200 INTRODUCTION

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

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

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

In Nevada, hospitals are licensed by the Bureau of Health Care Quality and Compliance (HCQC) within the Nevada Division of Public and Behavioral Health (DPBH).

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

201 AUTHORITY

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

B. Other authorities include:

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

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

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

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

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

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

7. NRS Chapter 449 (Hospitals, Classification of Hospitals and ~~Obstetric/~~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 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) and

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

203 INPATIENT HOSPITAL SERVICES POLICY

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

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

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

3. Meets the requirements for participation in Medicare; and

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

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

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

B. Out-of-State Acute Hospital Services

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

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

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

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

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

D. Newborns and Neonatal Intensive Care Unit (NICU)

The DHCFP utilizes ~~InterQual[1], MCG[2] and~~ the Optum 360 Uniform Billing (UB) Editor[3] to define LOCs needed for each infant and revenue billing codes[4]. These LOCs and revenue codes indicate the nursing care provided to newborn and premature infants in nursery accommodations. These revenue codes range from a healthy newborn to intensive care.

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

DHCFP has defined five levels of care for newborns which correlate to an associated revenue code. The billed revenue code must meet the associated level of care criteria and be supported by documentation in the recipient's medical record.

1. 0170 = General.

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
0170	General Classification Nursery	Normal Newborn Care – Normal healthy newborns with low complexity needs are physiologically stable and are rooming with mom. Hospital must meet American Academy of Pediatrics Level I facility guidelines.

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

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE

0171	Newborn – Level I	Level I Nursery/General Nursery Observation. Provides routine care of apparently normal full-term or pre-term, non-NICU newborn that is not discharged with the mother. Healthy newborns (birth weight > 2000 gms. or gestational age > 35 wks.) with low complexity needs and who are physiologically stable and require routine evaluation and observation during the immediate post-partum period. Examples of care at this level are routine bilirubin and blood glucose monitoring; initiation of phototherapy < 2 days, drug withdrawal management new or continued from higher level; isolette/warmer for thermoregulation of neonates > 35 weeks gestation; diagnostic work-up/surveillance on otherwise stable neonate; services rendered to growing premature infant without supplemental oxygen or IV needs. This level of care corresponds to InterQual Newborn Level I criteria and MCG Level I criteria. Hospital must meet American Academy of Pediatrics Level I facility guidelines.

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

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
0172	Newborn – Level II	Level II Special Care Nursery/Neonatal Intermediate Care. Takes care of the moderately ill or recuperating infants who are over the acute phase of illness. Newborns (birth weight < 2000 gms. or gestational age < 35 wks.) with moderately complex care needs or with physiological immaturity (apnea of prematurity, inability to maintain body temperature, or inability to take oral feedings) combined with medical instabilities. Examples of care at this level are: IV heplock meds; IV fluids; supplemental oxygen via hood or nasal cannula of less than 40%; or feeding via NG, OG, NJ or gastrostomy tube; intensive phototherapy; drug withdrawal therapy; non-invasive hemodynamic monitoring; continuous monitoring of apnea/bradycardia that requires tactile stimulation or periodic oxygen; sepsis evaluation and treatment. This level of care corresponds to InterQual Special Care Level II criteria and MCG Level II criteria. Hospital must meet American Academy of Pediatrics Level IIA facility guidelines.

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

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE

0173	Newborn – Level III	Level III Neonatal Intensive Care. Newborns (birth weight < 1500 gms., or gestational age < 32 weeks, or hemodynamically unstable) with complex medical conditions that require invasive therapies. Examples of care at this level are: supplemental oxygen via hood (2 l/min) or nasal cannula of greater than 40%; intubation with mechanical ventilation; IV pharmacologic treatment for apnea and/or bradycardic episodes; services for apnea or other conditions requiring assisted respiration; positive pressure ventilatory assistance; exchange transfusion, partial or complete; central or peripheral hyperalimentation; chest tube; IV bolus or continuous drip therapy for severe physiologic or metabolic instability; or maintenance of umbilical artery catheters (UACs), peripheral artery catheters (PACs), umbilical vein catheters (UVCs), and/or central vein catheters (CVCs). This level of care corresponds to InterQual Neonatal Intensive Care Level III criteria and MCG Level III criteria. Hospital must meet American Academy of Pediatrics Level IIB/IIIA facility guidelines.

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

REV CODE	REVENUE CODE DESCRIPTION	LEVEL OF CARE
0174	Newborn – Level IV	Level IV Neonatal Intensive Care. Newborns with complex medical conditions that meet Level III criteria and require extracorporeal membrane oxygenation (ECMO); high frequency ventilation; nitric oxide (NO) or complex pre-surgical/surgical interventions for severe congenital malformations or acquired conditions that require use of advanced technology and support or IV bolus or continuous drip therapy for severe physiologic/metabolic instability. This level of care corresponds to InterQual Neonatal Intensive Care Level IV criteria and MCG Level IV criteria. Hospital must meet American Academy of Pediatrics Level IIIB/IIIC/IIID facility guidelines.

~~The following table is a crosswalk from InterQual and MCG LOCs, to the UB Editor for LOCs and revenue codes for reimbursement. Hospitals will submit authorization requests in the Provider Web Portal at the most appropriate InterQual or MCG LOC and UB revenue code(s) based upon the table below:~~

~~LOCs by InterQual[1], MCG[2]~~	~~LOCs by UB Editor[3]~~	~~UB Revenue Codes[4] by UB Editor[3]~~
~~Newborn Nursery~~	~~Level I~~	~~0170 / 0171~~

~~InterQual I / MCG Level I / Transitional Care~~	~~Level II~~	~~0172~~
~~InterQual II / MCG Level II~~	~~Level III~~	~~0173~~
~~InterQual III & IV / MCG Level III & IV~~	~~Level IV~~	~~0174~~

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

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

A. DESCRIPTION

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

B. POLICY

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

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

C. PRIOR AUTHORIZATION IS NOT REQUIRED

D. COVERAGE AND LIMITATIONS

1. COVERED SERVICES

Freestanding b~~B~~irthing 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 freestanding birthing center protocol;

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

Freestanding b~~B~~irthing 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 freestanding birthing center. For emergency treatment provided in a hospital – refer to policy in MSM Chapter 200 – Hospital Services; and

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

E. PROVIDER REQUIREMENTS

Freestanding ~~obstetric/~~birthing centers must meet the following criteria:

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

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

3. Accreditation by ~~one of~~ the ~~following~~ nationally recognized accreditation organization~~s:~~, Commission for the Accreditation of Birth Centers (CABC).

~~a. The Accreditation Association for Ambulatory Health Care, (AAAHC) Inc.;~~

~~b. The Commission for the Accreditation of Birth Centers, (CABC); or~~

~~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 freestanding birthing center will be informed in writing at the time of admission of the nature and scope of the center's program and of the possible risks associated with maternity care and childbirth in the center.

~~5. The birth center must have a written 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