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.

POLICY

The DHCFP reimburses skilled nursing or intermediate administrative days authorized by the QIO-like vendor in increments not exceeding seven (7) 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.)

PRIOR AUTHORIZATION IS REQUIRED.

Retrospective authorization must be obtained when Medicaid eligibility is determined after admission to or discharge from a swing bed.

COVERAGE AND LIMITATIONS

COVERED SERVICES

1. Skilled nursing administrative (Skilled Nursing Level) days are covered in an acute inpatient hospital as a reduction in level of care for:
   a. a recipient waiting for evaluation and/or placement regarding a Nursing Facility (NF)/extended care facility, group home, independent living, residential treatment center (RTC), Institution for Mental Disease, psychiatric or an 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, or 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 prevent 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.
2. Intermediate administrative (Intermediate Care Level) days are covered in an inpatient or critical access hospital when:
   a. services do not meet an acute level of care;
   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.)

NON COVERED SERVICES

Administrative days are not covered when:

1. a recipient was not approved for at least one acute inpatient hospital day immediately preceding 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, 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.
4. a hospital has not provided documented evidence of a comprehensive discharge plan or an acceptable reason and timeframe of an unavoidable delay, such as awaiting a specifically identified court date (e.g., 12-10-2013) for court appointment of guardianship to allow an out-of-state NF placement.

PROVIDER RESPONISBILITIES

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.

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.

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.

POLICY

This policy is specific to an acute inpatient bed that provides post acute Nursing Facility (NF) services. DHCFP reimburses post acute/NF swing bed days when: a recipient receiving acute inpatient hospital services for at least three (3) 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 refused 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.

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 may require prior authorization. Reference the MSM Chapter applicable to the service type (e.g., MSM Chapter 1200 for Pharmacy Services and MSM Chapter 1300 for DME and Supplies) regarding authorization requirements.

COVERAGE AND LIMITATIONS

COVERED SERVICES

1. Medically necessary, post acute, nursing facility level of care services provided on an inpatient basis and reimbursed on a per diem rate. The per diem rate includes routine services and supplies, including a regular room, dietary, nursing services, social services, activities, medical supplies, oxygen, and the use of equipment and facilities.
2. The following services are separately reimbursed when the service meets policy requirements specific to that service:
   a. Drugs available by prescription only, including compounded prescriptions and TPN solution and additives.
   b. Nutritional supplements in conjunction with tube feedings.
   c. Personal appliances and devices, if recommended by a physician, such as eye glasses, hearing aids, braces, prostheses, etc.
   d. Customized durable medical equipment
   e. Emergency transportation.
   f. Physical, Occupational and Speech therapy services.
   g. Physician services.
   h. Laboratory, portable x-ray and other diagnostic services.

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

NON COVERED SERVICES

1. 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.
2. Swing bed days not authorized by the QIO-like vendor.

PROVIDER RESPONISBILITIES

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

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
   d. 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.

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.

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.

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 (e.g., MSM Chapter 300 for Radiology Services and MSM Chapter 1200 for Pharmacy Services) regarding authorization requirements.

COVERAGE AND LIMITATIONS

COVERED SERVICES

1. 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.
2. Observation days are covered when:
   a. a recipient is clinically unstable for discharge from an outpatient setting due to either:
      1. a variance from generally accepted, safe laboratory values;
      2. clinical signs and symptoms above or below normal range requiring an extension of monitoring and further evaluation;
      3. an unstable presentation with vague symptoms and no definitive diagnosis; or
      4. an uncertain severity of illness or condition in which a change in status requiring medical intervention is anticipated.
   b. a significant adverse reaction subsequent to a therapeutic service (e.g., blood or chemotherapy administration, dialysis) or diagnostic procedure (e.g., cardiac catheterization) or 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.

c. a recipient meets medical necessity criteria for observation services, the provider is notified that inpatient admission is denied because it does not meet acute level of care criteria, and the physician writes an order for observation status.

NONCOVERED SERVICES

1. Observation hours exceeding the 48 hour limit.
2. 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.
3. Diagnostic testing or outpatient procedures prescribed for a medically stable individual or services deemed by the DHCFP, DHCFP's QIO-like vendor, or other authorized agency as not medically necessary or appropriate.
4. 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.
5. 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)
6. 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.
7. Services that are routine preparation prior to or monitoring after a diagnostic test, treatment, procedure, or outpatient same-day surgery.
8. 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.
9. Services provided solely for the convenience of a recipient, recipient's family or physician.
10. 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.

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.