MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

May 11, 2010

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA STAGLIANO, CHIEF, COMPLIANCE M. Stagliano

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATIONS

Changes are being made to Medicaid Services Manual (MSM) Chapter 200 - Hospital Services to include removing language regarding coverage of inpatient respite services. New policy involves provider responsibility under federal requirements relating to benefits for mothers and newborns referenced in 203.1B.16. Modifications to Chapter 200, that do not represent a change in policy include: removing the "Reimbursement" heading and repetitive reimbursement language already specified in Chapter 700 or in the State Plan Amendment; consolidating and relocating non-reimbursement related language currently under the "Reimbursement" heading to appropriate chapter locations; clarifying policy language (e.g. when observation and emergency room services would be included in the inpatient per diem rate); and updating chapter references. Changes are effective May 12, 2010.

MATERIAL TRANSMITTED **MTL 17/10** Chapter 200 – HOSPITAL SERVICES	MATERIAL SUPERSEDED **MTL 20/03, 15/07** Chapter 200 – HOSPITAL SERVICES
Sec. 200	
Added "Health Care Quality and Compliance"	Deleted "Licensure and Certification"
Added "of those listed in the"	Deleted "of the four areas where Medicaid and"
Added "Manual,"	Deleted "policies differ as documented in"
Added "1000"	Deleted "3700"
Sec. 201.B.5	
Added "5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers	

and Newborns)"

Sec. 203.1
Added "mental disease"

Deleted "tuberculosis"

Sec. 203.1A.1.e
Added "Reimbursement for observation cannot exceed 48 hours."

Deleted "status"

Added "O"

Deleted "For authorization purposes, o"

Added "services"

Deleted "s"

Added "a physician writes an order for either inpatient admission, transfer to another health care facility, or discharge. Time related to the provision of medically necessary services after a physician writes the discharge order, but prior discharge, are reimbursed as long as the total time in observation does not exceed 48 hours. Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order."

Deleted "the nurses' notes indicate the recipient left the hospital. When a recipient is admitted as an inpatient subsequent to a maximum 48 hour observation stay, a separate dated and timed physician's order, on the physician order form, is required for the inpatient admission as defined above."

Sec. 203.1A.1.f
Added "f. Military or Veteran's Hospitals"

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

Sec. 203.1A.2
Added "any in-state or out-of-state acute inpatient"

Deleted "a"

Added "(e.g. general, Critical Access, Indian Health Services, Medical Rehabilitation or Long Term Acute Care Specialty hospitals)"

Sec. 203.1A.2.d
Added "/facility"

Added "nonemergent"

Sec. 203.1A.2.f.9

Added "Per diem reimbursement amounts are based on the level of care authorized by the QIO-like vendor."

Deleted "9. Respite care (inpatient) for children in the physical and/or legal custody of the Division of Child and Family Services (DCFS) or in the Special Needs Adoption Program. A maximum of 72 hours of respite care may be authorized at a frequency of no more than every 120 calendar days may be authorized."

Sec. 203.1A.2.f.10

Added "for admission criteria"

Sec. 203.1A.2.f.11

Added "in rural or Critical Access hospital"

Sec. 203.1A.2.f.12

Added "or Medical Rehabilitation Specialty"

Deleted "to the community"

Added "or involving an overnight stay. Reference 203.1A.3, Absences"

Sec. 203.1A.2.f.13

Added "When t"

Deleted "T"

Added "insurance"

Deleted "authorization is required"

Added "is the primary payment source. Reference Chapter 100, section 104"

Sec. 203.1A.2.f.14

Added "within 30 days of the receipt of the"

Deleted ". As soon as a provider is aware or receives documentation from"

Added "EOB indicating"

Deleted "that"

Added "Reference Chapter 100, section 103.2."

Sec. 203.1A.2.g.1

Added "a direct admission from an"

Sec. 203.1A.2.g.4

Added "direct inpatient"

Deleted "al status"

Added "as part of one continuous

Deleted "the"

encounter at the same facility"	Deleted "The inpatient admission is inclusive of the emergency and observation services"
Added "an"	
Added "Emergency or observation services resulting in a direct inpatient admission on the same calendar date and at the same facility as the inpatient admission are included in the per diem inpatient hospital rate"	
Sec. 203.1A.3 Added "Absences"	Deleted "Reimbursement"
Sec. 203.1A.3.a Added "Absences from an acute hospital or Medical Rehabilitation Specialty hospital are allowed"	Deleted "General acute care facilities are reimbursed per diem rates based on the following categories/levels of care authorized by the QIO–like vendor"
Sec. 203.1A.3.a.1 Added "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, a respite visit with parents in the case of a child, or death of an immediate family member, or"	Deleted "Medical/Surgical"
Sec. 203.1A.3.a.2 Added "Up to, but not exceeding 32 hours from a Medical Rehabilitation Specialty hospital for therapeutic reasons, such as preparing for independent living."	Deleted "Newborn Admissions"
Sec. 203.1A.3.a.3	Deleted "3. Maternity"
Sec. 203.1A.3.a.4	Deleted "4. Intensive Care Units (ICU)"
Sec. 203.1A.3.a.5	Deleted "5. Neonatal Intensive Care Unit (NICU) Level III"
Sec. 203.1A.3.a.6	Deleted "6. Trauma Level I"
Sec. 203.1A.3.a.7	Deleted "7. Administrative Days, Skilled Nursing or Intermediate level"
Sec. 203.1A.3.a.8	Deleted "8. Psychiatric/substance abuse"

Sec. 203.1A.3.b
Added "The following information must be documented in a recipient's medical record:"

Deleted "Psychiatric/Substance Abuse. Effective with service dates of July 1, 1992, general hospitals with a psychiatric and/or substance abuse unit are reimbursed an all-inclusive per diem daily rate. Effective July 1, 1994 freestanding psychiatric and/or substance abuse hospitals known as institution for mental disease (IMD) (42 CFR 435.1009) are reimbursed under the same all-inclusive per diem daily rate as a general hospital for a like service. In accordance with 42 CFR 441.13(a)(2), Nevada Medicaid will only reimburse IMD's for recipients under the age of 21 or 65 years of age or older. Reference Chapter 400, for coverage and criteria. If a recipient is initially admitted to a general hospital for acute care and is then authorized to receive psychiatric/substance abuse services, the acute care is paid at the appropriate medical/surgical per diem rate. The psychiatric and/or substance abuse treatment/service is paid at the psychiatric/substance abuse services rate for those days certified as acute care for psychiatric/substance abuse. Days certified as administrative are paid at the all-inclusive administrative day rate. General acute care hospitals are required to bill Medicaid separately for each of the two types of stays. QIO-like vendor certifies the various types of stays accordingly."

Sec. 203.1A.3.b.1
Added "1. A physician's order specifying the number of hours for the pass;"

Sec. 203.1A.3.b.2
Added "2. The medically appropriate reason for the pass prior to issuance of the pass; and"

Sec. 203.1A.3.b.3
Added "3. An evaluation of the therapeutic effectiveness of the pass when the recipient returns."

Sec. 203.1A.3.c	Deleted "c. Specialty (Rehabilitation/ LTAC) Hospitals are reimbursed an all inclusive per diem daily rate which is based on cost reimbursement."
Sec. 203.1A.3.d	Deleted "d. Take Home Drugs Take home drugs must be separately billed per the hospital's Provider 28, pharmacy, provider agreement. Reference Chapter 1200 Pharmacy Services for coverage and criteria."
Sec. 203.1A.3.e	Deleted "e. Federal Government Facilities Indian Health Services (IHS) and Tribal facilities are paid an all inclusive daily per diem rate in accordance with the most recent published federal register notice (42 CFR 136.11). Medicaid does not reimburse military or Veteran's hospitals."
Sec. 203.1A.3.f	Deleted "f. Hospitals Out-of-State Nevada Medicaid's QIO-like vendor must verify that the medical services requested for Medicaid eligible recipients are not available in Nevada. The out-of-state payment rate for inpatient care is based on one of the following criteria, whether emergency or elective in nature:"
Sec. 203.1A.3.f.1	Deleted "1. Reimbursed according to the Nevada Medicaid per diem rate as outlined under Section 203.1A(3); or"
Sec. 203.1A.3.f.2	Deleted "2. Nevada Medicaid may negotiate a rate through a letter of agreement only if an out-of-state hospital refuses to accept the rate methodology and meets the following criteria:"
Sec. 203.1A.3.f.2.a	Deleted "a. The Nevada Medicaid eligible recipient requires medical services which, if not provided within 30 calendar days, could result in severe pain, loss of life or limb, loss of eyesight or hearing, injury to self, or bodily harm to others; and"
Sec. 203.1A.3.f.2.b	Deleted "b. The specific surgery or medical procedure needed is provided or available

	only in an out-of-state hospital; and,"
Sec. 203.1A.3.f.2.c	Deleted "c. Nevada Medicaid determines the out-of-state hospital's negotiated rate to be the most cost effective rate available. The out-of-state hospital must contact the Nevada Medicaid Rate Department prior to admission to negotiate the rate."
Sec. 203.1A.3.g	Deleted "g. Critical Access Hospitals (CAH'S) For purposes of Medicaid payment, CAH's are reimbursed under Medicare's retrospective cost reimbursement (excluding psychiatric hospitals), as follows:"
Sec. 203.1A.3.g.1	Deleted "1. Inpatient hospital services which have been certified for payment by Medicaid's contracted QIO-like vendor, as specified in the contract between the two entities, upon final settlement, are reimbursed allowable costs under hospital-specific retrospective Medicaid principles of reimbursement in accordance with 42 CFR 413.30 and 413.40, Subpart C."
Sec. 203.1A.3.g.2	Deleted "2. On an interim basis, each hospital is paid for certified acute care at the lower of: 1) billed charges or 2) the rate paid to general acute care hospitals for the same service."
Sec. 203.1A.3.h	Deleted "h. Respite Care Services Medicaid may authorize acute medical or mental health hospital admissions for medically fragile children with severe and/or chronic medical problems which require specialized care, intensive medical follow-up, supportive treatment and continuous monitoring (e.g., ventilator dependent, AIDS), to provide a temporary relief interval period for their primary care givers. These children must either be in the physical and/or legal custody of the Division of Child and Family Services (DCFS) or in the Special Needs Adoption Program, where the state agrees to provide the child/recipient with a medical subsidy.

	The request for respite care must come directly from the recipient's social worker or adoptive parents. The recipient's physician must then contact the QIO-like vendor to obtain authorization for inpatient hospital admission. The QIO-like vendor will authorize the admission only if the recipient requires inpatient hospital care for respite purposes. A maximum of 72 hours of respite care may be authorized at a frequency of no more than every 120 calendar days. It is not permitted to accumulate excess available hours from one 120 calendar day period to the next. Hospitals will receive respite care reimbursement under Medicaid's hospital inpatient per diem rate. If the QIO-like vendor authorizes the stay as acute, Medicaid reimburses at the acute level of care. If the QIO-like vendor authorizes the stay at a skilled or intermediate level, Medicaid reimburses at the appropriate administrative day rate."
Sec. 203.1A.3.i	Deleted "i. Absences"
Sec. 203.1A.3.i.1	Deleted "1. In special circumstances, Nevada Medicaid may allow up to an eight hour pass from the acute hospital without denial of payment. Occasionally, a recipient who has been in the hospital on a long-term basis needs to be absent for a few hours for: a trial home visit; a respite visit with parents in the case of a child; a death in the immediate family, etc. Although not required for absences under eight hours, hospital staff must request prior authorization from the QIO-like vendor for any absences expected to last longer than eight hours."
Sec. 203.1A.3.i.2	Deleted "2. A recipient authorized by the QIO-like vendor for a stay in a comprehensive medical rehabilitation hospital or unit may go on pass from the hospital for therapeutic reasons, such as preparing for independent living. Overnight passes to go home and passes longer than

	eight hours for community or rehabilitation reasons must be prior authorized by the QIO-like vendor. Home passes may last up to, but not more than 32 hours."
Sec. 203.1A.3.i.3	Deleted "3. Any type of absence involving any hospital requires a physician's order that is medically appropriate to allow a recipient leave on pass. The therapeutic reason for the pass must be clearly documented in the recipient's medical chart prior to the issuance of the pass. Upon the recipient's return, the pass must be evaluated for therapeutic effect and documented by the hospital."
Sec. 203.1A.4 Added "and"	Deleted ", and Ryan White Care Act"
Sec. 203.1A.4.k	Deleted "k. Qualified Medicare Beneficiaries (QMBs). QMB hospital claims are paid as follows:"
Sec. 203.1A.4.k.1	Deleted "1. Payment is the lower of the Medicare deductible amount or the difference between the Medicare payment and the Medicaid per diem."
Sec. 203.1A.4.k.2	Deleted "2. Additional Medicaid reimbursement is not made when the Medicare payment exceeds the Medicaid per diem rate."
Sec. 203.1A.4.k.3	Deleted "3. Medicaid pays the Medicare deductible for each Medicare "benefit period" up to Medicaid allowable amounts not to exceed Medicare's allowable amounts. "Lifetime reserve days" are a prior resource to Medicaid."
Sec. 203.1A.4.k.4	Deleted "4. QMB claims denied by Medicare are also denied by Medicaid. A QIO-like vendor review is not conducted for Medicare/Medicaid crossover (QMB/ MED) admissions unless acute days have been exhausted and/or there has been a termination of Medicare benefits and the

	patient is/was at an acute or administrative day level of care. Medicaid authorization is provided for acute and administrative days only. A provider must notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted. When requesting a QIO-like vendor review, the provider must 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. If Medicare benefits are exhausted, prior authorization from Medicaid's QIO-like vendor must be obtained within 30 calendar days of the receipt of the Medicare EOB. Reference Chapter 100, Section 103."
Sec. 203.1B.2.2 Added "Health Care Quality and Compliance"	Deleted "Licensure and Certification"
Sec. 203.1B.15 Added "A provider must:"	Deleted "Any request to the QIO-like vendor for this authorization should be accompanied by a copy of the Medicare Explanation of Benefits (MEOB)."
Sec. 203.1B.15.a Added "a. Notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted."	
Sec. 203.1B.15.b Added "b. Attach a copy of the Medicare Explanation of Benefits (EOB) (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted when requesting a QIO-like vendor review."	
Sec. 203.1B.15.c Added "c. Obtain prior authorization from Medicaid's QIO-like vendor in accordance with 203.1A.2.f.15."	

Added "QMB claims denied by Medicare are also denied by Medicaid."

Sec. 203.1B.16
Added "16. 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."

Sec. 205.1
Added "PROVIDER SPECIFIC INFORMATION"

Deleted "POLICY RESOURCES"

Sec. 205.1.1
Added "1. Medicaid Services Manual Chapters:"

Added "Chapter 300 Radiology Services"

Added "Alcohol/"

Added "ies"

Added "Chapter 700 Rates and Cost Containment"

Added "Chapter 800 Laboratory Services"

Added "Chapter 900 Private Duty Nursing"

Added "Chapter 1100 Ocular Services"

Added "Chapter 1200 Prescribed Drugs"

Added "Chapter 1300 DME, Disposable Supplies and Supplements"

Added "Chapter 1400 Home Health Agency"

Added "Program"

Deleted "1."

Deleted "2."

Deleted "3."

Deleted "y Services"

Deleted "4."

Deleted "Services"

Deleted "5."

Deleted "("

Deleted ")"

Deleted "6."

Deleted "7."

Deleted "Medicaid Recipient"

Deleted "8."

Deleted "Surveillance and Utilization Review Section"

Added "Chapter 1600 Intermediate Care for the Mentally Retarded"	Deleted "9."
	Deleted "10."
Added "Chapter 1700 Therapy"	
Added "Chapter 1800 Adult Day Health Care"	
Added "Chapter 2400 Comprehensive Outpatient Rehabilitation (COR) Services"	
Added "Chapter 2500 Case Management"	
Added "Chapter 2800 School Based Child Health Services"	
Added "Chapter 2900 Mental Health Rehabilitative Treatment Services"	
Added "Chapter 3200 Hospice"	
Added "Program Integrity"	
Added "Chapter 3500 Personal Care Services Program"	
Sec. 205.1.2	
Added "2. Nevada Check Up Manual"	Deleted "11."
Added "1000"	Deleted "3700"
Added "Program"	
Sec. 205.1.3	
Added "3. Initial and ongoing eligibility for Medicaid benefits are determined by the Eligibility Specialist as set forth in the Division of Welfare and Support Services District Offices' "Eligibility and Payments Manual"."	
Sec. 205.2	
Added "FIRST HEALTH SERVICES CORPORATION"	Deleted "CONTACTS"
Sec. 205.2.A	
Added "Provider Relations Department First Health Services Corporation PO Box	Deleted "Division of Welfare and Support Services District Offices"

30042 Reno, NV 89520-3042 Toll Free number within Nevada: (877) NEV-FHSC (638-3472)"	
Sec. 205.2.B Added "Prior Authorization Department First Health Service Corporation Nevada Medicaid and Nevada Check Up Health Care Maintenance (HCM) 4300 Cox Road Glen Allen, VA 23060 Telephone number: (800) 525-2395 Fax number: (866) 480-9903"	Deleted "Initial and ongoing eligibility for Medicaid benefits are determined by the Eligibility Specialist as set forth in the Division of Welfare and Support Services District Offices' "Eligibility Payments Manual."
Sec. 205.2.C Added "Web announcements, billing manuals and guidelines, forms, provider enrollment, and pharmacy information can be found at http://nevada.fhsc.com."	Deleted "Fiscal Agent"
Sec. 205.2.D	Deleted "D. State Offices State offices in Carson City may be telephoned long distance free of charge (within Nevada only) by dialing 1-800-992-0900 and asking the State Operator for the specific office:"
Sec. 205.2.D.1	Deleted "1. Nevada Division of Health Care Financing and Policy Nevada Medicaid Office 1100 E William Street Suite 102 Carson City, Nevada 89701 Telephone: (775) 684-3600"
Sec. 205.2.D.2	Deleted "2. Nevada State Health Division Bureau of Licensure and Certification 1550 East College Parkway, Suite 158 Carson City, Nevada 89706 Telephone: (775) 687-4475."
Sec. 205.2.D.3	Deleted "3. Nevada Division of Health Care Financing and Policy Medicaid District Offices are listed in various Medicaid pamphlets. Local telephone numbers are: Carson City (775) 687-3651 Elko (775) 753-1191 Las Vegas – Belrose (702) 486-1550 Reno – Bible Way (775) 688-2811"
Sec. 205.2.E	Deleted "E. Quality Improvement

Organization (QIO-like vendor) Medicaid's QIO for payment authorization may be contacted at the following addresses and phone numbers: First Health Services Group 4300 Cox Road Glen Allen VA 23060 (804) 965-7400 http://www.fhsc.com The QIO may also be reached on-line. Payment Authorization Forms are available on the website as well."

Sec. 205.3

Deleted "FORMS"

Deleted "NOT SUPPLIED BY MEDICAID"

Deleted "Forms used by the hospital for billing purposes and not supplied by Nevada Medicaid are listed below: a. UB-92-Acute hospital patient billing form. Hospitals may order this form from any stationary supply store: b. CMS (HCFA) 1500 – Health insurance billing form. Forms following the sequence of the HCFA 1500 are acceptable. Providers may order this form from a private printer or purchase from: Government Printing Office Superintendent of Documents Room C836, Building G Washington, D.C. 20401"

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
TABLE OF CONTENTS

HOSPITAL SERVICES

200 INTRODUCTION

Inpatient 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 for the diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.

Medicaid may reimburse hospitals for providing the following services: medical/surgical, maternity, newborn, neonatal, rehabilitation, long-term acute, psychiatric, and substance abuse.

In Nevada, hospitals are licensed by the Bureau of Health Care Quality and Compliance within the Nevada State Health Division.

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

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 CFR 440.10) and outpatient hospital services (42 CFR 440.20).

B. Other authorities include:

1. Section 1861 (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) 449.021 (Types of Hospitals in Nevada)

5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers and Newborns)

202 DEFINITIONS

202.1 ADMISSIONS

An inpatient is a person who has been admitted to a hospital for purposes of receiving inpatient hospital services. The physician responsible for the recipient's care at the hospital is also responsible for deciding whether the recipient should be admitted as an inpatient based on the physician's assessment of the needed level of care.

202.2 AMBULATORY SURGICAL CENTERS

Ambulatory Surgical Centers (ASCs) are any distinct entities that operate exclusively for the purpose of providing outpatient surgical services to patients not requiring inpatient hospitalization, has an agreement with the Center for Medicare and Medicaid Services (CMS) to participate in Medicare as an ASC, and meets the conditions set forth in 42 CFR 416, parts B and C. Ambulatory Surgery services may be provided in either a freestanding or hospital-based ASC.

202.3 CONCURRENT REVIEW

Concurrent review is performed for patients who are Medicaid eligible at the time of inpatient admission. Review is conducted to certify length of stay, medical necessity and appropriateness.

202.4 CRITICAL ACCESS HOSPITAL (CAH)

Nevada Medicaid utilizes Medicare criteria when defining a CAH. Pursuant to section 1820 (a) of the Social Security Act, a state may designate a facility as a critical access hospital if the facility: 1) is located in a county in a rural area more than a 35-mile drive from a hospital and is certified by the state as being a necessary provider of health care services to residents in that area; 2) makes necessary 24-hour emergency care services that a state determines are necessary for ensuring access to emergency care services in each area serviced by a CAH; 3) provides not more than 15 acute care inpatient beds for providing inpatient care for a period that does not exceed 96 hours per patient (unless a longer period of time is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions); and 4) meets staff requirements as defined in section 1861 (e) and 1861 (mm)(1) of the Act.

202.5 INSTITUTION FOR MENTAL DISEASE (IMD)

Institution for Mental Disease(s) (IMD) is defined as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such (42 CFR 435.1009). In Nevada, IMDs are commonly referred to as "psychiatric hospitals".

202.6 LONG-TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL

Long-term acute care facilities are hospitals that specialize in acute care for medically complex patients, i.e., multi-system complications and/or failures that require extended hospitalization, specialized programs and aggressive clinical and therapeutic interventions. Specialty hospitals generally do not provide surgical, obstetric or psychiatric services. LTAC hospitals must comply with state and federal licensing requirements. This applies to both free-standing and hospital based units.

202.7 PRIOR AUTHORIZATION

Titles XI and XVIII of the Act provide the statutory authority for the broad objectives and operations of the utilization and quality control Quality Improvement Organization (QIO) program. The Peer Review Improvement Act of the Tax Equity and Fiscal Responsibility Act of 1982 established utilization and quality control Quality Improvement Organizations (QIOs).

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

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

202.8 REHABILITATION (REHAB) SPECIALTY HOSPITAL

A rehab hospital provides post-acute related services to recipients having, but not limited to, head and spinal cord injury, traumatic brain injury, cerebrovascular accident (CVA), wound care needs, cardiac-related disorders, respiratory failure and ventilator dependency. Rehabilitation hospitals generally do not provide surgical, obstetrical or psychiatric services. Rehab hospitals must meet state and federal licensing criteria. This applies to free-standing and hospital based units.

202.9 RETROSPECTIVE REVIEW

Retrospective review is performed for patients who are not Medicaid eligible when inpatient services were rendered, but become Medicaid eligible after services are rendered and/or after discharge. A review is conducted to certify length of stay, medical necessity, and appropriateness.

202.10 SWING-BED HOSPITAL

A swing-bed hospital is any hospital that meets the following criteria: 1) the hospital has a Medicare swing-bed provider agreement; 2) has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units; 3) the hospital is located in a rural area, including all areas not delineated as “urbanized” areas by the Census Bureau, based on most recent census; 4) the hospital does not have in effect a 24-hour nursing waiver; 5) the hospital has not had swing-bed approval terminated within two years previous to application; and 6) The facility is substantially in compliance with the skilled nursing facility requirements contained in 42 CFR, subpart B, part 483.

203 POLICY

203.1 INPATIENT HOSPITAL SERVICES POLICY

Inpatient hospital services are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that: a) is maintained primarily for the care and treatment of patients with disorders other than mental disease; b) is licensed as a hospital by an officially designated authority for state standard-setting; c) meets the requirements for participation in Medicare; and d) has in effect a utilization review 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 for the diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases (IMD), a Nursing Facility (NF), or an Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.

Out of State Acute Hospital Services

Non-emergency out-of-state acute inpatient hospital care requires prior authorization by the QIO-like vendor for Medicaid eligible and pending eligible recipients. Out-of-state inpatient hospital services may be authorized for specialized medical procedures not available in Nevada. The QIO-like vendor's authorization number must be recorded on the UB-92 billing claim. The referral for out-of-state services must come from the referring/transferring Nevada physician and/or hospital. Reference Chapter 100, Section 103.

In and Out-of State Acute Hospital Transfers

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, rehabilitation, specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor must make a determination regarding the availability of such services at the referring hospital or within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being met at the transferring facility.

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

203.1A COVERAGE AND LIMITATIONS

1. Admission Documentation

a. Medicaid considers the recipient admitted to the hospital when: 1) a physician provides the order for admission during the hospital stay, as verified by the date and time; 2) acute care services are rendered; and 3) the recipient has been transferred, or is awaiting transfer to, an acute care bed from the emergency department, operating room, admitting department, or other hospital services. The admission is certified by the QIO-like vendor based on supporting documentation available in the medical record.

The determination of each recipient's admission status and the related admission order is based on the physician's assessment of the recipient's needed level of care. The admission order, located on the physician order form, should clearly define whether a recipient is to be admitted as an inpatient, placed on observation status, same day surgery, or rollover from observation.

b. Admission Date

The admission date must be reflected on the authorization as the date and time the admission order was written during hospitalization. If the date and time of the physician admission orders are not clear or available, the QIO-like vendor applies the documentation most relevant to the admission determination contingent upon provision of acute care services.

c. 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.

d. 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. Physician orders for admission must be written at the time of admission or during the hospital stay and are only valid if they are signed by the physician. Verbal and telephone orders written by other allied personnel must be co-signed by the physician. Admission orders written after discharge will not be accepted. The role of the QIO-like vendor is to determine whether an admission was medically necessary based on the medical record documentation, not to determine

physician intent to admit.

e. Observation

Reimbursement for observation cannot exceed 48 hours. Observation begins when the physician writes and dates the observation orders, not when the recipient is placed in an observation bed. Observation services end when a physician writes an order for either inpatient admission, transfer to another health care facility, or discharge. Time related to the provision of medically necessary services after a physician writes the discharge order, but prior discharge, are reimbursed as long as the total time in observation does not exceed 48 hours. Inpatient admission from observation begins at the time and on the calendar date that a physician writes an inpatient admission order.

f. Military or Veteran's Hospitals

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

2. Authorization Requirements

Prior authorization review is conducted to evaluate medical necessity, appropriateness, location of service and compliance with Medicaid's policy prior to the delivery of service. Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, Critical Access, Indian Health Services, Medical Rehabilitation or Long Term Acute Care Specialty hospitals) or before authorization of payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient.

a. All QIO-like vendor determinations are based on the medical information provided by the requesting physician. Authorization refers only to the determination of medical necessity and appropriateness. Authorization does not guarantee benefit plan payment. Plan coverage is also conditional upon the recipient's eligibility and is subject to all other coverage terms and conditions of the Nevada Medicaid and Nevada Check Up programs.

b. Services requiring prior authorization which have not been prior authorized by the QIO-like vendor are not covered and will be denied for payment.

c. A prior authorization is valid for the dates of service authorized. If a recipient has a change of condition or the service cannot be provided during service dates authorized, this prior authorization becomes invalid. A new or updated prior authorization must be obtained.

d. It is the responsibility of the transferring physician/facility to obtain prior authorization for nonemergent transfers between in-state and out-of-state facilities, prior to the transfer of the recipient.

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

f. Providers must obtain prior authorization from the QIO-like vendor for the following services:

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

2. Antepartum admissions for the purpose of delivery when an additional elective procedure is planned (excluding tubal ligations).

3. Additional inpatient days must be requested before authorized inpatient days expire.

4. Dental admissions. Two prior authorizations for inpatient hospitalization for a dental procedure are necessary:

a. The Medicaid dental consultant must prior authorize the dental procedure; and

b. The QIO-like vendor must authorize it is medically necessary for the recipient to be hospitalized for the performance of the dental procedure.

5. Family planning admissions for procedures as defined by Medicaid regulations.

6. Non-emergency admissions to in-state and out-of-state facilities.

7. Psychiatric admissions to a psychiatric wing of a general acute hospital (regardless of age), or a free standing psychiatric hospital “Institution for Mental Disease” (IMD) for recipients age 65 or older or under age 21 (between ages 21 and 64 are non-covered). Reference Chapter 400.

8. Residential Treatment Center (RTC) admissions. Only covered for recipients under the age of 21. Reference Chapter 400, section 403.9.

9. All changes in level of care and/or transfer between units (e.g. medical/surgical, intensive care, obstetrics, newborn, neonatal intensive care, trauma level 1, psychiatric/detoxification, rehabilitation, administrative, and outpatient observation.) Per diem reimbursement amounts are based on the level of care authorized by the QIO-like vendor.

10. Substance abuse detoxification and treatment (inpatient) admissions. This includes transfers from detoxification to treatment within the same hospital. Reference Chapter 400 for admission criteria.

11. Swing bed admissions in rural or Critical Access hospital. Reference Section 203.3 of this Chapter.

12. Therapeutic passes from an acute or Medical Rehabilitation Specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference 203.1A.3, Absences.

13. When third party liability insurance, other than Medicare Part A, is the primary payment source. Reference Chapter 100, section 104.

14. Non-Medicare covered days within 30 days of the receipt of the Medicare EOB indicating Part A Medicare benefits are exhausted. Reference Chapter 100, section 103.2.

15. Admissions resulting from EPSDT screening.

g. Providers must notify (submit pertinent clinical information) and obtain authorization from the QIO-like vendor within one business day of patient admission for the following services:

1. All in-patient admission for an emergent condition, including admissions from a physician's office, urgent care, or a direct admission from an emergency room. (See the Emergency Diagnosis list on the QIO-like vendor's website.)

2. Obstetric or newborn admissions which, from the date of delivery, exceed three calendar days for vaginal or four calendar days for elective or emergency cesarean delivery. For newborns who do not have a Medicaid number until after the date of birth, providers must notify and obtain prior authorization from a QIO-like vendor within five business days of the eligibility date of decision.

3. Tubal ligations performed at the time of obstetric delivery must have a sterilization consent form meeting federal requirements on file. There must be 30 calendar days, but not more than 180 calendar days, between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. If premature delivery occurs within the 30 calendar day period, the physician must document the expected delivery date and certify the sterilization was performed less than 30 calendar days but not less than 72 hours after the date of recipient's signature on the Sterilization Consent Form.

4. Rollover admissions. These are direct inpatient admissions initiated through an emergency room or observation as part of one continuous encounter at the same facility when a physician writes an acute inpatient admission order. Emergency or observation services resulting in a direct inpatient admission on the same calendar date and at the same facility as the inpatient admission are included in the per diem inpatient hospital rate.

5. Medicare Part A Coverage.

6. Any newborn admission to a Neonatal Intensive Care Unit (NICU) requiring notification within one business day.

h. Utilization Review

1. Concurrent Review is the process in which requests for services are reviewed during the time period that services are being provided. For inpatient care, this is also referred to as continuing stay review. Requests for continued services will occur prior to the end of the existing authorization period. Initially the QIO-like vendor will assign a length of stay for the period authorized. The length of stay authorized will vary depending on the diagnosis and condition of the patient. For complex cases, the initial authorization may not include the full length of stay required to manage the medical condition. Additional days may be authorized through a concurrent review process. If additional days are requested, the provider must contact the QIO-like vendor prior to the expiration of the initial authorization to request further authorization.

2. Retrospective review defines the process of reviewing clinical information against established criteria to determine whether the services will be approved after the delivery of that service. If the clinical information does not support the medical necessity or appropriateness of the setting, services may be denied and payment retracted. Retrospective review is limited solely to cases in which eligibility is determined retrospectively.

3. The provider is notified if the QIO-like vendor's reviewer determines clinical information supports either a reduction in level of care, discharge, or denial of days. If the provider has additional clinical information that might alter this determination, the provider must submit this documentation to the QIO-like vendor within five business days.

i. Utilization Review Process

1. Notification of Admission:

a. Providers must notify the QIO-like vendor within 90 calendar days of the date of decision of eligibility for the retro eligible recipients not currently in a facility. These retro eligible notification requirements apply even if a recipient has prior resources or Third Party Liability (TPL).

b. If the recipient has prior resources or TPL, notification to the QIO-like vendor is also required within 30 days of the date of decision.

2. Level of Care and Length of Stay Determination

a. 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 level of care and authorized time period for the length of stay.

b. If there is not enough clinical information provided by the provider the QIO-like vendor will request the provider to submit additional information. For eligible recipients the provider has one business day to submit the additional information. For retro eligible recipients the provider has five days to submit the additional information.

c. The QIO-like vendor will make a determination on eligible recipients within one business day of receipt of all pertinent clinical information.

d. The QIO-like vendor will make a determination on retro eligible recipients who have been discharged within 30 calendar days of receipt of complete medical information.

3. Administrative Days - The primary purpose and function of administrative days is to assist hospitals that, through no fault of their own, cannot discharge a recipient who no longer requires acute level services, due to lack of, or a

delay in, an alternative appropriate setting. The provider will have to provide the QIO-like vendor with adequate and comprehensive documentation of discharge planning efforts. Administrative days are authorized through the QIO-like vendor as a reduction of level of care. The QIO-like vendor will authorize administrative days up to seven calendar day increments at their discretion depending on medical necessity.

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

1. The recipient is awaiting placement or evaluation for placement at a nursing facility/extended care facility, group home or other treatment setting for continuity of medical services (e.g. transfers to other facilities, rehabilitation or independent living, or hospice).

2. The recipient is to be discharged home and is awaiting home equipment set up/availability, nursing services, and/or other caretaker requirements (e.g. home health nursing, public health nursing, DME, or respite).

3. Conditions exist which may prevent a non-acute recipient from leaving the hospital (e.g., monitoring of labs, cultures for staph infection or any treatment/work up that could not be safely and effectively accomplished in another setting).

4. The recipient is awaiting placement at a residential treatment center, group home or psychiatric treatment center for continuity of psychiatric services.

5. A newborn awaiting placement due to medical complications.

6. The recipient is being prepared for surgery, which may not have been the original reason for admission, and is not requiring an acute level of care.

7. Recipient has mental disabilities that prevent nursing facility placement and the recipient will be placed in an Institution for Mental Disease.

b. Intermediate Care Level (ICL) is for those recipients who cannot be discharged due to social reasons. ICL days are authorized when one or more of the following apply or as determined by the physician reviewer:

1. Stable newborn awaiting adoption or discharge home when the mother is discharged.

2. Awaiting medical assisted transportation.

3. Victim of crime in need of assessment and evaluation.

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

1. Recipient, recipient's family or physician refused a Nursing Facility (NF) placement.

2. Recipient, family, or physician refuses a psychiatric Residential Treatment Center (RTC) placement.

3. Recipient, recipient's family or physician refuses placement to the available alternative settings that are arranged.

4. There is insufficient documentation (Monday through Friday contacts and results) in the chart reflecting adequate discharge planning.

4. Outpatient observation status - Consistent with federal Medicare regulation, Medicaid reimburses for hospital observation stays for a period up to, but no more than, 48 hours without prior authorization. Observation services are conducted by the hospital to evaluate the recipient's condition to asses the need for inpatient admission. Observation services refer to short term care provided at the appropriate location of the hospital when the recipient's medical needs do not meet acute care guidelines.

a. Observation and ancillary charges are not paid when the recipient is admitted to the hospital or following outpatient same-day surgery. Observation days are covered when:

1. Diagnosis is uncertain (diagnosis not established, additional information required by physician, more time is required to asses and evaluate systems, or an appropriate plan of care is undefined).

2. Specialized diagnostic tools and services are required (diagnostic services are only available onsite, proximity to testing equipment is required, diagnostic testing results are not yet available).

3. Observation days may be authorized when inpatient days are denied.

b. Observation days are not covered when:

1. A recipient's medical condition or treatment needs meet acute inpatient guidelines and standards of care.

2. Services are ordered as inpatient by the admitting physician.

3. The recipient requires preoperative diagnostic test that cannot be performed in an outpatient setting.

4. The recipient requires therapeutic interventions (measures) that can only be performed in an acute hospital setting.

5. 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.

6. Complications occur during or following an outpatient procedure that require acute inpatient treatment and intervention.

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

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

5. Adverse Determination

An adverse action or determination refers to a denial, termination, reduction, or suspension of a recipient's request for services

a. If a provider does not agree with Nevada Medicaid's QIO-like vendor's adverse action or determination, the provider may refer to the QIO-like vendor's billing manual regarding the appeal process.

b. If the provider disagrees with the results of the QIO-like vendor's appeal process, the provider may request a fair hearing through Medicaid. Reference Chapter 3100, Section 3104 and 3105.

3. Absences

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

1. In special circumstances, such as when a recipient is in the hospital on a long-term basis and needs to be absent for a few hours for a trial home visit, a respite visit with parents in the case of a child, or death of an immediate family member, or

2. Up to, but not exceeding 32 hours from a Medical Rehabilitation Specialty hospital for therapeutic reasons, such as preparing for independent living.

The following information must be documented in a recipient's medical record:

1. A physician's order specifying the number of hours for the pass;

2. The medically appropriate reason for the pass prior to issuance of the pass; and

3. An evaluation of the therapeutic effectiveness of the pass when the recipient returns.

4. Prior Resources

Many recipients eligible for Medicaid have coverage under private or group insurance, Medicare, Employer Insurance Companies of Nevada (EICON), CHAMPUS, or some other plan. Per federal law all such coverage is considered a prior resource and must be billed and applied to payment before billing Medicaid. The only exceptions are Bureau of Family Health Services (formerly Crippled Children's Services), Indian Health Services (IHS), and Victims of Violent Crime.

203.1B PROVIDER RESPONSIBILITIES

1. Patient Liability

a. Determination: Patient Liability (PL) is determined by eligibility personnel in the local Division of Welfare and Supportive Services District Office. The hospital is notified of PL on the "Notice of Decision" form. For questions regarding PL, please

contact the local Division of Welfare and Supportive Services 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 "Notice of Decision" 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 Division of Welfare and Support

5. Services prorates PL as in number 3 above. The facility will be sent a notice indicating the adjusted PL amount.

6. 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 level of care and per diem rate for that hospital.

7. IMDs/freestanding psychiatric hospitals and Residential Treatment Centers (RTC) are exempt from PL requirements.

2. Conditions of Participation

1. Licensure

The State Board of Health is responsible for developing the licensing standards, rules and regulations, pursuant to Nevada Revised Statutes 449.001 to 449.240, for all health care facilities within the State of Nevada.

The Nevada State Health Division is responsible for determination of satisfactory compliance with the provisions of the law and the issuance of such license. Licenses

are renewable annually.

2. Certification

To be approved for participation in the Medicaid program hospitals must be certified to participate in the Medicare program. Hospitals currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 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). The Nevada State Health Division, Bureau of Health Care Quality and Compliance, is the designated agency in Nevada.

3. Participating Agreements

Any hospital licensed by the state and certified for participation in the Medicare program may apply to become a participating provider under Medicaid.

To receive payment for covered services, the hospital administrator and/or those designated on the agreement form must enter into a provider agreement with Nevada Division of Health Care Financing and Policy and adhere to conditions stated in the agreement.

4. Termination

Nevada Medicaid 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 Medicaid Services Manual, Chapter 100, for termination, lockout, suspension, exclusion, and non-renewal of Medicaid provider enrollment).

3. Utilization Review

Parts 456.100 through 456.145 of Section 42 Code of Federal Regulations (CFR) prescribe the requirements for a written Utilization Review (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 utilization review program under a Quality Improvement Organization (QIO-like) or CMS has determined that the UR procedures established by the Medicaid program are superior to the procedures under the QIO-like vendor, and meet the UR plan requirements under 42 CFR 456.50 through 456.245.

4. Quality Assurance - Hospital Medical Care Evaluation Studies

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

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

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

5. Civil Rights Compliance

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

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

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

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

All hospitals are required to submit Form 3058 to their local Division of Welfare and Support Services 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 Division of Welfare and Support Services.

8. Patient Rights

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

9. Claims for Denied Admissions

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

10. Hospital Responsibilities for Services

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

11. Attending Physician

a. Pre-Admission Authorization

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

Oral and maxillofacial surgeons must also secure prior authorization from the Medicaid dental consultant to assure payment for the procedure. (See 203.1.D.11) Reference Chapters 600 and 1000 for covered benefits.

b. Physician Certification

The physician must certify for a recipient that inpatient services in a hospital are/or

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

c. Plan of Care

Before admission to a hospital or before authorization for payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. (42 CFR 456.80)

The plan of care must include:

1. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

2. A description of the functional level of the individual;

3. Any orders for medications, treatments, restorative and rehabilitative services, activities, social services, diet;

4. Plans for continuing care, as appropriate; and

5. Plans for discharge, as appropriate.

12. Discharge Planning

The hospital must designate separate, identifiable staff whose primary responsibility is discharge planning. The discharge planners must review all Medicaid admissions. Discharge planning activities must commence within 48 hours of admission (or up to 72 hours involving weekends) for every recipient.

The discharge planner formulates and records a discharge plan. The plan must specify goals and resolution dates. All alternatives to nursing facility placement must be explored (e.g., home health services, homemaker services, placement with family, subsidized housing, meals programs, group care, etc).

The discharge planner must coordinate the discharge plan with primary care staff, the family, the physician, the placement setting (if applicable) and the recipient. The planner must be aware of and identify the level of care or level of services necessary to maintain the recipient out of the hospital setting. The plan must be updated with changes in the recipient's

condition.

Documentation must be explicit, thorough and recorded on a timely basis. The frequency of documentation will depend on the barriers to discharge. For example, uncomplicated discharges may have reduced or minimal documentation requirements.

Significant contacts with family, the recipient, and/or ancillary personnel must be documented in the medical record. The recipient's understanding of his/her condition and situation should be described.

When the recipient requires transfer to a nursing facility, the hospital must request a Pre-Admission Screening (PASRR) from the QIO-like vendor. Each nursing home contact must be recorded by the discharge planner and those facilities refusing the recipient so identified with the reason for refusal. Placement efforts need to be concentrated on those facilities capable of handling the recipient's needs.

Resolution of the placement problem must be briefly described before the medical record is closed.

A discharge from the hospital is validated by a physician's discharge order. Any readmission following a discharge is treated as a new/separate admission, even if the readmission occurs within 24 hours of the discharge.

As a condition of participation in the Medicare and Medicaid programs, hospitals must comply with all discharge planning requirements set forth in 42 CFR 482.43.

13. Financial Data and Reports

Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the Nevada Medicaid 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. Hospital Audit Process

Nevada Medicaid does not audit hospital cost reports. Unaudited cost reports are utilized in the rate setting process.

15. 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 level of care. Medicaid authorization is provided for acute and administrative days only.

A provider must:

a. Notify the QIO-like vendor whenever there is a reason to believe that Medicare coverage has been exhausted.

b. Attach a copy of the Medicare Explanation of Benefits (EOB) (if obtained from Medicare) or other supporting documentation that clearly indicates that acute care hospital days have been exhausted when requesting a QIO-like vendor review.

c. Obtain prior authorization from Medicaid's QIO-like vendor in accordance with 203.1A.2.f.15.

QMB claims denied by Medicare are also denied by Medicaid.

16. 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.

203.2 SPECIALTY HOSPITAL

Specialty hospitals policy is consistent with the inpatient services for prior authorization and utilization review.

1. Medical (Rehabilitation) Hospital Services Policy

Medical (Rehabilitation) Hospitals provide intensive and acute services for the purpose of restoring an individual's capacity to function at an optimal level, following an accident or illness, contingent upon the individual's abilities and disabilities. Rehabilitation involves both retraining and relearning to bring about maximal restoration of physical, physiological, behavioral, social, and vocational function. Most commonly, rehabilitation hospitals treat

persons who have suffered a head or spinal cord injury, and who must be able to tolerate and benefit from a minimum of three hours of physical, speech or occupational therapy per day.

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

a. Admissions are only permitted from either an acute hospital or nursing facility.

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

2. Long-Term Acute Care (LTAC) Hospital Services Policy

LTAC hospitals provide comprehensive long-term acute care designed for patients who have suffered an acute illness, injury or exacerbation of a disease process. Most commonly, specialty or long-term acute care hospitals treat patients who require ventilator, wound care, or stroke-related services.

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

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

203.3 SWING-BED SERVICES POLICY

Pursuant to federal regulations at 42 CFR 482.66 and 409.30, rural hospitals may be swing-bed certified by the Centers for Medicare and Medicaid Services (CMS) provided the hospital; 1) has a Medicare provider agreement; 2) has been granted approval by CMS to provide post-acute nursing facility (NF) care; 3) has less than 100 beds; and 4) is located in a rural area. These swing-beds must be utilized on a temporary, not long-term, basis, and only when a recipient, who is in an acute bed but no longer, meets acute criterion, requires nursing facility care, but because there are no beds available, cannot be admitted into the hospital's nursing facility unit. The recipient may remain in the same bed, which then may "swung" over to, or designated as a swing-bed. Efforts must be made to transfer the recipient from the swing-bed to a nursing facility unit bed as soon as one becomes available. As with acute beds, all swing-bed stays must be certified by Medicaid's Quality Improvement Organization (QIO-like vendor) for payment purposes.

203.3A COVERAGE AND LIMITATIONS

1. The intent and purpose of swing-beds is to provide temporary placement for recipients who

require post-acute Nursing Facility (NF) care. Rural hospitals must always utilize available NF beds for Medicaid eligible recipients prior to using a swing-bed designation. Recipients who are in a swing-bed must be transferred to the first available NF bed in the hospital, or the next closest hospital or nursing facility. (Exceptions may be made to the "next closest hospital or nursing facility" requirement only if the hospital documents, in writing, the recipient's and/or family's objection to the recipient having to leave the hospital and rural community, and why). So long as the hospital clearly documents efforts to transfer the recipient from the swing-bed and admit into the hospital's nursing facility unit or the next closest nursing facility unit, when a bed becomes available, the recipient may remain in the swing-bed.

2. To qualify for swing-bed pre-admission status, all Medicaid recipients must: 1) have been hospitalized in an acute care hospital receiving inpatient services for at least three consecutive calendar days (not counting the day of discharge); 2) receive prior authorization for swing-bed admission/status from the QIO-like vendor.

3. Medicaid eligible recipients cannot be admitted directly from the community, or from a skilled or intermediate administrative day level of care hospital bed, to a swing-bed.

4. If all licensed NF beds and swing-beds are occupied, the hospital may bill for administrative days at the Skilled Nursing Level (SNL) or intermediate (ICL) payment rates, if certified as such by the QIO-like vendor.

5. As with acute and administrative day beds, all swing-bed stays must be prior authorized and certified by the QIO-like vendor for payment purposes.

203.3B PROVIDER RESPONSIBILITIES

1. Swing-Bed providers must secure a prior authorization from the QIO-like vendor.

2. Prior to transferring a recipient from a swing bed to a NF bed within the hospital or to another nursing facility bed, the hospital must obtain both a Pre-Admission Screening and Resident Review (PASRR) screening and Nursing Facility Level of Care (LOC) screening to ensure the recipient meets the criteria for the NF placement. The hospital may request these screenings from the QIO-like vendor.

203.3C AUTHORIZATION PROCESS

1. Admissions to swing-beds involving Medicaid eligible recipients, or recipients with primary insurance (except Medicare Part A) must be prior authorized by the QIO-like vendor.

   a. Prior Authorization

The QIO-like vendor's swing-bed prior authorization decisions will be based on the following criteria being met:

1. The recipient must be admitted to swing-bed status from an acute level of are following a minimum 72 hour stay (not counting the day of discharge)

2. The recipient requires skilled or intermediate nursing services; and

3. The hospital must provide documentation that no other NF beds are available, and that efforts are being made to place the recipient in either its own in-house nursing facility unit, or the next closest nursing facility (unless the exception criterion previously discussed has been met).

b. Concurrent Review and Certification

1. The QIO-like vendor conducts a concurrent review for the initial interim certification of a Medicaid eligible recipient in a swing-bed, if the recipient has been in swing-bed status for a full calendar month. Interim certifications are issued on a month-to-month basis thereafter.

2. The QIO-like vendor will notify the Medicaid District Office of the Swing Bed admission for care coordination services related to potential nursing facility placement.

3. At least monthly, the hospital must provide documentation of efforts to locate and place a patient in the hospitals or another facility's nursing facility unit for those unique and infrequent swing-bed cases which go beyond 30 calendar days.

c. Retrospective and Retroactive Eligibility Review and Certification

1. Retrospective review is not generally available for services requiring prior authorization. The only exception that applies is for cases which eligibility is determined after admission to the swing bed. For recipients who are in a swing bed at the time of the determination of Medicaid eligibility, the facility must notify the QIO-like vendor to initiate admission and concurrent review.
2. For recipients found to be retroactively eligible for Medicaid (generally after discharge), the QIO-like vendor will conduct review and certification retrospectively. The required documentation (detailed below) must be submitted to the QIO-like vendor within 90 calendar days of the date of the Medicaid eligibility decision.

3. Prior to expiration of the existing authorization, the facility must contact the

QIO-like vendor in order to extend the authorization. The facility must provide evidence that the recipient meets either a skilled or intermediate level of care and also of its efforts to identify a nursing facility placement for the recipient.

4. At least monthly the hospital must provide documentation, of efforts to locate and place a recipient in the hospital's or other nursing facility unit for those unique and infrequent swing-bed cases which go beyond 30 calendar days.

5. If medically necessary as evidenced by swing-bed criterion being met, the QIO-like vendor issues a certification within 30 calendar days of receipt of the complete medical record (for retrospective cases), and both complete medical record and eligibility verification documentation (for retroactive eligible cases).

c. Required Concurrent Retro eligible Swing-bed Documentation

The following swing-bed medical record documentation must be submitted to the QIO-like vendor with the request for interim certification.

1. History and Physical (H and P).

2. Physician orders including order to admit to swing-bed.

3. Monthly nursing assessment summary.

4. Documentation that an NF bed was not available.

5. The QIO-like vendor may request additional records if a determination cannot be made from the above records.

2. Hospital Swing-Bed Billing Requirements

Medicaid requires all swing-bed days be billed on the UB-92 claim form using the hospital's provider number and bill classification code 281 in locator number 4, entitled "Type of Bill." Revenue code 0550 must be used for skilled days and 0559 for intermediate days. Therapies, laboratory and radiology must be billed by the independent service providers. Prescription drugs may be billed by either an independent service provider or the hospital's outpatient pharmacy provider using the hospital's outpatient pharmacy provider number.

Swing-bed hospitals may bill for a stay after discharge (if less than 30 days) on an all-inclusive UB-92 claim form. Or, swing-bed hospitals may interim bill, month-by-month (for stays more than 30 days). If it certifies the stay with a SNL or ICL level of care, the QIO-like vendor electronically sends the certification to Medicaid's fiscal agent. It is not

necessary for the hospital to attach a copy of the certification. The QIO-like vendor provides the hospital with a hard copy of the certification for the hospital's records.

203.4 OUTPATIENT HOSPITAL SERVICES POLICY

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

203.4A COVERAGE AND LIMITATIONS

Outpatient hospital services provided by hospitals are subject to the same service limitations as other outpatient service providers. Please refer to Chapter 400 and 600.

1. Physician, advanced practitioner of nursing, physician assistants, urgent care sites, and outpatient hospital clinic visits. Refer to Chapter 600.

2. Pharmaceutical Services. Please refer to Chapter 1200.

3. Emergency Room Services

   Emergency 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.

   a. Non-emergency use of a hospital's emergency room must be coded at the lowest level of emergency services, using the most appropriate code, either 99281 or 99282.

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

      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 Medicaid benefit.

      Patients requiring mental health services while in the emergency room may receive such services if medically 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 Medicaid's QIO-like vendor is also required.

203.5 AMBULATORY SURGICAL 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, 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 COVERAGE AND LIMITATIONS

1. Nevada Medicaid 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 Section 203.10.D of this Chapter entitled Authorization Process).

2. Ambulatory surgical services are not reimbursable when:

   a. The recipient's medical condition or treatment needs meet acute inpatient guidelines and standards of care.

   b. The recipient requires preoperative diagnostic testing that cannot be performed in an outpatient setting.

   c. The recipient requires therapeutic interventions (measures) that can only be performed in an acute hospital setting.

   d. 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.

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

f. 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. Services are ordered as inpatient by the admitting physician.

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

3. 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. Non-Covered Procedures

Reference Chapter 600.

5. Approval Process

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

a. Procedures to be performed in a higher care setting;

b. Procedures that would not routinely be covered by Nevada Medicaid; and

c. 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 PROVIDER RESPONSIBILITY

Please consult Section 203.1.B of this Chapter for service provider responsibility.

203.5C AUTHORIZATION PROCESS

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

1. Provider must submit the required authorization form or request PA telephonically.

2. A copy of Medicaid card to confirm that the physician's office has verified the recipient's eligibility.

3. All supporting medical documentation that the requesting physician would like considered.

4. Procedure pre-approval requests:

   a. Cannot be accepted from the facility/hospital personnel.

   b. Require up to two working days to process.

   c. DOS must be within 30 days from the PA’s date of issue.

5. 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. Prior Authorization Is Required When:

   a. A procedure indicated as "MD-Office" is planned for a setting other than a physician's office, emergency room, or clinic. This includes an ambulatory surgery facility, a hospital-based outpatient surgery department, or inpatient treatment at an acute care hospital.

   b. A procedure indicated as "Amb Surgical" is planned to be done on an inpatient basis.

   c. 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. The physician can provide compelling evidence that a non-covered procedure is not cosmetic but is medically necessary.

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

   f. A listed procedure(s) requiring prior authorization is to be performed in conjunction

with a procedure(s) exempt from authorization.

g. Any procedure is to be performed out of state.

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

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

7. Prior Authorization is Not Required When:

a. Reference Accredited Standards Committee (ASC) Physician's Assistant (PA) list.

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

203.6 NURSING FACILITY PLACEMENT SCREENING REQUIREMENTS

There are two types of Screenings required for potential Nursing Facility Placements.

1. Level of Care (LOC) – The LOC screening must be completed prior to discharge from the hospital for all Medicaid eligible individuals.

2. Pre-Admission Screening and Resident Review (PASRR) – Please see Chapter 500.

The hospital completes the PASRR Level I Identification screening and the Level of Care screening forms and submits to the QIO-like vendor. The QIO-like vendor reviews and makes a determination (for both screening types – Level of Care or PASRR Level I Identification) and when indicated makes the referral for PASRR Level II evaluation. First Health Services Corporation (FHSC) sends the requestor the determination letter to confirm the completion of the screenings.

Hospital Responsibilities for Discharge to a Nursing Facility must include:

3. Making a reasonable effort to seek placement alternatives with appropriate documentation of such efforts.

4. Complete the Level of Care and/or PASRR Level I Identification forms with complete, accurate, and sufficient information. Submit the forms to FHSC as soon as an imminent discharge to a nursing facility is identified.

Do not discharge the patient to the nursing facility until a determination letter (Level of Care for Medicaid eligible's, PASRR Level I Identification for all payment sources, and/or

PASRR Level II for all payment sources, when indicated) is received showing the individual is appropriate to be admitted to a nursing facility.

Time Frames for Screening Process:

1. PASRR Screening Process:

   a. PASRR Level I Identification screenings are completed for acute care facilities within one business day of receipt.

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

2. Level of Care (LOC) Screening Process:

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

204 HEARINGS

Reference Chapter 3100 for Hearing Process.

205 REFERENCES AND CROSS-REFERENCES

205.1 PROVIDER SPECIFIC INFORMATION

1. Medicaid Services Manual Chapters:
Please consult other Medicaid Services Manuals which may correlate with Chapter 200, Hospital Services:

Chapter 100	Eligibility, Coverage and Limitations
Chapter 300	Radiology Services
Chapter 400	Mental Health and Alcohol/Substance Abuse Services
Chapter 500	Nursing Facilities
Chapter 600	Physician Services
Chapter 700	Rates and Cost Containment
Chapter 800	Laboratory Services
Chapter 900	Private Duty Nursing
Chapter 1000	Dental
Chapter 1100	Ocular Services
Chapter 1200	Prescribed Drugs
Chapter 1300	DME, Disposable Supplies and Supplements
Chapter 1400	Home Health Agency
Chapter 1500	EPSDT Healthy Kids Program
Chapter 1600	Intermediate Care for the Mentally Retarded
Chapter 1700	Therapy
Chapter 1800	Adult Day Health Care
Chapter 1900	Transportation Services
Chapter 2400	Comprehensive Outpatient Rehabilitation (COR) Services
Chapter 2500	Case Management
Chapter 2800	School Based Child Health Services
Chapter 2900	Mental Health Rehabilitative Treatment Services
Chapter 3100	Hearings
Chapter 3200	Hospice
Chapter 3300	Program Integrity
Chapter 3500	Personal Care Services Program
Chapter 3600	Managed Care Organization

2. Nevada Check Up Manual

Chapter 1000	Nevada Check Up Program

3. Initial and ongoing eligibility for Medicaid benefits are determined by the Eligibility Specialist as set forth in the Division of Welfare and Support Services District Offices' "Eligibility and Payments Manual".

205.2 FIRST HEALTH SERVICES CORPORATION

A. Provider Relations Department
First Health Services Corporation
PO Box 30042
Reno, NV 89520-3042
Toll free number within Nevada: (877) NEV-FHSC (638-3472)

B. Prior Authorization Department
First Health Services Corporation
Nevada Medicaid and Nevada Check Up Health Care Maintenance (HCM)
4300 Cox Road
Glen Allen, VA 23060
Telephone number: (800) 525-2395
Fax number: (866) 480-9903

C. Web announcements, billing manuals and guidelines, forms, provider enrollment, and pharmacy information can be found at http://nevada.fhsc.com.