MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

August 27, 2013

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual Chapter 200 will be implemented due to the passage of Legislative Bill AB1. The Nevada State Plan provides that certain non United States (U.S.) citizens, who otherwise meet the requirements for Title XIX eligibility, are covered for emergency dialysis services as defined by 42 Code of Federal Regulation (CFR) 440.255. Provision of outpatient emergency dialysis health care services through the Federal Emergency Services Program (FESP) is deemed an emergent service for this eligibility group.

These changes are effective September 1, 2013.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 12/13 CHAPTER 200 – HOSPITAL SERVICES	MTL 27/12 CHAPTER 200 – HOSPITAL SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
201	**Authority**	Added State and Federal authority for federal emergency dialysis services.
Attachment A	**Subject**	Added the title Federal Emergency Services Program – Dialysis.
	Introduction	Medicaid is adding emergency dialysis services to treat and stabilize certain non U.S. citizens with kidney failure.
	Definitions	Added federal emergent definitions, defining a medical condition manifesting itself by acute symptoms that requires immediate medical attention.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
	Coverage and Limitations	Outpatient ESRD dialysis are covered as an emergency service when the treating physician signs and completes the "Certification form". This form attests to the FES criteria that in the absences of receiving dialysis as certified, the emergent recipient's health would be in serious jeopardy.
	Prior Authorization	A Monthly Certification form must be completed by the treating physician and retained in the emergent recipient's clinical chart. Prior authorization is not required for dialysis services.
	Non Covered Services	Dialysis services provided prior to the coverage date of this policy and/or the emergency medical services do not meet the qualifications established in 42 CFR 435.406.
	Provider Requirements	Provider must complete the required forms to initiate treatment and to continue monthly dialysis. Maintain the emergent recipient medical records, and follow all billing instructions referenced in the QIO-like vendor's Billing Manual and/or PT 45 ESRD Billing Guideline.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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

The Division of Health Care Financing and Policy (DHCFP) may reimburse acute hospitals for providing the following services: medical/surgical/intensive care, maternity, newborn, neonatal intensive care, trauma level I, medical rehabilitation or long-term acute care specialty, administrative skilled or intermediate days and emergency psychiatric and substance abuse treatment and acute medical detoxification.

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

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of those listed in the NCU 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 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 (Obstetric/Birth Center Defined)

8. Nevada Administrative Code (NAC) Chapter 449 (Provision of Certain Special Services-Obstetric Care)

9. 42 CFR Part 440.255 Limited services available to certain aliens.

10. NRS Chapter 422 Limited Coverage for certain aliens including dialysis for kidney failure.

11. 42 CFR 435.406 (2)(i)(ii) (permitting States an option with respect to coverage of certain qualified aliens subject to the five-year bar or who are non-qualified aliens who meet all Medicaid eligibility criteria).

202 RESERVED

203 POLICY

203.1 INPATIENT HOSPITAL SERVICES POLICY

Inpatient hospital services are services ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician or dentist and furnished in an institution that:

a. is maintained primarily for the care and treatment of patients with disorders other than mental disease;

b. is licensed as a hospital by an officially designated authority for state standard-setting;

c. meets the requirements for participation in Medicare; and

d. has in effect a Utilization Review (UR) plan, applicable to all Medicaid recipients, that meets the requirements of 42 CFR 482.30 and 42 CFR 456.50-456.145.

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

A hospital is an inpatient medical facility licensed as such to provide services at an acute Level of Care (LOC) for the diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases. For purposes of Medicaid, a hospital meets the requirements for participation in Medicare as a hospital and does not include an Institution for Mental Diseases (IMD), a Nursing Facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR), regardless of name or licensure.

Out of State Acute Hospital Services

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

In-State and Out-of State Acute Hospital Transfers

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, rehabilitation, specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor

must make a determination regarding the availability of such services at the referring hospital or within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being met at the transferring facility.

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

203.1A COVERAGE AND LIMITATIONS

1. Admission

a. Admission Criteria

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

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

2. acute care services are rendered;

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

4. the admission is certified by the QIO-like vendor based on pertinent supporting documentation/submitted by the provider with the admission authorization request.

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, Critical Access, Medical Rehabilitation or Long Term Acute Care (LTAC) Specialty hospitals) or before authorization of payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. Reference 203.1B.11.c.

b. Admission Order

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

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

c. Admission Date

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

d. Planned and Transfer Admissions

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

e. Inpatient Admission from Observation

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

f. Military or Veterans' Hospitals

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

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

To be eligible for reimbursement, hospital admissions for EIOL prior to 39 weeks gestation must be prior authorized by the QIO-like vendor as medically necessary.

h. Admissions for Elective or Avoidable Scheduled Cesarean

Coverage/reimbursement of non-medically necessary 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 for a normal vaginal delivery.

2. Authorization Requirements

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

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

a. All inpatient QIO-like vendor determinations are based on pertinent medical information documented initially by the requesting physician and provided to the QIO-like vendor by a hospital with the request for admission.

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

c. Services requiring prior authorization which have not been prior authorized by the QIO-like vendor are not covered and will not be reimbursed. A prior authorization request inappropriately submitted for inpatient admission after an unauthorized, planned, elective inpatient procedure or surgery is performed, will be rejected and returned without consideration. Concurrent services related to these unauthorized admissions will also be returned without consideration, unless the services are specifically related to stabilization of an emergency medical condition that develops. Once the emergency medical condition is stabilized, no additional services related to this unauthorized elective admission will be reimbursed.

d. A prior authorization is valid for the dates of service authorized. If the service cannot be provided for any reason during authorized service dates (e.g. a recipient has a change of condition) the prior authorization becomes invalid. A new or updated prior authorization must be obtained for reimbursement of corresponding dates of service.

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

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

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

2. Hospital admissions for EIOL prior to 39 weeks gestation.

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

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

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

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

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

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

7. An admission for a family planning procedure (e.g. a tubal ligation or vasectomy).

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

9. Psychiatric admissions to a free standing psychiatric hospital IMD for recipients age 65 or older or under age 21or to a psychiatric wing of a general acute hospital, regardless of age.

10. All changes in LOC and/or transfer between units (e.g. medical/surgical, intensive care, obstetrics, newborn, neonatal intensive care, trauma level 1, psychiatric/detoxification, rehabilitation, administrative, and outpatient

observation.) Per diem reimbursement amounts are based on the LOC authorized by the QIO-like vendor.

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

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

13. A leave of absence or therapeutic pass from an acute or Medical Rehabilitation Specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference 203.1A.3, Absences.

14. When Third Party Liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference Chapter 100, section 104.

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

16. Admissions resulting from EPSDT screening.

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

1. All in-patient admission for an emergent condition including, but not limited to, any emergency admission (e.g. from a physician's office, urgent care or emergency room) or an emergency transfer from one in-state and/or out-of-state hospital to another.

2. Obstetric or newborn admissions which, from the date of delivery, exceed three calendar days for vaginal or four calendar days for medically necessary or emergency cesarean delivery.

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

4. Direct inpatient admissions initiated through an emergency room and/or observation status as part of one continuous episode of care (encounter) at

the same facility when a physician writes an acute inpatient admission order (rollover admissions).

The following criteria applies:

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

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

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

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

h. Utilization Review (UR) Process

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

1. Concurrent Review

Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period that services are being provided. Initially the QIO-like vendor assigns a length of stay

based on the diagnosis and condition of the recipient. For complex cases, additional days may be authorized to manage the medical condition through the concurrent review process. When additional days are requested, the provider must contact the QIO-like vendor prior to or by the last day of the current/existing authorization period.

2. Retrospective Review

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

3. Administrative Days

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

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

c. Administrative days are authorized through the QIO-like vendor based on medical necessity and as a reduction of LOC. The QIO-like vendor may authorize administrative days up to seven calendar days with the initial and each subsequent request, when medically necessary.

d. Levels of Administrative Days

1. Skilled Nursing Level (SNL) provides for ongoing hospital services for those recipients who do not require acute care and discharge to an alternate appropriate placement is

required. SNL days are authorized when one or more of the following conditions apply or as deemed necessary by the physician reviewer:

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

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

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

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

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

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

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

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

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

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

   b. A recipient is waiting medical assisted transportation.

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

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

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

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

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

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

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

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

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

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

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

3. Leave of Absence

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

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

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

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

1. last longer than eight hours from an acute hospital; or

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

c. A leave of absence from an acute inpatient hospital is not covered if a recipient does not return to the hospital by midnight of the day the leave of absence began (a reserved bed).

d. For a therapeutic leave of absence, the following information must be documented in a recipient's medical record:

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

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

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

203.1B PROVIDER RESPONSIBILITIES

1. Patient Liability

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

b. Collection: When a case is approved or PL changes, the recipient, facility and fiscal agent (and authorized representative, where appropriate) are notified of the amount and effective date. Collection of PL is the facility's responsibility.

1. If the application is approved, the facility is sent a NOD indicating the amount of PL due and the effective date. The recipient and the fiscal agent are also notified. If eligibility is retroactive and the date of decision on months of eligibility more than 24 months from month of decision, a Medicaid Case Status Form (2214-EM) will be sent to the medical facility.

2. PL for new approvals is effective the first month of eligibility for Medicaid. When a recipient's income changes, PL is adjusted beginning with the month of the change.

3. The monthly PL is deducted from the initial claim received by the QIO-like vendor from a qualified facility. There is no prorating of PL for recipients transferring facilities within the month.

4. If a recipient expires mid-month, the DWSS prorates PL as in number 3 above. The facility will be sent a notice indicating the adjusted PL amount.

5. No PL is taken from Medicaid recipients during periods of Medicare coverage. Beginning with the first non-Medicare covered day, hospitals

must access PL at the Medicaid LOC and per diem rate for that hospital.

2. Conditions of Participation

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

1. be in compliance with applicable licensure requirements.

2. be certified to participate in the Medicare program. Hospitals currently accredited by the Joint Commission or by the American Osteopathic Association (AOA) are deemed to meet all of the conditions of participation in Medicare. Centers for Medicare and Medicaid Services (CMS) makes the final determination of whether a hospital meets all Medicare criteria based on the recommendation of the state certifying agency (42 CFR Part 482).

3. have a Provider Contract with the DHCFP. Refer to Chapter 100, section 102, Provider Enrollment.

b. Termination

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

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

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

3. Utilization Review (UR)

Parts 456.100 through 456.145 of Section 42 CFR prescribe the requirements for a written UR plan for each hospital providing Medicaid services. The UR plan is deemed met for Medicare and Medicaid if a QIO-like vendor is conducting binding review.

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

4. Quality Assurance - Hospital Medical Care Evaluation Studies

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

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

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

5. Civil Rights Compliance

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

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

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

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

All hospitals are required to submit Form 3058 to their local DWSS District Office whenever a hospital admission, discharge, or death occurs.

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

8. Patient Rights

Pursuant to 42 CFR 482.13, a hospital must protect and promote each patient's rights. Hospitals are also required to comply with Nevada Revised 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 recipient is responsible for the recipient's service and treatment needs. If a hospital does not have the proper or functional medical equipment or services, and must transfer a recipient temporarily to another hospital or other medical service provider (generally for only a portion of that day) for testing, evaluation, and/or treatment, it is the transferring hospital's responsibility to fund the particular services and transportation if necessary.

11. Admission Medical Record Documentation

a. Pre-Admission Authorization

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

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

b. Physician Certification

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

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

c. Plan of Care

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

The plan of care must include:

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

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

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

4. plans for continuing care, as appropriate; and

5. plans for discharge, as appropriate.

12. Discharge Planning

a. The hospital must designate separate, identifiable staff whose primary responsibility is discharge planning. The discharge planners must review all Medicaid admissions.

b. Discharge planning activities must commence within 48 hours of admission (or up to 72 hours involving weekends) for every recipient.

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

d. The discharge planner must coordinate the discharge plan with primary care staff, the family, the physician, the placement setting (if applicable) and the recipient.

e. The planner must be aware of and identify the LOC or level of services necessary

to maintain the recipient out of the hospital setting.

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

g. There must be documentation that immediate action is taken regarding discharge alternatives whenever a specific discharge intervention or placement effort fails.

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

i. Documentation must be explicit, thorough and recorded on the date a service is provided. There must be documented evidence of frequent attempts by the provider to discharge the recipient to an alternative appropriate setting. The frequency of documentation will depend on the barriers to discharge.

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

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

k. The recipient's understanding of his/her condition and situation should be described.

l. When a recipient requires transfer to a NF, the hospital must request a Pre-Admission Screening (PASRR) from the QIO-like vendor. Each nursing home contact must be recorded by the discharge planner. Reasons why nursing facilities refuse the placement must also be documented. Placement efforts need to be concentrated on those facilities capable of handling the recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.

m. A recipient’s or recipient’s family’s or physician’s refusal to cooperate with discharge planning efforts to either find or accept available appropriate placement at NF, RTC or other appropriate alternate setting must be documented in the recipient’s medical record. Inpatient or administrative days are not reimbursed as of the date of the refusal.

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

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

13. Financial Data and Reports

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

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

14. Medicare/Medicaid Crossovers

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

A provider must:

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

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

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

QMB claims denied by Medicare are also denied by DHCFP.

15. Maternity/Newborn Federal Length of Stay Requirements

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

16. Sterilization Consent Form

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

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

a. Non Emergency Transfers

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

2. A receiving hospital is responsible for verifying that the transferring hospital obtained prior authorization for a non emergency transfer, prior to agreeing to accept or admitting the recipient and prior to the transfer.

b. Emergency Transfers

A receiving hospital is responsible for obtaining authorization for an emergency transfer within one business day of the inpatient admission.

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

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

b. 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 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. Submission of Medical Documentation

    a. Providers must identify and submit all pertinent (relevant and significant) written medical information that supports 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. Adverse Determination

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

    a. 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. A provider must provide all additional pertinent documentation or information not provided 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. 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. Verbal information provided by an individual other than a recipient's attending physician must be supported by either written attestation of this information by the attending physician or evidence of this information in the medical record specifically provided to the QIO-like vendor with the authorization or reconsideration review request.

2. If a provider disagrees with the results of the QIO-like vendor's peer to peer and/or reconsideration review, the provider may request a fair hearing through DHCFP. A provider must utilize internal grievance processes available through the QIO-like vendor prior to requesting a fair hearing through DHCFP. Reference Chapter 3100, Section 3104 and 3105.

21. Adherence to Requirements

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

203.2 SPECIALTY HOSPITAL

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

a. Medical (Rehabilitation) Hospital Services Policy

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

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

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

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

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

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

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

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

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

203.3 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 CMS provided the hospital:

a. has a Medicare provider agreement;

b. has been granted approval by CMS to provide post-acute NF care;

c. has less than 100 beds; and

d. 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 NF care, but because there are no beds available, cannot be admitted into the hospital's NF 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 NF unit bed as soon as one becomes available. As with acute beds, all swing-bed stays must be certified by Medicaid's 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 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 NF. (Exceptions may be made to the "next closest hospital or NF" 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 NF unit or the next closest NF 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:

   a. have been hospitalized in an acute care hospital receiving inpatient services for at least three consecutive calendar days (not counting the day of discharge).

   b. 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 LOC 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 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 NF bed, the hospital must obtain both a Pre-Admission Screening and Resident Review (PASRR) screening and NF 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 NF unit, or the next closest NF (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 NF 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 NF 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 LOC and also of its efforts to identify a NF 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 NF 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).

d. 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 LOC, 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 services.

203.4A COVERAGE AND LIMITATIONS

1. Outpatient hospital services provided by hospitals are subject to the same service limitations as other outpatient service providers. Providers must refer to Medicaid/DHCFP service manuals relevant to the specific services being provided. The following is a list of some of the chapters a hospital should reference:

   a. For physician, advanced practitioner of nursing, physician assistants, urgent care sites, and outpatient hospital clinic visits, refer to MSM Chapter 600.

   b. For radiologic services, refer to MSM Chapter 300.

   c. For pharmaceutical services, refer to MSM Chapter 1200.

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

2. 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.

   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 DHCFP 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 the DHCFP's QIO-like vendor is also required.

3. Observation Services

a. 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. Observation services are conducted by the hospital to evaluate the recipient's condition to assess 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.

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.

b. Observation days are covered when:

1. diagnosis is uncertain (diagnosis not established, additional information required by physician, more time is required to assess 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.

c. 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.

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

9. the recipient is admitted to the hospital on the same calendar date as observation services were rendered as part of one continuous encounter at that facility. Ancillary services, provided during observation hours that are incorporated into the inpatient per diem rate, are also included in the per diem rate. Ancillary services rendered during observation hours that exceed the 48 hour limit are not reimbursed.

10. following outpatient same-day surgery.

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. 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 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 the DHCFP; 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 Prior Authorization 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 Prior Authorization’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 list.

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

203.6 NURSING FACILITY (NF) PLACEMENT SCREENING REQUIREMENTS

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

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

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

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

Hospital Responsibilities for Discharge to a NF must include:

1. making a reasonable effort to seek placement alternatives with appropriate documentation of such efforts.

2. complete the LOC and/or PASRR Level I Identification forms with complete, accurate, and sufficient information. Submit the forms to MMA as soon as an imminent discharge to a NF is identified.

3. do not discharge the patient to the NF until a determination letter (LOC for Medicaid eligible's, PASRR Level I Identification for all payment sources, and/or PASRR Level II for all payment sources, when indicated) is received showing the individual is appropriate to be admitted to a NF.

Time Frames for Screening Process:

4. PASRR Screening Process:

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

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

5. Level of Care (LOC) Screening Process:

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

204 HEARINGS

Reference Chapter 3100 for Hearing Process.

POLICY #02-01	FREESTANDING OBSTETRIC/BIRTH CENTERS	EFFECTIVE DATE: October 10, 2012

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.

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.

PRIOR AUTHORIZATION IS NOT REQUIRED

COVERAGE AND LIMITATIONS

COVERED SERVICES

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

1. 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;

2. Completion of at least 36 weeks gestation and not more than 42 weeks gestation.

Birth centers are not eligible for reimbursement if:

3. The pregnancy is high-risk.

4. There is history of major uterine wall surgery, cesarean section or other obstetrical complications which are likely to recur.

5. The recipient is discharged prior to delivery.

NON COVERED SERVICES

1. 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
2. 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.

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, 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

    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 a 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.

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. Provision of outpatient emergency dialysis health care services through the Federal Emergency Services Program (FESP) is deemed an emergent service for this eligibility group.

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.

3. Federal Emergency Service (FES) – treatment of a medical condition 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) who receives services pursuant to 42 CFR 440.255(c).

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 semipermeable 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.

COVERAGE AND LIMITATIONS

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 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.

PRIOR AUTHORIZATION

1. Prior authorization is not required.

2. Refer to "Provider Requirements Section" for treating physician certification form requirements.

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:

   a. the "Initial Dialysis Case Creation" form is not on file with the QIO-like vendor;

   b. "Monthly Certification Form" is incomplete and/or missing from the FES recipient medical record.

PROVIDER REQUIREMENTS

1. Treating physicians must complete and sign the monthly certification form entitled, "Monthly Certification of Emergency Condition" 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 Dialysis Case 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.