200 AUTHORITY

A. In 1965, the 89th Congress added Title XIX of the Social Security Act authorizing varying percentages of federal financial participation for states that elect to offer medical programs. The states must offer at least 11 basic required medical services. Two of these services are inpatient hospital services (42 Code of Federal Regulations (CFR) 440.10) and outpatient hospital services (42 CFR 440.20).

B. Other authorities include:

1. Sections 1861 (b) and (e) of the Social Security Act (Definition of Services);
2. 42 CFR Part 482 (Conditions of Participation for Hospitals);
3. 42 CFR Part 456.50 to 456.145 (Utilization Control);
4. Nevada Revised Statutes (NRS) 449 (Classification of Hospitals in Nevada);
5. 29 CFR Part 2590.711 (Standards Relating to Benefits for Mothers and Newborns);
6. Section 2301 of the Affordable Care Act (ACA) (Federal Requirements for Freestanding Birthing Centers);
7. NRS Chapter 449 (Hospitals, Classification of Hospitals and Freestanding Birthing Center Defined);
8. Nevada Administrative Code (NAC) Chapter 449 (Provision of Certain Special Services-Obstetric Care);
9. 42 CFR Part 440.255~~;~~ "Limited services available to certain aliens";
10. NRS Chapter 422 Limited Coverage for certain ~~aliens~~non-citizens including dialysis for kidney failure;
11. 42 CFR 435.406 (2)(i)(ii) (permitting States an option with respect to coverage of certain qualified ~~aliens~~non-citizens subject to the five-year bar or who are non-qualified ~~aliens~~non-citizens who meet all Medicaid eligibility criteria);
12. 42 CFR 441, Subpart F (Sterilizations);~~ and~~
13. 42 CFR 447.253(b)(1)(ii)(B) (Other requirement)~~.~~; and
14. Newborns' and Mothers' Health Protection Act (NMHPA).

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

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

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

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

## 203.1 COVERAGE AND LIMITATIONS

### A. Admission

#### 1. Admission Criteria

The DHCFP considers the recipient admitted to the hospital when:

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

b. Acute care services are rendered;

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

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

Before admission to any in-state or out-of-state acute inpatient hospital (e.g. general, critical access, inpatient rehabilitation, or LTAC specialty hospitals) or before authorization of payment, a physician and other personnel involved in the care of the recipient must establish a written plan of care for each applicant or recipient. Reference MSM Chapter 200, Admission Medical Record Determination, Plan of Care.

2. Admission Order

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

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

3. Admission Date

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

4. Planned and Transfer Admissions

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

5. Inpatient Admission from Observation

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

6. Veterans' Hospitals

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

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

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

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

Coverage/reimbursement of ~~non-medically necessary~~ obstetric admissions for elective/non-medically necessary cesarean section (e.g., performed for the convenience of the physician or recipient) is not a covered service.~~limited to the minimum federal requirement (two days) for a normal vaginal delivery and must be prior authorized.~~

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

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

B. Authorization Requirements

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

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

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

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

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

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

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

6. Inpatient Admission Requiring Prior Authorization

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

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

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

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

   ~~c. Hospital admissions for elective/non-medically necessary cesarean sections.~~

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

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

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

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

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

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

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

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

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

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

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

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

~~n.~~m. Non-Medicare covered days within 30 days of the receipt of the Medicare Explanation of Benefits (EOB) indicating Part A Medicare benefits are exhausted. Reference MSM Chapter 100, Authorization.

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

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

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

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

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

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

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

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

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

The following criteria applies:

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

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

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

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

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

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

9. Utilization Review (UR) Process

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

a. Concurrent Review

Concurrent Review is a review of clinical information to determine whether the services will be approved during the time period services are being provided. Initially the QIO-like vendor assigns a length of stay based on the diagnosis and condition of the recipient. For complex cases, additional days may be authorized to manage the medical condition through the concurrent review process. Additional inpatient review days must be requested within five business days of the last day of the current/existing authorization period. If the clinical condition does not support the medical necessity or appropriateness of the setting, services are denied or reduced.

b. Retrospective Review

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

C. Leave of Absence

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

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

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

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

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

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

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

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

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

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

## 203.2 PROVIDER RESPONSIBILITIES

### A. Conditions of Participation

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

   a. Be in compliance with applicable licensure requirements.

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

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

2. Termination

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

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

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

### B. Utilization Review (UR)

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

CFR 482.30 provides that hospitals participating in the Medicaid program must have in effect a UR program under a QIO-like or CMS has determined the UR procedures established by the Medicaid program are superior to the procedures under the QIO-like vendor and meet the UR Plan requirements under 42 CFR 456.50 through 456.145.

C. Quality Assurance – Hospital Medical Care Evaluation Studies

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

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

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

D. Civil Rights Compliance

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

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

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

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

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

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

G. Patient Rights

Pursuant to 42 CFR 482.13, a hospital must protect and promote each patient's rights. Hospitals are also required to comply with Nevada Revised Statues (NRS) 449.730 pertaining to patient's rights.

H. Claims for Denied Admissions

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

I. Hospital Responsibilities for Services

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

J. Admission Medical Record Documentation

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

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

2. Physician Certification

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

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

3. Plan of Care

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

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

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

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

d. Plans for continuing care, as appropriate; and

e. Plans for discharge, as appropriate.

K. Discharge Planning

A hospital must ensure the following requirements are met:

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

2. A registered nurse, social worker or other appropriately qualified personnel reviews all Medicaid admissions and develops or supervises the development of a discharge plan. The discharge plan must specify goals and resolution dates, identify needed

discharge services, and be developed with input from the primary care staff, recipient and/or family, and physician as applicable.

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

4. The discharge plan includes documented evidence of:

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

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

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

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

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

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

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

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

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

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

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

Refer to MSM Chapter 500 for NF screening requirements.

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

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

L. Financial and Statistical Data Reports

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

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

M. Medicare/Medicaid Crossovers

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

A provider must:

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

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

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

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

N. Maternity/Newborn Federal Length of Stay Requirements

The Newborns' and Mothers' Health Protection Act (NMHPA) and 29 CFR 2590.711 allows~~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~~ 2 days after a normal vaginal delivery or ~~96 hours~~ 4 days after a cesarean section delivery except when an attending physician, in consultation with the birthing person, makes a decision to discharge a ~~mother~~ birthing person or newborn infant prior to these timeframes.

O. Sterilization Consent Form

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

# 207 AMBULATORY SURGICAL CENTER SERVICES POLICY

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

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

Observation/Medical short stay refers to the "ambulatory" recipient with a coexisting medical condition or some unforeseen medical situation who may remain in a hospital environment for an extended period. This extended stay, called observation or medical short stay can be used to assure recipient stability without an inpatient admission. The recipient may occupy any hospital unit. Observation recipients may be rolled over for inpatient admission any time the patient requires acute care services. All rollovers to inpatient care require QIO-like vendor's authorization within ~~24 hours~~5 business days of the admission/rollover. Observation stays which do not rollover to inpatient status are limited to ~~48 hours~~2 days.

## 207.1 COVERAGE AND LIMITATIONS

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

B. Ambulatory surgical services are not reimbursable when:

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

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

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

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

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

A. INTRODUCTION

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

B. DEFINITIONS

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

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

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

   b. Serious impairment to bodily functions; or

   c. Serious dysfunction of any bodily organ or part.

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

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

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

5. End Stage Renal Disease (ESRD)/Dialysis Services – Means the method by which a dissolved substance is removed from the body of a patient by diffusion, osmosis, and convection from one fluid compartment to another fluid compartment across a semipermeable membrane (i.e., hemodialysis, peritoneal dialysis, and other miscellaneous dialysis procedures). This chronic condition is covered.

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

C. COVERAGE AND LIMITATIONS

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

~~1.~~2. Any acute emergency medical condition that meets the definition of FES Program as identified above in the definitions described and 42 CFR 440.255.

~~2.~~3. Outpatient dialysis services for a FES recipient with ESRD are covered as an emergency service when the recipient's treating physician signs and completes the certification stating that in his/her medical opinion the absence of receiving dialysis at least three times per week, would reasonably be expected to result in any one of the following:

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

b. Serious impairment of bodily functions; or

c. Serious dysfunction of a bodily organ or part.

D. PRIOR AUTHORIZATION

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

2. Prior authorization is not required for ESRD services.

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

E. NON-COVERED SERVICES

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

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

3. Services deemed non-covered when:

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

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

F. ESRD PROVIDER REQUIREMENTS

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

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

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

A. DESCRIPTION

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

A. POLICY

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

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

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

B. 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.

C. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

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

b. Observation days are covered when:

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

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

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

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

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

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

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

2. NON-COVERED SERVICES

a. Observation hours exceeding the 48-hour limit.

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

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

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

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

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

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

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

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

j. Services provided to an individual not eligible (concurrently or retrospectively) for Medicaid or NCU on the date of service or not covered by or performed in compliance with this or any other MSM Chapter.

3. DOCUMENTATION REQUIREMENTS

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

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

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

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

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