Medicaid Services Manual
Transmittal Letter

November 28, 2023

To: Custodians of Medicaid Services Manual

From: Casey Angres Casey Angres
Casey Angres (Dec 7, 2023 09:58 PST)

Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 200 – Hospital Services

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 200 – Hospital Services are being proposed to clarify elective/non-medically necessary cesarean sections are not a covered service. Additionally, revisions are proposed to align the number of covered inpatient days before a prior authorization is needed for labor and delivery in accordance with the Newborns' and Mothers' Health Protection Act (NMHPA).

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: Outpatient Surgery (PT 10), Inpatient Hospital (PT 11), Outpatient Services, Hospital Based (PT 12), Psychiatric Hospital, Inpatient (PT 13), Behavioral Health, Outpatient (PT 14), Special Clinics (PT 17), Nursing Facilities (PT 19), Physician Services (PT 20), Home Health Agency (Including Private Duty Nursing (PT 29)), Personal Care Aide Provider Agency (PT 30), Ambulatory Surgical Centers (PT 46), Indian Health Service Hospital, Outpatient (Tribal (PT 51)), Indian Health Service Hospital, Outpatient (Tribal (PT 52)), Long Term Acute Care (LTAC) Specialty Hospitals (PT 56), Managed Care Organizations (PT 62), Residential Treatment Centers (RTC (PT 63)), Hospice (PT 64), Hospice, Long Term Care (PT 65), Intermediate Care Facilities for Individuals with Intellectual Disabilities/Private (PT 68), Nurse Midwife (PT 74), Critical Access Hospital (CAH) Inpatient (PT 75), Indian Health Service Hospital, Inpatient (Non-Tribal (PT 78)), Indian Health Service Hospital, Outpatient (Non-Tribal (79)), and Hospital Based End Stage Renal Disease (ESRD) Provider (PT 81).

Financial Impact on Local Government: Unknown at this time.

These changes are effective December 1, 2023.

Material Transmitted	Material Superseded
MTL 14/23	MTL 17/21, 05/20, 02/02
MSM 200 – Hospital Services	MSM 200 – Hospital Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
201B	**Authority**	Rename 'alien' references to non-citizens. Added Newborns' and Mothers' Health Protection Act (NMHPA).
203.1A(7)	**Coverage and Limitations**	Added the term "medically necessary."
203.1A(8)		Clarified non-medically necessary cesarean section is not a covered service. Added reference to ICD-10 Diagnosis Codes list and MSM Chapter 600, Physician Services for professional services.
203.1B(6)(c)	**Coverage and Limitations**	Removed the reference to hospital admissions for elective/non-medically necessary cesarean sections.
203.1B(7)		Changed three to two calendar days for vaginal deliveries and removed the terms "emergency" and "elective" from cesarean delivery.
203.1B(8)		Revised three obstetric and newborn inpatient days to two for vaginal deliveries.
203.2N	**Provider Responsibilities**	Added references to The Newborns' and Mother's Health Protection Act (NMHPA) and 29 CFR 2590.711. Added "in consultation with the mother" when making a decision to discharge.
Attachment A, #02-02	**Federal Emergency Services Only**	Renamed 'alien' references to non-citizens.
Attachment A, #02-02C(1)		Added reference to ICD-10 Diagnosis Codes list.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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200 INTRODUCTION

Inpatient and outpatient hospital services are a federally mandated Medicaid benefit. A hospital is an inpatient medical facility licensed as such to provide services at an acute Level of Care (LOC) for the diagnosis, care, and treatment of human illness primarily for patients with disorders other than mental diseases.

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

The Division of Health Care Financing and Policy (DHCFP) may reimburse hospitals for providing medically necessary services, as defined in MSM Section 100 under Medical Necessity, including, but not limited to: medical/surgical/intensive care, maternity, newborn, neonatal intensive care, pediatric care, emergency care, trauma level I, inpatient rehabilitation, long-term acute care specialty, administrative skilled or intermediate days, emergency psychiatric, 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), except 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. Sections 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 Freestanding Birthing Centers);

7. NRS Chapter 449 (Hospitals, Classification of Hospitals and Freestanding Birthing 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 non-citizens including dialysis for kidney failure;

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

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

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

14. Newborns’ and Mothers’ Health Protection Act (NMHPA).

202 RESERVED

203 INPATIENT HOSPITAL SERVICES POLICY

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

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

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

3. Meets the requirements for participation in Medicare; and

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

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

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

B. Out-of-State Acute Hospital Services

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

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

The attending physician who is transferring a Medicaid recipient from an acute hospital to any other acute hospital (general, medical/surgery, psychiatric, long-term acute care (LTAC) specialty, inpatient rehabilitation specialty) in or out-of-state is responsible to request authorization prior to the transfer. It should be noted that inherent in the decision to authorize transfers to another in-state or out-of-state hospital, the QIO-like vendor must make a determination regarding the availability of such services at the referring hospital or

within another facility in the state. This decision is also based on the appropriate level or quality of medical care not being available at the transferring facility.

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

D. Newborns and Neonatal Intensive Care Unit (NICU)

The DHCFP utilizes InterQual[1], MCG[2] and the Uniform Billing (UB) Editor[3] to define LOCs needed for each infant and revenue billing codes. These LOCs and revenue codes indicate the nursing care provided to newborn and premature infants in nursery accommodations. These revenue codes range from a healthy newborn to intensive care.

The following newborn UB revenue codes are utilized by the DHCFP to reimburse hospitals for the LOC provided to newborns for inpatient hospital stays. The LOC should be clinically evaluated on a daily basis, typically based on the resources provided to the infant. Please note that the levels identified below reference the LOC provided and not the licensure level of the facility. Licensure level of hospitals for newborn care is per Nevada Administrative Codes 442.380, 442.390, 442.401, and 442.405. LOCs are defined in the UB Editor. Levels III and IV are paid at the same rate due to the fluctuation of a newborn's health status. The revenue code of the newborns' highest LOC reached during a calendar day shall be billed by the hospital for that day. The intention of the DHCFP is to reimburse for the highest LOC per day based upon clinical documentation and review.

1. 0170 = General.

2. 0171 = Newborn – UB Level I: This level reflects routine care of apparently normal full-term or preterm neonates (considered to be newborn nursery).

3. 0172 = Newborn – UB Level II: This level reflects low birth-weight neonates who are not sick but require frequent feeding, and neonates who require more hours of nursing than do normal neonates (considered to be continuing care).

4. 0173 = Newborn – UB Level III: This level reflects sick neonates who do not require intensive care but require six to 12 hours of nursing each day (considered to be intermediate care).

5. 0174 = Newborn – UB Level IV: This level reflects newborns who need constant nursing and continuous cardiopulmonary and other support for severely ill infants (considered to be intensive care).

The following table is a crosswalk from InterQual and MCG LOCs, to the UB Editor for LOCs and revenue codes for reimbursement. Hospitals will submit authorization requests

in the Provider Web Portal at the most appropriate InterQual or MCG LOC and UB revenue code(s) based upon the table below:

LOCs by InterQual[1], MCG[2]	**LOCs by UB Editor[3]**	**UB Revenue Codes[4] by UB Editor[3]**
Newborn Nursery	Level I	0170 / 0171
InterQual I / MCG Level I / Transitional Care	Level II	0172
InterQual II / MCG Level II	Level III	0173
InterQual III & IV / MCG Level III & IV	Level IV	0174

[1]InterQual is published by Change Healthcare. All rights reserved.
[2]MCG. All rights reserved.
[3]Uniform Billing Editor is published by Optum360[0]. All rights reserved.
[4]Correspond with National Uniform Billing Committee revenue code descriptions and guidelines by the Uniform Billing Editor published by Optum360[0].

InterQual is proprietary, nationally recognized standard utilized by Nevada Medicaid's QIO-like vendor to perform utilization management, determine medical necessity and appropriate LOC. Many hospitals in Nevada also use this same selected tool for self-monitoring. However, hospitals may also use MCG to perform the same tasks.

203.1 COVERAGE AND LIMITATIONS

A. Admission

1. Admission Criteria

The DHCFP considers the recipient admitted to the hospital when:

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

b. Acute care services are rendered;

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

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

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, critical access, inpatient rehabilitation, or 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 MSM Chapter 200, Admission Medical Record Determination, Plan of Care.

2. Admission Order

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

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

3. Admission Date

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

4. Planned and Transfer Admissions

   For those instances in which the admission order was written (as defined above) before the recipient arrives at the hospital (planned elective admission), a signed physician order meets the requirements for admission. For transfers from other acute care hospitals, a signed physician order (as defined above) must be contained in the accepting facility's record. The admission date and time for the authorization is based on documentation most relevant and available to the admission determination contingent upon provision of acute care services and admission certification by the QIO-like vendor. Reference MSM Chapter 200, Provider Responsibilities, In-State or Out-of-State Hospital Transfers regarding provider responsibilities related to in-state and out-of-state acute hospital transfers.

5. Inpatient Admission from Observation

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

6. Veterans' Hospitals

   Inpatient hospital admission at a Veteran's Hospital is not a Medicaid benefit.

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

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

8. Obstetric Admissions for Elective/Non-Medically Necessary Cesarean Delivery

   Coverage/reimbursement of obstetric admissions for elective/non-medically necessary cesarean section (e.g., performed for the convenience of the physician or recipient) is not a covered service.

   Reference ICD-10 Diagnosis Codes Accepted by Nevada Medicaid Supporting Medical Necessity for Cesarean Section for a list of ICD-10 diagnosis codes which have already been determined to support the medical necessity for a cesarean section.

   Reference MSM Chapter 600, Physician Services for criteria related to professional services.

B. Authorization Requirements

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

Reference MSM Chapter 100, Medical Necessity regarding criteria related to medical necessity.

1. All inpatient QIO-like vendor determinations are based on pertinent medical information documented initially by the requesting physician and provided to the QIO-like vendor by a hospital with the request for admission. Pertinent information supporting the medical necessity and appropriateness of an inpatient admission must be submitted in the format and timeframes required by the QIO-like vendor as part of the authorization request. Failure of a provider to submit the required medical documentation in the format and within the timeframes specifically required by the QIO-like vendor will result in an authorization denial.

2. Authorization refers only to the determination of medical necessity and appropriateness. Authorization does not guarantee service reimbursement. Service reimbursement is also dependent upon the recipient's eligibility status and is subject to all other coverage terms and conditions of the Nevada Medicaid and NCU programs.

3. Services requiring authorization which have not been authorized by the QIO-like vendor are not covered and will not be reimbursed. An authorization request

inappropriately submitted for inpatient admission after an unauthorized, planned, elective inpatient procedure or surgery is performed, will be rejected, and returned without consideration. Concurrent services related to these unauthorized admissions will also be rejected and returned without consideration, unless the services are specifically related to stabilization of an emergency medical condition that develops. Once the emergency medical condition is stabilized, no additional services related to this unauthorized elective admission will be reimbursed.

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

5. When available, in-state providers and facilities should be utilized. Out-of-state inpatient admission authorization determinations will be considered when appropriate services are not available in-state or when out-of-state resources are geographically and/or fiscally more appropriate than in-state resources. Reference MSM Chapter 100, Out-of-State Services.

6. Inpatient Admission Requiring Prior Authorization

   Prior authorization is authorization obtained before services are delivered. Additional inpatient days must be requested within five business days of the last day of the current/existing authorization period.

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

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

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

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

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

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

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

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

f. Non-emergency admissions to in-state and out-of-state facilities. An out-of-state non-emergency admission may be denied by the QIO-like vendor if the service is available in Nevada.

g. Psychiatric admissions to a free-standing psychiatric hospital IMD for recipients age 65 or older or under age 21 or to a psychiatric wing of a general acute hospital, regardless of age. Reference MSM Chapter 400 for authorization requirements.

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

i. Substance abuse detoxification and treatment (inpatient) admissions. This includes transfers from detoxification to treatment within the same hospital. Reference MSM Chapter 400 for authorization requirements.

j. Swing bed admissions in a rural or critical access hospital (CAH). Reference MSM Chapter 200, Attachment A, Policy #02-03, Hospital with Swing Beds.

k. A leave of absence or therapeutic pass from an acute or inpatient rehabilitation specialty hospital expected to last longer than eight hours or involving an overnight stay. Reference MSM 200, Leave of Absence.

l. Admission when Third Party Liability (TPL) insurance, other than Medicare Part A, is the primary payment source. Reference MSM Chapter 100, Third Party Liability (TPL), Other Health Care Coverage.

m. 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, Authorization.

n. Admissions resulting from Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening.

7. Inpatient Admission Requiring Authorization Within Five Business Days of Admission

   Providers must submit pertinent clinical information and request authorization from the QIO-like vendor within five business days for the following services:

   a. An emergency inpatient admission, emergency transfer to another in-state and/or out-of-state facility or unit, or emergency change in LOC. Reference MSM Chapter 400 regarding emergency psychiatric or alcohol/substance use disorder treatment admission requirements.

   b. An obstetric admission which, from date of delivery, exceeds two calendar days for vaginal or four calendar days for a medically necessary cesarean delivery. After each scenario has been exceeded, the authorization must be submitted within five business days.

   c. A newborn admission which, from date of delivery, exceeds two calendar days for vaginal or four calendar days for a medically necessary cesarean delivery. After each scenario has been exceeded, the authorization must be submitted within five business days.

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

   e. Any newborn/neonate admission or transfer to a NICU.

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

      The following criteria applies:

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

      2. Emergency department services resulting in a direct inpatient admission at the same facility and provided as part of one continuous episode of care are included in the first inpatient hospital day per

diem rate, even if the emergency services are provided on the calendar date preceding the admission date.

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

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

a. Medicare and Medicaid dual eligible, there is no requirement to obtain Medicaid authorization for Medicare covered services. If services are non-covered for Medicare, the provider must follow Medicaid's authorization guidelines. Authorizations are not necessary for recipients who are eligible for Qualified Medicare Beneficiary (QMB) only since Medicaid pays only the co-pay and deductible. If Medicare benefits are exhausted (i.e., inpatient), an authorization from Medicaid's QIO-like vendor must be obtained within 30 days of the receipt of the Medicare EOB. Reference MSM 100 for authorization timeframes related to non-Medicare covered days for a dual eligible recipient.

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

9. Utilization Review (UR) Process

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

a. Concurrent Review

Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period 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 within five business days of the last day of the current/existing authorization period. If the clinical condition does not support the medical necessity or appropriateness of the setting, services are denied or reduced.

b. Retrospective Review

Retrospective review is a review of clinical information to determine whether the services will be approved after services are delivered. Retrospective review, for the purpose of this chapter, refers to cases in which eligibility is determined after services are provided. If the clinical information does not support the medical necessity or appropriateness of 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.

C. Leave of Absence

1. Absences from an acute hospital inpatient or rehabilitation specialty hospital are allowed:

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

   b. Up to, but not exceeding 32 hours from an inpatient rehabilitation specialty hospital for therapeutic reasons, such as preparing for independent living.

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

   a. Last longer than eight hours from an acute hospital; or last longer than eight hours or involving an overnight stay from an inpatient rehabilitation specialty hospital.

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

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

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

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

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

203.2 PROVIDER RESPONSIBILITIES

A. Conditions of Participation

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

a. Be in compliance with applicable licensure requirements.

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

c. Have a Provider Contract with the DHCFP. Refer to MSM Chapter 100, Provider Enrollment.

2. Termination

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

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

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

B. Utilization Review (UR)

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

CFR 482.30 provides that hospitals participating in the Medicaid program must have in effect a UR program under a QIO-like or CMS has determined 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 456.145.

C. 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.

D. Civil Rights Compliance

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

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

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

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

All hospitals are required to submit Form 3058 to their local Nevada Division of Welfare and Supportive Services (DWSS) District Office whenever a hospital admission, discharge or death occurs.

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

G. 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.

H. Claims for Denied Admissions

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

I. Hospital Responsibilities for Services

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

J. Admission Medical Record Documentation

1. Pre-Admission Authorization

The physician (or his/her staff) must obtain prior authorization from the QIO-like vendor for all non-emergency, elective, planned hospital procedures/admissions. Lack of a prior authorization for an elective procedure or admission results in an automatic denial which cannot be appealed. Reference MSM Chapters 200 and 600.

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

2. Physician Certification

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

A physician, physician's assistant, or advanced practice registered nurse 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)

3. Plan of Care

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

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

b. A description of the functional level of the recipient;

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

d. Plans for continuing care, as appropriate; and

e. Plans for discharge, as appropriate.

K. Discharge Planning

A hospital must ensure the following requirements are met:

1. There is documented evidence that a discharge evaluation is initiated as soon as practical after admission 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 initiated and completed; a recipient or a person acting on the behalf of a recipient requesting a discharge evaluation; or when requested by a physician.

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

3. Re-evaluation of a recipient's condition and needs is conducted, as necessary, during the discharge planning process and the plan must be updated with changes identified.

4. The discharge plan includes documented evidence of:

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

    b. An alternate plan when a specific discharge intervention or placement effort fails.

    c. Significant contacts with the recipient, family, or legally authorized representative, when applicable.

    d. A recipient’s understanding of his/her condition, discharge evaluation results and discharge plan.

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

    f. 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.

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

    h. 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.

5. Prior to NF placement, the following documents are completed and in recipient’s medical record:

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

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

Refer to MSM Chapter 500 for NF screening requirements.

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

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

L. Financial and Statistical Data 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.

M. Medicare/Medicaid Crossovers

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

A provider must:

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

2. 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.

3. Obtain prior authorization from the DHCFP's QIO-like vendor in accordance with the MSM Chapter 200, Coverage and Limitations, Authorization Requirements.

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

N. Maternity/Newborn Federal Length of Stay Requirements

The Newborns' and Mothers' Health Protection Act (NMPHA) and 29 CFR 2590.711 allows a recipient receiving maternity care or a newborn infant receiving pediatric care to remain in the hospital for no less than two days after a normal vaginal delivery or four days after a cesarean section delivery except when an attending physician, in consultation with the birthing person, makes a decision to discharge a birthing person or newborn infant prior to these timeframes.

O. Sterilization Consent Form

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

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

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

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

1. Non-Emergency Transfers

   a. 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.

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

2. Emergency Transfers

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

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

1. Reference MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services.

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

R. Submission of Medical Documentation

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

S. Adverse Determination

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

1. If a provider does not agree with the DHCFP QIO-like vendor's adverse determination, a peer-to-peer review or a reconsideration review can be requested. Reference the QIO-like vendor's/DHCFP's Billing Manual for details.

2. A provider must submit all additional pertinent documentation or information not included with the authorization request supporting services requested (e.g. documentation related to severity of illness, intensity of services, a physician's risk assessment) to the QIO-like vendor by the date of the reconsideration review. This information must be provided in the format required by the QIO-like vendor.

3. Pertinent medical information not provided to the QIO-like vendor in the required format by the reconsideration date of decision, will not be subsequently considered by the QIO-like vendor.

   a. Verbal information provided by an individual other than a recipient's attending physician must be supported by either written attestation of this information in the medical record specifically provided to the QIO-like vendor with the authorization or reconsideration review request.

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

T. 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.

204 ADMINISTRATIVE DAY POLICY

Administrative days are inpatient hospital days reimbursed at a lower per diem rate when a recipient’s status no longer meets an acute 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.

204.1 COVERAGE AND LIMITATIONS

A. COVERED SERVICES

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

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

3. Skilled administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital or CAH as a reduction in LOC for:

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

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

   c. A newborn with medical complications (not requiring acute care services) waiting for placement.

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

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

4. Intermediate administrative (intermediate care level) days are covered in an inpatient or CAH when:

    a. Services do not meet an acute LOC;

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

    c. 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).

B. NON-COVERED SERVICES

Administrative days are not covered when:

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

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

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

4. 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.

204.2 AUTHORIZATION REQUIREMENTS

A. Prior authorization is required.

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

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

204.3 PROVIDER RESPONSIBILITIES

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

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

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

1. All placement efforts, contacts and contact results;

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

3. Physicians' orders and/or progress notes;

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

5. Acceptable reason and timeframes of unavoidable discharge planning delay.

205 SWING BED SERVICES POLICY

Reference Chapter 200, Attachment A, Policy #02-03, Hospital with Swing Beds.

206 OUTPATIENT HOSPITAL SERVICES POLICY

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

206.1 COVERAGE AND LIMITATIONS

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

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

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

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

4. For Partial Hospitalization Program (PHP) – Policy on an outpatient alternative to an inpatient psychiatric care program with services furnished under a medical model by a hospital or Federally Qualified Health Center (FQHC). Refer to MSM Chapter 400 – Mental Health and Alcohol/Substance Abuse Services for PHP policy.

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

B. Emergency Department Services

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

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

Laboratory and radiological services ordered during the course of emergency department 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 department 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.

C. Outpatient Observation Services

Reference Chapter 200, Attachment A, Policy #02-04, Outpatient Observation Services.

207 AMBULATORY SURGICAL CENTER SERVICES POLICY

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

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

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

207.1 COVERAGE AND LIMITATIONS

A. The DHCFP reimburses for services provided in a freestanding ambulatory surgical center or an ambulatory surgical setting within a general hospital. Some ambulatory surgical center services require QIO-like vendor authorization Reference MSM Chapter 200, Ambulatory Surgical Services Policy, Authorization Process.

B. Ambulatory surgical services are not reimbursable when:

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

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

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

4. The probability of significant, rapid onset of complications is exceptionally high. Actual manifestation of such complications would require prompt intervention/measures available only in an inpatient setting.

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

6. 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.

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

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

C. Higher Setting of Service Delivery

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

D. Non-Covered Procedures

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

E. Approval Process

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

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

2. Procedures that would not routinely be covered by the DHCFP; and

3. 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.

207.2 PROVIDER RESPONSIBILITIES

Please reference MSM Chapter 200, Inpatient Hospital Services Policy, Provider Responsibilities for service provider responsibility.

207.3 AUTHORIZATION PROCESS

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

A. Provider must submit the required authorization form.

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

C. All supporting medical documentation the requesting physician would like considered.

D. Procedure pre-approval requests:

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

2. Require up to two working days to process.

3. Date of Service (DOS) must be within 30 days from the Prior Authorization's date of issue.

E. Retroactive Eligible Recipients

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

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

F. Prior Authorization Is Required When:

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

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

3. 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.

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

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

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

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

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

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

G. Prior Authorization is Not Required When:

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

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

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.

208.1 COVERAGE AND LIMITATIONS

A. COVERED SERVICES

1. The DHCFP reimburses medically necessary services meeting coverage requirements, provided in either a freestanding long-term acute care hospital or a long-term acute unit of a general hospital.

2. All of the following criteria must be met:

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

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

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

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

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

B. NON-COVERED SERVICES

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

1. A recipient does not meet eligibility requirements;

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

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

208.2 PRIOR AUTHORIZATION

A. Prior Authorization is required, except for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Reference MSM Chapter 100, Authorization.

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

C. LTAC specialty hospital's policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, Inpatient Hospital Services Policy, Coverage and Limitations, Authorization Requirements.

208.3 PROVIDER RESPONSIBILITIES

Providers must:

A. Be in compliance with provider responsibilities specified in the MSM Chapter 200, Inpatient Hospital Services Policy, Provider Responsibilities.

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

209 INPATIENT REHABILITATION SPECIALTY HOSPITAL SERVICES POLICY

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

209.1 COVERAGE AND LIMITATIONS

A. COVERED SERVICES

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

2. All the following criteria must be met:

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

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

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

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

e. Rehabilitative service is provided a minimum of either three hours per day, five days per week, or 15 hours within each seven-consecutive day period, beginning the date of admission.

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

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

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

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

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

   c. 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.

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

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

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

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

B. NON-COVERED SERVICES

Inpatient rehabilitation services are not covered when:

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

2. The level of rehabilitative care required can be safely and effectively rendered in an alternate, less intensive setting, such as an outpatient rehabilitation department or a SNF; or

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

209.2 PRIOR AUTHORIZATION

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

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

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

D. Inpatient rehabilitation hospital policy is consistent with applicable inpatient prior authorization and utilization review policies, MSM Chapter 200, Inpatient Hospital Services Policy, Coverage and Limitations, Authorization Requirements,

209.3 PROVIDER RESPONSIBILITIES

A. Providers must be in compliance with Provider Responsibilities specified in the MSM Chapter 200, Hospital Inpatient Services Policy, Provider Responsibilities.

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

1. 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.

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

3. 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.

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

1. Comprehensive, 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;

2. Individualized and specify the intensity, frequency, and duration of therapies and the anticipated, quantifiable treatment goals; and

3. Modified with changes in medical or functional status, as applicable.

210 HEARINGS

Reference MSM Chapter 3100 – Hearings for the hearings process.

A. DESCRIPTION

Section 2301 of the Affordable Care Act (ACA) requires coverage of services furnished at freestanding birthing centers. A freestanding birthing 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 freestanding birthing 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. Freestanding birthing center complies with Section 2301 of the ACA freestanding birthing center requirements related to the health and safety of recipients provided services by licensed freestanding birthing centers.

B. POLICY

The DHCFP freestanding birthing 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. Freestanding birthing center coverage and reimbursement are limited to women admitted to a freestanding birthing 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 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

a. Freestanding birthing 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 freestanding birthing center protocol;

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

b. Freestanding birthing centers are not eligible for reimbursement if:

1. The pregnancy is high-risk.

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

3. The recipient is discharged prior to delivery.

2. NON-COVERED SERVICES

   a. Emergency treatment as a separately billed service provided by the freestanding birthing 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 freestanding birthing center. For policy related to emergency transportation – refer to MSM Chapter 1900 – Transportation Services.

E. PROVIDER REQUIREMENTS

Freestanding birthing centers must meet the following criteria:

1. Have a provider contract with the DHCFP. Refer to MSM Chapter 100 – Medicaid Program, Provider Enrollment.

2. Meet applicable state licensing and/or certification requirements in the state in which the center is located.

3. Licensure from Health Care Quality and Compliance (HCQC) as a freestanding birthing center.

4. Informed consent: Each recipient admitted to the freestanding birthing 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.

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, titled "Limited Services Available to Certain Aliens." Provision of outpatient emergency dialysis health care services through the Federal Emergency Services (FES) Program is also deemed an emergent service for this eligibility group. The FES Program is also known as Emergency Medicaid Only (EMO).

B. DEFINITIONS

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

1. Federal Emergency Service (FES) Program – The DHCFP will reimburse only for the non-citizens care and services which are necessary for the treatment after sudden onset of an emergency condition. As defined in 42 CFR 440.255, an emergency condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

   a. Placing the FES recipient's health in serious jeopardy;

   b. Serious impairment to bodily functions; or

   c. Serious dysfunction of any bodily organ or part.

2. FES recipient – Means a qualified or non-qualified non-citizen as described by 42 CFR 435.406(c) and 42 CFR 436.406(c) who receives services pursuant to 42 CFR 440.255.

3. Acute – Means symptoms that have arisen quickly, and which are short-lived.

4. Chronic – Means a health-related state that is not acute persisting for a long period of time or constantly recurring. The only chronic condition covered by the FES Program is ESRD.

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). This chronic condition is covered.

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

1. Refer to ICD-10-CM Emergency Diagnosis Codes for Non-Citizens with Emergency Medical Only Coverage for a list of diagnosis codes that may meet the criteria of EMO services.

2. Any acute emergency medical condition that meets the definition of FES Program as identified above in the definitions described and 42 CFR 440.255.

3. Outpatient dialysis services for a 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:

   a. Placing the FES Program recipient's health in serious jeopardy;

   b. Serious impairment of bodily functions; or

   c. Serious dysfunction of a bodily organ or part.

D. PRIOR AUTHORIZATION

1. Authorization requirements for all emergency services under 42 CFR 440.255 must follow authorization requirements as outlined in MSM Chapter 200.

2. Prior authorization is not required for ESRD services.

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

E. NON-COVERED SERVICES

1. FES Program – 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 "FA 100 – Initial Emergency Dialysis Case Certification" form is incomplete and/or missing from the FES recipient's medical record.

   b. The "FA 101 – Monthly Emergency Dialysis Case Certification" form is incomplete and/or missing from the FES recipient's medical record.

F. ESRD PROVIDER REQUIREMENTS

1. Treating physicians must complete and sign the "FA 100 – Initial Emergency Dialysis Case Certification" form and the "FA 101 – Monthly Emergency Dialysis Case Certification" form. These forms must be maintained in the FES recipient's medical record. These forms are found on the QIO-like vendor website.

2. The DHCFP may audit FES Program recipient medical records to ensure compliance with the initial and monthly requirement.

3. For billing instructions, please refer to the QIO-like vendor's Billing Manual and/or PT45 and 81 Billing Guide.

A. DESCRIPTION

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

B. POLICY

This policy is specific to an acute inpatient bed that provides post-acute 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 for Medicare and Medicaid dual eligible recipients when Medicare benefits are not exhausted. Refer to MSM Chapter 100, Authorization.

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

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

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

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

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

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

      2. Nutritional supplements in conjunction with tube feedings.

      3. Personal appliances and devices, if recommended by a physician, such as eyeglasses, hearing aids, braces, prostheses, etc.

      4. Customized durable medical equipment.

      5. Emergency transportation.

6. Physical, occupational and speech therapy services.

7. Physician services.

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

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

2. NON-COVERED SERVICES

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

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 203.2, 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 NF 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 LOC; and

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

A. DESCRIPTION

Outpatient observation services are physician ordered, clinically appropriate, short term hospital outpatient services including diagnostic assessment and treatments provided when a recipient's medical needs do not meet acute inpatient care guidelines. A recipient's condition is further evaluated to determine if inpatient admission is required, or the recipient can be safely discharged. Outpatient observation services do not have to be provided in a designated hospital observation unit. Outpatient 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

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

Medically necessary ancillary services (e.g. laboratory, radiology and other diagnostics, therapy and pharmacy services) that meet the coverage and authorization requirements of the 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:

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

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

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

c. An unstable presentation with vague symptoms and no definitive diagnosis; or

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

e. A significant adverse reaction occurs subsequent to a therapeutic service (e.g., blood or chemotherapy administration, dialysis);

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

2. NON-COVERED SERVICES

a. Observation hours exceeding the 48-hour limit.

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

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

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

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

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

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

h. Services immediately preceding an inpatient admission for elective induction of labor (EIOL) prior to 39 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 NCU on the date of service or not covered by or performed in compliance with this or any other MSM Chapter.

3. DOCUMENTATION REQUIREMENTS

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

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

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

1. A significant complication or adverse reaction that requires services that would normally be included in a recovery or post-procedure period; or

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