MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

December 8, 2016

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATION

Chapter 200, Section 203.1B(12), Provider Responsibilities, Discharge Planning was revised and reorganized to be more concise and for clarity. Language was changed regarding when a discharge plan must be initiated and who must develop/supervise the development of a discharge plan. This language aligns with federal requirements. Language was added regarding providers: identifying recipient discharge needs; notifying recipients about discharge evaluations and plans; documenting reasons and timeframes of unavoidable discharge plan delays; and completing the Level of Care screening and the Preadmission Screening and Resident Review prior to Nursing Facility placement.

Chapter 200, Section 203.2, Specialty Hospital policy related to Long Term Acute Care and Inpatient Rehabilitation services was moved to Sections 203.6 and 203.7. The Administrative Day policy was moved from Attachment A, Policy #02-03 to Section 203.2. Language was added to the Administrative Day Policy to clarify that administrative days may be authorized when an inpatient hospital day does not meet an acute level of care, whether or not discharge is ordered, and that there must be evidence of comprehensive discharge planning when discharge is ordered. Language was changed to specify that one acute inpatient day must immediately precede an initial administrative day authorization request for policy consistency. Language was added stating that administrative day policy is consistent with inpatient prior authorization and utilization review policies.

Chapter 200, Section 203.6, Long Term Acute Care (LTAC) Specialty Hospital Services policy and Section 203.7, Inpatient Rehabilitation Specialty Hospital Services policy were modified and description, prior authorization, coverage and limitations, and provider responsibility policy was added. The Inpatient Rehabilitation Specialty Hospital Services policy was aligned with Medicare language.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Provider Type(s) 11 - Inpatient Hospitals, 51 - Indian Health Services Inpatient Hospitals (Tribal), 56 - Long Term Acute Care and Inpatient Rehabilitation Specialty Hospitals, 75 - Critical Access Hospitals, and 78 - Indian Health Services Inpatient Hospitals (Non-Tribal),

Financial Impact on Local Government: None.

These changes are effective December 9, 2016.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 27/16 Chapter 200 – Hospital Services	MTL 17/15 Chapter 200 – Hospital Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
203.1A 3	**COVERAGE AND LIMITATIONS**	Moved the "Administrative Days" subheading title to Section 203.2, and deleted the reference to Attachment A, Policy #02-03.
203.1B 12	**PROVIDER RESPONSIBILITIES**	Revised and consolidated language. Changed language regarding when a discharge plan must be initiated and the personnel that must develop/supervise the development of a discharge plan. Added language regarding identification of discharge needs, notifying recipients about discharge evaluations and plans, documenting reasons and timeframes of unavoidable discharge plan delays; completion of a Level of Care screening and Preadmission Screening and Resident Review (PASRR) Level I, and a PASRR level II and Summary of Findings letter, when applicable, prior to Nursing Facility placement.
203.2	**SPECIALTY HOSPITALS**	Reformatted, modified and moved policy into two new Chapter 200 Sections: 203.6, Long Term Acute Care Specialty Hospital Services; and 203.7, Inpatient Rehabilitation Specialty Hospital Services. Changed the 203.2 Section title to ADMINISTRATIVE DAYS. Moved Administrative Day policy from Attachment A Policy #02-03 to this chapter section. Modified administrative day language to clarify that administrative days may be authorized when an inpatient hospital day does not meet an acute level of care, whether or not discharge is ordered. Clarified that evidence of comprehensive discharge planning is required, however,

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		if discharge is ordered. Added that administrative policy is consistent with inpatient prior authorization and utilization review policies and administrative days are not covered if there is no evidence of comprehensive discharge planning when a discharge order is written. Removed: the word "nursing" after the word skilled in reference to skilled administrative days; "24 hours" in reference to one inpatient day immediately preceding an initial administrative day request; and "Monday to Friday" in reference to documenting placement efforts. Removed the words "a recipient must be approved for" regarding one inpatient day immediately preceding an administrative day request for policy consistency.
203.6	**NURSING FACILITY (NF) PLACEMENT SCREENING REQUIREMENTS**	Deleted this Chapter 200 Section. Requirements related to provider completion of a level of care and Pre-Admission Screening and Resident Review (PASRR) screenings and a PASRR level II and Summary of Finding letter, when applicable, were specified under Section 203.1B 12, PROVIDER RESPONSIBILITIES, Discharge Planning. Changed the 203.6 Section title to LONG TERM ACUTE SPECIALTY HOSPITAL SERVICES and added description, prior authorization, coverage and limitations, and provider responsibility language.
203.7	**INPATIENT REHABILIATION SPECIALTY HOSPITAL SERVICES**	Replaced the section title term "medical" with the term "inpatient" and reformatted the policy. Added policy allowing: coverage of rehabilitation services as long as fifteen hours of therapeutic services are provided within a seven consecutive day period, beginning the date of admission; admission of recipients with a brain injury on a trial basis; and a brief exception to the intensity of service rule. Added examples of medical conditions that benefit from inpatient rehabilitative services. Added coverage and limitations, non-covered services, authorization, provider responsibility and documentation policy.
Attachment A Policy #02-03	**ADMINISTRATIVE DAYS**	Deleted this Attachment. Modified and moved Section Title and policy to Chapter 200, Section 203.2.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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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 Individuals with Intellectual Disabilities (ICF/IID), 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 Division of Public and Behavioral Health (DPBH).

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

201 AUTHORITY

A. In 1965, the 89th Congress added Title XIX of the Social Security Act (SSA)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. Sections 1861(b) and (e) of the SSA (Definition of Services)

2. 42 CFR Part 482 (Conditions of Participation for Hospitals)

3. 42 CFR Part 456.50 to 456.145 (Utilization Control)

4. Nevada Revised Statutes (NRS) 449 (Classification of Hospitals in Nevada)

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

6. Section 2301 of the Affordable Care Act (ACA) (Federal Requirements for Birth Centers)

7. NRS Chapter 449 (Hospitals, Classification of Hospitals and Obstetric/Birth Center Defined)

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

9. 42 CFR Part 440.255 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).

12. 42 CFR 441, Subpart F (Sterilizations).

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

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 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 IMD, a NF or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), 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 Medicaid Services Manual (MSM) 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 non-emergent transfer from the QIO-like vendor prior to the transfer, and prior to the receiving hospital agreeing to accept/admit the recipient.

203.1A COVERAGE AND LIMITATIONS

1. Admission

a. Admission Criteria

The 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 (CAH), 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 Section 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 Section 203.1B(16) regarding provider responsibilities related to in-state and out-of-state acute hospital transfers.

e. Inpatient Admission from Observation

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

f. Military or Veterans Hospitals

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

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

To be eligible for reimbursement, an obstetric hospital admission for EIOL prior to 39 weeks' gestation must be prior authorized by the QIO-like vendor as medically necessary. Failure to obtain prior authorization from the QIO-like vendor will result in denial of claim reimbursement.

h. Obstetric Admissions for Elective or Avoidable Scheduled Cesarean Delivery

Coverage/reimbursement of non-medically necessary obstetric admissions for elective or avoidable cesarean section (e.g. performed for the convenience of the physician or recipient) is limited to the minimum federal requirement (two days) for a normal vaginal delivery.

2. Authorization Requirements

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

Reference 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 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 prior to or by the last day of the current/existing authorization period.

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

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

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

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

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

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

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

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 MSM Chapter 400 for admission criteria.

12. Swing bed admissions in rural or critical access hospitals. Reference MSM Chapter 200, Attachment A, Hospital with Swing Beds.

13. A leave of absence or therapeutic pass from an acute or medical rehabilitation specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference Section 203.1A(3), Absences.

14. When third party liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference MSM Chapter 100, Section 104.

15. Non-Medicare covered days within 30 days of the receipt of the Medicare Explanation of Benefits (EOB) indicating Part A Medicare benefits are exhausted. Reference MSM Chapter 100, Section 103.2.

16. Admissions resulting from EPSDT screening.

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

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

2. An obstetric admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or emergency cesarean delivery.

3. A newborn admission which, from date of delivery, exceeds three calendar days for vaginal or four calendar days for a medically necessary or elective/avoidable cesarean delivery.

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

5. A direct inpatient admissions initiated through an emergency room and/or observation status as part of one continuous episode of care (encounter) at the same facility when a physician writes an acute inpatient admission order (rollover admissions).

   The following criteria applies:

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

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

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

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

h. Utilization Review (UR) Process

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

1. Concurrent Review

   Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period that services are being provided. Initially the QIO-like vendor assigns a length of stay based on the diagnosis and condition of the recipient. For complex cases, additional days may be authorized to manage the medical condition through the concurrent review process. Additional inpatient review days must be requested prior to or by the last day of the current/existing authorization period.

2. Retrospective Review

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

3. 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 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 MSM 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 456.24.

4. Quality Assurance – Hospital Medical Care Evaluation Studies

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

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

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

5. Civil Rights Compliance

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

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

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

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

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

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 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 MSM Chapter 600.

Dental, oral and maxillofacial surgeons must also secure prior authorization from the DHCFP dental consultant to assure payment for the procedure. (Reference Section 203.1A(2)(f)(4)) and MSM 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 (POC)

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 POC 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 and diet;

4. plans for continuing care, as appropriate; and

5. plans for discharge, as appropriate.

12. Discharge Planning

A hospital must ensure the following requirements are met:

a. There is documented evidence that a discharge evaluation is initiated as soon after admission as practicable and in a manner to prevent discharge delays for: a recipient identified as likely to suffer an adverse health consequence upon discharge if adequate discharge planning is not received; a recipient or a person acting on the behalf of a recipient requesting a discharge evaluation; or when requested by a physician.

b. A registered nurse, social worker or other appropriately qualified personnel reviews all Medicaid admissions and develops or supervises the development of a discharge plan. The discharge plan must specify goals and resolution dates, identify needed discharge services and be developed with input from the primary care staff, recipient and/or family and physician, (as applicable).

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

d. The discharge plan includes documented evidence of:

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

2. evidence of an alternate plan when a specific discharge intervention or placement effort fails.

3. significant contacts with the recipient and family, when applicable.

4. a recipient's understanding of his/her condition, discharge evaluation results and discharge plan.

5. reasonable efforts seeking alternatives to nursing facility (NF) placement (e.g., home health services, homemaker services, placement with family, subsidized housing, meals programs, group care, etc.), when applicable.

6. NF contacts and contact results, when NF placement is required NF placement efforts need to concentrate on facilities capable of handling a recipient's needs. Resolution of the placement problem must be briefly described before the medical record is closed.

7. refusal by a recipient or recipient's family or physician to cooperate with discharge planning efforts to either find or accept available appropriate placement. Inpatient acute or administrative days are not reimbursed, effective the date of the refusal.

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

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

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

2. A PASSR Level II screening and a Summary of Findings letter, when applicable.

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

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

13. Financial Data and Reports

Providers must maintain sufficient financial records and statistical data for proper determination of costs payable under the 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 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 the DHCFP's QIO-like vendor in accordance with Section 203.1A(2)(f)(15).

QMB claims denied by Medicare are also denied by the 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 a valid sterilization consent form meeting all federal requirements is obtained prior to performing a sterilization procedure. Reference the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information for the specific procedures.

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

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

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.

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

21. Adherence to Requirements

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

203.2 ADMINISTRATIVE DAY POLICY

203.2A DESCRIPTION

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

203.2B COVERAGE AND LIMITATIONS

1. COVERED SERVICES

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

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

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

1. a recipient waiting for evaluation and/or placement in a Nursing Facility (NF)/extended care facility, group home, residential treatment center (RTC) Institution for Mental Disease, psychiatric or alcohol/substance abuse treatment hospital or unit, or other treatment settings (e.g., hospice) for continuity of medical services.

2. delays in discharge related to durable medical equipment availability, home equipment set up, or home health or hospice service arrangements.

3. a newborn with medical complications (not requiring acute care services) waiting for placement.

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

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

d. Intermediate administrative (Intermediate Care Level) days are covered in an inpatient or critical access hospital when:

1. services do not meet an acute level of care;

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

3. a recipient cannot be discharged for social reasons (e.g., a stable newborn either waiting for adoption or for the mother to be discharged, a recipient waiting for medical assisted transportation, a recipient requiring evaluation after being a victim of crime).

2. NON COVERED SERVICES

Administrative days are not covered when:

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

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

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

d. a discharge order is written and a hospital has not provided documented evidence of a comprehensive discharge plan or an acceptable reason and timeframe for an unavoidable delay, such as awaiting a specifically identified court date for court appointed guardianship related to out-of-state NF placement.

203.2C AUTHORIZATION REQUIREMENTS

1. Prior authorization is required

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

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

203.2D PROVIDER RESPONSIBILITIES

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

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

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

   a. all placement efforts, contacts and contact results;

   b. discharge planning notes from applicable social workers, case managers, and/or nurses;

   c. physicians' orders and/or progress notes;

   d. modifications to the discharge plan, whenever applicable; and

   e. acceptable reasons and timeframes of unavoidable discharge planning delays.

203.3 SWING-BED SERVICES POLICY

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

203.4 OUTPATIENT HOSPITAL SERVICES POLICY

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

203.4A COVERAGE AND LIMITATIONS

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

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

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

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

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

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.

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

   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

Reference Chapter 200, Attachment A, Policy #02-05, Observation Services.

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 LONG TERM ACUTE CARE (LTAC) SPECIALTY HOSPITAL SERVICES POLICY

203.6A DESCRIPTION

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

203.6B COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. The DHCFP reimburses medically necessary services meeting coverage

requirements, provided in either a freestanding long-term acute care hospital or a long-term acute unit of a general hospital.

b. All of the following criteria must be met:

1. Frequent, specialized, therapeutic interventions are required on an inpatient basis.

2. Services are ordered and supervised by a physician or another individual authorized by State licensure law to prescribe treatment.

3. Services include skilled nursing services, with 24-hour, on-site, registered nurse availability.

4. Services are provided in accordance with a multidisciplinary, coordinated plan of care.

5. Services are authorized as medically necessary by the QIO-like vendor.

1. NON COVERED SERVICES

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

a. a recipient does not meet eligibility requirements;

b. the services do not meet medical necessity requirements or are only for the convenience of a recipient or a recipient's family or physician; or

c. the services are limited to only rehabilitation, coma stimulation or pain management interventions (e.g., relaxation techniques, stress management, biofeedback).

203.6C PRIOR AUTHORIZATION

1. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Reference Medicaid Services Manual (MSM) Chapter 100.

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

3. LTAC specialty hospital's policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, Section 203.1A(2)(a-e), 203.1(A)(2)(f)

(5), (8), (10), (14) and (15), and 203.1A(2)(h)(1-2).

203.6D PROVIDER RESPONISBILITIES

Providers must:

1. be in compliance with provider responsibilities specified in 203.1B.

2. maintain evidence of Medicare certification and state licensure as an LTAC.

203.7 INPATIENT REHABILITATION SPECIALTY HOSPITAL SERVICES POLICY

203.7A DESCRIPTION

Inpatient rehabilitation specialty hospitals and distinct inpatient rehabilitation units in a general or critical access hospital provide intensive, multidisciplinary, coordinated rehabilitation services (e.g., physical, occupational, speech or prosthetics/orthotics therapy) to restore optimal function following an accident or illness, (e.g., spinal cord injury, brain injury, stroke, neurologic disorders, congenital deformity, burns, amputation, major multiple trauma, fractures of the femur or hip, severe advanced osteoarthritis, active polyarticular rheumatoid arthritis, systemic vasculitis with joint inflammation, knee or hip replacement). Inpatient rehabilitation involves both retraining and relearning to achieve the maximal level of function possible, based on a recipient's abilities and disabilities.

203.7B COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. The DHCFP reimburses medically necessary, intensive, inpatient rehabilitation services meeting coverage requirements, provided in either a freestanding inpatient rehabilitation hospital or an inpatient rehabilitation unit of a general or critical access hospital.

b. All of the following criteria must be met:

1. Services are ordered and provided under the direction of a physician with specialized training or experience in rehabilitation.

2. Services are authorized as medically necessary by the QIO-like vendor.

3. The inpatient admission is from an acute hospital or NF and is within one year from the initial injury or illness or most recent surgery/hospitalization as a result of the initial illness or injury.

4. Active and ongoing therapeutic interventions from multiple therapy disciplines are required on an inpatient basis.

5. Rehabilitative services are provided a minimum of either three hours per day, five days per week, or 15 hours within each seven consecutive day period, beginning the date of admission.

6. Physical and/or occupational therapy must be a component of rehabilitative services provided.

7. Inpatient rehabilitation is only ordered when a recipient is capable of making significant, measureable, functional improvement in activities of daily living within a specified period of time.

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

1. the exception is limited to once per admission and does not exceed three consecutive days;

2. comprehensive documentation of the unexpected clinical event is provided to the QIO-like vendor; and

3. a preadmission screening, post admission physician evaluation and the plan of care support that the recipient was initially able to actively participate in the inpatient rehabilitation program.

d. In cases of brain injury, a recipient can be admitted on a trial basis lasting no longer than seven days if a comprehensive preadmission assessment supports that the recipient could reasonably be expected to benefit from an inpatient stay with an interdisciplinary team approach to the delivery of rehabilitation services. Additional days can be requested if assessments during the trial period demonstrate the recipient will benefit from inpatient medical rehabilitation services.

e. A leave of absence not exceeding 32 hours for a therapeutic reason (e.g., preparing for independent living) is covered when authorized by the QIO-like vendor and when the following information is documented in a recipient's medical record:

1. a physician's order that specifies the number of hours for the leave;

2. the medically appropriate reason for the leave; and an evaluation of the therapeutic effectiveness of the leave.

2. NON COVERED SERVICES

Inpatient medical rehabilitation services are not covered when:

a. the services do not meet authorization or other policy coverage requirements (e.g., a preadmission screening demonstrates a recipient cannot participate with intensive rehabilitation services);

b. the level of rehabilitative care required can be safely and effectively rendered in an alternate, less intensive setting, such as an outpatient rehabilitation department or a skilled nursing facility; or

c. treatment goals necessitating inpatient services are achieved or further progress toward established rehabilitation goals is not occurring or is unlikely to occur.

203.7C PRIOR AUTHORIZATION

1. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Refer to Medicaid Services Manual (MSM), Chapter 100.

2. Prior authorization is also required for a leave of absence expected to last longer than eight hours or involving an overnight stay or a brief exception to the intensity of service rule.

3. Authorization must be obtained on a retrospective basis when Medicaid eligibility is determined after admission to, or discharge from, an inpatient rehabilitation hospital.

4. Medical rehabilitation hospital policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, Section 203.1A(2)(a-e), 203.1(A)(2)(f)(5), (8), (10), (14), and (15), and 203.1A(2)(h)(1-2).

203.7D PROVIDER RESPONSIBILITIES

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

2. Providers must ensure that the following documentation is maintained in a recipient's medical record and submitted to the QIO-like vendor, as applicable:

a. a preadmission screen specifying the condition that caused the need for rehabilitation, the recipient's level of function, functional improvement goals and

the expected frequency and duration of treatments required to accomplish these goals, any risk for clinical complications, and the anticipated post discharge destination.

b. a post-admission assessment performed by a rehabilitation physician documenting a recipient's status and any discrepancies between this assessment and the preadmission screening.

c. evidence of no less than 15 hours of therapy being provided per week, beginning with the date of admission, unless comprehensive documentation is provided to the QIO-vendor regarding an unexpected clinical event that meets the exception to intensity of service criteria.

3. Providers must ensure that the rehabilitation plan of care is:

a. comprehensive and developed and managed by a coordinated multidisciplinary team that includes, but is not limited to, a physician and nurse with special training or experience in the field of rehabilitation and a physical and/or occupational therapist;

b. individualized and specify the intensity, frequency and duration of therapies, and the anticipated, quantifiable treatment goals; and

c. modified with changes in medical or functional status, as applicable.

204 HEARINGS

Reference Chapter 3100 for Hearing Process.

A. DESCRIPTION

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

B. POLICY

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

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

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

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

a. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed birth center protocol;

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

Birth centers are not eligible for reimbursement if:

c. The pregnancy is high-risk.

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

e. The recipient is discharged prior to delivery.

2. NON COVERED SERVICES

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

b. Emergency medical transportation as a separately billed service provided by the birth center. For policy related to emergency transportation – Refer to MSM Chapter 1900 - Transportation Services.

E. PROVIDER REQUIREMENTS

Freestanding obstetric/birth center must meet the following criteria:

1. Have a provider contract with the DHCFP. Refer to MSM Chapter 100, Section 102, 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.

A. INTRODUCTION

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

B. DEFINITIONS

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

1. Acute – means symptoms that have arisen quickly and which are short-lived.

2. Chronic – means a health related state that is not acute.

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 semi permeable membrane (i.e., hemodialysis, peritoneal dialysis and other miscellaneous dialysis procedures).

6. Stabilized – with respect to an emergency medical situation, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

C. COVERAGE AND LIMITATIONS

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.

D. PRIOR AUTHORIZATION

1. Prior authorization is not required.

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

E. NON COVERED SERVICES

1. FESP – dialysis for an eligibility group not qualified under 42 CFR 435.406(2)(i)(ii).

2. Services covered prior to the coverage date of this policy.

3. Services deemed non-covered when:

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

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

F. 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.

A. DESCRIPTION

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

B. POLICY

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

C. PRIOR AUTHORIZATION

Prior Authorization is required, except when a recipient is Medicare and Medicaid dual eligible and Medicare benefits are not exhausted.

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

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

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. The DHCFP covers medically necessary, post-acute, nursing facility level of care services provided on an inpatient basis and reimbursed at a per diem rate. The per diem rate includes routine services and supplies, including a regular room, dietary services, nursing services, social services, activities, medical supplies, oxygen, and the use of equipment and facilities.

b. The following services are separately reimbursed when the service meets policy requirements specific to that service:

c. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.

d. Nutritional supplements in conjunction with tube feedings.

e. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.

f. Customized durable medical equipment.

g. Emergency transportation.

h. Physical, occupational, and speech therapy services.

i. Physician services.

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

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

2. NON COVERED SERVICES

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

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

E. PROVIDER RESPONSIBILITIES

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

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

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

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

F. DOCUMENTATION

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

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

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

b. a physician acute hospital discharge order and swing bed admission order;

c. NF placement efforts with documentation regarding NF bed unavailability or recipient or

family refusal of NF placement outside the rural area; and any additional documentation requested by the QIO-like vendor.

3. Submit the following documentation to the QIO-like vendor with a concurrent swing bed authorization request no less frequently than monthly (when applicable):

   a. ongoing NF placement efforts and either the reasons NF bed placement is not available or recipient or family refusal of NF placement outside the rural area;

   b. a monthly nursing assessment summary indicating a recipient continues to meet a skilled level of care; and

   c. any additional documentation requested by the QIO-like vendor.

A. DESCRIPTION

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

B. POLICY

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

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

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

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

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

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

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

b. Observation days are covered when:

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

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

e. clinical signs and symptoms above or below normal range requiring an extension of monitoring and further evaluation;

f. an unstable presentation with vague symptoms and no definitive diagnosis; or

g. an uncertain severity of illness or condition in which a change in status requiring medical intervention is anticipated.

h. A significant adverse reaction occurs subsequent to: a therapeutic service (e.g., blood or chemotherapy administration, dialysis); a diagnostic procedure (e.g., cardiac catheterization); or an ambulatory surgery that does not require inpatient admission, but does require monitoring and treatment for a period of time that is beyond the time usually considered a component of the service, procedure, or surgical recovery period.

i. The medically necessary services provided meet observation criteria, a provider is notified that inpatient admission is denied because it does not meet acute inpatient level of care criteria, a physician writes an order for observation status, and patient rights and utilization review federal requirements are met pertaining to changing an inpatient admission to outpatient observation status.

2. NON COVERED SERVICES

a. Observation hours exceeding the 48-hour limit.

b. Services rendered without a signed, dated physician order or documentation in the medical record that specifies the date and time observation services were initiated and discontinued.

c. Diagnostic testing or outpatient procedures prescribed for a medically stable individual or services deemed by the DHCFP, the DHCFP's QIO-like vendor, or other authorized agency as not medically necessary or appropriate.

d. Observation status when either a recipient's medical condition or treatment needs meet acute inpatient guidelines/standards of care or the probably of a significant, rapid onset complication is exceptionally high requiring prompt interventions available only in an inpatient setting.

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

f. Services limited to a therapeutic procedure (e.g., outpatient blood transfusion, intravenous fluids, chemotherapy administration, dialysis) when no other service is required or in the absence of a documented adverse reaction.

g. Services that are routine preparation prior to or monitoring after a diagnostic test, treatment, procedure, or outpatient same-day surgery.

h. Services immediately preceding an inpatient admission for elective induction of labor (EIOL) prior to 39 weeks' gestation when the EIOL is not authorized as medically necessary.

i. Services provided solely for the convenience of a recipient, recipient's family or physician.

j. Services provided to an individual not eligible (concurrently or retrospectively) for

Medicaid or Nevada Check Up on the date of service or not covered by or performed in compliance with this or any other MSM Chapter.

E. DOCUMENTATION REQUIREMENTS

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

1. A physician's order, clearly indicating the dates and times that observation begins and ends.

2. Comprehensive documentation that supports medical necessity and describes, when applicable:

   a. a significant complication or adverse reaction that requires services that would not normally be included in a recovery or post-procedure period; or

   b. a high probability of a significant, rapid onset complication requiring prompt interventions available in an observation setting.