF placement is required NF placement efforts need to concentrate on facilities capable of handling a recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.
 - ~~7.~~ **g. r**Refusal by a recipient or recipient's family, ~~or~~ physician, **or legally responsible representative** to cooperate with discharge planning efforts to either find or accept available appropriate placement. Inpatient acute or administrative days are not reimbursed effective the date of the refusal.
 - ~~8.~~ **h. a**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.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

e- 5. Prior to ~~Nursing Facility (NF)~~ placement, the following documents are completed and in recipient's medical record:

~~1-~~ a. ~~a~~ **A Level of Care (LOC)**, a pre-admission screening, and resident review (PASRR) Level 1 screening.

~~2-~~ b. ~~a~~ **A PASRR Level II screening** and a Summary of Findings letter, when applicable.

Refer to MSM, Chapter 500 for ~~nursing facility~~**NF** placement screening requirements.

~~f-~~ 6. Hospitals must be in compliance with discharge planning requirements specified in 42 CFR 482.43.

7. ~~The day of discharge is not reimbursed except when discharge/death occurs on the day of admission.~~

~~13-~~ **L. Financial and Statistical 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-~~ **M. 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-~~ 1. ~~n~~ **Notify the QIO-like vendor** whenever there is a reason to believe that Medicare coverage has been exhausted.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

~~b.~~ ~~2.~~ ~~a.~~ 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.

~~e.~~ ~~3.~~ ~~e.~~ Obtain prior authorization from the DHCFP's QIO-like vendor in accordance with the MSM Chapter 200, ~~Section 203.1A(2)(f)(15) Coverage and Limitations – Authorization Requirements.~~

QMB claims denied by Medicare are also denied by the DHCFP.

~~15.~~ **N. Maternity/Newborn Federal Length of Stay Requirements**

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.~~ **O. Sterilization Consent Form**

Providers must ensure a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure. Reference the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information for ~~requirements related to these procedures~~ ~~the specific procedures.~~

~~a.~~ ~~1.~~ An inpatient day during which sterilization is performed without a valid sterilization form is a non-covered service.

~~b.~~ ~~2.~~ Medically necessary inpatient days within the same episode of care, not including the day of the sterilization, may be reimbursed when the sterilization consent form was not obtained. An episode of care is defined as the admission date to date of discharge. All applicable ~~inpatient~~ coverage ~~inpatient~~ rules apply.

~~17.~~ **P. In-State or Out-of-State Hospital Transfers**

~~a.~~ ~~1.~~ **Non-Emergency Transfers**

~~+~~ ~~a.~~ It is the responsibility of the transferring physician/facility to obtain prior authorization for non-emergent 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.

DRAFT	MTL 17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 203
MEDICAID SERVICES MANUAL	Subject: POLICY

~~2.~~ b. 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.

~~b.~~ 2. Emergency Transfers

A receiving hospital is responsible for obtaining authorization for an emergency transfer within ~~one~~ **three** business days of the inpatient admission.

~~18.~~ Q. Admissions to Hospitals Without a Psychiatric Unit or Alcohol/Substance Abuse Treatment Unit

~~a.~~ 1. Reference MSM, Chapter 400, Mental Health and Alcohol/Substance Abuse Services.

~~b.~~ 2. Maintain and submit to the QIO-like vendor documentation demonstrating comprehensive efforts to expeditiously transfer a recipient to an appropriate alternate setting (e.g. a freestanding psychiatric hospital or a general hospital with a psychiatric unit or to an alcohol/substance abuse treatment hospital or a general hospital with a specialized alcohol/substance abuse treatment unit), upon request or when applicable.

~~19.~~ R. Submission of Medical Documentation

~~a.~~ 1. Providers must identify and submit all pertinent (relevant and significant) ~~written medical information that supports~~ **supporting documentation** for an inpatient admission with an authorization request and/or with a request for a QIO-like vendor reconsideration review. This information must be provided in the format required by the QIO-like vendor. In addition, any documentation specifically requested by the QIO-like vendor must be submitted within time frames specified by the QIO-like vendor. Failure to provide all pertinent medical information in the format and within time frames required by the QIO-like vendor will result in authorization denial.

~~b. Verbal information from an individual other than a recipient's attending physician (without provision of either an attending physician's written attestation or documentation of this information in the medical record) as part of an initial authorization or reconsideration review request, does not meet documentation submission requirements.~~

~~20.~~ S. Adverse Determination

An adverse action or determination includes, but is not limited to, a denied or reduced authorization request.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 204
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~a.~~ 1. If a provider does not agree with the DHCFP QIO-like vendor's adverse determination, a peer-to-peer review or a reconsideration review can be requested. Reference the QIO-like vendor's/DHCFP's Billing Manual for details.
- ~~b.~~ 2. A provider must ~~provide~~ **submit** all additional pertinent documentation or information not ~~provided~~ **included** with the authorization request supporting services requested (e.g. documentation related to severity of illness, intensity of services, a physician's risk assessment) to the QIO-like vendor by the date of the reconsideration review. This information must be provided in the format required by the QIO-like vendor.
- ~~c.~~ 3. Pertinent medical information not provided to the QIO-like vendor in the required format by the reconsideration date of decision, will not **be** subsequently considered by the QIO-like vendor.
 - ~~1.~~ a. Verbal information provided by an individual other than a recipient's attending physician must be supported by either written attestation of this information in the medical record specifically provided to the QIO-like vendor with the authorization or reconsideration review request.
 - ~~2.~~ b. 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 the DHCFP, **within the required timeframe**. A provider must utilize internal grievance processes available through the QIO-like vendor.

~~21.~~ **T. Adherence to Requirements**

To receive reimbursement for covered services, a hospital must adhere to all conditions stated in the Provider Contract, all applicable ~~the~~ 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.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 204
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203.2~~ 204 ADMINISTRATIVE DAY POLICY

~~203.2A~~ 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 Care~~ (LOC). If discharge is ordered, a recipient's medical record must contain documentation that alternative appropriate placement is not available, despite a hospital's comprehensive discharge planning efforts.

~~203.2B~~ 204.1 COVERAGE AND LIMITATIONS

~~+~~ A. COVERED SERVICES

- ~~a.~~ 1. The DHCFP reimburses two levels of administrative days when authorized by the QIO-like vendor in increments usually not exceeding seven calendar days per request: a skilled nursing care level (skilled administrative days) and an intermediate care level (intermediate administrative days).
- ~~b.~~ 2. At least one acute inpatient hospital day must immediately precede an initial request for skilled or intermediate administrative days. Reimbursement is not available for direct admission to an administrative ~~level of care~~ LOC or for admission to an administrative ~~level of care~~ LOC from an outpatient setting (e.g., emergency ~~room~~ department, observation status, a physician's office, urgent care, or clinic).
- ~~e.~~ 3. Skilled administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital or CAH as a reduction in ~~level of care~~ LOC for:
 - ~~1.~~ a. ~~a~~A recipient waiting for evaluation and/or placement in a ~~Nursing Facility~~ (NF)/extended care facility, group home, residential treatment center (RTC) ~~Institution for Mental Disease~~ IMD, psychiatric or alcohol/substance abuse treatment hospital, or unit or other treatment settings (e.g., hospice) for continuity of medical services.
 - ~~2.~~ b. ~~d~~Delays in discharge related to durable medical equipment availability, home equipment set up, ~~or~~ home health, or hospice service arrangements.
 - ~~3.~~ c. ~~a~~A newborn with medical complications (not requiring acute care services) waiting for placement.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2034
MEDICAID SERVICES MANUAL	Subject: POLICY

4. d. aA recipient requiring medical interventions not meeting acute care criteria that prevents the recipient from leaving the hospital (e.g., monitoring laboratory results, obtaining cultures, a specific treatment/workup).

5. e. pPreparation for a surgery unrelated to the original reason for admission that does not meet acute care criteria.

4. 4. Intermediate administrative (~~Intermediate~~ ~~Care~~ ~~Level~~) Days are covered in an inpatient or ~~critical access hospital-CAH~~ when:

1. a. sServices do not meet an acute ~~level of care~~LOC;

2. b. tThe days are authorized by the QIO-like vendor; and

3. c. aA 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 waiting for medical assisted transportation~~, a recipient requiring evaluation after being a victim of crime).

2. B. NON-COVERED SERVICES

Administrative days are not covered when:

a. 1. aAt least one acute inpatient hospital day did not immediately precede the initial request for administrative days.

b. 2. tThe days are only for the convenience of the recipient, recipient's family, or physician.

e. 3. aA recipient, a recipient's family, ~~legally authorized representative~~, or physician refuse to cooperate with discharge planning efforts or refuse placement at a NF, psychiatric facility, or other available alternative setting.

d. 4. aA 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 for court appointed guardianship related to out-of-state NF placement.

~~203.2C~~ 204.2 AUTHORIZATION REQUIREMENTS

1. A. Prior authorization is required.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2034
MEDICAID SERVICES MANUAL	Subject: POLICY

~~2.~~ B. Retrospective authorization must be obtained when Medicaid eligibility is determined after admission to, or discharge from, an inpatient bed.

~~3.~~ C. Administrative day policy is consistent with the inpatient prior authorization and utilization review policies.

~~203.2D~~ 204.3 PROVIDER RESPONSIBILITIES

~~1.~~ A. Submit all pertinent discharge planning information to the QIO-like vendor with a prior authorization request, when applicable, and obtain authorization for administrative days within timeframes required by the QIO-like vendor.

~~2.~~ B. Notify the QIO-like vendor when there is a reduction in LOC to administrative days.

~~3.~~ C. Maintain documentation of appropriate, comprehensive discharge planning in recipients' medical records. This includes, but is not limited to:

~~a.~~ 1. ~~a~~All placement efforts, contacts and contact results;

~~b.~~ 2. ~~d~~Discharge planning notes from applicable social workers, case managers, and/or nurses;

~~c.~~ 3. ~~p~~Physicians' orders and/or progress notes;

~~d.~~ 4. ~~m~~Modification to the discharge plan, whenever applicable; and

~~e.~~ 5. ~~a~~Acceptable reason and timeframes of unavoidable discharge planning delays.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2035
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203.3~~ 205 SWING- BED SERVICES POLICY

Reference Chapter 200, Attachment A, Policy #02-043, Hospitals with Swing Beds.

DRAFT

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2036
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203.4~~ 206 OUTPATIENT HOSPITAL SERVICES POLICY

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

~~203.4A~~ 206.1 COVERAGE AND LIMITATIONS

~~1.~~ A. 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.~~ 1. For physician, advanced practitioner of nursing, physician assistants, urgent care sites and outpatient hospital clinic visits, refer to MSM Chapter 600.
- ~~b.~~ 2. For radiologic services, refer to MSM Chapter 300.
- 3. For pharmaceutical services, refer to MSM Chapter 1200.
- ~~1.4.~~ 4. For Partial Hospitalization Program (PHP) – Policy on an outpatient alternative to an inpatient psychiatric care program with services furnished under a medical model by a hospital or Federally Qualified Health Center (FQHC). Refer to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services for PHP policy.

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

~~2.~~ B. Emergency ~~Room~~ Department Services

Emergency department services are defined as a case in which delay in treatment of more than 24 hours could result in severe pain, loss of life, limb, eyesight or hearing, injury to self or bodily harm to others.

Non-emergent services provided in an emergency ~~room~~ department are a covered service for recipients with full Medicaid eligibility. Providers are expected to follow national coding guidelines by billing at the most appropriate level for any services provided in an emergency ~~room~~ department setting.

Laboratory and radiological services ordered during the course of emergency ~~room~~ department services (when it is an emergency diagnosis and not a clinic diagnosis) are payable without prior payment authorization.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2073
MEDICAID SERVICES MANUAL	Subject: POLICY

Charges made for stat performance of laboratory or radiological procedures ordered during a hospital's normal operating hours in the applicable department are not a DHCFP benefit. Patients requiring mental health services while in the emergency ~~room~~ department may receive such services if medically ~~appropriate, but~~ appropriate but must first be stabilized. Every effort must be made to transfer the patient to a psychiatric hospital or unit, accompanied by a physician's order. Authorization from the DHCFP's QIO-like vendor is also required.

3. C. Outpatient Observation Services

Reference Chapter 200, Attachment A, Policy #02-054, Outpatient Observation Services.

DRAFT

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2073
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203.5~~ 207 AMBULATORY SURGICAL CENTER SERVICES POLICY

Ambulatory Surgical Centers refers to freestanding or hospital based licensed ambulatory surgical units that can administer general anesthesia, monitor the recipient, provide postoperative care, and provide resuscitation as necessary. These recipients receive care in a facility operated primarily for performing surgical procedures on recipients expected to return safely home within 24 hours.

By contrast, physician office (MD-Office) services refers to a setting limited to use of local anesthesia, including private physician office, emergency-room department, urgent care centers, and clinic settings.

Observation/Medical short stay refers to the “ambulatory” recipient with a coexisting medical condition or some unforeseen medical situation who may remain in a hospital environment for an extended period. This extended stay, called observation or medical short stay can be used to assure recipient stability without an inpatient admission. The recipient may occupy any hospital unit. Observation recipients may be rolled over for inpatient admission any time the patient requires acute care services. All rollovers to inpatient care require QIO-like vendor’s authorization within 24 hours of the admission/rollover. Observation stays which do not rollover to inpatient status are limited to 48 hours.

~~203.5A~~207.1 COVERAGE AND LIMITATIONS

1. A. The DHCFP reimburses for services provided in a freestanding ambulatory surgical center or an ambulatory surgical setting within a general hospital. Some ambulatory surgical center services require QIO-like vendor authorization. ~~(please see Reference MSM Chapter 200, Section 203.10(D) of this Chapter entitled Ambulatory Surgical Services Policy – Authorization Process).~~
2. B. Ambulatory surgical services are not reimbursable when:
 - a. 1. ~~¶~~The recipient’s medical condition or treatment needs meet acute inpatient guidelines and standards of care.
 - b. 2. ~~¶~~The recipient requires preoperative diagnostic testing that cannot be performed in an outpatient setting.
 - c. 3. ~~¶~~The recipient requires therapeutic interventions (measures) that can only be performed in an acute hospital setting.
 - d. 4. ~~¶~~The probability of significant, rapid onset of complications is exceptionally high. Actual manifestation of such complications would require prompt intervention/measures available only in an inpatient setting.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2037
MEDICAID SERVICES MANUAL	Subject: POLICY-AMBULATORY SURGICAL CENTER SERVICES POLICY

~~e.~~ 5. ~~e~~Complications occur during or following an outpatient procedure that requires acute inpatient treatment and intervention.

~~f.~~ 6. ~~s~~Services are not reasonable and medically necessary for diagnosis or treatment of a recipient when provided for the convenience of the recipient, recipient's family, or the physician.

~~g.~~ 7. ~~s~~Services are ordered as inpatient by the admitting physician.

~~h.~~ 8. ~~s~~Services can be provided in a less restrictive setting (e.g., physician office, emergency ~~room~~ department, clinic, urgent care setting).

~~3.~~ C. Higher Setting of Service Delivery

When any listed procedure is planned in a higher setting, the physician or his/her office staff must contact the QIO-like vendor for prior authorization of the setting. These procedures are listed in the booklet entitled "Surgical Procedures Recommended for an Ambulatory Setting (including inpatient prior authorization guidelines)."

~~4.~~ D. Non-Covered Procedures

Reference **MSM Chapter 600, Ambulatory Centers (ASC) Facility and Non-Facility Based.**

~~5.~~ E. Approval Process

The procedure approval process is designated to establish the medical necessity and appropriateness for:

- ~~a.~~ 1. ~~p~~Procedures to be performed in a higher care setting;
- ~~b.~~ 2. ~~p~~Procedures that would not routinely be covered by the DHCFP; and
- ~~c.~~ 3. ~~p~~Procedures to be performed outside Nevada.

The requesting physician must provide the QIO-like vendor with the medical documentation and justification to establish medical necessity and appropriateness.

~~203.5B~~ 207.2 PROVIDER RESPONSIBILITY

Please ~~consult Section 203.1(B)-~~reference **MSM Chapter 200, Inpatient Hospital Services Policy – Provider Responsibilities of this chapter** for service provider responsibility.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2037
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203.5C~~207.3 AUTHORIZATION PROCESS

The provider must contact the QIO-like vendor 48 hours prior to the procedure date.

- ~~1.~~ A. Provider must submit the required authorization form. ~~or request Prior Authorization telephonically.~~
- ~~2.~~ B. A copy of Medicaid card to confirm that the physician’s office has verified the recipient’s eligibility.
- ~~3.~~ C. All supporting medical documentation ~~that~~ the requesting physician would like considered.
- ~~4.~~ D. Procedure pre-approval requests:
 - ~~a.~~ 1. ~~e~~Cannot be accepted from the facility/hospital personnel.
 - ~~b.~~ 2. ~~r~~Require up to two working days to process.
 - ~~c.~~ 3. ~~DOS~~Date of Service(DOS) must be within 30 days from the Prior Authorization’s date of issue.
- ~~5.~~ E. Retroactive Eligible Recipients

For those recipients who applied for Medicaid eligibility after services were rendered, the QIO-like vendor must be contacted for retro eligible authorization.

The QIO-like vendor reviews the information for medical necessity, appropriateness of the procedure and compliance with Medicaid program benefits. Written notification of the review determination is sent to the physician and facility within 30 days of receipt of all required documentation.

- ~~6.~~ F. Prior Authorization Is Required When:
 - ~~a.~~ 1. ~~a~~A procedure indicated as “MD-Office” is planned for a setting other than a physician’s office, emergency ~~room~~ department or clinic. This includes an ambulatory surgery facility, a hospital-based outpatient surgery department, or inpatient treatment at an acute care hospital.
 - ~~b.~~ 2. ~~a~~A procedure indicated as “Amb Surgical” is planned to be done on an inpatient basis.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2037
MEDICAID SERVICES MANUAL	Subject: POLICY

~~e.~~ 3. ~~a~~A procedure appearing on the list is planned for a recipient who is currently being treated in an acute care hospital and the procedure is unrelated to the original reason for admission. Authorization is not required if the procedure is for treatment related to the admitting diagnosis.

~~d.~~ 4. ~~t~~The physician can provide compelling evidence that non-covered procedure is not cosmetic but is medically necessary.

~~e.~~ 5. ~~t~~The Medicaid coverage is secondary to any other private, non-Medicare insurance plans.

~~f.~~ 6. ~~a~~A listed procedure(s) requiring prior authorization is to be performed in conjunction with a procedure(s) exempt from authorization.

~~g.~~ 7. ~~a~~Any procedure is to be performed out--of--state ~~that requires a prior authorization in-state.~~

~~h.~~ 8. ~~a~~Any procedure that is to be performed on an inpatient basis.

~~i.~~ 9. ~~a~~A recipient is going to be rolled-over from ambulatory or observation status to an acute inpatient admission.

~~7.~~ G. Prior Authorization is Not Required When:

~~a.~~ ~~reference Accredited Standards Committee (ASC) Physician's Assistant list.~~

~~b.~~ 1. ~~a~~A procedure is covered by Medicare Part B and Medicaid (QMB eligible) is only required to pay coinsurance, up to the DHCFP allowable maximum.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2038
MEDICAID SERVICES MANUAL	Subject: POLICY

203.6 208 LONG TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL SERVICES POLICY

203.6A 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 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.

203.6B 208.1 COVERAGE AND LIMITATIONS

1. A. COVERED SERVICES

- 1.** The DHCFP reimburses medically necessary services meeting coverage requirements, provided in either a freestanding long-term acute care hospital or a long-term acute unit of a general hospital.
- 2.** All of the following criteria must be met:
 - 1.** a. Frequent, specialized, therapeutic interventions are required on an inpatient basis.
 - 2.** b. Services are ordered and supervised by a physician or another individual authorized by State licensure law to prescribe treatment.
 - 3.** c. Services include skilled nursing services, with 24-hour, on-site, registered nurse availability.
 - 4.** d. Services are provided in accordance with a multidisciplinary, coordinated plan of care.
 - 5.** e. Services are authorized as medically necessary by the QIO-like vendor.

2. B. NON-COVERED SERVICES

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

- 1.** aA recipient does not meet eligibility requirements;
- 2.** †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

DRAFT	MTL 27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2093
MEDICAID SERVICES MANUAL	Subject: POLICY

~~e.~~ 3. ~~†~~The services are limited to only **medical** rehabilitation, coma stimulation, or pain management interventions (e.g., relaxation techniques, stress management, biofeedback).

~~203.6C~~ 208.2 PRIOR AUTHORIZATION

~~1.~~ A. 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, ~~Section: Authorization.~~

~~2.~~ B. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to or discharge from an LTAC specialty hospital.

~~3.~~ C. LTAC specialty hospital's policy is consistent with applicable inpatient prior authorization and utilization review policies within the MSM Chapter 200, **Inpatient Hospital Services Policy – Coverage and Limitations – Authorization Requirements. Section 203.1A(2)(a-e), 203.1(A)(2)(f), (5), (8), (10), (14) and (15) and 203.1A(2)(h)(1-2).**

~~203.6D~~ 208.3 PROVIDER RESPONSIBILITIES

Providers must:

~~1.~~ A. ~~b~~Be in compliance with provider responsibilities specified in **the MSM Chapter 200, Inpatient Hospital Services Policy – Provider Responsibilities-203.1B.**

~~2.~~ B. ~~m~~Maintain evidence of Medicare certification and state licensure as an LTAC.

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2093
MEDICAID SERVICES MANUAL	Subject: POLICY

~~203.7~~ 209 INPATIENT REHABILITATION SPECIALTY HOSPITAL SERVICES POLICY

~~203.7A~~ DESCRIPTION

Inpatient rehabilitation specialty hospitals and distinct inpatient rehabilitation units in a general or ~~critical-access-hospital~~CAH provide intensive, multidisciplinary, coordinated rehabilitation services (e.g., physical, occupational, speech, or prosthetics/orthotics therapy) to restore optimal function following an accident or illness, (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 rehabilitation involves both retraining and relearning to achieve the maximal level of function possible, based on a recipient's abilities and disabilities.

~~203.7B~~ 209.1 COVERAGE AND LIMITATIONS

~~1.~~ A. COVERED SERVICES

- ~~a.~~ 1. The DHCFP reimburses medically necessary, intensive, inpatient rehabilitation services meeting coverage requirements, provided in either a freestanding inpatient rehabilitation hospital or an inpatient rehabilitation unit of a general or ~~critical-access-hospital~~CAH.
- ~~b.~~ 2. ~~All of~~All the following criteria must be met:
 - ~~1.~~ a. Services are ordered and provided under the direction of a physician with specialized training or experience in rehabilitation.
 - ~~2.~~ b. Services are authorized as medically necessary by the QIO-like vendor.
 - ~~3.~~ c. The inpatient admission is from an acute hospital or NF and is within one year from the initial injury or illness or most recent surgery/hospitalization as a result of the initial illness or injury.
 - ~~4.~~ d. Active and ongoing therapeutic interventions from multiple therapy disciplines are required on an inpatient basis.

DRAFT	MTL 27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2039
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~5.~~ e. Rehabilitative service is provided a minimum of either three hours per day, five days per week, or 15 hours within each seven-consecutive day period, beginning the date of admission.
- ~~6.~~ f. Physical and/or occupational therapy must be a component of rehabilitative services provided.
- ~~7.~~ g. Inpatient rehabilitation is only ordered when a recipient is capable of making significant, measurable, functional improvement in activities of daily living within a specified period of time.
- e.a. 3. 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), covered when:
 - ~~1.~~ a. ~~†~~The exception is limited to once per admission and does not exceed three consecutive days;
 - ~~2.~~ b. ~~e~~Comprehensive documentation of the unexpected clinical event is provided to the QIO-like vendor; and
 - ~~3.~~ c. ~~a~~A preadmission screening, post admission physician evaluation, and the plan of care support that the recipient was initially able to actively participate in the inpatient rehabilitation program.
- ~~d.~~ 4. 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. 5. 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. ~~a~~A physician's order that specifies the number of hours for the leave;
 - ~~2.~~ b. ~~†~~The medically appropriate reason for the leave; and an evaluation of the therapeutic effectiveness of the leave.

DRAFT	MTL 27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2039
MEDICAID SERVICES MANUAL	Subject: POLICY

~~2.~~ B. NON-COVERED SERVICES

Inpatient ~~medical~~-rehabilitation services are not covered when:

- ~~a.~~ 1. ~~¶~~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.~~ 2. ~~¶~~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-SNF~~; or
- ~~c.~~ 3. ~~¶~~Treatment goals necessitating inpatient services are achieved or further progress toward established rehabilitation goals is not occurring or is unlikely to occur.

~~203.7C~~ 209.2

PRIOR AUTHORIZATION

- ~~1.~~ A. 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, ~~Authorization~~.
- ~~2.~~ B. 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.~~ C. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to, or discharge from, an inpatient rehabilitation hospital.
- ~~4.~~ D. ~~Inpatient M~~medical rehabilitation hospital policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, ~~Inpatient Hospital Services Policy – Coverage and Limitations – Authorization Requirements–Section 203.1A(2)(a-e), 203.1(A)(2)(f)(5), (8), (10), (14) and (15) and 203.1A(2)(h)(1-2)~~.

~~203.7D~~ 209.3

PROVIDER RESPONSIBILITIES

- ~~1.~~ A. Providers must be in compliance with Provider Responsibilities specified in ~~the MSM Chapter 200, Hospital Inpatient Services Policy – Provider Responsibilities–203.1B~~.
- ~~2.~~ B. Providers must ensure ~~that~~ the following documentation is maintained in a recipient's medical record and submitted to the QIO-like vendor, as applicable:

DRAFT	MTL-27/16CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 2039
MEDICAID SERVICES MANUAL	Subject: POLICY

- ~~a.~~ 1. ~~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.~~ 2. ~~a~~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.~~ 3. ~~e~~Evidence of no less than 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.~~ C. Providers must ensure that the rehabilitation plan of care is:
- ~~a.~~ 1. ~~e~~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.~~ 2. ~~i~~Individualized and specify the intensity, frequency and duration of therapies and the anticipated, quantifiable treatment goals; and
 - ~~c.~~ 3. ~~m~~Modified with changes in medical or functional status, as applicable.

DRAFT	MTL-17/15CL
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 20410
MEDICAID SERVICES MANUAL	Subject: HEARINGS

204 210 HEARINGS

Reference MSM Chapter 3100, Hearings for the hHearings pProcess.

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POLICY #02-012	FEDERAL EMERGENCY SERVICES PROGRAM DIALYSIS BIRTH CENTERS	EFFECTIVE DATE: September 1, 2013
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A. DESCRIPTION

Section 2301 of the Affordable Care Act (ACA) requires coverage of services furnished at freestanding birth centers. A freestanding birth center is described as a health facility that is not a hospital or physician's office, where childbirth is planned to occur away from the pregnant woman's residence. The birth center must be in compliance with applicable state licensure and nationally recognized accreditation organization requirements for the provision of prenatal care, labor, delivery, and postpartum care. "Obstetric Center," Nevada's legal term for birth center, complies with Section 2301 of the ACA birth center requirements related to the health and safety of recipients provided services by licensed birth centers.

B. POLICY

The DHCFP birth center coverage and reimbursement is limited to medically necessary childbirth services which use natural childbirth procedures for labor, delivery, postpartum care, and immediate newborn care. Birth center coverage and reimbursement are limited to women admitted to a birth center in accordance with adequate prenatal care, prospect for a normal uncomplicated birth defined by criteria established by the American College of Obstetricians and Gynecologists and by reasonable generally accepted clinical standards for maternal and fetal health.

Refer to the Maternity Care section of ~~Medicaid Services Manual (MSM)~~ Chapter 600 – Physician Services, for comprehensive maternity care coverage provided by physicians and/or nurse midwives.

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Birth center reimbursement includes childbirth services for labor, delivery, post-partum, and immediate newborn care when the following pregnancy criteria are met:

- a. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed birth center protocol;
- b. Completion of at least 36 weeks² gestation and not more than 42 weeks² gestation.

Birth centers are not eligible for reimbursement if:

- c. The pregnancy is high-risk.
- d. There is history of major uterine wall surgery, cesarean section, or other obstetrical complications which are likely to recur.
- e. The recipient is discharged prior to delivery.

September 4, 2015	HOSPITAL SERVICES	Attachment A Page 1
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POLICY #02-012	FEDERAL EMERGENCY SERVICES PROGRAM DIALYSIS BIRTH CENTERS	EFFECTIVE DATE: September 1, 2013
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2. NON-COVERED SERVICES

- a. Emergency treatment as a separately billed service provided by the birth center. For emergency treatment provided in a hospital – refer to policy in MSM Chapter 200 – Hospital Services; and
- b. Emergency medical transportation as a separately billed service provided by the birth center. For policy related to emergency transportation – Refer to MSM Chapter 1900 – Transportation Services.

E. PROVIDER REQUIREMENTS

Freestanding obstetric/birth center must meet the following criteria:

1. Have a provider contract with the DHCFP. Refer to MSM Chapter 100, ~~Section 102~~, **Medicaid Program** - Provider Enrollment.
2. Meet applicable state licensing and/or certification requirements in the state in which the center is located.
3. Accreditation by one of the following nationally recognized accreditation organizations:
 - a. The Accreditation Association for Ambulatory Health Care, (AAAHC) Inc.;
 - b. The Commission for the Accreditation of Birth Centers, (CABC); **and/or**
 - c. The Joint Commission, for institution-affiliated outpatient maternity care programs which principally provide a planned course of outpatient prenatal care and outpatient childbirth service limited to low-risk pregnancies.
4. Informed consent: Each recipient admitted to the birth center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.
5. The birth center must have written ~~Memorandum of Understanding (MOU)~~ with a backup hospital (or physician with admitting privileges) which will accept and treat any woman or newborn transferred from the center in need of emergency obstetrical or neonatal medical care.
6. The birth center must have a written MOU with ambulance service which is routinely staffed by qualified personnel to manage critical maternal and neonatal patients during transport to each backup hospital.

For billing instructions and a list of covered procedure and diagnosis codes, please refer to the QIO-like vendor's Billing Manual.

POLICY #02-02	FEDERAL EMERGENCY SERVICES PROGRAM DIALYSIS	EFFECTIVE DATE: September 1, 2013
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A. INTRODUCTION

The Nevada State Plan provides that certain non-United States (U.S.) citizens, who otherwise meet the requirements for Title XIX eligibility, are restricted to receive only emergency service as defined by 42 CFR 440.255, titled “**Limited Services Available to Certain Aliens.**” Provision of outpatient emergency dialysis health care services through the Federal Emergency Services Program (FESP) is **also** deemed an emergent service for this eligibility group.

B. DEFINITIONS

For the purpose of this chapter, the following definitions apply:

1. Acute – means symptoms that have arisen quickly and which are short-lived.
2. Chronic – means a health-related state that is not acute, **persisting for a long period of time or constantly recurring.**
3. Federal Emergency Service (FES) – treatment of a medical condition (**including emergency labor and delivery**) manifesting itself by acute symptoms of sufficient severity; (including severe pain); such that the absence of immediate medical attention could reasonably be expected to result in:
 - a. Placing the FES recipient’s health in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.
4. FES recipient – means a qualified or non-qualified alien as described by 42 CFR 435.406(2)(ii)(c) **and 42 CFR 436.406(c)**-who receives services pursuant to 42 CFR 440.255(e).
5. End Stage Renal Disease (ESRD)/Dialysis services – means the method by which a dissolved substance is removed from the body of a patient by diffusion, osmosis, and convection from one fluid compartment to another fluid compartment across a semi-permeable membrane (i.e., hemodialysis, peritoneal dialysis, and other miscellaneous dialysis procedures).
6. Stabilized – with respect to an emergency medical situation, means ~~that~~ no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

C. COVERAGE AND LIMITATIONS

Any acute emergency medical condition that meets the definition of FES as identified above in the definition described.

Outpatient dialysis services for an FES recipient with ESRD are covered as an emergency service when the recipient’s treating physician signs and completes the certification stating that in his/her medical

September 4, 2015	HOSPITAL SERVICES	Attachment A Page 3
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POLICY #02-023	ADMINISTRATIVE DAYS- FEDERAL EMERGENCY SERVICES PROGRAM DIALYSIS	EFFECTIVE DATE: MARCH 1, 2015 September 1, 2013
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opinion the absence of receiving dialysis at least three times per week, would reasonably be expected to result in any one of the following:

1. Placing the FES recipient's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of a bodily organ or part.

D. PRIOR AUTHORIZATION

1. Prior authorization is not required.
2. Refer to "Provider Requirements Section" for treating physician certification form requirements.

E. NON-COVERED SERVICES

1. FESP – dialysis for an eligibility group not qualified under 42 CFR 435.406(2)(i)(ii).
2. Services covered prior to the coverage date of this policy.
3. Services deemed non-covered when:

~~4.a.~~ The "Initial **Emergency Dialysis Case Certification-Creation**" form is not on file with the QIO-like vendor;

~~5.b.~~ "Monthly **Emergency Dialysis Case Certification-Form**" form is incomplete and/or missing from the FES recipient's medical record.

F. PROVIDER REQUIREMENTS

1. Treating physicians must complete and sign the monthly certification form entitled, "Monthly **Emergency Dialysis Case Certification-of-Emergency-Condition**" form and retain the certification in the FES recipient's medical record. The form is found on the QIO-like vendor website.
2. For initiation of treatment, the treating physician must submit an "Initial **Emergency Dialysis Case Certification-Creation**" form to the QIO-like vendor with the initial claim. The form is found on the QIO-like vendor website.
3. The DHCFP may audit FES recipient medical records to ensure compliance with this monthly requirement.
4. For billing instructions, please refer to the QIO-like vendor's Billing Manual and/or PT45 Billing Guideline.

POLICY #02-034	HOSPITAL WITH SWING BEDS	EFFECTIVE DATE: MARCH 1, 2015
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1. A. DESCRIPTION

A swing bed is a bed in a rural or Critical Access Hospital (CAH), certified as a swing bed by the ~~Centers for Medicare and Medicaid Services (CMS)~~, which can be used to provide either acute care or post-acute skilled nursing services. A recipient admitted to a swing bed for post-acute skilled nursing services following discharge from acute inpatient care, does not have to change beds or locations in a facility, unless required by the facility.

2. B. POLICY

This policy is specific to an acute inpatient bed that provides post-acute Nursing Facility (NF) services. The DHCFP reimburses post-acute/NF swing bed days when: a recipient receiving acute inpatient hospital services for at least three consecutive calendar days (not including the day of discharge) requires post-acute, skilled nursing services seven days a week and no NF placement is available or the recipient or family refuses NF placement outside the rural area. The three-day qualifying acute inpatient stay does not have to be from the same facility as the swing bed admission. Placement in a swing bed must be on a temporary (not long term) basis.

3. C. PRIOR AUTHORIZATION

Prior Authorization is required, except ~~when a recipient is for~~ Medicare and Medicaid dual eligible recipients ~~when and~~ Medicare benefits are not exhausted. Refer to MSM, Chapter 100, Authorization.

Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to or discharge from a swing bed.

Services not included in the per diem rate may require prior authorization. Reference the MSM Chapter applicable to the service type regarding authorization requirements.

4. D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

- a. The DHCFP covers medically necessary, post-acute, ~~nursing facility~~ ~~NF level of care~~ LOC services provided on an inpatient basis and reimbursed at a per diem rate. The per diem rate includes routine services and supplies, including a regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen, and the use of equipment and facilities.
- b. The following services are separately reimbursed when the service meets policy requirements specific to that service:
 - e.1. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.
 - e.2. Nutritional supplements in conjunction with tube feedings.

POLICY #02-034	HOSPITAL WITH SWING BEDS	EFFECTIVE DATE: MARCH 1, 2015
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~~e~~.3. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.

~~f~~.4. Customized durable medical equipment.

~~g~~.5. Emergency transportation.

~~h~~.6. Physical, occupational, and speech therapy services.

~~i~~.7. Physician services.

~~j~~.8. Laboratory, portable x-ray, and other diagnostic services.

~~k~~.9. Repair of medical equipment and appliances which belong to the recipient.

2. NON-COVERED SERVICES

~~i~~ a. Swing bed placement when ~~nursing facility~~NF placement is available in the rural area where the hospital is located or in another rural or urban area acceptable to the recipient or family.

~~ii~~ b. Swing bed days not authorized by the QIO-like vendor.

~~5~~ E. PROVIDER RESPONSIBILITIES

1. Ensure compliance with Provider Responsibility requirements specified in Chapter 200, Section 203.1B, federal and state swing bed requirements and the DHCFP coverage and authorization requirements.

2. Utilize available NF beds prior to requesting swing bed placement, unless NF placement is outside the rural area and there is documented evidence that a recipient or family objects to placement outside the rural community.

3. Transfer a recipient to the first available NF bed.

4. Reference Chapter 500 for Pre-Admission Screening and Resident Review (PASRR) and ~~Nursing Facility-NF Level of Care (LOC)~~ screening requirements prior to a recipient being transferred from a swing bed to a NF bed within the hospital or at another facility.

~~6~~ F. DOCUMENTATION

1. Notify and submit required documentation to the QIO-like vendor to initiate admission and concurrent review authorizations when a recipient is retro eligible.

2. Submit the following documentation to the QIO-like vendor with the initial authorization request:

a. ~~a~~A history and physical or acute inpatient discharge summary indicating the need for skilled nursing services;

March 1, 2015	HOSPITAL SERVICES	Attachment A Page 6
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POLICY #02-034	HOSPITAL WITH SWING BEDS	EFFECTIVE DATE: MARCH 1, 2015
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- b. ~~a~~A physician acute hospital discharge order and swing bed admission order;
 - c. NF placement efforts with documentation regarding NF bed unavailability or recipient or family refusal of NF placement outside the rural area; and any additional documentation requested by the QIO-like vendor.
3. Submit the following documentation to the QIO-like vendor with a concurrent swing bed authorization request no less frequently than monthly (when applicable):
- a. ~~e~~Ongoing NF placement efforts and either the reasons NF bed placement is not available or recipient or family refusal of NF placement outside the rural area;
 - b. ~~a~~A monthly nursing assessment summary indicating a recipient continues to meet a skilled ~~level of care~~LOC; and
 - c. ~~a~~Any additional documentation requested by the QIO-like vendor.

POLICY #02-045	OUTPATIENT OBSERVATION SERVICES	EFFECTIVE DATE: MARCH 1, 2015
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a.A. DESCRIPTION

Outpatient Observation services are physician ordered, clinically appropriate, short term hospital outpatient services including diagnostic assessment and treatments provided when a recipient's medical needs do not meet acute inpatient care guidelines. A recipient's condition is further evaluated to determine if inpatient admission is required or the recipient can be safely discharged. **Outpatient Observation** services do not have to be provided in a designated hospital observation unit. Observation services can be provided in any area of a hospital, such as on an obstetric unit or an intermediate/progressive coronary care unit.

b.B. POLICY

Outpatient Observation services are reimbursed when ordered by a physician or other clinician authorized by State licensure law and hospital staff bylaws to order services and at an hourly basis up to 48 continuous hours.

Medically necessary ancillary services (e.g. laboratory, radiology and other diagnostics, therapy, and pharmacy services) that meet the coverage and authorization requirements of the ~~Medicaid Services Manual (MSM)~~ applicable to the service are separately reimbursed.

Observation and ancillary services provided at the same facility and on the same calendar date as an inpatient admission, as part of one continuous episode of care, are included in the first inpatient day, per diem rate (a rollover admission). Observation hours (not exceeding the observation 48-hour limit) and ancillary services rendered on the calendar date(s) preceding the rollover inpatient admission date are separately reimbursed.

c.C. PRIOR AUTHORIZATION IS NOT REQUIRED for hourly outpatient observation.

Medically necessary ancillary services may require prior authorization. Reference the MSM Chapter applicable to the service type regarding authorization requirements.

d.D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. Observation begins the date and time specified on the physician's observation order, not when the recipient is placed in an observation bed. Observation ends when the 48-hour policy limit is reached or at the date and time the physician writes an order for either inpatient admission, transfer to another healthcare facility, or discharge.

b. Observation days are covered when:

c.1. A recipient is clinically unstable for discharge from an outpatient setting due to either:

d.a. aA variance from generally accepted, safe laboratory values;

POLICY #02-045	OUTPATIENT OBSERVATION SERVICES	EFFECTIVE DATE: MARCH 1, 2015
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- ~~e.b.~~ ~~e~~ Clinical signs and symptoms above or below normal range requiring an extension of monitoring and further evaluation;
- ~~f.c.~~ ~~a~~ An unstable presentation with vague symptoms and no definitive diagnosis; or
- ~~g.d.~~ ~~a~~ An uncertain severity of illness or condition in which a change in status requiring medical intervention is anticipated.
- ~~h.e.~~ ~~a~~ A significant adverse reaction occurs subsequent to a therapeutic service (e.g., blood or chemotherapy administration, dialysis);
- ~~i.f.~~ ~~t~~ The medically necessary services provided meet observation criteria, a provider is notified that inpatient admission is denied because it does not meet acute inpatient ~~level of care~~ LOC criteria, a physician writes an order for observation status and patient rights and utilization review federal requirements are met pertaining to changing an inpatient admission to outpatient observation status.

2. NON-COVERED SERVICES

- a. Observation hours exceeding the 48-hour limit.
- b. Services rendered without a signed, dated physician order or documentation in the medical record that specifies the date and time observation services were initiated and discontinued.
- c. Diagnostic testing or outpatient procedures prescribed for medically stable individual or services deemed by the DHCFP, the DHCFP's QIO-like vendor or other authorized agency as not medically necessary or appropriate.
- d. Observation status when either a recipient's medical condition or treatment needs meet acute inpatient guidelines/standards of care or the ~~probably~~ ~~probability~~ of a significant, rapid onset complication is exceptionally high requiring prompt interventions available only in an inpatient setting.
- e. Services that can be safely and effectively provided in a less restrictive setting (e.g., a physician's office, emergency ~~room~~ ~~department~~, clinic, urgent care setting).
- f. Services limited to a therapeutic procedure (e.g., outpatient blood transfusion, intravenous fluids, chemotherapy administration, dialysis) when no other service is required or in the absence of a documented adverse reaction.
- g. Services that are routine preparation prior to or monitoring after a diagnostic test, treatment, procedure, or outpatient same-day surgery.
- h. Services immediately preceding an inpatient admission for elective induction of labor (EIOL) prior to 39 weeks² gestation when the EIOL is not authorized as medically necessary.

POLICY #02-045	OUTPATIENT OBSERVATION SERVICES	EFFECTIVE DATE: MARCH 1, 2015
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- i. Services provided solely for the convenience of a recipient, recipient's family or physician.
- j. Services provided to an individual not eligible (concurrently or retrospectively) for Medicaid or ~~Nevada Check-Up~~ NCU on the date of service or not covered by or performed in compliance with this or any other MSM Chapter.

e.3. DOCUMENTATION REQUIREMENTS

Ensure the following information is maintained in a recipient's medical record:

- a. A physician's order, clearly indicating the dates and times that observation begins and ends.
- b. Comprehensive documentation that supports medical necessity and describes, when applicable:
 - i. 1. ~~a~~A significant complication or adverse reaction that requires services that would normally be included in a recovery or post-procedure period; or
 - ii. 2. ~~a~~A high probability of a significant, rapid onset complication requiring prompt interventions available in an observation setting.