MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 12, 2015

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 200 – HOSPITAL SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 200 are being proposed to clarify policy regarding: authorization and reimbursement of elective cesarean delivery and early induction of labor prior to 39 weeks gestation; authorization requirements related to newborn admissions and deliveries prior to a hospital admission; concurrent review submission timeframes; and sterilization consent forms. The administrative days, hospitals with swing beds, and observation policies have been clarified and relocated from the body of Chapter 200, to Chapter 200 Attachment A. Policy was added regarding: authorization requirements and reimbursement of ancillary services in addition to the swing bed per diem rate and the observation hourly rate; reimbursement of ancillary services subsequent to the observation 48 hour policy limit; and covered/non-covered observation services. Required documentation related to administrative days, hospitals with swing beds, and observation services was added. In addition, QIO-like vendor processes, billing language, and language already in other MSM Chapters were removed.

These changes are effective March 1, 2015.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 05/15 CHAPTER 200 - HOSPITAL SERVICES	MTL 20/11, 27/12 CHAPTER 200 - HOSPITAL SERVICES

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
200	**Introduction**	Updated the name of the Nevada Health Division.
201	**Authority**	Added the Code of Federal Regulations authority related to sterilization services, administrative days, and NRS Chapter 449 authority headings.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
203.1A.1.g	**Coverage and Limitations**	Clarified authorization requirements and reimbursement regarding early induction of labor prior to 39 week gestation and elective cesarean section.
203.1A.2.f.5	**Authorization Requirements**	Clarified concurrent review submission timeframes.
203.1A.2.f.12	**Authorization Requirements**	Modified reference regarding location of the swing bed policy.
203.1A.2.g.3,4	**Authorization Requirements**	Clarified newborn admission authorization requirements related to both medically necessary and elective cesarean section delivery, and delivery prior to hospital admission.
203.1A.2.h.3	**Authorization Requirements**	Moved Administrative Days policy to Attachment A, Policy #02-03.
203.1B.16	**Provider Responsibilities**	Removed sterilization consent form language, referenced MSM Chapter 600 and the QIO-like vendor's Sterilization and Abortion Billing Instructions.
203.3	**Swing-Bed Services Policy**	Moved policy to Attachment A, Policy #02-04.
203.4.A.3	**Outpatient Hospital Services Policy-Coverage and Limitations**	Moved Observation Services policy, to Attachment A, Policy #02-05.
Policy #02-03	**Administrative Days**	Added documentation requirements, removed QIO-like vendor process language and clarified policy.
Policy #02-04	**Hospital with Swing Beds**	Added authorization requirements, coverage of services reimbursed in addition to the per diem rate, provider responsibilities and documentation requirements, and language referencing Chapter 500 PASRR and LOC requirements. Removed QIO-like vendor process and billing language and language duplicated in other MSM Chapters.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Policy #02-05	**Outpatient Observation Services**	Added reimbursement of ancillary services both in addition to and subsequent to the observation 48 hour policy limit. Added and clarified covered and noncovered services and provider responsibilities.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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200 INTRODUCTION

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

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

In Nevada, hospitals are licensed by the Bureau of Health Care Quality and Compliance (HCQC) within the Nevada 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 authorizing varying percentages of federal financial participation for states that elect to offer medical programs. The states must offer at least 11 basic required medical services. Two of these services are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20).

B. Other authorities include:

1. Section 1861 (b) and (e) of the Social Security Act (Definition of Services)

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

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

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

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

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

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

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

9. 42 CFR Part 440.255 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 requirements

202 RESERVED

203 POLICY

203.1 INPATIENT HOSPITAL SERVICES POLICY

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

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

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

c. meets the requirements for participation in Medicare; and

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

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

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

Out of State Acute Hospital Services

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

In-State and Out-of State Acute Hospital Transfers

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

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

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

203.1A COVERAGE AND LIMITATIONS

1. Admission

a. Admission Criteria

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

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

2. acute care services are rendered;

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

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

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

b. Admission Order

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

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

c. Admission Date

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

d. Planned and Transfer Admissions

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

e. Inpatient Admission from Observation

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

f. Military or Veterans' Hospitals

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

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

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

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

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

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

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

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

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

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

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

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

5. Additional inpatient days must be requested 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 21or to a psychiatric wing of a general acute hospital, regardless of age.

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

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

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

12. Swing bed admissions in rural or Critical Access Hospital. Reference 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 203.1A.3, Absences.

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

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

16. Admissions resulting from EPSDT screening.

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

1. 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. Administrative Days

Reference Chapter 200, Attachment A, Policy #02-03.

4. Leave of Absence

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

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

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

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

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

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

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

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

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

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

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

203.1B PROVIDER RESPONSIBILITIES

1. Patient Liability

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

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

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

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

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

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

5. No PL is taken from Medicaid recipients during periods of Medicare coverage. Beginning with the first non-Medicare covered day, hospitals must access PL at the Medicaid LOC and per diem rate for that hospital.

2. Conditions of Participation

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

1. be in compliance with applicable licensure requirements.

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

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

b. Termination

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

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

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

3. Utilization Review (UR)

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

CFR 482.30 provides that hospitals participating in the Medicaid program must have in effect a UR program under a QIO-like or CMS has determined that the UR procedures established by the Medicaid program are superior to the procedures under the QIO-like vendor, and meet the UR plan requirements under 42 CFR 456.50 through 456.24

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 Nevada Revised Statues (NRS) 449.730 pertaining to patient's rights.

9. Claims for Denied Admissions

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

10. Hospital Responsibilities for Services

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

11. Admission Medical Record Documentation

a. Pre-Admission Authorization

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

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

b. Physician Certification

A physician's order, written prior to or at the time of admission, is required for all

inpatient admissions. If a recipient applies for assistance while in the hospital, a physician's order for inpatient admission is required before reimbursement is authorized.

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

c. Plan of Care

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

The plan of care must include:

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

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

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

4. plans for continuing care, as appropriate; and

5. plans for discharge, as appropriate.

12. Discharge Planning

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

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

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

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

e. The planner must be aware of and identify the LOC or level of services necessary to maintain the recipient out of the hospital setting.

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

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

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

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

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

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

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

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

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

n. A discharge from the hospital is validated by a physician's discharge order. Any

readmission following a discharge is treated as a new/separate admission, even if the readmission occurs within 24 hours of the discharge.

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

13. Financial Data and Reports

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

14. Medicare/Medicaid Crossovers

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

A provider must:

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

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

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

QMB claims denied by Medicare are also denied by DHCFP.

15. Maternity/Newborn Federal Length of Stay Requirements

A provider must allow a recipient receiving maternity care or a newborn infant receiving

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

16. Sterilization Consent Form

Reference MSM Chapter 600, Attachment B, Sterilization Consent Form; and the QIO-like vendor's Sterilization and Abortion Policy under Provider, Billing Instructions, Billing Information.

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

a. Non Emergency Transfers

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

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

b. Emergency Transfers

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

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

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

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

19. Submission of Medical Documentation

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

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

20. Adverse Determination

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

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

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

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

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

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

21. Adherence to Requirements

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

203.2 SPECIALTY HOSPITAL

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

a. Medical (Rehabilitation) Hospital Services Policy

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

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

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

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

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

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

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

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

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

203.3 SWING-BED SERVICES POLICY

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.

   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 NURSING FACILITY (NF) PLACEMENT SCREENING REQUIREMENTS

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

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

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

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

Hospital Responsibilities for Discharge to a NF must include:

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

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

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

Time Frames for Screening Process:

4. PASRR Screening Process:

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

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

5. Level of Care (LOC) Screening Process:

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

204 HEARINGS

Reference Chapter 3100 for Hearing Process.

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

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

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

Administrative days are inpatient days reimbursed at a lower per diem rate when a recipient's status no longer meets an acute level of care (LOC) and placement in an alternative appropriate setting is not available despite a hospital's documented, comprehensive discharge planning efforts.

B. POLICY

The DHCFP reimburses skilled nursing or intermediate administrative days authorized by the QIO-like vendor in increments not exceeding seven calendar days per request.

At least one acute inpatient hospital day (24 hours) must immediately precede an administrative skilled nursing or intermediate LOC. Reimbursement is not available for admission directly 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. PRIOR AUTHORIZATION IS REQUIRED.

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

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

a. Skilled nursing 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 regarding 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.

b. 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. a recipient was not approved for at least one acute inpatient hospital day immediately preceding 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 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 (e.g.,12-10-2013) for court appointed guardianship related to out-of-state NF placement.

E. PROVIDER RESPONSIBILITIES

1. Submit all pertinent discharge planning information to the QIO-like vendor with the prior authorization request 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.

F. DOCUMENTATION

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

1. Monday through Friday 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. modifications to the discharge plan, whenever applicable; and

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

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

b. skilled nursing services;

c. 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:

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

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

g. n unstable presentation with vague symptoms and no definitive diagnosis; or

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

i. 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.

j. 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.